Social Characteristics of Private Medical Colleges in India: A Study of Select States

Thesis Submitted to the Jawaharlal Nehru University in
Fulfilment of the Requirements for the Award of Degree of

DOCTOR OF PHILOSOPHY

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2016

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DECLARATION

Date: 21/07/2016

I hereby declare that the thesis entitled **"Social Characteristics of Private Medical Colleges in India: A Study of Select States"** submitted to the Jawaharlal Nehru University by me for the award of the degree of Doctor of Philosophy is my original work and it has not been submitted in part or full for the award of any other degree of this University or any other University.

Archana Diwate

Certificate

We recommend that this thesis be placed before the external examiners for evaluation for the award of the degree of Doctor of Philosophy

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Dedicated to Aai and Pappa

For their enduring support and love

ACKNOWLEDGEMENTS

Finally writing an acknowledgment for PhD thesis gives immense pleasure that the dream of completion of PhD is coming true. The journey of writing PhD was not at all an lonely journey and in this process there are many people who have believed in me and supported me in many ways and without them writing this thesis wouldn't have been possible.

First and foremost, I am immensely grateful to have Prof. Rama V. Baru as my supervisor. Her constant supervision, guidance and insightful ideas throughout my M. Phil. and PhD provided perspective to this thesis. What I am today is because of her constant encouragement and emotional support that helped me to boost my confidence and believed in me. I am indebted for her support especially during my difficult times that I had to face. She has always been with me whenever I needed her help. It is because of her I am able to finish my thesis. Thank you Mam for being with me always.

I cannot move ahead without expressing gratefulness to all the faculty members of the CSMCH centre as they have shaped and build up a perspective in my thinking and action in these seven years of journey. It is all the faculty members who have supported both of us in difficult times and provided the much needed help in our life.

I am extremely thankful to the CSMCH centre for selecting me to visit the Department of Epidemiology and International Public Health, Bielefeld University, Germany in 2014. I am grateful to the DAAD for providing me the Fellowship to visit the Bielefeld University. I would like to thank to the Department of Epidemiology and International Public Health, Bielefeld University for providing me their time to find out Indian doctors in Germany. Especially I would like to thank Miss Judith Wenner and Miss Jesica for their constant support and time during my stay in Germany. Special thanks goes to Prof. Mario Rutten for his valuable suggestions on my PhD thesis during my visit to University of Amsterdam. I would like to express my deep gratitude to Prof. Maarten Bode who invited me to visit the University of Amsterdam and for his valuable time and support in Amsterdam.

I am extremely grateful to Indian Council of Social Science Research for granting me the fellowship to pursue my doctoral work. This financial support helped me to complete my study.

It is important to recognize the great help provided by the respondents. Especially in Bangalore I would like thank to Dr. Ravi Narayan, Dr. Thelma Narayan, Dr. H. Sudarshan, Dr. D. K. Shrinivas, Dr. Pruthvish, Dr. Priyadarshani, Dr. Hemant, Dr. Venkatesh and Dr. Girish Rao for their valuable time. In Maharashtra I would like to thank Dr. Girija Wagh, Dr. Y. S. Kulkarni, Dr. Kandalkar, Dr. Prakash Doke, Mr. Todkar, and Mr. Prasad Kajale who have provided the needed information and support.

I would like to mention special thanks to Prof. Imrana Qadeer and Dr. Arthi PM for their valuable and critical comments on my PhD work.

It is important to recognize the great help by Jyoti Madam and Dinesh Sir in using documentation unit of CSMCH. I am thankful to the staff of the CSMCH centre Jeevan Mam, Satishji and Rawat Sir who helped me in number of ways during these years. I am also thankful to the JNU library staff who always been supportive in issuing the books and other resources. I would like to express my gratitude to Institute of Social and Economic Change, Bangalore for allowing me use their library. I am extremely thankful to Subhash for helping me in library as well as for my accommodation in Bangalore.

I would like to express my sincere gratitude towards all who have helped and shaped my understanding during study period. I would like to thank the people around me who not only encouraged but also believed in my potentials because of which I could finish my thesis writing. I owe my faithful gratitude to Dr. Pradeep and Samya, Dr. Prachin and Dr. Jayashree, Dr. Milind Awad, Dr. Jyoti Bhosale, Prof. Kharat, Prof. Alone Dr. Vikas Bajpai for their constant guidance and support during my PhD work.

I would like to thank many friends who have always motivated me. Their constant encouragement, support and help not only academically but also at personal level which helped me in a number of ways. I thank, Manisha, Ipsha, Soniya, Tia, Santosh, Pradeep, Sandeep, Ajit, Catherine, Aparna, Jisha, Ipshita, Swapnali, Pravin-Panchi, Chavi, Anjali, Saya, Manisha Paswan, Rakesh, Sameer-Vibha, Rahul, Swapnil, Ashwini, Ramya-Pradeep, Ketaki.

Special mention to Lakshmi Kutti who have always been there for moral and academic support during my PhD work. I am especially gretful to my friend Daksha. Without her support I would have not finished this work. Really thank you so much Daksha. My special thanks goes to Satya-Eddie for their support, encouragement and guidance which always made me feel positive. I am also thankful to Chris-Madhura for their constant support and guidance in my work.

Most special gratitude towards my special friends Pallavi and Kiran for always being with me, motivating me in my difficult times and for their constant emotional support. They have always made me feel good. I am indebted to them for their continued support and love and for being there with me always.

There are no words to express my gratitude and feelings towards my Aai and Pappa. I dedicate this dissertation to both of you. I am thankful to Tai-Bhauji, Dadya-Bhagyashree, for their continued support, patience and love. Shweta with whom I share a different space and her love and constant motivation made this journey less stressful. Sanju Mama and Mami, Appa Mama and Mami, Mahesh Mama-Uja Tai, Yogesh Mama and Mami, Lata Mavashi thanks for being with me always and you all made my field work so comfortably in Karad and Mumbai. Sharvil and Pradynesh thanks for bringing so much joy in my life.

I am extremely grateful towards my in-laws Aai-Anna who have always been supportive and motivated me to finish this work very peacefully. It's their emotional support which led me to finish this work. I am extremely thankful towards my brother-in law Vikas and Sister in law Reshma and my niece Pari for their love and support. Thanks Vikas for always helping me out in many ways especially during my PhD work.

I am immensely grateful to have Dipak as my life partner, who have always supported and motivated me especially in my difficult times. Whenever I felt low during my PhD work he stood behind me and made me to believe on to have hope in life. As his favourite sentence is "*hope is a good thing*". It feels really good that we both are finishing our PhD together.

Archana Diwate

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LIST OF ABBREVIATIONS

AI-PMT	:	All India- Pre Medical Test
AP	:	Andhra Pradesh
BJP	:	Bharatiya Janata Party
BLDEA	:	Bijapur Liberal District Educational Association
BOG	:	Board of Governors
CBHI	:	Central Bureau of Health Investigation
CBI	:	Central Bureau of Investigation
CHC	:	Community Health Centre
CM	:	Chief Minister
COMEDK	:	Consortium of Medical, Engineering and Dental Colleges of Karnataka
CVO	:	Chief Vigilance Officer
EAG	:	Empower Action Group
FAIMER	:	Foundation of Advancement of International Medical Education and Research
GMC	:	General Medical Council
GOI	:	Government of India
GOK	:	Government of Karnataka
GOM	:	Government of Maharashtra
GOM	:	Government of Maharashtra
HDI	:	Human Development Index
HLEG	:	High Level Expert Group
HP	:	Himachal Pradesh
IMED	:	International Medical Education Directory
J & K	:	Jammu and Kashmir
KIMS	:	Kempegowda Institute of Medical Sciences
MBBS	:	Bachelor of Medicine and Bachelor of Surgery
MCI	:	Medical Council of India
MLA	:	Member of Legislative Assembly
MLC	:	Member of Legislative Council
MOU	:	Memorandum of Understanding

MP	:	Member of Parliament
NGO	:	Non-Governmental Organisation
NKR	:	North Karnataka Region
NRI	:	Non Resident of India
OBC	:	Other Backward Caste
PBT	:	People for Better Treatment
PHC	:	Primary Health Centre
PHU	:	Primary Health Unit
PIL	:	Public Interest Litigation
PSM	:	Preventive and Social Medicine
SC	:	Schedule Caste
SKR	:	South Karnataka Region
SOCHARA	:	Society for Community Health Awareness, Research and Action
ST	:	Schedule Tribe
UHC	:	Universal Health Coverage/Care
UK	:	United Kingdom
UP	:	Uttar Pradesh
USA	:	United States of America
UT	:	Union Territory
WFMS	:	World Federation of Medical Education

Introduction

Medical education is one of the important sub systems of the health service system. The aim of medical education is to produce a professional cadre who will serve the health needs of the people. Medicine like law, engineering and information technology are professional courses that occupy a privileged position in higher education for which there is a high demand. Today, India has the largest number of medical colleges in the world and also produces large number of doctors. According to Medical Council India (MCI) data, there are total of four hundred and twelve medical colleges in India which has annual intake capacity of 52,275 seats.[1] This clearly indicates the high level of production of medical doctors in India. Despite the large numbers of doctors being produced India faces huge shortage of doctors (Neelakantan, 2008).

Historically, the health service planning exercises in India have not only conceived of structure for services, but also the required personnel, as reflected in the reports of the Bhore (Bhore Committe, 1946) and the Mudaliar Committee (Mudaliar Committee, 1961) and the Five Year plans. Efforts have been made on specific issues regarding manpower were confronted, as in the case of Multi Purpose Workers Committee (Kartar Singh Committee, 1973) and the Srivastva Committee reports (Srivastva Committee, 1975). Despite these exercises, it is well known that the health services have became lopsided with greater emphasis on urban institutions, an early specialist orientation, and a slowing down of the growth of infrastructure in rural areas. Over time, while the training of paramedics got neglected, a significant increase occurred in the number of medical colleges. After the 1970s, this was primarily in the private sector. These discrepancies that crept in during the late sixties, have been linked to the economic slowdown that brought growth rates to 3.3 percent by the year 1970 (Chandrasekhar and Ghosh, 2002, p.6) and lowered investments in the social sector. It has been argued that, constrained by its social base, the ruling regime was slow to deal with persistent inequalities in society. It was unable to introduce adequate land reforms, and the nature of industrial growth failed to expand employment and consumer markets to the extent needed, despite state support (ibid). It has been

[1] MCI (15th Jan 2016). Medical Council of India, Colleges and Courses Search. As available on http://www.mciindia.org/InformationDesk/CollegesCoursesSearch.aspx as accaessed on 15th Jan 2016.

pointed out that a section of the organised labour class and the rich peasantry were partially accommodated by the ruling alliance (Mathew, 2002, p.94) thus expanding social opportunities for certain classes. When the state could no more support the prevailing direction of development, instead of cutting on its undesirable investments, to protect capitalist classes it opted for external borrowing. As a consequence the state had to accept structural reforms, that included health sector reforms inevitably pressed for privatization (Chandrasekhar and Ghosh, 2002).

These explanations largely relate to the economic and political aspects, barely touching upon the sociological dimensions of shifts in the health sector. Over the last three decades, specifically after 1990, the southern and western States have seen a marked increase in the number of private medical colleges over government medical colleges. While shrinking state investment and the accompanying push for privatization explains the rise of private medical colleges, the questions we ask are, what are the socio-political determinants that would explain the exact processes behind this trend and what are its implications? In other words, why should one be concerned about the growth of these private medical colleges?

It is important to mention that the proliferation of medical colleges was seen in the last few decades mostly after 1970s. Up till 1970 there was a prominent role played by the state to establish government medical colleges in order to achieve self-reliance in human resources in health care. In the decade of 1980's there was a withdrawal of the state role in the social sectors that have impacted on the education sector as well. Thus, there was an increase in the commercialization of health services and medical education due to the space provided by the state. This paved the way to establish large number of medical colleges in the private sector. Today the private sector accounts for over 51.45 per cent as against 48.54 per cent of medical colleges in the government sector[2]. The high level of commercialization and corruption in the medical education in India has impacted upon the nature and quality of medical education (Collier, 2010). The high level of capitation fees in private medical colleges clearly points out that those who can afford this huge cost can only avail medical education. The shortage of faculty in the medical colleges is deteriorating the standards of medical education. Hence, the kind of doctors that are being produced is creating a huge risk

[2] ibid

in the health sector (Ananthakrishnan, 2007; Ananthakrishnan, 2010; Chaudhury, 2008). As Chaudhury (2008) notes that "no country in the world can possibly cope with such an explosive increase in the number of students without a simultaneous increase in the number of trained teachers to impart quality training" (Chaudhury, 2008, p.119).

It is observed that the growth of medical colleges is higher in the southern and western regions of India. Specifically Karnataka, Tamil Nadu, Andhra Pradesh, and Maharashtra. The present study is arguing that the growth of medical colleges have not occurred independently of the government. It has to be contextualised in its social and political environment which led to increase in this growth particularly in the private sector. It is a collusion of various actors which plays an important role in the kind medical education today we have in this country. The recent Vyapam scam is the best and foremost example of this which illustrates the kind of commercialization, corruption and fraudulent process that took place in medical education admission (Baru and Diwate, 2015[3]; Sengupta, 2015; BBC News, 2015).

Karnataka and Maharashtra are the two states have been chosen for the present study as they have large number of medical colleges in India specifically in the private sector. The reasons for the growth is rooted in the history and socio-political context of these states. Scholars have described the process of diversification of agricultural capital. A class of rich peasants or capitalist farmers started investing their surpluses into a variety of enterprises and, over generations, accessed higher education and gained social mobility. They contributed to the commercialization of the economy and social services while retaining their rural roots (Omvedt, 1981; Upadhya, 1988a; Upadhya, 1988b; Rutten, 1986). Growth of private health services was a part of this process (Baru, 1987).

The growth of private higher educational institutions needs to be understood within its social economic and political context. Hence, in this study historical trends and distribution of medical colleges in India have been studied and it undertakes an analysis of the socioeconomic and political determinants of this growth. It shows how

[3] Baru, R. and Diwate, A. (2015, July 12). Vyapam is the Symptom, Criminalisation of Medical Education is the Disease. *The Wire*. Retrieved from http://thewire.in/6170/vyapam-is-the-symptom-criminalisation-of-medical-education-is-the-disease/ 15th October 2015.

the regional elites (or dominant castes) have invested in these institutions as a form of increasing social prestige and business opportunity. It looks at caste and class background of the promoters and their engagement with local and state politics which has created a multi-layered relationship between caste, class (ownership of wealth) and diversification of economic activities in the state of Maharashtra. It also underlines the complexity of social processes underlying the commercialization in health sector, as a part of health sector reforms, which were propelled not just by the economic crisis but also by vested interests.

The first chapter is dealing with the history of medical education and the kind of influence western medical education have on Indian medical education system. It has attempted to see the policy level analysis from independence to the present. The second part of the chapter discusses the research methodology which includes the rational of the study, research questions, objectives, methods and tools, and the data sources that has been used in the study. It also discusses the challenges faced by the researcher while conducting this study which influenced the methodology of the study.

Second chapter analysed the growth and inter-state inequities in the distribution of medical colleges in India. It has discussed, how the growth of medical colleges has taken place both in the public and private sector. As well as through mapping of medical colleges in India, it shows how the medical colleges have been established in uneven manner. It argues that the states which are developed, witnessed the growth of medical colleges and particularly this growth is in the private sector. It also explores the question of human resource planning in health workforce and density of doctors in India. It asks a question whether the growth of medical colleges which produces doctors is able to provide adequate number of doctors in the public health system.

The third chapter discusses socio-political determinants of the growth of private medical colleges in India and argues that the inequities in the provisioning of medical colleges is not merely an empirical artefact. It argues that the growth of institutions has to be located into its historical and socio-political factors that influence the growth of institutions in general and in this case medical colleges in particular. The chapter reviews studies that demonstrate the linkages between development, class/caste and

entrepreneurship in rural and urban areas. It also shows the reflection of these trends on political processes that influences the growth of institutions.

The fourth and the fifth chapters discusses the specific case of the states of Karnataka and Maharashtra. The chapter on Karnataka deals with the growth, trend and the inter-regional disparities in the establishment of medical colleges in the state. The inter-regional disparities in the establishment of medical colleges have been contextualised in its historical development of different regions and pointed out the reasons behind the uneven development which impacted upon the uneven distribution of medical colleges in the state. The social and political background of the owners of the private medical colleges has been elaborated along with the interviews that have been conducted in the state. It attempts to explain, why there has been a huge growth in the private sector and who have invested in these colleges.

Similarly the fifth chapter discusses the case of Maharashtra, which deals with similar issues of the growth, trend and the inter-regional disparities in the establishment of medical colleges in the state as well as the socio-political determinants of this pattern of growth.

Both the chapters are specifically trying to show that, how the intermediate peasant class have emerged during independence and subsequently became as a rich peasant class which started diversifying their capital into different ventures and medical education is one among them which led to the huge growth in private medical colleges in the state. It shows the interlinkages between the caste associations, class and political power which has influence on the growth of private medical colleges. It discusses the complexities around these mentioned factors. It also discusses the concerns around the quality of medical education by analysing reported availability of faculty in the colleges both in public and private sector shows the faculty shortages by using the MCI as a gold standard. The other factor discussed is the fees structure in the public and private colleges. It also discusses the serious concerns about the quality of medical education and the kind of corrupt practices that exists in the medical education in the states.

The sixth chapter deals with the regulatory aspects of the medical education in India. It discusses the role of the Medical Council of India (MCI) as a highest regulatory

body for regulating medical education. This is been discussed while providing an example of the kind of powerful lobby that was there in the election processes in the MCI. It asks certain questions on how the regulatory body which itself is corrupt will be able regulate the medical education system. Why is the MCI is unable to act? What is it that prevents the MCI to act and implement its rules and regulation to impart quality and standard of medical education?

The last chapter is the analysis of the growth and distribution of medical colleges in India. Employing a political economy perspective it seeks to explain the above and highlights the socio-economic processes by focussing on two high growth states – Maharashtra and Karnataka. This analysis is important in order to underline its contribution to planning for human resources in health. The availability, distribution, accessibility and affordability and quality of medical education is being discussed in the context of the growth of private medical colleges. It also discusses the role of medical council of India as a regulatory body and the corruption existing in it. Finally, it discusses the implication of these trends for medical practice and public health.

Chapter-I

History of Medical Education in India: From Colonial to Post Independence Period

The following chapter presents a detailed review of literature that covers the history of medical education from the colonial period to the present. The first section discusses the introduction of western medicine in India by the Europeans that later gained dominance with active support from the colonial government. Many of these trends continued even during the post-independence period. Through a reading of government documents and other academic writings this chapter traces the history of medical education. The second section discusses the key research questions and methodology of the study and outlines the design of the study in detail and provides a brief description of the key informants.

History of Medical Education in India

- ***The Colonial period***

The introduction of western medicine was initiated by the Portuguese in Goa in 1510. Albuquerque, a Portuguese, established Royal Hospital in 1510 (Keswani, 1970; Narayan, 1991). This was the first hospital which was established in city of Goa. Fátima da Silva Gracias (1994) mentions that this hospital was established primarily "to cater the needs of the Portuguese soldiers who were in need to recover from long sea journeys, from wars of conquest and sea monopoly they sought to enforce, and from the infectious diseases which they imported or acquired locally. Hospitals and other facilities were designed with the interests of the Portuguese as their priority" (Silva Gracias, 1994, p.205). In 1591, the administration of the Royal Hospital was handed over to the Jesuits (Pandya, 1982). Looking at the unhealthy conditions in Goa the Viceroy asked the Home Government to send doctors who can teach medicine to the natives. However, there was unwillingness from Portuguese doctors to come to India on account of poor incentives, tropical climate and prevailing diseases (Silva Gracias, 1994, p.175). After many appeals in the year of 1702 the informal rudimentary kind of medical training was started by the Portuguese with Cipriano Valadarews as its master. Initially along with the practical knowledge only two subjects were taught Cadeira Prima and Cadeira de Vespera, at the Royal hospital.

The doctors trained in the Royal Hospital were absorbed in hospital or had private practice (ibid, p.176). The medical training was not carried out on a regular basis due to the inadequate number of teachers and also the chief physicians refused to teach because they were overburdened at the hospital. During 1775 to 1800 no medical training was carried out. During this time the governors of Goa requested the Home Government to send doctors who can teach medicine. The Portuguese government appointed a professor to teach medicine in 1800. He was expert in Pharmacology, Botany and was a good administrator. In 1801 a three year course was started by Dr. Miranda Almeaida. In 1821, it expanded into a four year course by Dr. Antonio Jose de Lima Leitao (Silva Gracias, 1994, pp.177-178; Jeffery, 1988). In 1842, the Goa Medical School was established along the similar lines of French and Portugal schools (Silva Gracias, 1994, p.178). By this time the British had taken over and consolidated allopathic medicine into India. European doctors and surgeons used to visit India and practiced among the European troops as well as Indians. The major concern of the European's was the protection of the army and its people from illness and diseases (Ramasubban, 1982). In this context allopathic medicine was mainly confined for the Europeans. Hence, the hospitals were established in the major British presidencies such as Calcutta, Madras and Bombay where number of European civil official population and troops were staying. However, before the early 19th century little knowledge was available about the diseases in India. The increasing rates of illness and increasing number of deaths had created the risk to European forces and hence the health of the Europeans in India was the major concerns for the British colonial state (Ramasubban, 1982; Jeffery, 1988; Arnold, 1993). Europeans needed more number of medical personnel specifically, hospital assistants to overcome the problem of increasing illness and diseases to the European forces. Hence, Europeans started looking for Indian assistants who had some knowledge about the allopathic medicine.

- ***Native Medical Institution in Colonial India***:

Hospitals were established by the colonial government in 1664 in Madras, 1670 in Bombay and 1707 in Calcutta. There were three large hospitals established in Bombay by 1784, out of which two were for Britishers and one for Indian troops. The need for establishing hospitals in an institutional form was emphasised as the rate of illness and death was very high among the British soldiers (Harrison, 1998). These

hospitals required helpers to assist the medical officers as the work burden was high. Hence, they picked up the indigenous helpers and these helpers gradually learned the knowledge of allopathic medicine while doing their duties in the hospital (Kumar, 1998). Harrison (1998) mentions that "posts often filled by Indians trained in the rudiments of Western medicine, in addition to indigenous traditions" (Harrison, 1998, p.2). Till 1812, the assistants who were trained under the supervision of surgeons on the basis of apprenticeship called as 'native doctors' or 'black doctors'. In 1812, these native doctors were recruited under the Subordinate Military Medical Department and were termed as third class servants (Kumar, 1998, p.18).

In 1822, Native Medical Institution was established in Calcutta where indigenous system of medicine and allopathic medicine being taught together. This dual system of teaching in medicine was established in order to fulfil the needs of the British military. Also the native doctors who sought to be taught in their vernacular language for English medium was difficult. So, in this backdrop it was decided to teach both allopathic and indigenous medicine side by side (Kumar, 1998). Till 1830, the East India Company was showing concern and helped in a way to patronize the indigenous systems of medicine. Indigenous systems of medicine were being taught in Calcutta Sanskrit College (Ayurveda) and Calcutta Madrassa (Unani) (Arnold, 1985). In 1827, John Tytler a noted Orientalist started teaching anatomy and mathematics along with the indigenous systems of medicine at Calcutta Sanskrit College. At the time of his teaching he translated many European texts into local language (Keswani, 1970, p.357). Orientalist view argued for teaching of indigenous systems of medicine along with allopathic medicine in Sanskrit, Persian and Arabic texts in vernacular language but opposed introduction of practical anatomy and dissection (Arnold, 1985). However, in 1833 Lord Bentinck constituted a committee to investigate and study the status of Native Medical Institution to recommend improvements and to build it in efficient way. The committee's report explained the ineffectiveness of the institution and suggested its abolition. Thus, the Anglicist view as pointed out by Arnold (1985) "that the medical classes at the Sanskrit College and Madrassa should be scrapped and replaced by a medical college devoted exclusively to Western medicine and with English as the language of instruction" (Arnold, 1985, p.176). The major reason put forward for the closing down was that the dual system of teaching both allopathic and indigenous system was expensive. The other reason was that the translation of the

education material was a difficult task and was able to provide only superficial knowledge. The third reason was that the lack of practical anatomy makes medical education unfinished and incomplete. Thus, the recommendations made by the committee has resulted in the abolition of the Native Medical Institution. Also the medical classes which were carried out at Calcutta Sanskrit College and Calcutta Madrassa were discontinued. The same order permitted the establishment of new form of medical college where only allopathic medicine was taught in English. Hence, in 1835 Calcutta Medical College was established in British India (Kumar, 1998; Kumar 1997). The committee appointed by William Bentinck was to work out the principles on which medical education should be established. The principles were adopted on the western model and thus till today the medical education in India is highly influenced by the westernized model (Bajaj, 1998) The British established medical colleges in the Bengal, Bombay and Madras presidencies to train Indian doctors. However, it was the period where Europeans wanted to set the allopathic medicine on the British lines and hence the indigenous systems of Medicine got marginalised. Kumar (1997) pointed out that "Indigenous systems were so marginalised that their practitioners often sought survival in resistance rather than collaboration" (Kumar, 1997, p. 166)

The Calcutta Medical College (1835):

In the first batch there were fifty students joined to be trained in allopathic medicine. At that time they were getting a monthly stipend ranging from Rs. 7 to 12. There was no any distinction on the basis of caste or religion for the admission. The only criterion was the ability to read and write English and Bengali and that they should be between 14 to 20 years. This was a three years course, on completion of the course the degree awarded was a Diploma in Medicine and Surgery. This degree was given by the college until the establishment of Calcutta University in 1857. Later on the university granted the degrees of Doctor of Medicine (MD) and Licentiate in Medicine and Surgery (LMS). In 1860, it added the degree of Bachelor of Medicine (MB). Adding to the degrees the duration and the criteria for admission was also raised such as duration rose to four and later on to five years in 1845. Matriculation in 1857 and later in 1860 Fine Arts was the criteria made for admission. It is important to note that after finishing college the native doctors were employed as sub assistant

surgeons on the payment ranging from Rs. 60 to Rs. 100 per month. However, they were not compelled to join the government service and were free to establish their private clinic (Kumar, 2005, pp.162-164).

- ***Social Background of Doctors in Calcutta Medical College:***

It was noted that in the period of 1820-1830, the Mughal's aristocracy declined and lost control over rural Bengal. The Muslim aristocracies was later occupied by the upper caste Hindu's specifically the Brahmins (mainly the Bhadralok), Baidyas and Kayasthas. The new avenues and opportunities were opened up by the Britishers. They were the main social groups who had the benefits of employment opportunities in government offices, judiciary, professions, education, and business and so on. This happened because during the second half of the eighteenth century, upper castes Hindus were the agents and collaborators of the East India Company. Kumar (1998) states that "the Hindu elites, for centuries had learned to maintain their power through the mastery of the language of their rulers" (Kumar, 1998, p.23). The prejudices and traditional taboos tightly connected with not touching the human dead body among the Hindu upper caste, specifically among the Brahmins, was a major impediment in allopathic medical education. However this taboo was kept aside by the Brahmins after the first Brahmin called Pandit Madhusudan Gupta, a teacher along with his four students secretly carried out dissection on human body in Calcutta Medical College in 1836. This was marked as a major change and victory of the western medicine over the Indian traditions and taboos (Arnold, 1985). After two years of the opening of Calcutta Medical College the large number of Brahmins and Baidyas began to do dissection on the human body (Kumar, 1998).

In the report of the Medical College of Bengal it has been stated that 'in 1849 in the English class of the Calcutta medical college, there were 15 Brahmins, eight Vaidyas, 24 Kayasthas. There were three weavers, four barbers, two blacksmiths and five Muslims (Report of the Medical College of Bengal 1849-50 as cited in Kumar, 1997, p.170). Jeffery emphasizes that on surgery and anatomy in western medical education, there were large number of Brahmins undertaking western medical education which was against their traditional and caste norms (Jeffery, 1979, p.304).

Madras Medical College (1835):

Madras Medical College was established in 1835 soon after the establishment of Calcutta Medical College. The first batch started in July 1835 with 21 students among which 10 were medical apprentices (Eurasians) and 11 students were local Indians. Initially the medical school started in the General Native Hospital and later on in 1836 the new building was established for teaching western medicine. The Madras Medical College initiated three different types of courses for the students when civilians started taking admission in the medical school. There was a four year course for the physicians, a four year course for the apothecaries and a three year course for the dressers. The idea of this medical school was initially to teach the subordinates for various medical needs of the army. Eurasians and the local Indian students were taken admission into the medical school however, in 1838 civilians were also promoted for admission to the medical college (Keswani, 1970, p.359). In 1847 the civilian had taken admission for the five year course of medical diploma and after the completion of the college they were employed as sub-assistants surgeons. This was the first batch who received diploma from the college after qualifying in 1852. In 1855-56, the Royal College of Surgeons, London recognized the diploma of the Madras Medical College (Crawford, 1914 as cited in Kumar, 1998, p.37).

"E. G. Balfour, Surgen General of the Indian Medical Department, in a long communication to the acting chief secretary to the government of Madras in August 1877, accounted extensively for the state of medical practices in Madras Presidency, the conditions of the people and their health needs and put forward a proposal for a particular type of medical education best suited to the local needs and conditions" (Kumar, 1998, p.38). He observed that there were 8,000 medical practitioners in the Madras presidency among which 450 practitioners were serving for the army and or limited to civil populations and the others were the practitioners of indigenous systems of medicines mainly the Hindu *vaids* and Muslim *hakeems*. Based on this he argued that there was a need for more medical practitioners in the Madras Presidency since there was only one practitioner for 60,000 population. He also mentioned the reality of the poverty among the Madras presidency and stated that the people cannot pay for the expensive medical services therefore it needs to be affordable for the local people. Hence, the state has to take care of the kind of professional medical education

for which people can pay (NAI, 1877 as cited in Kumar, 1998). He advocated for the expansion of the large number of native doctors, dressers and hospital assistants to meet the needs of poor people in Madras Presidency. He also advocated for the training of *vaids* and their sons through the vernacular languages so that the rural people will be able access the medical services (O'Malley, 1941 as cited in Kumar, 1998).

However the government did not came forward to implement any of the suggestions put forward by E. G. Balfour in the coming years. The medical college continued to teach in English medium language and never gave any importance for the vernacular language (Kumar, 1998).

In 1875, the only major step taken forward which was considered to be radical was when admissions for the women candidates were opened. This was the time when not only in India but even in Britain, women's were being excluded and discouraged to take the admission in medical education (Keswani, 1970, p.359). In 1888-89, Madras University was the first to realized the importance of hygiene and hence initiated a new degree called Licentiate in Sanitary Science. It included the subjects of general pathology, hygiene and analytical chemistry. By the first decade of the twentieth century the Madras Medical College expanded to include five departments that included college department, the department of apothecary, the hospital assistants, the chemists and druggists department, and the sanitary department and hence was in a leading position in the medical sciences (Kumar, 1998, p. 39).

The Bombay Medical College (1845)

The establishment of medical college in Bombay took place in 1845 and was called as Grant Medical College. This college was established by the leading initiative of the Sir Robert Grant, the governor of the Bombay presidency. Prior to the establishment of Grant Medical College in 1826, there was an attempt made by Elphinstone to establish a native medical college based on the Calcutta model. The main objective of Elphinstone was that the natives of the India should gain knowledge of the western medicine and then should practice it in the districts. In this period there was an effort to translate medical knowledge into Marathi and Gujarati. However this effort could not be sustained for a long time because of low funds, lack of interest of government,

and the translation of the medical knowledge into vernacular language was a difficult and a very expensive task. Due to all these reasons, the native medical college somehow worked only for 6 years until 1832. After this, Sir Robert Grant took initiative and proposed for establishment of a medical college in 1838. This proposal was sent to Calcutta and was approved by the Lord Auckland's government. However Sir Robert Grant passed away before this message. A public meeting took place and it was decided to subscribe the fund which amounted to Rs. 44,800 for the establishment of the medical college. The court also sanctioned this proposal with the name of Grant Medical College and added the same amount. The first batch consisted of 22 students of which 19 students were stipendiary and three were free. In 1851, the first batch passed out. Six students were successfully awarded Diploma and later on the government employed them as Sub Assistance Surgeons. In 1880 the classes of the native doctors and hospital apprentices were transferred into the vernacular medical schools and hence over the years there was good amount of medical literature translated into Marathi from English. In 1884, the College was kept open for women students. In 1872 there was a provision made for paying students for the category of Civil Sub Assistance Surgeons. The fee was Rs. 5 per month and hence 25 students were qualified for admission and enrolled as paying students (Kumar, 1998).

- ***Social Background of the Medical Students in Bombay***:

According to reports of the Board of Education of relevant years between 1847- clearly indicates the social composition of the medical students (Kumar, 1998). It shows the difference in Bengal and Bombay. In Bengal, there were representations of the Brahmin castes even though there were traditional taboos and prejudices. However, in Bombay the picture was different and not a single Brahmin was found in the first batch of the Grant Medical College in 1846-47. The representation was mostly of Parsees and the Portuguese and the *Shenwi*, *Vaishya* and *Prabhu* castes with one each. However this contrast becomes more evident when analyzing the representation of the Brahmins in other educational institutes as presenting more than 90 percent. It clearly reflects the deep minded traditional taboos regarding the notions of purity and impurity among the Brahmins. The education which is traditional and supposed to be pure, such as philosophy, literature, mathematics and so on, were given preference (Kumar, 1998, p.43). Ramanna (1989) also shows that the Brahmins

were having one of the highest representations in English Medium and Marathi Medium schools. The other higher representation was of the *Prabhu* and *Shenwi.* In Grant Medical College in the year 1849-50, only one representative of Brahmin caste was admitted and then in 1853-54, it started growing to four representatives and remained in same numbers till 1858-59. Whereas Parsees and Portuguese were in large numbers in pursuing medical degrees as of the total strength the numbers of the Parsees rose from 44 percent in 1846 to 59 percent in 1859. This perhaps indicates the ingrained prejudices regarding touching the dead body by the upper Hindu castes especially by the Brahmins (Ramanna, 1989).

Post-Independence Period: Review of Policy Documents

At the time of independence the health of the Indian population was very poor with high prevalence of morbidity and mortality. In the colonial period the measures for health policy or improvement in health services adopted by the Britishers was primarily in their own self-interest. This was to retain and protect their trade and profit interests. Hence investing in the health of the army and British civilians was seen as a form of protection. Their political and economic interests were challenged by the poor health conditions of the native and British population in India. Huge burden of diseases, lack of public health structure, lack of medical manpower, lack of medical colleges, lack of interest and support for traditional medicine in India which flourished the western medicine as in centre stage which all led to India in poor condition at the dawn of independence (Qadeer, 2005).

Bhore Committee Report (1946):

The post-independence period primarily starts with the Bhore committee report in 1946 which was constituted in 1943. The report came out with comprehensive, valuable and concrete suggestions for health service development in India. It gave suggestions on medical education. At the time of independence there were 19 medical schools in India and majority of them were run by the state. Out of 19 medical schools 12 medical schools were maintained by governments and two were run by missionaries, one by Mysore state and four were run privately. Of these 19 medical schools, 9 were in Bengal and 4 in Bombay (Bhore Committee, 1946).[4] It certainly

[4] Bhore Committee (1946). Report of the Health Survey and Development Committee-Vol. I

shows regional variations and also that these medical colleges were primarily established in the cities of the British India provinces. For 400 million populations only 1,200 students were admitted each year which was extremely low (ibid). There were around 47,400 doctors (Medical Graduates and Licentiates) available and the ratio was that one doctor for 6,400 populations that a large number of doctors were concentrated in cities and towns. As a result populations in rural areas were left without any trained medical manpower. Even though there were certain numbers of traditional practitioners in rural areas, there was total denial of these by the 'scientifically' trained medical doctors (Bhore Committee, 1946)[5]. Therefore, rural areas were un-served resulting in huge disparities for accessing health care.

With this backdrop, the Bhore Committee gave suggestions for short term plans for a period of ten years. It suggested that there should be increase in the new medical colleges and at the end of the ten years there should be 43 medical colleges. It clearly states that 'if our recommendations are accepted and given effect to immediately then at the end of the first ten years, the medical teaching institutions in the country should be capable of an annual output of 4,000 to 4,500 doctors as compared with less than half that number of graduates and licentiates combined produced each year at present' (ibid, p.337). It also suggested that there should be only one type of highly trained medical doctor instead of two different courses such as graduates and licentiates. It suggested that given the huge scarcity of resources it will be better if we pull all the resources in a given condition and create only one type of doctor as a 'basic doctor' and therefore should abolish the licentiate course. It suggested the establishment of Preventive and Social Medicine Department in every medical college to give insights to the student about health as a social problem by placing them into the community. After qualification of the exams there has to be internship for a period of one year where students will be placed in public health unit for three months and the remaining period will be in an approved standard hospital (Bhore Committee, 1946, p.61)[6]. These major recommendations on undergraduate medical education given by the Bhore Committee. However, the Bhore Committee remained silent on the issue of private sector or the growth of private medical education which would take place in the future.

[5] Bhore Committee (1946). Report of the Health Survey and Development Committee -Vol. II
[6] Bhore Committee (1946). Report of the Health Survey and Development Committee-Vol IV

- ***Mudaliar Committee Report 1961*:**

After twelve years in 1959, the Ministry of Health set up a committee under the chairmanship of Dr. A. Lakshmanaswami Mudaliar to review the developments which took place after the recommendations of the Bhore Committee in 1946. This was primarily with an aim to plan further developments in regards to health programmes planning in subsequent years. The report came out in 1961 and the committee observed that there were a total of 61 medical colleges (with an intake capacity of 5, 900) in India. This was more than what the Bhore Committee had recommended (43) at the end of ten years. It clearly indicates unexpected expansion of medical colleges within ten years. It reviewed that all medical schools except one which provided licentiate course were converted into medical colleges that awarded a Bachelors in Medicine and Bachelors in Surgery (MBBS) degree (Mudaliar Committee, 1961, p.37).

The committee recommended the establishment of a 20 medical colleges with an additional intake capacity of 2000 students by the end of the third five year plan. This meant that at the end of the third five year plan (1966) there should be a total of 81 medical colleges. At the end of the third five year plan there were total of 91 medical colleges existed in India (MCI, 2016). The 91 included a private medical colleges. This was the period when there was a slow growth of private medical colleges. This clearly shows that the growth of medical colleges expanded in excess to what was recommended by the Bhore and Mudaliar Committees.

The committee also pointed out that the medical colleges should be distributed equally among the states, so that the states which have less number of medical colleges will get an opportunity to establish adequate number of medical colleges (Mudaliar Committee, 1961, p.344).

This committee pointed that out the Bhore committee did recommended one medical college for a population of three million. However, the Mudaliar Committee recommended one medical college for a population of five million. This had been recommended on the basis of considering all aspects of the prevailing situation which was existed during that period. It considered the availability of trained personnel that could be required for medical colleges and suggested that although it was desirable to

establish one medical college for three million population. Given the constraints in financing and availability of human resources it would be practical to establish one medical college for five million population for the next two plan periods (Mudaliar Committee, 1961, p.343).

- ***Kartar Singh Committee Report (1973):***

This report observed that considering the health services in India, medical colleges and attached hospitals are working separately and there is lack of co-ordination between health services and medical colleges. It argued that these colleges were giving education at the graduate and postgraduate levels and provided services to those who come to the hospital as out-patient or inpatient. Their introduction with the community was very less. The speciality services or the advanced technology hardly reaches or gets extended to the community at a large. It is supposed that each medical college should have rural and urban field practice, many do have, however it just superficial activity and hardly caters to the need of the community. Hence, the committee suggested that,

1. A medical college with its attached hospital is made responsible for the entire Health, Family Planning, and Nutrition Programmes for three districts.

2. Medical College should work with close co-ordination with District Health and Medical Officers with concerned districts. A referral system should be built from Primary Health Centre (PHC) to Taluka level Community hospital, to the district hospital and to the medical college hospital. The medical college should organize in consultation with the District Health and Medical Officers the training programmes for the doctors, nurses and paramedical staff within their jurisdiction. This programmes certainly relevant to the day to day needs of the community. It should improve the follow up services, records of the patients and vital statistics.

3. In addition to the involvement of the medical colleges with rural health institutions, specializing in certain fields such as cardiology, neurology, orthopedics etc. will have to be created on zonal basis. The extra medical colleges in the large cities of India could be converted into such specialty institutions and also suggested that this concept needs further deep examination.

4. The committee is unanimously of the view that there has to be integration not only at the peripheral workers but right up to the state headquarters (Kartar Singh Committee Report, 1973, pp.32-33)

- ***Srivastava Committee Report (1975):***

Srivastava Committee is one of the major landmarks which reiterated for modification of medical education to meet the changing requirements and provide services to meet community needs in rural areas. It observed that the current medical education was highly urban centric, focussed on curative and diagnostic tests and a lack of focus on preventive and social medicine. It emphasised on the importance of community health needs and recommended the following (Srivastava Committee Report, 1975, pp.25-44) (See-Box-1.1)

Box-1.1

1. The need for redefining the objectives of Undergraduate medical education in which the need to define the skills that a doctor should have and the qualities that he should possess along with focusing on positive community orientation.

2. Premedical education should aim at balanced education in humanistic and scientific studies and deeply embedded in the framework of Natural Sciences, Humanities and Social Sciences.

3. The Preventive and Social Medicine (PSM) department should not remain in isolation in their teachings and hence it should be a joint venture of the entire faculty and all the departments, so, to impart community orientation to the undergraduate medical students.

4. The need for internship which enables a student to acquire practical experience and to mature from a fledgling to full grown medical is absolutely necessary therefore the need is to ensure the internship period is fully and fruitfully utilized. Along with this it recommended that the training of the interns should not be carried out in teaching hospitals of medical colleges but in the district-sub-divisional/taluka hospitals which should be used as outreaches of the medical colleges for entering into the community.

5. The importance of Continuing Education is to maintain, upgrade and extend professional competence in the medical profession and it should be community oriented. Hence, should develop an organizational pattern for continuing education of doctors, where they serving in government or private as joint activity between the medical colleges, the professional health service and health services.

6. Development of National System of Medicine where modern and indigenous systems of medicine should be integrated appropriately.

7. The Establishment of the Medical and Health Education Commission by an act of parliament, for the co-ordination and maintenance of standards in health and medical education. It should be a representative body consisting of representation from central and state governments and the universities, representation from various national councils and leading persons in the field of medical education, health and health services. Its role shoul promotive and supportive and should be responsible for planning and implementing in the Health and Medical Education. It should function as an apex body coordinating agency working in close and effective collaboration with all the National Councils (Srivastava Committee Report, 1975, pp.25-44).

Thus the committee certainly recommends reforms in medical education with focusing on the medical training programme based on the community needs and the integration of modern and indigenous health systems of medicine through the national system of medicine. It also focuses on the establishment of health and medical education commission. However the committee as well remain silent on the growth of private sector in the health services and medical education.

Reorientation of Medical Education (ROME) (1977):

It is analysed by Qadeer and Nayar (2005), that "the significant shift was the introduction of ROME scheme in 1977 following the Srivastava committee report on medical education and support manpower. The objectives of the ROME scheme were

to involve the medical colleges in the direct delivery of health services to the rural population as well as to expose the students to the rural environment. Some foreign governments even donated huge mobile clinics for the rural areas under the programme, which of course did not serve the purpose because the vans could not traverse the narrow and unpaved rural roads. The ROME scheme was implemented initially in 25 medical colleges and was extended to all the medical colleges recognized by the MCI. The salient features of the scheme were included in the Medical Council's recommendations on undergraduate medical curriculum adopted in 1981. Accordingly, it was mandatory for the medical colleges to implement the scheme for recognition of the undergraduate degree. However, evaluations have shown that the MCI guidelines on the scheme were not fully adopted by any of the participating institutions" (Poulose and Natarajan, 1989 cited in Qadeer and Nayar, 2005, p.60).

The Report Of A Study Of Indian Council Of Social Science Research and Indian Council of Medical Research: Health For All: An Alternative Strategy (1980)

The ICSSR and ICMR Committee (1980) undertook a review of health sciences and medical education. The report reviewed the past trends in the production of doctors and stated that "in spite of all expansion, doctors are still largely urban based and their distribution between different states in uneven. Standards have improved in some institutions and some sectors, but the average has declined considerably because of the proliferation of substandard institutions. There is little congruence between the role of the physician and the needs of the society, little equilibrium between medical education and health care. Medicine is still regarded essentially as an enterprise of science and technology, the physician is the responsibility of all knowledge and dispensation, specialization is the hall mark of progress; and the training ground is the teaching hospital" (ICSSR/ICMR, 1980, p. 109).

It proposed general principles for organizing the health services for the future (see Box-1.2).

Box-1.2

1. Values system of medicine which is science and technology based but the greater emphasize is now should be on cultural, social, and even moral aspects of its action and purposes
2. Not to over emphasize high technology and create a mystic about it but to evolve simpler technologies to deal with more complex problems.
3. Training of health services personnel should be fully oriented to the people – their social, cultural and economic conditions and their health profile.
4. Health services should be pyramidically organized- with a large base in Primary Health Care and a narrow top in the specialized and highly specialized institutions
5. Preventive, promotive and curative problems should be defined accurately at each level and this should be on the basis of actual studies and not on assumptions
6. The skills, services and facilities should be defined
7. Selection of personnel and their training should be on the basis of requirements on specific jobs and skills. The education level of personnel must be adequate and not excessive.
8. Selection at the lower levels should be of persons from within the community itself
9. The service conditions should be properly defined and more equitable than at present. It should be more on a democratic and team sharing decisions and responsibilities than as bureaucracy, organized on vertical basis of authority
10. Training should be as close to workers as possible – jobs specific, decentralized, efficient and economic (ICSSR/ICMR, 1980, p. 110).

The analysis of the report is best pointed out by Narayan (2015) which mentioned that with specific regard to health science education to support such an alternative it suggested on following (See Box-1.3)

Box-1.3

1. No new medical colleges and no increase in intake of existing colleges
2. No need to setup new additional institutions to train additional doctors through short term courses
3. Training of doctors should be community oriented with an inter-disciplinary holistic approach
4. The curriculum will have to be severely more practical and doctors should be able to confidentially undertake simple procedures at community level.
5. Doctors should be oriented on training, organizing and assisting health team with practical field oriented training in epidemiology and health education working intimately with community
6. Doctors should also be taught principles of sociology, human behavior, social/political structure of society and organization and management of health services.
7. Training should be in close collaboration with health care services

The report also recommended on strengthening a more broad based health team, it should have specialist training from cadre of doctors with practical experience, training in public health through a chain of public health schools established on regional basis, continues education at all levels and medical and health education commission to implement all these ideas and reforms which apart from counsel representatives will have senior persons from disciplines such as sociology and education and eminent persons from general community who command national respect" (Narayan, 2015, pp.6-7).

National Health Policy (1983):

The section on medical education and health it says that "it is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a

coordinated action programme. It is, therefore, of crucial importance that the entire basis and approach towards medical and health education, at all levels, is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socially motivated to effectively deal with day-to-day problems, within the existing constraints" (GOI, 1983, p.4).

Towards this end, it is necessary to formulate, separately, a National Medical and Health Education Policy which

(i) sets out the changes required to be brought about in the curricular contents and training programme of medical and health personnel, at various levels of functioning;
(ii) takes into account the need for establishing the extremely essential inter-relations between functionaries of various grades;
(iii) provides guidelines for the production of health personnel on the basis of realistically assessed manpower requirements;
(iv) seeks to resolve the existing sharp regional imbalances in their availability; and
(v) Ensures that personnel at all levels are socially motivated towards the rendering of community health services" (GOI, 1983, p.5).

In regard to private practice by government doctors the policy states that "it is desirable for the States to take steps to phase out the system of private practice by medical personnel in government service, providing at the same time for payment of appropriate compensatory non-practising allowance. The States would require to carefully review the existing situation, with special reference to the availability and dispersal of private practitioners, and take timely' decisions in regard to this vital issue" (GOI, 1983, p.9).

National Education Policy in Health Sciences, A draft (1989): (Bajaj Committee)

In accordance with National Health Policy (1983), the Bajaj Committee had emphasised on separate formulation of National Medical and Health Education Policy. Along with this there were many other committees such as Medical Education Review Committee, 1983; a empowered committee 1984; Expert Committee on

Health Manpower Planning, Production and Management 1987 recommended for the separate policy on medical education. In 1989 the National Education Policy in Health was drafted by J. S. Bajaj, Chairman of the committee. However the policy remained as a draft and was never formulated into policy for political reasons. The important goal of the Health Science Education was to enable health manpower to deal, in the most effective manner, the health problems of society. It emphasised that all learning experience is based on scientific methods and all learning activities are community-oriented and student centered. The health professionals of all categories must be imbue the spirit of enquiry and must have acquired behavioural attributes including care, compassion and concern for the people (GOI, 1989, p.9). Major recommendations of Bajaj Committee (see Box-1.4).

Box-1.4

1. Quantitative and qualitative development of appropriately trained health manpower for all categories of health care providers;
2. Definition of educational strategies and curricular reforms considered essential for the community oriented training of different categories of health personnel with a view to establishing essential interrelation between functionaries of different grades.
3. Organisation of appropriate structure(s) in order to bring about necessary modifications in education depending upon the changing national needs, and on the outcome of research developments in the philosophy of learning process and technology of education;
4. Development and implementation of a proper and adequate evaluation system for health professionals and health programmes; and
5. Development of agencies for implementation of various elements of national education policy in health sciences (GOI, 1989, p.9)

The National Education Policy in Health was envisaged broad spectrum of the issues in the medical education. It provided educational strategies for a proper balance between technology and humanistic medicine; a holistic approach covering

promotive, preventive curative and rehabilitative aspects of medicine; balance between the tertiary care hospital-based and primary care community-based education. It provided a detail outline of the Faculty Development which emphasises that "the social attitudes of teachers must receive consideration both during recruitment and promotion and opportunities must be provided so that the teachers irrespective of discipline or affiliation obtain first-hand experience in community health" (GOI, 1989, p.5). It has also given importance to the development of health manpower with emphasising on the basic doctors. The policy has also given in detail the mechanisms for the implementation such as Education Commission in Health Sciences, University of Health Sciences, linkages between health care delivery and education in health sciences, optimal utilization of practitioners of Indian system of medicine and homeopathy and Medical education and research (ibid).

Qadeer and Nayar, (2005) analysed this policy document and mentions that "it treated specialisation as more crucial than basic doctor's training and claimed that 'specialisation is the order of the day'. The key disciplines identified had general medicine as the first and public health as the last priority. Super-specialisation was also considered critical for future doctors. With such a vision, how the claim to strive for achieving a harmonising balance between generalist and specialist and super-specialists' would be created was never made explicit" (Qadeer and Nayar, 2005, p.62).

Hence, it is important to note here that, up till 1980, there is no discussion about the role of the private sector in providing health services.

Rationale of the Study and Methodology:

Medical education is one of the important sub systems of the health service system. One of the aims of medical education is to produce a professional cadre who will serve the health needs of the people. Medical education like law, engineering and information technology are professional courses that occupy a privileged position in higher education.

At the time of independence there was an effort by the government to invest in higher education in order to achieve self-reliance in human resources (Bhore Committee 1946). The government set up medical colleges across states and these were the sole

avenue for training doctors. During the post-independence period the trend in the growth of government medical colleges is marked by inter-state variations.
By the 1970s a new trend emerged with the establishment of private medical colleges in the Western and Southern states. The last three decades have seen an increase in the number of these colleges and in some states like Karnataka, Maharashtra, Tamil Nadu, Andhra Pradesh etc. where their proportion is higher than the government medical colleges. Given the emerging pattern of distribution of private medical colleges, several questions arise. Firstly, why is there a higher proportion of private medical colleges in these states? What are the socio-political determinants that would explain this trend and finally why should one be concerned about the growth of these colleges?

There are very few studies, in sociology and public health, which have examined the growth of private medical colleges and the socio-political factors that have shaped it. The socio-political determinants include caste and class background of the promoters and their engagement with local and state politics. The relationship and intersections between caste, class and power is the framework that we employ to analyze the growth of the private medical colleges. We draw upon Rekha Kaul's (1993) study that demonstrated the relationship between caste, class and political power in professional educational institutions in Karnataka.

From a public health perspective, the growth of private medical colleges has consequences for the nature and quality of medical practice. Given the demand for medical education and capitation fees in private medical colleges, it is only the affluent from rural and urban areas who can afford to seek admission. Students belonging to families of professionals, bureaucrats, big businessmen, rich peasants or politicians are only able to afford the high capitation fees and therefore access to private medical colleges (Qadeer and Nayar 2005; Ananthakrishnan 2010; Diwan, et al. 2013). Diwan, et al. (2013) observe that 'students in private medical schools were more likely to have a physician parent that those in public sector ones' and it also pointed out that students from public medical schools are more likely to work in rural areas than the students from private medical schools (Diwan, et al. 2013). Doctors, who graduate from these colleges, are keen to recover the investments made and tend to move to the private sector. This then leads to the further strengthening of private

health services. The study conducted by Baru in All India Institute of Medical Sciences (AIIMS) has highlighted the implications of commercialization on changing professional values and the culture of medical practice among doctors. The doctors in this leading hospital opine that commercialization of health services undermines public institutions at a deep level because the private sector pays much more. This often leads to frustration among mid-career doctors who feel that their peers able to afford a better lifestyle (Baru, 2005). Kakade (2003) shows the social background of the medical doctors and states that large number of medical doctors are from the upper caste and class backgrounds (Kakade, 2003).

It is apparent that access to medical education is largely dominated by the upper and middle castes while admission to government medical colleges is through merit, the entrance to put medical colleges is mixed. A certain proportion is based on merit, payment of money and through the management quota.

If one has to understand the patterns in the supply of doctors at the all India and state levels, then it is necessary to examine the numbers and distribution of medical colleges. The data suggests that these medical colleges are in both the public and private sectors.

The available studies do cover the aspects of growth of medical colleges (Supe and Burdick, 2006; Mahal and Mohanan, 2006), quality of medical education and shortage of faculty in the medical colleges (Deshpande and Deshpande-Naik, 2009; Srinivas and Adkoli, 2009; Yathishand and Manjula, 2009; Ananthakrishnan, 2010; Ananthakrishnan, 2007), the background of doctors (Kakade, 2003). However these studies do not answer the question of interstate regional variations and variations within the state and why do these variations occur. There is no any attempt being made to see the social characteristics of the private medical colleges. As a social scientist this is not just a technical kind of enquiry, there is a larger theorizing of the socio-political determinants of growth of private medical colleges. The understanding of caste and political dynamics will inform the scope, possibility and resistance to regulation of private medical colleges.

The proposed research study does not attempt to measure or judge the quality aspect of medical education. However the literature review suggests that there are implications on quality of medical colleges as there is a shortage of faculty,

infrastructure and other related issues. The importance of studying private medical colleges is that it has consequence for the kind of doctors produced. To elaborate, it is well known that all private medical colleges have a capitation fee and the fee structure is much higher than the public sector. Secondly, it is not clear weather reservation policy is implemented in the private medical colleges as it is implemented in the public medical colleges. Thirdly it is very well acknowledge that there is a shortage of faculty in private medical colleges especially in the senior and middle levels (Ananthakrishnan, 2007). Reports of the Medical Council of India (MCI) have also showed that there is sharing of faculty and hospital resources between the public and private sector. Inspection by MCI team and CBI investigation revealed that several private medical colleges do not have required number of faculty for teaching (Vijaykumar, 2012). Given all the above factors there is a question arises regarding the values and aspiration trained in these colleges, their commitment to public services and their role expanding to private sector.

It is also important to mention that this is not a comparative study between public and private or between Maharashtra and Karnataka. Instead it focuses in the growth of private colleges and uses the two states to exemplify the importance of socio-economic factors for the growth of private medical colleges.

There are very few studies on the diversification of regional capital into health services. A study of regional variations in growth of private health services in Andhra Pradesh demonstrated the role of agrarian surpluses for investing in this sector (Baru 1987). Another study of private nursing homes in Hyderabad showed the link between intermediate castes and investment in these enterprises (Baru 1998). Urmila Budhkar's study in Maharashtra also showed that the regions who have developed and experienced agrarian prosperity witnessed the growth of the private sector in health services compared to poorer regions such as Vidarbha. It also illustrated the significant presence and involvement of sugar co-operatives and their foray into education and health in some regions of Maharashtra (Budhkar 1996). Baviskar in his extensive study of sugar co-operatives in Maharashtra suggests the relationship between the Marathas, rise of co-operatives and later the diversification into private engineering and medical colleges (Baviskar 2007).

