(2021)

EVOLUTION, SOCIAL DYNAMICS AND PATTERNS OF PRIVATE MEDICAL CARE IN CALCUTTA : AN EXPLORATORY STUDY

Dissertation submitted to the Jawaharlal NehruUniversity in partial fulfilment of the requirements for the award of the degree of

MASTER OF PHILOSOPHY

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Date: 22/07/2002

CERTIFICATE

Certified that the dissertation entitled **"EVOLUTION, SOCIAL DYNAMICS AND PATTERNS OF PRIVATE MEDICAL CARE IN CALCUTTA: AN EXPLORATORY STUDY"** submitted by Ms. Bijoya Roy is in partial fulfilment of the requirements for the degree of **MASTER OF PHILOSOPHY** of this University. This dissertation has not been submitted for any other degree of this university, or any other university, and is her own work.

(BIJOYA ROY)

We recommend that this dissertation be placed before the examiners for evaluation.

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To

Ma And Bapi

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ACKNOWLEDGEMENT

It gives me great pleasure to record my indebtedness, gratitude to my faculty, many other individuals, institutions and friends who have contributed in many ways without which this work would not have come into reality.

First and foremost I owe an immeasurable debt to my guide, Dr. Imrana Qadeer who guided me in every step with her thoughtful and constructive suggestions. I am privileged to have the unrestricted access to her inspite of her maintaining a very busy schedule. She was also kind enough to edit painstakingly my work.

To attend Dr. Rama Baru's classes on Comparative Health System was always a matter of great interest. Her resourceful lectures on the subject helped to imbibe my interest in private sector in medical care in our country. My special thanks go to her. I also thank Dr. Alpana Sagar for the guidance and support during the course of my work.

I am extremely thankful to my department for its resourceful documentation centre and for providing with the computer facility.

No word is sufficient to thank Dr. Gouripada Dutta – the veteran physician, social worker and Chairman of the Subject Committee on Health and Family Welfare, Calcuttal.

My particular thanks goes to the librarians and staff of National library, Asiatic library, Secretariat library, Archives, and JIMA library.

I acknowledge with thanks to all the nursing homes, medical college and hospitals, their management and staff for their kind co-operation in sparing valuable times and services at the time of interviews for building up the data bank.

I take this special opportunity to thank my friends. Sumita di and Soma deserve a special mention as they have always encouraged me in my endeavours. In the two years of my hostel life I express my immense thanks to Reshmi, for extending support and anchorage during my dissertation phase. And I also thank Moumita, Tapas and Vijaya for their love and care.

Ever smiling and caring too, my naughty little nephew Bholu gave his support for this work by his pranks and playfulness. This work would never have been completed without the support of my Ma, Bapi, Dada and Didi.

Finally, I am solely responsible for any shortcomings and errors in the study.

New Delhi: 22/07/02 *(BIJOYA ROY)*

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ABBREVIATIONS

ABP	–	Ananda Bazar Patrika
A/C	–	Air Conditioned
AHA	–	American Hospital Association
BUPA	–	British United Provident Association
CAT Scan	–	Computer Augmented Tomography
CBHI	–	Central Bureau of Health Intelligence
CCU	–	Critical Care Unit
CMC	–	Calcutta Medical College
CMDA	–	Calcutta Municipal Development Authority
DHA	–	District Health Authorities
ECG	–	Electro Cardiography
EEG	–	Electro Encephalography
ENT	–	Ear Nose Throat
ESR	–	Erythrocyte Sedimentation Rate
F. No.	–	File Number
GDP	–	Gross Domestic Product
GOI	–	Government of India
GSDP	–	Gross Domestic Product
HCA	–	Hospital Corporation of America
HMOs	–	Health Maintenance Organisations
ICU	–	Intensive Care Unit
ICCU	–	Intensive Cardiac Care Unit
ICMR	–	Indian Council for Medical Research
ICSSR	–	Indian Council for Social Science Research
IMA	–	Indian Medical Association
IMS	–	Indian Medical Service
MCI	–	Medical Care Institutions
MB – Medical Branch		Proceedings of the Government of Bengal, Local Self Government Department,
MRI	–	Magnetic Resonance Imaging
NEP	–	New Economic Policy
NGO	–	Non-Government Organisations
NHP	–	National Health Policy
NHS	–	National Health Service
NRS	–	Nilratan Sircar College and Hospital
OBG	–	Obstetric/ Gynaecology
OECD	–	Organisation for Economic Cooperation and Development
OPD	–	Out Patient Department
Progs.	–	Proceedings
RHA	–	Regional Health Authorities
SAP	–	Structural Adjustment Programme
SBHI	–	State Bureau of Health Intelligence
SHSP	–	State Health System Project
TC/DC	–	Total Count/ Differential Count
WB	–	World Bank

INTRODUCTION

INTRODUCTION

In any country the adequacy of infrastructure and the level of financing projects the States commitment to the provision of medical care. After independence India opted for the mixed economy and the state decided to play a significant role in the welfare sector. In health sector the initial assumption was that the public sector would grow fast and make the private sector redundant. Thus, Bhore Committee magnanimously let them continue despite banning private practice in the public sector (GOI 1946), and Mudaliar Committee after 15 years let them use the public sector infrastructure in an attempt to overcome the gap in services (GOI, 1961). Over the years however, the public sector in the country faced dwindling financial allocation. The priorities of the health sector planning started getting distorted (Quadeer, 2000) and the public-private mix became a permanent feature of this sector.

The private sector in medical care that had long existed in the country has now grown over the years without much state control or regulation. It has provided medical care through individual practitioners and institutions like nursing homes, hospitals, private laboratories and diagnostic centres. Some of the states in India have experienced a boom in the private sector in comparison to the public sector. The private sector growth is not homogenous and there are various types of formal and informal practitioners and their relative proportions vary from state to state, as its primary motive is profit making and that depends upon the levels of economic development in a region (Baru, 1993). Its growth also deflects from the prevailing priorities. Despite its massive expansion over the past decade, it focuses only on medical care and that too of those problems that provide high and one time profits. Thus, chronic ailments, care of the old and poor are ones that do not attract private sector. In addition, preventive services are also not its domain. Even when it takes responsibility for activities like immunisation it is with state supplies of vaccines where the providers make profit on it.

Thus, the pattern and nature of private sector growth varies in countries and within countries. Given India's diversity in socio-economic condition, facilities and

governance, it is also evident that the pattern of privatisation varies from state to state. There have been very few studies in this area and that is why the present dissertation chooses to focus upon this issue.

In West Bengal, the state provisioning and financing of the health care system started prior to independence. Over the years after independence the public sector gained eminence but the private sector has also continued to grow. The latter has not been very significant and large. It began in mid sixties and gained momentum in the seventies and eighties. The records show increasing involvement of the private sector through nursing homes and hospitals. This trend has become very prominent in the nineties as a part of the health sector reforms that are being introduced in the public sector infrastructure by the state.

At this juncture therefore, it is very crucial to understand the new changes occurring in the medical care sector precisely because this state for long has emphasised to provide social justice to the unserved and underserved people. This research is an endeavour to understand the post-independence changes in the nature of public sector medical care provisioning, the role and pattern private sector growth in medical care and whether the changes through health sector reforms in West Bengal are in any way different from other parts of the country. It is in this context that the study tries to understand historically the development of the private sector in medical care in Calcutta[1]. It examines the post-independence trends in medical care in the city and the dimensions of the private institutional medical care in Calcutta. Another interesting aspect of the study is the social background of the medical entrepreneurs who are moulding the course of privatisation in the state of West Bengal.

Such a study we believe would help us understand the myriad ways in which health sector reforms imposed by international funders are being tackled by various states. It may reveal possibilities that may help plan better and less inequitable medical

[1] The name Calcutta has been changed to Kolkata under the West Bengal Capital City (Change of name) Act, 2001 effective from 01.01.2001. For the purpose of my study I am referring Calcutta instead of Kolkata.

care service within the health sector reform. It also explores the social reasons that push people into private nursing homes, clinics, and hospitals. It is hoped that the study would also contribute to a better understanding of modification and alteration that must be incorporated in health sector reform if genuine equity is to be achieved.

The study is organised in six chapters. The first chapter of this study reviews the existing literature on privitisation. In review of literature we see how American and British health systems are affected by market-based strategies, competition to control costs and streamline medical care strategy. Drawing experiences from these two countries we reflect upon Indian situation, which draws upon similar approaches for its health system. The second chapter discusses the conceptual framework of the problem. The methodology followed in the study is explained in detail. It states the objectives and explains the research design of the study.