Karnataka and Maharashtra are the two states who have large number of private medical colleges in India and there is very little empirical work done on this area. The increasing proportion of private medical colleges and it is increasingly coming out to public knowledge through media the extent of corruption and nexus between regional political parties and entrepreneurs. The unregulated nature of this growth has implications on quality of medical education and leads to greater commercialization in health sector.

As a part of the interest in the commercialization of the health sector, the focus of this study is examining the quantum, characteristics and distribution of private medical colleges in India.

Some of the key questions addressed are:

- What are the phases in the growth of medical colleges? (Time trend analysis)
- What is the regional distribution of this growth in India?
- What is the pattern of intra-regional distribution of private medical colleges in Karnataka and Maharashtra?
- What is the caste and class background of the promoters of private medical colleges in the high growth states?
- What is the status of teaching faculty in both government and private medical colleges?

Overall Objective:

- To study the social characteristics and trends in the growth of private medical colleges in selected states of India.

Specific Objectives:

- To study the trend and growth of government and private medical colleges across states in India.
- To study regional variations in the growth of private medical colleges in India with a focus on Karnataka and Maharashtra.
- To study the socio-political dynamics behind the growth of private medical colleges in Karnataka and Maharashtra.

Methodological Approach:

The study has been conducted at three levels. At the macro level it examined the trends and regional variations in the establishment of medical colleges in India. The study employed mixed methodology, qualitative as well as quantitative. To understand the trends and regional variations in medical colleges, data has been collected through Medical Council of India (MCI) website.

Hence, the researchers largely relied on the MCI records which are available on website and have done extensive review of literature which includes the published government reports, research articles and reports, News-paper articles, websites search of each private medical colleges. On the basis of this information analysis was being done for regional variations and trends in India.

At the meso level, it focused on Karnataka and Maharashtra because these states have the highest proportion of private medical colleges in India. It focused on the regional variations and trends in the establishment of medical colleges as well as on caste and class dynamics and regional characteristics of promoters of private medical colleges. To understand the regional variations and characteristics, the data has been gathered from MCI website as well as data from the respective states. In addition we accessed the websites of all the private medical colleges in the two states. The websites provided the information on name of the founders and basic information about the infrastructure of the college. We reconstructed the caste backgrounds by identifying surnames and crosschecking it with academicians and medical doctors from each of the states. We also tried to locate their linkages with political parties. In-depth interviews with key informants have been conducted to understand the aspects of caste background of the owners of private medical colleges and their political powers. The key informant in-depth interviews conducted with the individuals who have familiarity and have been active in the area of medical education, civil servants, faculty members who are teaching in private medical colleges, Non-Government Organization (NGO) members, students from private medical colleges, local political leaders, local journalists.

In this study it was observed that the number of faculty are reported on the websites of each medical colleges both government and private in selected states (Karnataka and

Maharashtra). This information was used against the MCI norm for faculty requirement and then the extent of shortfall was arrived at.

Design of the Study:

Given the nature of the study, it employed mixed methodology by using qualitative and quantitative research techniques which captured the socio-political determinants of growth of private medical colleges. The study has used both primary and secondary sources of data. The study is an exploratory in nature. In order to achieve these objectives it has undertaken in-depth interviews with the various key informants and accessed secondary data.

Table-1.1
Research Objectives and the Source of Data

Specific Objective	Data Source
To study the trend and growth of government and private medical colleges across states in India	• Records of Medical Council of India website
To study regional variations in the growth of private medical colleges in India with focus on Karnataka and Maharashtra	• Records of Medical Council of India website and extensive review of secondary data Promoters of the private medical colleges and their regional locations, as well as interviews conducted with key informants
To study the socio-political dynamics behind the growth of private medical colleges in Maharashtra & Karnataka	• Literature review of Secondary data-Books, Published-unpublished Reports, Analysis of News Paper Reports, Journal Articles, extensive Web Search of each private medical college websites • The social and political background of the ownership of the private medical colleges in Karnataka and Maharashtra through visiting websites of the private medical colleges as well as interviews conducted with key informants • Linkages of the founders of the private medical colleges with politics through secondary literature review and websites of each private medical college

In addition in the secondary sources it includes published, unpublished reports in India and also the respective states, micro level studies, published journal articles, books and website materials of the private medical colleges, news-paper reports which was referred and analyzed extensively during the study period. Secondly an extensive web search has been conducted to get the background of the private medical colleges and their social characteristics.

Sampling:

In this study purposive and snowball sampling methods is being used. This is because during the course of initial phase of field work it was realized that getting information from private medical colleges is extremely difficult. Therefore keeping the various kinds of complexities in mind, it was decided to use purposive and snowball sampling to be able to get the information as in possible ways.

38 in-depth interviews were being conducted with the key informants who were willing to share their views on growth and social characteristics of private medical colleges. These informants were selected in keeping in mind that those have understanding and familiarity regarding the subject.

Table-1.2
Brief Profile of Respondents

Details of the Respondents	No of Interviews and location
Faculties who are currently teaching in private medical colleges-one faculty had been an ex-government official in Maharashtra (ex-Directorate of Health Services)	Total-8 Four-(Maharashtra) Four-(Karnataka)
Students who are currently studying in private medical college	Total-8 Three-(Maharashtra) Five –(Karnataka)
Alumni students of private medical college	Five-(Maharashtra)
Faculty members who are teaching in Government Medical College, Mumbai	Two-(Maharashtra)
Non-Government Organisation (NGO) working in Health	One-(Maharashtra) Three-(Karnataka)
MBA by profession and Hospital Administrative Management officer at Private Medical College	One-(Maharashtra)
Ex- Health Secretary in Karnataka	One-(Karnataka)
Ex-Dean of Jawaharlal Institute of Medical Education and Research, Pondicherry, and Ex	One-(Karnataka)

Consultant-Curriculum Development at Rajiv Gandhi University of Health Sciences, Karnataka	
Professor who is teaching in NIMHANS Bangalore and had been active on Health issues.	One-(Karnataka)
Local Informant-Medical Doctor- private OPD clinic	One –(Maharashtra)
Local Informant- Faculty and private practice of Homeopathy as well as active in local politics and political development in Maharashtra	One –(Maharashtra)
Local Informant-Local political leaders	Three-(Maharashtra)
Local Informant-Local Journalist in local news-paper called 'Punyanagari'	One-(Maharashtra)
Informal Discussion with peon of one of the private medical college	One-(Maharashtra)

Methods and Tools of Data Collection:

The study used both primary and secondary source of data. In this study, we tried to use the method, questionnaire in order to get basic information of the private medical colleges in India and also to understand the regional variations in the establishment of private medical colleges in India. The questionnaire was sent through post to all private medical colleges in December 2012, however, we got very poor response. Out of 192 questionnaires sent to the private medical colleges in India only five questionnaires were sent back with incomplete details. Second attempt was made in the month of April 2013. In the second attempt questionnaire was sent through E-mail. However, we did not get any response. Only two medical colleges replied asking us to refer their websites. Due to poor response, we accessed the records of MCI to put together a list of private colleges. For in-depth interview we used interview guideline

Data Processing:

The quantitative data about the number of medical colleges, the years of establishment, management etc. was gathered from the MCI website. The data was processed and analyzed by using Microsoft Excel. The qualitative data gathered through in-depth interviews along-with the information available on websites of private medical colleges in Karnataka and Maharashtra. With the consent of the

respondents and those who agreed for recording their interviews were recorded. These interviews were then transcribed and translated into English. The data collected through above mentioned different sources have been organised and the key themes were identified and analyzed.

Challenges and dilemmas faced and the need for reflexivity in methodology

There have been many methodological issues to conduct this research as it focuses on the socio-political dynamics behind the growth of private medical colleges in Karnataka and Maharashtra. Initially I was very much enthusiastic to do this research and was quite sure that I will get the data. However, after pursuing this topic of research, after one year I visited two private medical colleges in Pune to get an idea for data collection and interview few trust members as well as faculty members and students. I went without any personal contact, however I had an official letter written by my supervisor stating about the study. The letter was not explicitly written on socio-political dynamics but mentioned that the student would like to study the contribution of the founders to provide health services to the people and the history and motivation to establish the medical college. Along with this it also mentioned that I would like to interview some of the official members, faculty members and students. When I entered at medical college at the gate itself I was being asked by the peon to whom I am going to meet at the college. I informed that I would like to meet to Dean of the college or Medical Superintendent of the hospital. He asked me the motive of the visit and I replied that I am a doctoral student and want to meet them regarding my research. The peon prevented me to meet them and argued that for this kind of students the officials do not have time. He said that he was authorised not to permit the outside students in the campus. However, I tried to emphasize that, I want to meet at least one person from the college. However, he didn't allow me to enter into the campus. Hence, I could not enter the campus. I could see some of the students outside the campus and I started interacting them. It was an informal discussion but approaching them was difficult as well. Some students right away denied talking to me. I could talk to three-four students and asked very general questions about the admission policy and the fees and how did they come to this college and why they choose this college. The experience that I had in my first visit itself made me realised that it would be difficult to obtain data from the private medical colleges. In the same period, I visited another private medical college in Pune, there also I had a more or

less similar experience. The second college which I visited, not a single student was willing to talk to me. I approached them in the canteen areas which was in the campus but was outside the main college premises. These experiences disappointed me on mental and physical level and I thought that I would change this topic, as it was very difficult to approach the elite and influential people in the private medical colleges. Specially, for a student who doesn't have much contacts in the field becomes much more difficult to approach these people.

I almost made my mind that I will change the topic, however after discussing the experiences with the supervisor she gave me a confidence that this is the area which is unexplored and there will be many more obstacles and getting a denial is also a data. We then decided that we have to try out different methods to obtain relevant data.

Initially, methodological approach was proposed, to prepare a basic questionnaire and to post it to all private medical colleges to get a basic understanding of founders, trust members and their caste background. Secondly, it was decided to map the time trend and regional variation of medical colleges in India through obtaining information from MCI. Thirdly, it was decided that the study will focus on Karnataka and Maharashtra. The rationale to select these states was that, both Karnataka and Maharashtra have high number private medical colleges in proportion to the public medical colleges. It was decided to conduct interviews with the owners and the trust members as well as the faculty members and the students of private medical colleges who were willing to participate in the study. The idea behind to conduct interviews with these informants was to obtain information on the motivation and inspiration to start a private medical college, the information of the trust under which the medical college is registered, the reasons behind the regional variations in the establishment of medical colleges, the opinions and views of faculty and students on the growth of private medical colleges, how do they see the implication of this growth, the political linkages and the source of income to establish private medical college. Thirdly, it was decided to study in detail by taking one private medical college from selected states to have an in-depth understanding of one private medical college from both the states.

This was the methodological approach proposed in the initial phase of study and the researcher started following it up.

Research Steps

Pilot Study Phase:

During the course of pilot study it was realized that getting information from private medical colleges is extremely difficult. In June 2012, the researcher, visited two private medical colleges in Pune and was not allowed to meet the professors. It was difficult to get entry into the private medical colleges without having any strong networks in the field. Even students were reluctant to talk. Initially, the researcher introduced her study and then started to talk to medical students but students didn't share any details about the college, admission procedure, fee structures, reservation criteria etc. The students just refused to talk.

First Step:

In the initial phase of the study, researcher prepared a questionnaire to get a basic understanding on the aspects of caste background of the owners and the trust members of private medical colleges as well as the admission policy and reservation criteria, if any that the medical colleges followed. It included questions on basic information of the private colleges such as name of the founder, caste background of the founder, name of the trust members and their caste background, intake of the students, gender aspect, is it only for MBBS course, annual fee structure, do they get any kind of government aid and reservation criteria.

The list of all private medical colleges and their postal address was obtained from MCI website. Then in the month of October, 2012 the questionnaire was sent to all the 192 private medical colleges in India which were recognized and permitted by MCI. However, the response rate was very low and only five responses were received with incomplete details.

Second Step:

After around six months, a second attempt was made to gain this information by sending the same questionnaire through emails. The email ids of all private medical colleges was obtained from MCI website as well as by visiting each private medical college website online. Researcher has emailed the questionnaire to each and every

private medical college in the month of April 2013. However, there was no any response.

The Third Step:

The third step was to visit the MCI office in New Delhi and obtain information from them. Hence, researcher visited to MCI and wanted to see the files that are being kept for each medical colleges as these files includes the details of the colleges. However, here as well the officials were not willing to share the files and stated that MCI is under the CBI investigation and many issues are going on, so it was difficult for them to give time and show the files.

Therefore, keeping all these issues in mind it was decided that we have to use different methods to be able to get the information in all possible ways. So, it was decided to conduct in-depth interviews with different resource persons, those who have familiarity and have been active in the area of medical education. It includes civil servants (health officials), professors who are teaching in private medical colleges, students who are graduating as MBBS doctors and some alumni students from different private medical colleges, local key informants such as local politician and journalists. It was also decided that most of the information is available on the websites of MCI, as well as each private medical college has their own website which provides basic information about the college, student's capacity, founder member, infrastructure etc. so it was decided to do an extensive Web Search and then analyze that data.

The Fourth Step:

I tried to use personal contacts to reach to the persons from private medical colleges. Hence, I could trace out personal contacts at four private medical colleges and visited private medical colleges in Ahmednagar, Mumbai, Satara and Pune. In three colleges, I had given a formal application to get permission for data collection. After number of follow ups private medical college at Ahmednagar denied the permission to collect the data and stated that there is no Memorandum of Understanding (MOU) between the two universities or college (i.e the private medical college and the university in which I was enrolled). Meanwhile, I could talk to two faculty members and two students. Through personal contacts, I could talk to local informants who did reflected

upon the growth and political linkages of the founder of the college. It took almost two months for follow up and finally to get an answer in negative. After Ahmednagar, I visited another private medical college in Karad, district Satara. My uncle, who is a local politician and knew the son of the founder of the college who is currently handling the college administration. I went through this personal contact and approached directly the son of the founder of the college. His cabin, was a meeting hall, which was full of people. I could meet him surrounded with this entire crowd around him. While waiting to meet him, I observed one conversation regarding giving an admission to one of the candidates relatives. The first question the son of the founder asked to his personal assistant, do they belong to our ward, if they are from our ward then do it. This conversation highlights how a candidate is seen as a political vote-bank. Thereafter, I told the son of the founder about my study, he didn't reply directly to me and said he will think about it and asked me to give a formal application. I wrote an application stating about my study and submitted to his personal assistant. He asked us to contact his personal assistant and not to bother him. Day after day we tried to contact his personal assistant but we didn't receive any positive response and they kept us hanging on the matter. Meanwhile, I interviewed two local political leaders, one local journalist and one alumni student of that college. The third medical college I visited in Mumbai and I had a similar experience, however after giving formal letter, they orally informed me that there is no MOU between the two colleges, so it is out of the policy of the college. Similarly in Pune too, the authorities did not allow me to collect the data.

Chapter-II

Growth and Inter-State Inequities in the Distribution of Medical Colleges in India

This chapter examines the growth and inter state inequities in the distribution of medical colleges in India. Given the fact that India made a choice for a doctor centred health services, the importance of medical education is critical for the supply of doctors at the primary, secondary and tertiary levels of care. Thus the focus of policy was on how to increase the supply of doctors and also how to ensure their distribution according to the differential needs of each states. As the Mudaliar Committee in 1961 observed:

> "The medical colleges should be distributed in a manner that each state may have a certain number so that the establishment of medical colleges in each state will give a better scope for development of medical relief facilities as well as training of students of that states" (Mudaliar Committee, 1961, p.344).

The Mudaliar Committee (1961) had recommended the equitable distribution of medical colleges across states. Even though this has been suggested as early as the 1960's, the inequitable distribution of medical college's remains a major concern even today. The uneven distribution of medical colleges increases the regional disparity in the availability of doctors that has implications for the functioning of health services. The functional quality of health services in turn has a bearing on access and utilisation. (Rao, et al. 2009).

The first section of this chapter gives an overview of medical colleges in the world and finds that India has the largest number of medical colleges in the World. The second section deals with the growth of medical colleges in India since independence in both public and private sectors. The third section analyses the regional distribution of medical colleges across states along with the type of management of these medical colleges. The fourth section elaborates upon the uneven distribution of medical colleges in developed and under developed states. The socio-economic determinants for the uneven distribution is explained by analysing various government documents on the socio-economic disparities among the states and its relation to the availability

of medical colleges in developed and undeveloped states. It has used national human development indicators to show the relation. The fifth section discusses the human resources in health in terms of density of doctors across states and its relation to the availability of medical colleges.

Brief Overview of Medical Colleges in the developed and developing countries:-

The data on total numbers and distribution of medical colleges in the world has been maintained by the International Medical Education Directory (IMED). This directory is maintained and updated by the Foundation of Advancement of International Medical Education and Research (FAIMER). The IMED provides an updated web-based data on the medical colleges which are recognised by the government authorities of the respective countries. There is another new World Directory of Medical Schools, which is developed through a partnership between World Federation of Medical Education (WFMS) and the FAIMER. The World Directory was created by merging FAIMER's International Medical Education Directory (IMED) and WFME's Avicenna Directory[7]. There are hardly any studies which give an overview of medical institutions in the world. There are three articles which provide an overview of the worldwide distribution of medical colleges and the physician density. The first article by Eckhert published in 2002, used multiple data sources and the result shows that there was a total of 1642 medical schools in 157 countries, 12 nations were without any medical college. The three nations China, India, and the United States of America (USA) have more than 100 medical schools (Eckhert, 2002:607). The Second article published in 2007 by Boulet et al., used the data source of IMED and the result shows that there was a total of 1935 operating medical schools in 169 countries. 'Over one-third of all the world's medical schools are located in one of five countries (India, USA, China, Brazil, and Japan); nearly half are located in 10 nations.' It shows that India has the largest number of medical schools (219) followed by USA (147) and China (130) (Boulet et al. 2007:21-22). The third recent article published in 2014 by Duvivier et al., is much more accurate,

[7] WFME is the global organization concerned with education and training of medical doctors whereas FAIMER seeks to improve the health of communities by improving health professions education. The detail of the information is available on http://www.wdoms.org/ and http://www.who.int/hrh/wdms/en/ as accessed on12th May 2016.

comprehensive and systemic in nature. The data used in this study is IMED and Avicenna Directories and an internal education programme database along with this it used semi-structured questionnaire and information from key informants to gather data on medical schools in the world. It used a combined data from different sources to show authentic results. The results of this paper show that there are 2597 operating medical schools in the world as on 1st September 2013. India has the largest number of medical schools (304), followed by Brazil (182), USA (173), China (147) and Pakistan (86). It states that of 207 independent states, 24 have no medical school and 50 have only one (Duvivier, et al. 2014: 860-863). The article also points to regional differences within the USA. The USA has the highest number of medical schools with an even distribution in all sub-regions except the Caribbean. The Caribbean has one medical school per 0.56 million inhabitants. In the African Continent, the distribution is skewed and again within sub-regions. Nigeria in West Africa, accounts for 32 of 61 medical schools. In the European regions, the distribution is much fairer. The distribution of medical schools as the ratio of population per school ranges from 1.4 million to 2.2 million. It states that as a continent, Asia has the highest total number of medical schools (n=1188) However, although over 60 percent of the world population lives in Asia, only 46 percent of all medical schools are located there (Duvivier, et al. 2014, pp.863-864). The article also clears that there is a mismatch between the number of medical schools and population size as in Caribbean region small countries have a large number of medical schools. 'Many of the institutions in this region train physicians for the international rather than the national labour market' (Zanten and Boulet 2013 as cited in Duvivier, et al. 2014, p.866).

The table-2.1 is based on the listings available on IMED as of May 2016. However, the data does not reflect all functioning medical schools in the world. According to the IMED data, currently, there are 2,669 medical colleges in the world of which 37.42 percent of medical colleges are located in Asia, which includes 45 countires. Following this Europe has the largest number of medical colleges (20.23 percent) with 41 countries. This is followed by South America and North America has a large number of medical schools.

Table-2.1
Region Wise No. of Countries and No. of Medical Colleges in the World[8]

Region Name	No. Of Countries in the Region	No. Of Medical Colleges	Percent in Total
Africa	45	202	7.56
Asia	31	999	37.42
Central America/Caribbean	26	121	4.53
South America	12	353	13.22
North America	3	269	10.07
Europe	41	540	20.23
Oceania /Pacific Island	10	32	1.19
Middle East	14	153	5.73
Total	182	2669	100.0

Source: International Medical Education Directory (IMED). Foundation for Advancement of International Medical Education and Research. As available on https://imed.faimer.org/ as accessed on 12th May 2016.

Table-2.1 clearly shows the huge variations in the distribution of medical schools. It could be clearly seen that North America that includes the USA, Mexico and Canada have 269 medical schools whereas Africa continent has 45 countries with only 202 medical colleges.

In the above context, the trend shows that India has always remained on top in the establishment of medical schools. However, within India there are large regional variations. Well developed states have witnessed the growth of medical colleges particularly in the private sector as compared to the states which are less developed (Mahal and Mohanan, 2006; Choudhury, 2014; Choudhury 2016).

The following section will look at the growth, trends and regional variations of medical colleges in India.

[8] The researcher could not find disaggregate data on public and private medical colleges in the world.

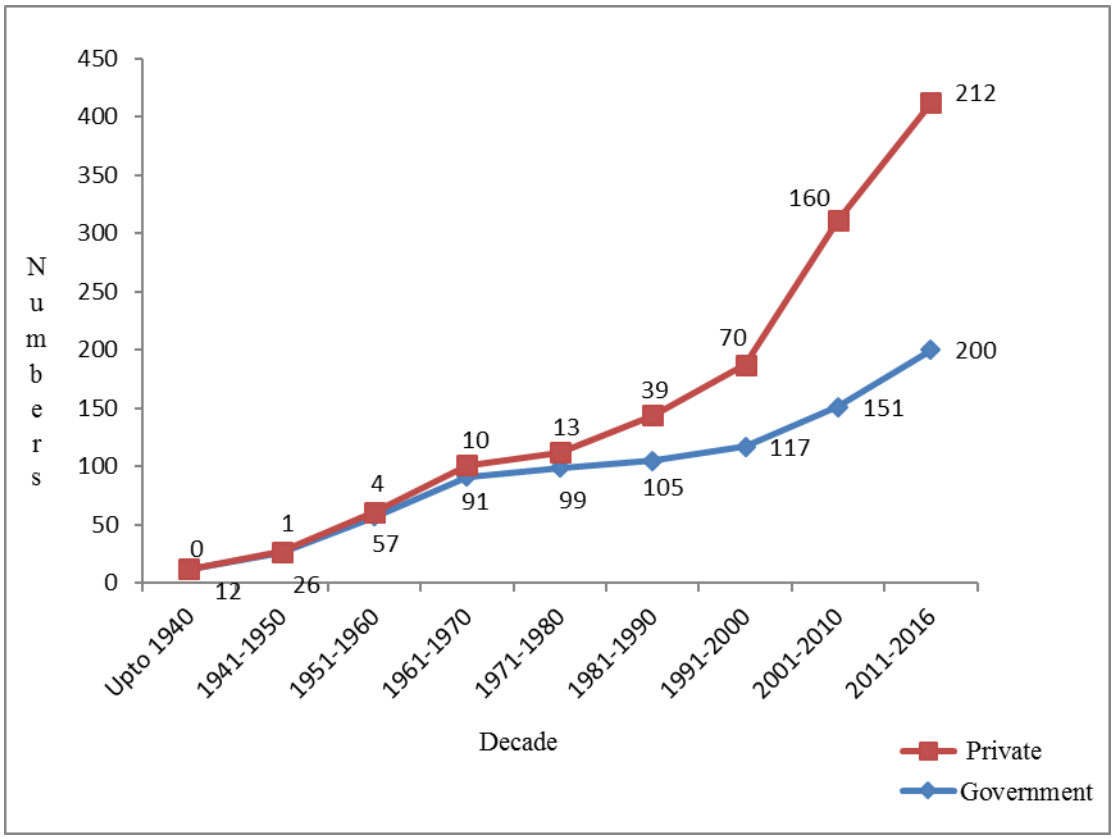
Medical Colleges in India: **Time Trend Analysis**

During the last four decades there has been a substantial growth in medical colleges in India; however, this is mostly to the private sector (Supe and Burdick 2006). At the time of independence, there were only 23 medical colleges in India (Ananthakrishnan, 2010). In 2011, according to Medical Council of India, there were 335 medical colleges, among this 183 colleges were private and 152 were government (MCI, 2011). The process of establishing private medical colleges received a boost during the early 1980s. Ananthakrishnan (2010), pointed out that nearly 70 percent of medical colleges established since 2005 were in the private sector. The growth in the private sector is largely driven by economic motivations rather than for educational purpose (Ananthakrishnan, 2010). In the current scenario, the market is playing a dominant role and influencing the growth of medical colleges.

In the 1940s, there were nineteen medical colleges for a population of 400 million in India. A total of 1200 students were admitted each year resulting in a ratio of one doctor for 6,400 population. In order to improve the doctor: patient ratio, the Bhore Committee suggested that 43 medical colleges be additionally set up over a period of ten years (Bhore Committee, 1946, p.337). In order to achieve self-reliance in human resources, government policy initiatives were directed towards state interventions in establishing medical colleges (Bhore Committee, 1946; Mudaliar Committee, 1961; Srivastava Committe, 1975).

With this backdrop, Figure-2.1 shows that up to 1950 there was a total of 27 government medical colleges which reached up to 412 in 2016. It shows that up to 1970 there was active state involvement in the establishing of medical colleges. After 1970 the trend changed with the slow emergence of private medical colleges that received a boost during the early 1980s.

Figure-2.1
Decadal Growth of Medical Colleges in India (In Numbers)



Source: Medical Council of India website as available on http://www.mciindia.org /Information Desk/Colleges Courses Search.aspx as accessed on 15th Jan 2016.

The pace in increase of private medical colleges was gradual until 1970. Between 1941 and 1980 government medical colleges were growing at the rate of 280 percent[9], the growth rate in private colleges was 1200 percent, and the overall growth rate was 314 percent (Figure-2.1). Till 1970, the role of the state in establishing medical colleges was prominent but over 1971-1980 and later it declined significantly. Since 1981, the relative growth of private colleges was much higher with a sharp increase during the decade of 2001-2010. During the period of 1990 to 2016, the government medical colleges increased only by 90 percent whereas in the private it increased by 443 percent with an overall growth of 186 percent (Figure-2.1).

[9] The percentage were calculated by using formula for growth rate. For Example in this case 280 percent is calculated as =(99-26)/26*100. Same formula is applied for calculating growth rate in this chapter.

Table-2.2

Share of Medical colleges in India in Government and Private Sector

Period	No of Medical colleges (% share)		
	Government	Private	Total
Up-to 1940	12 (100)	0	12
1941-1950	26 (96.30)	1 (3.70)	27
1951-1960	57 (93.44)	4 (6.56)	61
1961-1970	91 (90.10)	10 (9.90)	101
1971-1980	99 (88.39)	13 (11.61)	112
1981-1990	105 (72.92)	39 (27.08)	144
1991-2000	117 (62.57)	70 (37.43)	187
2001-2010	151 (48.55)	160 (51.45)	311
2011-2016	200 (48.54)	212 (51.46)	412
CAGR (1941-2016)	**2.76**	**7.40**	**3.70**

Source: Medical Council of India Records as accessed on 15th Jan 2016.

Table-2.2 shows that the period of 1941-1950 the share of government medical colleges was 96.30 percent which reduced to 48.54 percent in 2016. During the same period the share of the private sector increased from 3.70 percent to 51.46 percent in 2016. It shows that in the period of 2001-2016 the percent share remained more than half in the private sector, and the share has increased sharply compared to the earlier decades (table-2.2). However, it is important to mention that, till 2000 though the share for government medical colleges was higher (table-2.2), the rate of growth of private medical colleges was much higher (Figure-2.1).

During 1941 to 2016, the average compounded annual growth rate for government medical colleges is 2.76 percent compared to 7.40 percent in the private sector with an overall growth rate of 3.70 percent (table-2.2).

This high growth of private medical colleges after 1980's can be largely attributed to the neo-liberal policies that emphasise on the withdrawal of state intervention and increasing spaces for private investment (Qadeer and Nayar, 2005). Varghese (2015) states that "with the liberalization policies of the 1990s and introduction of

market-friendly reforms, privatization of public institutions became an acceptable practice in India" (Varghese, 2015, p.31).

The rapid growth of medical colleges led to faculty shortages, inadequate infrastructure and low quality of education (Rao et al. 2011; Antia 1990, Chaudhury 2008; GOI, 2016). Faculty shortages in medical colleges, the old and newly established ones was calculated by applying the MCI norms. The calculations revealed that nearly 26,000 medical teachers were required to staff the existing medical colleges adequately that includes 260 colleges for the MBBS course alone (Ananthkrishnan, 2007, p.25). It also mentions that most of the departments are faced with faculty shortage which ranges between 20 to 25 percent and in some departments it goes up to even 33 percent. The reason behind this shortage is due to the non-availability of qualified staff. It also adds that along with these vacancies, there is a 10 to 15 percent annual decrement in the existing staff which is due to superannuation, resignation, etc. (ibid, p.27).

The shortage of faculty leads to corrupt practices. At the time of MCI inspection, many of these private medical colleges tend to fill up the empty hospital wards with hired patients and doctors. These are then shown as regular faculty of the college. Even instruments are borrowed from colleges (Chattopadhyay, 2013). There are unethical practices in many private medical colleges such as to get recognition from MCI-they put up lists of non-existing staff, showing false records, false faculty, leaking questions papers, etc. (Deshpande and Deshpande-Naik 2009; Chattopadhyay, 2013). The quality of learning through practical exposure has remained a major issue due to very few patients in private medical college hospitals compared to public medical colleges which has high volume of patients (Supe and Burdick 2006).

Regional Distribution of Medical Colleges[10]: Interstate analysis

We look at the regional distribution of medical colleges in India through the six zones proposed by the Ministry of Home Affairs. The southern zone is constituted by six Indian States, has the largest number of medical colleges (44.93 percent) with an intake capacity of (44.93 percent), followed by the western zone. Taking these two zones together (eleven States), 60.92 percent of medical colleges have an intake

[10] Regional distribution of medical colleges includes both government and private sector.

capacity of 63.25 percent. In contrast, the eastern and north-eastern zone with 12 States have only 13.10 percent of medical colleges and 12.27 percent of total intake capacity (Table-2.3). The six states of the southern zone have 63.53 percent share of private medical colleges (intake 61.11 percent) as compared to 36.46 percent in government colleges (intake 38.88 percent). The northern, eastern, and north-eastern zone, the share of government medical colleges, is higher than the private medical colleges whereas the southern (63.53 percent) and central (51.66) zones the share private medical colleges is high as compared to the government sector. However in the central zone, the share of intake capacity in government medical colleges (51.84 percent) is higher than the private medical college intake capacity (48.16) (table-2.3).

Within the western zone, Maharashtra has the highest number of private colleges (68.57 percent) with an intake capacity of 64.70 percent. Gujarat and Maharashtra combined have 98.57 percent of colleges having a similar intake (table-2.3). Most of these medical colleges are largely located in urban areas.

Table: 2.3

Regional Distributions of Medical Colleges and Intake Capacity in India (%)

Regional Zones	State/UT	Colleges			Intake Capacity		
		Gov.	Private	Total Zonal	Gov.	Private	Total Zonal
Southern Zone	Andhra Pradesh	13 (7.18)#	14 (7.73)#	27 (14.91)##	2050 (8.73)	1750 (7.45)	3800 (16.18)
	Telangana	5 (2.76)	15 (8.28)	20 (11.04)	850 (3.62)	1900 (8.09)	2750 (11.71)
	Karnataka	15 (8.28)	35 (19.33)	50 (27. 62)	1950 (8.30)	4955 (20.46)	6855 (28.76)
	Kerala	9 (4.97)	21 (11.6)	30 (16.57)	1250 (5.32)	2150 (9.15)	3400 (14.47)
	Tamil Nadu	22 (12.15)	23 (12.7)	45 (24.86)	2810 (11.96)	2700 (11.49)	5510 (23.46)
	Pondicherry	2 (0.55)	7 (3.86)	9 (4.97)	225 (0.96)	1050 (4.47)	1275 (5.43)
	Total	**66 (36.46)***	**115 (63.53)***	**181 (43.93)****	**9135 (38.88)**	**14355 (61.11)**	**23490 (44.93)**
Western Zone	Goa	1 (1.42)	0	1 (1.42)	150 (1.57)	0	150 (1.57)
	Gujarat	16 (22.85)	5 (7.14)	21 (30.0)	2580 (26.95)	650 (6.79)	3230 (33.73)

	Maharashtra	21 (30.0)	27 (38.57)	48 (68.57)	2900 (30.29)	3295 (34.41)	6195 (64.70)
Total		**38 (54.28)**	**32 (45.71)**	**70 (16.99)**	**5630 (58.80)**	**3945 (41.20)**	**9575 (18.31)**
Central Zone	Chhattisgarh	5 (8.33)	1 (1.66)	6 (10.0)	550 (8.15)	150 (2.22)	700 (10.37)
	Uttarakhand	2 (3.33)	2 (3.33)	4 (6.66)	200 (2.96)	300 (4.45)	500 (7.41)
	Uttar Pradesh	16 (26.66)	20 (33.33)	36 (60.0)	1949 (28.88)	1800 (26.67)	3749 (55.55)
	Madhya Pradesh	6 (10.0)	8 (13.33)	14 (23.33)	800 (11.85)	1000 (14.82)	1800 (26.67)
Total		**29 (48.33)**	**31 (51.66)**	**60 (14.56)**	**3499 (51.84)**	**3250 (48.16)**	**6749 (12.91)**
Northern Zone	Haryana	4 (8.51)	4 (8.51)	8 (17.02)	500 (8.27)	300 (4.96)	800 (13.23)
	Himachal Pradesh	2 (4.26)	1 (2.13)	3 (6.38)	200 (3.31)	150 (2.48)	350 (5.79)
	Jammu and Kashmir	3 (6.38)	1 (2.13)	4 (8.51)	400 (6.62)	100 (1.65)	500 (8.27)
	Punjab	3 (6.38)	7 (14.89)	10 (21.28)	450 (7.44)	695 (11.50)	1145 (18.94)
	Rajasthan	8 (17.02)	5 (10.64)	13 (27.66)	1400 (23.16)	700 (11.58)	2100 (34.74)
	Delhi	6 (12.77)	2 (4.26)	8 (17.02)	850 (14.06)	200 (3.31)	1050 (17.37)
	Chandigarh	1 (2.13)	0.00	1 (2.13)	100 (1.65)	0.00	100 (1.65)
Total		**27 (57.45)**	**20 (42.55)**	**47 (11.40)**	**3900 (64.52)**	**2145 (35.48)**	**6045 (11.56)**
Eastern Zone	Bihar	9 (21.43)	4 (9.52)	13 (30.95)	950 (18.48)	300 (5.84)	1250 (24.32)
	Jharkhand	3 (7.14)	0.00	3 (7.14)	290 (5.64)	0.00	290 (5.64)
	Orissa	3 (7.14)	5 (11.90)	8 (19.05)	550 (10.70)	500 (9.73)	1050 (20.43)
	West Bengal	14 (33.33)	3 (7.14)	17 (40.48)	2050 (39.88)	400 (7.78)	2450 (47.67)
	Andaman & Nicobar Islands	1 (2.38)	0.00	1 (2.38)	100 (1.95)	0	100 (1.95)
Total		**30 (71.43)**	**12 (28.57)**	**42 (10.19)**	**3940 (76.65)**	**1200 (23.34)**	**5140 (9.83)**
North Eastern	Assam	6 (50.0)	0	6 (50.0)	726 (56.90)	0	726 (56.90)

Zone	Manipur	2 (16.67)	0	2 (16.67)	200 (15.67)	0	200 (15.67)
	Tripura	1 (8.33)	1 (8.33)	2 (16.67)	100 (7.84)	100 (7.84)	200 (15.67)
	Meghalaya	1 (8.33)	0	1 (8.33)	50 (3.92)	0	50 (3.92)
	Sikkim	0	1 (8.33)	1 (8.33)	0	100 (7.84)	100 (7.84)
Total		**10 (83.33)**	**2 (16.67)**	**12 (2.91)**	**1076 (84.33)**	**200 (15.67)**	**1276 (2.44)**
Grand Total		200 (48.54)	212 (51.45)	412 (100)	27180 (51.99)	25095 (48.00)	52275 (100)

Source of Regions: - Government of India, Interstate Council Secretariat, Ministry of Home Affairs, (14th Jan 2016) Zonal Councils Composition as available on http://interstatecouncil.nic.in/zonalcomposition.html#subnav2_2 as accessed on 15th Jan 2016

Source of Data: MCI Records as accessed on 15th Jan 2016

In each Zone the percent of government and private medical colleges is out of the total Zonal colleges ## The percentage is out of total Zonal colleges. Same applies to Intake Capacity section.

*In each Zone the percent share of government and private medical colleges is out of the total Zonal colleges. **In each Zone the total Zonal percentage of medical colleges is out of total Indian medical colleges. Same applies to intake capacity.

Note:-Daman & Deu, Dadra & Nagar Haveli, Arunachal Pradesh, Nagaland and Mizoram do not have any medical college

More than half the private medical colleges are located in six states of Southern Zone (54.24 percent) and 69.33 percent are located in Southern and Western Zones with 72.92 percent of intake capacity. If we include six states of the southern zone with Maharashtra, then it shows that 66.98 percent of private medical colleges are located only in these seven states. In contrast, the northern, eastern, north-eastern zones constitute of twenty states have only 16.03 percent of private colleges out of the total of all (212) private medical colleges. Moreover, the States of Goa, Chandigarh, Jharkhand, Assam, Manipur Meghalaya and one Union Territory i.e. Andaman-Nicobar do not have private medical colleges. In each state of Chhattisgarh, Himachal Pradesh, Jammu and Kashmir, Tripura and Sikkim have only one private medical college that too these are established in the recent period. There are three States and two Union Territories without any medical college (table-2.3).

Central government has done little to redress the inequity between less developed and better developed states in relation to medical education Specifically, it is in the states of Empower

Action Group States[11] and north-eastern states (CBHI, 2015, pp.163-165). Specifically, in the north and eastern regions, the states get less support from the government as well as from the private endeavours to establish new medical colleges. These trends suggest that the recommendations of the High Level Expert Group (HLEG) report on Universal Health Coverage (UHC) that advocated for higher public investment for medical colleges in the states which have less availability of human resources in health (Choudhury, 2014, p.6; Planning Commission, 2011).

Table-2.4
Period, Region and Ownership Wise Distribution of Medical Collegess in India: Regional and Ownerhip Pattern

Name of the Region	Up-to 1970			1971-1990			1991-2016		
	Gov	Priv.	Total	Gov	Priv.	Total	Gov	Priv.	Total
Southern Zone	25 (27.5) #	7 (70.0) ##	32 (31.7) **	3 (21.4)	13 (44.8)	16 (37.2)	38 (40.0)	95 (54.9)	133 (49.6)
Western Zone	17 (18.7)	1 (10.0)	18 (17.8)	4 (28.6)	14 (48.3)	18 (41.9)	17 (17.9)	17 (9.8)	34 (12.7)
Central Zone	14 (15.4)	0	14 (13.9)	1 (7.1)	0	1 (2.3)	14 (14.7)	31 (17.9)	45 (16.8)
Northern Zone	13 (14.3)	2 (20.0)	15 (14.9)	4 (28.6)	0	4 (9.3)	10 (10.5)	18 (10.4)	28 (10.4)
Eastern Zone	19 (20.9)	0	19 (18.8)	1 (7.1)	2 (6.9)	3 (7.0)	10 (10.5)	10 (5.8)	20 (7.5)
North Eastern States	3 (3.3)	0	3 (3.0)	1 (7.1)	0	1 (2.3)	6 (6.3)	2 (1.2)	8 (3.0)
Total	91 (90.1) *	10 (9.9) *	101 (100)	14 (32.6)	29 (67.4)	43 (100)	95 (35.44)	173 (64.55)	268 (100)

Source of Data: MCI Records as accessed on 15th Jan 2016
Percentages are from the total of all government medical colleges in the specific period (up to-1970 period)
percentages are from the total of all private medical colleges in the specific period (up to-1970 period). Same applies to other sections of each period
** Percentages are from the total of all medical colleges in the specific period (up to-1970 period) Same applies to other sections of each period
* These are the percent share from the total of all medical colleges in the specific period (up to-1970 period). Same applies to other sections of each period

[11] Empower Action Group states are the group of states who are less developed and have high demographic indicators as well as have high MMR and IMR (GOI, 2001).

Table 2.4 clearly shows that even in1970, the distribution of medical colleges was marked by interstate variations. It shows that 31.7 percent of medical colleges are concentrated in the southern zone with a high concentration of government and private medical colleges. Followed to this, eastern zone and western zone had a high number of medical colleges that too all (except one) are established by the government. Seventy percent of all the private medical colleges were concentrated in southern zone. In the northern zone; Punjab had two private medical colleges and in the western zone, Maharashtra had one private medical college. During this period the growth of the private sector is negligible compared to the government sector. Uptil 1970 the medical colleges were almost in the government sector as the share of government medical colleges was 90.1 percent compare to only 9.9 percent in the private sector. However, it is important to note that this period (1970's period) even the government medical colleges were spread unevenly with a high concentration in southern zone followed by eastern and western zone.

During the next period (1971-1990) there is a contrasting trend with private medical colleges in southern (44.8 Percent) and western regions (48.3 percent) and within the eastern zone, Bihar had two private medical colleges. However within southern zone there are 13 new private medical colleges established out of which nine are established only in Karnataka state. And within western zone there are 14 new private medical colleges established out of which ten are established only in Maharashtra. This reflects that private sector growth was largely occurred in these two states. While in the central, northern and north-eastern zone had no private medical colleges particularly in the period of 1971-1990. Out of the total medical colleges established in the period of 1971-1990, 67.4 percent are from the private sector (table-3.4). The share is increased from 9.9 percent in 1970 to 67.4 percent in 1990 (table-2.4).

After 1991 the emergence of private medical colleges received a boost particularly in the region of the southern and central region. Within all private medical colleges more than half of the private medical colleges established in the southern zone (54.9 percent). The central zone (includes four states - table-2.3) which had no private medical college up-to 1990, only after 1991, 31 medical colleges emerged in the private sector. (table-2.4). The growth of private sector on the north side has started in the last decade as it is noted that Uttar Pradesh has 20 private medical colleges (table-2.3) out of which 17 are established after 2005. Moreover, the central, northern, eastern, and north-eastern zone except Punjab and Bihar had no private medical college up to 1990. Within Southern zone, it is important to mention that Kerala,

Pondicherry and Andhra Pradesh (excluding Telangana) had no private medical college up to 1990. Before 1990, it was only in Telangana that there was one private medical college. And most of the colleges established in the southern states after 1990 is in the private sector.

Maharashtra and Karnataka are the only states who had established more than half of the private medical colleges before 1990. In Karnataka, the involvement of the private sector started much earlier, i.e. since 1950 and 1960s. In Maharashtra, the emergence of private involvement boosted in the period of 1980's[12]. Whereas on the other hand almost 22 states and UTs of India had no private medical colleges till 1990.

The revival of increased medical colleges after 1991 was "under the pretext that large number of posts were lying vacant in many place especially rural areas. The existing data clearly demonstrates that the shortages were certainly not for PHC (Primary Health Centre) medical officers. The shortages existed for specialists at the Community Health Centres and of the para-medical workers. The shift in policy was therefore due to reasons other than concern for manpower of PHC infrastructure" (Qadeer and Nayar, 2005, p.63).

These three pahes of growth of institutions have been analysed by Varghese (2015) in the context of growth of higher educational institutions in India. It pointed out that the growth of institutions in between 1950 and 1970 witneesed a strong public support and iberal government funding to expand the system and considered as the golden period of public higher education in India. The period of 1970's and 1980 was the period of declining trend in the institutional growth, enrolment and a decline in the share of resources allocated to higher education. "It was during the decade of 1970s that the private sector started entering the higher education scene. From the mid-seventies, the private individuals and trusts established self-financing colleges in professional and technical subject areas. This phenomenon of private self-financing institutions started in the state of Karnataka and soon spread to the states of Andhra Pradesh, Tamil Nadu and Maharashtra. The period 1970–1990 was a period of relative decline in public funding, privatization of public institutions and marked the beginning of private unaided higher education institutions in India" (Varghese, 2015, pp.5-6). The period of 1990 onwards or late 1980's experienced the revival and massaive exapansion of growth of higher educational institutions and enrolment. However this growth is largely in private sector

[12] In Maharashtra there was only one private medical college established in the period of 1960's and commercialization of medical colleges only started in the period of 1980' when there were ten new private medical colleges initiated.

and large part of the expansion was financed by households. In the 1990s, the cost- recovery and self-financing of public institutions increased with proliferation of self-financing higher education institutions in the private sector and these were mostly for-profit private institutions (ibid, p.6).

It is being argued that the colleges established in the 1950's and 60's were on philanthropic basis (Choudhury, 2014, p.8). Tilak (2014) argues that the educational colleges established in the private sector are not a homogeneous, and it has variations. The higher educational colleges established in late 1980's and 1990's are prominently private self-financing colleges (Tilak, 2014) commonly known as capitation fee colleges (Tilak, 1994). According to him, "people with some money in the 1950s and the 1960s used to donate to public colleges or set up philanthropy-based private schools and colleges; today, though, those with even a small fraction of that money prefer to set up a private, self-financing college or university. This is because investment in colleges and universities is found to be the most rewarding, yielding quick and very high pay-offs, with little risk. Philanthropy and charity have been replaced with greed for profit and narrow, selfish financial interests" (Tilak, 2014, p.35).

Table-2.5
Ownership of Medical Colleges in India

	Government			Private		
	Government	Gov. Society	University	Trust	Society	Private
	190	8	2	197	12	3
Total	200			212		

Source: MCI Records available on the website as accessed on 15th Jan 2016.

Table 2.5 shows the general overview of ownership of medical colleges and the heads under which it is being run. However, MCI data does not give any clarity what it means to Government-Society, University, Trust, Society, and Private. Under the head of government medical colleges, there are three categories, Government, Government-Society, and University. The eight medical colleges which are run under the head of Government-Society is a recent phenomenon. In 2013 out of eight medical colleges seven were run under the head of Society and all these seven medical colleges are from Gujarat and the remaining one medical college is from Assam. There is no explanation being found or provided by the MCI for why all these seven medical colleges which were run in 2013 under the society are now being run under the head of Government-Society. It is a possibility that instead of government investing

in more medical colleges they started to take over and run it as a partnership. Similarly, colleges run under the head of University; there is no any clarity on what it means.

There are three categories under the head of private medical colleges- Trust, Society, and Private. The proportion of for-profit (private) medical colleges is very less (only two medical colleges) (Table-2.5), this is because any higher educational institution is allowed to set up by Trust or Society. It is being mentioned that "policy makers are opposed to setting up of higher educational colleges as for-profit corporate entities, ostensibly because education is a public good and hence should be outside the purview of commerce." It also states that "No doubt the intentions behind having a 'Not-For-Profit' structure might be noble, yet the question one needs to ask is whether this is serving the desired purpose. The fact, that everybody including law makers know but fail to acknowledge is that commercialization of education can happen even in educational bodies set up by a society or a trust" (Sudarshan and Subramanian, 2013, p.180).

If one were to analyse this growth with population size, then it is notable that the states with the largest population in India possess very few medical colleges (table-2.6).

Table- 2.6
Overview of Number of Required, Existing, and Difference of Medical Colleges in the Major States of India

Name of the State	Population (in Crore)	Medical College Required @ one per 50 lakh population	Existing Medical Colleges (Jan 2016)	Difference
States having excess number of medical colleges than required				
Karnataka	61095297	12	50	38
Tamil Nadu	72147030	14	45	31
Andhra Pradesh	84580777	17	47	30
Maharashtra	112374333	22	48	26
Kerala	33406061	7	30	23
Gujarat	60439692	12	21	9
Pondicherry	1247953	1	9	8
Delhi	16787941	3	8	5
Punjab	27743338	6	10	4

Haryana	25351462	5	8	3
Himachal Pradesh	6864602	1	3	2
Jammu and Kashmir	12541302	3	4	1
Chhattisgarh	25545198	5	6	1
Manipur	2570390	1	2	1
Tripura	3673917	1	2	1
States having less number of medical colleges than required				
Bihar	104099452	21	13	-8
Uttar Pradesh	199812341	40	36	-4
Jharkhand	32988134	7	3	-4
Madhya Pradesh	72626809	15	14	-1
Rajasthan	68548437	14	13	-1
Arunachal Pradesh	1383727	1	0	-1
West Bengal	91276115	18	17	-1
Mizoram	1097206	1	0	-1
Nagaland	1978502	1	0	-1
Dadra and Nagar Haveli	343709	1	0	-1
Daman and Diu	243247	1	0	-1

Source: Population figures are from Census of India 2011, and a number of medical colleges are from MCI Jan 2016.

Mudaliar committee (1961, p.340) set up a norm for one medical college for 5 million population, even though it is an old norm, it shows the interstate variations in the spread of medical institution. Using the norm of one medical college for fifty lakh population southern and western states which include Karnataka, Tamil-Nadu, Andhra Pradesh, Maharashtra, Kerala, Gujarat and Pondicherry have an excess of 8 to 38 medical colleges. 60.67 percent of medical colleges located in all these seven states which constitute only about 35 percent of the population. Whereas in contrast to this, the states of Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Rajasthan, Arunachal Pradesh and West Bengal, which constitute 47.14 percent of the population, have just 23.30 percent of medical colleges. The states of Uttar Pradesh and Bihar have large populations and they need 8 and 4 more medical colleges respectively (table-2.6). It shows that the states of southern and western regions have an excess of medical colleges and primarily it is due to the investment by the private sector.

HLEG on UHC (2011) estimated the need for new medical colleges to be established in the

next ten years while looking at the grossly unequal distribution of medical colleges which has resulted in the skewed and unequal availability of doctors across the country. Therefore, it recommended selectively setting up (an estimated 187) new medical colleges over the next 10 years in currently underserved districts with a population of more than 1.5 million. It pointed out that medical colleges should be linked to district hospitals and mandating substantial proportion to local student (Planning Commission, 2011, p.22).

The following table-2.7 analyses the estimated number of medical colleges to be established in next ten years across states and see how many medical colleges being established from 2011.

Table-2.7
Number of Medical Colleges Estimated To Be Established in Next Ten Years (From 2011) And Number of New Medical Colleges Established From 2011

State	Estimated No. of Medical Colleges*	No of Medical Colleges From 2011#		
		Government	Private	Total
Uttar Pradesh	49	6	9	15
Bihar	27	3	1	4
West Bengal	20	4	2	6
Madhya Pradesh	18	0	3	3
Rajasthan	17	1	2	3
Orissa	10	0	2	2
Jharkhand	10	0	0	0
Assam	8	2	0	2
Gujarat	8	7	1	8
Chhattisgarh	7	2	1	3
Haryana	5	3	1	4
Punjab	3	0	2	2
Maharashtra	3	2	5	7
Jammu & Kashmir	1	0	0	0
Meghalaya	1	0	0	0
Total	187	30	29	59

Source: * Planning Commission (2011). HLEG Report on Universal Health Coverage. Planning Commission, Government of India (pp-23)
Data on medical institutes obtain from MCI 15th Jan 2016.

Even though Maharashtra and Gujarat have a high number of medical colleges, these two states are in a leading position to establish new medical colleges as Gujarat fulfilled the recommendation of establishing eight medical colleges within five years of the period. Similarly, medical colleges in Maharashtra exceed the numbers recommended by HLEG report (three medical colleges in ten years) and established new seven medical colleges within five years of the period (Table-2.7). Moreover, in Jharkhand, there is a total of three government medical colleges and that too last one established in 1969. After 1969 there is not a single medical college being established in Jharkhand. Similarly UP and Bihar needs a number of medical colleges to be established (Table-2.7). However, there is less attention being given to establish new medical colleges in these states. Most of the states mentioned in the table-3.7 are Empower Action Group states which are considered low in demographic and socio-economic indicators (GOI, 2001; GOI, 2011c).

The HLEG report recommended the state involvement in establishing medical colleges, however it shows that the role of the private sector is still prominent (Table-2.7).

Specifically, this is seen in the states of Madhya Pradesh, Orissa, and Punjab where new medical colleges being established only by the private sector. Even in UP, the private sector is prominent as nine new private medical colleges being established within five years of the period (Table-2.7). This clearly shows that even though there is constant say to reduce the unevenness, inequality in the distribution of medical colleges, still there are gross inequalities in the distribution of medical colleges.

However, the HLEG report does not comment on the problems in the private medical colleges such as low quality of education, infrastructure, corruption, lack of regulation, capitation fee, and the powerful lobbies behind this growth pattern and the private investments in medical education. It is these that we explore in our study.

Human Development and Distribution of Medical colleges in India:

The growth of the medical colleges has taken place mostly in the developed and richer states of India (Mahal and Mohanan 2006; Choudhury, 2016). In 2001, Ministry of Health and Family Welfare had formed a group called ‘Empower Action Group’ (EAG). It is a group of states which are low in socio-economic indicators and have high fertility rate, infant mortality rate, and maternal mortality ratio. It includes eight states of Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan. Alongwith these states,

Assam has also been included in the Annual Health Survey plan (GOI, 2001; GOI, 2011c; Arokiasamy and Gautam 2008).

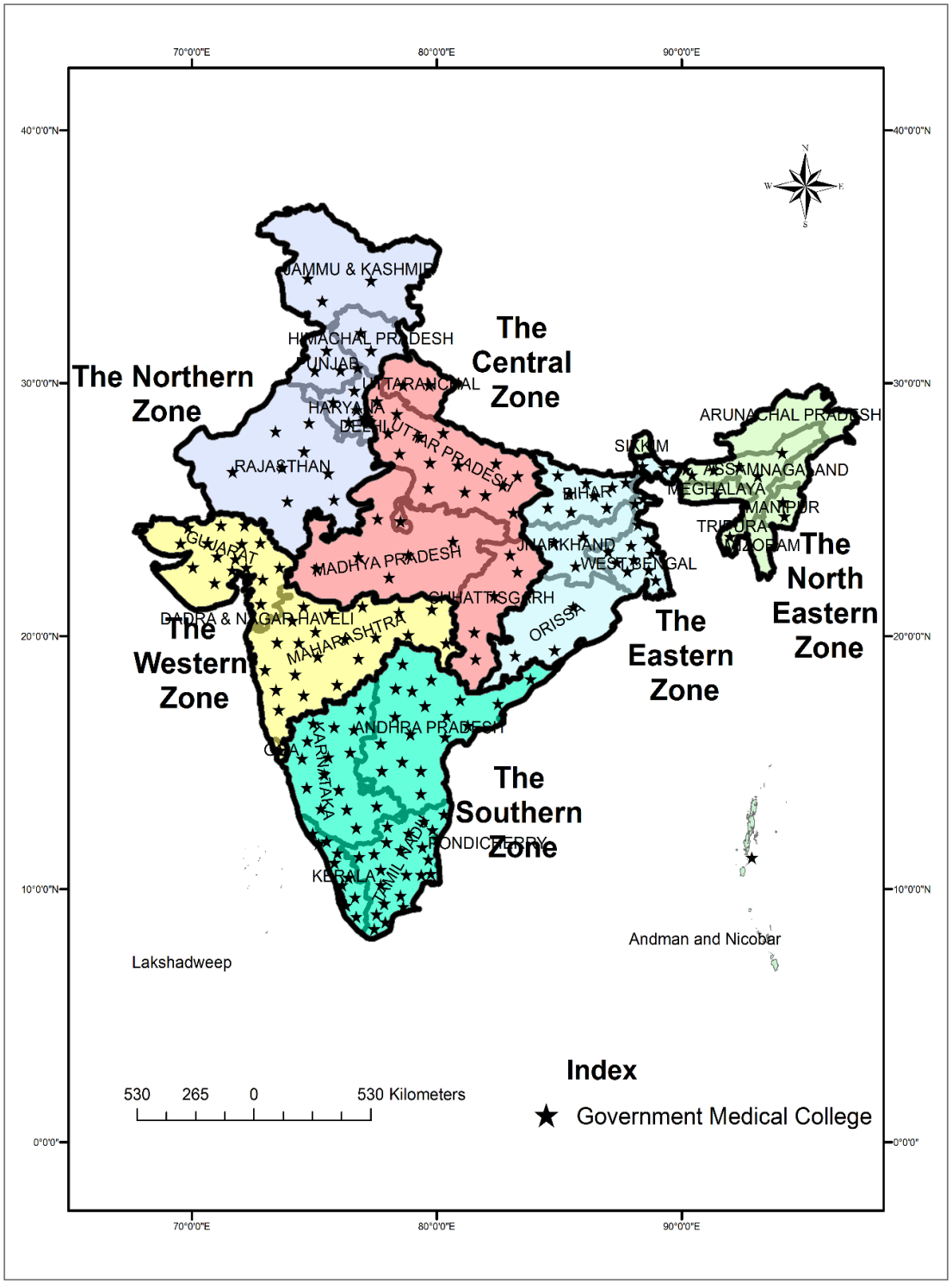
The report of the government of India (2011) and Sample Registration System (2011) shows that most of the states in the northern, central, eastern and north-eastern considered as high focus states and are relatively low in many health indicators such as infant mortality rate, maternal mortality ratio, under five mortality rate, low levels of HB among pregnant women, low levels of anti-natal check-ups and post-partum care, low levels of births assisted by doctor/Nurse/ANM or any other health personnel, low percentage of institutional delivery etc. In all these health indicators most (not all) of the states from the northern, central, eastern and north-eastern are below than the national average (GOI, 2011a; GOI, 2011b; CBHI, 2015).