The third chapter examines the growth of allopathic medicine in Calcutta prior to 1947. It studies the rise of hospitals during the colonial period, social backgrounds of the entrants to medical system, emerging private interest within the public sector and the private sector at that point of time. The fourth chapter explores the post independence trends in medical care in West Bengal particularly in Calcutta. This chapter is divided into two sections. Section I looks at the medical care sector after 1947 and section II explores the private sector of today in Calcutta. The second section is based on the field data collected by the researcher.

The fifth chapter deals with the socio-economic profile of the medical entrepreneurs in Calcutta. It is also based on the field data. This chapter explores the various aspects related to the social background of the entrepreneurs. Finally, issues emerging from the study and areas for further research are delineated in the discussion that contributes the sixth and the last chapter.

CHAPTER – I

REVIEW OF LITERATURE

INTRODUCTION

Private sector plays a key role in medical care. It has carved out a niche for itself in the health care system. In developing countries like India private sector has grown and expanded without any kind of regulation. The issue of control is pertinent here as the profit motive guides the private sector and it fails to address the public health concerns. Under these circumstances the state's role and regulatory mechanisms assume utmost importance in order to ensure universality, equity and provision of comprehensive care.

Historically states have intervened differently in the provisioning and financing of health services. They are determined by the socio-economic and political forces of the country (Baru, 1998). In an attempt to classify the health systems on the basis provisioning and financing of health services there are two main models called Bismarkian model and the Beveridge model. In Bismarkian model, it is through the social insurance system that the health care needs of the consumer are met. The social insurance system is a state run and regulated scheme. Germany, Austria, Luxemburg and Netherlands are few countries where this model has been implemented. In this system each member of the group is given access to health services through indirect payment. It has broad package of health services and covers a large proportion of the population. The health system in United Kingdom, Spain, Denmark, Sweden, Finland falls under the category of Beveridge model. It is financed through general taxation (Maarse & Paulus, 2001; Koivusalo, 2001). This system controls costs more effectively but there is a chance of under provision of care. Here state plays a significant role in the provision and it is more progressive in nature. This provides a universal health system. Apart from these two, in other countries there is prevalence of mixed model where the private sector plays an important role – varying in its scope - in the provisioning and financing of health services.

Increasing interconnectedness among the countries and the growth of capitalism in the world has encouraged market-based strategies for the recent health policies. Market strategy relies greatly on competition to control costs and streamline care. The health policy and planning is fiercely driven by profit maximisation. In our review of literature we see how American and British health systems are affected by

these strategies. Drawing experiences from these two countries we reflect upon Indian situation, which draws upon similar approaches for its health system.

AMERICA: THE CORPORATISATION OF HOSPITALS & UNDERDEVELOPMENT OF THE PUBLIC SECTOR

In the market-oriented economy of America, medical care services are largely delivered and funded in a pluralistic fashion. The services are largely profit oriented and the nature of private medical care sector heavily influences the Government policy. In America apart from the needs of the very poor, health problems of the relatively self-sufficient are considered as personal problems, which cannot be taken care from the pubic fund. Yet, the private sector enjoys the state subsidies.

The United States spends more on health than any other OECD country both as a percentage of GDP and in real terms. After 1990s expenditures have increased annually. In 1998 health expenditures accounted for 14 percent of GDP. In spite of this, health indicators do not show much of an improvement and costs of health care system have escalated. There is no universal health system. In 1996, 34.7 percent of total health expenditures was for the hospital care, 19.5 percent for physician services, 7.6 percent for nursing home care, 25.9 percent for other personal care, 3 percent on research and constructions and 9.3 percent on all other care. Around 42.5 percent of the total health expenditure were for the institutionalised individual curative care (Scott, 2001). Hospitals, physicians and nursing home industry are the three most powerful health associations (Harrington, 1984).

In this section we review literature from US about institutional forms of care in private medical sector.

Rise of Hospitals

During mid-nineteenth century private non-profit hospitals emerged as the main providers of medical care rather than the public system. It was like a cottage industry. There were private practitioners who provided care on fee for service basis and the patients paid directly out of pocket. In 1870, there were hospitals funded by

the private philanthropists and the many rich millionaires (Whiteis & Salmon. 1987, White 1990). During that time there was hardly any market for the paying patients.

The modern structure of the hospital industry in US can be traced since 1920s. By 1928, over 4000 general short-term hospitals were there in the United States with an average bed size of 78 beds. The hospitals made large capital investments in the plant, equipment and employed large number of specialised nursing and technical personnel (White 1990). Hospital sector was perceived as no less than any other commercial venture driven by profit motive.

The structural characteristics of hospital provision were set during 1920 and 1930s. For the paying patients, fee for service sector was instituted in the non-profit hospitals. There was rapid entry of the for-profit hospitals. By 1935, 90 percent of all hospital beds were in non-profit hospitals and it also accounted for 94 percent of hospital capital. Apart from, this there was proprietary sector of hospital (White, 1990). Local government provided service for the poor, pubic health and teaching facilities, state government took charge of psychiatric hospitals and federal government provided for the military hospitals. It was observed that during the depression, the public sector hospitals were more stable than the charitable private hospitals. This was followed by an increased cost of medical care and many physicians could not recover costs from the patients (Jahiel, 1998).

The proprietary hospitals grew in number between 1890 and 1909 because of increasing demand from the paying patients. After 1909 – 10 their share reduced from 59 percent to about 11 percent in 1968, some of them converted to non-profit type of ownership and many others closed.

Table 1.1: Opening and closure of hospitals in US between 1962-68 by ownership

Ownership pattern	Opened (N = 1292)	Closed (N=954)
Proprietary	37%	59%
Non profits	30%	26%
Government	33%	15%

Source: Steinwald and Neuhauser (1970) as cited in Mahapatra, P et al,, 2001

Only 15 percent Government hospitals closed between the period 1962 –68 (table 1.1). Single owner hospitals faced the highest closure, lowest closure rates were observed in corporate hospitals. Partnership based hospitals were in between. The span of proprietary hospital is associated with the professional career of their physician founder. Many of them could not stand up to the competition posed by the stringent standards that increased the cost for establishment and maintenance of hospitals. They also declined in number as they provided limited range of service in comparison to the demand (Mahapatra, P, et al., 2001).

Table 1.2: Change in ownership form of for-profits hospitals in US between 1960-67

Status in 1967	Single Owner (n = 234)	Partnership (n =212)	Corporation (n=435)
Single Owner	26%	3%	1%
Partnership	5%	41%	2%
Corporation	14%	9%	65%
Nonprofit	4%	7%	13%
Closed	51%	40%	19%

Source: Steiwald & Neuhauser (1970) as cited in Mahapatra, P, et.al,, 2001

In US between 1960 – 1967 corporate sectors in medical care institution grew (table 1.2). This is when the entrepreneurs in the field of medical care started utilising the modern business rules to expand and reap in profits. In the period following depression a series of federal policies provided benefits to the private medical sector that supported the hospitals and strengthened the private hospitals. In the 1960s many proprietary hospitals were purchased by corporate entitles. Hospital Corporation of America (HCA) Inc. was found in 1968, the country's first hospital company. In the later half of 1970s acquisition and the mergers contributed significantly to the growth of corporate hospitals and in the 1980s many non-profit hospitals were acquired by corporate hospitals. The non-profit hospitals lacked the capacity to generate capital and meet operative costs. They also could not change the ownership to for-profit institutions as certain problems evolved with regard to legal formalities (Mahapatra, P, et al., 2001). In the 1950s, many medical research programmes were contracted out to private medical schools and hospitals. This consequently led to understaffing of the public sector medical institutions.

Non-Profit Medical Care Institutions

As noted earlier, the dominance of non-profit medical care institution over the nineteenth century US continued in twentieth century as well. In 1998, 60 percent of the short-term hospitals had non-profit ownership and 70 per cent of the beds were in this sector. Only 13 percent of the bed strength was in for profit sector (Mahapatra, P, et al., 2001). Non-profit hospitals have increasingly experienced corporatisation by copying their for-profit counter parts and are more concerned with financial gain. As a result medical care is limited in these hospitals. This has forced the displaced patient to avail care from the expensive teaching institutions (Whiteis and Salmon, 1987).

Corporatisation of hospitals

The payment for service through Blue Cross and Blue Shield in the late 1930's and Medicare and Medicaid in the 1960s downplayed the preventive care and community based models. Here it is not to be overlooked that with the interconnection between the medical industry and larger economic system, corporate suppliers were attracted to medical care. This resulted in the establishment of power and monopoly where technology gained upper hand (Whiteis & Salmon. 1987). During Nixon's administration, health maintenance organisations (HMOs) further assisted in the corporatisation of the hospitals. This was for a short while. With recession, sky-rocketing health care costs, increasing Government deficits and inflation, the medical care delivery was affected. The Government had to prescribe limits for the private hospital charges, bed occupancy. Many hospitals shifted their area of specialisation to the profitable ones like psychiatry, drug addiction (Baru, 1998). By the 1970s and 1980s large hospital systems emerged as important players.

In the eighties, Reagan administration viewed health care as a marketable commodity. The policy shifted to cost containment strategies and the third party payers involvement grew to limit the medical care expenditures. This increased the financial risk of the patients; cost sharing increased for them. Yet, the medical care costs began to soar up (Whiteis & Salmon. 1987)

This had a major impact on the medical care industry. The urban and the teaching hospitals could make profit on Medicare patients but small urban and rural community hospitals were hurt because of the cost containment. Because of the

financial crunch many hospitals had to cut staffs and beds. Management oriented companies took advantage and appropriated these resources. Thus the growth of multihospital systems accelerated. Now the administrator further legitimised the profit oriented decisions (Ibid.). The multihospital emphasised now on ambulatory care, outpatient surgical and rehabilitation services, diagnostic and imaging services, occupational medicine through different corporations and physicians. Health South Corporation also established business abroad in countries like Great Britain, Canada, Puerto Rico, Saudi Arabia and Australia.

Closure of Hospitals

Sager (2001) had done a study on urban hospital closure, mergers and change in ownership between 1980 and 1995. It was based on the study of acute care hospitals in 52 large and mid sized US cities. It was found that the number of hospitals and beds decreased fast and considerably from 1980 to 1990 and from 1990 to mid 1990s. In the 1980s of the total acute care hospitals, which opened more than a quarter of it closed by mid 1997. One quarter of non-profit, one tenth of public hospitals and more than half of for profit hospitals closed by 1997. For profit hospitals faced the largest closure. Non teaching hospitals closed down more than the teaching hospitals. In the study period of 17 years, 45 percent of non-teaching hospitals, 13 percent of hospitals with minor medical schools closed and 8 percent of hospitals with major medical school affiliations closed. During the same period 28 percent of hospital beds were reduced.

It was noted that large teaching hospitals and hospitals in the minority neighbourhood community were fast to close down. Race was identified as a significant variable prior to 1990. However, according to Sager (2001) in the nineties, race was not a very important factor for the closure of hospitals. Among the existing hospitals, it was seen that the teaching hospitals in urban areas were open. They were at an advantage over other hospitals as they received reimbursement for the Government health programmes. Thus, their sustainability was less jeopardised than the non-teaching hospitals. Hospitals with more financial resource remained open compared to the ones with more patients. In the 1990-97 financial resource and number of beds seems to emerge as the crucial determinant to influence the closure of hospitals. From 1980s onward the process of closure, merger, acquisition and change

in ownership, service in urban hospitals of US have been accelerated. The hospital closure pattern tells us that the African Americans have been affected more in terms of access over many decades.

A historical analysis of the corporatisation of medical care in US shows shift of hospitals from charity based to one suitable to meet the individual needs of the upper and middle classes. It has grown with a business and managerial orientation in alliance with the upper class interests. It is now completely a profit driven medical care system where isolated and intervention oriented high technology gained precedence over the holistic approach towards well being of the population. Approximately 43 million individuals equivalent to 18.3 percent of Americans under the age of 65 are uninsured. The rapid intrusion of the for-profit sector and diversion of the public sector capital into the private sector had consequently lead to centralisation of the delivery system. The multihospital chain, a recent phenomenon showed a 15 percent increase in total beds between 1982 and 1983 and 15.1 percent increase between 1983 and 1984. Studies show that mid 80s hospitals serving the poor and minority population have closed down. Between 1980 and 1984, 156 community hospitals closed in large metropolitan areas, as they were not members of multihospital systems (Whiteis and Salmon, 1987). Corporate strategies used cost saving technique that restricted the access of many middle class clienteles, racial minorities, medically indigent patients, the working poor and elderly women and children. The increasing number of uninsured then put heavy burden on small voluntary and public hospitals, which were also financially vulnerable.

It can be concluded that for-profit hospital and the corporatisation of non-profit' hospitals are removing medical care from those most in need. Forbidding this population from necessary services will systematically diminish the public utilisation of medical services. The implications of this corporate transformation predict further breakdown of community and family earning networks. This has to be seen in the light of current efforts on the part of international capital to maximise profits by diverting public goods into private control (Ibid.).

NATIONAL HEALTH SERVICE AND PRIVATE SECTOR IN BRITAIN

The post-war welfare state in Britain was an attempt to increase state intervention in the economic and social sphere. To avert the crisis after war in 1948, state opted to administer National Health Service (NHS). It was an outcome of dialogue between the contending groups and political compromises (Doyal et al 1999). The service was to be provided free of cost to all the citizens.

The service was structured on a tripartite system viz., the hospital sector, the executive council sector and the local health authorities. This commitment to provide health service to all its citizens was diluted by providing the permission to allow private practice. By doing this, the state provided the space for the private sector to continue. The private medical sector continued to exist directly or indirectly also through the presence of pay beds in NHS hospital, pharmaceutical and medical equipment manufactures (Doyal, 1979). Till the seventies the private sector maintained a low profile.

Hospitals emerged as the dominant sector. Initially 45 percent of the total NHS expenditure was accounted for by hospital services and by 1974 it increased to 65 percent. (Ibid.) Now hospitals and community health services comprise about two-thirds of total expenditure (Scott, 2001).

In Britain, historically, majority of the private hospitals were provided by the charitable and religious organisations. This sector was small and financially vulnerable. The above hospitals did not approve of the commercialisation of medical care, which is why there were only two private hospital associations. For many years, the private market comprised of nursing homes, voluntary hospitals and a few insurance companies, which were owned by the British United Provident Association (BUPA) and Nuffield. In Britain BUPA is the oldest hospital company. Nuffield was formed by BUPA in 1957 as a supplement to NHS pay-bed provision so that independent nursing homes did not face closure (Rayner, 1987).

During 1970s, the private hospitals had bed strength of 30 to 40. Religious organisations, charitable trust and for profit companies owned them. With reforms, large corporations owning hospitals began to appear in Britain in the late 70s. They initially owned 28 percent of the private beds and nearly 52 percent by mid eighties. Very similar to the US experience, large corporations took over the small hospitals with some closing down (Baru 1998).

Health Sector Reforms in Britain

In 1980s, Thatcher government, considered the state run health care service as inefficient, bureaucratic, uncompetitive and unsustainable (Doyal et al 1999; Giaimo & Manow, 1999). It introduced reform policy, which redefined the role of the state in the provisioning and finances of medical care service and introduced internal market in the NHS institutional structure. The health sector reforms were part of a larger economic and social policy. It was to promote competitive economy, lower public expenditure and taxes, bring about a reduction in welfare dependency and promote greater individual choice regarding social services. The functions and structure of NHS organisations were modified. The consultants were allowed to practice privately, consultant owned hospitals expanded and tax concessions were given to purchase private health insurance (Baru, 1998). Previously in NHS, corporate actors like private insurers, providers, employers and unions were absent to whom the managerial task could be assigned (Giaimo & Manow, 1999). The Conservative Government wholly welcomed the market perspective and the introduction of business methods into the management of NHS (Rayner, 1987).

After the reforms the purchase and delivery of care can be categorised into 3 broad delivery systems – hospital care, primary care and community/social services, and long-term care. In the hospital sector, there were 14 regional health authorities (RHAs) and each RHA was divided into approximately 15 district health authorities (DHAs). Prior to the reforms DHAs had the responsibility to plan and operate health services, apart from general practice. Post reform, hospitals became self-governing NHS hospitals (Scott, 2001). The reforms converted the DHAs into purchasers to appropriate health care from the hospital providers. Now private hospitals could compete with the public institutions.

With the changes in restriction policy since 1979, the private sector has rapidly risen (Rayner, 1987). The large Corporations that began to operate diversified their field of work into areas like dental care, diagnostic facilities, optical care, and abortion facilities (Baru, 1998). These were the areas that required sophisticated technology. In 1986, there were nine U.S. hospital companies in Britain including an HMO. In Britain, besides U.S. investment, capital from Arab countries also supplemented the private medical sector. Thereafter, commercial chains were formed in Britain. It was interesting to note that the US based hospitals were located not only in areas closely accessible by the consultants but also close to NHS hospitals as they were usually poorly equipped and manpower was inadequate. There were only 53 private hospitals with operating rooms and resident doctors (Rayner, 1987). In the 1980s and the early 1990s, in order to increase efficiency, there was greater emphasis on contracting and management practice within the NHS. During the 1980s under funding led to increasing the number of pay beds in the public hospitals, and they began to rent out space within the hospitals for shops and other businesses. Even this could not bring about much of the changes as desired by the reformers (Scott, 2001).