Even in socio-economic indicators, the states are performing low mostly belong to the northern, central, eastern and north-eastern side. The CBHI (2015) report on national health profile have pointed out that the states of Bihar, Arunachal Pradesh, Rajasthan, Jharkhand, Andhra Pradesh, Jammu and Kashmir, Uttar Pradesh, Madhya Pradesh, Chhattisgarh Chandigarh and Assam are below the national average in terms of literacy rate (CBHI, 2015, p.30). The percentage of population below the poverty line is highest in Arunachal Pradesh and Dadra & Nagar Haveli (39 percent) and states of Assam, Bihar, Chhattisgarh, Jharkhand, MP, Manipur and Orissa have above 30 percent population below poverty line and UP it is 29.4 percent (ibid, p.34).

This has been pointed out in terms of to see the states which are low in health, demographic and socio-economic indicators are also having less number of medical colleges (Map-2.1 and 2.2) This can be seen more in detail through national human development and distribution of medical colleges across states (see Map 2.1, 2.2 and 2.3).

Map-2.1

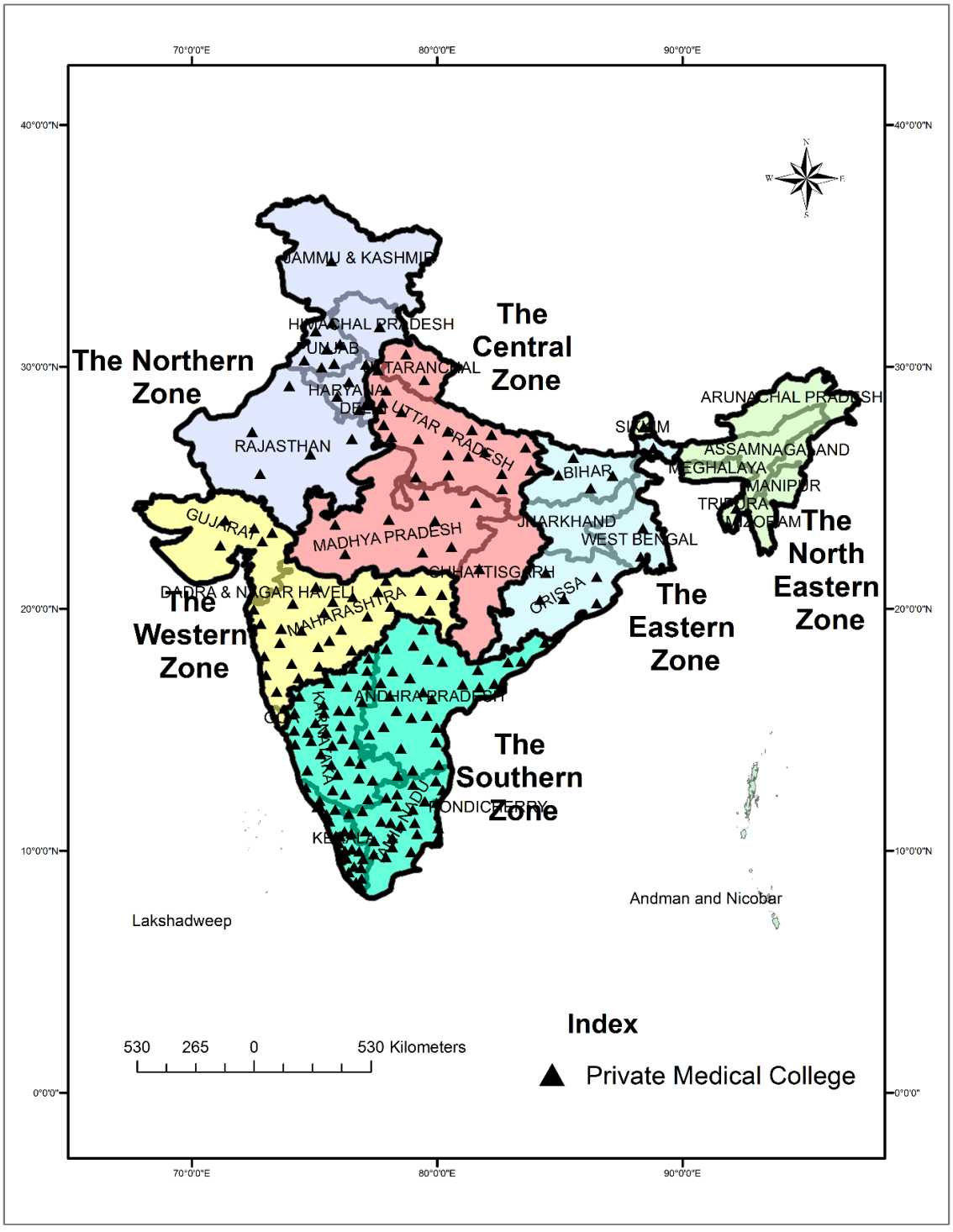
Regional Distribution of Government Medical Colleges in India



Source: Map is prepared based on data available on MCI Records as accessed on 15th Jan 2016.

Map-2.2

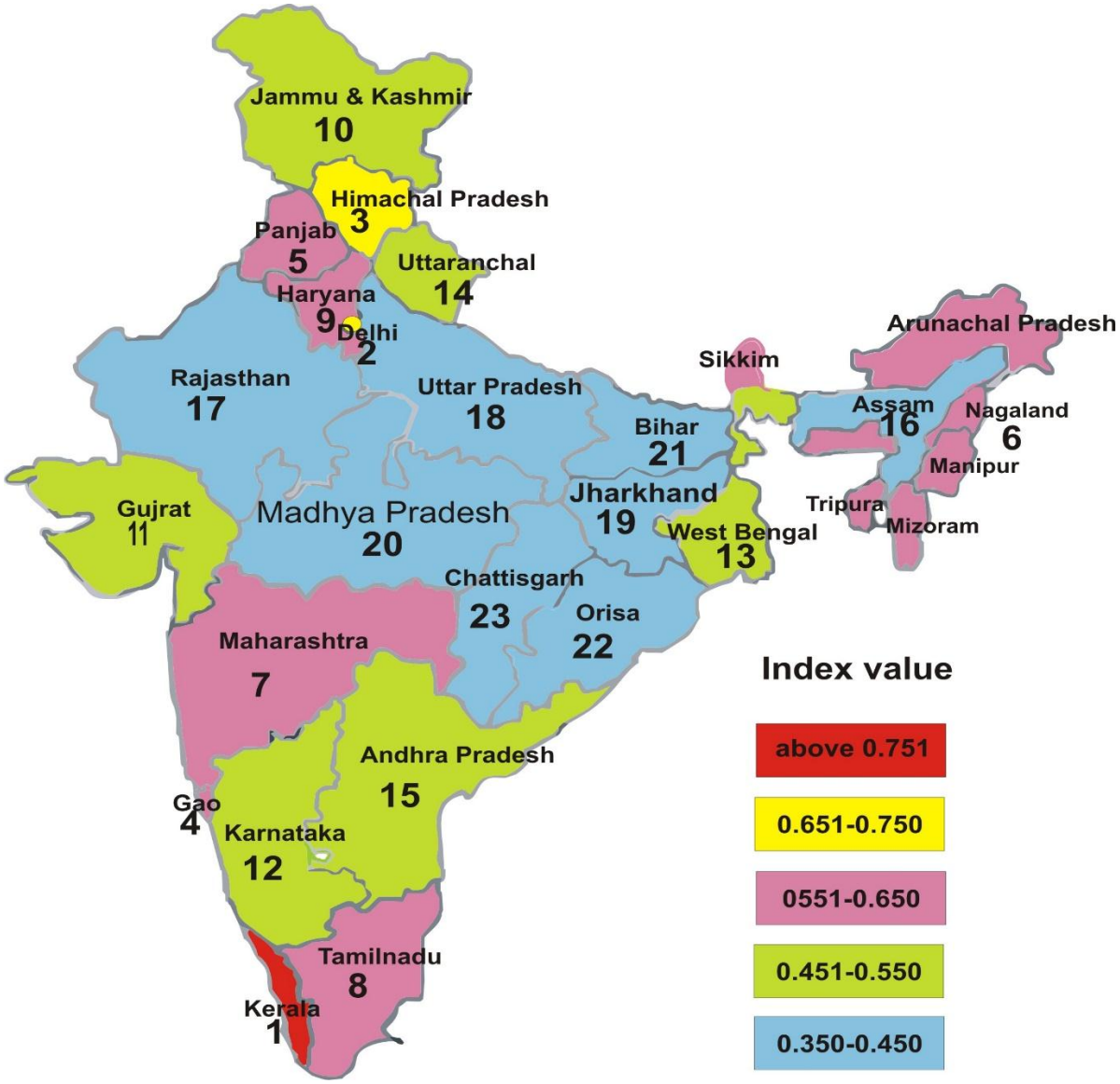
Regional Distribution of Private Medical Colleges in India



Source: Map is prepared based on data available on MCI Records as accessed on 15th Jan 2016.

Map-2.3

National Human Development Index (2007-08)



Source: Institute of Applied Manpower Research (IAMR) and Planning Commission 2011.

The map of national human development (Map-2.3) shows that the states of Chhattisgarh, Orissa, Bihar, MP, Jharkhand, UP, Rajasthan, and Assam are in lowest ranking in human development indicators and have HDI below the national average. The summary report on human development index (2011) mentions that the states that perform better on health and education outcomes are also the states with higher HDI and thus higher per capita income (IAMR and Planning Commission, 2011, p.1).

If we relate this with the distribution of medical college in India (Map-2.1 and 2.2), then it clearly shows that the states which are less developed in terms of its human development index have relatively less number of medical colleges. Moreover, this is witnessed both in the government and private medical colleges. Whereas the states which are relatively developed, have a high number of medical colleges.

Few reasons cited for this kind of pattern of growth across states is that it is the possibility that the students from better-off states might have the capacity to pay the high cost of medical education in private medical colleges. Secondly, it is relatively easy to fulfil MCI norms to establish medical college as in southern states there are doctors returning to home states from foreign countries, and therefore the availability of qualified teaching faculty required to establish medical institution meets the MCI norms. And thirdly, the competition amongst the states to attract private investment in medical education and hence states specifically in the southern and western regions have offered various tax exemption and other facilities to the private investors (Choudhury, 2016, p.76). It is also the fact that the students from the northern region coming to the southern and western states to pursue medical education in private medical colleges and mostly these are the students from a rich background.[13] The another point is that the rapid increase in medical seats in last three and a half decade is because of the rapid expansion of private medical colleges in India (Rao, et al. 2011).

Human Resources in Health: Density of Doctors:-

At the time of independence there was scarcity of human resources in health. Accessibility and availability of health services was an important input to improve the poor health status of the Indian population. Skilled human resources was an important input for health services development. (Bhore Committee, 1946). The Bhore Committee (1946) recommended establishing more medical colleges in order to achieve self-reliance in human resources in health (ibid). Thereby implicitly accepting a doctor dominated model of health service development. This led to the importance of investing in medical over nursing and paramedical education.

[13] Some of the interviews conducted in the Maharashtra and Karnataka have mentioned this fact and the students along with their parents come with bulk of amount to pay high capitation fee and the tuition fees.

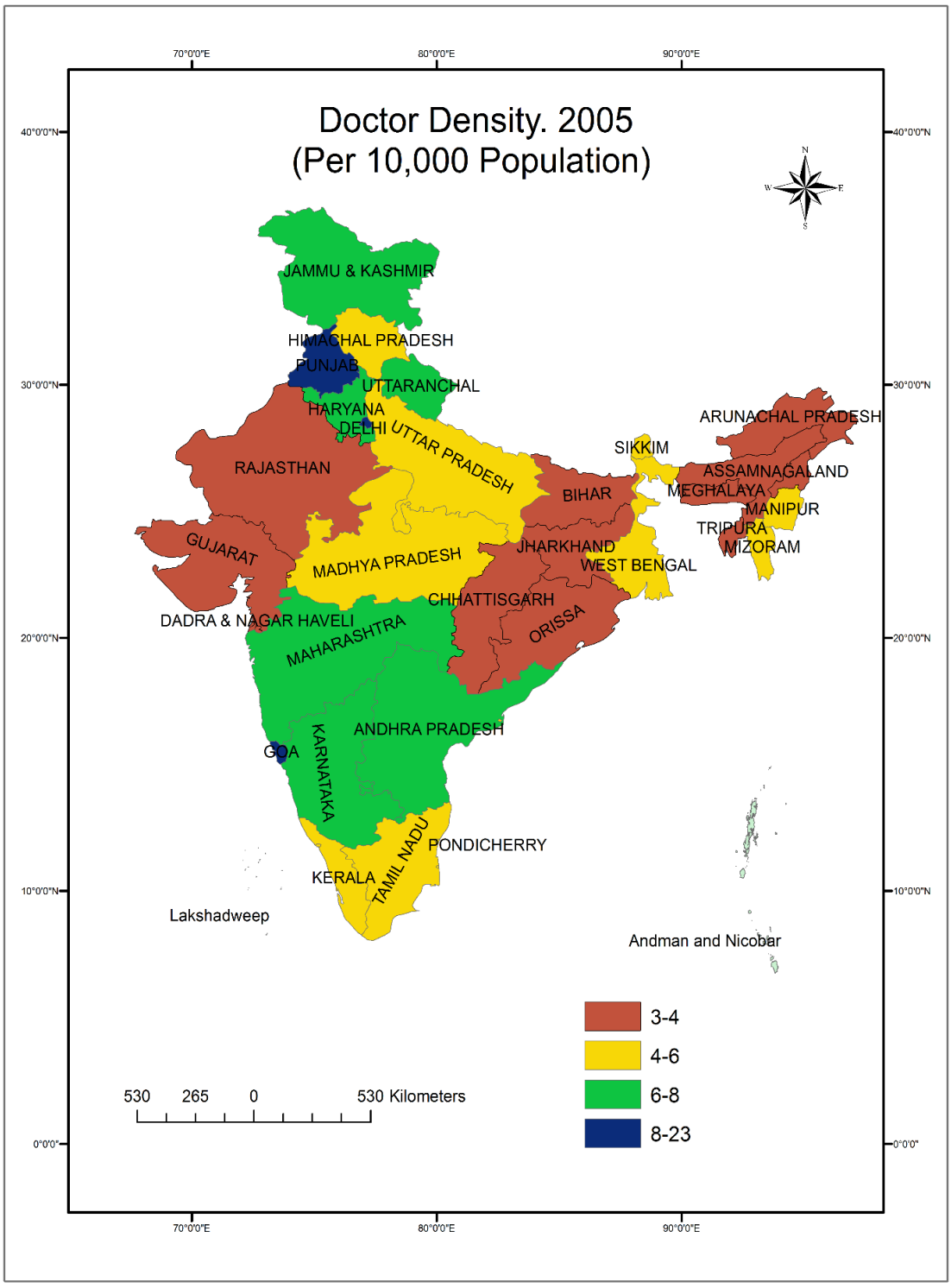
However, we have seen in the earlier sections that, over a period of time the rapid growth of medical colleges have taken place and specifically in last three decades it is in the private sector. So then it is important to ask does the public health system have an adequate number of the skilled health workforce in the system?

Human resources in health is an important aspect to achieve the goal of Universal Health Care as the health of the population as well as the quality of care is depended on the kind of skilled health manpower available in the system (Hazarika, 2013; GOI, 2005). Even to provide health care services at the primary, secondary and tertiary levels, there is a need to produce an adequate number of skill mixed health workers and their fair distribution across the population (Rao, et al. 2009; Rao, et al. 2011; GOI, 2005; GOI, 2016). However, even though there is a huge expansion in establishing of medical, dental and nursing education, there is a huge shortage of human resources in health. Moreover, there is highly uneven distribution of available human resources thereby increasing inequalities in access to the health services (GOI, 2005; Hazarika, 2013; Rao, et al. 2009; GOI, 2016). One of the important challenges to achieving health policy goals is to have adequate availability and expertise in the health workforce. It is being mentioned that, acute shortage of human resources with an average for all districts of 0.4 doctors per 1000 and 0.32 nurses per 1000 population as against the national average of 0.59 for doctors and 0.79 for nurses per 1000 population and a global norm of 2.25 of human resources per 1000 is made worse with nearly two-thirds concentrated in urban towns (GOI, 2005, p.51).

Rao, et al. (2009) using Census data, analysed the size, composition and distribution of health workforce in India. The study found that there are significant interstate variations in the health workforce. It observed that the density of health workforce is below the global norm (2.25/1000). Within India it ranges from 23.2 in Chandigarh to 2.3 in Meghalaya. Goa and Kerala have doctor densities up to three times as high as states like Orissa and Chhattisgarh. The health workforce is highly concentrated in urban areas and mostly works in the private sector both in rural and urban areas (Rao, et al. 2009, p.1).

The following map 3.4, the density of doctors across states shows the unequal distribution of medical doctors in India. It shows the correlation between the availability of medical colleges and the density of doctors. The density of doctors is relatively high in those states which have large number of medical colleges (see map-2.1, 2.2 and 2.4).

Map-2.4



Source:- Rao, et al. 2009 (pp-3).

It shows that Kerala and Goa which have relatively high number of medical colleges, the density of doctors is three times higher than the state of Chhattisgarh and Orissa which have less number of medical colleges (Rao, et al. 2009).

Similarly, in the southern and western regions the states of Andhra Pradesh, Karnataka, Tamil Nadu, Pondicherry, Kerala, and Maharashtra have relatively high doctor density which ranges from 4-8 doctors per 10,000 population with Goa reporting highest doctor's density which is of 13 per 10,000 people. Similar doctor density (4-8/10,000) is also found in the states of MP, UP, Uttaranchal, Punjab, Haryana, Delhi, J&K, Chandigarh, HP, West Bengal, Manipur, Sikkim, and Mizoram. However, it shows that the states of Bihar, Jharkhand, Chhattisgarh, Orissa, Assam, Rajasthan, Gujarat, Arunachal Pradesh, Nagaland, Meghalaya, Tripura have the lowest doctor's density which ranges as low as 3 to 4 doctors per 10,000 population (Map-2.4).

There are about 3.8 allopathic doctors per 10,000 population. However, the doctor's density is high in urban areas compare to rural areas. The number of allopathic doctors per 10,000 people is more than three times larger in urban areas (13·34) than in rural areas (3·28). It is also the fact that most of the health workforce is employed in the private sector as around 70 percent of all health workforce is employed in the private sector and most importantly the 80 percent of allopathic and AYUSH doctors and 90 percent dentists work in private sector. This is both in urban and rural areas (Rao, et al. 2009; Rao, et al. 2012; Rao, et al. 2008).

Rao et al. (2012) show that in general there is an association between health workforce density and the health outcomes as it suggests that the better health workforce density, the better the health outcomes. It also points out that there are several other factors associated with the better utilization of services and health outcome other than the health workforce density, such as per capita state spending on health, workforce density and health. It shows that the Bihar and Uttar Pradesh with low levels of health workforce density have a high level of infant mortality compare to Kerala and Goa which is opposite that of Bihar and UP. It mentions that, in general, states with higher per capita health spending have higher workforce density and better health outcomes. (Rao, et al. 2012, p.5).

This clearly shows that the uneven distribution of doctors across states, the rural-urban disparity in doctor's density along with predominant private sector leads to increasing disparity in accessing health services, specifically among poor and lower sections of the society which ultimately leads to increasing disparity in the health status of the population (GOI, 2016).

Doctor-Population Ratio:

According to the parliamentary standing committee report on Medical Council of India (2016), there are 9.29 lakh doctors registered in the Indian Medical Register (as on 2014). However it is important to note that the medical register maintains by MCI and state councils are not the live register thereby getting factual data on the exactly registered doctors is a major challenge. Hence calculating doctor population ratio is highly difficult. Even with this figure (9.29 lakh registered doctors) and assuming 80 percent availability it is estimated that, 7.4 lakh doctors might be in the actual service. Hence the doctor population ratio is estimated to be of 1:1674. The WHO norm for doctor population ratio is of 1:1000 (GOI, 2016, p.12). This shows that even though there is an expansion in the production of doctors, there is a shortfall of doctor population ratio, specifically this shortfall is acute in remote and rural areas. The density of allopathic physicians in urban areas was four times that of rural areas, and for nurses and midwives, it is three times that of rural areas (Rao, et al. 2009, p.2).

Choudhury (2016), shows that the number of registered doctors per million population varies widely across states. It is the lowest in Jharkhand and highest for Goa. Most of the states belonging to the northern and eastern regions of India have less than five doctors per million population, whereas most of the southern and western states have 5-10 doctors or more than 10 doctors per million population (Choudhury, 2016, p.76).

***Shortage of Doctors in Public Health System*:**

Even though over a period of time there is a growth in the production of health workforce there are vacant positions of the medical and para-medical staff in the public health system (GOI, 2016; Rao, et al., 2011).

Bulletin on rural health statistics 2010 and 2015 gives a picture about the shortage of the medical personnel in the public health system. Comparative analysis was done on the shortfall of doctors in Primary Health Centre (PHC) and Community Health Centre (CHC) in 2010 and 2015; then it shows that the shortfall has increased significantly. The data provided by rural health statistics (2010) shows that there was a 10.03 percent shortfall of allopathic doctors in PHC's whereas the 2015 data shows that there is an 11.9 percent shortfall of allopathic doctors in PHC's of the total requirement of existing infrastructure. The shortfall has increased by 1.6 percent from 2010 to 2015. At CHC level it shows that the shortfall of specialists has increased by 18.6 percent from 2010 to 2015. As in 2010, 62.6 percent of an overall shortfall of specialists at CHC's whereas in 2015 it shows that 81.2 percent of an overall shortfall of specialists for existing infrastructure. Among the specialists at CHC, the

shortfall of surgeons has increased by 20.6 percent, for Obstetricians & Gynaecologists it increased by 21.1 percent, physicians by 11 percent, and paediatricians by 12.6 percent from 2010 to 2015 (GOI, 2010; GOI, 2015)

The report on rural health statistics (2015), mentioned that the specialist doctors at CHCs, the number has declined from 4091 in 2014 to 4078 in 2015. Major decreases have been noticed in the states of Rajasthan (125) and Punjab (29) (GOI, 2015, p. iii)
It pointed out there is a total of 2041 PHC's are working without doctors, 9649 are without lab technician, and 5553 PHC's are without pharmacist (ibid: 63). There is a total of 2477 vacant positions[14] of surgeons at CHC's, and this is majorly seen in the states of West Bengal, Uttar Pradesh, Rajasthan, Gujarat, and Madhya Pradesh where vacancy ranges from 188 to 546. Similarly there are total of 2242 vacant positions for Obstetricians & Gynaecologists at CHC and this is largely seen in the states of West Bengal (746), Uttar Pradesh (409), Madhya Pradesh (242), Orissa (235), Rajasthan (172), and Chhattisgarh (136) (GOI, 2015, pp.65-66). These are the states have relatively high IMR and MMR as well as have relatively less number of medical colleges.

This chapter made clear that the growth of private medical is seen largely in the developed states of India which has been driven by the private investments. This uneven growth of medical colleges increases the regional disparities in the states. However, there are also other social, political and regional determinants of this pattern of uneven growth in medical colleges across states. The expansion of private sector in higher education with a focus on medical colleges have been explored in the next chapter. While the fourth and the fifth chapters explores in detail the socio-political and regional detereminants that has shaped and influenced the growth in private medical colleges, with a specific focus in the states of Karnataka and Maharashtra.

[14] Vacant positions means the number of positions sanctioned but not filled and shortfall means the positions required for existing infrastructure but not fulfilled the required numbers.

Chapter-III

Socio-Political Determinants of Growth of Medical Colleges in India

The inequities in the growth and distribution of government and private medical colleges has been demonstrated by few studies (Mahal and Mohanan, 2006; Supe and Burdick, 2006; Hazarika, 2013; Ananthakrishnan, 2010) and the previous chapter has garnered additional sources to highlight these inequities. The inequities in the provisioning of medical colleges is not merely an empirical artefact. This requires an explanation of the trends that we have observed. The explanation needs to draw from the disciplines of social sciences that gave importance to the historical, socio-political factors that influence the growth of institutions in general and in this case medical colleges in particular. This chapter reviews major studies that demonstrate the linkages between development, class/caste and entrepreneurship in rural and urban areas.

Economists, sociologists, anthropologists and political scientists have examined these intersections in relation to the economy, society and politics in rural and urban areas. They have examined the relationship between the diversification of agrarian surpluses into a range of commercial activity, the rise of intermediate caste and class that have contributed to commercialization of the economy and social services. Scholarly work shows how agrarian prosperity and accumulated surplus due to the green revolution, has created a class of rich peasants or capitalists farmers. This class had started investing their surpluses into a variety of enterprises. Overtime these classes have accessed higher education and gained social mobility. Over generations this class has moved into urban areas while retaining their rural roots. Thus, these certain caste and class groups have maintained their power in rural as well as in urban areas (Upadhya, 1988a; Upadhya, 1997; Omvedt, 1981; Rutten, 1986; Rutten, 2003, Kamat, 2011). These trends have a bearing on the growth of higher educational institutions with special focus on professional education (Kamat, 2011; Kaul, 1993).

Social and Regional Determinants of the Growth:

The important question that arises out of the interstate variations in the distribution of medical colleges is why is this so? To provide an answer to this question, one needs to

study the role of social and regional characteristics behind this growth of private medical colleges. In terms of the social characteristics the caste and class background and its role in the development of private medical colleges and in terms of regional characteristics urban-rural spread, regional development, political powers are the important aspects to explore.

In India since independence specifically after the green revolution the rise of upper caste landowner's and their assertions in the economic and political domain has increased tremendously. However, it is a well-studied fact that in the southern states and western state of Maharashtra the Brahmins domination was challenged more effectively in the early twentieth century (Frankle and Rao, 1989) whereas Kohli (1988) pointed out that this is distinct from the north Hindi speaking belt where Brahmin domination was challenged relatively recently (Kohli, 1988, p.15). Further, he explains that in the southern states the power base in terms of economic and political was dominated by the middle castes and classes (ibid). On the similar lines, Palshikar also argues that the rise of the locally or regionally 'Dominant Castes' took place because in the fifties the Non-Brahmin Movement in the south led to the regionally 'Dominant Caste' mostly the middle peasant castes to extend their political power at the regional level (Palshikar, 2006).

The Concept of Dominant Caste:

The concept of dominant caste is evolved by M. N. Srinivas (1955), and he theorized it as

> "a caste may be said to be "dominant" when it preponderates numerically over the other castes, and when it also wields preponderant economic and political power. A large and powerful caste group can be more easily dominant if its position in the local caste hierarchy is not too low" (Srinivas 1955 as cited in Srinivas, 1959, p.1).

The above definition provides different elements of domination that is a numerical strength, economic and political power and hierarchical position in the society. The author also provides another important element that is education. The level of education can be one of the means to acquire dominance. The author did an anthropological study in the Ramapura village of Mysore city in South Karnataka. He

analyzed that in Ramapura village peasants are dominant and have more than one element of dominance. It states that,

> "….a caste which is numerically strong and wealthy will be able to move up in the ritual hierarchy if it Sanskritizes its ritual and way of life, and also loudly and persistently proclaims itself to be what it wants to be. It is hardly necessary to add that the more forms of dominance which a caste enjoys, the easier it is for it to acquire the rest" (Srinivas, 1959, p.3).

Palshikar (2006) argues that there is a link between caste and location (region) and provides evidence that many castes are located in certain pockets or by regions, such as in Andhra Pradesh, Kammas are mostly located in Krishna, Guntur and Prakasam regions, and the Reddys are located in Rayalaseema and Telangana regions. In Maharashtra, Maratha caste and its sub-castes such as Kunbi Maratha are spread all over the state and in the Konkan region mostly one sees the Agri caste. In Karnataka, Vokkaligas are concentrated in Mysore region. Gounders and Naidu's in Tamil-Nadu State etc. Along these lines Palshikar argues that this region wise and location wise caste associations have resulted in two political ways. One is that the rise of the dominant caste. Local domination indicates the links between the domination and numerical strength. The castes which have numerical power with control over resources such as land create local domination in terms of economic and numerical strength. The other political way resulted in terms of political elections. He says that "localized pockets of castes have come to mean that candidates of a particular caste will always get elected from certain areas. Our study of Maharashtra gives ample evidence of this: The Maratha-Kunbi caste cluster, which is spread almost over the State, manages to send the largest number of Member of Legislative Assembly's (MLA) to State legislature irrespective of political upheavals. In 51 constituencies, the elected candidate has always been a Maratha, consecutively for six elections since 1978" (Palshikar, 2006, p.5).

"From mid-fifties onwards, politics in most states centered around one (or two) regionally dominant caste(s). In most cases, middle level (often peasant) castes sought to contest the ritual superiority, material ascendance and political domination of 'upper' castes - mostly Brahmans, and in the north, Kayasthas and Thakurs. In the first half of the twentieth century, the middle-caste protests took the form of non-Brahman movements in Maharashtra and in the south. In the second half of the

twentieth century, the middle castes extended their claims to state power at the regional level. In both these phases, the middle castes sought to transcend the localized nature and assume a 'regional' identity" (Palshikar, 2006, p.6).

It has been noted that there were capitalist farmers before Independence. However, their significance as capitalist farmers and their inclination towards agricultural enterprises and reinvestment in industry increased after independence (Rudra, et al. 1969). As Daniel Thorner (1967) in his study mentioned that the large and small peasants have benefitted from the green revolution and government also helped them in terms of the loan with low interests. He says that in Andhra Pradesh after 1959 during his second visit in 1966, the changes took place over a period of time was impressive. Large and small farmers started using high technology and variety of seeds, fertilizers, pesticides, etc. "The best-off families in the villages were benefiting in ample measure from government help. They were getting Japanese, Polish and other foreign power-cultivators, tractors, etc. through government loans at low interest. The really large scale farmers in effect, millionaire cultivators were investing their gains from agriculture in trade, transport, money lending, and industry" (Thorner, 1967, p.241).

It is implicitly explained that the land reforms which took place in India in terms of redistributing lands among the tenants or to the land of the tiller was a failure. It analyses that the land reforms failed in India because the political authorities were more inclined towards keeping the class interests of the rural regions. They were disinclined to face up with the powerful castes and classes in the countryside (Kohli, 1988). Kohli (1988) clearly points out that "the attempts to redistribute land to the landless, to provide education and health to the poor, and to create employment via public works type of programs, have all been largely ineffective. The underlying causes include the absence of a real commitment among state elites, poor quality peripheral bureaucracy, but most of all, powerful vested interests who have often opposed or subverted such efforts" (ibid, p.3). In this regard, it also observed that after independence number of legislations was being passed with regards to land reforms. However, there was an ambiguity in the legislation which were kept intentionally and that made a possibility among dominant landowners to redistribute their land amongst the relatives. Thus, it was possible for them to evade a difficulty by moving out the

tenants and using multiple sources to escape from legislations and thus indirectly keeping the land on their names only (Jodhka, 2004). Jodhka (2004), analyzed the transformations which took place in agriculture and shows how the commercialization of land and how the land was seen as a commodity in the periods of colonial rule. He also analyzed the changes that took place after land reforms and green revolution and argued that there is an emergence of a new capitalist mode of production, technology, and market-oriented agricultural production which has certainly strengthened the rich farmers economically and politically. It led to the emergence of a new class of surplus producers. Also, the development programmes which took place after independence were mostly benefited to the large middle-level caste groups (Jodhka, 2004).

Mario Rutten (2003) conducted a study in central Gujarat of Kheda district also demonstrates that the introduction of green revolution with the use of new technologies, expansion of irrigation, application of new fertilizers, varieties of seeds, pesticides, etc. has led to the development of agricultural production and thus increased the capital intensity of agriculture over the decades. This development led not only to increase in agriculture but also resulted in the expansion of industries. He states that "this process of long-term agricultural development and rural diversification in central Gujarat has been socially confined to the class of middle-large farmers, traders, and small-scale industrial entrepreneurs. In the Charotar tract, this class consists primarily of members of the *Patidar* community, an upwardly mobile, middle-ranking peasant caste which makes up about 15 to 20 percent of the population in this part of Gujarat" (Rutten, 2003, p.44). This *Patidar* community has the control over resources (largest amount of land) and has dominance in the villages of this region. So this is the community which has benefited a lot from the agricultural development in the region. The majority of the *Patidar* community members are found to be in the agriculture, business, trade and industrial entrepreneurship. The high level of accumulation of surpluses has been diversified in the agricultural trade as well as non-farm activities which have more profits. This rural economic diversification has increased during the last few decades (Rutten, 1986; Rutten, 2003).

Harish Damodaran (2008) also observes that in Gujarat and Maharashtra the two dominant castes of *Patidar* and Maratha respectively gained upward economic mobility through the co-operative movements. Numerically these are the largest communities in the state and they were in a position to make alliances between the

small and large land holders within these respective communities. In Maharashtra, the co-operatives are being headed by one of the rural industrialist and these are mostly by Maratha's who have political influence in the state. The main chief ministers in Maharashtra belongs to the Maratha community as first was the Yeshwantrao Chavan from 1956 to till 1962 and then the Vasandada Patil, who was elected two times and then one of the significant person Sharad Pawar, who was elected three times in Maharashtra (Damodaran , 2008).

Baviskar's work highlights the politics of co-operatives and rural development in India in general and Maharashtra in particular. The most important finding of his study is the transformation of *Sahakar Maharshis* to *Shikshan Maharshis* through the sugar co-operative societies in Maharashtra (Baviskar, 2007; Bawiskar, 1980).

Similarly in Andhra Pradesh landowning peasant castes primarily the Kammas, Reddys and Rajus have diversified agrarian surpluses into the industrial sector (Damodaran, 2008; Upadhya, 1988a; Upadhya, 1988b). Damodran (2008) explains in detail the Kamma dominance and their investment since just before the independence. Primarily after the great depression, investment started on a smaller scale. Initially, these investments were made by the rich farmers who were the *zamindars.* Gradually the well to do farmers also started investing their income into the trade, business, and industry. The initial investment was mainly in the construction, government contracts, and transport. The film industry was also dominated by Kammas and Reddys. So over a period of time Kammas have entered into the whole range of profit-making activities from sugar, rice and tobacco industry to transport, government contracts, ferro-alloys, textiles to Cinema (Damodaran, 2008).

Upadhya (1988b) argues that income generated through land and agriculture was one of the important sources of capital to start a business or industry in urban settings. This is being added to the strong kinship social networks benefitted to sustain rural-urban ties. The study shows that there is a substantial outflow of resources either in cash or in kind from rural to urban areas. Whereas it is found that this outflow of resources doesn't happen in vice versa such as income generated through business or industry doesn't seem to be invested in purchasing land or developing agricultural activities (Upadhya, 1988b, p.1438). Thus, this process has created a new class of businessmen and it has several factors associated with such as historical processes that

led to emergence of capitalist farmers, commercialisation of agricultural economy, emergence of rich peasant class, development of cities and its integration with rural areas, early interest in education, the politicisation of caste identity and, later, the green revolution and land reforms (ibid, p.1433).

In Karnataka, Narayan (2011) also points to the stability in the dominance of Vokkaligas and Lingayat communities. He states that "local dominance across the state is regionally balanced between the two major communities in that the Vokkaligas tend to dominate eastern districts of Karnataka and the Lingayats the west. This partly explains why although every chief minister of the state was Vokkaliga until 1956, only Lingayat chief ministers ruled the unified state between 1956 and 1972. In the latter period, the Lingayats came to dominate the Vokkaligas" (Narayan, 2011, p.5).

Caste and Class Nexus in Higher Education*:*

The work of Kaul (1993) clearly pointed out the nexus between the caste, money power and politics and its linkages to education in Karnataka. It shows, how the capitation fee colleges have been used by the caste based associations to gain political support or seen as vote banks in electoral politics. The study revealed that "political or caste leader is able to secure a college for his area gives him social prestige and gets him the electoral support of his caste members, and caste structures serve as convenient mechanisms for mobilising electoral support and building 'vote-banks.' Such leaders also rely on financial support for themselves from such colleges during elections" (Kaul, 1993, p.243). The class analysis of the aspect of caste, class and politics of capitation fee colleges shows that most of the managers of caste based colleges belong to the big landlords, businessmen, industrialists, bureaucrats or lawyers. Often they are political leaders as MLA's and Member of Parliment's (MP). "Hence, with the support of the community, political power, and financial strength they are able to influence the government for permission to start an institution. Later, they were able to exert pressure on the government to ensure that the admission policy was so framed as to be conducive to their own political interests" (ibid, p. 243). "Private enterprises in education have undergone major changes, where control over educational resources is seen as one involving material rewards, prestige, and power. Under these changed circumstances setting up and managing professional colleges by

caste based associations has taken on a more narrow and partisan meaning" (Rudolph and Rudolph, 1972 as cited in Kaul, 1993, p. 29).

Kamat, Mir and Mathew (2004) as well pointed out the caste basis in the establishment of professional colleges in India especially in the southern and western states. They pointed out the privatization of technical education and the rise of middle castes and states that "almost all were formed under the patronage of caste-based trusts that then spun off as Educational Societies that came to dominate the techno-managerial education sector in the 1980s. These institutions openly claimed their caste basis and their caste specific educational goals…. The organization of caste groups into 'secular' trusts had its origins in the nationalist movement. Most of these trusts started in the 1930s and 1940s, diversified into primary and secondary education in the 1950s and engaged in large-scale expansion of techno-managerial education in the 1970s. This strategic caste-based mobilization was a conscious strategy that dates back to the colonial period" (Kamat, Mir and Mathew, 2004, p.11).

In the context of Andhra Pradesh Kamat (2011) shows that in erstwhile Andhra Pradesh, Hyderabad has become a major feeder to the global economy. She studies the caste and class relations in the education sector. She argues that the state has supported and promoted private investment through providing subsidies in land and other infrastructural support. It has also provided accreditation and credibility to these private higher educational institutions. The study highlights how the state was responsible for the stagnation in the growth of the public sector while promoting political aspirations of powerful caste based communities to further expand the private sector. As Kamat (2011) observes,

> "Affluent rural caste groups that were disadvantaged in a public education sector that was both small in scale and highly selective founded their own degree-granting institutions that were subsidized by the state. Over a period of a decade, an extensive network of 'aided' colleges that were financed with an agricultural surplus by wealthy peasant caste groups offered science, engineering degrees, and medical degrees. Demand for professional degrees only grew and by the 1980s this sector of aided private higher education in engineering and the sciences rapidly expanded. Caste based investment in higher education was thus a primary mode through which economic mobility occurred and set the stage for the development of an extensive private higher education sector funded by coastal Andhra capital" (Kamat, 2011, p.193).

Krishnan (2014) points out the relationship between the post liberalisation period and the growth of private professional colleges and argues that the role of the state which led this expansion to occur. It states that "reform-driven economic and cultural transformations do not tell the entire story. Rather, privatisation in the higher education sector was a distinctively political phenomenon, albeit one triggered by economic reform" (Krishnan, 2014, p.70).

Upadhya's (2014) work pointed out the cultural economy of education. It observes how engineering degrees have high status among the Indian middle classes by locating the phenomenon in the context of caste and class relationship which shaped during the colonial and postcolonial period. The emergence of regional elites who saw education as one of the means of upward mobility started investing on their children's education. In the context of Andhra Pradesh it also discussed in detail how the urban areas such as Vijayawada and Guntur became the centres of attraction for education. It also states that "The strong interest in education in Andhra was also linked to the rise of caste politics and the consolidation of the major dominant castes into region-wide social categories in the early 20th century. The deep interest amongst the Kammas, for example, in education was reflected in the establishment of a number of schools, colleges and student hostels by wealthy caste members from the 1920s, often through family trusts that continue to manage educational institutions in the region even today" (Upadhaya, 2014, p.9). The work also pointed out how the education has become business because the regional elites and business class saw a lucrative opportunity in education. It points out that education became as an interest for Kamma's in Andhra Pradesh because it provides "social service or philanthropic gesture, thereby enhancing the social status of the founders. From at least the 1970s, education became a major avenue for the accumulation of capital in Coastal Andhra" (Upadhaya, 2014, p.9). It pointed out the link between regional capitalist classes and the growth of private educational institutions (ibid). "Education was a key sector for investment by these new business classes, while the flowering of private engineering, medical and other such colleges was also an important factor behind the emergence and consolidation of these classes. From coastal Andhra to central Gujarat to western Maharashtra and coastal Karnataka, the rise of private educational empires has gone hand in hand with the appearance of "new capitalists", yet the significance of this phenomenon has hardly been noted by sociologists" (Upadhaya, 2009, p.24). "Most

of the older colleges have grown into large groups of institutions, or 'education empires', which include everything from nursery and primary schools to intermediate colleges and engineering and other professional institutes. Most of these groups expanded organically over several decades, usually starting out as an engineering college funded by a family trust which then branched out into other kinds of institutions" (Upadhaya, 2014, p.10). The convergence of education with regional capital has meant that owners and managements of educational institutions have become powerful forces in the state, and a tight nexus has been forged between politicians, government agencies, and education entrepreneurs (ibid, p.10).

The growth of higher professional education increases the concerns over who has access to the educational institutions. Jayaram's (1987) argues that there are implications of inequalities in opportunity for higher education in urban areas. He argues that the "higher education, contrary to expectations, has not been contributing to upward social mobility; instead it has been functioning as an instrument for status retention or as a status stabilizer in urban India" (Jayaram's, 1987, p. 15). It points out that the "the private medical colleges are costlier and more sophisticated in their admission formalities than the government medical colleges. It is generally those who are not confident of securing admission into the government medical college who make use of private institutions, which, therefore, make more demands of such students. Eventually, only a select group of people who can meet all these demands succeed in getting entry into the private medical college. The private medical colleges in essence act as a channel of elite perpetuation" (ibid, p.94).

Studies also have shown how these social groups have diversified their interests by investing in private hospitals in the coastal districts of Andhra Pradesh (Baru, 1987). In recent times they have also promoted specialty corporate hospitals. Prominent among them is Dr. Prathap Reddy, who is the promoter of Apollo Hospitals (Baru, 1998).

In sum, the growth of private medical colleges in India specifically in the southern and western region is dominated by intermediate castes. The dominant castes group who had historically owned resources such as land have invested into agriculture and agricultural related activities and immensely benefited from it. These benefits have been further invested in non-agricultural activities such as industry, business, cinema,

sports, education, health, etc. which had surplus value. Mostly these are the same communities who have significant political power at the local, state and national level. Hence, the power of economic and political strength remained in certain sections of the community mostly among the dominant caste of the states. However, this has changed over a period of time, and in some states the ascendancy of Other Backward Caste (OBC) in socio-political eye needs further examination.

Chapter-IV

Caste, Class and Political Power: Private Medical Colleges in Karnataka

Introduction:

The state of Karnataka is important for study of privatization of medical education in India. It is the state in which the first private medical college based on capitation fee basis came into existence in 1953 as Kasturba Medical College. This was founded by Manipal Academy of Higher Education by Dr. Tonse Madhav Ananth Pai (Brahmin). Following this a number of private medical colleges were established and till today the phenomenon of private medical college is dominant in the state.

The following chapter delineates the historical background of regional variation within Karnataka and the growth of dominant peasant caste. With this background the next section follows the time trend analysis of medical colleges in Karnataka along with its regional variations in medical colleges. The chapter tries to explore why in Karnataka private medical colleges are prominent. Who are the promoters behind this growth and what would be the social and political determinants for this growth.

Regional Disparities in Socio-economic development in Karnataka:

The historical persistence of regional disparities in Karnataka is necessary to understand and contextualize the regional variations in the establishment of medical colleges. It will also help to understand how the class and caste formations took place in different regions.

Karnataka came into being as a state of the Union of India on November 1, 1956 as a result of the merger of five territories where Kannada was the language of the people. These were: four districts of the erstwhile Bombay state; three districts of the erstwhile princely state of Hyderabad; two districts and one taluk of the former Madras state; the former Part C state of Coorg (now known as Kodagu); and nine districts of the former princely state of Mysore. The new state was initially known as Mysore, but subsequently, in 1973, it was renamed ‘Karnataka’, thereby fulfilling a

long standing demand of the people of the state. There were initially, at the time of re-organization, 19 districts, but over time more districts were created. Bangalore Urban district was created in 1986 and, subsequently, in 1997-98, another restructuring led to the creation of more districts (Government of Karnataka, 2006, p.3). In terms of Human Development Index (HDI) Karnataka ranks seven among all the states of India and at International level it position is 120 while India ranks 127 (Government of Karnataka, 2006, p.307).

There is a huge fragmentation and variation in Karnataka since the state was administered by six different authorities during the British period. These six authorities included the princely state of Mysore administered by the Maharaja, the Bombay presidency, the Madras presidency, the Nizam of Hyderabad, Coorg and the tiny princely state of Sandur. Because of these different administrations there is huge difference in the development of regions and variation in caste-class configuration. Manor (1989) observes that during the early twentieth century the Vokkaliga jati, who are traditionally cultivators, were largely confined within the old Mysore state. The Lingayat jati has not been referred to in the Madras presidency. Hence, in the 1931 census there is no category of Lingayat in Bellery district. As contrast to this the Lingayats were in fact dominant in the Bellary district. So it becomes difficult to come on to any generalization on the history of caste in this region based on census data. However, the most common usage by ordinary people was of Lingayat and Vokkaliga jati clusters which were found in old Mysore state. These two categories were found to be traditionally dominant in their control over land almost all over Karnataka (Manor, 1989, pp.326-327). The regional variations within Karnataka can be broadly divided into three. This includes Malnad region which includes Uttara Kannada, Dakshina Kannada and Shimoga districts. The second one is the northern region which includes Belgaum, Bidar, Bijapur, Dharwar, Gulbarga and Raichur districts and the third is the southern region which includes Bangalore, Bellary, Chickmagalur, Chitradurga, Kodagu, Hassan, Kolar, Mandya, Mysore, and Tumkur district (Pani,1983, pp.8-9). In India before the re-organizations of states on the basis of language, (before 1956) there were provinces and the south region administration was under the old princely Mysore state. The Malnad (except Shimoga districts) and North region were divided among three administrations, Bombay Presidency, Madras Presidency and the kingdom of Nizam of Hydrabad. There are historical explanations

in the growth of these three regions. Tipu Sultan was having hold on the south region and had direct control, hence the growth of private feudal landholdings was limited in the south region. Whereas less control of Maratha and the Nizam's in north region paved the way for development of private feudal landholdings (Pani, 1983). Similarly the review done by Shiddalingaswami and Raghavendra (2010), has explained the historical processes of regional disparities in the state of Karnataka which pointed out that in Karnataka there were three regions, Mysore province was divided into three parts that is Hyderabad Karnataka, Bombay Karnataka and Old Mysore State. Historically, Old Mysore state was one of the developed regions as there were many social welfare programmes and planned activities conducted by the Mysore Kings. Hyderabad Karnataka and Bombay Karnataka were relatively neglected by the Nawabs and Marathas. However, it points out that Bombay Karnataka was reasonably better than the Hyderabad Karnatakka (Shiddalingaswami and Raghavendra, 2010). Human Development Report (2006) of Karnataka, too mentions that the princely state of Hyderabad was neither interested in growth and development of the region nor in investing in human capital (Government of Karnataka, 2006). Hence, it describes the state of regional imbalances that was there since the inception of the state and it is reflected even after the state formation.

The government of Karnataka had set up High Power Committee in 2000 to study the regional disparities and the level of development under the chairmanship of D. M. Nanjundappa and it submitted its report in 2002. The committee had taken thirty five socio-economic indicators to assess the state of development of all the taluka's in Karnataka (175 taluka). The committee has identified 114 talukas as backward talukas. The following table-4.1 is showing the distribution of talukas under the classification of backward, more backward and most backward taluks in Karnataka.

Table 4.1

Distribution Most Backward, More Backward and Backward Talukas by Administrative Divisions

Division	Total No of Taluka	Relatively Developed	Backward	More Backward	Most Backward	No. of Backward Talukas
Bangalore	51	18	09	13	11	33
Mysore	44	22	10	10	02	22
Belgaum	49	18	14	12	05	31
Gulbarga	**31**	**03**	**02**	**05**	**21**	**28**
North Karnataka	**80**	**21**	**16**	**17**	**26**	**59**
South Karnataka	**95**	**40**	**19**	**23**	**13**	**55**
Total (state)	**175**	**61**	**35**	**40**	**39**	**114**

Source: High Power Committee on Redressal of Regional Imbalances, Government of Karnataka 2002 (Nanjundappa Committee Report)

The table-4.1 clearly pointed out the regional disparities as there are total of 39 most backward talukas out of which 26 talukas are in North Karnataka as against only 13 in South Karnataka. The Gulbarga Region (Hyderabad-Karnataka Region) has total number of 31talukas out of which 28 (90%) are backward and of which 21 are most backward talukas. The most backward talukas includes Bidar, Gulbarga, Raichur, Koppal, Yadgir and Bellary (Government of Karnataka, 2002). Therefore, it shows the larger level of incidence of backwardness in North Karnataka in which Gulbarga region means Hyderabad Karnataka region has high level of backwardness and needs high level of attention for the development of this region. The paper by Shiddalingaswami and Raghavendra, (2010) has analyzed the Karnataka by division and district wise domestic product and its growth rates of eighteen years (1990-2008). It shows that in 1991 per capita domestic product was higher in Mysore region followed by Bangalore region as compare to Gulbarga and Belgaum regions. The situation has changed significantly over period of time, as in 2007-08 Bangalore region performed better than Mysore region followed by Belgaum and Gulbarga region. The Bangalore region has 1.5 times of per capita income than of Gulbarga region. This clearly explains the regional disparities in the state and shows that Gulbarga region (Hyderabad Karnataka) is relatively a backward region

(Shiddalingaswami and Raghavendra, 2010). The Human Development Report *of* Government of Karnataka (2006), also assessed that among the five top districts in terms Human Development Index southern districts are at the forefront and north region districts namely Koppal, Gulbarga and Raichur are at the bottom. All the districts from the Hyderabad Karnataka Region are below the state average in HDI (Government of Karnataka, 2006).

Class Formation and Growth of Dominant Castes in Karnataka:

In the southern region the landlords are numerically small but these landlords have much larger farms as compared to other rural households. In the Malnad region along with landlords there were wage laborers, small landholder tenants and bonded laborers. Mostly the investments in agriculture in terms of irrigation development, mechanization in farms, chemicals and pesticides as well as investments in non-agricultural activities comes from the landlord section. Relatively this investment is largely in the southern and Malnad region as compared to the northern region. The landless agricultural laborers are small in numbers in the southern region followed by Malnad and northern region. The less number of landless laborers in southern part is partly the result of less investment in agricultural activities. The landlords and the big farmers have started investing in non-agricultural trade related business. Pani (1983) shows that in the southern region landlords are less in numbers but this class has huge farms compare to other regions. This class in terms of hierarchy functions at the top level and top front in political sphere. This class experienced investments in both agriculture and non-agricultural activities. Below this class there is a large category of cultivators which includes large, medium, and small peasants. It found that there is a relatively less number of landless agricultural laborers in the southern region. In the northern region there are two categories of landlord farmers. First are those farmers who were traditionally very large landowners and have had the land for at least couple of hundred years and second are those farmers who are moneylenders. These farmers bought land in the famine during the second of the nineteenth century. Compared to the rest of Karnataka large numbers of cultivators could be found in this region however the land essentially is in the dry area and hence the cultivators in this region are indebted to landlords. The northern region, large proportion of population is landless agricultural laborers (Pani, 1983, pp.49-53). Similarly, in southern region there was low levels of tenancy whereas in northern region the tenancy level is high.

"In Malnad region there are not only high levels of tenancy but the bulk of the tenants are among the lowest sections of the rural society" (Pani, 1983, p.23).

The process of change in agrarian system is being analyzed by two ways, transition from above and transition from below. The transition from feudal to agricultural capitalist class in the norther and southern region can be seen as the transition 'from above'. In this situation, the former feudal landowners possessing huge lands became capitalist farmers and they continued to be the dominant class. While in the Malnad region the transition was 'from below', where the middle and big farmers became dominant tenants as well as capitalist farmers and have replaced the feudal landlords as the dominant class (Pani, 1983, pp.109-111).

Manor (1989) explained that the old Mysore region witnessed high proportion of owner cultivators and less number of landless laborers whereas in Bombay presidency there was a higher proportion of tenants and less number of owner cultivators. The two coastal districts which now is Dakshina Kannada stands apart from other parts of Karnataka in terms of its social composition and different agrarian structure which is characterized by low number of owner cultivators. It is explained that this pattern was a result of pre-existing control over land and local power (Manor, 1989, pp.328-329).

Manor (1977) observes that compared to other states, Karnataka's society is cohesive. There was mass conversion movements by social groups for example fighting against caste or Jati clusters in other states in India where as in Karnataka it is not evident that there were no mass conversions taken place or nor there were any violent revolt taken place of people against government or peasants (Manor, 1977). In contrast, M. N. Srinivas (1959) has pointed to the Brahmin domination, even though they were numerically less. They had significant amount of land in the villages during the early part of the twentieth century. Brahmins held most of administrative posts and had monopoly over the bureaucracy. The western education introduced by the Britishers paved the way for new economic opportunities and Brahmins were the first who could access and get benefitted from it. The Brahmins migrated to urban areas during the first half of the twentieth century and hence majority of the land passed to the peasant caste. This led to the emergence of new social forces that started becoming dominant in villages. The Anti-Brahmin Movement in the first half of the twentieth century was mainly against the Brahmin hegemony and supremacy and the

leaders of the Anti-Brahmin Movement realized the importance of education to acquire high positions and power (Srinivas, 1959; Srinivas, 1957). The Veerashaiva movement is an outcome of this Brahmin domination and challenged the social evil of Brahmin domination (Bali, 1979).

The caste based associations were created during the early twentieth century to impart the significance of education through the establishment of a number of educational institutions. For example Vokkaligara Sangha (1906), Shri Basaveshwar Veerashaiva Vidhya Vardhaka Sangha (1906), Bijapur Lingayat Development Education Association (1910), Karnataka Lingayat Education Society (1916) etc. These Sanghas established student hostels for the young and future generations of their own community.[15] The Non Brahmin movement started demanding scholarships for non-Brahmin students and reservations in colleges as well as preferences in government jobs and hence started the emergence of Non Brahmin educated youths (Srinivas, 1959; Srinivas, 1957). The Sangha leaders expected that their youth would acquire education and get government jobs in order to help their caste members and kinsfolk (Srinivas, 1959). Kaul (1993) also reiterates that the caste based associations were formed not only to assert their caste solidarity but also to increase the political strength and representation in the state (Kaul, 1993).