During the last decade (1990s) the successive Governments tried to improve the quality of NHS services and bring about private investment in the public sector, especially in the long term care. One sees various reports in the early 90s like the *Audit Commission* in 1990, a review of the NHS in 1988/89, and the White Paper *Working for Patients, 1989,* proposing a series of reform proposals. They recommended changes in the area of funding, purchasing and provision of care. A shift from general taxation towards private insurance was evident. Following the public's high consideration for the NHS the reforms were confined to the purchasing and provision of care (Scott, 2001).

Hospitals in UK

The NHS hospital system provides secondary care and highly specialised services. Presently in UK, six organisations dominate the private hospital market: NHS and five private hospital groups: BMI Health care, BUPA, Nuffield Hospitals, community hospitals group and HCA international. There are just 300 private hospitals and private patient units in NHS trust hospitals (www.carehealth.co.uk).

Table 1.3: Main Private Hospital Organisations in UK

Main Private Hospital	Number of Hospitals	Percentage (%) of beds belonging to the hospital
NHS Trust	88	13
BMI health care	44	20
Nuffield	40	14
BUPA	36	15
Community hospital group	22	8
HCA International	6	7

Source: www.carehealth.co.uk

Significantly there are more NHS Trust private patient units than hospitals belonging to any of the main private hospital groups. NHS private patient units have smaller number of beds, typically 10 or 12, and are dedicated as private patient wards. There are more private beds in total than the NHS Trust private patient units. In UK there are approximately 11,250 private beds. In addition to this, there are approximately 40 smaller groups and independent private hospitals. Independent hospitals have some of the best-known private hospitals. Several hospitals are run by charities and religious organisations (www.carehealthco.uk).

Crisis Within NHS

The health system in Britain has faced continuously rising costs, increasing number of tasks, regional inequalities and variability in the service delivery. Continuous publicity about the shortage of resources and long waiting lines in NHS has compelled many patients to opt for the private treatment. Many elderly people also have to go for private treatment as the NHS has age based rationing of medical services. It is a very difficult situation for the elderly population, as the health insurance schemes are becoming very costly. The patients are forced to opt for private insurance and through that pay for treatment in private hospitals. Many subscribers are not satisfied with private health insurance schemes as the subscription fee is regularly increasing with escalating charges. The insurance schemes are withdrawing covers for the conditions, which requires several sessions of treatment. Besides these, concerns have been raised over the training of the technical staff in private hospitals, while range of facilities, specialist staff, drugs for emergency and intensive care are

not always available. They generally tend to ferry away seriously ill patients to NHS hospitals for treatment.

The key points in favour of reform were choice, efficiency and competition that partly increased efficiency. For the success of the internal market it was realised that both purchasers and providers required not only accurate information on the health care needs but also finances. Many uncompetitive hospitals closed down and affected the access to care for the poor. The costs of care are continuing to rise no matter how efficiently it is being managed.

In comparison to Germany and France, Britain has the lowest practising physicians (1.6 per 1000 population) and also lowest hospital beds (4.7 per 1000 population) (Doyal, L et. al., 2001). With reforms class based inequalities in access to care has increased. The UK experience of the internal market projects state of crisis in the medical care. Many of the health care needs of the British population cannot be met. Private medical care is gradually growing both within NHS and outside. Furthermore the NHS will now use private hospitals to reduce hospital waiting lists. Now this will make every person in UK a potential user of private health care.

US and UK experience indicates commercialisation of medical care by the policy makers. In US despite the economic boom of the 1990s there are now greater number of Americans lacking medical care than the 1960s. Senior citizens are experiencing increasing out of pocket payment. There are glaring inequalities in medical care, in spite of paying a great deal for the medical care. Despite this, the policy debate is still dominated by wealthiest Americans who undermine the role of state provisioning and financing of medical care. However, there is now an advocacy group, which is campaigning for national health insurance. Perhaps this will save the US medical care from complete commercialisation and technocentric approach to medical care.

In Britain the private sector in medical care has proceeded at a steady pace. Health services still continue to be publicly funded but private provisioning has increased. Commercialisation in Britain differs from US. The process is evident within the NHS and in the private sector. Though greater choice has been introduced

within NHS, but the cost of care is escalating and due to lack of services within NHS, people are opting for private care. Again the private sector seeks NHS help in case of high-risk cases or cases that require critical care. Now what is alarming is that there is push for private financing by political forces. As a result, it questions the fundamental ethos of NHS that was built on universality, comprehensive care and equity.

Therefore crisis is perceived in both the countries differently and both bear relevance to our country as the level of deprivation and marginalisation is very high in the country.

THE PRIVATE MEDICAL SECTOR IN INDIA

In the early twentieth century, the ownership and financing of hospitals and dispensaries was dominated by the state. The state ownership increased from 68.5 percent in 1910 to 87.3 percent in 1940. Also public financed medical care institutions increased from 74.5 percent in 1910 to 92.4 per cent in 1940 (Duggal, 2000). They were urban centred and did not reach out to the people well. The qualified allopathic practitioners were increasing. In 1930 among the qualified practitioners only 25.58 percent were allopaths (Duggal, 2000). Their growth took place without any kind of control and regulation.

Despite these proportions it is well known that medical care services were extremely inadequate before independence. Yet, there was large proportion of individual private practitioners. After independence the State committed to develop into a self-reliant economy, tackle poverty and invest in welfare services like education, health and other social services. It also undertook to promote the goal of universal health care. Independent India carried over the British model – that of Government service and private practice with emphasis on the establishment of urban and curative hospitals (Zurbrigg, 1984).

In this section, Committee Reports and Policy documents are studied to understand the shifts in private sector vis-à-vis the state provisioning of medical care.

Shifts in Approaches to State Provision of Medical Care

The Bhore Committee Report (1946) envisaged the provision of medical care services by the state to all irrespective of the ability to pay. The Committee's survey showed that 92 percent of were state financed medical institutions and the rest 8 percent were maintained by the private organisations. The private institutions were small in number but the individual private practitioners comprised a large proportion. There were 72.6 per cent of allopathic doctors in private practice with the rest 27.4 per cent in the Government service (GOI, 1946).

The Report recommended prohibition of private practice by the full time salaried Government doctors and, to meet the needs of the people in the long term, it proposed to utilise the service of the private practitioners on part time and honorary basis. It commented upon as to how the service of the private practitioners would be used but the role of private sector in the medical care service was not outlined. It did not jeopardise the interests of individual private allopathic practitioners (GOI, 1946).

The First five-year plan had clearly set out that the private sector would operate within the conditionalities created by the state and would receive support from the Government in the form of tariffs, fiscal concessions and other direct assistance. Thus the state promised to render help to the private sector from the beginning. The planned health service development began to take place under the premise that poverty was the central problem, which could be taken care of if the other sectors make progress in their respective fields (GOI, 1957). The second five-year plan recommended banning private practice by the Government medical teachers (GOI, 1956).

After 15 years of the Bhore Committee Report, the Mudaliar Committee Report (1961) marked a shift in the policy. It acknowledged the presence of large proportion of (40 – 70 percent) private practitioners in different states. It identified the individual private practitioners as separate group whose interests would not be thwarted, - " *independent medical practitioners have to be considered as a separate entity (from the existing public system) whose efficiency could be preserved and whose legitimate interests must be protected" (*GOI, 1961). Very similar to the

colonial health policy it also wanted to utilise the service of the private practitioners for the state health service in part time and honorary capacity to meet the manpower shortage. They were encouraged to use the Government resources to treat their patients. In the meantime many of the Government doctors privately practiced and the state could not prohibit it in any way.

The current plans and the succeeding ones restricted their discussion to banning private practice by the Government doctors and encouraged the non-government organisations to take up some of the provisioning activity. There was rapid growth of private institutions in the country from the mid-seventies. Many Government doctors practised privately in the nursing homes and private hospitals and also owned nursing homes (Baru, 1998). The Indian Council for Social Science Research / Indian Council for Medical Research Committee (ICSSR / ICMR) in 1980, identified the interface between the public and private sector in the provisioning and financing of the medical care services. But the role of the private sector was still very ambiguous. At this juncture it was already felt that the medical care services were not yet universally available in an equitable way. Subsequently, the 1983 National Health Policy (NHP) enunciated the need to restructure health services because of resource constraints and urban centred curative medical services. It recommended that in order to reduce the Government expenditure private practitioners, NGOs and private investment for curative centres should be encouraged.

Compared to the previous policy documents, NHP for the first time articulated the role of private sector in medical care. The state recognised the large existence of private sector and simultaneously anticipated how the private sector resource could be utilised. It was during the same time that the Indian state, which was driven by the socialistic goals, began to shift emphasis in economic policy and a growth centred approach began to take shape (Qadeer, 2000). In 1984 Rajiv Gandhi, the then prime minister, in his speech to the nation clearly articulated the economic plan to open up increasingly to the private sector. In the seventh five-year plan hospital facilities available in the country, voluntary organisations and other private institutions, non-communicable diseases, need for greater logistics, effective and efficient management information system became the new areas of concern. These areas required huge investment and usage of high technology. These new concerns acknowledged the new

developments in the private sector and the urge to operate with the private sector (GOI, 1985).

The New Economic Policy (NEP) in 1991 began to reorient the role of the state. The development strategy geared up towards broad-based private sector under the discipline of competition and free market. In the major sectors private investment was welcomed. Now the role of the private sector became clearly defined. The reform process beginning in the eighth five-year plan continued into the ninth plan also. Both the plans find significant presence of private sector in the field of medical colleges, hospital and other services and therefore the state Government must encourage them. This is an endeavour by the state to raise financial resources through alternative means. By the way of reducing state intervention in health, axing the budget, and enhancing the private sector, it wants to transfer the responsibility of medical care services to the individual. This transfer of responsibilities accompanied "*the emphasis on hospital based, technologically oriented medicine and especially individual, acute – episodic care*" (Qadeer, 2000). Contextually, it is important to emphasise the fact that the state has directly and indirectly given support to the private sector (Baru, 1998; Duggal, 2000).

The private sector at present controls substantive share of medical service provision. This becomes evident with the utilisation of medical care data. The number of qualified doctors in the private sector, the number of private institutions and cuts in the health expenditure in the last decade show that liberalisation of Indian economy and the implementation of structural adjustment programme (SAP) has given an impetus to the private sector. The medical care priorities within the private are distorted. The fact that public sector still caters for illnesses epidemiologically significant, shows that public sector takes better responsibility of national priorities.

Apart from the individual private practitioners there are private nursing homes and hospitals. Private nursing homes and hospitals form a significant part of the institutional care. From the late seventies, in agriculturally prosperous states and urban areas, private institutions began to grow. This period of growth and expansion coincided with the availability of new medical technologies and increased number of specialist doctors in the country (Duggal, 2000). Private medical care sector is

complex in nature and it affects the health structure, delivery system in the country, the cost and quality of the services (Baru, 1998).

Health Sector Reforms in India

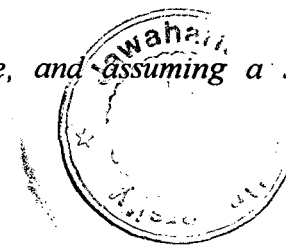
Investing in Health, the World Bank's blue print for the new health policy within the context of structural adjustment, is postulated on a neo-liberal paradigm. It defines Health as a private responsibility and health care as a private good. They should be provided as commodities in the market. The prime concern is to expand the medical market. This implies pruning of Government intervention, responsibility with the promotion of privatisation (WB, 1993). SAP introduced health sector reforms in India. Qadeer (2000) identified five types of mechanisms of privatisation operating in India:

i) Cuts in health sector investments.
ii) Opening up of medical care to the private sector.
iii) Introduction of user fees.
iv) Private investments in public hospitals
v) Purely technocentric approach to public health interventions

As a consequence, it can be said that it is restructuring the public sector through private investment and limiting the role of public sector gradually. First target is to commercialise secondary and tertiary level-care and thereafter move on to the primary level care. This in a way mutilates the chain of referral system that starts with primary health care to secondary and finally to the tertiary level (Qadeer, 1997). Gradually under the pressure of international financial agencies the state was forced to go in for less direct provisioning of care and transfers this role to the private and NGO sector. This became evident when a senior health specialist in the Health, Nutrition and Population Department of the South Asian Region said:

" *Reform options include a greater investment by the central and state governments in the financing of health care, stronger accountability for services funded, and* ***less involvement in the direct provision of care.*** *The national and regional government should be able to foster the development of more effective, efficient and equitable health services by* ***increasing the autonomy of public hospitals,*** *partnering with*

NGOs, investing in the expansion of primary care, and assuming a stronger purchasing role on behalf of the poor."
(http://www.worldbank.org/html/extdr/extme/075.htm)



The Prime Minister's Advisory Council on Trade and Industry and National Health Policy (NHP), 2001 evidently supports this point of view. Shri Mukesh Ambani and Shri Kumarmangalam Birla, members of the Prime Minister's Advisory Council on Trade and Industry, declared that health care reform is the immediate requirement and for this there is need for strong Government commitment at the centre and the provincial level to make it successful. It proposes to convert large number of Government hospitals into corporate ones and let them operate with autonomy (www.nic.in/pmcouncils/reports/health/summary.html).

Similar prescriptions are echoed in the draft NHP 2001. The role of private organisations in the achievement of public policy, goals and objectives has been given emphasis. The draft prescribes privatisation through numerous formulations of the health care system. Under the garb of civil society and other such institutions greater role is being consigned to NGOs and for sub-contracting public health to the private sector. In addition the policy wants to '*capitalize*' on '*the supply of services to patients of foreign origin on payment*' (Draft NHP, 2001). This proposition seems to serve the interests of the global health market and lead to resource drain within the country. In an overview on better health systems for the poor World Bank advocates greater managerial role for the Government (WB, 2001). Thus, while it promotes the purchase of medical care from the private sector through insurance schemes, it recommends the least direct state provision of out door services. As most of the private money is spent here the Bank advocates handing it over to the private sector. In its view the massive public expenditure required to revitalise the entire network must be curtailed. It therefore relegates and nullifies the value of the existing public facilities.

Between 1960 and 1991 in Jaipur the cumulative growth rate of private beds was 95 per cent. Highest number of bed was added between 1980-85. Sharp increase in the private health care facility in the past decade coincided with privatisation from

1991. Alongside in the urban areas small private speciality hospitals grew (Kabra S.G. & Malti Patni, 1991).

Expansion of Private sector: Size and spread

Certain limitations were faced in acquiring data on private medical care. The available data on infrastructure largely deals with the public sector medical care. The data provided for a particular head of information is inconsistent and in the time series data analysis it poses difficulty (Jesani, 1993, Nandaraj 2000). As a result, the study not only looks at the Government data source but also at other studies in the same area. The private medical care sector was very small till the early mid seventies. From the late seventies and eighties the sector began to expand and grow and it is not uniform in all the states.

Table 1.4: Ownership status of Hospitals and Hospital beds

Year	Hospitals			Hospital Beds		
	Government	Private	Total	Government	Private	Total
1974	2832 (81.4)	644 (18.6)	3476 (100.0)	21355 (78.5)	57550 (21.6)	268885 (100.0)
1979	3735 (64.7)	2031 (35.3)	5766 (100.0)	331233 (74.2)	115372 (25.8)	446605 (100.0)
1981	3747 (56.2)	2923 (43.8)	6670 (100.0)	334049 (71.5)	132628 (28.4)	466677 (100.0)
1984	3927 (54.6)	3256 (45.4)	7181 (100.0)	362966 (72.5)	137662 (27.5)	500628 (100.0)
1986	4093 (54.7)	3381 (45.3)	7474 (100.0)	394553 (73.9)	141182 (26.1)	533735 (100.0)
1988	4334 (44.1)	5497 (55.9)	9831 (100.0)	410772 (70.9)	175117 (29.9)	585889 (100.0)
1993	4597 (33.5)	9113 (66.5)	13710 (100.0)	385216 (64.6)	210987 (35.4)	596203 (100.0)
1997	4799 (31.6)	10371 (68.4)	15170 (100.0)	414723 (62.6)	247631 (37.4)	662372 (100.0)
1998	4817 (31.7)	10371 (68.3)	15188 (100.0)	418008 (62.8)	247631 (37.2)	6655639 (100.0)

Figures in the bracket denote the percentage share
Source: Health Information of India, CBHI, GOI, and various years.

Table 1.4 shows us the ownership status of hospitals and the percentage share of government and private beds. The private ownership of hospitals in the country has

taken a big leap in the past two decades from 18.6 percent in 1974 to 68.3 percent in 1998. Till the mid-eighties the Government owned hospitals occupied a little above 50 per cent. In comparison to the growth in the private owned hospitals, the share of private beds is not considerably high (37.2%) (table 1.4). The private institutions are largely small nursing homes, with an average bed capacity of 10 and are owned by doctors (Nandaraj 2001) either singly or in partnership. They generally provide general and maternity services (Baru, et al., 2001).