Dominant Castes in Karnataka

The Vokkaliga and Lingayat castes are considered as the "dominant caste" in Karnataka (Srinivas, 1959; Kaul, 1993; Manor, 1989; Patil, 2007). The '*Okkaliga*' term is originated from the Kannada word '*Okku*'. It means 'to thresh' and in the real sense Okkaliga means who cultivates. This is also used synonymously as '*ryot'* and 'husbandman' and in the early 19th century it implied as tiller of the soil (Yule and Burnett 1903; Onions 1959 as cited in Manor, 1977). Manor (1977) explains that during the period of 1871 the term Okkaliga referred to an occupation and not a community. However, over a period of time in the census of 1901 it is being considered as a single caste. For convenience all the sub categories were merged into one category and considered it as single caste (Manor, 1977, pp.172-173).

[15] Veerashaiva Vidhyavardhaka Sangha website as available on http://www.vvsanghabellary.org/ as accessed on 7th April 2015.

Lingayats: Lingayat is a religious and devotional sect that developed during the 12th century. The Virasaiva movement headed by Basavanna during the 12th century brought the Lingayat community under one roof. Its main religious and ethical teachings are against the principal of Hindu Brahmin and denied the authority of the Brahmins. The Virasaiva movement was a reaction to the caste hierarchy principally, as against to the social ethos of the Brahmins. Supremacy among the Brahmins and lower gradation to the other caste people led to increased humiliations which created anger among the non-Brahmins. In this context the Virasaiva movement evolved to protest and challenge the social evil of Brahmin domination and hence advocated a casteless society. As a result Lingayats as the members of the same sect were united all the time even though some other occupation were included in the Lingayat community. The symbol of the Lingayat community is that they wear a *"linga"* as a symbol of *Siva* and they advocate vegetarianism. They have their own priests and for rituals they do not depend upon Brahmins. The leaders of the Virasaiva movement realized that if the movement needs to be sustain in a longer run then there is a need of organizational framework to propagate religious thoughts and philosophy of Virasaiva sect. Hence, as parallel to the Brahmins, religious *Mutts* were established all over the places where Virasaivas resided (Manor, 1977; Manor, 1989; Bali 1979). As mentioned earlier, along with this they established many associations in many parts of the state to promote educational, social, cultural and economic interests of the community. For example, establishment of The Lingayat Education Association, Dharwad in 1883 to provide scholarships to the deserving students from the community.[16] For the development of Lingayat community it established All India Veerashaiva Mahasabha in 1904 with active participation of Kumaraswamiji of Hanagal, Srimant Lingaraj Desai, Rao Bahaddur Malappa Warad, etc. Over a period of time number of associations was established by the Lingayat community. A study on Lingayat community by Patil (2007), states that "the Lingayat community has the largest number of educational institutions in the private sector in Karnataka and is one of the leading private educational institution builders in India. Some of them are giants in the educational fields. The Jagadguru Sri Shivarathreeshwara Maha Vidya Peetha of Sutturu, Mysore, runs nearly three hundred educational institutions inside and outside Karnataka" (Patil, 2007, p.668).

[16] Hurakadli Ajja Law College website as available on http://www.halawcollege.com/ as accessed on 14th April 2015.

Bhat (1978) explains that the Lingayat's and Vokkaligas were listed as a single caste in 1901 census and for certain period of time these caste communities were united and fought against Brahmin power. However, in the 1930's and 40's these castes started to lose their unity and initiated demands for separate representation in the assembly as well as government services. Hence, these communities started fighting among themselves for power at both the political and economic levels. These communities are the ones who, as a backward class, enjoyed all the constitutional benefits such as in terms of reservation in education, employment, politics and welfare schemes (Bhat, 1978).

Economic and Political Power of the Caste:

Large amount of agricultural land was concentrated among these two dominant castes, Lingayats and Vokkaligas. Along with this, historically the political powers were also concentrated among these two castes as large number of them is represented in the legislative assembly (Kaul, 1993, p.47). Thimmaiah (1983) observed that 'the largest proportion of the rich comes from the dominant majority castes (includes Vokkaliga, Reddys, Lingayat and Kunchitiga) in the rural areas, and the next largest comes from the non-dominant minority castes (include Brahmins), followed by the other unspecified caste groups' The study reveals that the dominant majority castes are economically dominant in rural areas and in the urban areas Brahmins are economically dominant (Thimmaiah, 1983, p.37). The following table gives a glimpse of their political power in Karnataka.

Table-4.2

Composition of the Karnataka Legislative Assembly by Caste: 1952-1972 Elections

Caste/ Community	1952 No (%)	1957 No (%)	1962 No (%)	1967 No (%)	1972 No (%)
Brahmin	14 (11)	9 (6.3)	8 (6)	8 (5.8)	11 (6.2)
Lingayat	45 (35)	47 (33)	45 (34)	49 (35)	43 (24)
Vokkaliga	33 (26)	35 (24)	35 (26)	36 (26)	52 (29)
Other Hindus	12 (9.5)	22 (15.5)	20 (15.2)	17 (12.3)	37 (20.8)
Scheduled Caste	20 (15.7)	22 (15.5)	21 (15.9)	24 (17.4)	23 (12.9)
Scheduled Tribe	-	2 (1.4)	1 (0.8)	-	2 (1.1)
Christian	-	1 (0.7)	-	1 (0.7)	5 (2.8)
Jain	2 (1.6)	3 (2.1)	1 (0.8)	1 (0.7)	1 (0.6)
Muslim	1 (0.8)	1 (0.7)	1 (0.8)	2 (1.5)	4 (2.2)
Total	127 (100)	142 (100)	132 (100)	138 (100)	178 (100)

Source: GOK, Karnataka Backward Classes Commission Report Vol. IV 1975 as cited in Kaul 1993, p.48

As Rao (1968) stated that the "the political elite of the caste play a crucial role in promoting the interests of the association in turn they, benefit from the support of the caste association, since such support can be used to put pressures to get certain decisions through even when the politicians themselves do not have the authority to take the decisions" (Rao, 1968, p.779).

It is observed that "the theory that Lingayats and Vokkaligas constitute a 'vote-bank' is based on three erroneous assumptions. The first is that they are a numerical majority in certain districts of the State. Secondly, members of these communities vote only for a community candidate. Third, a non-Vokkaliga or non-Lingayat cannot win from a constituency in which one of these groups dominates without getting the community vote. In other words, the two communities are internally undifferentiated and the primary identity marker of their members is caste" (Menon and Bageshree,

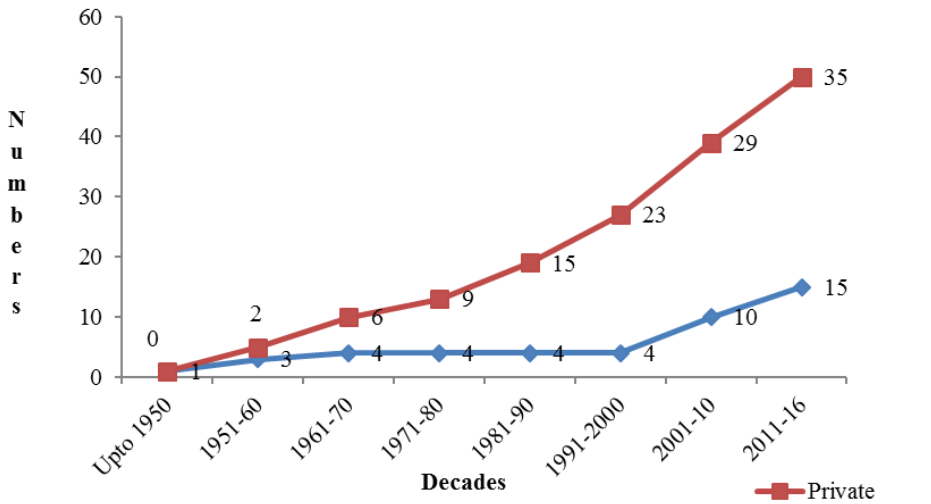
2009).[17] The Vokkaliga community constitute of around nine percent of the population have political power as so far it has produced five chief ministers and a prime minister (Arun, 2010)[18]. Whereas the Lingayat community which constitutes around 17 to 21 percent of the population too have have strong hold in politics as it is observed that "they are a decisive factor in a candidate's victory in at least 100 of the total 224 constituencies" (Maramkal and Aiyappa, 2011)[19].

Growth of Medical Colleges in Karnataka:

Karnataka state has witnessed a high growth in medical colleges and it is the only state that has highest number of medical colleges in the country. The following section explains the growth of medical colleges in Karnataka. Starting with one medical college in 1950 it has reached to 50 medical colleges in 2016 with a total intake capacity of 6855 medical students. Currently there are a total of 50 medical colleges in Karnataka 12.13 per cent of medical colleges of India are concentrated in this state alone. Out of total of 50 medical colleges 30 percent colleges are in the government and 70 percent are in private sector (Figure-4.1). The annual total intake capacity in government medical colleges is 1950 and in private medical college is 4955 combined 6855 students are taking admissions to medicine (MCI, 2016). These figures clearly explain the dominance of private sector in medical colleges in Karnataka as out of total number of intake capacity 72.3 percent intake is in private sector.

[17] Menon, P. and Bageshree, S. (2009, May 13). Caste and Electoral Choice: the Karnataka Case. *The Hindu*, Opinion page.
[18] Arun (2010, January 22). Is Vokkaliga Community Losing Strength? *Indian Express*. Retrieved form http://www.newindianexpress.com/states/karnataka/article225108.ece?service=print as accessed on 15th May 2015.
[19] Maramkal, M. and Aiyappa, M. (2011, July 26). Lingayat Mutts Turn Kingmakers. The Times of India. Bangalore. Retrieved from http://timesofindia.indiatimes.com/city/bengaluru/Lingayat-mutts-turn-kingmakers/articleshow/9366249.cms as accessed on 15th May 2015.

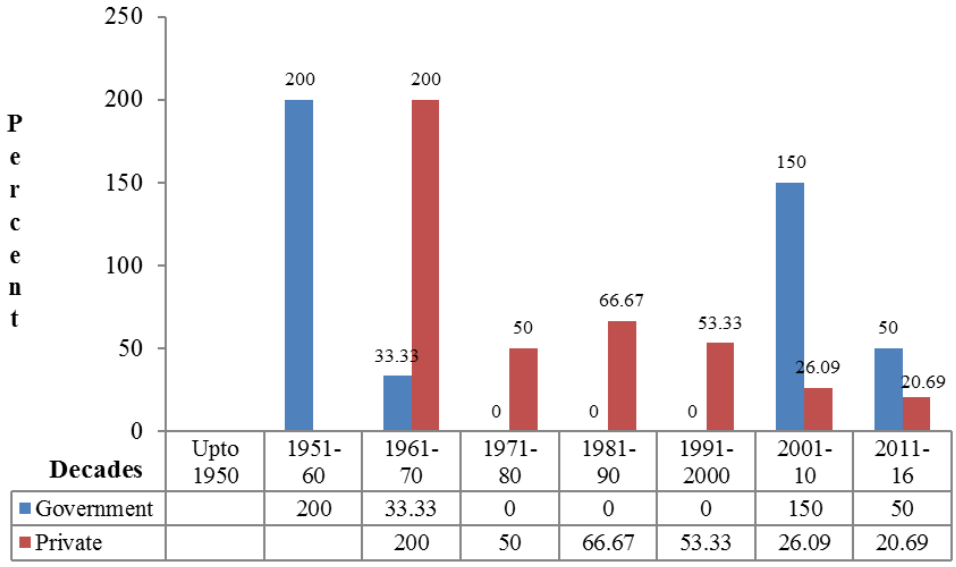
Figure-4.1
Growth of Medical Colleges in Karnataka (in Numbers)



Source: MCI records as accessed on 15th Jan 2016

In the case of Karnataka, growth of medical colleges shows that in 1950 there was only one government medical college. This rose to 15 in 2016 with an intake capacity of 1950. Whereas in private sector at the time of 1950 there was no single medical college run by the private sector. It is only in the 1953 first private medical college established which rose to 35 in 2016 with an intake capacity of 4855. It means from 1951 to 2016 government medical colleges were growing at the rate of 400 whereas the growth rate in private medical colleges was 1650 percent with an overall growth rate of 900 percent (Figure-4.1).

Figure-4.2
Decadal Growth Rate of Medical Education in Karnataka



Source: MCI records as accessed on 15th Jan 2016

Government Private

Table- 4.3

Trends in Medical Institutions in Karnataka 1950-2016

Year (period)	Number (Gov.)	% Share	Number (Private)	% share	Total
Up-to 1950	1	100	0	0	1
1951-60	3	60	2	40	5
1961-70	4	40	6	60	10
1971-80	0	0	9	100	9
1981-90	0	0	15	100	15
1991-2000	0	0	23	100	23
2001-10	10	25.64	29	74.36	39
2011-16	15	30	35	70	50
CAGR	**2.50**		**4.50**		**3.60**

Source: MCI records as accessed on 15th Jan 2016

The growth of medical colleges can be categorized in three phases as first phase of independence period 1950-1970, second phase 1971-1990 and the third phase would be post liberalization period 1991-to 2015.

First Phase (1950-1970) Emergence of Private Sector:

The figure-4.1; 4.2 and table-4.3 are about the historical trends and growth of medical colleges in Karnataka. It shows that there was only one government medical college before independence (Before 1950). This was the Government Medical College Mysore which was established in the year of 1924. The independence period witnessed a growth led by the government and the main aim was to build independent institutions to achieve self-reliance in human resources. However, the Karnataka case is different with the establishment of the first private medical college called Kasturba Medical College, Manipal in 1952. Table -3.3 clearly shows that up to 1960, the share of government colleges in the total number of medical colleges was 60 percent as against 40 percent in private sector. In the next decade (1960-70) the trend shifted vice versa as the share of private medical colleges in the total number of medical colleges increased by 20 percent (from 40 to 60 percent) whereas in the government sector it decreased by 20 percent (from 60 to 40 percent). Hence, the slow emergence of private sector started in the decade of 1960 to 70's (Table-4.3).

Second Phase (1970-1990): Dominance of Private Sector:-

Particularly in Karnataka, the period of 1970 to 1990 is the period of increased growth private sector and stagnation in the growth of government medical college. The figure-4.2 clearly shows that the growth rate of government medical colleges declined to zero percent in 1970's in comparison with 1960 decade whereas it increased by 50 percent in private sector. During the period of 1970 to 1990 medical colleges in private sector has increased by 67 percent (from 9 to 15) with a similar overall growth (9 to 15) during this period (table-4.3). As against this the government medical college's growth was zero percent as not a single government medical college was established during this period (Figure-4.2).

Third Phase 1990 to 2016- Expansion of Private Sector:

The period after 1990 is the period of post liberalization which witnessed expansion in the growth of the private sector. The figure-4.1 clearly show increase in the number of private medical colleges. In the period of 1990 to 2015 the private sector increased by 133 percent (from 15 to 35) with an overall growth of 233 percent (from 15 to 50). In 2016 the share of private sector is 70 percent as against 30 percent in government sector (table-4.3).

The figure-4.1 shows that after 1961 the state has not established a single medical college for four decades. From 1962 to 2005 not a single medical college was established by the government. The last government medical college was established in 1961 and after that in 2006 three government medical colleges were established. It means that for four decades (44 years) the state has not invested in establishing government medical college.

In these four and half decades (1961-2005) there was a complete dominance of the private sector which established total of 26 private medical colleges as against only one in government sector. In the decade of 2000-2010, the government set up a total of six new medical colleges and surprisingly all of these six medical colleges were started within a span of two years (2006-2007). In the same decade again there was a total of six new private medical colleges started which means there is no any regulation on the growth of private medical colleges.

Why this pattern of growth?

The growth up to the 1990 clearly reflects two major trends first is expansion of the private sector and the second is visible shrinkage in the share of public sector. It is also important to mention that the growth in the private sector has witnessed the success of private medical colleges which were established in earlier decades. As it could realize that the students who are aspiring for medical education were ready to pay and certainly those who could afford it, started taking admission in these private medical colleges. Hence, the promoters soon started to establish medical colleges in the private sector. Along with this the government also stressed that it lacks funds and resources to establish medical colleges and hence gave a space to the private

promoters to establish colleges.[20] The successive governments have actively encouraged the growth of private enterprise in engineering and medical education (Kaul, 1993).

Pinto (1994) has analyzed the policy paper on Education for the Eighth Five-Year Plan of Karnataka-1989, and states that "no more capitation-based colleges should be permitted in the state for any courses since it is an educational sin resulting in corrupting the educational system and eroding all ethical values" (Pinto, 1994, p.31). Clearly this was not the view of the political class in Karnataka. This was clearly shown by an expert committee appointed in 1999. This expert committee was headed by Prof. Savadatti and in their report pointed out the need for more professional colleges in Karnataka. Based on this report the state gave approval and certified an additional twenty medical colleges in the state. Of these, one was in in the government sector and the remaining in the private sector. The Society for Community Health Awareness, Research and Action (SOCHARA) raised some concerns and campaigned against the state decision to start new medical colleges. SOCHARA also conducted research on medical education in Karnataka and submitted its report to the sub-committee on Medical Education of the Parliamentary Standing Committee on Human Resource Development (year). The study clearly pointed out that the share of private medical colleges in 1970 was 33 percent which increased up-to 78.9 percent in 1993. It raised serious concerns about the commercialization of medical education. It states that "all the new private medical colleges belong to the 'capitation' fee charging variety of medical colleges with capitation fees rising from 5 lakhs in the 1980s to 35 lakhs in the 1990s. All were initiated by trusts and societies with either caste or communal affiliations or by individuals and groups representing specific sectoral lobbies in agriculture and other areas (sugar barons in Maharashtra, and other pressure groups in Karnataka and Andhra Pradesh), with little or no involvement in higher education and health care" (SOCHARA, 1998, pp.7-8). The study also raised concerns about the falling quality standards of medical education, increasing erosion of norms of medical ethics and inadequate social and community orientation. It recommended "a comprehensive and total ban on medical college expansion today till the controversies and distortions are tackled legally and supported by the strengthening of the monitoring of standards

[20] Based on Interviews conducted in Karnataka.

structures in the state with the full involvement of the Rajiv Gandhi University of Health Sciences. The ban should be further supported by ensuring that colleges with 'mega' educational efforts (150-300 seats) that were regulated recently maintain that level gradually bring down to 100 seats for undergraduate medical education to improve standards and quality of the programmes by reaching better staff/student ratio and student/hospital bed ratios" (ibid, p.17). However even though there was this recommendation the growth of private medical colleges continued to take place in the state.

Demand From Neighboring State Fueled Commercialization:

It has been observed that the market for private medical institutions in Karnataka is fueled by the demand from neighboring states. Many students from neighboring states, bordering Karnataka, started coming to pursue medical education. A faculty member, who is currently teaching in a private medical college, explained his journey to become a doctor. His father is a doctor by profession and it influenced on him to become a doctor. He himself belonged to Andhra Pradesh (AP) and to pursue medical education he came to Karnataka. He could not get admission to medical college in AP and hence he joined a private medical college in Karnataka by paying capitation fee. This was in 1995. This was reiterated in another interview conducted with the students who are currently pursuing medical education in private medical college, they couldn't get an admission in their respective state (Kerala and AP) so came to Bangalore to pursue medical education (Interview conducted in Bangalore, 11th September 2015).

The period of 1980's and 1990's witnessed high level of demand to become engineer or doctor. These two professions were highly demanded and considered as noble professions. Parents were willing to pay high fees and capitation fee because of the high returns from these two professions. So to get admission in medical or engineering colleges were the main agenda in front of parents and students. Jayaram (1987) study on institutions and students in Bangalore from the fields of medicine, science and technology shows that there was a heavy demand for these courses (Jayaram, 1987, p.15). In order to support students who came from outside Bangalore residential colleges were established.

As a senior faculty who is teaching in private medical college in the department of community medicine observed:

> "The kind of society at that point in time was (1980-1990) to become either a doctor or engineer. These were the only two professions choice was there and the rest profession didn't exist at that time……..The culture of residential colleges came around 1985 in AP. I joined residential college in 1988. It's a kind of a package deal, two years of intermediate plus they will give you coaching for entrance exams where there is Physics, Chemistry and Biology (PCB) or Physics, Chemistry and Math's (PCM), engineering or medical. So it's a package deal. So majority of the children will go. And there were some three to four hubs of these residential colleges. So either of us get into either of this residential colleges to pursue medical or engineering profession" (Bangalore, 11th September 2015)[21].

This reflects the demand for the professional courses and early commercialization of higher education saw the growth of residential colleges. Kaul (1993) observed that there was a trend that large number of students from AP who were given admission to professional colleges in Karnataka, resulting in a large outflow of money from that state (Kaul, 1993). "Most of these colleges served the interest of non-Karnataka students. The majority of students in some of these colleges were not even from Karnataka" (Pinto, 1994, p.32)

Even today Karnataka, specifically Bangalore, is a hub for attracting students from different parts of the country. Students come from northern, central and eastern parts of country to pursue medicine, engineering, MBA, IT software engineering etc. Sengupta, (2011) conducted an interview with few agents to understand the role of the agent in providing seats in private professional colleges in Bangalore. The interviews with these few agents explored the way in which the racket of the market and business in higher educational institutions take place. One of the agents who is

> "Kaushal Barnwal, from Muzaffarpur in Bihar, came to Bangalore to study BSc in biotechnology from Presidency College in the city. He then completed an MBA degree. Barnwal works for a company called

[21] Interview conducted with one of the faculty member who is currently teaching in private medical college in Bangalore. The name of the college and the name of the faculty member unrevealed because of confidentiality.

> Aryawarth where they insist on taking money only after the admission is over and through demand drafts and cheques. He and his network of agents target teachers of classes XI and XII in the far-flung areas of India, paying them between 5,000 and 10,000 for a single reference. They also advertise in local cable channels. Jammu & Kashmir, Bihar, Assam, and Orissa are his main playing grounds and this year he recruited 70 students, of whom 45 were for MBA courses and the rest for the medical stream" (Sengupta, 2011)[22].

Growth of capitation fee colleges has resulted in unhealthy competition. The role of agents who pay commissions to teachers to get students is an example of this. The above narration also reflects the kind of corruption and commercialization of education take place in Karnataka and that too somewhat openly.

Regional Distributions of Medical Colleges in Karnataka:

The regional variation in the distribution of medical colleges corresponds to the socio-economic development in the State. Better performing regions have more colleges as compared to the poorer.

The table-4.4 shows that the Bangalore division constituted of eight districts is ahead in terms of institutions and intake capacity followed by Mysore division.

Table-4.4
Spatial Distribution of Medical Colleges and Intake Capacity in Karnataka

Division	Districts	Medical Institutions			Intake Capacity		
		Gov.	Private	Total	Gov	Private	Total
Bangalore Division	Bangalore Rural-Urban	2 (10.0)#	10 (50.0)#	12 (60.0)##	350 (12.5)	1260 (44.9)	1610 (57.4)
	Chittradurga,	0	1 (5.0)	1 (5.0)	0	100 (3.6)	100 (3.6)
	Davanagere	0	2 (10.0)	2 (10.0)	0	395 (14.1)	395 (14.1)
	Kolar	0	1 (5.0)	1 (5.0)	0	150 (5.3)	150 (5.3)
	Shimoga	1	1 (5.0)	2 (10.0)	100 (3.6)	150 (5.3)	250 (8.9)

[22] Sengupta, D. (2011, December 25). Show Me the Money, I Have a Seat. *Economic Times*, Bangalore. Retrieved From http://epaper.timesofindia.com/Default/Layout/Includes/ETNEW/ArtWin.asp?From=Archive&Source=Page&Skin=ETNEW&BaseHref=ETBG%2F2011%2F12%2F25&ViewMode=HTML&EntityId=Ar01400&AppName=1 as accessed on 25th May 2016.

	Tumkur	0	2 (10.0)	2 (10.0)	0	300 (10.7)	300 (10.7)
	Ramanagara	0	0	0	0	0	0
	Chikkaballapur	0	0	0	0	0	0
Total		**1 (15.0)***	**17 (85.0)***	**20 (40.0)****	**450 (16.0)**	**2355 (84.0)**	**2805 (40.9)**
Belguam Division	Bagalkot	0	1 (12.5)	1 (12.5)	0	150 (13.6)	150 (13.6)
	Belgaum	1 (12.5)	1 (12.5)	2 (25.0)	100 (9.1)	200 (18.2)	300 (27.3)
	Bijapur	0	2 (25.0)	2 (25.0)	0	250 (22.7)	250 (22.7)
	Dharwad	1 (12.5)	1 (12.5)	2 (25.0)	150 (13.6)	100 (9.1)	250 (22.7)
	Haveri	0	0	0	0	0	0
	Gadag	1 (12.5)	0	1 (12.5)	150 (13.6)	0	150 (13.6)
	Uttara Kannada	0	0	0	0	0	0
Total		**3 (37.5)**	**5 (62.5)**	**8 (16.0)**	**400 (36.4)**	**700 (63.6)**	**1100 (16.0)**
Gulberga Division	Bellary	1 (11.1)	0	1 (11.1)	150 (13.6)	0	150 (13.6)
	Bidar	1 (11.1)	0	1 (11.1)	100 (9.1)	0	100 (9.1)
	Gulbarga	2 (22.2)	2 (22.2)	4 (44.4)	250 (22.7)	250 (22.7)	500 (45.5)
	Koppal	1 (11.1)	0	1 (11.1)	150 (13.6)	0	150 (13.6)
	Raichur	1 (11.1)	1 (11.1)	2 (22.2)	100 (9.1)	100 (9.1)	200 (18.2)
	Yadgir	0	0	0	0	0	0
Total		**6 (66.7)**	**3 (33.3)**	**9 (18.0)**	**750 (68.2)**	**350 (31.8)**	**1100 (16.0)**
Mysore Division	Chamarajanagar	0	0	0	0	0	0
	Chikmagalur	0	0	0	0	0	0
	Dakshina Kannada	0	7 (53.8)	7 (53.8)	0	950 (50.0)	950 (50.0)
	Hassan	1 (7.6)	0	1 (7.6)	100 (5.3)	0	100 (5.3)
	Kodagu	0	0	0	0	0	0

	Mandya	1 (7.6)	1 (7.6)	2 (15.4)	100 (5.3)	150 (7.9)	250 (13.2)
	Mysore	1 (7.6)	1 (7.6)	2 (15.4)	150 (7.9)	200 (10.5)	350 (18.4)
	Udupi	0	1 (7.6)	1 (7.6)	0	250 (13.2)	250 (13.2)
Total		**3 (23.1)**	**10 (76.9)**	**13 (26.0)**	**350 (18.4)**	**1550 (81.6)**	**1900 (27.7)**
Grand Total		**15 (30.0)**	**35 (70.0)**	**50 (100)**	**1950 (28.4)**	**4955 (72.3)**	**6855 (100)**

Source of Regions: accessed from Karnataka government website http://www.karnataka.com/districts/about-districts/ as accessed on 15th Jan 2016

Source of Data: Table is prepared based on MCI records as accessed on15th Jan 2016.

In each division the percent share of government and private medical college is out of total of district colleges and same applies to intake capacity.

In each division the percent of total district colleges is out of total divisional medical colleges. Same applies to intake capacity.

* In each division in the total section, the percent share of government and private medical colleges is out of total of divisional medical colleges. Same applies to intake capacity.

** In each division the divisional percent of medical colleges is out total of state medical colleges. Same applies to intake capacity.

It shows that Bangalore division has largest number of medical colleges compared to other regions. Forty percent of medical colleges with an intake capacity of 40.9 percent are located in this region. Following this, the Mysore division has the next largest number of medical colleges compared to Belgaum and Gulberga division. Both these divisions (Bangalore and Mysore) also known as South Karnataka Region (SKR). 66.0 percent of the medical colleges with an intake capacity of 68 percent are located in this region. In contrast, the Belgaum and Gulberga division known as North Karnataka Region (NKR) comprising of thirteen districts have only 33.0 percent of medical colleges and 32.0 percent of total intake capacity (table-4.4).

The share of private medical colleges in Bangalore division is 85 percent (intake 84.0 percent) as compared to government medical colleges which is only 15 percent (intake 16.0 percent). Whereas in Belgaum and Mysore divisions, the share of government medical colleges is relatively higher than the Bangalore division (table-4.4).

It is very important to note that the Gulberga division is relatively undeveloped, has lowest number of private medical colleges and the share of government medical college is higher and it is the only division that has this kind of observation (table-4.4).

Of all private medical colleges (35), 48.6 percent of private medical colleges are located only in Bangalore division followed to this 28.6 percent in Mysore division which means 77.2 percent of private medical colleges are located only in these two divisions. As against 22.9 percent in Belgaum Gulberga division.

Within these divisions there are sub regions and most of the medical colleges are located in urban and semi-urban areas. This is witnessed as Bangalore and Mangalore alone have total of 17 means 34 percent of medical colleges (out of 50 medical colleges). Within Bangalore division out of twenty medical colleges twelve (60.0 percent) medical colleges are located in Bangalore rural-urban areas (ten private and two are in government). Similarly, in Mysore division, out of thirteen medical colleges, seven (58.3 percent) medical colleges are located in Dakshina Kannada district of which five are located in Mangalore city. All the seven medical colleges are in the private sector (Table-4.4). Moreover, there are seven districts namely Ramanagara, Chikkaballapur, Haveri, Uttara Kannada, Yadgir, Chamarajnagar, Kodagu are without any medical college (table-4.4).

As a doctor by profession and a senior health activist who was part of the Task Force Report on Health observed that,

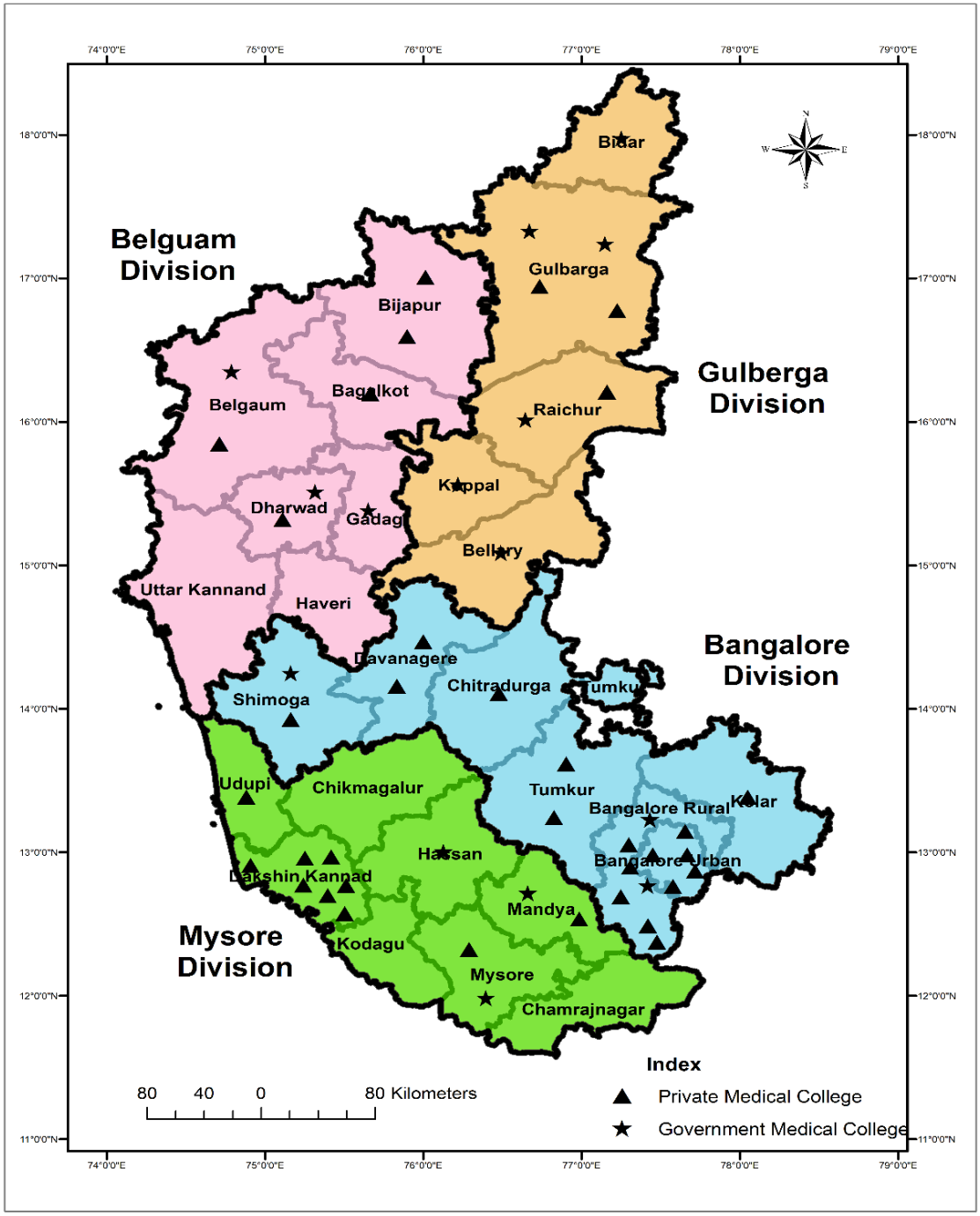
> "the Mysore region has number of medical colleges because Mysore region has a history of progressive policies. It was Mysore region, which established first Primary Health Unite (PHU) in 1929 and the first PHU was set up in the world in 1929 in United Kingdom (UK). The Maharaja's and specifically the Diwan called Mirza Ismail was very progressive and he was responsible for these kind of initiatives. They set up Mysore hospitals which later became Mysore teaching hospital and medical college" (Interview conducted in Bangalore on 5th September 2015).

Distribution Of Medical Colleges And Human Development Ranking Of Districts

For an in-depth analysis we have prepared a map of distribution of medical colleges both government and private colleges across districts and a map of human development rankings in districts of Karnataka to show that the districts which relatively low in terms of socio-economic indicators witnessed less number of medical colleges compared to the developed districts.

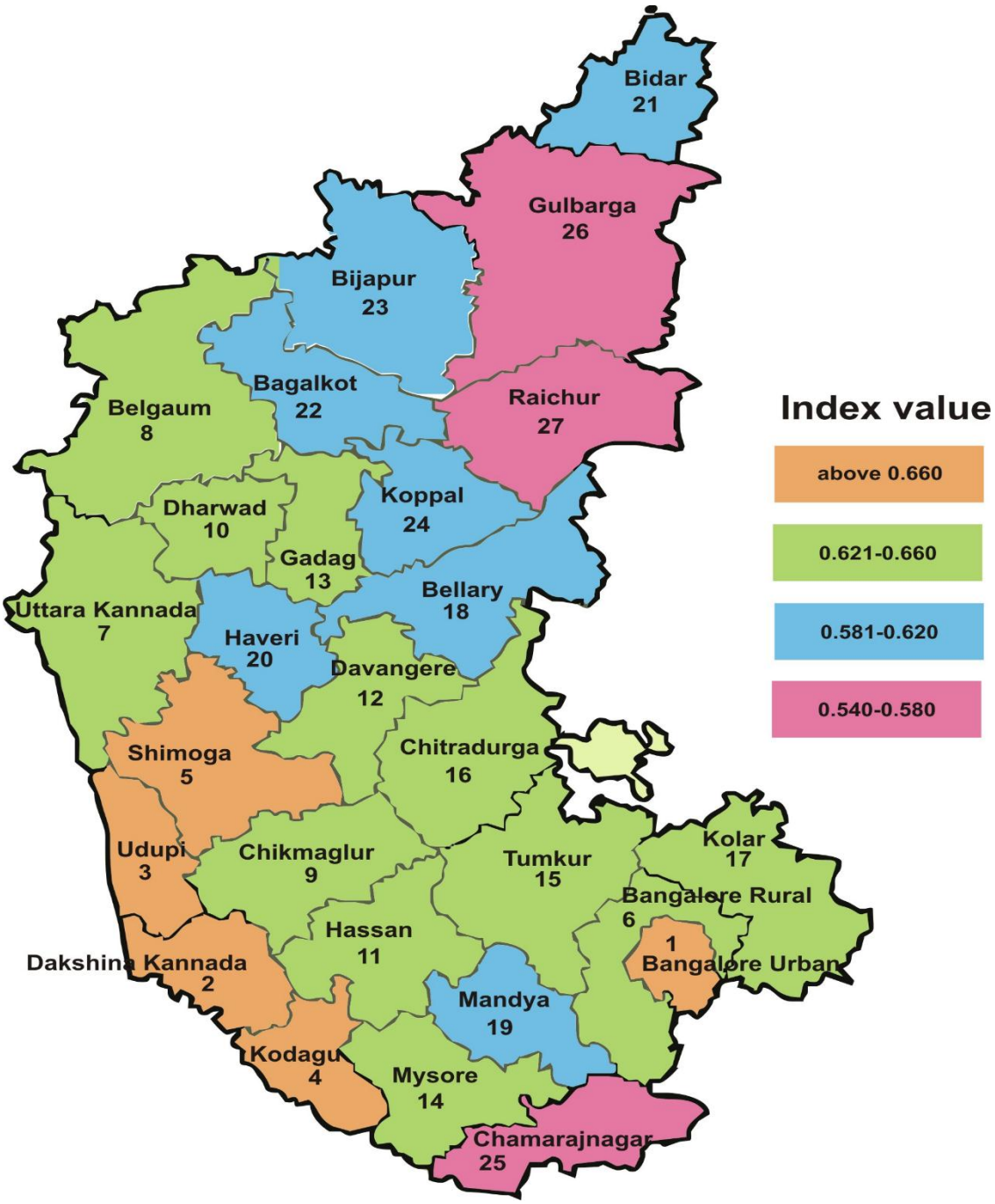
Map-4.1

Number and Ownership Wise Distribution of Medical Colleges in Karnataka



Source: Map is prepared based on MCI data 15th Jan 2016

Map-4.2
Human Development Ranks of Districts in Karnataka



Source: Map is prepared based on the data available on Karnataka Human Development Report 2005: Investing in Human Development, Government of Karnataka (2006, p.15).

It indicates the regional disparities in the establishment of medical colleges where large number of medical colleges are located in developed regions and mostly in urban cities as against Gulbarga and Belgaum divisions (NKR Regions). It shows that the historically under developed regions have less number of medical colleges which again reiterates the regional disparities.

As a senior doctor by profession and health activist who was part of the Task Force Report on Health in Karnataka has observed:

> "….the Dakshina Kannada have large number of medical colleges however if we see the impact upon the health status of the people then the health indictors in Dakshina Kannada is quite similar to that of Kerala. The Infant mortality rate in Dakshina Kannada is only ten. So, probably, this reflects that there is a role of the private medical colleges in providing health services to the community. But the way in which the commercialization is taking place in private medical colleges is a major concern for quality of doctors that we are producing" (Interview conducted in Bangalore 4th September, 2015).

According to a retired senior doctor and who is currently a consultant at Rajiv Gandhi University of Health Science (RGUHS) in Karnataka as well as conducts programmes for Continuing Medical Education (CME) in Karnataka mentioned that

> "The clustering of medical colleges in certain pockets is a concern. Medical colleges are mostly thought of as instruments of commercialization of medical education. If we do a mapping of medical colleges in Karnataka then we see the clustering of medical colleges in certain pockets because it has its vested interests. Because that's where the students can come, that's where the business can take place and that's where the commercialization can happen" (Interview conducted on 6th September, 2015).

Table-4.5

Social Background of the Promoters of Private Medical Colleges in Karnataka (Total No. 35)

Number of private colleges	Religion	Caste
5 (14.3%)	Hindu	Brahmin
8 (22.9%)	Hindu	Lingayat
4 (11.4%)	Hindu	Vokkaliga
5 (14.3%)	Hindu	OBC
1 (2.9%)	Hindu	Backward Class
2 (5.7%)	Hindu	SC
1 (2.9%)	Hindu	Tamil Nadu Temple Trust
1 (2.9%)	Hindu	Reddy's From Andhra
3 (8.6%)	Muslim	-
3 (8.6%)	Christian	-
1 (2.9%)	Jain	-

Source: Data of caste and religion of the founders has been enquired from key informants and academicians. The list of name of the founders has been compiled from each college website. Note: It was not possible to find out caste background of owner of one private medical college. The percentages are calculated as out total of 35 medical colleges and hence one medical college percentage is not in the list.

Table-4.5 shows the social background of the promoters of private medical colleges in Karnataka. The table presents details of religious and caste background of promoters. Eighty percent of the private medical colleges are owned by Hindus and nine per cent each belong to Muslims and Christians. Within Hindus 22 percent of the private medical colleges are owned by the Lingayat community; 11 percent each by Brahmins and Vokkaligas and 14 percent to Other Backward Caste community. A small percentage of 6 percent is owned by Schedule Castes. There is one college that belongs to a Tamilnadu Temple trust. The above table indicates that there is a dominance of Lingayat and Vokkaligas in the ownership of private medical colleges.

More importantly there is some kind of mobility can be seen among the OBC as they are owning 5 (14 per cent). Similarly there is also representation from the SC community as they own 2 (6 per cent) medical colleges. It shows that there is some kind of representation from OBC and SC communities in the ownership of private medical colleges (table-4.5).

To put this into in detail analysis of socio-political context we have prepared a table - 4.6 which explains the political and social background of the chief ministers in Karnataka and the number of colleges established during specific periods of chief ministers.

Table 4.6
Political and Social Background of the Chief Ministers In Karnataka And Number of Medical Colleges Established During Their Regime

Chief Minister	Political Party	Period	Caste Background	No of Medical Colleges Established (year)	
				Gov.	Private
K. Hanumanthaiah	Congress	March 30, 1952 – August 19, 1956	Vokkaliga[23]	1	2
S. Nijalingappa	Congress	November 1 1956 - May 16, 1958	Banajiga Lingayat[24]	1	0
B. D. Jatti	Congress	May 16, 1958 – March 9, 1962	Lingayat[25]	1	0
S. Nijalingappa	Congress	June 21, 1962 May 29, 1968	Banajiga Lingayat	0	4
D. Devaraj Urs	Congress	February 28, 1978 – January 7, 1980	Backward Class[26]	0	1
R. Gundu Rao	Congress	January 12, 1980 – January 6, 1983	Brahmin[27]	0	2
Ramakrishna Hegde	Janata Party	January 10, 1983 – August 10, 1988	Brahmin[28]	0	6
J.H. Patel	Janata Dal	May 31, 1996 – October 07, 1999	Banajiga Lingayat[29]	0	6

[23] Caste background of the chief minster as available on http://timesofindia.indiatimes.com/india/Which-way-now-for-the-Lingayats/articleshow/544877.cms and http://www.karnataka.com/personalities/kengel-hanumanthaiah/ as accessed on 15th January 2015.
[24] Caste background of the chief minster as available on http://timesofindia.indiatimes.com/india/Which-way-now-for-the-Lingayats/articleshow/544877.cms and http://timesofindia.indiatimes.com/india/Which-way-now-for-the-Lingayats/articleshow/544877.cms as accessed on 15th January 2015.
[25] opcit
[26] opcit
[27] opcit
[28] opcit
[29] opcit

S.M. Krishna	Congress	October 11, 1999 – May 28, 2004	Vokkaliga	0	6
Dharam Singh	Congress-JD(s) coalition	May 28, 2004 – Jan 27, 2006	OBC	0	1
H D Kumaraswamy	BJP-JD(s) coalition	Feb 3, 2006 – October 8, 2007	Vokkaliga	6	1
B S Yeddyurappa	BJP	May 30, 2008 – July 31, 2011	Lingayat[30]	0	2
D.V Sadananda Gowda	BJP	August 4, 2011 – July 11, 2012	Vokkaliga	1	1
Jagadish Shivappa Shettar	BJP	July 12, 2012 – 8 May 2013	Lingayat[31]	1	
Siddaramaiah	Congress	May 13, 2013 – Present	Kuruba (OBC)[32]	3	3

Source: The data of caste background of the chief ministers has been enquired from key informants as well as compiled it from different news-paper articles. The list of name of the chief ministers, party affiliation and their period has been compiled from Karnataka government website called karnataka.com as accessed on 15th may 2015. The data of medical colleges has been accessed from MCI website on 15th Jan 2016.
Note: There are 15 government medical colleges in Karnataka, one medical college established in 1924 hence not listed in this table.

It is important to note here that continuously from independence till 1982, the Congress Party remained in power and in this period most of the chief ministers were from the Lingayat community. During the decade of 1961-1970, total of four private medical colleges established of which three medical colleges are promoted by the Lingayat community. All the three medical colleges were established when S. Nijalingappa was the chief minister who also belonged to the Lingayat (Banajiga) community (Ataulla, 2004)[33]. The remaining medical college was founded by Christian.

In the next decade (1971-1980) three private medical colleges were started of which one college was started in the year of 1979 and it belongs to an Other Backward Class

[30] Caste background of the chief minster as available on http://www.hindustantimes.com/columnsothers/they-don-t-caste-their-vote/article1-1056432.aspx as accessed on 15th January 2015
[31] Caste background of the chief minster as available on http://www.rediff.com/news/report/caste-dynamics-that-won-congress-power-in-karnataka/20130509.htm as accessed on 15th January 2015
[32] opcit
[33] Ataulla, N. (2004, March 8). Which way now for the Lingayats? *The Times of India*. Retrieved from http://timesofindia.indiatimes.com/india/Which-way-now-for-the-Lingayats/articleshow/544877.cms as accessed on 15th May 2015.

(OBC) community. Remaining two colleges were started in 1980; one established by nine members belonged to Scheduled Caste community and one established by the Vokkaligara Sangha (OBC) community. During this period D. Devraj Urs was the chief minister of Karnataka and he belonged to the Backward Classes.

The caste and class background plays an important role in facilitating the establishment of private medical colleges. This is evident from the table -4.6, as two medical colleges were started from deprived sections of the community when the chief minister was also belong to Backward Class community as against this three medical colleges were promoted by the dominant caste members when the chief minister was also belong to the dominant caste.

The following decade (1981-1990) six private medical colleges were established in the span of 1984 to 1988 and all of these six colleges were started when Ramkrishna Hegade (Janata Party) was the chief minister who belonged to the Brahmin community. There are variations in the ownership of these colleges as two colleges belongs to Lingayat community, one each belonging to Vokkaliga, OBC, Scheduled Caste, and Muslim.

From 1991-2000, eight new private medical colleges were founded. Out of the eight medical colleges, five medical colleges were founded in 1999 during the Janata Dal period when J. H. Patel was the chief minister belonged to the Lingayat (Banajiga) community. All these eight medical colleges promoters are from Brahmin, Lingayat, Vokkaliga, OBC, Christian, and Muslim communities (table -4.6).

Similarly, in the decade of 2001-2010 twelve new medical colleges were established six in private and six in government sector. Four private medical colleges were established during the period of S. M. Krishna (Congress Party) who is from Vokkaliga Community. The promoters of six private medical colleges belong to different community members include two Lingayat, two OBC (Telugu), one Backward Class (Bunts), one belongs to Hindu Temple Foundation (Jain), one belongs to Tamilnadu Temple and one belongs to Muslim community (table -4.6).

In the next four years (2011-2015) total of 8 new medical colleges were established, two in government and 6 in private sector. These figures again explain the dominance

of private sector in medical education. These six private medical colleges belong to Brahmin, Vokkaliga and OBC community.

This trend clearly points out that the proportion of private medical colleges is much higher than the government colleges. In the initial decades it shows that the caste associations with the ownership of medical colleges and the caste background of the Chief Ministers significantly points out the nexus between them. It is being pointed out that "In north Karnataka, Lingayat politicians from all parties have stakes in private schools and colleges. Big Lingayat names in the educational field are Congress MLC Prabhakar Kore, former Congress MP, now in BJP, B.G. Jawali, and Khandre himself" (Ataulla, 2004).[34]

Private Medical Colleges: Its Linkages with Religious *Mutts*, Political Power and Caste:

It is well known that most of the religious *Mutts* established in Karnataka belonged to the Lingayat or Vokkaliga communities. There is a strong link between these religious *Mutts*, political power and their active investment in education in Karnataka. The religious leaders are the caste leaders in Karnataka and have strong hold on politics and their venture into education and professional higher education (Pinto, 1994; Patil, 2007; Menon, 2004; Maramkal and Aiyappa, 2011)[35]. "All the Lingayat dominated villages, towns and cities have the monasteries of priestly class. The Lingayat 'monasteries' are the largest in number among all the monasteries in Karnataka. Many of them run free boardings for poor Lingayat students, have established several educational institutions and have been publishing Veerashaiva/Lingayat literature" (Patil, 2007, p.666).

Pinto (1994) has clearly pointed out how the political regimes, religious *Mutts* and the professional colleges in Karnataka are linked to each other and influence policy decisions. The private college managements demanded seat matrix as 50:50 means 50 percent seats will be allotted as government seats in private colleges and the remaining 50 percent seats should open as the management quota. However, the fee

[34] Ataulla, N. (2004, March 8). Which way now for the Lingayats? *The Times of India*. Retrieved from http://timesofindia.indiatimes.com/india/Which-way-now-for-the-Lingayats/articleshow/544877.cms as accessed on 15th May 2015.

[35] Menon, P. (2004). The spread in the South: Karnataka. Frontline. 21(6).
Maramkal, M. and Aiyappa, M. (2011, July 26). Lingayat Mutts Turn Kingmakers. *The Times of India*. Bangalore. Retrieved from http://timesofindia.indiatimes.com/city/bengaluru/Lingayat-mutts-turn-kingmakers/articleshow/9366249.cms as accessed on 15th May 2015.

structure decided by the government was not acceptable to the private managements. He points out that, "the heads of five major *Mutts* running professional colleges said that they would not run institutions unless they were given the right of admission up to 50 per cent of seats. In spite of the 20 per cent raise in fees, they found the fee structure unscientific. The Sringeri Mutt Swami asserted that the managements were not just contractors to admit students sent by the government but promoters of higher education. All of them claimed that the right to select students was a part of administration. The religious heads found support in the caste leaders of the community. Venkatagiri Gowda, a member of the parliament and president of the Vokkaligara Sangha, speaking on behalf of the Sangha said that the managements of Vokkaliga colleges were reluctant to admit students because the fee structure was far lower than prescribed by the All India Council of Medical Education". Patil pointed out that "the *Mutts* of both the Lingayat and Vokkaliga communities were supported by political leaders. Ramesh, the MLA in the dissident camp, apologized to the swamis of various *Mutts* on behalf of Moily. The government backtracked on the ordinance" (Pinto, 1994, p.32).

It is observed that the former Chief Minister (CM) of Karnataka, B. S. Yeddyurappa, provided large amount of money to different religious organizations (Maramkal and Aiyappa, 2011)[36]. It is observed that around Rs.110 crore of taxpayer's money was given to different religious *Mutts*. The biggest beneficiary of this were the *Mutts* promoted by Lingayats, the same community as of the then CM. It states that "the Kudalasangama Development Authority, which oversees Kudalasangama, a pilgrimage centre for Lingayats, was granted 5 crores. Similarly, another pilgrimage centre Basavakalyan received 5 crore from the government. More than 20 temples managed by Lingayat *Mutts* in Shimoga district from where Yeddyurappa hails, received a combined grant of 10 crore. Temples in BJP bastions such as Udupi, Hubli-Dharwad, Chikmagalur, and Dakshina Kannada too received generous grants from his government" (Gowda, 2011)[37].

The following table-4.7 gives an overview of the religious *Mutts* having hold on the private medical colleges. Eight medical colleges are run by the three religious

[36] Maramkal, M. and Aiyappa, M. (2011, July 26). Ibid.
[37] Gowda, A. (2011, September 4). Yeddyurappa Gave Temples Rs 110 Crore Of Taxpayers' Money. *India Today.* Bangalore. Retrieved from http://indiatoday.intoday.in/story/yeddyurappa-doled-out-crores-to-temples/1/150044.html as accessed on 15th May 2015

communities, Lingayat, Vokkaliga and Jain. The dominant among them is the Lingayat community which runs four private medical colleges followed by Vokkaliga which runs three medical colleges and one by Jain community. All these medical colleges are established by the religious *Mutts*.

Table-4.7
Private Medical Colleges and Their Affiliation to Religious *Mutts*

Name of the College	Year of College establishment	Name of Educational Turst	Year of Trust establishment	Name of founder of the trust	Caste
Adichunchanagiri Institute of Medical Sciences Bellur	1985	Sri Adichunchanagiri Shikshana Trust	1973	Sri Adichunchanagiri Math Jagadguru Sri Sri Sri Dr. Balagangadharnatha Maha Swamiji	Vokkaliga
Basaveswara Medical College and Hospital, Chitradurga	1999	Sri Jagadguru Murugharajendra Vidyapeetha	1966	Jagadguru Late Sri Mallikarjuna Murugharajendra Mahaswamiji,	Lingayat
BGS Global Institute of Medical Sciences, Bangalore	2013	Sri Adichunchanagiri Shikshana Trust	1973	Sri Adichunchanagiri Math Jagadguru Sri Sri Sri Dr. Balagangadharnatha Maha Swamiji	Vokkaliga
Jagadguru Jayadeva Murugarajendra (JJM) Medical College, Davangere	1965	Bapuji Educational Association	1958	Sri. Dr. Shamanur Shivashankarappa	Lingayat
JSS Medical College, Mysore	1984	JSS Mahavidyapeetha Trust	1954	Jagadguru Dr. Sri Shivarathri Rajendra Swamiji	Lingayat
Kempegowda Institute of Medical Sciences, Bangalore	1980	Vokkaligara Sangha	1906	Vokkaligara Sangha	Vokkaliga
S. Nijalingappa Medical College & HSK Hospital & Research Centre, Bagalkot	2002	Shri Basaveshwar Vidya Vardhak Sangha	1906	Shri Gurubasava Mahaswamiji	Lingayat
SDM Medical College , Dharwad	2003	Sri Dharmasthala Manjunatheshwara (SDM) Educational Society		Dr. D. Veerendra Heggade	Jain

Source: Name of the College and year of establishment accessed from MCI website. Name of the educational trust, year of educational trust and the name of the founders of the trust was enquired from key informants as well as various websites of the colleges and trust.

The Vokkaligara Sangh which was established in 1906[38] as a trust have invested in building up number of educational institutions from school, colleges to higher professional educational institutions. It includes around 15 higher educational institutions and four hostels where around 8000 students are enrolled in this professional education. The professional educational institute includes medical college and hospital, dental college and hospital, Institute of Technology (Offering courses in Civil, Mechanical, Electrical, Electronics, Instrumentation, Computer Science, Architecture, MCA, MBA etc.), College of Arts, Commerce, Science and college of Law.[39] Kempegowda Institute of Medical Sciences (KIMS) which was established in 1980 by the Vokkaligara Sangh (A Religious Mutt). The kind of support and land the Sangha received from the political connections to establish this college is witnessed from the information provided by the college website which states "On 30.11.1980 the Hon'ble Chief Minister Shri. R Gundu Rao laid the foundation stone of the Kempegowda Institute of Medical Sciences and Hospital in the premises of the Sangha and announced the grant of vacant land in Banashankari to be used for the construction of college building and hostels" (KIMS website as accessed on 7th April 2015).[40]

[38] The history of Vokkaligara Sangha is mentioned in the websites which illustrates that in the early twentieth century the kind of support and money they received from the Maharaja which paved the way for their dominance in establishing educational institutions. As it is mentioned on their website, "The First General Meeting (Maha Sabha) of the Sangha was held for 3 days from 7th Oct.1906 to 9th Oct.1906 at Bangalore. This meeting was presided by Sri B S Marappa. Sri V P Madhava Rao, Dewan of was Mysore the Chief Guest. The Sangha had the blessings of the Maharaja of Mysore. The British regime also recognized the Sangha. Sri Madhava Rao announced that an area of 12 acres and 13 guntas was granted to the Sangha to carry on its activities. A sum of Rs.30,000/- (very hefty amount during those days) was donated by Sri B S Marappa and his brother Sri B S Muniswamappa to construct a student's hostel in a portion of the land that was granted. The Novodaya Period from 1948-1972 saw a quantum jump to the Sangha's activities and a host of educational institutions were built and educational assistance to the needy and deprived were provided. A government hospital was also built in the land of the Sangha which was later to be handed over to the Sangha. All-round progress was witnessed among the people of the Community and their patronage to the Sangha also increased. The third period was the Mahodaya which was from 1973 saw the Sangha's activities reach the zenith. The total area of the land that now belongs to the Sangha is 13.9 acres in what is now the bustling Visveswarapuram in the Heart of Bangalore. The glorious Bangalore Institute of Technology and the renowned Kempegowda Institute of Medical Sciences (KIMS) and hospital came into existence in the early 1980s. Since then these institutes have been churning out innumerable and efficient engineers and doctors. This apart, the Sangha has been into several acts of phiolantrophy. Almost every Vokkaliga in Bangalore is today a member of the Sangha"as available on http://vokkaligarasangha.com/history.html as accessed on 7th April 2015.

[39] Information is accessed from the websites of Medical college and Vokkaligara Sangha as available on http://vokkaligarasangha.com/facilities.html and http://www.kimsbangalore.edu.in/vsabout.html as accessed on 7th April, 2015.

[40] KIMS website as available on http://www.kimsbangalore.edu.in/about.html as accessed on 7th April, 2015

As pointed out by one of the respondent who is a doctor by profession, runs an NGO which works on health issues and was an ex-member of Lok Ayukta in Karnataka observed that

> "These religious *Mutts* do not have the accountability and transparency. They do accept the black money which somebody gives them. Deve Gowda belongs to Vokkaliga community gave donation to Adichunchanagiri Hospital which also belong to Vokkaliga religious Mutt and Kempegowda Institute of Medical Sciences (KIMS) is another one. So lot of money is coming into this private medical college" (Interview conducted in Bangalore on 6th September 2015).

Similarly Basaveshwar Vidya Vardhak Sangha which was founded in 1906 by Shri Gurubasava Mahaswamiji at Bilur established S. Nijalingappa Medical College and HSK Hospital and Research Centre in 2002.

S. Nijalingappa Medical College & HSK Hospital & Research Centre:

The college and hospital is located in the new (Navanagar) and old city of Bagalkot which is also a district headquarters. Bagalkot district comes under the administrative division of Belgaum. The college is established in the year of 2002 under the trust name Shri Basaveshwar Vidya Vardhak Sangha (BVVS).[41] The trust was founded in the year of 1906 by his Holiness, Shri Gurubasava Mahaswamiji of Bilur. The Sangha was started with an opening of a Sanskrit Pathshala in 1907.[42] Now the Sangha runs a large number of educational institutions which over a period of time nurtured more than 100 educational institutions. It ranges from pre-school, primary school, high schools, undergraduate colleges, technical and professional colleges which includes

[41] The actual name of the trust is Shri Basaveshwar Veerashaiva Vidhya Vardhaka Sangha, but on the college website it mentioned as Shri Basaveshwar Vidhya Vardhaka Sangha see http://www.snmcbgk.in/ and http://www.bvvsawcb.org/index.php?option=com_content&view=article&id=47&Itemid=54 as accessed on 10th April 2015.

[42] In 1909 in the 5th All India Veerashaiva Mahasabha, it was proposed to establish a Veerashaiva Vidhya Vardhaka Sangha. The Sangha was emerged with the guidance of Sri. H. H. Hanagal Kumarswamygal and H. H. Jagadguru Sri. Siddhalinga Shivacharya Swamiji of Ujjaini. Formally it was registered in the year of 1918 as 'Madras Veerashaiva Vidhyavardhaka Sangha'. Later on in 1933 it was changed with 'Veerashaiva Vidhyavardhaka Sangha', Bellary, when the district was merged with Mysore state. It was started to provide a free hostel of their community students means to the Veerashaiva Sect students (Lingayat Community). See http://www.vvsanghabellary.org/ as accessed on 10th April 2015.

engineering, medical, nursing, Law etc. These educational institutions spread over two districts, Bagalkot and Belgaum. The hospital was started (in 2000) before the establishment of medical college in 2002. The hospital and college is spread over 114 acres of land. The hospital is being named after the Late His Holiness Shri Kumaraswamiji of Hanagal (Hanagal Sri Kumareshwar hospital) as he was one of the pioneers of the Sangha's development. It is important to mention here that the name of the college is named as S. Nijalingappa because when the S. Nijalingappa was the chief minister of Karnataka, he granted 250 acres of land on lease for a period of thirty years and later on when J. H. Patel was the chief of Minister of Karnataka, he regularized and granted the land.[43] Dr. S. J. Nagalotimath and Dr. T. M. Chandrashekhar have contributed immensely in the beginning and development of medical college and hospital. Currently Shri Siddanna Shettar is the leader and guiding the development of college and hospital. The medical college is recognized by Medical Council of India (MCI) and permitted for the annual intake of undergraduates to a maximum of 150 students. The college is affiliated to the Rajiv Gandhi University of Health Sciences. The medical college has 23 departments with an attached teaching hospital. The hospital was initially started with a 300 beds and now it has 750 general beds and 144 intensive care beds. On hospital website it states that the hospital "provides service to Below Poverty Line (BPL) card holder's through Yeshasvini Scheme, Vajpayee Arogyashree, Thayi Bhagya Scheme, and Balasanjeevini which are initiated by the government. It is also impaneled with EGHS Scheme, Military officer's welfare scheme, KSRTC Employees union, TTK, ICICI Lombard for weavers, and many more health Insurance".[44]

Shri B. M. Patil Medical College, Hospital & Research Centre:

This college is located in the heart of the city of Bijapur which is also a district headquarter. The Bijapur district comes under the region of Belgaum. The college is established in the year of 1986 under the trust named Bijapur Liberal District Educational Association (BLDEA). When the trust was founded in 1910, the name of the trust was Bijapur Lingayat Development Education Association (BLDEA). It

[43]The information is available on the college website. See http://www.snmcbgk.in/college.html as accessed on 10th April 2015.

[44] The information is available on hospital website. See http://www.snmcbgk.in/hospital.html as accessed on 10th April 2015.

clearly indicates the trust is an outcome of veerashiva sect of Lingayat community. The trust runs a large number of educational institutions which nurtured 75 institutions. These include schools, pre university colleges and professional colleges (Engineering Medical, Nursing, Pharmacy, Business Administration, Law etc). The trust was founded by philanthropists and visionaries, mainly the late Dr. P. G. Halakatti, who took initiative with some other visionaries to establish the association. During the First World War the German Mission was running a school which was handed over to the association and the journey towards development of education started. In 1942, the association's leadership came under the late Shri Shri Sanganabasaveshwar Maha Shivayogigalu of Banthanal, who was a religious leader and founded the number of educational institutions. He played a significant role in the development of association and education mainly by establishing primary school, secondary school and higher education. Later, in the period of 1960's Sri B.M. Patil contributed immensely in the spreading of significance of education in North Karnataka mainly in the districts of Bijapur and Bagalkot. The trust now has its deemed University called Bijapur Liberal District Educational University (BLDE University). Shri B. M. Patil Medical College is recognized by Medical Council of India and permitted for the annual intake of undergraduates to a maximum of 150 students. The college has 23 departments with an attached teaching hospital with a facility of 1000 beds. The hospital provides out-patient, in-patient, casualty and emergency services. The medical college and hospital is spread over 45 acres of land. On the MCI website the medical college is associated with the Rajiv Gandhi University of Health Sciences, however on the college website it says the college is under the deemed university of BLDE. [45] All the above mentioned leaders of the BLDEA belong to Lingayat community and have religious background.

It shows the way in which the Sangha's religious leaders built up trusts to provide services to their own community by establishing free hostel for the students of their community. It is also very important to note that both the chief ministers who granted the land to establish medical college and hospital belong to Lingayat community.

[45] The information is compiled from different websites of mainly from the organization website, BLDE University and Medical college website, MCI website as available on http://www.bldea.org/, http://www.bldeuniversity.ac.in/sponsiring.html, http://www.bldeuniversity.ac.in/medcol/about-us.html and http://www.mciindia.org/InformationDesk/CollegesCoursesSearch.aspx as accessed on 8th April 2015.

Historically, they built up the networks and resources which led them to be dominant caste and class. Here, it is clearly evident that the kind of resources one can get if the political and powerful person belongs to the same caste.

"The religious heads had support from the political leaders to establish and run these colleges. The religious leaders in turn provided the much needed support to these political leaders of their respective communities; politicians built up their vote banks with a close nexus with religion and professional education. That is the sole reason for further growth of professional education in Karnataka in spite of the constant profession of politicians to curb the malaise in the field" (Pinto, 1994, p.33).

Implications for Quality of Medical Education:

The focus of the present study was not to measure the quality of medical education, however there were concerns raised about quality of medical education due to the way in which commercialization of medical education is taking place in the state. Hence, few issues are discussed here.

Faculty Shortage:

The table-4.8 is prepared based by using the MCI norms for faculty positions and their availability in medical colleges in both government and private sector. It is based on the data reported on each medical college website.[46] While looking at the data we found that there is a mismatch in filling up the positions according to MCI norms. We found that some positions are over filled while some are not fulfilled. Even within departments many positions have not been specified on college website. In most of the colleges few departments do not exist, most among them are the department of Radiology Diagnosis and Dentistry. Hence, the data is not provided on the website of all the departments. Whereas MCI mandates all the information should be put up on website. However, there are six private medical colleges and three government medical colleges either do not have website or have not specified the faculty positions on website.

[46] The data is based on reported on college website in 2014 hence there might be changes and cannot be generalised

Table-4.8
Faculty Shortage in Medical Colleges in Karnataka in 2014

Ownership	Prof.	Asso. Prof	Assi Prof.	Tutors	Epidemiologist	Statistician	Junior Resident	Total	Number of Institute
Gov.	44	60	43	287	7	3	311	755	12
Private	33	285	153	943	14	6	726	2160	27
Total	77	345	196	1230	21	9	1037	2915	39

Source: MCI records as accessed on 27th Feb 2014. Note: The data is filled up between March to May 2014. Three government medical colleges were established after 2014 hence not included in the list. There are six private medical colleges in which either website was not available or the positions were not mentioned and two medical colleges established after May 2014 hence not included in the list

Table-4.8 gives an overview that there is a huge faculty shortage in both the government and private medical colleges in the state. The shortage of faculty positions is reflected at the level professor in government sector as in 12 medical colleges there are 44 professors' needs to be fulfilled. Similarly, for associate professor 60 faculty positions were needed. However, in the private sector most of the faculty positions are required at the level of associate professor. There is a shortage of 285 faculties in 27 private medical colleges Overall, there is a shortage of total of 2915 faculty at different levels to be staffed in 39 medical colleges, which includes both government and private (table-4.8)

The shortage of faculty has serious implications on the quality of medical education. A senior faculty who is teaching in private medical college in the department of community health expressed his experience in private medical college

> "The college was newly started and we were from the 4th batch of MBBS students. And there was not much of stuff we use to have, we had only MBBS tutors who use to come and teach us. One or two qualified, all of our seniors who had passed their MBBS joined back as tutors, so it was all seniors. So you can imagine what was the kind of teaching that use to go" (Interview conducted in Bangalore 11th September 2015).

> "Across the departments there was shortage of teachers, even if you go by the MCI standard. For that matter many subjects we didn't knew how a person who has done his forensic medicine looks like because there was no qualified forensic medicine teacher in our college. Similarly for MD biochemistry, there was no qualified MD teacher which is required according to MCI norms but what we had was the M.SC biochemistry teacher" (Interview conducted in Bangalore 5th September 2015).

However, the interviews also reflected that we cannot categorize all private medical college as having shortcomings leading to poor quality. The respondents opined that those colleges which are established since 30-35 years back are established colleges and they have very good of teachers and hence their quality of teaching is good " (Interview conducted in Bangalore 11th September 2015).

> "In MBBS I was placed in Tumkur private medical college and for post-graduation I was placed in Ramaiah medical college. Both are private medical college but Tumkur medical college was newly started when I joined for MBBS in Tumkur. I could clearly make out the difference between these two private medical colleges because I experienced it. The main thing was, it is an established college being in a Bangalore city and having full and qualified staff as well as the infrastructural facility is excellent. The most of the staff joined during the inception of the college and continued till their retirement. So majority of the faculty that you see in Ramaiah are experienced" (Interview conducted in Bangalore 7th September 2015).

In an interview with a student, she described her choice of going to a private medical college. She got a seat in a government medical college in a rural area of Karnataka. However, she refused to take it because of the distance. Instead of enrolling herself in the government college she chose to take admission in Ramaiah private medical college in Bangalore because it is reputed colleges in Karnataka. It was possible for her to take admission in a private medical college because she could afford the tuition, hostel and mess fees.

Capitation Fee and Fee structure:

Table-4.9

Annual Fee Structure in Karnataka

Government	Government seats in Private college	Private	Deemed Universities
16, 700/-	62,500/-	4, 25,000 /-	6 to 8 Lakhs (NRI ranges 50 lakhs to one crore)[47]

Source: - Information obtained from key informants interview, private medical college websites as well as information available on the website of Karnataka Examination Authority **http://www.kea.kar.nic.in/cet2015/matrix/coll_cour_categ_fee.pdf**; **http://www.kea.kar.nic.in/cet2015/final_allotted_medi.pdf** as accessed on 15th December 2015.

A faculty member who is teaching in private medical college specifically mentioned that:

> "I could not write the Karnataka entrance exam so had to take admission through the management quota. Because of my father's social network, the capitation fee was very minimal and they took around three to four lakhs including tuition fee for the entire period of education. The college was recently started just three to four years old hence the capitation fee was minimal compare to other established private medical colleges" (Interview conducted in Bangalore, 5th September 2015).

He specifically gave the details of the of the fees and donation as mentioned

> "60,000 was the yearly fees for outside Karnataka students. So for entire MBBS course I paid around 2.7 lakhs and some Rs. 80,000 to one lakh rupees I paid as a donation. So, in total I paid around 3.7 lakhs. This was very big amount in 1995" (Interview conducted in Bangalore, 5th September 2015).

The Supreme Court judgment allowed up to a maximum of 15 per cent of the seats for NRIs.(full form) This is a virtual endorsement of giving a legal license for converting education into a commodity that can be sold in the market to those who can afford it. In a situation where the State is increasingly withdrawing itself from the field of

[47] Information on Fees in Deemed universities in Karnataka obtained from the news-paper article as available on http://www.deccanchronicle.com/150701/nation-current-affairs/article/karnataka-cet-medical-aspirants-confused-over-fee-structure as accessed on 15th December 2015.

expanding the existing facilities in higher education it is only natural that commercialization of higher education would follow" (Sharma, 2005, p.69).

Corruption:

Capitation fee leads to corrupt practices in medical education as there are number of evidences which shows the way in which corrupt practices do take place. The Parliamentary Standing Committee Report on MCI has pointed out the way in which corruption takes place in capitation fee colleges and thereby raises a serious concern about the quality of medical education (GOI, 2016).

Interview conducted with one of the ex-Lok Ayukta member in health services in Karnataka has explained the way in which corruption takes place in health services as well as in medical education. He mentioned that there are different levels of corruption and this corruption take place in both government and private medical colleges. First level of bribes is for issuing essentiality certificate which is needed from the state to start medical college and to apply for MCI permission. The bribe goes for essentiality certificate, which is around one to two crore of rupees. Then the second level is when MCI inspections take place. The private college authorities put MCI inspectors in five star hotels, they bribe the MCI for around two to three crore of rupees. They violate all the norms and take all seats on approval. Then at the level of examination, impersonation means somebody else is writing your exam. Recruiting staff at government medical college where the range of bribes is rupees five to six lakhs.

The respondent stated that

> "There is corruption in both the sectors, in government also there is corruption but it is lesser evil because it is a small amount and it is within the system but the private sector corruption is much higher" (Interview conducted in Bangalore on 6th September 2015).

There is a corruption at the level of entry for passing the entrance exam specifically it is more prominent in the private sector. Then to pass in each subject, the student has to pay certain amount to subject wise professor it is called as '***not to fail amount'*** this is prominent in both sectors and has the only difference is amount. Even to acquire degree certificate you have to pay the amount as demanded by the college authority and this is more prominent in private sector.

This clearly shows the level of corruption that take place in both the sectors which leads to malpractice in the health sector.

Allocation of Seats and Reservation Policy:

Table-4.10 provides an overview of the government seats that is being allocated in the government and private medical colleges in the academic year of 2015-16. It shows that in government medical colleges 15 percent of seats are allocated for all India quota which is 15 percent and is filled up by the All India Pre Medical Test (AIMPT) and which is on merit based. Remaining 85 percent of seats are filled up as state quota and is fully based on exam conducted by the state. The reservation policy of the state is implemented as for Scheduled Caste (SC) 15 percent, Schedule Tribe (ST) three percent and Other Backward Class (OBC) 36 percent.[48]

Table-4.10

Distribution of MBBS Government Seats Among Various Categories both in Government and Private Medical Colleges For the Academic Year 2015-16

Name of the Medical Colleges	Total Intake	AIQ	Government Quota Seats				KPCF/KRL MPCA		MQ
			Total SQ	SP_Q	NHK	HK	NHK	HK	
Government Medical Colleges	100%	15%							
Bangalore Medical College and Research Institute, Bangalore	250	38	212	8	188	16			
Belgaum Institute of Medical Sciences, Belgaum	100	15	85	6	73	6			
Bidar Institute of Medical Sciences,Bidar	100	15	85	6	24	55			
Gulbarga Institute of Medical Sciences, Gulbarga	150	23	127	4	37	86			
Gadag Institute of Medical Sciences, Mallasamudra, Mulgund Road, Gadag	150	23	127	5	112	10			
Hassan Institute of Medical Sciences, Hassan	100	15	85	6	73	6			
Karnataka Institute of Medical Sciences, Hubli	150	23	127	8	109	10			
Koppal Institute of Medical Sciences, Koppal	150	23	127	4	37	86			
Mandya Institute of Medical Sciences, Mandya	100	15	85	5	74	6			
Government Medical College,	150	23	127	6	111	10			

[48] There are different category under the OBC quota includes Category-I four percent, Category-II (A) 15 percent, Category-II (B) four percent, Category-III (A) 4 percent, Category-III (B) five percent (information obtained from Directorate of Medical Education, Government of Karnataka, Bangalore)

Mysore									
Raichur Institute of Medical Sciences,Raichur	100	15	85	5	24	56			
Shimoga Institute of Medical Sciences,Shimoga	100	15	85	6	73	6			
Vijaynagar Institute of Medical Sciences, Bellary	150	23	127	7	36	84			
Total	1750	266	1484	76	971	437			

Non-Minority Private Medical Colleges (40%)

Adichunchanagiri Institute of Medical Sciences Bellur	150	0	60	3	52	5	60	0	30
Basaveswara Medical College and Hospital, Chitradurga	100	0	40	2	35	3	40	0	20
Dr BR Ambedkar Medical College, Bangalore	100	0	40	2	35	3	40	0	20
JJM Medical College, Davangere	245	0	98	4	86	8	98	0	49
K V G Medical College, Sullia	100	0	40	3	34	3	40	0	20
Kempegowda Institute of Medical Sciences, Bangalore	150	0	60	4	51	5	60	0	30
Mahadevappa Rampure Medical College, Gulbarga	150	0	60	3	17	40	18	42	30
M S Ramaiah Medical College, Bangalore	150	0	60	4	51	5	60	0	30
S. Nijalingappa Medical College & HSK Hospital & Research Centre, Bagalkot	150	0	60	3	52	5	60	0	30
S S Institute of Medical Sciences& Research Centre, Davangere	150	0	60	2	53	5	60	0	30
Total	1445	0	578	30	466	82	536	42	289

Minority Private Medical Colleges (25%)

A J Institute of Medical Sciences & Research Centre, Mangalore	150	0	37	2	32	3	83	0	30
Al-Ameen Medical College,Bijapur	100	0	25	1	22	2	55	0	20
Father Mullers Institue of Medical Education and Research, Mangalore	100	0	25	2	21	2	55	0	20
Khaja Banda Nawaz Institute of Medical Sciences, Gulbarga	100	0	25	0	7	18	16	39	20
MVJ Medical College and Research Hospital, Bangalore	150	0	37	1	33	3	83	0	30
Navodaya Medical College, Raichur	100	0	25	0	7	18	17	38	20
Rajarajeswari Medical College & Hospital, Bangalore	100	0	25	2	21	2	55	0	20
SDM Medical College , Dharwad	100	0	25	2	21	2	55	0	20
Subbaiah Institute of Medical Sciences, Shimoga, Karnataka	150	0	38	2	33	3	82	0	30
Vydehi Institute Of Medical Sciences & Research Centre,	250	0	63	2	56	5	137	0	50

Bangalore									
Total	1300	0	325	14	253	58	638	77	260
Deemed University Medical Colleges									
JSS Medical College, Mysore	200	0	12	0	11	1	0	0	0
Kasturba Medical College, Manipal	250	0	28	1	25	2	0	0	0
Kasturba Medical College, Mangalore	250	0	50	1	45	4	0	0	0
K S Hegde Medical Academy, Mangalore (Nitte University)	150	0	12	0	11	1	0	0	0
Total	850	0	102	2	92	8	0	0	0

Source: Information provided by the Directorate of Medical Education, Government of Karnataka, Bangalore
AIQ-All India Quota; SQ:- State Quota; SP_Q:-Special Quota; NHK:- Non Hyderabad Quota; HK:- Hyderabad Quota; MQ Management Quota; KPCF/KRLMPCA:-Karnataka Professional College Foundation and Karnataka Religious and Linguistic Minority Professional College Association (COMEDK).

In private non-minority medical colleges 40 percent of the seats are allotted to government and in Minority private medical institutions 25 percent of the seats are allotted as government quota (Table-4.10) There are only four deemed universities which have different percentages for government quota. However, the reasons behind these differential percentages for quota in deemed universities could not be explained. The seats which are allotted as government quota in private medical colleges, fulfils the reservation policy according to the norm. However, the fees are higher for students who enroll in private medical colleges under government quota seats (table-4.10). Besides the tuition fee there are other expenses which includes hostel fee and mess fee which is a burden for students.

It indicates that the students who can afford the cost of medical education can only aspire to become a doctor thereby increasing inequality in educational opportunities.

This chapter has clearly discussed the regional disparities in availability of medical colleges in Karnataka, the uneven and iniquitous growth and expansion of private medical colleges in comparison to the government medical colleges, the role of the caste, class and political power in determining the setting up of the medical colleges in the private sector and the role of the religious mutts in medical colleges. The next chapter will discuss the growth and expansion of medical colleges in Maharashtra.

Table-4.11

Details of the Private Medical Colleges, Owners Socio-Political Background and Society/Trust Information in Karnataka

Sr. No.	Name of the College	Year of Coll	Annual Intake	Name of the Founder	Caste	Political Affiliation	Name of the society or trust (year of establishment)	founder of the society	Attached hospital and No. of Beds
1	A J Institute of Medical Sciences & Research Centre, Mangalore	2002	150	Mr. A.J Shetty	Backward class- Bunts	pioneer industrialist of South Kanara, philanthropist, Managing Trustee of Kadri Sree Manjuneshwara TempleThe (Trust being a Family Trust)	Laxmi Memorial Education Trust (1991)	Mr. A.J Shetty	1000
2	Adichunchanagiri Institute of Medical Sciences Bellur	1985	100	Sri Adichunchanagiri Math Jagadguru Sri Sri Sri Dr. Balagangadharnatha Maha Swamiji	Vokkaliga	1) Chief Promoter and President of Amanath Co-operative Bank Ltd. 2) Founder Chairman of Al-Ameen Islamic Finance and Investment Corporation (India) Ltd. 3) Aligarh Muslim University Treasurer and Pro-Chancellor.	Sri Adichunchanagiri Shikshana Trust (1973)	Sri Adichunchanagiri Math Jagadguru Sri Sri Sri Dr. Balagangadharnatha Maha Swamiji	805

3	Al-Ameen Medical College,Bijapur	1984	100	Dr. Mumtaz Ahmed Khan	Muslims	–	Al-Ameen Charitable Fund Trust (1979)	Dr. Mumtaz Ahmed Khan	not available
4	Basaveswara Medical College and Hospital, Chitradurga	1999	100	Jagadguru Late Sri Mallikarjuna Murugharajendra Mahaswamiji, currently Dr. Sri Shivamurthy Murugha Sharanaru is President	Lingayat	–	Sri Jagadguru Murugharajendra Vidyapeetha (1966)	Jagadguru Late Sri Mallikarjuna Murugharajendra Mahaswamiji,	500
5	BGS Global Institute of Medical Sciences, Bangalore	2013	150	Dr. Balagangadharanatha Maha Swamiji	Vokkaliga	–	Sri Adichunchanagiri Shikshana Trust (1973)	Dr. Balagangadharanatha Maha Swamiji	390
6	Dr. B. R. Ambedkar Medical College, Bangalore	1980	100	9 founder trustees	SC administration	–	Anandaa Social and Education Trust (1980)	9 founder trustees	600
7	Father Mullers Institue of Medical Education and Research, Mangalore	1999	100	Rev. Fr Augustus Muller SJ	Christian – Roman Catholic,	–	Father Muller Charitable Institutions (1880)	Rev. Fr Augustus Muller SJ	1250
8	Jawaharlal Nehru Medical	1963	200	Corruntly leader of the KLE Society	Lingayat	MP (political affiliation-BJP)	Karnataka Lingayat	7 member founded the society with	2400

	College, Belgaum			Dr.Prabhakar Kore		chairmen of KLE society and Chancellor of KLE University	Education Society (1916)	three members added later period (10)	
9	Jagadguru Jayadeva Murugarajendra (JJM) Medical College, Davangere	1965	245	Sri. Dr. Shamanur Shivashankarappa	Lingayat	MLA and Minister of Horticulture & APMC, Karnataka (political affiliation-Congress)	Bapuji Educational Association (1958)	Sri. Dr. Shamanur Shivashankarappa	
10	JSS Medical College, Mysore	1984	200	Jagadguru Dr. Sri Shivarathri Rajendra Swamiji and now Present leader is 24th Peethadhyaksha, Sri Shivarathri Deshikendra Mahaswamiji,	Lingayat	–	JSS Mahavidyapeetha Trust (1954)	Jagadguru Dr. Sri Shivarathri Rajendra Swamiji	1200
11	K S Hegde Medical Academy, Mangalore	1999	150	Nittte Education Trust members	Brahman	former Justice of the Supreme Court of India and former Speaker of the Lok Sabha	Nittte Education Trust (1979)	Late Justice Kowdoor Sadananda Hegde	1200
12	K V G Medical College, Sullia	1999	100	Dr. Kurunji Venkatramana Gowda	Vokkaliga	known as an able administrator and philanthropist	Academy Of Liberal Education (1967)	Dr. Kurunji Venkatramana Gowda	Not Availabl e

13	Kasturba Medical College, Mangalore	1955	250	Dr. Tonse Madhav Ananth Pai,	Brahmins – GSBs (Gowda Saraswath Brahmins), Konkani Linguistic Minority	an Indian doctor, educationist, banker and philanthropist	Manipal Academy of Higher Education got changed Manipal University Trust	Dr. Tonse Madhav Ananth Pai,	600
14	Kasturba Medical College, Manipal	1953	250	Dr. Tonse Madhav Ananth Pai,	Brahmins	"	Manipal Academy of Higher Education got changed Manipal University Trust	Dr. Tonse Madhav Ananth Pai,	
15	Kempegowda Institute of Medical Sciences, Bangalore	1980	120	Vokkaligara Sangha	Vokkaliga	–	Vokkaligara Sangha (1906)	Vokkaligara Sangha	810
16	Khaja Banda Nawaz Institute of Medical Sciences, Gulbarga	2000	100	Dr. Syed Shah Khusro Hussaini	Muslims	–	Khaja Education Society (1958)	Janab Syed Shah Muhammad Al Hussaini	500
17	M S Ramaiah Medical College, Bangalore	1979	150	Sri M.S.Ramaiah	OBC	entrepreneur,industrialist and philosopher (family Trust)	Gokula Education Foundation Medical (GEFM) (1980)	Sri M.S.Ramaiah	1050

18	Mahadevappa Rampure Medical College, Gulbarga	1963	150	Late Sri Mahadevappa Rampure	Lingayat	Member of Parliament Sri S. Nijalingappa, the then Chief Minister, Govt. of Karnataka, Sri. Veerendra Patil and Dr. D. C. Pavate helped in establishing the Medical college (political Affiliation_congress)	Hyderabad Karnataka Education Society (1958)	Late Sri Mahadevappa Rampure	820
19	MVJ Medical College and Research Hospital, Bangalore	1997	100	Dr M V Jayaraman	Brahmin	–	Venkatesha Education Society (1970)	Dr M V Jayaraman	950
20	Navodaya Medical College, Raichur	2000	100	Shri.S.R.Reddy	OBCs - Telugu	–	Navodaya Education Trust (1992)	Shri.S.R.Reddy	
21	Rajarajeswari Medical College & Hospital, Bangalore	2005	150	Sri A.C. Shanmugam, B.A.L.L.B.	Tamilnadu (temple)	former M.P and MLA in the year 1992	MOOGAMBIGAI CHARITABLE AND EDUCATIONAL TRUST (1992)	Sri A.C. Shanmugam, B.A.L.L.B.	900
22	S S Institute of Medical	2006	150	allround development of this	Lingayat	–	Bapuji Educational		

	Sciences& Research Centre, Davangere			family is Dr. Shamanur Shivashankarappa, the present Hon. Secretary of the association			Association (BEA) (1958)		
23	S. Nijalingappa Medical College & HSK Hospital & Research Centre, Bagalkot	2002	150	Shri S. Nijalingappa (granted 250 acres of land) Dr. S. J. Nagalotimath and Dr. T. M. Chandrashekhar (contributed immensely)current leadership is Shri Siddanna Shettar	Lingayats	Shri S. Nijalingappa (was Chief Minister of Karnataka)	Shri Basaveshwar Vidya Vardhak Sangha (1906)	Shri Gurubasava Mahaswamiji	900
24	Sapthagiri Institute of Medical Sciences & Research Centre, Bangalore	2011	150	Sri G. Dayanand	OBC	–	Sri Srinivasa Educational & Charitable Trust (1999)	Late. Sri. T. Giriyappa	
25	SDM Medical College , Dharwad	2003	100	Dr. D. Veerendra Heggade	Hindu Temple foundation Jain	The Head Of A Religious Institution	Sri Dharmasthala Manjunatheshwara (SDM) Educational Society	Dr. D. Veerendra Heggade	

26	Shri B M Patil Medical College, Hospital & Research Centre, Bijapur	1986	150	Shri B. M. Patil	Lingayat	–	Bijapur Liberal District Educational Association (BLDEA) (1910)	Dr. P.G. Halakatti	1000
27	Shridevi Institute of Medical Sciences & Research Hospital, Tumkur	2013	150	Dr. M. R. Hulinaykar, MBBS, MS - Founding Chairman	OBC	–	Sri Shridevi Charitable Trust (1992)	Dr. M. R. Hulinaykar, MBBS, MS - Chairman	300
28	Sri Devaraj URS Medical College, Kolar	1986	150	Shri.R.L.Jalappa, Champion of co-operative movement	OBC - Ediga	–	Sri Devaraj Urs Educational Trust (1984)	Shri.R.L.Jalappa, Champion of co-operative movement	1050
29	Sri Siddhartha Medical College, Tumkur	1988	150	Late Shri. H.M.Gangadharaiah Founder	SC-Holeya	–	Sri Siddhartha Educational Society (1959)	Late Shri. H.M.Gangadharaiah Founder, S.S.E.S	1350
30	Srinivas Institute of Medical Research Centre, Srinivasnagar	2011	150	Mr. A. Raghavendra Rao	Brahmins	a famous Chartered Account and Industrialist of Mangalore	A. Shama Rao Foundation (1988)	Mr. A. Raghavendra Rao	

31	St. Johns Medical College, Bangalore	1963	60	Catholic Bishops' Conference of India	Christian Minority	–	Catholic Bishops' Conference of India (1944)	permanent association of the Catholic Hierarchy of India was constituted at the Metropolitans' Conference held in Madras	1200
32	Subbaiah Institute of Medical Sciences, Shimoga, Karnataka	2012	150	Hon. Sri. T.Subbaramaiah	–	–	Tadikela Subbaiah Trust	**Hon. Sri. T.Subbaramaiah** (Dr.Nagendra S, Dr.Srinivas S, Dr.Lata R Telang, Dr.Vinaya Kumari)	500
33	The Oxford Medical College, Hospital & Research Centre, Bangalore	2014	150	Vidyashree Shri. S Narasa Raju	Reddys From Andhra	guidance and leadership of Shri. S.N.V.L Narasimha Raju	Children's Education Society (1974)	Vidyashree Shri. S Narasa Raju	750
34	Vydehi Institute Of Medical Sciences & Research Centre, Bangalore	2002	150	Dr. D.K.Audikesavulu Naidu	OBC - Telugu	–	–		

35	Yenepoya Medical College, Mangalore	1999	150	Mr Yenepoya Abdulla Kunhi.	Muslims	Dynamic entrepreneur and an industrialist in south India. Timber trade has gradually diversified into commerce & industry, hospitality and health care. he was one of the leading supplier of timber sizes for sleepers in the Indian Railways	Islamic Academy of Education Recognised as deemed university on 27 February 2008,	Mr Yenepoya Abdulla Kunhi.	1020

Source:- The data is obtained from multiple sources which includes each college website, trust website, newspaper article and interviews conducted with the key informants
Note: _Some sections information could not be found

Chapter-V

Caste, Class and Political Power: Private Medical Colleges in Maharashtra

Introduction

This chapter is divided into three parts. The first part focuses upon the historical review of the growth of intermediate caste in Maharashtra especially the Maratha-Kunbi caste cluster. This review provides the bases for locating the social characteristics of the owners of private medical colleges in Maharashtra. The second part deals with the growth and trends of medical colleges in Maharashtra along with the inter-regional disparities in the establishment of medical colleges. It explores why there have been inter-regional disparities in the establishment of medical colleges by locating the historical reasons of uneven developments of different regions of Maharashtra. The third part deals with the social background of the promoters of private medical colleges and explores why there has been huge growth in the private medical colleges in the state. The chapter locates the growth of private medical colleges and social background of the owners of private medical colleges in the context of its social and political development in the state and the emergence of intermediate peasant caste (Maratha-Kunbi). It argues that the growth of the private medical colleges in the state has to be seen in the context of its social and political development.

Brief State Profile:

The state of Maharashtra was formed in 1960 based on the linguistic criteria by merging parts of three provinces that is Bombay province, Hyderabad region and Madhya Pradesh where Marathi speaking areas were prominent. Hence, before independence the state was divided into three political regions. The Kokan and Western Maharashtra region was part of Bombay province, Vidharbha-Nagpur was part of Central Provinces of Madhya Pradesh and Marathwada was part of Hyderabad region. At the time of formation, Bombay province was far more developed in terms of its economic and social growth than the other two regions and this regional

disparity till today is being carried out throughout the years (Lalvani, 2009). Today, it has 35 districts divided into six administrative divisions- Amrawati and Nagpur division (Vidarbha Region), Aurangabad (Marathwada Region), Konkan and Pune (Western Maharashtra Region), Nashik (Northern Region). In terms of population and geographical area, Maharashtra is the second largest state in India. Maharashtra's population is 11.24 crore (Census of 2011) which is 9.3 per cent of the total population of India. The state is highly urbanised with 45.2 per cent people residing in urban areas. Maharashtra is considered as one of the rapid growing state as in terms of Gross State Domestic Product (GSDP) it is estimated Rs. 11,99,458 at current prices for 2011-12 which contributes around 14.4 per cent to the national Gross Domestic Product (GDP). According to Economic Survey of Maharashtra (2013), the state has 226.1 lakh hectors of land under cultivation and agriculture and its related activities sector contributes around 12.9 per cent to the state income. Presently industrial and services sector both together contribute about 87.1 per cent of the State's income. The literacy rate of the State is 82.9 per cent as against 74 per cent at national level as per Census 2011. It is 5th in Human Development Index (Government of Maharashtra, 2013, pp.1-2).

Historical Review:

The Emergence of Maratha-Kunbi Caste Cluster as Dominant Caste in Maharashtra:

It is well known fact that in Maharashtra, Maratha is a dominant caste and till today it remained dominant in many spheres as numerically, economically and politically (Lele, 1982; Lele, 1990; Omvedt, 1976). However, it is important to trace its dominance in its historical perspective and hence the following section briefly explains the emergence of Maratha as a dominant caste.

Historically, the Maratha dominance existed through kinship networks and had several subgroups such as the Patils, the Watandars, the Deshmukhs and the cultivating Kunbis (Lele, 1990). The Patils' were held the hereditary officers and they were the head of the villages and the Kulkarni (Brahmin) were the accountant of the villages. Hence, the power in terms of social status and economic status led the poor people to oblige them. The poor people in the same kinship ties as well as others

started accepting their status and giving them loyalty and surplus. Similarly, the *Deshmukh* (Maratha) and *Deshpande* (Brahmin) had similar administrative posts at the district level (Lele, 1982; Omvedt, 1976). Brahmins (Deshpande, Kulkarni) constituted the other powerful section of priests and accountants and landlords and the two were joined by a growing class of moneylenders who migrated from the Gujarat and Rajasthan (Marwaris). It is important to note that the *watandars*[49] (landlords) were the members of the hereditary officers of Patil's lineages (village headman) who had hereditary rights on the land and Kunbi's were never been regarded as *watandars* (Carter, 1974).

Distinction between Maratha and Kunbi Caste in History:

In the pre-colonial and even in colonial times the Marathas and Kunbis were considered to be a different caste. Proper Marathas (*Patil* and *Deshmukh*) claims their decedents from the Rajputs and hence claims to be Kshatriya. The Proper Maratha's differentiate Kunbis from themselves and do not consider them Kshatriya. Kunbis are cultivators and belongs to the lower ranks in hierarchy (Marchant 1996). Kunbi means 'Peasants'(Omvedt, 1976). However, Russell (1916) states that "the Marathas are a caste formed from military service, and it seems probable that they sprang mainly from the peasant population of Kunbis, though at what period they were formed into an separate caste has not yet been determined" (Russell, 1916, p.199). Maratha caste is a representation of merging of several families of various castes (Lohar, Sutar, Bhandari, Thakar, Dhangar etc.) which still exists as a caste (Gordon 1993). Russell (1916) noted that Maratha caste claim their origin with the Rajput lineages as some names (Chauhan, Panwar, Solanki etc.) are from the Rajput tribes. However, it is applicable only to the few leading houses and the remaining bulk of the Maratha caste is principally derived from the Kunbis. In the Satara Gazetter, it is mentioned as census 1851 includes Marathas with the Kunbis and not as a separate caste (Russell, 1916, p.200). The difference between the Kunbi and Maratha was precisely on the basis of marital relations and the rights they gain from the military services as 'Watans' and 'Inams' (Gordon, 1993, p.15). However, Omvedt (1976) mentions that

[49] Watandars were those who got land from the government or from the overlords and used to have certain rights on it. They used to collect the land revenue and taxes from the cultivators and give it to the overlords or emperor. Watandars were the one who used to get hereditary offices and these watandari remains in one family and gets transferred from generation to generation. Watandari system remained the same even if the ruler or emperor got changed (Carter1974; Omvedt, 1976; Lele, 1981).

"under earlier Hindu and Muslim rule only the aristocracy was described as "Maratha" and the rest being simply peasant Kunbis". Till the British period the distinction between them was prevalent. However, it was noted that a rich Kunbi being able to marry to an accepted Maratha family which indicates the crossing lines between the Maratha and Kunbi. Within proper Marathas there were again distinctions as five families, seven families (*Satghare*) and ninety-six families (*Shahannav Kuli*). "In the twentieth century the identity of these various ill-defined categories began to merge. In the Deccan, 'Kunbis' practically vanished in 'Maratha' caste, though the distinctions continued to be made in the Kokan and Vidharbha where 'Kunbis' were considered to represent the earlier population and 'Marathas' more recent arrivals with the troops of Shivaji and his successors" (Omvedt, 1976, p.69). Enthoven (1922) also reiterates that there was a distinction been made between Kunbi and Maratha until 1911. However, the distinction was based on the class rather than on the caste, as traditionally 'Marathas' were landlords and chiefs of the villages' whereas Kunbis were the cultivators of the land. At around 1911 Kunbi caste was being merged or absorbed with the general Maratha community (Enthoven, 1922 as cited in Carter 1974). Even the merging of the Kunbis into Maratha it remained as a Maratha-Kunbi caste cluster so now the Kunbis regard themselves as Maratha-Kunbi and Maratha's remained as Maratha.

Maratha's regarded as *watandars* used to hold a large land and hence were the big land-lords whereas Kunbis were the peasants and used to cultivate their land hence used to have small amount of land. The difference between them was rather on class character and hence had inequality within the community and this remained even in the post-independence period. Lele (1990) argues that "the ruling elite of the so-called dominant caste maintain their dominance over the underprivileged members of their own caste, and other subordinate castes, by manipulating established political institutions and regimes and, if necessary, by changing them so as to conform to their interests" (Lele, 1990, p.115).

Maratha Power in Shivaji's Era

In the mid-17th century the emergence of Shivaji's (born in 1627) power and his takeover over the Muslim Bijapur king for foundation of Hindu Kingdom has actually led to the increased power among the Maratha's as Ksahtriya status. However, Shivaji

as king was aware about the increased power of the aristocrat Maratha's and he made an attempt to break this power through takeover over the forts, castles, wade's which these aristocrat Maratha's built up when they got surplus from the *watandari* system from the overlords.Shivaji was a supporter of the peasants and he wanted to breakdown the feudatory system of the *watandars* (Omvedt, 1976). "He warned the *Deshmukhs* as well as his own appointed officers to end the harassment of the Kunbis" (Lele, 1990, p.133) and started recruiting peasants Kunbis in his army (ibid). Hence, the power of the aristocrat Marathas started decline.

However, Shivaji was a believer of the religious tradition and he maintained the historical alliance between Maratha and Brahman as in his tenure there were many Brahmins under him who were the chief advisors of him (Lele, 1982). Kulkarni (1969) pointed out that "the outcome of his rise to power was clearly the stabilization of the old village order and the regional system of tax collection, a system jointly run by the Maratha and Brahmin" (Kulkarni, 1969 as cited in Lele 1982, p.50). Soon after the death of Shivaji (1680) the Peshwas (Brahman) ruled over the Deccan land. At around 1700 the Peshwas emerged as powerful military force and with the support of the Maratha warriors they extended their territories (Merchant, 1996). During Peshwas rule the boundaries between the caste and the disciplinary rules of inter-dining and intermarriage were strictly being enforced (Fukazawa, 1968 as cited in Deshpande, 2003, p.8) Numerically Brahmans were about five to six per cent yet they dominated the region in terms superior social status as well as administrative rule and political status (Gore, 1989a).

British Rule:

The British rule brought major changes in the society such as changes in land revenue system and cash transactions, new forms of administration, new cash crop farming, market and introduction of new administrative-judiciary system (Lele, 1990, p.139). This new forms of structures led to the disputes within the elite Maratha lineages and there was increased indebtedness due to strict revenue demands and increased cash transactions during the British rule. During the British rule there was a growing class of moneylenders who basically migrated from the Gujarat and Rajasthan, known as Gujars and Marwaris. This merchant class became one of the wealthier and powerful classes. However, in the villages the landlords who were mainly the village headman,

Brahman accountant and village priests too lent money to the poor peasants and agricultural labourers acquired mortgages and land control. It was in this period in the Deccan territory the major dominant caste primarily were the Brahmans, Gujars, and Marwaries (Omvedt, 1976). Hence, in the 19th Century, the Maratha lineages was undermined with indebtedness due to strict revenue demands of the British and changes in rules, while the Marwaris and the 5-6 percent Brahmins acquired land and wealth to become the dominant caste (Omvedt, 1976,Carter, 1974, Lele, 1982, Gore1989a).

In Maharashtra the British rule started in 1818 and the British East India Company took over the civil and political authorities into their hands. Britishers brought the idea of liberal thoughts, new knowledge and egalitarian values into the Indian society but did not eliminate the feudal authorities and hereditary offices especially at the village level. They only diminish the traditional authorities where it was needed for them which ultimately benefitted them. They took over the Peshwa rule and abolished the hereditary offices in the government but at the village level they did not intervened much (Gore, 1989b). At this juncture the decline of aristocracy began with new rules of land holding and the property of land came under British capitalism (Omvedt, 1976). This British rule brought the new opportunities and new ways to fill up the government, executive and judiciary jobs and at this period the Brahman were among the first one who took the benefit of these opportunities. These services recruited only on the basis of merit debarring the caste obligations however the access to education was only among the Brahmans and hence the dominance of the Brahmans in the administrative posts began to increase. The dominance of the Brahmins and the few upper caste such as Chitpavan Brahmins, Kayastha and Prabhu were seem to be seen in the newly educational institutions which were started in Bombay and Pune (Gore, 1989b). Gordon Johnson (1970) pointed out the dominance of Brahman intelligentsia as in the Fergusson College of Pune out of 610 students 526 were Brahmans and among these 256 were Chitpavans, in 1902 the Marathi newspapers editors in the province were among the Chitpavans which was 38.3 per cent and other Brahmans constituted 43.4 per cent. In the Public Service Commission, 41.25 percent Deputy Collectors, 75.5 per cent mamledars (assistant deputy collectors) and 71 per cent of subordinate judges were belong to Brahmans (Johnson 1970 as cited in Omvedt 1976, p.79).

This illustrates that there was an over representation of the Brahmans in every sphere where the upward mobility and high social status remain intact. During this period there was some kind of mobility that occurred among the backward castes as Gore (1989a) stated that

> ".....a few of the backward castes not attached to land as cultivators were drawn to the urban areas to meet the demand for construction workers, contractors, industrial workers, labour contractors and small traders. These individuals had experienced relative upward mobility; some of them who were road and construction contractors supported the idea of promoting education among those castes which traditionally did not send their children to school" (Gore 1989a, p.932).

However, it is important to note that the Marathas and Kunbis were largely left out from the new opportunities of education and government service jobs. In the late 19th century they started realizing the importance of education and some of them did take the advantage of education (Gore, 1989b). Omvedt (1976) points out that in the early 20th century the literacy rate among the Maratha and Kunbi caste was relatively very poor than the other backward caste (Omvedt, 1976, p.77).

In this context where there was an increasing monopoly and hegemony of Brahmans in every sphere and along with this there was an increased consciousness and realization among the backward caste people about their own deprivation and denial of rights which led to the emergence of Non-Brahmin Movement.

Non Brahmin Movement in Maharashtra:

The emergence of the non-Brahman movement was started at the last quarter of the 19th century and Jotiba Phule paved the way for it. In Maharashtra, Jotirao Phule (1827-1890) is the pioneer of the non-Brahman movement. He belongs to a *mali* [50](backward) caste. Jotiba Phule took education in Scottish English mission school till

[50] The *malis* grew flowers and vegetables and these products had urban markets. The *malis* were different caste from that of a Maratha aristocracy and hence did not developed a Kshatriya status. The *malis* due to their occupation did got introduced to the urban markets and came into the contact of all sections of the society which led to some upward mobility among them (Gore, 1989b). Even As Rosolind O'Hanlan (1985) stated that "Mali caste often acted as a medium of contact between rural areas and the growing urban centres of western India. The Malis ranked as *Shudra* in the four-fold varna scheme. In the local caste hierarchy, however, they appear to have occupied quite a respectable position, roughly equivalent to that of Maharashtra's large grouping of peasant, land-holding, and cultivating castes, the *Maratha-Kunbis*" (O'Hanlan, 1985, p.105)

secondary level. In the school Jotiba Phule got introduced to the new thoughts of western liberal values and was influenced by the work of Thomas Paines who was an American writer. The new liberal values made him to think in a humanitarian way and he was the one who questioned the religious values and hierarchy and thought of bringing equality in the society through social reform. One of the instances which hit him to question the religious orthodoxy when he was invited in a Brahman marriage ceremony and then one of the orthodox Brahman denied Jotiba Phule to participate in ceremony due his backward caste. This incidence made him to consolidate his thinking on the social issues and deep rooted social inequality in the caste system. He realized that the education is crucial and fundamental to bring social reform in the society and started educating his own wife and in 1848 he decided to establish first school for girls in Pune. He continued his major emphasis on education and established schools in later period. That time it was a radical decision to provide education to girls who were from lower caste. Later on in 1852, he started school for untouchables. It is important to note that some of the liberal Brahmans, who were too, influenced by the western education and believed on social equality supported to Jotiba Phule's reforms. Jotiba Phule published several of his work for the enrichment of the lower caste and in 1865 he published *Jatibhed Viveksar*. In the 1873 Phule published a major book called *Gulamgiri* (Slavery) and in the same year to provide an organizational base for the struggle he founded the Satyashodhak Samaj (Truth Seeking Society) and provide common platform for the all Non-Brahmin caste to unite and fight for the religious reform for their own emancipation. He took open radical stands against the Brahmanism and its orthodox religious values and denied the Brahman's importance in the Hindu rituals (Omvedt, 1976; Gore, 1989b). O'Hanlan (1985) mentioned that "Phule's collection of ballads, priest craft exposed, attempted to undermine existing belief in the necessity of a Brahman to carry out religious ritual. No such intermediary was necessary between man and God; and where Brahmans did attempt to interpose themselves; this was in search only of money or power, and not of the spiritual well-being of Hindus themselves" (O'Hanlan, 1985, p.208). Until his death (1890) Phule, insisted that the movement's primary focus should be on social, religious and cultural revolution than political (Gore, 1989a).

However, after his death the goal of the social revolution could not be able to carried out by his followers as there was lack of support by the colonial government to carry out the social revolution programme and the elite dominated national movement did not want any hindrance in the mass participation due to any social revolution changed somewhat the direction of the movement (Omvedt, 1976). Lele (1990) mentioned "earlier Phule had attempted to mobilize all the backward classes with a view to establishing a society based on a *sarvajanik dharma.* That goal now shrank to that of reasserting Maratha hegemony and fulfilment of elite *maratha* interests. Some of Phule's major goals were rejected. His attack on inequality and all casteism, his battle against untouchability, his active promotion of women's equality and his opposition to the oppressive social practices were mainly forgotten" (Lele, 1990, p.153).

Chhatrapati Shahu Maharaj (1874-1922), the Maharaja of Kolhapur from Maratha, formally became a ruler in Kolhapur and promoted education for all sections of the society. In 1894, at the age of 20 he formally held a power as a ruler in Kolhapur. He was being considered as one of the major patron of the Non Brahman Movement in Maharashtra. Shahu Maharaj was leaned towards the importance of education and promoted education in the society especially among the lower socio-economic background people who were traditionally denied of education. In his tenure he built up many hostels for the students and schools where there was no any bar on caste. In 1899, he started hostels in rural areas, so that the backward class children can avail the education. He had resentments against the Brahman domination in education, professions and in administrative services. The *Vedokta*[51] controversy in 1902 led him to adopt a policy of recruiting non Brahmins through a 50 per cent reservation in the government service. His opposition of Brahmins got him recognition among the backward communities (Gore, 1989b). He supported Dr. Babasaheb Ambedkar to pursue his higher studies at abroad and also helped him to publish '*Muknayak*', a Marathi periodical from Bombay in 1920. Along with this he supported to organise a conference for untouchable under the chairmanship of Dr. Ambedkar (Dahiwale, 1995, p.337). However, it is mentioned that he was proud of his Maratha lineages and he attempted to bring back the Maratha (Copeland, 1973) through a policy of

[51] Vedokta controversy emerged around 1900 when the Brahman's opposed to the acceptance of Marathas as Kshatriya status and hence Shahu Maharaj was denied to get the Vedic rites in performing of the religious ceremonies in the palace (Gore, 1989b).

inclusion of Marathas in education and employment and setting up a school for the training of *Patil* (village headman Maratha) in 1911. He maintained the traditional order but as against the *Kulkarnis (*Brahmains) who always took the benefit of their education in villages (Omvedt, 1976).

The Satyashodhak Samaj movement increasingly spread out in Kolhapur. However, "the movement underwent a change from being a movement for 'cultural revolution' to being a movement for political power" (Gore, 1989b).Shahu Maharaja did not fully accepted the radical stand of the Satyashodhak Samaj and even though he supported the movement, he refused to become a member of the Satyashodhak Samaj (Omvedt, 1976; Deshpande, 2003). In 1920, he established Shivaji Kshatriya Vedic School for the training of Maratha Priests. It has been argued that "in the state of Kolhapur between 1900 and 1920, a mutual influence of a Kshatriya oriented aristocratic anti Brahmanism and the mass based radicalism of the Satyashodhak movement took place" (Omvedt, 1976, p.130). The increasing unity among the Marathas and the Maratha-Kunbi caste cluster gave them a numerical advantage (Gore, 1989b). The Marathas mainly the peasants (the kunbis) in villages took a central place and participated in the Non Brahmin Movement as they could see return of power through it. "Thus, village *Patils* and local Maratha land owners found in Non Brahman ideology both an explanation for this traumatic change in their status and powers and the practical means to recoup their position" (O'Hanlan, 1985, p.281). There were many conferences that took place on the bases of caste lines, such as Maratha Education Conference (1907), Mali Education Conference (1910), Bhandari Education Conference (1910), Ramoshi Education Conference (1917), Arya Kshatriya Dnyanwardhak Samaj (1915) (Omvedt, 1976). This led to the socio-economic mobility among the intermediate landowning caste and their aspirations for the political power increased especially among the Marathas.

The shift of the Non Brahman Movement from social reforms in the late 19th century to a struggle for political power in the early 20th century led to the rise of Maratha caste and the peasantry (Pol, 2008). In Maharashtra the peasant class comprises the Maratha-Kunbi caste cluster which was numerically strong.[52] To acquire the political power and to retain its power in the Congress dominated state, they projected

[52] The estimated figures are at round 31 per cent of the state's population belong to this Maratha-Kunbi caste cluster (Deshpande, 2004)

themselves as one and united (Deshpande, 2004). This mobilization of the intermediate peasant caste for political power exists till today as a dominant feature of Maharashtra (Lele, 1990). The Maratha-Kunbi dominant caste cluster who are around 31 percent of the population (ibid, p.116) had monopolised power positions due to their control over agricultural wealth, panchayat raj and co-operatives (Vora, 1996, p.171). Baviskar (2007) as well pointed out that the period of 50's and 60's witnessed the new centres of power and these were the panchayat raj, co-operative society and Congress party. "Marathas occupied important positions in the panchayats, cooperatives, Congress Party and the state legislature and were the largest single caste group in the state" (Baviskar, 2007, p.4217).

Economic and Political Power in Maharashtra:

The historical context of the Marathas has pointed out that the Maratha-Kunbi caste cluster is basically an agriculturally land owning dominated caste in Maharashtra (Lele, 1982; Lele 1990; Carter, 1975; Omvedt, 1976). "The owner cultivators with holdings in the medium and large size categories were disproportionately drawn from elite *marathas.* Most of the rurally oriented state policies since Independence- land reforms, new educational institutions and agricultural development programmes were initiated from this class and implemented in its interests" (Lele, 1990, p.178). In a Girvi village of Phaltan taluka in Maharashtra shows that the bulk of wetland which is also a valuable irrigated land owned by Marathas. The Marathas comprise 56.9 percent of the total village population owns 74.5 percent of wet land and 72.4 percent of dry land (Carter, 1974, p.70). "The *watandar* Marathas own more than half of the valuable wet land occupied by the village residents and nearly thirty percent of the dry land. They are the largest employers of agricultural labour. They are able to borrow on a larger portion of their landed resources than other groups of comparable size and have obtained more than three quarters of the credit available from the Girvi Credit Society. It is this great economic strength enables the Kadam[53] to dominate the politics of villege" (ibid, p.76). Baviskar (1980), showed that in the Kisan Co-operative Sugar Factory of Ahmednagar district, Marathas occupy 40 percent of the population but there are 60 percent Marathas among the shareholders, mainly because they are a major landowning and cultivating group (Baviskar, 1980, p.52.).

[53] Kadam is surname in the village and they are *watandar* Marathas (Carter, 1974).

Small scale study on land holding patterns of 15 villages conducted in five districts of Maharashtra (four are from Western Maharashtra and one is from Konkan region) as well as detail study of one village from Kolhapur district found that the Maratha are numerically high and in these 15 villages they hold large chunk of land. The detail study of one village as well reiterated the fact that out of 914 households of the village 76.59% or 700 households belonged to the Maratha caste and about 80 per cent of the land holdings belong to them[54]

An empirical study conducted by the scholars from University of British Columbia has also pointed out the local level economic and political dominance by the Marathas in three regions Western Maharashtra, Marathwada and Vidharbha. The data is gathered from 300 villages and 9132 households were been surveyed from these three regions. The study shows the numeric preponderance of the Maratha caste as in 41 percent of villages, Maratha forms the majority. The fact that in 59 per cent of villages studied Marathas own most of the land (Anderson, Francois, and Kotwal 2011, p.10).