There are variations in the growth of private hospitals and hospital beds in the country. Analysis tells us that the growth has not been uniform in the past three decades. From the seventies onward, states like Andhra Pradesh, Gujarat, Kerala and Maharashtra experienced sharp increase of private hospitals. In the north east states the private sector growth was very low. In states like West Bengal, Uttar Pradesh, Orissa, Bihar, the private sector growth was very slow. Whereas in Tamil Nadu it was steady. The states of Andhra Pradesh, Gujarat, Kerala and Maharashtra had more private hospital beds than public beds from the early nineties (Health Information of India, CBHI, GOI, and various years).

Private Medical care institutions and providers

In India the growth of private non-profit hospital has not been significant. In India, non-profit medical care institutions can be traced to the activities of Christian missionaries (VHAI, 1997). Hindu reform movements during 19th and 20th century and the Gandhian-Sarvodya Movement worked towards setting up of charitable hospitals and dispensaries for the indigent people. Till mid sixties, the medical care in the voluntary sector was confined to hospital based care organized *"by rich family charities or religious institutions"*.

Table 1.5: Ownership and share of Voluntary Hospitals and Beds

Ownership	1983		1987	
	Hospitals (%)	Beds (%)	Hospitals (%)	Beds (%)
Voluntary	569 (8)	53513 (11)	935 (10)	395062 (13)
Total	7398 (100)	512474 (100)	9603 (100)	573578 (100)

Source: Directory of Hospitals in India, 1985 and 1988.

There is limited capacity and number of voluntary hospitals in comparison to total number and bed size in the country (table 1.5). These non-profit medical care institutions have diversified into community based services. A rough estimate shows the presence of 7000 voluntary organizations working in the health sector. Geographical distribution of these organizations show limited non-profit initiatives in the states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh in comparison to the better off states like Kerala, Maharashtra (VHAI). The limited growth that has occurred is restricted to the better-off areas in the district.

Shah (1997), in his study on plague in Surat, discusses about the evolution of the charitable hospitals in Surat, the services they offer and a few other characteristics. It was the Hindu and Parsi merchant class settled in Bombay and the religious groups that had invested their capital to provide medical relief to the poor. They catered to people from various communities. The patients in these hospitals were charged and for the indigent patients charges were subsidised. Significantly, fees constituted 85 percent of the total income of these hospitals. There were very few doctors who were on regular appointment and the visiting doctors who were on honorary basis used it as a springboard for their private practice.

Baru's (1993) study of health services between advanced and backward districts in Andhra Pradesh looked at the allopathic health services provided by public, private and voluntary sectors. The bed strength in the nursing homes was relatively high in the advanced districts. Majority of the non-profit voluntary sector was established by missionaries and was distributed in the better off taluks of the advanced districts. Similar trend was noticed for the public sector too. The study showed that in Krishna, Guntur and Mahabubnagar districts the number of private beds exceeded the public beds. The author here linked the growth of private health sector with level of economic development of a particular region as it provided the surplus to invest in commercial enterprises. She also attributes better infrastructural facilities for the above development.

In the twin cities of Hyderabad and Secundrabad majority of the large nursing homes emerged after 1979 and the smaller ones (77 percent) were established in the eighties. Single owners owned 68 percent of the small nursing homes. It is noted that

the bed size did not grow uniformly in the small and big nursing homes (Baru, 1998). In Madras majority (68.5 percent) of the hospitals were owned by the sole-proprietors. Most of the hospitals were small with an average number of 23 beds. Large proportion (88 percent) of the private medical care MCIs defined themselves as profit seeking hospitals (Muraleedharan, 1999). The study of private health sector in Andhra Pradesh explored the trends of privatisation for different types of health care institutions (solo clinics, small hospitals, big hospitals and diagnostic facilities). In the state, almost all private solo clinics, large proportions of small hospitals and diagnostic facilities were in the proprietorship category. The study also revealed that half of the big hospitals were registered as non-profit organisations. This was perhaps to exempt tax. 30 percent of them were incorporated as companies. The main motivation behind setting up proprietorship based health care institutions was to provide the physicians with the facility to practice (Mahapatra, P, et. al., 2001).

The study further observed that public sector health care institutions in the state increased steadily from 1931 to 1970, again picked up momentum during 1981-90 and reduced later on. Compared to this private health care institutions started to increase 1981 onwards. Now a day's more private diagnostic facilities are established than the private hospitals and clinics. The establishment of non-profit sector hospitals had reduced. The proprietary and partnership based institutions appeared to slow down between 1980-2000 (Ibid.).

Cutback in the Public Sector Funding and Provisioning

The implications of reforms are most crucial for the growth of health sector specially the public sector in health. The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 20 percent of the aggregate expenditure is public health spending. *In contrast the private health expenditure is 80 percent.* The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while in the States it has declined from 7.0 percent to 5.5 percent (Draft NHP, 2002). The cuts in health sector have bottlenecked Government's capacity to expand the health services (Qadeer, 2000). In the public health delivery system basic health services and the referral

linkage to the secondary care institutions has suffered. This has a major impact on the utilisation of the health services as shown in the next section.

Utilisation pattern of the public and private enterprises

At the all India level the private sector dominates both the out-patient and in-patient utilisation. In between the 42nd NSS (1986 – 87) round and 52nd NSS (1995 – 96) round the non-hospitalised treatment of ailments in the Government source declined in the rural and urban areas from 21 per cent to 19 percent and 24 percent to 20 percent respectively. The dependence on public sector has declined and there is greater reliance on the private sector for the hospitalised treatment in rural and urban areas. This shift is more prominent in urban areas. In addition the shift to private sector is much more in the higher income groups. It is evident from the table 1.6 that the reliance on all Government sources had declined steeply and there is greater reliance on the private (non-government) sector.

Table 1.6: Distribution of hospitalised treatments by type of hospital (cases /1000 population)

Type of hospital	Rural		Urban	
	1986 – 87 (42nd)	1995 – 96 (52nd)	1986 – 87 (42nd)	1995 – 96 (52nd)
Public hospital	554	399	595	418
PHC/CHC	43	48	8	9
Public dispensary	-	5	-	4
All govt. sources	597	438	603	431
Private hospital	320	320	296	410
Nursing home	49	80	70	111
Charitable dispensary	17	8	12	6
All non-govt. sources	403	562	397	569
All hospitals	1000	1000	1000	1000

Source: 52nd NSSO round

On the whole, the rural population relies more on the public sector than the urban population. Inter-state analysis shows that Orissa, Rajasthan, West Bengal and Assam are the four states with greater trust on the public sector for hospitalised treatment. Hospitalised Indians spend more than half (58%) of their total annual expenditure on health care. It is found that hospitalised people borrow money or sell money to cover the expenditure (WB, 2001).

Range of Service in Private Medical Care Institutions

This question addressed here is whether the private institutions have a preference in providing some specific services and in the process focus on profitable services? The preventive and promotive service is a critical issue for for-profit private medical care institutions as they may not generate good revenue but they can increase the credibility and reputation of the institution. Therefore, provision of restrictive services is debatable as the theoretical basis of cream skimming is questioned. Hence the incidence of cream skimming varies from time to time even in the developed countries (Mahapatra, P et al., 2001).

Most of the MCIs are small in size, which limit their range of services to reproductive services, abdominal surgery, general medical and paediatric cases. They depend on one doctor (Mahapatra, P, et. al, 2001) or on part-time consultants who provide speciality care (Muraleedharan, 1999). In Andhra Pradesh an overall of 78 percent of the private MCIs reported to offer general medicine services. General surgical, paediatrics and maternity services were available in 52 percent, 45 percent and 43 percent of the private MCIs respectively. Specialist clinical services like burns, diabetes, ENT, urology, dental, gastroenterology, cardiology, neurology, neonatology, physiotherapy, psychiatry, ophthalmology, eye testing were more available in the big hospitals in comparison to small hospitals and clinics. Cardiology services were almost equally available in private MCIs and public sector MCIs. Obstetric and gynaecological cases were higher in private hospitals than in public hospitals. This kind of trend spoke of the two possibilities viz. (i) small nursing homes and hospitals provided practice space for obstetricians; (ii) the availability of OBG services was almost similar for private and public MCI.

Even in Muraleedharan's (1999) study, similar observations were found. Majority of the hospitals offered OBG services. Even in corporate private limited hospitals radiology, OBG and paediatric were among the top three clinical services to be offered. Special clinical services appeared more frequently with shift in ownership from sole proprietorship to partnership and corporate private limited. Delhi study of the nursing homes shows that small and medium size nursing homes ranked OPD services, maternity, and surgical services as high profit areas. In large category diagnostic facilities were included beside the above range of services. Among the

maternity services normal delivery, caesarean sections, and pre-natal and post-natal check-up was the most profitable area (Baru and Nanda, 1994). In the twin cities of Hyderabad and Secundrabad, the general nursing homes provided maternity services. Private nursing homes treated malaria, followed by tuberculosis and typhoid. Filaria and leprosy were treated in very few nursing homes but they did not maintain any record (Baru, 1998).