Scholarly work shows the dominance of the single party of congress in the state and the political power remained in the hands of the Maratha-Kunbi caste cluster (Lele, 1990; Datar and Ghotale, 2013). After independence the control over political positions and hold of congress among the Marathas was prominent. "In Maharashtra, including Bombay, 16 per cent of the Congressmen were Brahmins and 66 per cent were non-brahmin Marathas. This accounts for the charge made in 1962 that all the District Congress Committee Presidents and Secretaries in Maharashtra were marathas and that 75 per cent of all Congress candidates in the 1962 general elections were also of this group" (Kochanek 1968 as cited in Dahiwale 1995, p.340).

The continuation of the Maratha's in state politics is witnessed in the assembly elections in 1995, Vora (1996) pointed out that "Maratha and Kunbis maintained their-strength of 114 and 24 respectively making the proportion of the maratha caste cluster 47.91 percent (their proportion in population is 31.19 per cent). If we take out the reserved constituencies (40) from the total of 288, the proportion of maratha-

[54] The information is available on Shodhganga website but full reference could not be obtained hence the chapter from which the data is obtained from the website of as retrieved from http://shodhganga.inflibnet.ac.in:8080/jspui/bitstream/10603/19005/10/10_chapter%204.pdf as accessed on 15th July 2015.

kunbhis becomes 55.64 per cent in 248 unreserved constituencies" (Vora, 1996, p.173). "Estimated about 40 per cent of the population, the Marathas have controlled nearly 80 per cent of the positions of political power" (Lele, 1982, p.xii). As analysed by Datar and Ghotale (2013) that there are two features in the Maharashtra state politics, one is the numerical strength and the dominance of the Maratha-Kunbi caste cluster, and their entry into the Congress party since 1930 led to increased power of Congress party in the rural masses. The other feature is that complete hold of a power by a single congress party for decades as till 1990 congress party was in power in the state. These two features have been strengthened by the Maratha-Kunbi Caste cluster hold on the co-operative sectors especially, sugar co-operatives (Datar and Ghotale, 2013, p.37). In a study conducted by Datar and Ghotale (2013), who have selected 16 cabinets since 1960 to 2010 to quantify the Maratha dominance in the politics shows that out of 173 sampled cabinet ministers, 78 ministers belong to the Maratha-Kunbi caste cluster (ibid, p.38).

Table:5.1
Caste Profile of Selected Maharashtra Cabinets (1960-2010)

Cabinets	Caste Group								
	Maratha-Kunbi	Upper Caste	Intermediate Castes	OBCs	SCs	STs	Muslim	Others	Total
Y.B.Chavan 1960	6	2	1	1	1	0	1	2	14
YB Chavan 1962	9	1	1	2	1	0	1	2	17
V P Naik 1967	10	1	1	2	1	0	1	1	17
V P Naik 1972	4	1	2	2	0	0	2	1	12
S B Chavan 1975	9	0	2	1	0	0	2	0	14
Vasantdada Patil 1977	14	1	3	2	2	0	1	0	23
Vasantdada Patil 1978 (Coalition)	8	1	0	3	1	0	0	1	14
Sharad Pawar 1978 (Coalition)	8	2	0	1	2	0	1	3	17
A R Antulay 1980	9	1	0	1	0	1	1	2	15
Vasantdada Patil 1983	6	0	1	2	2	1	1	1	14
S B Chavan 1986	5	0	0	0	1	1	1	0	8
Sharad Pawar 1990 (Coalition)	9	0	0	1	3	1	1	0	15
Manohar Joshi 1995 (Coalition)	4	5	0	6	2	1	1	2	22
Vilasrao Deshmukh 1999 (Coalition)	16	0	0	4	2	3	1	0	26
Vilasrao Deshmukh 2004 (Coalition)	13	0	1	4	2	3	2	2	27
Prithviraj Chavan 2010 (Coalition)	15	0	0	4	3	3	2	2	29

Source: Datar and Ghotale 2013, p.39

Marathas occupy the largest group in the state cabinets except in 1995 when Shiv-Sena and Bhartiya Janata Party (BJP) formed the cabinet. Out of these 16 cabinet ministers ten belongs to Maratha community (Datar and Ghotale, 2013, p.39). Of the 16 chief ministers, 10 belong to Maratha-Kunbi caste cluster (Datar and Ghotale, 2013, pp.38-39).

A large scale empirical study conducted by the scholars of the British Columbia University has pointed out the local level political and economic dominance of the Marathas. It shows that in their sample population Marathas comprise the 40 per cent of the population but they are the Pradhan (Gram Panchayat Leader or Sarpanch) in over 60 per cent of villages (Anderson, Francois, and Kotwal 2011, p.13).

Dahiwale (1995) states that "the politics of the *maratha* elite in joining the Congress during the Gandhi era and recently, the conservative parties, is aimed solely at maintaining power. They are pragmatic, rather than ideological in their approaches to secular matters, and by hook or crook acquire power to multiply economic and educational advantages and thereby various positions in the power structure" (Dahiwale, 1995, p.340).

This reflects that to maintain their hegemonic dominance in the state, the Marathas play an important role in the state politics which is still in continuation.

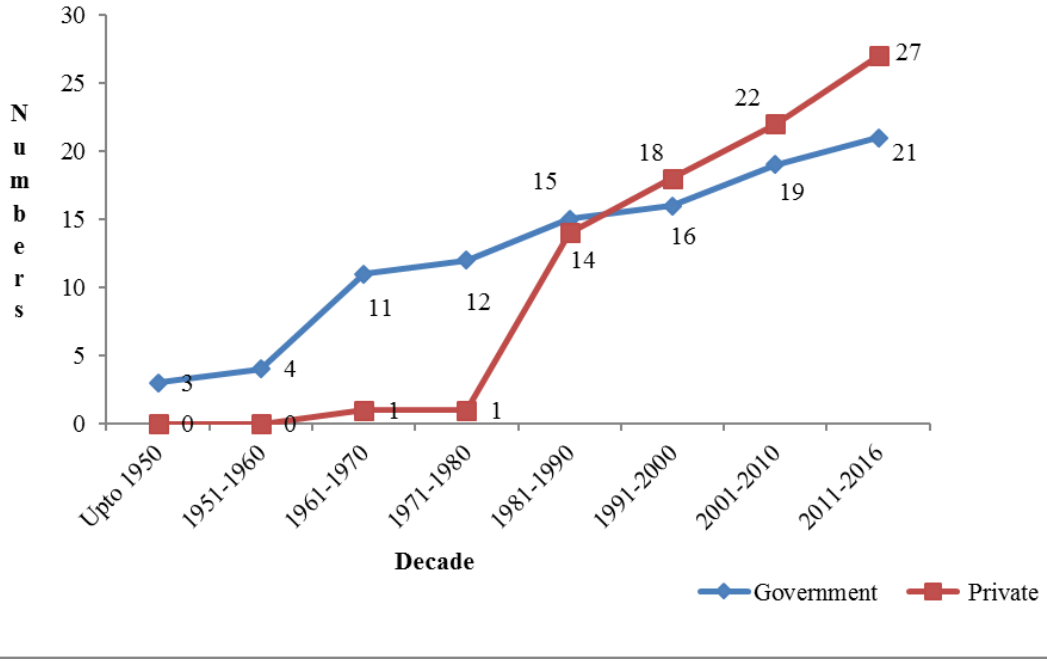
The above context was an important factor to understand the growth and regional variations of medical colleges in Maharashtra as it is exploring the social basis of this growth of medical colleges' specifically private medical colleges. Given the above context the next section is mapping the growth and regional variations of medical colleges in Maharashtra.

Growth of Medical Colleges in Maharashtra:

Maharashtra ranks second in having large number of medical colleges after Karnataka as well as witnessed high growth of private medical colleges in the state. Starting with three medical colleges in 1950 it has reached to 48 medical colleges in 2016 with a total intake capacity of 6195 medical students. In India 11.7 percent of medical colleges are placed in this state. There are a total of 48 medical colleges in the state of which 43.75 percent are in government sector and 56.25 percent are in private

medical sector. Out of 21 government medical colleges 16 medical colleges are run by state government, four are run by Municipal Corporation and one by central government. Among the total of 27 private medical colleges 10 are deemed universities and 15 are private medical colleges (DMER, 2015).

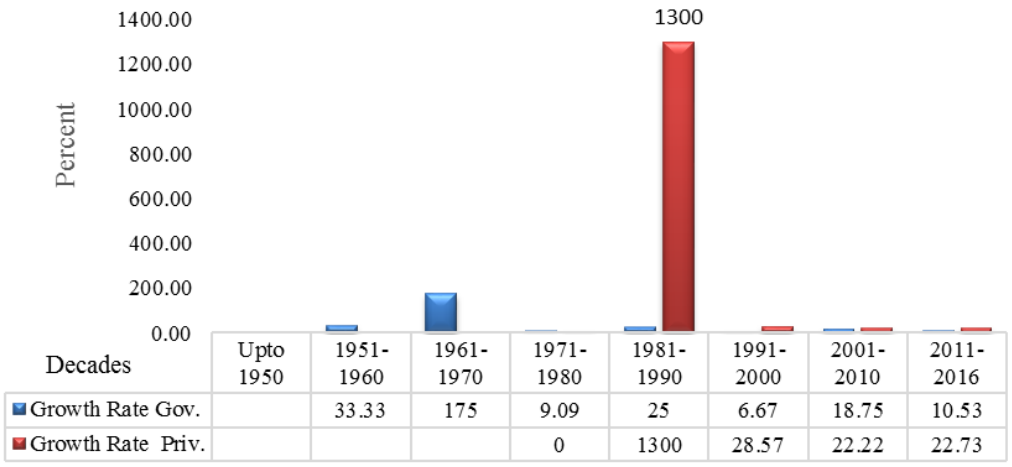
Figure-5.1
Decadal Growth of Medical Colleges in Maharashtra (in numbers)



Source: MCI records as accessed on 15th Jan 2016.

In the case of Maharashtra it shows that at the time of 1950 there were three government medical colleges which rose up-to 21 in 2016 with a total intake capacity of 2900. Whereas there were no private medical college at the time of 1950 (Figure-5.1).

Figure-5.2
Decadal Growth Rate of Medical Colleges in Maharashtra 2016



Source: MCI Records as accessed on 15th Jan 2016

Table-5.2
Trends in Medical Colleges in Maharashtra

Decade	Government	% Share Gov.	Private	% Share Priv.	Total
Upto 1950	3	100	0	0	3
1951-1960	4	100	0	0	4
1961-1970	11	91.66	1	8.33	12
1971-1980	12	100	0	0	12
1981-1990	15	51.72	14	48.27	29
1991-2000	16	47.05	18	52.94	34
2001-2010	19	46.34	22	53.65	41
2011-2016	21	43.75	27	56.25	48
CAGR	**(1951-2016)-2.58**		**(1961-2016)--6.18**		**3.90**

Source: MCI Records as accessed on 15th Jan 2016

Till 1970 the growth of medical colleges was prominent in the government sector. However, the growth of private medical colleges started in the period of 1981. First private medical college was established in 1969 which rose up-to 27 in 2016. Since

1981 to 2016, there are a total of 26 private medical colleges established as against only nine in government sector. There are 13 new private medical colleges established in the decade of 1981-1990 (Figure-5.1).

The rate of private medical college's increased by 1300 percent[55] in the period of 1971-1990 where as it increased only 25 percent in government sector in the same period (Figure-5.2). From 1981 to 2016 government medical colleges were growing at the rate of 40.0 percent whereas the growth rate in private medical colleges was 92.9 percent with a total overall growth rate of 65.5 percent.

Table-5.2 shows that in 1950, the share of government medical college was 100 percent which remained same till 1960. However, it decreased by nine percent in the next decade (1971-1980). Overall, it shows that the share of government medical college reduced from 100 percent in 1950 to 43.7 percent in 2016. While the share of private medical colleges was 8.33 percent in the decade of 1961-1970, it increased to 56.25 percent by the year of 2016. The annual average growth rate for government medical college during 1951 to 2016 is 2.58 whereas for private sector it is 6.18 percent during 1961-2016 with an overall growth rate of 3.90 percent for total medical colleges during 1951-2016 (Table-5.2).

Overall the role of the government in establishing government medical college was prominent till 1970. It is only in 1969 first private medical college was established. However there was no private medical college established in the period of 1970 to 1983. The growth of privatization primarily emerged only in 1984 when three private medical colleges were opened up only in this year and later on there was high level of expansion that occurred in this sector.

Why This Pattern of Growth:

This growth of private medical colleges particularly in 1984 started because firstly it witnessed the success of private medical colleges in neighbouring state of Karnataka. The students of Maharashtra who couldn't get admission in professional colleges in the state started migrating to Karnataka to pursue higher education. It was only the

[55] The percentage were calculated by using formula for growth rate. For Example in this case 1300 percent is calculated as =(14-1)/14*100. Same formula is applied for calculating growth rate in this chapter.

students who could afford the cost were able to migrate to Karnataka. The other reason would be that there was a high demand for professional degrees and the state couldn't accommodate this high demand which led to high growth of private sector in the state. Thirdly, the state policies that favoured private investments in professional colleges.

Except from 1995-1999, when the Shiv Sena was in power- the party that remained in power in the state was the Indian National Congress. As it is important to mention that of the thirteen new private medical colleges which were established during the decade of 1981-1990, three private medical colleges came up, in 1984 when Vasantdada Patil was the Chief Minister (CM). The remaining ten private medical colleges were established just in a span of two years (1989-1990) when Sharad Pawar was the CM. Vasantdada Patil announced the private investment in professional colleges when he was CM in 1984. "In 1983, faced with burgeoning demand for higher education and the inability of the state government to create enough institutes to cater to the demand, the then chief minister Vasantdada Patil allowed private players initially in professional courses such as engineering" (Singh, 2014).[56] The announcement of private players in medical colleges led to the huge agitation among the medical fraternity and there was a protest against this government's decision. Number of resident doctors from all over state went on indefinite hunger strike but it didn't helped much because the CM was not in position to compromise this decision "J.G. Lalmani, President, Maharashtra Association of Resident Doctors (MARD) said that the private medical colleges are just an excuse for the government to legalise corruption. It is commercialisation and politicisation of the medical profession and will lead to a big fall in academic standards" (Kapoor, 1984).[57] CM Vasantdada Patil said "if the state did not sanction private medical colleges, Maharashtra's talent and money would just go across the border to the capitation colleges of Karnataka. The new colleges in Maharashtra will also give a chance to poor students the state Government feels" (ibid). The three medical colleges that were granted permission in 1984 includes Rural Medical College, Loni initiated by Pravara Trust, Krishna

[56] Singh, G. (8th November 2014). Maharashtra's Educational Barons. Business World. As available on http://businessworld.in/article/Maharashtra-s-Education-Barons/08-11-2014-66314/ as accessed on 26th May 2015

[57] Kapoor, C. (1984, August 15). The College Craze. India Today. Retrieved from http://indiatoday.intoday.in/story/maharashtra-government-decision-to-give-clearance-to-three-new-private-medical-colleges-raises-a-storm-of-protest/1/360927.html as accessed on 15th October 2015.

Institute of Medical Sciences, Karad initiated by Krishna Charitable Trust and Dr. Panjabrao Alias Bhausaheb Deshmukh Memorial Medical College, Amravati initiated by Shivaji Education Society.[58] All these three trusts are family trusts and were promoted by the Maratha-Kunbi caste cluster.

In the next decade (1991-2000) all four private medical colleges were established when Sharad Pawar was the CM. Both Vasandada Patil and Sharad Pawar belong to Maratha Caste and most of the private medical colleges established in the two decades of 1981-1990 and 1991-2000 are founded by Maratha-Kunbi caste cluster. Dahiwale (1995) states, "the Maratha Mahasangha (founded in 1980) congratulated Vasantdada Patil, the former chief minister, for granting permission to medical and engineering colleges on non-grant basis. These colleges accept huge amount of capitation fees during admissions" (Dahiwale 1995, p.340). This clearly reflects the association between political support, caste associations and the promoters of private medical colleges.

Regional Disparities in Maharashtra:

In Maharashtra there are generally four regions i.e., Western Maharashtra, Konkan, Marathwada and Vidarbha. However, administratively there are six divisions in Maharashtra which are mentioned in the following table. Western Maharashtra and Konkan region are much ahead in terms of development compare to Marathwada and Vidarbha regions. The large shares of state's resources are concentrated in Western Maharashtra. The strong alliances among communities along with strong political power led to the agricultural and socio-economic development of Western

[58] The Shri Shivaji Education Society, Amravati is a premier educational institution of Central India with branches in all the districts of Vidarbha in Maharashtra. It is registered as a Public Charitable Trust (R.N. F/89) and Society was registered in December 1932. Its founder President was the late Dr. Panjabrao alias Bhausaheb Deshmukh who established various schools, colleges, hostels and other teaching and technical institutions and devoted all his energy for strengthening and enlarging the activities of the Society. In 1958, it had one primary school, seven middle schools and eight colleges. Today it runs 24 senior colleges, 54 junior. colleges, 75 middle schools, 35 hostels mainly in the region of Vidarbha but also in other parts of the state. The educational institutions cover areas like agriculture, arts, bio-technology, computers, education, physical education, engineering, horticulture, information technology, law, medicine, micro-biology and the pure sciences. It also runs a Polytechnic for boys and girls at Amravati. The information is available on the website Shivaji Education Society as available on http://www.ssesa.org/pages/society.php as accessed on 15th May 2015.

Maharashtra and Konkan regions which lacks in Marathwada and Vidharbha regions (Mohanty, 2009). Maharashtra is one of the leading growth states however this growth is not transferred or not distributed in equitable manner among the different districts of Maharashtra leading to huge inter-regional disparities (GOM, 2012). The report of the fact finding team on Vidarbha has clearly pointed out the backwardness in Vidarbha region is a result of acute and continued neglect by the state (GOI, 2006). Vidarbha region has reported a number cases of farmer suicides and Indira Gandhi Institute of Development Research (IGIDR) study (2006) pointed out that the rate of farmer suicidesdeaths are higher among the Amravati (Vidharbha), Nagpur (Vidharbha) and Aurangabad (Marathwada) divisions than the rest of Maharashtra. Indebtedness is one of the major reasons for farmer's suicide (Mishra, 2006).[59] Expert Group on Agricultural Indebtedness (2007) had done a country level analysis of indebtedness in 2003 and it shows that Maharashtra is the second state who has high level of incidence of indebted households (GOI 2007). In the same report 100 districts were identified as agriculturally less developed and distressed districts in all over India out of them eleven districts are from Maharashtra. These eleven districts are from Vidharbha (nine districts) and Marathwada regions (two districts) (ibid). There are several attempts been made to reduce the regional imbalances in the state. One among them was in 1983 when CM Vasantdada Patil appointed a committee to see the regional imbalances named as 'Fact Finding Committee on Regional Imbalances'. The committee is known to be as V.M. Dandekar committee as he was the chairman of the committee. The committee found that there is an overall huge backlog in nine development sectors and it suggested that 85 per cent of the development fund should be utilized for backlog removal. However, the government of Maharashtra made few allocations for backlog removal but didn't accept its report (GOM, 2013c, p.22). After a decade to assess the backlog removal position and to assess the extent of backwardness, in 1995, the Governor of Maharashtra appointed a committee called "Indicators and Backlog Committee". The final report was submitted in 2000 and it found Rs. 14007 crore backlog as on April, 1994 (ibid). The huge diversion of irrigation funds to the Rest of Maharashtra (includes Western Maharashtra and Konkan and Nashik division) led to the huge backlog in the Vidharbha and

[59] Sainath, P. (2010) has pointed out the official count of the farmers suicides as 44,000 from 1995 in Maharashtra.

Marathwada regions. This ultimately resulted in widening regional disparities and backwardness in different regions of Maharashtra (Kurulkar, 2009).

The recent Maharashtra Human Development Report (2012) has pointed out that there have been improvements in the HDI among the different districts in Maharashtra from 2001 to 2012. However, the disparity between developed districts and backward districts still remains a major concerned issue (GOM, 2012).

Table-5.3
Maharashtra Human Development Status of Districts 2011

Low HDI Districts	Very high HDI Districts
Nandurbar (0.604)	Sangli (0.742)
Gadchiroli (0.608)	Nashik (0.746)
Washim (0.646)	Sindhudurga (0.753)
Hingoli (0.648)	Raigarh (0.759)
Usmanabad (0.649)	Kolhapur (0.770)
Nanded (0.657)	Nagpur (0.786)
Jalna (0.663)	Thane (0.800)
Latur (0.663)	Pune (0.814)
Dhule (0.671)	Mumbai (0.841)
Maharashtra (0.752)	

Source: Maharashtra Human Development Report, Government of Maharashtra (2012, p.14)

As it is clearly evident from the table-5.3 that most of the districts from Marathwada and Vidharbha are relatively low in terms of its HDI value. In contrast most of the districts from Western Maharashtra and Kokan except Nagpur and Nashik perform very high in HDI value (GOM, 2012).

The recent report of the High Level committee on Balanced Regional Development Issues in Maharashtra has measured per capita income of Marathwada and Vidarbha as ratio to per capita income of Rest of Maharashtra. “It is observed that per capita income of Marathwada is 40 percent lower than that of Rest of Maharashtra. Similarly, the per capita income of Vidarbha is 27 percent lower than that of Rest of Maharashtra. This ratio has gradually deteriorated in Marathwada and Vidarbha

during past 10 years, the pre-existing disparity (0.66 and 0.82) further worsened by 0.07 and 0.06 respectively" (GOM, 2013c, pp.2-3).

The Pune Division is known as the highest sugar producing region and with Konkan, it is also the prominent industrial area. In the Vidarbha region only Amravati and Nagpur districts are urban and have industries, the rest is not very developed and large parts are tribal. Konkan Division has the highly urbanized Mumbai on the one hand and the poorly developed Sindhudurga and Raigarh districts. Northern Division has a mix of industry (including sugar) and agriculture (GOM, 2013b) (see Map-5.2).
In the above context of huge inter-regional disparities in the state the next section will attempt to understand see the distribution of medical colleges in different regions of Maharashtra.

Regional Variations in Medical Colleges in Maharashtra:

If one were to analyse the data on the inter district distribution of the medical colleges then one finds distinct variations.

Table-5.4 shows that the share of government colleges is 43.8 percent and for private it is 56.3 percent. It indicates that Pune division (Western Maharashtra), that includes five districts has largest number of medical institutions (29.17 percent) and enrolment capacity of (32.12 percent) followed by Konkan region. Pune, Mumbai and Mumbai suburban alone have 15 medical colleges - 31.2 percent of the colleges in Maharashtra; while Pune and Konkan Divisions taken together (ten districts), have more than half of the State's medical colleges (52.08 percent) as well as the intake capacity (53.26 percent). Pune (Western Maharashtra) and Konkan are the most privileged Divisions when we look at average distribution of medical colleges per district, as it comes to be more than two medical colleges. This average is 1.4 for Nashik (North Maharashtra) and just one for Nagpur (Vidarbha region). Only in Aurangabad (Marathwada region) and Amravati (Vidarbha region) this average falls below one medical college per district.

Table -5.4
Regional Distribution of Medical Colleges in Maharashtra State
(Total of 48)

Region	Districts	Medical Colleges			Intake Capacity		
		Gov.	Private	Total	Gov.	Priv	Total
Pune (Western Maharashtra)	Pune	2 (33.3)#	4 (66.7)#	6 (42.9)##	340 (34.3)	650 (65.7)	990 (49.7)
	Sangli	1 (50.0)	1 (50.0)	2 (14.3)	150 (50.0)	150 (50.0)	300 (15.1)
	Satara	0	2 (100.0)	2 (14.3)	0	200 (100)	200 (10.1)
	Kolhapur	1 (50.0)	1 (50.0)	2 (14.3)	100 (40.0)	150 (60.0)	250 (12.6)
	Solapur	1 (50.0)	1 (50.0)	2 (14.3)	150 (60.0)	100 (40.0)	250 (12.6)
Total		5 (35.7)*	9 (64.3)*	14 (29.2)**	740 (37.2)	1250 (62.8)	1990 (32.1)
Konkan	Mumbai	5 (55.6)	4 (44.4)	9 (81.8)	750 (65.2)	400 (34.8)	1150 (87.8)
	Thane	1 (100)	0	1 (9.1)	60 (100)	0	60 (4.6)
	Ratnagiri	0	1 (100)	1 (9.1)	0	100 (100)	100 (7.6)
	Raigad	0	0	0	0	0	0
	Sindhudurga	0	0	0	0	0	0
Total		6 (54.5)	5 (45.5)	11 (22.9)	810 (61.8)	500 (38.2)	1310 (21.1)
Aurangabad (Marathwada)	Aurangabad	1 (50.0)	1 (50.0)	2 (28.6)	150 (50.0)	150 (50.0)	300 (35.3)
	Jalana	0	1 (100)	1 (14.3)	0	100 (100)	100 (11.8)
	Parbhani	0	0	0	0	0	0
	Hingoli	0	0	0	0	0	0
	Nanded	1 (100)	0	1 (14.3)	100 (100)	0	100 (11.8)
	Osmanabad	0	0	0	0	0	0
	Beed	1 (100)	0	1 (14.3)	100 (100)	0	100 (11.8)
	Latur	1 (50.0)	1 (50.0)	2 (28.6)	150 (60.0)	100 (40.0)	250 (29.4)
Total		4 (57.1)	3 (42.9)	7 (14.6)	500 (58.8)	350 (41.2)	850 (13.7)
Amravati (Vidarbha)	Buldhana	0	0	0	0	0	0
	Akola	1 (100)	0	1 (33.3)	150 (100)	0	150 (37.5)
	Amaravati	0	1 (100)	1 (33.3)	0	100 (100)	100 (25.0)
	Washim	0	0	0	0	0	0

	Yavatmal	1 (100)	0	1 (33.3)	150 (100)	0	150 (37.5)
Total		2 (66.7)	1 (33.3)	3 (6.3)	300 (75.0)	100 (25.0)	400 (6.5)
Nashik (North Maharashtra)	Nashik	0	2	2 (28.6)	0	120 (100)	120 (16.1)
	Dhule	1 (50.0)	1 (50.0)	2 (28.6)	100 (50.0)	100 (50.0)	200 (26.8)
	Nadurbar	0	0	0	0	0	0
	Jalgaon	0	1 (100)	1 (14.3)	0	150 (100)	150 (20.1)
	Ahmadnagar	0	2 (100)	2 (28.6)	0	275 (100)	275 (36.9)
Total		1 (14.3)	6 (85.7)	7 (14.6)	100 (13.4)	645 (86.6)	745 (12.0)
Nagpur (Vidarbha)	Nagpur	2 (66.7)	1 (33.3)	3 (50.0)	350 (70.0)	150 (30.0)	500 (55.6)
	Wardha	0	2 (100)	2 (33.3)	0	300 (100)	300 (33.3)
	Bhandara	0	0	0	0	0	0
	Gondiya	0	0	0	0	0	0
	Gadchiroli	0	0	0	0	0	0
	Chandrapur	1 (100)	0	1 (16.7)	100 (100)	0	100 (11.1)
Total		3 (50.0)	3 (50.0)	6 (12.5)	450 (50.0)	450 (50.0)	900 (14.5)
Grand Total		21 (43.8)	27 (56.2)	48 (100)	2900 (46.8)	3295 (53.2)	6195 (100)

Source of Data: MCI records as accessed on 15th Jan 2016
Source of Regions: Government of Maharashtra, (4th May 2013). Retrieved on 15th September 2013 https://www.maharashtra.gov.in/1128/Districts
In each division the percent share of government and private medical college is out of total each district college and same applies to intake capacity.
In each division the percent of total district colleges is out of total divisional medical colleges. Same applies to intake capacity.
* In each division in the total section, the percent share of government and private medical colleges is out of total of divisional medical colleges. Same applies to intake capacity.
** In each division the divisional percent of medical colleges is out of total state medical colleges. Same applies to intake capacity

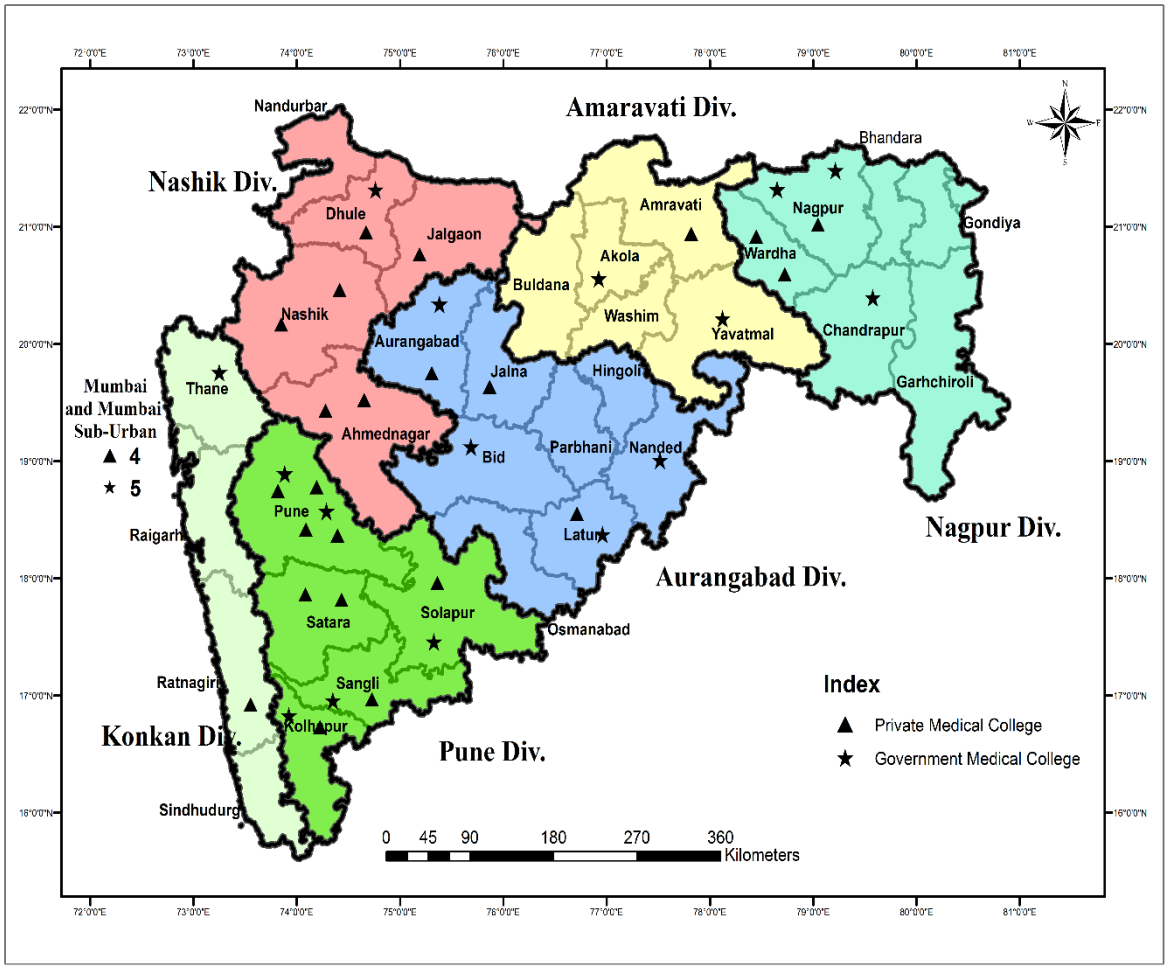
In Konkan Division, Mumbai has nine of its 11 medical colleges with the largest intake capacity. Thane and Ratnagiri have one college each (Ratnagiri College came up only in 2015) and Raigad and Sindhudurga have none. Amravati Division of Vidarbha region, including five districts, has just three medical colleges - all in urban locations. Similarly, three out of six districts of Nagpur and two out of five in

Amravati have no medical colleges. Thus, within Divisions also, there are huge inequities (Table-5.4). Amravati Division has the lowest number of institutions and enrolment capacity while Pune Division has the highest institutions and intake.

The share of government medical colleges in total annual intake capacity for the State is 46.8 percent and of private colleges is 53.2 percent (Table-5.4) showing the relative importance of private colleges. Interestingly, Nashik Division stands out with 85.7 percent of its medical colleges being private. This is followed by Pune, Nagpur, Konkan and Aurangabad Divisions within which the share of private colleges is 64.3, 50.0, 45.5 and 42.9 percent respectively. Amravati has the lowest proportion of 33.3 percent private colleges. Nashik stands out as its six private colleges are in the urban and in the sugar producing areas.

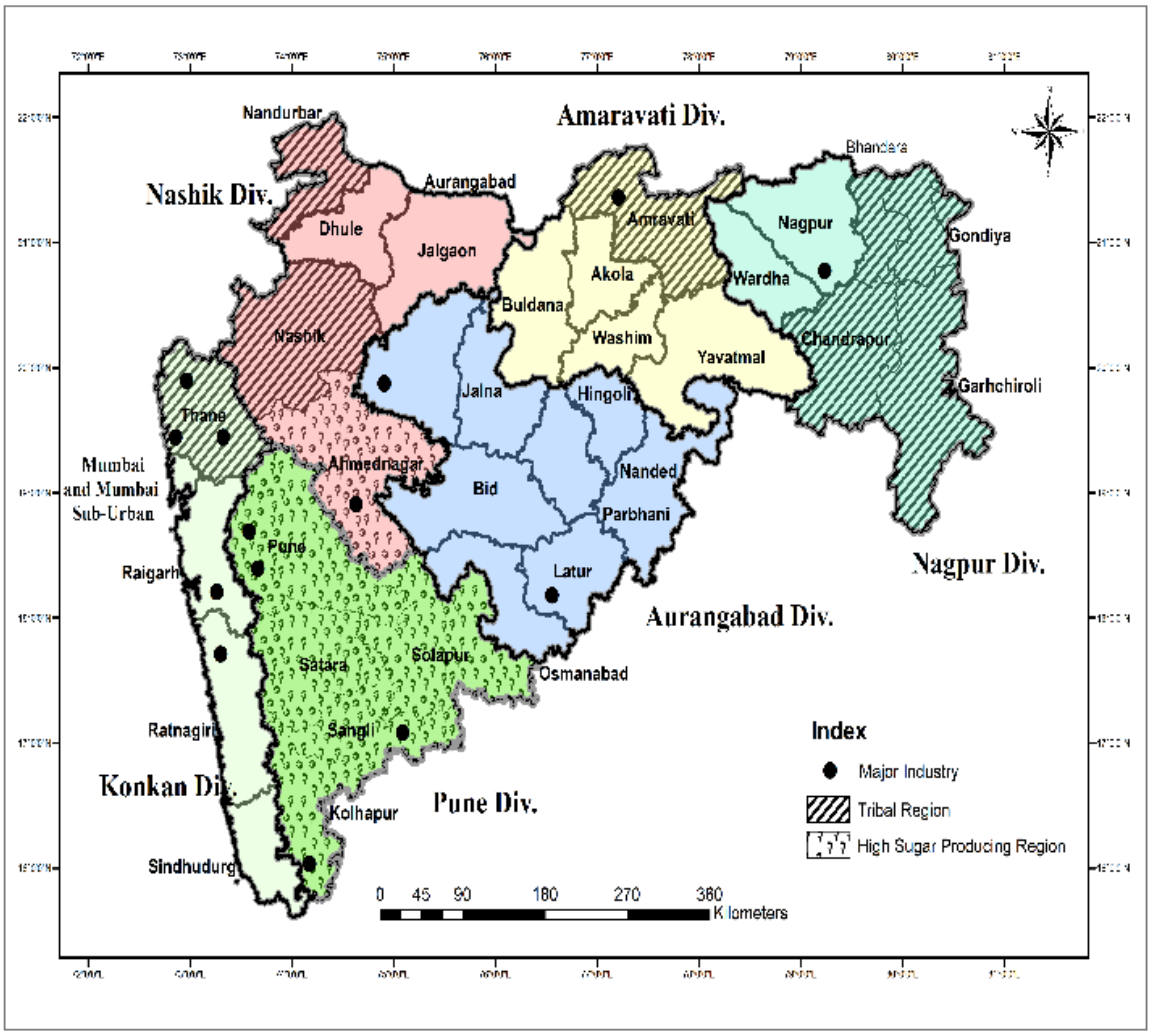
The growth of the medical colleges, as we see, is largely either in the developed districts or the richer urban parts of relatively less developed districts. These are the wealthier industrial and cash crop areas whereas Marathawada and Vidarbha are the most backward regions of Maharashtra, much of it being tribal as well. The officially measured per capita income of Marathwada and Vidarbha as ratio to per capita income of Rest of Maharashtra is revealing. "It is observed that per capita income of Marathwada is 40 percent lower than that of Rest of Maharashtra. Similarly Per Capita Income of Vidarbha is 27 percent lower than that of Rest of Maharashtra. This ratio has gradually deteriorated in both regions during past 10 years" (GOM, 2013c, pp.2-3).The recent Maharashtra Human Development Report (2012) has pointed out that Sangali, Kolhapur, Pune, Mumbai, Thane, Nashik, Nagpur etc. are very high human development districs whereas Hingoli, Usmanabad, Washim, Nandurbar, Gadchiroli, Jalna, Nanded, Latur and Dhule are low human development dstricts. As table-5.4 clearly shows, Hingoli, Usmanabad, Washim, Nandurbar, Gadchiroli do not have a single medical colleges, not even a government college. Growth of private medical colleges is significant only in Pune, Mumbai, Satara, Nashik, Ahmadnagar, Sangli, and Kolhapur.

Map-5.1
Regional Distribution of Medical College in Maharashtra



Source: MCI records as accessed on 15th Jan 2016

Map-5.2
Division Wise Development of Districts in Maharashtra



Source: High Sugar Producing Region: Vasantdada Sugar Institute, Maharashtra Statistics. Retrieved on 17th April 2016 http://www.vsisugar.com/india/statistics/maharashtra_statistics.htm
Tribal Region: GOM (2013b:471)
Major Industrial Area:- Retrieved on 17th April 2016 http://4.bp.blogspot.com/-OG9WkJt2yOA/UHc_BvGcl1I/AAAAAAAAAMA/xMHXeDZGtDM/s1600/majorIndustrialRegions.gif

Since 2011, seven new medical colleges have been established, two by government and five by private entities. Three private colleges came up in the districts of Solapur, Satara and Nashik where medical colleges already existed, and the other two in Ratnagiri and Jalna where there was none. One government medical college came up in Chandrapur which had none, the other in Mumbai with several medical colleges.

The neglect of underserved and relatively backward districts, the continuation of regional disparities and, the dominance of private sector is thus visible.

Social Basis of Private Medical Colleges:

The high number of medical colleges in certain regions may be because of certain caste groups who have invested in the lucrative business of medical colleges. It is clear that investing in medical education can be a profitable venture, so most of the dominant castes has been started to invest in the medical education. The multiple dimensions of power and the emergence of medical colleges, especially private medical colleges, is reflected in the regional development of Maharashtra (Map-5.1 and Map-5.2).

In this context the next section is to see the social background of the owners of the private medical colleges in Maharashtra.

Table-5.5
Social Background of the Promoters of Private Medical Colleges in Maharashtra (Total number of colleges 25)*

Number of Colleges	Religion	Caste
15 (60%)	Hindu	Maratha (Open)
1 (4%)	Hindu (Gujarat)	Patidar (Open)
1 (4%)	Hindu (Gujarat)	Kutchi-Lohana (Open)
1 (4%)	Hindu	Khatri Caste(Open)
3 (12%)	Hindu	Kunbi (OBC)**
1 (4%)	Hindu	Mali (OBC)
2 (8%)	Hindu	Vanjari (VJNT)[60]
1 (4%)	Muslim	-

Source: The list of the Name of the founders has been compiled from each college website. Data of caste and religion of the founders has been enquired from local key informants and academicians.

*In 2016 there are 27 private medical colleges, however the data is collected in 2013 and the two medical colleges established after 2013 for which caste background of founders could not be obtained.

**One medical college is established by a trust and the trust was established by a person who was politically strong and belonged to a Kunbi community. However, today who is leading the trust is not clear.

[60] In Maharashtra VJNT is a separate caste category and have reservations for this category. It is called Vimukta Jati and Nomadic Tribes (VJNT)-(GOI, 2008).

The social background of the promoters of private medical colleges in Maharashtra shows that by religion wise most of the private medical colleges are owned by Hindu's. Of the 25 private colleges all were Hindu owners except one, who was a Muslim. It means 96 per cent of colleges belongs to Hindu religion. Among Hindu owners, 72 percent of medical colleges are established by open caste categories, 16 percent by OBC and 8 percent by VJNT. Within Hindu, most of the college's means of the 25 private medical colleges, 15 are owned by the Maratha and three are owned by Kunbi's. Hence, when seen in terms of the political domination of Maratha-Kunbi caste-cluster, then their ownership of private medical colleges is 72 percent (Table-5.5)

There are two colleges owned by Patel (Gujarati) which is also an upper caste. It shows some level of mobility among the Vanjari Community as they own two medical colleges and among the OBC's which have just one medical college. However, even though Maharashtra is known for its historically strong social movements there is no any representation from SC community in terms of establishment of private medical college owned.

It can be seen that the dominant castes particularly Marathas have the hegemony on the establishment of these private medical colleges. This inference can be drawn on the above table -5.5 and most of the owners of these private medical colleges belong to Maratha caste. Most of these owners are politically affiliated to the Congress Party or to the Nationalist Congress Party. Of the total of 25 private medical colleges seventeen colleges are owned by twelve people and all these twelve owners had occupied political positions such as Member of Parliament (MP), Member of Legislative Assembly (MLA), and Member of Legislative Council (MLC), and have been Ministers at the State and Central level. Of these, eight owners at some point were linked to sugar co-operatives. Their political leadership at the local level has either evolved through sugar co-operatives or has helped them acquire it. Some of the even today have a strong hold on the sugar co-operatives.

This has been reiterated in an interview conducted with one of senior professor who is teaching in private medical college in the department of Obstetrics and Gynaecology in Pune and stated that

> "...especially in Maharashtra these are mainly the politicians who have established private medical colleges such as Bharti Vidyapeeth (Pune) is established by Patangrao Kadam, D. Y. Patil Medical College (Pune), Krishna Medical College in Karad established by Jayawant Bhosale, Pravara Medical College in Ahmednagar established by Vikhe Patil so like that the majority of these are politicians....Frankly speaking Maratha community is dominating but they are not intervening in the students and teachers relations and there is no interference in clinical management....So on that part it is fine that there is no interference in day to day activity of the college" (Interview conducted in Pune on 9th August 2013).

Another senior professor who is teaching in private medical college in the department of Obstetrics and Gynaecology in Pune observed,

> "In Pune district there are two government medical colleges one is run by central government. Plus there are four private medical colleges, if four private medical colleges could have accommodated in the city of Pune then why the government or corporation did not feel like doing it. And if we look at who are running these medical colleges, the politicians are running it, if they are the basic decision makers then why did they not take the decisions on behalf of the government. Why they are doing this individually? Why did they convert into a business… we need to think over this. It is fine that the state probably must have earned the resources from other states but where these resources are going? They are going to these people only. None of these private colleges or very few private medical colleges which are running free services… so why then they cannot…if they wanted to do it they could have done it in a public private partnership along with the government if they want it. But they didn't want it to do. They have converted into a business. Because finally they are the one who are making this decision and they are the ones who are doing this" (Interview conducted in Pune on 9th August 2013).

Along with these the faculty also mentioned that there is a strong political support by the congress party as many of the owners of these colleges are the members or leaders of the congress party.

Similar observation is explained by one of the local political leader[61] in Karad, who states that

[61] The person by profession is a journalist and he was associated with Shiv-Sena Party as he worked as a city head of Karad. Later on he resigned from the party due to some differences in the party. He is running a small pan shop at the centre of the city. After completing journalism he worked few years in a local news-paper. He is quite aware about the local politics in Satara.

> "…..there are around twenty Maratha families and these are very powerful families in electoral politics as Maharashtra's politics is in the hands of these twenty families. They exchange their relationships through marriages. These families includes Mohite-Patil family, Bhosale family, Deshmukh, Pawar, Vikhe Patil, all these are ruling families in Maharashtra. Because all these families are in the politics and they are the ones who have educational institutions as well as sugar co-operatives and co-operative banks. So all the economic, co-operative, education and political positions is being played by these twenty families. For example in Patan (Dis. Satara) there is a factory lead by Shambhuraj Desai and they have number educational institutions. Now if you see another person Balasaheb Patil, he also owns co-operative factory and build educational institutions as well as banks. So there is a total Maratha lobby" (Interview conducted in Karad on 6th August 2013).

Thus the nexus between the caste associations and political linkages at the local and the State level indicates the hegemony of the Maratha-Kunbi caste-cluster in establishing private medical colleges in Maharashtra.

Private Medical Colleges and Its Linkages with Caste, Political Power and Co-operative Society:

The control over the co-operative sector in Maharashtra, that was the base of rural industry - mainly sugar, has been one of the important means to acquire political power by the rich peasants chiefly the Marathas. The success for the sugar co-operative sector is due to the kind of support and encouragement provided by the congress regime (Lalvani, 2011). Chithelen (1985), studied the history of sugar co-operatives in Maharashtra and the rich peasants primarily the Marathas and how they sustained their economic and political power in the early twentieth century. The study found that "(a) by the existence of a rich peasant strata belonging to numerically large, and therefore politically powerful, cultivating non-Brahman upper castes, (b) the extensive and intensive cultivation of sugarcane by rich peasants, made possible by the spread of canal irrigation, (c) a cooperative infrastructure serving the credit and marketing needs of rich peasants farming sugarcane,(d) the attraction of high profits to be earned by processing sugarcane in to a higher valued commodity like sugar and (e) the favourable changes in the political arena, all worked together to bring about the establishment of the pioneering co-operative sugar factories, in Ahmednagar

district of Maharashtra, in the early1950s" It also pointed out this that results are applicable to the districts of Western Maharashtra where sugarcane factories were prominent (Chithelen, 1985, p.611). The surpluses gained from the sugarcane were diversified in the extension of industries by the rich peasantry as Chithelen, (1983) states that "the payment of sugarcane prices—through which the rich peasant cultivators of sugarcane use the industrial extension of their agrarian operations to further their accumulation of capital" (Chithelen, 1983)[62]

The prominent chief ministers in Maharashtra belongs to the Maratha community as first was the Yeshwantrao Chavan from 1956 to till 1962 and then the Vasandada Patil who had elected two times and then one of the significant person Sharad Pawar who had elected three times in Maharashtra (Damodaran 2008). All these figures and number of MLA's and ministers in the state have a strong hold on sugar co-operative and thus there are strong interlinkages to the sugar co-operatives, political power and caste associations. For example, the Warana Co-operative Sugar Factory at Kolhapur established in 1959 and Tatyasaheb Kore was the chairmen of the society and under his guidance it has developed number of schools right from kindergarten to higher professional education which includes engineering college, Dental College, Pharmacy, and Technology etc. (Merchant, 2014). "A man who has built schools, colleges, and hospitals in his district must have a bit of political clout. Just imagine, his co-operative factory has thousands of members. They are indebted to him and in an election would certainly vote for the candidate he supports…….Former chief ministers Y.B. Chavan and V.P. Naik were his good friends. He may deny it now. But it is a fact that Kore personally handed over to Naik in 1972 a sizeable donation for the chief minister's defence fund. And it is also a fact that it was Y.B. Chavan who inaugurated the Warana Sugar Factory, when he was the chief minister of Maharashtra" (ibid)[63]

This illustrates the kind of political connections and co-operative societies worked hand in hand and increased the economic and political power.

[62] Page number was not available.
[63] Merchant, M. (18th march 2014). Sugar Barons: A Bitter Taste. *India Today*. As available on http://indiatoday.intoday.in/story/the-economic-and-political-influence-of-sugar-cooperatives-in-maharashtra/1/434623.html as accessed on 15th May 2015.

It is observed that more than 72 percent of co-operatives are controlled by Marathas (Deshpande 2014). Documents accessed by Hindustan Times revealed that "Sugar mills controlled by at least 34 politicians cutting across party lines have not paid more than Rs 1,200 crore to sugarcane farmers for the past six months" (Shrivastava, 2015)[64].

In an interview, one of the senior professors of a private medical college in Pune mentioned that the trend towards private medical education was started by the co-operative movement.

He states that,

> "....In Maharashtra there was wave of co-operative movement going on, especially sugar co-operative factories, but after a point there was saturation in the co-operative sector and now they have to find out new avenues, so there was not a great vision in establishing medical colleges" (Interview conducted in Pune, 9th August, 2013).

Baviskar (2007) clearly explains the role of co-operative politics and rural development in Maharashtra. The transformation of *Sahakar Maharshis* to *Shikshan Maharshis* through the sugar co-operative societies in Maharashtra is explained as,

> "The leaders in co-operative societies set up educational trusts and foundations in their own areas and compelled the sugar factory members to "donate". However, they cleverly kept these trusts legally separate from the cooperatives. They appointed themselves and their family members as life-long trustees and thus ensured that the trusts remained under their control even if they lost control over the sugar cooperatives or allied organizations. In this way, trusts controlling crores of rupees came into existence all over Maharashtra. Corruption in this manner became an open and integral feature of cooperatives in Maharashtra with the silent approval of all concerned. With the money collected from ordinary members of co-operatives, the leaders set up big educational enterprises. They charged heavy capitation fees for admission to their engineering, medical, computer and management colleges. Yesterday's 'sahakar maharshis' (cooperative bosses) thus transformed themselves into 'shikshan maharshis' (education barons). All transactions were "under-

[64] Shrivastava, K (28th September 2015). Maharashtra's Sugar-Baron Politicos Owe Farmers Crores. *Hindustan Times*, New Delhi. As available on http://www.hindustantimes.com/india/maharashtra-s-sugar-baron-politicos-owe-farmers-crores/story-vbutex3yxk0UbgPLme8XHJ.html as accessed on 15th June 2016.

> the-table" and without any receipts and audit, there was no record of the capitation fees" (Baviskar 2007, p.4219).

Baviskar (2007) also explains that most of the co-operatives led by a single family members and the power is being transferred by generation to generation. The emergence of this new moneyed class is reflected in the ownership of private medical colleges which is presented in the earlier section.

Rural Medical College, Loni and Dr. Vithalrao Vikhe Patil Foundations Medical College (Ahmadnagar):

Rural Medical College, Loni and Dr. Vithalrao Vikhe Patil Foundations Medical College, both are established by a single man. Rural Medical College is established in 1984 under the trust named Pravara Medical Trust. Currently the college is a unit of Pravara Institute of Medical Sciences Deemed University which got its status as deemed university in 2003. There are six professional educational institutions established under this deemed university which ranges from dental, nursing, biotechnology, physiotherapy, social medicine and medical college in rural area of Loni. The Pravara Medical Trust (PMT), the parent organization of Pravara Institute of Medical Sciences, Deemed University was established in the year 1972, by the visionary, Padmashri Dr. Vitthalrao Vikhe Patil. The Spectrum of this movement is being carried ahead by his son Shri. Balasaheb Vikhe Patil.[65]

Dr. Vithalrao Vikhe Patil Foundations Medical College is established in 2003 under the trust name Dr. Vithalrao Vikhe Patil Foundations. The trust is established in the year of 1982 by Padmashri Dr. Balasaheb Vikhe Patil with the sole aim to spread technical, medical, paramedical, Ayurvedic education in the developing rural areas. There are ten educational institutions established under this trust which includes engineering, dental, nursing, physiotherapy, etc.[66]

The Padmashri Dr. Vithalrao Vikhe Patil who was the first pioneer of sugar co-operative society in Asia and established first sugar co-operative society in 1950-51 and later on this legacy was being transferred to his son Padmabushan Shri Balasaheb

[65] Pravara Institute of Medical Sciences University website, as available on http://www.pravara.com/university.html as accessed on 26th May 2013.

[66] PDVVP Foundation website, about us page, as available on http://www.pdvvpfa.org/about-us.php as accessed on 26th May 2013.

Vikhe Patil and the then to his grandson to Shri Radhakrishna Vikhe Patil (Baviskar 2007). Continuously for three generations power was retained by this family.

Balasaheb Vikhe Patil was the MP for over two decades and was the Minister of Industry (Heavy Industries & Public Enterprises) for Government of India from 2002 -2003. He was the Minister of State for Finance (Expenditure, Banking & Insurance) Government of India, from 1999-2002. He continued his father's legacy in co-operative sugar factory as he was the chairman of the Pravara Sahakari Sakhar Karkhana Ltd., Pravara Nagar for a decade from 1966 to 1977 and then in 1978 to 1981 & 1982 to 1987.[67] He is the founder of the three sugar co-operative societies namely Parner Co-operative Sugar Factory, Parner, Ahmednagar Jagdamba Co-operative Sugar factory, Karjat, Ahmednagar and Vridheshwar Co-operative Sugar Factory, Pathardi and one co-operative bank called Pravara Sahakari Bank Ltd., Loni.

Currently Radhkrishna Vikhe Patil son of Balasaheb Vikhe Patil's is the chairman of the foundation and he was the Minister for Agriculture & Marketing, Government of Maharashtra from 2010 to 2014, Minister for Transport, Ports, Law & Judiciary Goverment of Maharashtra, from 2009-2010, Minister for School Education & Law and Judiciary, Government of Maharashtra, 19th Feb. 2009 to 6th Nov. 2009 and Member of Legislative Assembly since March 1995.[68]

In a website of their own it is clearly mentioned that "Shri. Balasaheb Vikhe Patil was veteran parliamentarian, his sons Shri. Radhakrishna Vikhe Patil, Cabinet minister of Government of Maharashtra & Dr. Ashok Patil, CEO, Pravara Medical Trust & the first Indian to become a President of International Association of Agricultural Medicine and Rural Health (IAAMRH)" (PDVVP Foundation website as accessed on 26th May 2013)[69].

"To realize the visionary thoughts of Padmashri Dr. Vithalrao Vikhe Patil, his worthy son, Hon'ble Padmabhushan Shri. Balasaheb Vikhe Patil, established "Padamashri Dr. Vithalrao Vikhe Patil Foundation" (PDVVP Foundation) in the year 1982, with sole

[67] PDVVP Foundation website, Founder page, as available on http://www.vims.edu.in/node/15 as accessed on 26th May 2013.
[68] Information is available on Dr. Vithalrao Vikhe Patil Foundations website http://www.vims.edu.in/node/16 as accessed on 25th June 2015.
[69] PDVVP Foundation website, Inspiration page, as available on http://pdvvpfa.org/about-us.php as accessed on 26th May 2013

aim to spread technical, medical, paramedical, Ayurvedic education in the developing rural areas" (PDVVP Foundation website as accessed on 26th May 2013)[70].

It is also important to see the strong hold of the Congress party, as up-to the high level there is strong connection between the two. It is mentioned on their own website about the Prime Minister Dr. Manmohan Singh's visit to the Pravra Nagar in Ahmednagar in 2008.

It states that

> "Hon'ble Prime Minister of India Dr. Manmohan Singhji has visited Pravara Complex on the occasion of the publication of Late. Dr. Dhananjayrao Gadgil's Postal Stamp and the Farmers Rally on the 8th Feb.2008. It was the most unique and historic movement in the life of all farmers of the country. During the visit Hon'ble Prime Minister was highly impressed by witnessing the various developmental activities introduced for the comprehensive rural development by Pravara Agro industrial, Educational and Cultural Complex". Along with this there was a visit by the Congress President Sonia Gandhi and it mentioned "President of the Congress Party Hon'ble Soniaji Gandhi paid visit at 19th June 2008 to Pravaranagar, Ahmednagar (M.S.) on the occasion of Women's & Farmers Rally" [71] (College website accessed on 25th June 2015).

Thus, it is one of the important examples to see how the leadership emerged in the state during colonial time in Maratha community and the strong hold of the congress party spread out in rural areas of the state. The political leadership which got strengthened through co-operative societies as the Asia's first co-operative society was established in 1948 by the Maratha leader Dr. Vithalrao Vikhe Patil and since then their foray into establishing different educational institutions from primary schools to professional colleges. This legacy is still in continuation for three generations.

[70] PDVVP Foundation website, about us page, as available on http://pdvvpfa.org/about-us.php as accessed on 26th May 2013

[71] Information is available on Dr. Vithalrao Vikhe Patil Foundations website http://www.vims.edu.in/node/16 as accessed on 25th June 2015.

Krishna Institute of Medical Sciences (Karad):

The Krishna Medical College is located in Karad city, district Satara. Satara district comes under the region of Western Maharashtra. The college is established in the year of 1984 and the current intake capacity of the MBBS course is 200. The campus is spread over 60 acres of land. The college is attached to the Krishna Institute of Medical Sciences Deemed University (KIMDU). In 1982 the thought of building KIMDU came from Shri Jaywantrao Bhosale. In the year of 2005 it got the status of deemed university.

Shri Jaywantrao Bhosale is one of the pioneers of the expansion in educational institutions in rural areas of Karad and is one of the prominent leaders in the development of sugar co-operatives. His foray into education started way back in 1964 with the establishment of Shetkari Shikshan Prasarak Mandal (Society for Promotion of Education in Farmers). In 1974 he established Krishna Charitable Trust with the aim of providing school, medical education and health care to the rural population.[72] It ranges from pre-school, primary school, high schools, undergraduate colleges, technical and professional colleges which includes engineering, medical, nursing, dental etc. Since 1954, he was member of Krishna Co-operative Sugar Factory and elected on the board of sugar co-operative. For thirty years (1960-1989) he served as the chairman of Krishna Sugar Co-operative. In his tenure he was socially and politically active as in 1964 he served as President of the Deccan Sugar Technologists Association, Chairman of the Maharashtra Federation of Co-operative Sugar Factories (1967-69), Chairman of National Federation of Co-operative Sugar Factory (1967-69), Member of Western Maharashtra Development Board (1971-1982), Member of the Finance Committee of Government of India and In 1980-1982 was member of the State Legislative Council.[73]

The kind of political linkages that was developed in establishing medical colleges is well explained and written on their own website which says, in 1982 the Krishna

[72] Information is available on Krishna Charitable Trust website http://www.krishnaded.com/trust.html as accessed on 25th June 2015.

[73] Information available on Krishna Institute of Medical Sciences website http://kimsuniversity.in/Founder as accessed on 25th June 2015. Marathi News Paper, Karad Representative (6th August 2013). *Sahakarmaharshi Jayawantrao Bhosale Yanche Nidhan*. Pudhari, Satara. pp.1-2. Marathi News Paper, Malkapur (tal. Karad) (6th August 2013). *Sahakaratil Ardhvau Jayawantrao Bhosale Yanche Nidhan.* Sakal, Satara, pp. 1,3

Hospital was started with 200 beds and in 1984 he succeeded in persuading the Government of Maharashtra and the then Chief Minister Shri. Vasantrao Dada Patil,[74] to allow private participation in medical schools and engineering colleges. The Late Chief Minister was a member of the Board of Trustees and a guiding force. The Medical College has now grown into a large organization with 840 bedded modern hospital and facilities for critical care, joint replacements, lithotripsy, endoscopic surgeries, dialysis etc.[75]

In an interview conducted in Karad (Dist. Satara) with a local political leader who explained the politics of the co-operative societies in building up the educational institutions in Maharashtra states,

> "....initially what they did…Krishna sugar factory headed by Jayawantrao Bhosale. He remained a chairman for 29 years of this sugar factory. The membership of this factory is in large number. They collected money from the members of the factory as in terms of share and told them that we are opening up a hospital, they showed a dream and likewise they collected money from the members. However, they registered as a trust and created their ownership on the trust. It was not on the principle of co-operative. Krishna Hospital was built up through people's money. On paper they created a separate trust and all trust members are belongs to their family[76] and now the whole Krishna Hospital's ownership is on Jayawantrao Bhosale's name" (Interview conducted with local political leader on 6th August 2013).

He also mentioned that,

> "...there was an idea by Jayawantrao Bhosale to establish a Shetakari Shikshan Prasarak Mandal. At that time around 1960, members have donated around Rs. 51,000 and based on this money they started their educational development. In 1962 they established Shikshan Prasarak Mandal, after that they started primary school. In 1972 they started

[74] Late Vasantrao Dada Patil belongs to Maratha community and was in the congress party.

[75] Information available on Krishna Institute of Medical Sciences website http://kimsuniversity.in/Founder as accessed on 25th June 2015.

[76] The information provided by the respondent is in fact true and can be verified on the website of the Krishna Charitable Trust. The two trustees are the sons of the Jayawantrao Bhosale and other trust member too belongs to the family relatives. The respondent said the trust members are "He himself (Jayawantrao Bhosale), his (Vyahi) daughter in laws B. G. Shirke. (His daughter got married in this family B. G. Shirke's Family), then Mohite's family, Bhosale's family. There are five members as trust members. P. D. Patil was the trust member, now he is no more. Now I don't know who the trust member on his place. I never have been there since three years" (Interview conducted with local political leader on 6th August 2013).

English medium school. In 1975 they initiated Junior Science College and then in 1978 started Krishna Mahavidyalaya Science, Arts and Commerce College. They started nursing college and then in 1984 they established medical college" (Interview conducted with local political leader on 6th August 2013).

Bharati Vidyapeeth University Medical College, Pune and Sangli

Dr. Patangrao Kadam established Bharati Vidyapeeth in Pune in 1964. Bharati Vidyapeeth runs more than 78 schools and 60 educational units of various kind right from pre-primary schools to postgraduate institutions and a full-fledged professional university. Among these are colleges of Medicine, Dentistry, Ayurveda, Homeopathy, Nursing, Pharmacy, Law, Biotechnology, Engineering, Management, Hotel Management & Catering Technology, Environment Science, Agriculture, Physical education and more. Bharati Vidyapeeth has its major campuses in New Delhi, Navi Mumbai, Pune, Solapur, Kolhapur, Sangli, Karad, Satara, and Panchgani and at quite a few other places. In 1996 the Government of India, granted the status of Deemed to be University

He was elected as MLA four times and represented the Indian National Congress Party. He is presently a Cabinet Minister in the Council of Ministers of Maharashtra (Forests)[77].

Patangrao Kadam's work acknowledge by various numerous awards one of them is "Maratha Vishwa Bhushan Puraskar" by Maratha Seva Sangh for outstanding contribution in the field of education. This trust runs 180 institutions and nearly 200,000 students pass out from the portals of its various colleges and technical institutes every year (Singh, 2014).

Like education, Co-operative sector is another area in which Dr. Kadam has done commendable work. It is with his initiative that several cooperative units, like Bharati Cooperative Bank (multi-state scheduled bank with 18 branches), Sonhira Cooperative Sugar Factory, Sagreshwar Cooperative Spinning Mill, Sonhira Cooperative Kukkut Palan Sangh, Krishna-Verala Cooperative Spinning Mill etc. were established as sister concerns of Bharati Vidyapeeth. Among other cooperative units under the Bharati

[77] Information is available on http://www.vishwajeetkadam.com/Inspiration/default.aspx as accessed on 29th June 2015.

Vidyapeeth's umbrella are: Cooperative Consumer Stores at Pune, Sangli and Kadegaon and Mahila Industrial Cooperative Society at Kadegaon. All these units are doing very well.

It is being pointed out that "Patangrao Kadam represented the Maratha community in western Maharashtra who had accumulated money and political power but chafed at the intellectual control of the Brahmins. The initial boost came from the powerful cooperative movement that bankrolled these education trusts. Kadam, before he became an MLA from Sangli district in 1985, had launched three cooperatives: milk, sugarcane and a bank. Son Vishwajeet estimates these have a turnover today of Rs 650 crore" (Singh, 2014)[78].

It is possible for these politicians to establish educational institutions because of the government support which provides number of subsidies and prominent among them is the land subsidy. The kind of illegality in acquiring the land subsidies is being pointed out in Comptroller and Auditor General of India (CAG) report which stated that "Patangrao Kadam, who chairs the large empire of Bharati Vidyapeeth, had sanctioned a huge plot belonging to the Maharashtra Industrial Development Corporation (MIDC) to his own institute while being the chairman of the MIDC. This "irregular disposal" of an 18,953 sq mt plot at Kharghar in Navi Mumbai to Bharati Vidyapeeth resulted in a revenue loss of Rs 6.49 crore. The rate of land for the plot, which was earlier reserved for residential purpose, was Rs 3,950 per sq mt but was sold to the Bharati Vidyapeeth at Rs 525 per sq mt. The MIDC extended an irregular benefit of Rs 6.49 crore to the Vidyapeeth" (The Economic Times 20th April 2006)[79].

This clearly indicates the power and transformation of *'sahakar maharshis' (cooperative bosses)* to *'shikshan maharshis' (education barons)* in Maharashtra. It clearly indicates the nexus between the caste associations and political linkages and the hegemony of the Maratha caste on establishing private medical colleges in Maharashtra.

[78] Singh, G. (8th November 2014). Maharashtra's Educational Barons. Business World. As available on http://businessworld.in/article/Maharashtra-s-Education-Barons/08-11-2014-66314/ as accessed on 26th May 2015

[79] The Economic Times (20th April 2006). State's Education Barons Come Under Cag Scrutiny. The Economic Times. As available on http://articles.economictimes.indiatimes.com/2006-04-20/news/27429810_1_cag-report-cag-notes-educational-institutes as accessed on 15th May 2014.

Issue of Quality in Medical Education:

The issue of quality of medical education is being raised by many respondents and hence been reflected here. However, the study focus was not to measure the quality but have been discussed here based on the views reflected by the respondents. Few respondents pointed out that many private medical colleges are very substandard in their teaching and the clinical material meaning availability of patients. It is also being mentioned that there is a complete disconnect as when the students come out after the four and half years of training and cannot perform up to the mark.

Clinical Exposure:

Few respondents pointed out that the aspirations of higher education make students stressful and huge burden of it impacts on their clinical inefficiency in their internship programme. As one of the senior professor who is teaching in private medical college pointed out that,

> ".....all the internship where during the time they are supposed to show their clinical efficiency, however they are busy working for that entrance exam to pursue post-graduation because imagine if that child doesn't get his post-graduation, for example if child wants to do an Orthopaedics, if he wants specialize in Orthopaedics and if he doesn't get through in any kind of entrance exam, in a private medical college he will have to spend 1.5 crores of rupees for admission" (Interview conducted in Pune on 9th August 2013).

An alumni of one of the private medical college in Maharashtra has explained the poor quality of medical education.[80] The respondent mentioned that,

> "...the wards were always empty, there were very few patients and at the time of inspection they used to rent a healthy patient by paying them some amount and used to show patients load in the college hospital...practical learning was very bad and even theoretical learning was not up-to the mark.." (Interview conducted in Mumbai with Alumni of private medical college on 23rd July 2013).

[80] The name of the medical college has not been mentioned here as the respondent asked to not to mention.

Another student in Ahmednagar mentioned,

> "Few of my friends are in the government medical college and there you get lot of practical learning because there is a load of different patients and you tend to learn in many ways however in the private medical college there is a lack of practical learning as there are very few patients who come to the college hospital but in terms theory it is quite good..." (Interview conducted in Ahmednagar with the student of private medical college 28th July 2013)

***Fee Structure in Government and Private Medical Colleges*:**

The annual fee in government medical colleges is around Rs 60,000 which includes tuition and development fee. Hostel Fee, admission fee, sports and library fee goes around Rs. 9000 annually. Thus, approximately 69,000 rupees is the annual cost for MBBS course in government medical colleges (DMER, 2015). However, in private medical colleges the annual cost goes more than six times and in deemed universities it goes more than ten times. In Maharashtra there is a committee to regulate the fees in private and unaided medical colleges and the committee is called 'Shikshan Shulk Samiti'. However, the deemed universities does not fall under this committee hence the fees for MBBS course are different for each deemed university. The committee has laid down the fees for private medical colleges which are mentioned in the following table-5.6.

Table- 5.6
Fee Structure for the Private and Un-aided Medical Colleges in Maharashtra (2014-2015)

Name of the College	Intake	Fee Structure		
		Tuition	Development	Total
ACPM Medical College, Dhule	100	300926	24074	325000
Dr. Panjabrao Alias Bhausaheb Deshmukh Memorial Medical College, Amravati	100	462963	37037	500000
Dr. Ulhas Patil Medical College & Hospital, Jalgaon	100	482407	38593	521000
Dr.Vasantrao Pawar Med. Col. Hosp. & Research Centre,Nasik	120	393519	31481	425000
Indian Institute of Medical Science & Research, Jalna	100	370370	29630	400000

Institute of Medical Science and Research, Vidyagiri, Satara	100	509259	40741	550000
KJ Somaiyya Medical College & Research Centre, Mumbai	50	672222	53778	726000
Maharashtra Institute of Medical Sciences & Research, Latur	100	393519	31481	425000
Maharashtra Institute of Medical Education & Research, Pune	100	425926	34074	460000
N. K. P. Salve Institute of Medical Sciences, Nagpur	150	509259	40741	550000
Padmashri Dr. Vithalrao Vikhe Patil Foundations Medical College, Ahmednagar	100	462963	37037	500000
Smt. Kashibai Navale Medical College and Hospital,Narhe,Pune	100	652778	52222	705000
Terna Medical College, Navi Mumbai	100	388889	31111	420000
Ashwini Rural Medical College, Hospital & Research Centre, Solapur	100	509259	40741	550000

Source:-Shikshan Shulk Samiti 2014-2015[81]

Table- 5.7
General Overview of Annual Fee Structure in Medical Colleges in Maharashtra

Gov.	Private	Deemed University
69,000/-	6 to 7 lakhs	10 to 12 lakhs (NRI ranges 50 lakhs to one crore)

Source: DMER, 2015; Shikshan Shulk Samiti 2014-2015 and Interview with students

The average annual fee for private medical colleges goes around 5,04,071 rupees however it does not include the hostel fee, mess fee and sports fee. The hostel fee and mess fees are different for every private medical colleges and it varies from fifty to seventy thousand for each. Hence the cost goes around seven to eight lakhs. (DMER, 2015).

[81] Shikshan Shulk Samiti-2014-15. Committee on fee fixation for Medical and Technical Education in Maharashtra. Government of Maharashtra. As available on http://www.sssamiti.org/Medical-2014.htm as accessed on 15th June 2016.

One of the senior professors teaching in private medical college responded that

> "…only 20 per cent of the students who couldn't get admission in government medical college just because of two to three per cent difference are coming to private medical college and have high desires of becoming doctors. Other remaining 80 per cent students are coming just because they have money or they are pressurised by parents" (Interview conducted in Pune on 10th August 2013).

On contrary to this one of the senior professors teaching in private medical college and ex directorate of health services in Maharashtra responded that,

> "….around 60 to 70 per cent of students who takes admission in private medical colleges are intelligent and deserve to become a doctor. Other remaining students are not competent enough to take this thorough medical education training but they are getting because they have money" (Interview conducted in Mumbai on 13th January 2014).

There have been concerns raised by the few faculty members that the government should take the responsibility of these students and should accommodate all of these students in government medical college hence should build enough government medical college.

As one of the senior professors who is teaching in a government medical college in Mumbai responded that

> "The huge capitation fees making students out of reach to acquire education which is real. Doctors who paid huge capitation fees and passed out will ultimately try to recover the money they spend on it. So, the patients at the periphery level are going to suffer as the doctors will not prefer to work at periphery level because of low level of facilities" (Interview conducted in Mumbai 25th July 2013).

In this regard senior professor teaching in private medical college and ex directorate of health services in Maharashtra responded that,

> "The students do not like to go to rural areas and work in the public health system. It is a problem of our education which makes them to think like this. It is a very individualistic and urban centric education as well as high aspirations for higher education (means post-graduation) which makes them very competitive. It has impact upon public health system, such as even though there are large numbers of doctors passing out from the

> medical colleges students are not willing to join. There are numbers of reasons for not to join, as many times state doesn't open the positions, the positions are on contract based, low salary and the student who has paid huge cost in his/her education then why they will join in the public health system on low salary. Private hospitals are paying them bulk of amount so they will join them to recover the cost" (Interview conducted in Mumbai on 13th January 2014)

One of the senior professors who is teaching in private medical college in the department of Obstetrics and Gynaecology in Pune observed,

> "… you are talking of that there are no health facilities available for patients, doctors are not wanting to go to periphery. (kaise jayenge) how they will go, see if the child has spent to the tune of 35 lakhs of rupees let say for five years… this person has to recover that money" (Interview conducted in Pune on 8th August 2013).

Seat Allocation and Reservation Policy in Maharashtra:

There are total of 21 government medical colleges with an intake capacity of 2900 medical students. In government medical colleges (including corporation medical colleges) the 15 percent seats reserved for All India Quota and are being filled through All India Pre-Medical Test (AI-PMT). These seats are filled up by the Ministry of Health & Family welfare. Remaining 85 percent seats are filled up by the Maharashtra CET exam through the state merit list. Currently, there are nine private medical colleges who have joined the Maharashtra CET-Directorate of Medical Education and Research (DMER) and these nine private medical colleges fill up their seats through CET exam conducted by Maharashtra (DMER, 2015).

The nine private medical colleges which are attached to DMER have 15 percent management or Non Residence Indian (NRI) quota. In these nine private medical colleges remaining 85 percent of seats are filled up through merit (CET conducted by Maharashtra state).

There are total of 27 private medical colleges with an intake capacity of 3295. Out of these 27 private medical colleges, nine colleges are attached to DMER. Ten medical colleges comes under eight deemed universities and Deemed universities conduct their individual entrance exam to fill up their seats and they are fully autonomous. There are eight more private medical colleges in the state. There is association of private medical colleges which conduct separate entrance exam and filled up the seats in this eight private medical colleges.

Reservation in Government and Private Medical Colleges:

In government medical colleges the 15 percent seats are reserved for All India quota. If these 15 percent seats are not filled in first round then the seats goes to state government. 65 percent is reserved for category students which include SC ST OBC and Maratha (Maratha reservation has not yet been implemented as they were waiting for the official circular) SC & ST converts to Buddhism-13 percent, ST-7 percent, VJ/NT-11 percent, OBC-19 percent, Children of Defence Personnel five seats, physically handicapped five seats and Maharashtra-Karnataka disputed border area residents five seats (Whose mother tongue is Marathi), NRI 15 percent in private colleges.[82] Earlier reservation was 50 percent now 15 percent additional reservation added for Maratha community. Hence, total reservation reaches up-to 65 percent. 20 percent is for open category. Private medical colleges attached with DMER are implementing reservations in 25 percent of seats. The Deemed universities do not implement any reservation policy.

Faculty Shortage:-

The following table-5.8 provides a general overview of shortages in both government and private medical colleges. The table is prepared based on the data provided on website of each medical colleges.

Table-5.8
Shortage of Faculty in Private Medical Colleges in Maharashtra

Ownership	Prof.	Asso. Prof	Assi Prof.	Tutors	Epidemiologist	Statistician	Junior Resident	Total	Total No. of Institutions
Government	40	100	103	798	7	5	308	1361	10
Private	20	124	53	732	16	6	888	1839	21
Total	60	224	156	1530	23	11	1196	3200	31

Source: MCI records as accessed on 27th Feb 2014. Note : There are Nine government and four private medical colleges either website is not there or the positions have not mentioned on website

[82] Reservation details available on http://www.educationinfoindia.com/compExams/Maharashtra%20medical.html as accessed on 15th May 2016.

It highlights that there is a severe shortage of faculty in both government and private medical colleges. It is largely at the senior and middle level posts which seems to be have a severe shortage.

This chapter clearly showed the historical dominance of the Marathas-Kunbi caste cluster in Maharashtra. It also discussed the regional disparities and uneven development in the state. The chapter examined the growth of private medical colleges and the regional inequities in their establishment. It also discussed the strong nexus between the Marathas and the political leaders in the state. It also examined how the sugar cooperatives played an important role in the emergence of the private medical colleges as a profitable venture that led to the significant expansion and growth of these colleges in the state. The next chapter will discuss about the role of Medical Council of India as a regulatory body.

Table-5.9
Details of the Private Medical Colleges, Owners Socio-Political Background and Society/Trust Information in Maharashtra

Sr. No.	Name of the College	Year of Coll	Annual Intake	Name of the Founder	Caste	Political Affiliation	Name of the society or trust (year of establishment)	founder of the society	Attached hospital and No. of Beds	Total No. of Insti. Under the trust
1	ACPM Medical College, Dhule	1990	100	Late Shree Annasaheb Chudaman Patil	Maratha	MLC : 1952-1957, MLA: 1957-1962, MP 1962-1977	Jawahar Medical Foundation (1984)	Late Shree Annasaheb Chudaman Patil	650	7
2	Ashwini Rural Medical College, Solapur	2012	100	M.M. Patel	Patidar-(Gujarati)		M.M. Patel Public Charitable Trust	Established by Patel Family Memebers	300	
3	Bharati Vidyapeth, Sangli	2005	100	Dr. Patangrao Kadam	Maratha	currently heading the forest ministry, (May 2009 – Apr 2014) Minister co-operation	Bharati Vidyapeeth as trust (996 granted the status of "Deemed to be University)) (1964)	Dr. Patangrao Kadam	500	12 constituent units of Bharati Vidyapeeth Bharati Vidyapeeth runs more than 78 schools and 60 institutions of higher education, including those of professional education.
4	Bharati Vidyapeeth, Pune	1989	150	Dr. Patangrao Kadam	Maratha	"	"	Dr. Patangrao Kadam	850	"
6	Dr. Panjabrao Alias Bhausaheb Deshmukh Memorial Medical College, Amravati	1984	100	Shivaji Education Society	Kunbi	Minister of Agriculture in the first cabinet of Pandit Jawaharlal Nehru in 1952.(Indian National Congress)	Shivaji Education Society (registered as a Public Charitable Trust (R.N. F/89) (1932)	Dr. Panjabrao Alias Bhausaheb Deshmukh	570	153 (24 senior colleges 54 Jr. colleges, 75 middle schools, 35 hostels)
7	Dr. Ulhas Patil Medical College & Hospital, Jalgaon	2008	100	Godavari Foundation (Dr. Ulhas Patil)	Maratha	MP (Indian National Congress) (Currently affiliated to BJP)	Godavari Foundation (is registered organization vide registration no. F-2246 (Jalgaon) dated 12/08/93 under Mumbai Public Charity Act -1950 and MAH / 2406 / Jalgaon dated 2/04/93 under Societies Registration Act - 1860)	Dr. Ulhas Patil	500	22 institutions

						(1993)				
8	Dr.Vasantrao Pawar Med. Col. Nasik	1990	120	Late Dr Vasantrao Pawar was a founder of the college and was Ex Sarchitnis of Maratha Vidhya Prasarak Samaj, Nashik	Maratha	MLC (2004-2006,2006-2012) MP (Loksabha 1991-1996) Secretary, Nationalist Congress Party	Nashik District Maratha Vidya Prasarak Samaj (registered under Bombay Public Trust Act) (1914)	6 members established the trust	920	332 educational Institutions
9	Indian Institute of Medical Science Jalna	2013	100	Hazrat Maulana Gulam Mohammad Vastanvi	Muslim		The Jamia Islamia Ishaatul Uloom (1979)	Hazrat Maulana Gulam Mohammad Vastanvi	300	82 residential educational centers and 2646 pry primary schools in 99 districts of 16 states all over India.
10	Institute of Medical Science, Satara	2012	100	Dr. Mahadev Ramchandra Deshmukh	Maratha		Shri Chhatrapati Shivaji Education Society (registered under Karnataka Society Register act 1960 with registration No. 5/92-93) (1992)	Dr. Mahadev Ramchandra Deshmukh	395	6 Institutions
11	Jawaharlal Nehru Medical College, Sawangi	1990	200	Shri.Datta Meghe	Kunbi	MP (Rajya Sabha 2002 – 2008) elected to 15th Lok Sabh from Wardha constituency in Maharashtra state	Datta Meghe Institute of Medical Sciences is a Public Trust registered under Bombay Public Trust Act, 1950. It was previously known as Smt. Radhikabai Meghe Memorial Medical Trust. (Datta Meghe Institute of Medical Sciences, a Deemed University was granted this status by the UGC in 2005.)	Hon'ble Shri.Dattaji Meghe	1206 (http://dmimsu.edu.in/?page=hospital)	7 colleges comes under the university (Society has established 27 institutions right from pre-primary to postgraduate levels) http://www.mginagpur.com/main/mgi_visionary.html
12	KJ Somaiyya Medical College Mumbai	1991	50	Late Shri.Karamshi Jethabhai	Kutchi-Lohana (Open)		Somaiya Medical Trust.	Shri.Karamshi Jethabhai Somaiya and the legacy was	500	3 institutions are run by the trust (The Somaiya Vidyavihar campus

				Somaiya, an entrepreneur, philanthropist and a visionary. (owned by Somaiya Medical Trust.)				further continued by his son Dr. S. K. Somaiya and then to his granson Samir Somaiya		comprises 34 individual institutes)
13	Krishna Institute of Medical Sciences, Karad	1984	150	Jaywantrao Krishnarao Bhosale	Maratha	elected as the Chairman of one of the first co-operative sugar factories in India In 1959, Chairman of the Maharashtra Federation of Co-operative Sugar Factories (1967-69), member of the Finance Committee of GOI and MLC, The Late CM Vasantdada Patil was a member of the Board of Trustees and a guiding force. (Congress, NCP and BJP)	Krishna Chritable Trust (1974)	Jaywantrao Krishnarao Bhosale	1100	
14	MIMS, Latur	1990	100	Prof. (Dr.) Vishwanath D. Karad	VJNT		Maharashtra Academy of Engineering & Education Research (MAEER), Pune (1983)	Prof. (Dr.) Vishwanath D. Karad	610	71 Institutions delivering KG to PG education.
15	MIMS, Pune	1994	100	Prof. (Dr.) Vishwanath D. Karad	VJNT		"	Prof. (Dr.) Vishwanath D. Karad		71 Institutions delivering KG to PG education.
16	MGIMS, Sevagra, Wardha (India's first experimental rural medical college).	1969	65	Dr Sushila Nayar	(Nayar) Khatri is a caste from the northern Indian subcontinent mainly Punjab	Elected to the Legislative Assembly of Delhi, 1952-1955, was Health Minister in Nehru's cabinet, In 1957 elected to the Lok Sabha and served till 1971. Union Health Minister again from 1962 -1967, (Congress and Janata Party)	Kasturba Health Society (1962)	Dr Sushila Nayar	1000	
17	MGM Medical College, Aurangabad	1989	150	Shree Kamal Kishore Kadam	Maratha	former Education Minister of Maharashtra,	The Mahatma Gandhi Mission (MGM) Trust (as	Shree Kamal Kishore Kadam	729	50 different institutes spread over 5 different cities

						Former Dy. Speaker, Legislative Assembly Maharashtra State, Elected as MLA twice for Maharashtra, MLC from Nanded Constituency for two times consecutively	a charitable trust registered under the Society's Registration Act, 1860 and also registered under Bombay Public Trusts Act, 1950 on 30th April 1983) The MGM Deemed University has been notified as a Deemed to be University in 2006 (1982)			
18	MGM Medical College, Navi Mumbai	1989	150	Shree Kamal Kishore Kadam	"	"	"	"	500	"
19	N. K. P. Salve Institute of Medical Sciences, Nagpur	1990	150	Padmashri Kamaltai Hospet and after her death Shri.Ranjeet Deshmukh leading the trust*	Shri.Ranjeet Deshmukh belong to Kunbi community	Mr.Ranjeet Deshmukh a mechanical engineer by profession was the Ex.Minister for Agriculture and Textiles in the Maharashtra Government (1999-2004)	VSPM Academy of Higher Education (Formerly known as Vidya Shikshan Prasarak Mandal) Vidya Shikshan Prasarak Mandal is registered under the Societies Registration Act 1860 (1971)	Padmashri Kamaltai Hospet	910	50 quality education institutions right from primary schools to medical college
5	Dr. D. Y. Patil Kolhapur	1989	150	Dr. D. Y. Patil	Maratha	Elected to the Kolhapur Municipal Council as a Congress candidate in 1957-1962, MLA from 1967-78, Governor of Bihar 2013-2014 (Indian National Congress)	D.Y.Patil Education Society registered under Societies Registration Act, 1860 (In 2005 was accorded Deemed to be University status) (1987)	D.Y.Patil	750	(Under this society runing only 2 institutions college and hospital) however around150 educational institutions including 3 deemed universities each one at Mumbai, Pune and Kolhapur run by this founder
20	D Y Patil Medical College, Pimpri, Pune	1995	150	Dr. D Y Patil	"	"	(In 2003 was accorded Deemed to be University status)	Dr. D Y Patil	1590	8 constituent colleges
21	D.Y.Patil Medical College, Navi Mumbai	1989	150	Dr. D Y Patil	"	"	*	Dr. D Y Patil	1540	9 constituent institutions
22	Vithalrao Vikhe Patil Foundations Medical	2003	100	Shri. Balasaheb Vikhe Patil	Maratha	MP for over two decades (Shri. Radhakrishna Eknathrao	Padmashri Dr. Vithalrao Vikhe Patil Foundations	Shri. Eknathrao alias Balasaheb	700	10 institutes under the foundation

	College, Ahmednagar					Vikhe Patil 15th June,1959 Minister for Agriculture & Marketing 2010-2014, Minister for Transport, Ports, Law & Judriciary 2009-10, Minister for School Education & Law and Judiciary 2009, MLA since March 1995, 2004 won Assembly Election) **(Congress Party)**	registered under Bombay Public Trust Act 1950, dated - 5th July, 1982 (Dr. Vitthalrao Vikhe Patil 29 August 1901 - 27 April 1980) (1982)	Vikhe Patil		
23	Rural Medical College, Loni	1984	125	Padmabhushan Shri. Eknathrao alias Balasaheb Vikhe Patili	Maratha	Member of Parliament for over two decades 1971–1991+ 1998–1999.+ 1999–2004 **(Congress Party)** Minister of State for Finance (Expenditure, Banking & Insurance) Govt. of India, New Delhi-1999-2002. Minister of Industry (Heavy Industries & Public Enterprises) 2002-2003.	The Pravara Medical Trust (Pravara Institute of Medical Sciences University was established under on 29th September, 2003 by Government of India) (1972)	Dr. Vitthalrao Vikhe Patil	800	6 institutes under the university
24	Smt. Kashibai Navale Medical College Narhe,Pune	2007	100	Prof. M. N. Navale	Mali (OBC)		Sinhgad Technical Education Society (1993)	Prof. M. N. Navale	800	107
25	Terna Medical College, Navi Mumbai	1991	100	Dr. Padmasinha Bajirao Patil	Maratha	MP (NCP), A seven-term MLA for Osmanabad Cabinet Minister in Home, Irrigation Ministry in Maharashtra state for more than 25 yrs.	Terna Public charitable Trust (1980)	Dr. Padmasinha Bajirao Patil	500	14 under the trust (http://www.terna.org/trust_institutes.php)
26	SMBT Institute of Medical Sciences Nashik	2014	0	1. Shri. Balasaheb Bhausaheb Thorat and 2. Dr. Sudhir Bhaskarrao		Balasaheb Thorat is a leader of farmers and Indian National Congress legislator. He is well known in the cooperative movement, as the founder of the Milk Cooperative, and	Sau. Mathurabai Bhausaheb Thorat Sevabhavi Trust			

				Tambe	former president of the Sangamner District and State Cooperative Bank. Sudhir Tambe is a MLC			
27	B.K.L. Walawalkar Rural Medical College, Ratnagiri	2015	100	Shri Vithalrao Joshi Charities Trust	With the support of Shri Kamlakarpant Walawalkar, a builder-industrialist by profession, but essentially a philanthropist, who was Managing Trustee of both the TRUSTS, The hospital has been established at an investment of approximately, Rs.20 Crores and has been almost entirely funded by Walawalkar family from their business gains	Shri Vithalrao Joshi Charities Trust (SVJC Trust) (1977)	Shri Vithalrao Joshi alias Shree Digambardas Maharajthe (born on October 17, 1912 and Mahasamadhi May 21, 1989	500

Source: The data is obtained from multiple sources which includes each college website, trust website, newspaper article and interviews conducted with the key informants.

ACPM: Annasaheb Chudaman Patil Medical College; MGM-Mahatma Gandhi Missions Medical College; MGIMS: Mahatma Gandhi Institute of Medical Sciences; MIMS: Maharashtra Institute of Medical Sciences; MLC: Member of Legislative Council; MLA: Member of Legislative Assembly; MP-Member of Parliament

Note: “

Chapter-VI

Regulation of Medical Education: The Role of Medical Council of India

This chapter discusses the role of the Medical Council of India (MCI) in regulating the medical education in India. It firstly describes the brief history of MCI, highlights what is the present scenario of MCI regulation of medical education in India and then discusses the corrupt and unethical practices that have been prevalent in the MCI in recent times. The role of MCI assumes importance because it is one of the important regulatory body influencing the growth and expansion of medical education and colleges in the country.

Medical Council of India: A Brief History

In India the beginning of the modern medicine in an institutional form, began in 1835 with the establishment of medical colleges in Calcutta and Madras. After a decade in 1845 the Grant Medical College was opened at Bombay. There were few medical schools established to provide training for hospital assistants and sub-assistant surgeons, later known as licentiates. In 1906, the need for university standard education was recognized and 1911 the medical college was established at Lucknow. However, in 1857 the Calcutta University was established and the Calcutta Medical College became affiliated to the university. This was followed by other schools as well and in 1925 there were ten medical schools which had university standards (Butt, 1946:369). In the colonial period, Indian medical degrees were approved by the General Medical Council of Great Britain. At around 1892, students who passed from Indian medical universities started to register under General Medical Council of United Kingdom. Before 1892, the registration was done by the local authorities (Dutta, 1991).

Hence, the medical education in British India was in the hands of the Britishers primarily with the British led Indian Medical Services. Till 1912, there was no such body established in India to evaluate the standard and status of medical education and the registration of medical degrees. In the period from 1912 to 1936, there were medical councils established in each of the British Provinces except North-West and

Sind province and these were chiefly concerned to maintain the standard of medical education in their respective provinces (Butt, 1946:370). The Bombay Medical Council Act was passed in 1912 and followed to this Bengal Medical Council Act was passed in 1914. The state medical councils had the powers to evaluate the standards of medical education, inspect medical colleges and give suggestions to the improvement of the medical institutions. The council was also authorised to register individual qualified persons in the medical register (Bradfield, 1938 as cited in Dutta, 1991).

Thus, till 1933 there was no any central authoritative body established in British India to maintain a minimum standard of medical education in the whole country. The need for having a central authoritative body aroused in a context when the General Medical Council (GMC) refused to recognise the Indian Medical Degrees.

As part of the rules and regulation, General Medical Council's (GMC) role was to inspect the medical institutions for maintaining the standards of medical education. The controversy of recognising Indian medical degrees was there for ten years. In 1921, the GMC could see in the teaching field, the insufficient knowledge and skills for practising medicine, surgery and midwifery in the Indian Medical Universities (Bombay, Calcutta, Lucknow, Madras, and Punjab). It was not up-to the standards of the GMC. In the period of ten years the inspection was done for twice. In 1922, Sir Norman Walker, upon the invitation of the government visited India and prepared a report. In the report he expressed the need for improvements in each university and the required standards which will match the GMC regulations. Followed to this Colonel Needham inspected the Indian Medical Universities and he too in his report observed the inadequate facilities and inefficiency in the teaching. However, he could observe and acknowledge some of the improvements and upon his recommendations the conditional recognition was given to Indian Medical Degrees. In this backdrop, in 1924 the Calcutta University opposed the inspection conducted from the outside authority and denied the presence of the inspector in the examination hall. As a consequence of this the GMC withdrew its recognition to Indian Medical Universities (Butt, 1946; The British Medical Journal, 1930).

Thus, under this backdrop the time had come that India should have its own authoritative body which will look after the recognition and uniform standards of medical education in the country. In regard to this in 1930 second conference was

being called by the Government of India that consisted of representatives of the provincial governments and all the Indian medical universities. In the conference, consensus was made to draft a bill for the establishment of All-India Medical Council. Accordingly in 1933, a Medical Council Act was passed in the central Legislative Assembly (Butt, 1946).

Hence under the Medical Council Act 1933, the Medical Council of India was established in 1934. The functions of the council fall under two heads:

(1) The maintenance of a uniform minimum standard of higher medical qualifications for the whole of British India; and

(2) The furtherance of the recognition of these qualifications in States and countries outside British India, with its corollary, the recognition in that country of approved qualifications of such States or countries (ibid:370).

The council at that period of time had not been entrusted with maintenance of a register. The responsibility of the registration was in the hands of State Medical Councils'. It had no and does not still have any disciplinary power over non-registered medical practitioners (Bradfield, 1938 as cited in Dutta, 1991:45).

Medical Council of India: Current Scenario

The Medical Council of India was established in 1934 under the Indian Medical Council Act, 1933, now repealed, with the main function of establishing uniform standards of higher qualifications in medicine and recognition of medical qualifications in India and abroad. The number of medical colleges had increased steadily during the years after independence. It was felt that the provisions of Indian Medical Council Act were not adequate to meet with the challenges posed by the very fast development and the progress of medical education in the country. As a result, in 1956, the old Act was repealed and a new one was enacted. This was further modified in 1964, 1993, 2001, 2005, 2010, 2012 and 2013.[83]

[83] GOI, (2013). The Indian Medical Council (Amendment) Bill, 2013. Ministry of Health and Family Welfare, Government of India, New Delhi. Report presented to the Parliament of India, Rajya Sabha. Information is also available on Medical Council of India, Introduction. Available on http://www.mciindia.org/About MCI/Introduction.aspx as accessed on 27th June 2015

The objectives of the Council are as follows:

- Maintenance of uniform standards of medical education, both undergraduate and postgraduate.
- Recommendation for recognition/de-recognition of medical qualifications of medical institutions of India or foreign countries.
- Permanent registration/provisional registration of doctors with recognised medical qualifications,
- Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.[84]

As mentioned earlier the functions of the MCI runs, according to the main Medical Council Act 1956 and there have been many additions and modifications brought out through the number of amendments. It is a regulatory statutory body for medical education, and a government agency under the Ministry of Health and Family Welfare.

However, it is being said that the bringing uniform standards of medical education is one of the prime responsibility of the MCI. However, Dutta (1991) points out that the uniformity in medical education has not been achieved in its proper sense, both at graduate and postgraduate levels. The problem is so deep and complicated that it requires an in-depth study (Dutta, 1991:46-47).

The Powers of the MCI:

Following are important powers of the MCI:[85]

1. Granting permission for establishment of new medical college as well as new course of study. It is a compulsory process to have permission from MCI to start a new college or course study. Permission to increase its admission capacity in any course of study or training

[84] Medical Council of India. Introduction. (Internet) as Available on http://www.mciindia.org/About MCI/Introduction.aspx as accessed on 27th June 2015

[85] It is important to mention that all powers has not been mentioned here, only the important powers are highlighted . For a complete detail of the powers of MCI see Medical Council of India Act 1956 available on MCI Website http://www.mciindia.org/ActsandAmendments/TheMedicalCouncilAct1956.aspx as accessed on 26th June 2015.

2. Non-Recognition of Medical Qualifications in Certain Cases.
3. Recognition of Medical Qualification Granted by Universities or Medical Institutions in India
4. Recognition of Medical Qualifications Granted by Medical Institutions in Countries with which there is a Scheme of Reciprocity
5. Power to require Information, as to Courses of Study and Examinations
6. Inspection of Examinations
7. Visitors at Examinations
8. Withdrawal of Recognition
9. Minimum Standards of Medical Education
10. Professional Conduct
11. Indian Medical Register
12. Supply of Copies of the State Medical Registers
13. Registration in the Indian Medical Register
14. Removal of Names from the Indian Medical Register
15. Power to Make Rules and Regulations

Given the kind of powers MCI has and its proper functioning certainly would have large effect on the entire medical education system and hence the health services systems in the country. However, in the last few years it has been observed that there have been major issues within the MCI. Despite having all of these powers primarily on inspecting the quality of medical education and medical ethics, the MCI itself have major issues such as inefficiency, lack of transparency and corruption within the MCI.

Corruption Issue in MCI: Case of Dr. Ketan Desai

As it is the fact that last few years there have been major controversial issues in MCI. Firstly, in 2001, the President of MCI, Dr. Ketan Desai was asked to remove from his post by an order from Delhi High Court. It is being stated that he had been elected under a 'flawed constitution' (Madhavan and Manghnani, 2006). At the beginning in 2000, Ketan Desai was been appointed as against post vacant in MCI. Later, central government nominated him as a member of MCI in February, 2000. However, in 1999 Ketan Desai was already been elected from the Gujarat, as a representative of faculty members to the MCI. According to MCI act 1956, section 5 (2) which states that "no person may at the same time serve as a member in more than one capacity",

so in this context the question arises that how come Dr. Ketan Desai was allowed to pose a membership in more than one capacity? (Rajalakshmi, 2001). Even, how come central government had nominated his name as a member of the MCI when the fact was that he was already elected as a member to the MCI?

In this context, Dr. Harish Bhalla a private practitioner filed a writ petition against Dr. Ketan Desai and challenged his appointment as a president of the MCI along with demanding directions to the Central government to constitute the Council. In 2001, Delhi High Court gave an order of his removal from the post until the fresh elections have been conducted. "The Union of India and Ketan Desai filed appeals against the order. On June 4, a Division Bench of the High Court stayed the order and permitted the MCI to hold elections to the post of president and vice president as scheduled. Harish Bhalla approached the Supreme Court. The apex court passed an order on June 18 substantially maintaining the Division Bench ruling. It directed the Delhi High Court to dispose of the appeals expeditiously. The petitioner filed an additional affidavit in the High Court. The final hearing began after all parties concerned filed their affidavits, rejoinders and counter affidavits" (Rajalakshmi, 2001:2).

According to the Delhi High Court Judgement (2001), there were three important allegations made, firstly, the failure of the central government to constitute MCI in accordance with act, secondly, eligibility of Ketan Desai to seek election as President of the Medical Council and to hold office as such and thirdly, allegations have been made of misuse of office by Ketan Desai by indulging in corrupt practices which disentitle him to continue to hold office of the President of the Council (Delhi High Court Judgement, 2001).

The allegations being made against the central government because the composition of the MCI was not according to the MCI act mentioned. The composition was not representing the body of various medical community members. The intention behind making the Council a wide body is that the various constituents of the medical profession get representation in the Council. The ratio between elected and nominated members is that elected members are more than double as compared to nominated members. However, it was found that the nominated members were more than the elected members. The council was supposed to have 123 members however it has only 77 members. There were many vacancies and most of it was in elected

categories. Thus, it shows the role of the central government to constitute the MCI body where it failed to perform its duty (ibid). According to MCI Act 1956 section 3 it says, 'the Central Government shall cause to be constituted a council members',[86] consisting of the nominated and elected members from different constituencies of medical profession. Hence, the judgement says that, "it was owing to this failure that the Council had lost its representative character. The Central Government had not at all made bona fide efforts and not adopted effective measures to ensure that elected members are in place" The judgement said that the fact that Ketan Desai had won the election to the post of president with an overwhelming majority proved that he sought to retain control over the Council by such manoeuvres. A body supposed to be controlled by elected members is being controlled through nominations. The spirit of the statute is being subverted." (Delhi High Court Judgement, 2001:5).

Misuse of Office and Corruption Charges:

The petitioner had pointed out with all proofs of copies attached to the petition that Dr. Ketan Desai had used his office position and manipulated all the affairs of the council by taking all the important decisions within his control. The MCI Act1956 section 10(A) provides a process for the permission of the establishment of new medical college, new course/study etc. It says that to start a new medical college or new course/study or increase of admission capacity in any course/training, Central Government's permission is required. In this case to obtain permission, according to the act, the medical institution has to submit the required papers or proposal to the Central Government. In turn the Central Government refers these papers of proposal to the Medical Council of India for its recommendations. After receiving the proposal the MCI should follow its rules and regulations such as examining the proposal, asked for required information from concerned college, inspection of the college etc. After scrutinising the details MCI sends back the proposal to the Central Government along with its recommendations. It is upon the Central Government whether to approve it of

[86] Medical Council of India Act 1956 available on MCI Website http://www.mciindia.org/ActsandAmendments/ TheMedicalCouncilAct1956.aspx as accessed on 26th June 2015.

disapprove.[87] In this inspection becomes more critical as based upon the inspections, reports of recommendation are being made. Here allegations being made that the inspection reports are manipulated on the order of President of the MCI. In this case Dr. Bhalla provided two examples and proofs of it and in the judgement 2001 mentioned it as,

1. "D.Y. Patil Medical College, Pimpri, Pune had bed occupancy of 3% in June 2000 when permission for admitting another batch of medical students was given, violating all the regulations regarding minimum standards as required by a medical college which is 80% bed occupancy of the required bed strength. Surprisingly in 6 months time the bed occupancy increased to 96%, this bed occupancy shown falsely increased with admitted fake patients not for teaching purposes. Despite this the college had been recommended permission and now recognition given to MBBS degree after re-inspection in April 2001.

2. Santosh Medical College, Ghaziabad was refused recommendation of permission and recognition of its MBBS degree in Oct 2000 for want of adequate clinical material, infrastructure and teaching staff and the inspecting team commented that there were fake patients, fake teachers and fake instruments. Then the same college was found deficient in January 2001 and similar refusal continued but in April 2001 suddenly everything became excellent and up to the mark and the recommendation for permission for admission of new batch of students and recognition of MBBS degree was given" (ibid).

These above two examples clearly explain the kind of affairs being manipulated by a high position person where in practical the person was supposed to perform its duty to monitor and regulate such practices to increase the standards of medical education.

Moreover the charges of corruption were being proofed. The petitioner has shown the record of illegal donations taken by Dr. Ketan Desai and shown the record of bank drafts of total value of Rs. 65 lakhs on his and his family member's name. Even it incorporated the point that Income Tax Department raided his business and residential premises in February 2000. In accordance with this Dr. Ketan Desai denied the

[87] Medical Council of India Act 1956 available on MCI Website http://www.mciindia.org/ActsandAmendments/ TheMedicalCouncilAct1956.aspx as accessed on 26th June 2015

allegations and said that president cannot do anything alone and all the decisions were being through the MCI Executive Committee. Hence, the court ordered for three years record of Minutes of Executive Committee meeting from 1998 to 2000. Interestingly, it came out that, "these minutes of the Executive Committee meetings are a big pointer to the fact that the entire affairs of the Council are being controlled and managed by its President. The President has managed and manipulated the affairs of the Council in a manner that he exercises complete control regarding affairs of the Council. This is obvious from the fact that in the election to the office of the President and Vice President held on 21st June, 2001, he got 69 out of 73 votes. This is how he exercises complete control over the Council. The Executive Committee is being used to legitimise his activities by the President" (ibid: 14).

The Judgement order 2001 says that

> "Investigation as per letter of the Joint Commissioner of Income-tax shows that these were slush money payments/generated gifts. The allegations of petitioner against Dr. Ketan Desai regarding minting money stands established. With this it stands established that Dr. Ketan Desai, has misused his position as President of the Medical Council of India. He is using the office for making illegal monetary gains for himself and his family members. Prima facie a case for prosecution of Dr. Ketan Desai on charges of corruption under the Prevention of Corruption Act is clearly made out" (Delhi High Court Judgement, 2001:16).

The court ordered that, "the Medical Council of India Act does not contain any provision for disqualifying a person from holding office in the Medical Council of India. But there is no bar either in the Act against removal of an elected office bearer before expiry of his term. Therefore, we direct that Dr. Ketan Desai, shall cease to hold office of President of the Medical Council of India with immediate effect". The central government directed to reconstitute MCI as per MCI Act and after constituted in accordance with statute, election be hold for the offices of President , Vice-president and executive committee members, till then Mr. Major General (Retd.) S. P. Jhingon was being appointed by the court as the administrator who will perform all the functions of the President of the Council (ibid: 18).

In the above context many articles were published in media and journals for example article published in British Medical Journal (2001), article published in Frontline

(2001) by Rajalakshmi who analyzed the court order, the article published in Indian Journal of Medical Ethics by S. K. Pandya in 2009 analyzed the events and misconduct which took place in MCI over a period of ten years. An r article was also published in Indian Express titled, Power Play Practitioner by Mascarenhas and Shukla (2010).

It is important to note that even the Delhi High Court passed a judgement on Dr. Ketan Desai as corrupt and one who misused his post, he was re-nominated in several committees as Rajalakshami notes (2001) that "he was re-nominated to several committees at the AIIMS in August 2001. Union Health Minister C.P. Thakur is the president of the institute and the chairman of the governing body. The AIIMS Faculty Association's plea against Ketan Desai's continuance in the institute body went unheard" (Rajalakshami, 2001:2). Similarly a petition filed against Dr. Ketan Desai by the People for Betterment[88] an NGO reiterates the fact that even though he was charged for corruption and Delhi High Court ordered for his removal from the post, he was holding the post of president in Indian Medical Association (IMA) president of Gujarat Medical Council along with many other high posts in different constituency of medical profession (Saha, 2014).

Dr. Ketan Desai's Re-Emergence in 2009:

Pandya (2009) pointed out that "In the minutes of the general body meeting held on March 1, 2009, the president (acting) "was also happy to share with the House" that the Interim Appeal which was preferred by him before the Hon'ble Supreme Court challenging the decision of the Hon'ble Delhi High Court of November 2001 before the Hon'ble Supreme Court "has been totally upheld vide order dated 05.02.2009". As a result of this," not only the composition of the MCI with reference to its desired represent active character stands testimonised, but also the decks have been cleared for the conduct of election of the office bearers of the Council, which has been itemized in the agenda. In a way he can say with all humility at his disposal that the

[88] Dr. Saha founded an NGO to fight against the corruption in the medical system. See news paper article written in, Mail today (14th October 2010). The Country Needs a Dr. Saha For Every Desai. Mail Today, New Delhi, as available on http://www.thefreelibrary.com/The+country+needs+a+Dr+Saha+for+every+Desai.-a0239425295 as accessed on 25th June 2015.

destiny has made the Council move a full circle back on to its path of committed responsibility, fair name and credibility" (Pandya, 2009).

Accordingly in 2009 Dr. Ketan Desai's name was nominated for the post of president and interestingly there was only one nomination and that was Dr. Ketan Desai. He was elected for the post of president as 'unopposed' through the support of his unscrupulous medical colleagues (Saha, 2014).

Subsequently, in 2010 Dr. Ketan Desai was caught red hand by Central Bureau of Investigation (CBI) for accepting bribe of over Rs. 2 crore for granting recognition to a Private Medical College in Punjab. Soon after his arrest, the CBI also raided his home in Gujarat and filed additional charges for having "disproportionate wealth" at around Rs. 1,800 crore against him, and his wife. These instances made huge chaos in the country as there were number of media coverage and pressure from the public made the government to dissolve the MCI. Entire body of MCI with its more than 100 doctor members, who unanimously elected Dr. Desai as their president in 2009 and many of them who were helping him to run a reign of corruption in the MCI , was also dissolved by the central health ministry in April 2010. While Dr. Desai stayed in jail for almost 7 months, he has been free on bail since late 2010 waiting to stand trial on serious charges of bribery and corruption. The central government appointed seven members committee as Board of Governors (BOG) to run the functioning of MCI through Indian Medical Council Amendment Ordinance 2010. Upon the charges of corruption and bribery, Desai's medical registration was also cancelled by the MCI (Times of India, 2010; The Hindu, 2010; Bhattacharya, 2014; Pasha, 2013; Nagral, 2010; PBT, 2011; Pandey 2005; Economics Times Bureau, 2010; Saha 2014).

In October 2013, the central government abolished the above BOG. The health ministry now announced the establishment of a new MCI, with elected/nominated members from different states/universities in accordance with the Indian Medical Council (Amendment) Ordinance, 2013. These nominations were made by the governors of the different states in their capacity as chancellors of the universities. Ketan Desai also managed to get himself nominated in this round as a member of MCI from Gujarat University even as his licence to practise medicine remained suspended by the council. When questioned on this by Julio Ribeiro, Chairman of the Public Concern for Governance Trust in Mumbai, the Governor's office in Gujarat

responded citing the reported 'opinion' of Justice AM Ahmadi, former Chief Justice of India, that the MCI has no jurisdiction or authority to suspend the registration of any doctor registered with any state medical council. In December 2013, the freshly constituted MCI held elections for the post of President, Vice-President and Executive/Post graduate committee members. The manner in which these elections were conducted came under severe attack (Bhattacharya, 2014).

Fraudulent MCI Elections 2013:

A writ petition file by Dr. Kunal Saha, President of an NGO called People for Better Treatment (PBT) which says that "this Public Interest Litigation (PIL) attempts to expose how a few corrupt vested interests have perpetuated their unhealthy strangle-hold on the highest Regulatory Body of Allopathic Medicine in India, namely the Medical Council of India (MCI), by gross manipulation in the election process and also how the composition of the MCI wherein nominated members predominate goes to assist this unhealthy state of affairs" (Saha, 2014). The detail description in the PIL filed by Saha, clearly pointed out the manner in which the elections were conducted in MCI as the close associates of Dr. Ketan Desai who supported him in the 2009 elections and was part of the corruption again got themselves to be re-nominated to become a members and acquire top positions of the new MCI in 2013. The most important fact is that even Dr. Ketan Desai managed to get nominated from Gujarat University as to become a member of new MCI, even though his medical registration remained suspended by MCI since 2010 and he was on bail with a pending criminal trial on serious charges of bribery and corruption. According to the ordinance 2013 the nominated members by central government and members selected by different universities were increased significantly. The petitioner says, "..it came to know from inside sources that in order to regain control of the new MCI, a deep-rooted conspiracy to manipulate and rig the proposed MCI election on 10th and 11th December, 2014 was hatched by Dr. Desai along with his close associates who had already managed to get themselves re-elected/re-nominated for the new MCI" (Saha, 2014:19-20). The General Body Meeting minutes conducted on 10th December 2013 explains the kind of possible corruption would have taken place in the new MCI election. It notes that there were eighty five members present in the meeting. Elections were conducted for the post of President, Vice President and Executive

Committee Members. For Executive Committee Members elections, there were three members nominated by Government, four members were University Representative Group and two members were Representatives of Registered Medical Graduates, interestingly all of them were elected unopposed. Even the President and Vice President positions were elected unopposed. Members of the Postgraduate Medical Education Committee as well were elected unopposed (MCI GOB Minutes, 2013). The petitioner also states that, "the members who were elected "unopposed" to these top MCI positions are known to be closely associated with Dr. Ketan Desai. As mentioned above, many of these members were also part of the previous MCI who voted to make Dr. Desai MCI president in 2009" (Saha, 2014:20). In the petition it points out with the evidence that how one persons (Dr. Ketan Desai) influence managed to hold power within the MCI of having his own cronies in the top positions. It explains as,

> "A dinner cocktail party was hosted by Dr. Ketan Desai at the Indian Medical Association (IMA) House in Delhi the presence of most of the newly elected/nominated members who would vote next day to elect new MCI president/vice-president and important Executive/Post-graduate Committee members. A printed list was circulated at this dinner party which contained names of members who are closely associated with Dr. Desai to be elected next day as new MCI president/vice-president and Executive/Postgraduate Committee members along with the names of those who would nominate these individuals ("proposers") and those who would support the nominations ("seconders") for the election next day. This entire scenario was described by Dr. Balvir Tomar, a newly elected/nominated MCI member through a formal complaint lodged with the health ministry" (Saha, 2014: 5).
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> The Hindu (2014a) news-paper noted that, "Addressing a seminar in the city on Sunday on medical negligence, Balbir S. Tomar said that the MCI lacks a formal and ethical structure of nominating its members. The nomination procedure to the MCI got over in just 10 minutes against the two-day procedure stipulated by the government. The members were pre-decided and the nomination procedure was merely eyewash, he said" (The Hindu, 2014a).

It reiterates the fact that the election was nothing but a bogus exercise in which all the high position elected members were already chosen in accordance to a list prepared by Dr. Ketan Desai before the election. The Hindu (2014b) also reported that the Aam

Aadmi Party (AAP) alleged that there is political patronage from Congress, Bharatiya Janata Party (BJP), and Samajawadi Party where all of them are paving the way for the re-entry of Dr. Ketan Desai, even though his criminal cases are pending in the law (The Hindu, 2014b).