The above studies show that obstetric and gynaecological services, general medicine, general surgery are commonly available in the private MCIs and are recognised as the most remunerative service areas. It is with the shift towards more complex kind of ownership pattern that special and high technology based services are offered. The private medical institutions treat communicable diseases but not that frequently. The pattern of the availability of clinical services reveals an unsaid disposition over certain kind of services.

Diagnostic Facilities

From the late eighties labs began to proliferate in the cities. Nowadays diagnostic facilities are more established than private clinics or hospitals. Diagnostic facility under one roof reduces the delay of clinical service and increases the managerial work. In Delhi case study it was identified as the third most profitable area. Analysis shows that 70 percent of the nursing homes had diagnostic facilities and 63 percent had imaging facility (X-ray, ECG and EEG). Larger nursing homes tend to have scanning facility (Nanda & Baru, 1994).

In the twin city study, 23 percent of the small and half of the large nursing homes had attached diagnostic laboratory (Baru, 1994). Majority of the big private hospitals offered pathology, biochemistry, microbiology, X-ray, ECG and ultrasound facilities. Along with these, hi-tech based diagnostic facilities were more commonly found in these kinds of hospitals (EEG, Gestroscopy, Bronchoscopy, Holter Monitoring test etc.). Most private clinics provided limited services. Even smaller hospitals offered various services but biochemistry, ECG and X-ray were frequently offered.

In the absence of diagnostic facility within the premises the cases were referred to outside labs. There was an unsaid network between hospitals and diagnostic centres and more common in case of small hospitals for radiological, CT Scan, MRI and dialysis cases. For the referral cases a certain amount of commission was given. This practice was common and it initiates a kind of competition that influences the selection of laboratories, number and nature of tests (Baru, 1998; Muraleedharan, 1999). In order to maintain a regular number of referral cases corporate diagnostic centres provided concessions to doctors. At times social links like caste also influence referrals (Baru, 1998).

In the hospital market, provision of services viz. clinical and diagnostics are motivated by financial incentives, by size and nature of ownership of private MCIs. To survive in the highly competitive market there is a strong nexus between the MCIs, doctors and pathological/diagnostic centres. Different kinds of commissioning strategies are being evolved which in the long run can raise questions on quality of care, number of tests being done and kind of medical practice.

Staffing Pattern

Staffing pattern is one of the crucial aspects for the quality of care provided to the patient. Private MCIs are labour intensive organisations. The states employ minimum regulatory mechanisms to check on the adequacy of staff and qualifications of the personnel in the private nursing homes and hospitals. It was generally seen that majority of the private MCIs employed nurses who were trained on job. Very few of them hired doctors and owner-doctor mostly provided medical care in smaller MCIs (Baru, 1998). Workers Solidarity Report (2000) described the working conditions of the fourth class employees of the big private hospitals in Delhi. The large hospitals tried to keep the total wage bill within 30 percent of all expenditures and significant proportion was spent on paying the specialist consultants. Generally, these hospitals kept fourth-class staff on contract, curtailing certain benefits to them. Especially ayahs, ward boys, sweepers, electricians, security guards were kept on contract basis. Ayahs, ward boys and nurses were at times over worked due to shortage of labour. Under these circumstances they may work without any kind of break. This extra hour of work was not adequately compensated in terms of any facility. This on one hand

leads to job insecurity among the fourth class workers and also on the other side raises the issue of quality of care rendered to the patients by the private MCIs.

Social Links of the Private Medical Entrepreneurs

From understanding the heterogeneity within the private institutions we now explore the social background of the medical entrepreneurs who are moulding the course of privatisation. What is critical to understand is which social class in the medical sector owns the medical care institutions, controlling the income and wealth out of it? This is important as "*the manner in which the social classes occupy their positions in the hierarchy will also determine how the superior (and exploiting) classes will define a concept of good health and what the health services system designed by them will actually deliver to the inferior (and exploited) classes" (Qadeer, 1985).* It is they who suggest reforms and bring about marginal changes in the policy further to strengthen the inequitable system and also to absorb the dissent (Ibid.).

There are very few studies dealing with the sociology of the medical entrepreneurs in India. The studies looked into the religion and caste composition of the promoters, family's occupational background, educational qualification and other social aspects. A study of the private nursing homes in Delhi looked into the professional background of the promoters. The main findings of the study tell us that almost 65 percent of the promoters were in Government service. They either resigned or took early voluntary retirement to establish private enterprises in the medical care sector. Promoters showed more than 30 percent were from business background investing into the private establishment. A large number of promoters used personal funds or had taken loans at commercial rate of interest and a few availed Government loans. Non-medical promoters with interests in other business were increasingly financing private medical enterprises (Nanda and Baru, 1994).

The study of Hyderabad and Secunderabad showed that majority of the owners are from forward castes with a few owners belonging to Muslim and Christian community. Majority of the owners had agricultural background followed by business and professional families viz., doctors and engineers. Owners from the agricultural

background could be broadly classified as the landlords and wealthy peasants who transferred their surplus capital into other areas. This was primarily due to the fact that other avenues of business apart from agriculture gave power to them. Largely the owners of the small nursing homes and large nursing homes were qualified with medical degree. Only a few of owners with non-medical background were partners in the medical enterprises. Owners of the small nursing home invested their own capital whereas in the case of large nursing homes bank loans were taken. Interestingly majority of the owners had worked abroad to accumulate capital. Some of the owners ventured in other business mostly in areas like diagnostic laboratories, chemist shops, clinics, with a few others in non-medical fields (Baru, 1998). In both the studies link with public sector shows the proliferation of the private sector.

In the eighties, indigenous business groups and non-resident Indian doctors were among the early promoters to invest in the corporate sector hospitals of the southern cities of Hyderabad and Madras (Baru, 2001). They started to register hospitals under trusts or societies. The Government allowed the profitable business houses to set up such institutions. On one hand it was seen as a contribution to social welfare and at the same time they were exempted from taxes (Baru, 2001; Duggal, 2000). To mention a few, Tatas, Birlas, Hindujas, Modis, Nandas, Goenkas, Singhanias, Chabbrias and Oberois largely established specialist hospitals. They were the elite industrial class, which surfaced in the 1960s and 1970s (Baru, 1998). Similarly in Calcutta, G. P. Birla group promoted B. M. Birla Heart Institute in 1989 as research-cum- treatment centre. Following Chabbrias, Shaw Wallace and the Goenkas planned to promote hospital projects of Rs. 30 crore and Rs. 50 crore respectively (Ibid). In the nineties secondary level private hospitals expanded. Many corporate and trust hospitals (table 1.7) began to collaborate with the state governments and also with the multinational corporations (Baru, 2001).

Table 1.7: Collaborations in the Tertiary Private Hospital Sector, 1997

Sl. No.	Indian Company	Collaboration	Type of Hospital	Location
1	C. K. Birla Group	Kleveland KlinK of the US	Super speciality hospital with 350 beds	Jaipur
2	Escorts Heart Institute	Gleneagles Singapore	Duncan's Gleneagles Super speciality hospital with 900 beds	Calcutta
3	Wockhardt	-	Health Care Centre	Bombay
4	Sterling Gujarat	-	Corporate hospital	Baroda
5	Ranbaxy Laboratories	-	Corporate Hospital	Mohali, Chandigarh
6	Apollo Hospital	Jardine, Insurance, U.K.	Health Maintenance Organisation	Delhi
7	Apollo Hospital	Delhi Admn.	Multi speciality hospital	Delhi
8	-do-	-do-	800 beds hospital	Delhi
9	Royalton healthcare (India) Pvt. Ltd.	Montreal based Medical Management	Tertiary	Gandhinagar

Source: Compiled from the newspaper and magazine clippings 1997 as cited in Baru 2001.

This Section of the study has primarily tried to delineate the pattern of private medical sector, social characteristics and its involvement in provisioning of medical care. The private sector in the health care system has carved out a significant space for itself. It is now one of the booming industries.

Our review throws on two kinds of explanations on private sector in medical care, the one using broader political economy framework and the other which specifically focuses on the local experiences. Given the paucity of regional studies we have chosen Calcutta as a case to study its private sector in medical care and its characteristics and to explain these characteristics within West Bengal's larger context especially its health sector reforms.

CHAPTER – II

RESEARCH METHODOLOGY

In the previous section we see that there are very few regional studies related to the structure, profile and characteristics of the medical entrepreneurs. Neither there has been much work on the evolution of private sector in different states. Based on this we developed our conceptual framework of the study.