Union Health Secretary Keshav Desiraju: Sudden Transfer

The kind of political patronage going on for the re-entry of Dr. Ketan Desai can be evident when Union Health Secretary an eminent IAS officer Keshav Desiraju's sudden transfer was made by the Congress regime. Media covered the reason behind this was Keshav Desiraju took the stand that Dr. Ketan Desai disqualifies to contest MCI elections as there is CBI charged cases pending in the court. When explanations were being asked on this move, the then Health Minister Gulam Nabi Azad said that, "Officers' and ministers' portfolios change-it is a regular affair" (Economic Times Bureau, 2014; Asrar, 2014). I, Noted Economist and Nobel Laureate Amartya Sen questioned the move whereas; Aam Aadmi Party alleged that Desiraju was moved because he opposed the return of tainted Ketan Desai to the MCI who was arrested on charges of bribery in 2010. Desiraju 'was unfairly and arbitrarily transferred' by Health and Family Minister Ghulam Nabi Azad as he (Desiraju) was against the return of Desai to the helm of the MCI, the AAP said in a statement (Dutta, 2014). The Hindu (2014b) noted "the senior Lawyer and AAP's leader, Prashant Bhushan said that Dr. Ketan Desai also flayed Congress leader and Union Health Minister, Ghulam Nabi Azad, for "unfairly" transferring Health Secretary Keshav Desiraju "for the simple reason that he resisted the Congress and BJP facilitated return of Desai to the helm of MCI" (The Hindu, 2014b).

Chief Vigilance Officer (CVO) in MCI:

The major role of the CVO in MCI is clearly stated on the MCI website and it states that,

> This department in Medical Council of India is headed by the Chief Vigilance Officer.
>
> "Keeping in view the main objectives and functions of the Council as laid down in the various enactments, the Chief Vigilance Officer assists the Chairman, Board of Governors in maintaining the transparency and

> integrity in general administration and in increasing the efficiency as well as productivity in MCI through various preventive measures. Punitive actions are taken where the preventive measures fail to produce the desired results. Considering the principal areas and activities of MCI, wherever dealings with public are involved, the emphasis by the Vigilance Department is specially given on the procedures. During the investigations of complaints or checks, whenever any inadequacies in the laid down procedures are noticed, suggestions are made by the CVO to the MCI Administration for rectifying such procedures. The basic objective, thus, of the Vigilance Department in MCI is to improve the system and to reduce any ambiguity in the interpretation and implementation of the connected rules and procedures. Needless to say, such guidelines, procedures and directives issued by the Vigilance Department from time-to-time need to be transparent and implementable and are carefully prepared keeping in view the objectives of the Medical Council of India" (MCI, 2016).

Thus, it clearly shows that the CVO's role is to see the transparency and integrity in the functioning of MCI as well as reporting the irregularities to the MCI administration. However in 2013, when, CVO called Harish Jethi was appointed in MCI himself reported harassment by the MCI authorities when he tried to sought the irregularities and number of corruption cases in MCI. However, the MCI officials were not supportive and non co-operative to him rather he faced harassment by the MCI administration. Hence, he requested his repatriation to his parent organization Indian Ordnance Factories Service (IOFS) and he complained to the Central Vigilance Commission (CVC) by mentioning victimization and harassment by the MCI administration (Ramachandran, 2014; Patil, 2014; Baru and Diwate, 2015; Ray, 2014; PBT, 2014).[89] The news-paper article in The Hindu reports that,

> "In April 2014, Mr. Jethi had written a letter to the Secretary, Ministry of Health, complaining of victimisation for taking up a "drive against corruption." Seeking repatriation to the IOFS, he had written, "I have already expressed apprehension that I may be a victim of statutory and

[89] PBT (2014). Shocking Revelation Of Wide-Spread Corruption In MCI: Chief Vigilance Officer (CVO) Is "Scared" And Quits Investigation Of MCI Corruption. As available on http://www.pbtindia.com/archives/2402 as accessed on 15th May 2015. The original documents of the letter written by Jethi is obtained by PBT and the scanned copy of it is available on http://www.pbtindia.com/wp-content/uploads/2014/10/MCI-Corruption-CVO-Harrasment-Oct-2014.pdf as accessed on 15th May 2015. DNA India as well reported the issue as available on http://www.dnaindia.com/india/report-chief-vigilance-officer-of-mci-hk-jethi-had-sought-repatriation-harsh-vardhan-clarifies-2033299 as accessed on 15th May 2015.

> physical harassment...in retaliation to my drive against corruption undertaken by the vigilance section in the MCI. The situation has not improved, instead [it is] getting worse and the president of MCI is using all pressure tactics for destabilising the functioning of vigilance division" (Ramachandran, 2014)
>
> The letter has details about the MCI president forcing Mr. Jethi to issue a letter to the CBI with contents that he had not agreed to, and when he expressed his inability to do so, he was "harassed". Dr. Mehta also referred to the MCI inaction against irregular appointments made in the MCI on the basis of fake documents and other irregularities pointed out by the CVO (Ramachandran, 2014).
>
> "The situation is getting worse and the MCI president is using all pressure tactics for destabilising the functioning of the vigilance division. I am feeling scared as I am fighting alone against corruption in MCI against the wishes of strong lobby in their premises, among their employees without any support," (Ray, 2014).

This clearly reflects the kind of lobby and the way in which power plays.

Unethical Practices:

In response to a complaint that a doctor was present for an MCI inspection in a medical college other than the one in which he was employed, the MCI's ethics committee noted:

> "The Ethics Committee feels that Dr *** was forced by the management of Basaveswara Medical College & Hospital, Chitragurga to attend the MCI inspection on 1.6.2005... It is very clear that the college has taken advantage of his inexperience and helplessness to force him to face MCI inspection. "...Such behaviour of the college towards medical teachers is highly objectionable and deserved to be condemned... Therefore, Ethics Committee decided to absolve him (Dr ***) from the charge of serving simultaneously in two medical colleges. The matter may be treated as closed." (11) What action did the Medical Council of India take against the management of Basaveswara Medical College and Hospital, Chitragurga for behaviour that was "highly objectionable and deserved to be condemned"? (Pandya, 2009)

The newly constituted MCI has stated

> "The MCI was constituted as a recommendatory body to the central government and the government has usually accepted the

> recommendations of the MCI. However, in 2003, the central government went against its recommendations, and gave permission to four colleges in Andhra Pradesh to increase the number of seats. The Supreme Court censured the central government for bypassing the MCI and restrained it from granting further permission to any other college without the recommendation of the MCI" (Madhavan and Manghnani, 2006).
>
> "A letter written to the CBI by the Joint Secretary in the Ministry of Health and former CVO, Dr Vishwas Mehta acknowledges that the Chattisgarh Nagrik Sangharsh Samiti, Raipur had also written to the health ministry alleging that the MCI was granting seats to private medical colleges for money, while reducing seats in other medical colleges without basis. The Samiti also referred to the involvement of the MCI with mafia groups" (Bhattacharya, 2014)[90].

Thus, the above issues highlighted in the chapter clearly points out how the MCI has been unable to perform its main function of regulating medical education. The unethical and corruption practices prevent the MCI to implement its rules in a proper and an effective manner. This has serious implications in the quality and standards of medical education in the country. The next chapter will provide an analysis of the entire study.

[90] The PBT has obtained a letter written by Joint Secretary Dr. Vishwas Mehta an IAS and CVO of Ministry of Health and Family Welfare to the CBI. See the link http://www.pbtindia.com/wp-content/uploads/2014/10/MCI-Corruption-CVO-Harrasment-Oct-2014.pdf as accessed on 5th July 2015

Chapter-VII

Socio-Political Determinants of Private Medical Colleges and Inequities in Access: An Analysis

> "*The capitation fee brings to the fore a clear class bias. It enable the rich to take admission whereas the poor has to withdraw due to financial inability. A poor student with better merit cannot get admission because he has no money whereas the rich can purchase the admission. Such a treatment is patently unreasonably, unfair and unjust"* (Supreme Court Judgment, 1992, p.4).

This chapter seeks to analyse the growth, distribution and determinants of private medical colleges in India. Employing a political economy perspective it seeks to explain the above and highlights the socio-economic processes by focussing on two high growth states – Maharashtra and Karnataka. This analysis is important in order to underline its contribution to planning for human resources in health. The availability, distribution, accessibility and affordability and quality of medical education is being discussed in the context of the growth of private medical colleges. It analyses the role of medical council of India as a regulatory body and its corruption. Finally, it discusses the implication of these trends for medical practice and public health.

Medical education is one of the important sub-systems of the health service system. The evolution of the health service system and especially medical education is influenced by history, social, political and economic factors and the role of this sub-system is very critical for human resource planning and the overall functioning of the health service system. Given the fact that India has opted for highly doctor centric model of health service system, the availability and distribution of allopathic doctors is extremely critical for the functioning of the health service system.

Importance of Human Resources in Health:-

It is hard to achieve the health status of the population without having adequate number of qualified health workers in place. The availability of human resources becomes a critical concern to provide quality health services to the people. Even to achieve Universal Health Care (UHC) which is defined, as access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access (coverage) (WHO 2005), we need fair distribution and availability of health care professionals (Hazarika, 2013). Also, the Millennium Development Goals of reducing child mortality and achieving better maternal health largely depend on the availability of qualified health workers at the primary, secondary and tertiary levels of care (Behera and Na-Nongkhai, 2014; Nandan and Agarwal, 2012).

Even though there are large number of medical, nursing and dental colleges in India, there is a scarcity of human resources in public health services. This is particularly acute in rural, remote and underserved areas. Studies have shown this scarcity of health workforce (Rao, et al, 2009; Rao et al, 2012; Rao et al, 2011; GOI, 2010, GOI, 2015) and it is a challenge to achieve better health outcomes of the population (Berman, et al, 2009; Behera and Na-nongkhai, 2014). Moreover, it is important that the human resources should be evenly distributed as many studies have shown that the health workforce in India is highly unevenly distributed (Rao, et al., 2009; Rao, et al., 2012; GOI, 2010; Nandan, et al. 2007).

So in this context, availability and accessibility of health workforce becomes a major concern for health service planning. Availability of the full compliment of personnel is critical for the functioning of health institutions. In turn, the utilisation of services is dependent on its functionality. In case of educational institutions that are privately owned, both financial and social accessibility becomes an issue. Since private institutions demand capitation fee and have management quotas, then social accessibility may not follow the principles of inclusion.

It is also important to understand that human resource policy for doctors is dependent on what kind of a health service system that we vision. So even the Parliamentary Standing Committee Report of Medical Council of India (2016) while it recommends that we need numbers of medical colleges to fill the gap of human resources in health,

one may question whether we required such a doctor dependent model at all. There are other models which are led by nurse practitioners at the primary and secondary level care.

Availability and Distribution:

The chapter-II had examined the availability of medical institutions both in the public and private sector and its distribution across states. It is specifically looking at the overall availability of medical institutions for training MBBS doctors. India has largest number of medical colleges in the world. However, at the national level, we found that more than half the medical colleges are in the private sector. The share of public medical colleges is 48.5 percent as against 51.4 percent in the private sector (MCI, 2016). We find a significant involvement of the Indian state in establishing medical colleges till the 1970s. This trend changed, however, with the emergence of private medical colleges that received a boost during the early 1980s. As far as distribution is concerned, these colleges are unevenly distributed. They are mainly concentrated in the southern and western parts of India. The states which are relatively developed witnessed a large number of private medical colleges. Even government medical colleges are relatively less mal-distributed, but a higher proportion are in the south and western part of India[91].

An in-depth analysis of medical colleges at the state level provides a similar picture to that of the national level. Karnataka and Maharashtra have the largest proportion of medical colleges in India. The share of private medical colleges in both these states is more than fifty-five percent. The distribution of medical colleges within these states is highly uneven. The districts which are relatively developed have a large number of medical colleges.

The data shows that even the government medical colleges are unevenly distributed, and a relatively large proportion of government medical colleges were concentrated in the southern zone (up to 1970). During the post 1980's the government medical colleges are unevenly distributed. A large proportion of government medical colleges are concentrated in the southern and western zones of India. The private medical colleges also follow the same pattern as the government medical colleges.

[91] Chapter three have elaborated on this aspect. Please see chapter three.

This uneven distribution raise serious concern for human resources planning. The planning process should have played a pro-active role to correct the mal-distribution of government medical colleges. However, what is happening is that the unregulated growth of the private sector has only exacerbated the inequities in the distribution. We find that there is a clustering of medical colleges and states which have a relatively higher number of government medical colleges also have private medical colleges. Thereby skewing the availability of medical colleges and creating divisions between and within states. This clearly shows the gap in health service planning and the lacuna in planning for medical education in the country.

The important issues that need to be addressed is whether the available medical colleges are really enough for the supply of doctors to provide health services to the vast population. The Parliamentary Standing Committee Report on MCI (2016) recommends the establishment of more medical colleges to bridge the gap in the existing doctor population ratio (GOI, 2016).

The present state of existing medical colleges, shows the uneven quality of medical education. This is due to shortage of faculty, the lack of professional ethics of doctors, which has led to the deterioration of medical education (Gadre and Shukla, 2016, Ananthakrishnan, 2010; Chaudhury, 2008, Choudhury, 2016; Rao, et al. 2011). The erosion of professional ethics of doctors is a serious concern for quality of medical education. The current malpractice in the profession such as unnecessary tests for fulfilling the targets of the hospital, the strong lobby between the doctors, pharmacists and corporate hospitals results undermining of patient interest. Due to growing malpractice there is lack of trust between doctors and patients. Hence the training of medical students becomes most critical part in improving the professional ethics among the medical graduates who are going to be future doctors.

Accessibility:

From the interviews conducted in Maharashtra and Karnataka it is apparent that the private medical colleges have given an opportunity for students who could not get admission in government medical colleges. The high concentration of medical colleges in the southern and western region is due to the investments done by the private sector. The private investment in the north and central region is a relatively recent phenomenon.

It is important to study who gets access to these private medical colleges. The clustering of private medical colleges are in the southern and western zones means that the students from these states have relatively higher chances of getting admission. There is much evidence which shows that the students from north and central part of India, who were unable to get admission in the respective states, and those who can afford to pay huge amounts of money are going to the southern and western states to study medicine[92].

There is a gap in the fee structure between government colleges, private medical colleges, and deemed universities. The fee structure (apart from capitation fee) in private medical colleges is five to six times higher and in deemed universities, it is ten to eleven times higher than the government medical colleges[93]. The students who are unable to get admission in government medical colleges have to rely on these private medical colleges and deemed universities. Here the ability to pay such huge amount of money determines who can apply to private medical colleges. Capitation fee is adding to the problem of accessibility to study medicine, even though efforts to ban capitation fee through various court judgments have been ineffective.

We have seen that there is a complex interaction around the caste, class and political power in the emergence of private medical colleges in Maharashtra and Karnataka. It shows that the rise of dominant caste due to certain reasons has come to play an important role. Prominent among them is the anti-Brahmin movement in Maharashtra, which paved the way for the upliftment of lower sections of the society as well as growing assertions for political power and early realisation of the importance of education for caste members which led to the emergence of intermediate dominant caste in the state. In the case of Maharashtra and Karnataka, history shows that members of dominant caste invested in educational institutions and hostels during the early twentieth century. Education was seen as one of the important means for their social mobility. This dominant caste mostly belonged to the rich landed communities. In the case of Maharashtra, it is the Maratha-Kunbi caste cluster and in Karnataka, it is the Vokkaliga and Lingayat communities. This rich peasant caste prominently

[92] Interview conducted in Maharashtra have reflected on the students coming from UP, Bihar, Haryana etc. It is also pointed out that the parents from north side come with the bulk of amount and pay for their children education

[93] The analysis of fee structure is based on the information collected in Maharashtra and Karnataka. It may differ from state to state.

emerged in independence period and after the green revolution, the income generated through agriculture and agricultural activities have been diversified in the range of commercial activities. In Maharashtra and Karnataka, investment in establishing private medical colleges is mostly done by these dominant caste members. This investment is partly done from the surpluses from agricultural activities. The representation of these dominant castes in state politics have given them the power to establish private medical colleges.

Why did these dominant castes invest in private medical colleges? It is very clear that investing in private colleges has seen as one of the channels for economic gain as well as it increases the prestige and power in the society (Kaul, 1993). Secondly, it is easy for the dominant castes to invest in private colleges by mobilising their political and social networks. Several of these dominant castes had occupied positions of Member of Legislative Assembly, Chief Minister and Member of Parliament. Many of the private medical college are owned by ministers of the state. Thirdly the kind of economic strength they acquired over a period of time provided the possibilities for investment. Fourthly, it might be the case that because of reservation policies the children from their caste do not have opportunity to access professional education. Hence, in order to expand opportunities for professional education they established medical colleges. One would agree with Kaul (1993) who concluded that the dominant castes set up these colleges to widen educational opportunities for their caste members (Kaul, 1993, p.242).

Data on ownership of medical college's shows that the proportion of 'for-profit' is very small because any higher educational institution can only be set up as a trust or society (Sudarshan and Subramanian, 2013). However, it is important to understand that even though educational institutions set up under the trust or society and the motive is not-for-profit yet it can become commercialised one (ibid).

Why Variations?

In this study at the larger level, we mapped the growth, time trend analysis and distribution of medical colleges at India level and then focused upon the Maharashtra and Karnataka state. In order to explain the variations and distribution, we adopted a political-economy approach in order to understand how history, social and economic factors are determinants of why this pattern of growth. It is specifically looking at the

specificities of the socio-political and historical factors and the way in which the caste, class and political power reflects in this pattern of growth.

Karnataka and Maharashtra:

The growth, time trend analysis and spatial distribution of medical colleges of Maharashtra and Karnataka match with the national level trends. It shows the uneven distribution. The districts which are relatively developed and rich have a high number of medical colleges as compared to the districts which are less developed. The number of private medical colleges varies across districts, and there are some districts have a high number of colleges compared to others. The majority of them are located in urban areas than the rural.

Social, Economic, and Political Background of the Owners reflects that most of the owners of private medical colleges belong to the dominant caste specifically Maratha-kunbi caste cluster in Maharashtra and Vokkaliga and Lingayat in Karnataka. These communities belonged to the agricultural peasant caste along with this they dominated in the powerful political positions in the state.

Medical colleges in Maharashtra and Karnataka, especially the private colleges, reveals the inevitability of their inequitable distribution and skewed towards urban and economically developed areas. Private colleges emerged as a tool for wealth generation through diversification of capital produced either in the agriculture or agriculture-related industry, business or religious organisations.

Contrast:

There is not one pattern we see in this phenomenon of growth of private medical colleges in Karnataka and Maharashtra. Both these states offer a very interesting contrast. Though these two states have a large number of private medical colleges they do represent the different social history and the growth of private medical colleges, have had different trajectories.

Growth of private medical colleges:

Growth pattern in Maharashtra shows that the growth of private medical college did take place after 1980. As there were only two private medical colleges before 1980. However after 1980 there was a huge expansion in the private medical colleges as it established ten new private medical colleges as against only one in earlier decades.

Whereas, the emergence of private medical colleges in Karnataka did take place in the period of 1950-60 and in the later period there is the continuous growth of private medical colleges.

This difference is that the growth of private medical colleges in Maharashtra took place after 1980 as it witnessed the success of private medical colleges in the neighbouring state of Karnataka. Secondly, it is being realized that the money is going to the neighbouring state as most of the students who could not get the opportunity to study medical education in the state started going to the neighbouring state of Karnataka. Hence state started promoting initiation of private medical colleges in the state. Particularly when Vasantdada Patil was the Chief Minister of Maharashtra in 1984, who promoted the private investment in higher education especially in medical and engineering education (Dahiwale, 1995; Kapoor, 1984; Singh, 2014)[94]. Despite agitations against the setting up of private medical colleges, the state government promoted private investment. A newspaper article highlighted this by stating that "Chief Minister Vasantdada Patil is in no mood to compromise. He feels that if the state did not sanction private medical colleges, Maharashtra's talent, and money would just go across the border to the capitation colleges of Karnataka" (Kapoor, 1984).[95] Moreover, the investment in higher professional education has the possibility of wealth generation and along with this, it increases the prestige and political power in the society (Kaul, 1993; Singh, 2014).[96] The larger neo-liberal policies after 1990's had an impact on the growth of private medical colleges in Maharashtra. Lack of expansion of the public sector since 1970's was an important reason for private investment.

Emergence of Dominant Caste:

In Maharashtra, there is a history of the anti-Brahmin movement which brought social reforms and the emancipation of lower socio-economic sections of the society. However, there was a shift in the anti-Brahmin movement from social reforms to gain

[94] See the website http://www.dypatilpolytechnic.ac.in/dypg-rait.html as accessed on 15th July 2016.
[95] Kapoor, C. (1984, August 15). The College Craze. *India Today*. Retrieved from http://indiatoday.intoday.in/story/maharashtra-government-decision-to-give-clearance-to-three-new-private-medical-colleges-raises-a-storm-of-protest/1/360927.html as accessed on 15th October 2015.
[96] Singh, G. (8th November 2014). Maharashtra's Educational Barons. *Business World*. As available on http://businessworld.in/article/Maharashtra-s-Education-Barons/08-11-2014-66314/ as accessed on 26th May 2015.

and struggle for political power in the early 20th century. This led to the rise of the Maratha caste and the peasantry (Pol, 2008). In Maharashtra, the peasant class comprised of the Maratha-Kunbi caste-cluster which was numerically strong. To acquire political power and to retain it in the Congress dominated State, they projected themselves as one (Deshpande, 2004).

We have seen that this combine in Maharashtra have large investments in private medical colleges as well as they are the ones who owns other professional medical colleges such as engineering, nursing, dental, MBA, etc. As contrast Karnataka does not have the history of Anti-Brahmin Movement. However, there is an existence of dominant caste of Lingayat and Vokkaliga.

In Karnataka along with dominant caste of Lingayat and Vokkaliga, there is another community representations in establishing private medical colleges such as Brahmin, OBC, SC whereas, in Maharashtra, there is less representation from other communities in establishing private medical colleges other than Maratha-Kunbi cluster.

Source of Capital:

There is a contrast in the source of capital in Maharashtra and Karnataka. In the case of Maharashtra, we have seen that there is a close relation between the sugar co-operative sector and the private medical colleges. The co-operative sector in Maharashtra was the base of rural industries, mainly sugar. This has been one of the important means to acquire political power and has been controlled by the dominant caste cluster of the Maratha-Kunbis. The initial capital came from these sugar co-operative societies to invest in private colleges, as most of the owners of these cast based medical colleges have a strong hold on sugar co-operatives. One of the examples of this is Dr. Patangrao Kadam, who is a powerful political figure in Maharashtra. Before he became as MLA in 1985, he had launched three co-operative societies in Maharashtra. Now he has Deemed University in which there are two medical colleges, one is in Sangali, and another is in Pune. Apart from private medical colleges, under this deemed university there are 12 educational units and the trust runs more than 78 schools and 60 higher professional educational institutions[97].

[97] Bharati Vidyapeeth University http://www.bharatividyapeeth.edu/default.htm as accessed on 15th June 2014.

Whereas in Karnataka, the picture is different where we see the prominence of religious Mutts in education. The close relationship between private medical colleges and the religious Mutt's is reflected upon the name of the some of the private medical colleges. There ten private medical colleges in Karnataka, which have close associations with religious Mutts as these college founders or the trust founders, are religious guru's, and mostly these belong to either Lingayat's or Vokkaliga communities Mutts. These two communities are very successful agricultural communities but the money never been invested to set up something like co-operative society. However, the money is being kept within themselves through the idea of religious Mutts. So they donated this money to religious Mutts for the betterment of their own community. These religious Mutts played a very important role in providing education or establishing educational institutions for their own and upliftment and social mobility. As pointed out by Kaul (2000), that the community and caste colleges are often supported by religious leaders and their Mutts. These served as important vote banks for caste leaders (Kaul, 2000, p.3).

Influence of the Dominant Caste Communities on State Intervention:

The historical Maratha- Kunbi caste alliance that holds political power in Maharashtra till today, makes it easy for the moneyed of these castes to influence and interfere with policy implementation. State investments are often determined according to their conveniences as it is evident from the spread of state medical colleges in Maharashtra. Though less mal-distributed, the government medical colleges are also set up without consideration for the deserving areas. Thus we find an urban concentration of government medical colleges and the neglect of more needy districts.

As we have seen in Karnataka, state investments in establishing medical colleges have been very minimal. For 44 (from 1962-2005) years there was no single medical college established by the state government as against in these 44 years of span there were 26 new medical colleges were established by the private sector. There was only twelve government medical college till 2014 and that too only in 2015 three new government medical colleges were established.

The reasons behind this that the state had very limited resources and hence promoted the private investment[98]. Here it reflects the influence of the dominant caste community members in establishing private medical colleges and withdrawal of state role.

Issue of Reservation Policy:

It is known that each state has its own reservation policy and specific quota requirements such as Tamil Nadu has 69 per cent reservation, Maharashtra has 52 per cent while Karnataka, Andhra Pradesh, and Telangana have 50 per cent reservation (Ishaqui, 2016). In the study, there is ambiguity whether the reservation policy is implemented or not in all private medical colleges. In Karnataka few of the non-minority private medical colleges 40 percent and in minority institutions 25 percent seats are government quota seats. In Maharashtra 25 per cent seats are government quota seats in private medical colleges however it is not clear whether it is applicable to all private medical colleges or not [99]. In Karnataka, four deemed universities have government quota seats, but it's very less than the non-minority and minority private medical colleges. In Karnataka, there is a total of eleven (four deemed universities and seven private medical colleges) private medical colleges do not have government quota seats. In Maharashtra deemed universities does not have government seats.

So, there is ambiguity regarding reservation policy in private medical colleges because not all private medical have government quota seats. Those private medical colleges who havegovernment quota seats they do implement the reservation policy within the government quota which is relatively very low. However, we are unable to find out the reasons behind this ambiguity of some private medical colleges have government quota seats and some are not. The deemed universities are autonomous and therefore have their own admission policy. Hence the deemed universities do not implement any reservation policy.

Studies on social composition of doctors' show that majority of students belong to the upper strata of society. A study conducted by Ramalingaswami (1985) shows that a

[98] Interviews conducted in Karnataka showed that there is no any clarity on why the state has not established medical college for 44 years. Some reasons put forwarded that the state had no adequate financial resources to start medical colleges. Another reason put forwarded that if the private sector is ready to invest in medical colleges then state promoted such investment.

[99] The data is obtained from Directorate of medical education department from respective states however could not get the information for all medical colleges as well as reservation policy.

large number of students belong to the upper middle class with having a lower proportion of students from middle class. Even the educational and income background of the parents are indicative of middle and upper strata of the society. It shows that the immediate beneficiaries of medical education are the middle and upper-class strata of society (Ramalingaswami, 1985, p.12).

Caste background of the medical doctors in a selected study population reveals that 36 percent belonged to the upper caste whereas only 9.48 percent belong to SC/ST population. It also pointed out that the percentage of doctors belonging to SC and ST categories was more in the government hospital than in the private hospital. The study shows that the parental background of the doctors was highly educated, and a significant number of doctors had parents from medical practitioner background. They were either from government servants (such as IPS, class I and II officers, etc.) or were professionals or businessmen/self-employed (Kakade, 2003, pp.137-142)[100]. Similarly, Baru (2010) pointed out the overview of the social background of doctors and mentions that before independence most of the medical doctors belonged to the upper-caste and upper-class sections of the society. However by 1970 there was a mixed picture of representation from the different backgrounds in medical education due to the affirmative action policies for marginalized sections of the society. However, in southern and western regions due to the growth of private medical colleges largely the new middle class gained access to medical education (Baru, 2010, p.86). The socio-economic background of the students from private colleges does reflect that most of the student's parents belong to the rich or middle-level farmers as well as owners of business or run an industry. Even some belong to the professional or bureaucrats salaried jobs (Kaul, 1993).

In this context, the question of affirmative action policies in private and deemed universities gets exempted thereby the students from lower socio-economic background have less access to the medical education. They have to compete only in the government medical colleges and in the government quota seats. The quota in private medical colleges which is very low. Therefore it raises a serious concern

[100] The study is conducted in two hospitals in Bombay, one was public and the other was in private. There were total of 116 medical doctor respondents in the study (66 from government sector and 50 from private sector), out of which 36 percent belong to upper caste. It is interesting to note that 31 percent of the respondents did not mentioned their caste background this partly because they might be hesitant to reveal their low caste status (Kakade, 2003).

regarding access to medical education. The growth of private medical colleges has this characteristic of, those who have money can buy medical education. If this growth would have been in the government sector, then the whole picture would have been different in terms of medical doctors as well as for public health system.

Implications for Quality of Medical Education:

The study's main focus was not studying the quality of medical education. However, there are many pieces of evidence in the literature and few interviews which have reflected upon the quality of medical education in India. There are many determinants that hampers the quality of medical education.

***Faculty Strength and Infrastructure*:**

The number of medical colleges has increased specifically private; the simultaneous process would have been to increase the number of faculties to provide quality training which in fact, is not the case. However, there was no such plan or policy to increase the number of trained faculty. Hence there is an acute shortage of faculty to train the undergraduate and postgraduate medical students. The shortage affects both the government and private medical colleges. The parliamentary standing committee report on MCI (2016) has mentioned that there is approximately 30 to 35 percent or even more shortage of faculty in medical colleges (GOI, 2016).

It is also evident that on a temporary basis the faculties have been transferred from one government medical colleges to another government medical college at the time of MCI inspection. Such kind of malpractices have a bearing upon teaching in medical education and as well as increases the burden on the faculty (GOI, 2016)[101]. Moreover, in private medical colleges showing fake faculties, salary slips and patients are examples of malpractices which raises a serious concern about the kind of quality of medical education and medical ethics that is being provided in these private medical colleges.

Parliamentary Standing Committee Report on MCI (2016) mentions that keeping fake rolls of medical teachers and showing expenditure under the salary head is a common

[101] This is a personal experience shared by a faculty member who was teaching in government medical college and then transferred to another government medical college. Now she is teaching in private medical college.

tactic adopted by managements of private medical colleges (GOI, 2016:52). It is being found from interviews and MCI records which show that 'some private colleges solve the problem by cheating – they recruit doctors to pose as full--time faculty members during government inspections. The physicians work there for just a few days or weeks. Two MCI officials estimated that there are several hundred Indian companies involved in recruiting them' (Macaskill, Stecklow, and Miglani, 2015)[102].

Another important issue is to have adequate infrastructure in place to provide quality of education. However, there are many reports which claim the lack of infrastructure have bearing upon the quality of medical education (GOI, 2016; Pathak, 2014). It is important to have well equipped teaching hospitals attached to the medical colleges before the admissions. There are some colleges that initially started without a teaching hospital attached or proper infrastructure[103]. Even today there are many colleges both public and private have these deficiencies and it is being pointed out by the investigations done by the Reuters that there are numerous deficiencies, including a shortage of faculty, residents and lecture theaters (Macaskill, Stecklow, and Miglani, 2015)[104].

It is also mentioned in a newspaper article that in the period of 1984 there were three new private medical colleges were given clearance from the state government of Maharashtra[105].

> "Both the Pravara and Krishna trusts have no college or hostel buildings. At Pravara some of the hospital wards have been cleared out to accommodate classrooms and at Loni temporary barracks have been built for hostels. Though the Medical Council of India (MCI) lays down a requirement of one professor for 10 students and a much higher ratio of lecturers, the Krishna Medical Centre has at present only three professors and two lecturers and the Pravara trust college only three professors. The

[102] Macaskill, A.; Stecklow, S. and Miglani, S. (2015, June 16). Broken Health: Rampant Fraud at Medical Schools Leaves Indian Healthcare In Crisis. *Reuters Investigation*. Retrieved from http://www.reuters.com/investigates/special-report/india-medicine-education/ as accessed on 15th June 2016.

[103] This has also been reflected in an interview conducted in Karanataka

[104] Macaskill, A.; Stecklow, S. and Miglani, S. (2015, June 16). ibid

[105] In the period of 1984 there were three private medical colleges were permitted one was Pravara Medical Trust in Loni, second Krishna Medical Centre, Karad, and the third was Shivaji Shikshan Sansthan in Amravati.

> third institution granted permission, the Shivaji Shikshan Sansthan, does not even have a hospital of its own. Remarked Dr R.K. Gandhi, dean of the faculty of medicine, Bombay University, and an executive member of the MCI: "The only department in these colleges which is well staffed is the accounts section, which is all set to collect Rs. 2 crore within the next two weeks" (Kapoor, 1984)[106].

Today Pravara medical college and Krishna Medical Colleges comes under deemed universities and all these three colleges considered as one among the reputed and established colleges in Maharashtra. Here comes the issue of old and new medical colleges as it pointed out in an interview that old private medical college which was established in the period of 1980's and before are reputed one in today's context. Such as in Karnataka, Kasturba Medical College Manipal, and Mangalore; M. S. Ramaiah Medical College, Bangalore, Jawaharlal Nehru Medical College, Belgaum, etc. are considered as one among the best of medical colleges.

In an interview conducted with the director of AIIMS Bhubaneshwar, Prof A. K. Mahapatra has pointed out that only 20 percent of India's medical colleges are doing really good, there are many colleges that are not even at the optimal level as they lack infrastructure and faculty, so we have to work towards raising their levels (Anand, 2016b, p.85)

In this context, it is important to mention that private medical colleges are not a homogenous category, and it have variations.

Clinical Exposure:

There is growing concern about the quality of clinical exposure that students get from government and private medical colleges. The students from some newer private medical colleges are lacking in the clinical exposure.[107] Majority of the private

[106] Kapoor, C. (1984, August 15). The College Craze. *India Today*. Retrieved from http://indiatoday.intoday.in/story/maharashtra-government-decision-to-give-clearance-to-three-new-private-medical-colleges-raises-a-storm-of-protest/1/360927.html as accessed on 15th October 2015.

[107] It is based on few interviews conducted in Maharashtra and Karnataka as few of them pointed out that the colleges which are established ones are in good reputation and have enough patient load. So few of the private medical college's students do get enough clinical exposure. But it has to be further explored whether the students do feel that they are getting enough exposure. However the interviews conducted with students some of them reflected that they do not get clinical exposure in the way the government students get.

medical college students do not get the required clinical exposure and hands on experience. There is much evidence which shows that at the time of MCI inspection these private medical college show healthy individuals as patients in their ward. Investigations done by Reuters on medical education found that to demonstrate that the teaching hospitals has enough patients for clinical training they round up healthy people to pretend they are sick. (Macaskill, Stecklow, and Miglani, 2015; GOI, 2016).[108]

A senior gynaecologist observed:

> "Nowadays the practice of putting a stitch at the mouth of the uterus has increased a lot. There is an important reason for this: this is what is taught in certain private medical colleges. In these colleges, students only learn how to read a sonography report, not how to examine a patient. In a private medical college 20-25 caesareans take place in a month. There are only three to four normal deliveries. These doctors have little knowledge about normal deliveries. They quickly get scared and perform a caesarean" (Gadre and Shukla, 2016, p.70).

This is why many times doctors and students[109] say that the government doctors are more experienced, and that the students from government medical colleges get a chance to examine a larger number of patients. Another important aspect of clinical training is the variety of cases that you get to examine. It is basically that the clinical acumen is not only based on the theoretical learning but the actual practical learning. The teacher gets the team of students in the hospital and teaches or explains the cases. This gives the student a chance to observe the cases. The students can then examine patients under the supervision of their teachers. These are things which are at most important to have clinical exposure in the hospital settings.

So it is important to raise certain issues such as if the students in their training are not able to get enough clinical exposure then what would be the quality of their practice

[108] Macaskill, A.; Stecklow, S. and Miglani, S. (2015, June 16). Broken Health: Rampant Fraud at Medical Schools Leaves Indian Healthcare In Crisis. *Reuters Investigation*. Retrieved from http://www.reuters.com/investigates/special-report/india-medicine-education/ as accessed on 15th June 2016.

[109] Interviews conducted with the students have mentioned that they don't have so much of patient load which government medical college has.

after graduating as MBBS doctors? A poorly trained doctor is a high risk for the patients' health and life. So, in this case, it is pertinent to point out that for human resource planning both quantity and quality are equally important. The basic doctor is expected to diagnose common ailments and treat the patient without referring to a specialist, perform normal deliveries, etc. However, medical doctors do not have the confidence to practice independently after their MBBS training and there is no guarantee that they will do the correct diagnosis. In a study conducted among doctors in Madhya Pradesh, found that there is hardly any differences between the trained and untrained doctors in adherence to clinical checklists. It mentions that 'correct diagnoses were rare and incorrect treatments were widely prescribed.' It concluded that 'training in and of itself is not a guarantor of high quality' (Das, et al. 2012:2774).

Capitation Fee, Fee Structure, and Corruption:

As mentioned above that the fee structure in private medical colleges is higher than the government. It is known that both the management quota and NRI quota are filled up with the capitation fee. It can be argued that through this manner merit is compromised by money. "With an increasing number of candidates paying to get into medicine, merit has taken a back seat," argues Samiran Nundy, chairman of the department of surgical gastroenterology and organ transplantation at Sir Ganga Ram Hospital, Delhi. "As a result, the overall quality of graduates is very poor" (D'Silva, 2015:2).

When medical education becomes a revenue earner then it fuels commercialisation of health services. In order to recover the high capitation fees graduates of these private medical colleges often have to either set up their own practice, join family practices or employees in private nursing homes and hospitals. It is also seen that demanding a large at the time of marriage is also a way of recovering huge capitation fees (Tilak, 1992; Sengupta, 2011[110]; Baseerat, 2012[111])[112].

[110] Sengupta, D. (25th December 2011). Show Me the Money, I Have a Seat. *Economic Times*, Bangalore. Retrieved from http://epaper.timesofindia.com/Default/Layout/Includes/ETNEW/ArtWin.asp?From=Archive&Source=Page&Skin=ETNEW&BaseHref=ETBG%2F2011%2F12%2F25&ViewMode=HTML&EntityId=Ar01400&AppName=1 as accessed on 25th May 2016.

If such mal-practices are taking place at the level of education then what kind of values and ethics that we are giving to the students who are the future of India's health service system.

It is evident that corrupt practices at different levels takes place in both the government and private medical colleges. these include issuing essentiality certificate, at the time of MCI inspection, passing entrance exams, subject wise money for **'not to fail amount',** impersonation, getting degree certificate, etc[113].

In a recent newspaper article, it has been reported that India is the second number in the list of education sector for 'Black Money' generation. This is due to the capitation fees that is being charged in professional educational colleges. It pointed out that around 66, 144 corer paid as capitation fees in professional colleges during the last year (Subramaniam, 2014). Similarly, the role of middle man or agent in professional higher education for providing a seat in private colleges is another added issue in the industry. These agents charge a commission from the college as well as from the students for providing a seat in private colleges. A story of an agent who is native to Bihar, came to Bangalore in 1994 to study but now is working as an agent (from 2001) in Bangalore. He developed this industry in such a way that he places around 275 students every year by charging one lakh rupees from each of them (Sengupta, 2011)[114]. "Corruption traps millions of people in poverty, perpetuates the existing inequalities in income and health, drains the available resources, undermines people's access to healthcare, increases the costs of patient care and, by setting up a vicious cycle, contributes to ill health and suffering" (Chattopadhyay, 2013, p.153). The corruption has become institutionalised and ethical conduct as an exception in which the patient are the most sufferers (Rao, 2016).

A bill has been introduced in both the houses on The Prohibition of Unfair Practices in Technical Educational Institutions, Medical Educational Institutions and University Bill, 2010 to curb the unethical practices that are prevalent in professional higher

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[111] Baseerat, B. (2012 July 15). The Reality Behind Rising Number of Women Medicos in Andhra Pradesh. *The Times of India*, Hyderabad. Retrieved from http://timesofindia.indiatimes.com/city/hyderabad/The-reality-behind-rising-number-of-women-medicos-in-Andhra-Pradesh/articleshow/14921163.cms as accessed on 25th May 2016

[112] This fact is also pointed out in one of the interview conducted in Karnataka.

[113] Interview conducted in Karnataka from one of the Lok Ayukta member who have elaborated on corruption in medical colleges and health services.

[114] Sengupta, D. (2011). ibid

education (Sanyal, 2010)[115]. However, even though the bill is presented in both the houses, it has not been followed up later. What would explain this? It is a collusion of powerful lobbies in the center and state levels (Baru and Diwate, 2015), which plays an important role to prevent such kind of initiatives which might be harmful to their existance.

The Supreme Court Judgement on the Rohilkhand Medical College & Hospital, Bareilly vs. MCI, 2013 clearly pointed out that…

> "Mushrooming of a large number of medical, engineering, nursing and pharmaceutical colleges, which has definitely affected the quality of education in this country, especially in the medical field which calls for serious introspection. Private medical educational institutions are always demanding more number of seats in their colleges even though many of them have no sufficient infrastructural facilities, clinical materials, faculty members, etc. Reports appear in every now and then that many of the private institutions which are conducting medical colleges are demanding lakhs and sometimes crores of rupees for MBBS and for post-graduate admission in their respective colleges. Recently, it is reported that few MBBS seats were sold in private colleges of Chennai. We cannot lose sight of the fact that these things are happening in our country irrespective of the constitutional pronouncements by this Court in TMA Pai Foundation that there shall not be any profiteering or acceptance of capitation fee etc. Central Government, Ministry of Health and Family Welfare, Central Bureau of Investigation or the Intelligence Wing have to take effective steps to undo such unethical practices or else self-financing institutions will turn to be students financing institutions" (Rohilkhand Medical College & Hospital, Bareilly versus Medical Council of India, 2013, pp.34-35).

It is the prime responsibility of the central government and state government to regulate availability accessibility and quality of medical education as well as unethical practices however there is a lacuna in the part of these institutions.

Medical Council of India as Regulatory Body:

As we have seen (in chapter-6), Medical Council of India is a statutory regulatory body for medical education in India. Its main functions are to recognise medical

[115] Sanyal, K. (2010). The Prohibition of Unfair Practices in Technical Educational Institutions, Medical Educational Institutions and University Bill, 2010. *PRS Legislative Research*. Centre for Policy Research: New Delhi.

colleges, maintenance of uniform standards of medical education, recognise medical degrees and regulate professional conduct. During the last one and half decades this body came under criticism for corruption, lack of transparency, and lack in implementing its rules and regulations. Scholars have argued that "the MCI and the State Medical Councils play an important role in setting and implementing guidelines for the curriculum, entrance exams, ethical standards and practices of doctors. However, in practice, the MCI has reneged on its responsibility to enforce standards. It has been widely reported that an important reason for this failure was the deep-seated corruption in the MCI over which Dr. Ketan Desai, former council president, and members of the board presided" (Baru and Diwate, 2015). MCI as the regulatory body supposed to look at the availability and quality of medical education, however, we have seen that it lacks in its functions as the way in which the growth of medical colleges had taken place.

Why is it so? Why is the MCI unable to act? It is clearly shown in chapter-6 that it is the medical mafia at the central and state level that influences the MCI. It is the powerful lobby of senior doctors, private corporate doctor's, owners of private medical colleges, MCI functionaries and MCI inspectors who inspect medical colleges to grant permission to establish or increase medical seats in medical colleges (Sengupta, 2016)[116]. This has resulted in the poor quality of medical education and the Parliamentary Standing Committee Report on MCI (2016) has pointed out that "Due to massive failures of the MCI and lack of initiatives on the part of the Government in unleashing reforms, there is total system failure due to which the medical education system is fast sliding downwards, and quality has been hugely side-lined in the context of increasing commercialization of medical education and practice. The situation has gone far beyond the point where incremental tweaking of the existing system or piecemeal approach can give the contemplated dividends" (GOI, 2016:82).

The Report on MCI (2016) also mentioned that if in the regulatory body of MCI have people from the same profession then there are chances of a conflict of interest and corruption. As the MCI has all the members of the medical profession and a substantial number of representatives are either from private medical institutions or

[116] Sengupta, A. (16th June 2016). Reforming the Regulator: Parliamentary Committee Report on Medical Council of India. *News Click.* As available on http://newsclick.in/india/reforming-regulator-parliamentary-committee-report-medical-council-india as accessed on 1st July 2016.

private practice. Moreover, there is the dominance of specialized disciplines of surgery and medicine. This creates a conflict of interest and might influence the decisions of the MCI body. It is clearly stated that across the world, a perspective had gained ground that self-regulation alone does not work because medical associations have fiercely protected their turf and any group consisting entirely of members of the same profession is unlikely to promote and protect public interest over and above their own self-interest, and therefore check-and-balance mechanisms are required (GOI, 2016, p.23).

Baru has pointed out the importance of Parliamentary Standing Committee Report on MCI and said the committee made far-reaching recommendations, which, if implemented, is bound to transform health care delivery and medical education in the country in a big way (Anand, 2016a, p.82).

Implications for Medical Practice and Public Health:

It is very important to understand why we are really concerned about the growth of private medical colleges, its quality and its socio-political collusion in the medical educational profession. Medical education has to be considered as a special case and needs strict regulations and ethical concerns because it deals with the human being when they are most vulerable. It is because it has repercussions on the kind of medical practice that is being provided by the medical professionals. The kind of malpractice that is being practiced has been effectively reflected within the profession who pointed out that "patients are made to undergo unnecessary investigations, hospitalisations and even surgeries in cases where there may be no need for any of that. In a majority of small nursing homes, doctors own medical stores and laboratories. Unnecessary prescriptions of expensive drugs are asked to be procured with no explanation given whatsoever to patients and relatives. Nobody is interested in the concept of generic medicine" (Bawaskar, 2015)[117]. Moreover, it is also pointed out the powerful lobby between the multinational drug companies and the doctors. The drug companies do expensive gifts sometimes abroad packages to the prominent doctors who often then prescribes the drugs of that company to the patient (Bawaskar, 2014). Dr. Arun Gadre and Abhay Shukla (2016) have conducted a study and

[117] Bawaskar, H. (2015, July 1). Unethical Medical Practice in India is Rampant: Dr. Himmatrao Bawaskar. Retrieved from http://www.dnaindia.com/india/column-unethical-medical-practice-in-india-is-rampant-dr-himmatrao-bawaskar-2100559 as accessed on 15th June 2016.

collected evidence from the practising doctors from both the public and private sectors from different locations in India. They have depicted the way in which patients becomes vulnerable and get exploited by the dodgy medical doctors and hospitals in India. It exposes the different levels of corruption that is prevalent in the medical profession and the way in the practice of 'cut's does take place in this healthcare industry which makes treatment very costly for the patient. Dr. Pandav professor and head at the centre for Community Medicine, AIIMS, New Delhi, stated that "nowadays private practice is something done only to earn money, not to provide service; making more and more money, to pay the instalments on your Mercedes and for your foreign trips. That is the only purpose of private practice nowadays. Now we have moved from the Science of Health to the Science of Exploitation" (Gadre and Shukla, 2016, p.29). The professional misconduct and the medical negligence has serious adverse implications for the patient (Johari, 2014).

So in this context, it is important to understand why this unethical practice do take place? It is because the regulatory system itself fails to implement its rules and regulations and this regulatory body itself lacks in transparency (Rao, 2016). If a student who enters in medical profession introduced by the capitation fee and such malpractices, then what do we expect that the student who becomes a future doctor of the country will do?

In terms of public health, need to understand does this production of doctors really matching with the healthcare needs of the population. The medical students are more inclined to do post-graduations with super speciality and more inclined to work in the urban areas. Specialization in curative medicine, practice in urban areas and in hospital settings, and an individualistic perspective are the hallmarks of this professional enterprise. Its focus is on western technology and income-generating medical industry as a lucrative business, without consideration for social aspects of the illness or community as a whole (Antia, 1990). This orientation perpetuates disparities in the health system and creates an urban-oriented mind-set seeking specializations (GOI, 2007a). A report of the working group on medical education by the National Knowledge Commission (2007) also noted that almost all medical colleges that have been established are in urban areas, and mindset of the medical doctors are urban oriented. Their training prepares them to serve in urban areas or equips them to take further opportunities in fulfilling the specialization in their own

field. It mentions that "according to the Health Information of India (2005-6), in 2001 post-graduate degrees were awarded to 3,181 doctors in a single year but out of these only 58 were in Community Medicine" (GOI, 2007a, p.6). These maladies are only heightened in private medical colleges[118]. Evidence shows that the high growth of the private medical colleges has resulted in an increase in the cost of health care, but not in access (Joy, et al. 2007).

Even though there is a large production of medical doctors every year however there is a huge shortage of medical doctors in the public health system in India. Bulletin on rural health statistics 2010 and 2015 gives a picture about the shortage of the medical personnel in the public health system (GOI, 2010; GOI, 2015). The reasons behind the shortage of doctors in the public health systems are that most of the medical students prefer to work in the private sector in the urban areas as they can get good salary compared to the government sector. They get good opportunities to utilize their skills in the private sector because government sector often lacks basic equipment and facilities. The other reason is that they can get good living conditions which include their children's development (Raha, et al. 2009; Rao, et al. 2011). The high rate of migration to abroad is also one of the reasons for shortages in the public health system as in a retrospective cohort study in All India Institute of Medical Sciences (AIIMS) conducted by Kaushik (2008) found that around 54 percent of AIIMS graduates migrated during 1989-2000 to abroad (Kaushik, et al. 2008). Baru (2005) in shows that in AIIMS there were significant numbers of government doctors had moved into the private sector. 'Higher salaries, minimal administrative interference, availability of high technology and lighter patient load were ranked as the most important reasons for moving to private hospitals' (Baru, 2005, p.108).

It appears then that the increasing numbers of private medical colleges in several states is not a very helpful trend for UHC. Despite the large production doctors every year, there is a shortage of doctors in the public health system in India. The socio-economic and political basis of the emergence of private medical colleges as instruments of profit is the very reason why these colleges are not a solution for taking towards UHC. Their prime objective puts a question mark on their ability to contribute to resolving the crisis of access to medical care. These institutions and their

[118]Singh M.M. et al argue that private colleges tend to bring quality down by focusing on fee and capitation and corrupt practices Retrieved on 10.4.2016 http://www.bmj.com/content/350/bmj.h237/rr-3

products are not inclined to participate in expanding medical care systems. The notion that their partnership with the state can cover the unreached is highly misplaced due to the reasons discussed above. Maharashtra's Maratha-Kunbi caste cluster and Karnataka's Vokkaliga and Lingayat castes based social and political power structure, and its economic roots and vested interests, helps us to understand the intricate threads of the national political economy that supports international pressure in support of privatization of medical education specifically, and of the health sector at large. It is also evident that the interest of the private college owners is money through capitation and regular fee not necessarily the quality of education or community need. They will, therefore, fuel the medical market and not necessarily cater to the needs of partnerships for rational and affordable Universal Health Care.

Baru (2012) in the context of Universal Health Coverage points out that just statement to regulate private sector is not going to help any longer as well as it should not be seen only as a technical or administrative problem. The nexus between the different actors, different alliances of powerful lobbies including political power at the local, state, national and international level and complexities amongst it, which has major roles in private health care industry has to be taken into consideration (Baru, 2012, p.65).

A doctor who hopes for positive change wrote that "working as a physician in remote areas of Maharashtra for the last 37 years, treating life-threatening tropical emergencies without access to modern ICU gadgets, counselling grieving families and researching on rural health problems, I have many often encountered challenging and stressful situations. But my work gives me such satisfaction which money can never buy. There is still room for honesty, dedication, sincerity and devotion in this profession" (Bawaskar, 2015).

Jayaram (1987) observed

> "The system of medical education in India is not only unsuited to the medical needs of the country, but is also latently dysfunctional in its consequences. It contributes towards the perpetuation of inequality of both in status and educational opportunity, on the one hand and in medicare, on the other" (Jayaram, 1987, p.95).

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Questionnaire for Private MBBS Medical Colleges in India

1. Name of the College:

2. Year of Establishment:

3. Location of the Collage: Rural ☐ Urban ☐

4. Name of the founder of the MBBS Medical College:

_____

5. Religion and Caste background of the founder _____

6. Name of the all **Executive Board of Members** and their Caste background

Name	Education	Occupation	Religion	Caste

7. Management of the Collage? Trust ☐ Society ☐ or any other (specify) ☐

8. Under which registration act your institution is registered? Please mention the name of the act and year of the act?

9. Name of the **all Trust Members** and their Caste background (please specify the caste)

Name	Education	Occupation	Religion	Caste

10. Annual intake of students for MBBS course: ☐

11. What is the proportion of

Male: ☐ Female: ☐

12. Number of female and male candidates in the MBBS course in current batch (2012-2013)

Male: ☐ Female: ☐

13. Do majority of your students belong to any particular Religion / Caste / Economic background? (Please specify).

14. Do you have any specific quota for local candidates or candidate from other States?

Yes: ☐ No: ☐

15. If yes then please specify it:

16. Is there any management quota (Please specify in %):

17. Is there any religion quota (Please specify in %):

18. Is there any quota for religious denominations? (Please specify the religion and %)

19. Is there any caste based quota (Please specify in %):

20. Is there any NRI quota (Please specify in %):

21. Specify the fee structure of the college

22. Is there a separate fee structure for NRI students (Please specify):

23. Did your institution received government subsidy while establishment of the medical college?

    Yes: ☐ No: ☐

24. If yes what were the forms?

    a. Land

    b. Electricity

    c. Water

    d. Money

    e. Any Tax Exemptions

    f. Mention if any other

25. Is your institution currently receiving any government aid? Yes: ☐ No: ☐

26. If yes please specify how much aid do you get and in what forms?

27. Is there a hospital attached to the college? Yes: ☐ No: ☐

If yes,

A) What is the total bed Strength?

B) How many and what are the departments there in the hospital?

C) What are the services offered?

a) General

b) Specialist

Date:

Signature

Name of person----------

Designation----------

Interview Guide for Key Informants

- Personal Information
- When did the growth of medical colleges started?
- When medical colleges started to established? At what point or in which period
- In which part (Geographical area) these medical colleges started?
- When did the growth of private medical colleges started?
- Within the state in which region, private medical colleges established in large numbers?
- Why it is so ? What is the reason behind this growth?
- Why it is established in particular region?
- How the uneven distribution of medical colleges is impacting upon health system?
- Who finances these medical colleges?
- Do they get any political support?
- According to you which political party supports these institutions? Why they support?
- Who are the major actors who supports for these institutions other than political actors?
- Do you see any major community which supports or establishes these institutions?

- Do you see any political and caste alliances behind this growth of private medical colleges? If yes which are these?

- In your view what are the problems that these private medical colleges faces?

- What kind of difference do you see in government and private medical college in terms of students, quality of teaching, infrastructure, facilities, payment, team work etc?

- In what way the quality of medical education is getting suffered?

- In your opinion what are implications of this growth of private medical colleges?

- There are lots of news and cases of corruption. What is your view and opinion on this issue?

- Your view on Corruption in MCI and State medical Council and what way it is impacting upon the larger health system?

- If you know any of the private medical college history (socio-political dimension, corruption, land or any kind of government grant that has been availed by the private medical college) can you please share it?

Date: 29/07/2013

To,
Deputy Director Sir,
Pad. Dr. Vitthalrao Vikhe Patil foundation's
Medical college & Hospital, Ahmednagar.

Respected sir,

I Mrs. Archana Diwate, pursuing PhD at the centre of 'Social Medicine and Community Health', Jawaharlal Nehru University, New Delhi. I am working under Prof. Rama V. Baru. My study topic is 'Social characteristics & Trends of Private Medical colleges in India'.

I am here with reference of Dr. Swapnali Patil. Previously I have visited this college & hospital with her & found that this college & hospital providing services to rural population which are 'immeasurable & valuable. This certainly increases accessibility ~~of~~ ~~toward~~ rural health/population. This needs to be documented. In this contribution of founders needs to be noticed.

Mr. Kajale Sir & Dr. Swapnali Patil introduced me to you & that time you assured me that you will provide information.

Henceforth, your guidance & other professors & students information will enrich my Research-

I would be greatful, if you kindly co-operate by finding some time from your

busy &heduld for this.
I would be also greatful, if you give me permission to conduct interviews with others

I want to assure you that data provided by you & others will be used only for academic purpose.

Thanking You.

Mrs. Archana Diwate
PhD Scolar
JNU, New Delhi.

As MOU Has been Signed b/w Pravara Rural University, No other Student can be permitted to carry out Survey/Study.

31/7