I. CONCEPTUAL FRAMEWORK OF THE PROBLEM

Withdrawal of state intervention from the general health and medical services and deteriorating conditions of the public sector institutions are compelling the people to go for private sector services. The economic reforms with its marked importance on the private sector has once again emphasised on the private institutions and services. The World Bank proposes to have least state involvement in the provision of curative care. Similarly, the elite classes and Birla's and Ambani's, representing business groups in the country as members of the Prime Minister's Advisory Council on Trade and Industry, are not under any compulsion to use the public services. They have appealed to the state for reforms as it is sought by the World Bank as a primary objective to secure good health for India's population. Though all the sections avail the services of the private medical care institutions, it basically meets the need of upper and middle class.

In some ways India's implementation of measures for cost containment, efficiency and low cost public health seem to repeat the experience that Britain and United States has gone through. Taking advantage of the large size and variation in Indian situation, it would be interesting to see the impact of SAP across different states as each one has a different socio-economic base and planning process given the state autonomy in India.

United States and Britain's experiences point out some very critical aspects of transition. Earlier sole proprietorship based hospitals gradually disappeared and were devoured by the upcoming private limited companies and ultimately by the corporate sector. Secondly, institutions that had more resources with fewer patients survived better than those who had larger number of beds but little resource. Last but not the least, the

state had played a very critical role in the transformation either by shifting state resources to the private sector or by opening up public sector to private investment and at times by giving them heavy subsidies from taxes and by provision of land.

This gives us the framework to analyse the transformation of medical care structure at the state level wherein we propose to examine the dimensions of the private institutional medical care in terms of size, ownership pattern, rates and charges, and the staffing pattern. The study examines the rate of growth, the extent of corporatisation, the degree of linkage with public sector and the shifts from proprietary to private limited which will indicate the extent of privatisation and its implication for equity. It also tries to understand the range of services, which are usually provided by the private sector. An effort has been made to critically understand the sociological background of the owners of private medical care institutions, as they are significantly shaping the nature of private sector in the country.

We specially focus on the two categories of private medical care institutions (MCIs) i.e. nursing homes and hospitals. Labs, clinics and other MCIs are not covered in the present study. *The term MCI therefore in this study only refers to nursing homes and hospitals.* The study deals with only allopathic medical care institutions. It explores the range of services offered that comprise of clinical services, diagnostic facilities (imaging and pathological) and auxiliary services. Auxiliary services include telephone service, food service, pharmacy, ambulance and blood bank.

The sociological profile of the owners of private medical care institutions examines the owners age, caste, educational qualification, place of origin of the family, landed or not, fathers occupation, siblings occupation, whether anyone practised abroad or not and the professional background of the owner and resource base for financing their MCIs.

The term size in the context of hospitals and nursing homes can mean the number of beds, number of inpatient and out patient it caters to and assets the medical care

institution holds. *In this study the term 'size' is used to mean the total number of beds.* Private medical care institutions can have different ownership pattern. For the purpose of the study it is useful to classify the different ownership patterns.

1. Sole proprietorship: In this category, individuals (physicians or non-physician) own nursing homes and hospitals. It has unlimited liability. In this case the owners are directly involved in the management of the organisation.

2. Partnership: Institutions under this category have two or more but less than 20 partners and profits are shared with partners. They have unlimited liability.

3. Private Limited Company: Under this category organisations have more than 20 but less than 50 partners and have limited liability. Profits are shared with partners.

4. Public Limited Company: The owners have limited liabilities. They raise resource through the public issue of shares. The profits are shared with shareholders and the company need not be listed in stock market. The shareholders control the company through their right to vote in the annual general meeting.

5. Trust bodies: Trust hospitals or nursing homes get tax concessions since they can re-deploy their profits in hospital related investment and cannot distribute their profits among partners.

This study proposes to look at the experience of Calcutta and try and understand how the experience is different from other states and countries for which data is available.

II. OBJECTIVES

Given the conceptualisation of the problem we set the following objectives. To explore the social history of the private sector in Calcutta and assess its present size and characteristics. This main objective could be broken into three areas of exploration:

1. To understand the social history of the private sector in medical care
2. To determine the size and growth of the private sector in medical care
3. To identify the characteristics of private enterprise

III. STUDY DESIGN

Based on the conceptualisation of the problem and the above objectives the following design was evolved for the study:

Selection of the Study Area

Calcutta has been identified as the area for doing the study. The total area of the Calcutta is 185.00 sq. km. In the 1991 Census Garden Reach municipality, South Suburban municipality and Jadavpur municipality area has been included into Calcutta Municipal Corporation area. Calcutta Municipal Corporation map with 141 wards from the 1991 census and another map of the city with detailed roads was obtained. On it mapping of the nursing homes registered under the Clinical Establishment Act, 1950 was done.

The area in north, north eastern and central part of the city between Nimtala road in the north to Acharaya Jagadish Chandra Bose Road was identified as the study area (Map I). This encompasses the places where the first medical college and schools, hospitals in the city were established. It covers areas where the nursing homes were first started and a part of the area has also has witnessed the growth of new nursing homes and modernisation of the old ones in the past twenty years. Apart from this, the area identified is also accessible to the researcher.

WEST BENGAL

DISTRICT CALCUTTA

Km 1/2 0 1 2 3 4 5 Km

N

DISTRICT BOUNDARY . . . . . .
WARD BOUNDARY WITH NUMBER 106
METALLED ROAD . . . . . .
RAILWAY LINE WITH STATION BROAD GAUGE/METRE GAUGE. .
RIVER . . . . . .
CANAL . . . . . .
LAKE . . . . . .

Study Area.

HOOGHLY RIVER

NORTH TWENTY FOUR PARGANAS DISTRICT

HOOGHLY DISTRICT

SOUTH TWENTY FOUR PARGANAS DISTRICT

FORT WILLIAM

AREA GOVT. BRICK FIELD

TO BUDGE BUDGE

TO BARUIPUR

BASED UPON CALCUTTA MUNICIPAL CORPORATION MAP AND 141 WARDS SHOWN AS PER RECORDS OF 1985.

Data Collection and Time Frame

The study was conducted in three phases. In the first phase of the study preliminary work was done that included the review of relevant literature on the private sector in general and on private medical care in Calcutta. Other than these, data was also collected from a few senior allopathic practitioners in the city were interviewed. This phase was intensive for two months and was then combined with fieldwork depending upon time availability. In the second phase of the study primary data was collected from the private nursing homes and hospitals and senior allopathic practitioners in the city were interviewed. This phase required three months. Analysis and writing took four months and constituted the third and the last phase of the study.

First Phase

First of all, the list of clinical establishments (private) registered under the West Bengal Clinical Establishment Act, 1950 was obtained. As per the Act clinical establishments include nursing homes, physical therapy establishment, clinical laboratory, hospitals, dispensary (with bed), medical camp, medical clinic, medical institution of analogous establishment. The majority of the clinical establishments are registered in Calcutta Municipal Corporation area. Very few among them are in CMDA (Calcutta Metropolitan Development Authority Area). This particular study confines itself to private nursing homes and hospitals in the study. The different types of clinical establishments are not categorised in the list as per the Act. As a result just by the name of the institutions it was difficult in some cases to ascertain whether it was a clinic or a nursing home or diagnostic centre under one roof. Therefore, cross-referring and checking over the telephone was done to finalise the list. To get a geographical spread of these private MCIs mapping was done.

Secondly, along with identification of the private medical care institutions, library and archival work was done to understand the evolution and growth of medical care service with a focus on the private sector in Calcutta. For this other than Calcutta

Archives, National library, Asiatic library, Secretariat library and a few others were regularly explored.

Second phase

With the help of mapping, an area was identified in the city to conduct the study. In the identified area, the nursing homes identified were 72. Out of this, a sample of 36 nursing homes was selected by systematic sampling method, taking every alternate nursing home in the population after a randomly selected first MCI. Out of the sampled nursing homes, four were found to have closed down. Apart from this one private limited hospital was included in the study. Thus the total MCIs studied were 33.

After the selection of the MCIs an interview schedule was built, based on the objectives of the study. The interview schedule contained structured as well as semi structured questions. The schedule contained questions related to year of establishment, ownership pattern, bed size, nature of services and facilities, cost the services, staffing pattern and social background of the medical entrepreneur. This schedule was pre-tested on a few MCIs and then finalised for the application to the chosen sample. Interviews were mainly conducted with the owners of the MCI. But at times in the absence of the owners, managers or senior staffs were interviewed.

Along with this, in the second phase, library and archival work also continued and the interviews of the senior medical practitioners were taken.

Third Phase

In this phase data sets have been coded and tabulated on the basis of the conceptualisation of the study. Based on the emerging trends, sets of tables were generated. The quantitative data to offer explanations for the trends have been integrated with the qualitative data collected wherever necessary.

Research Tools

1. *In-depth interview*

This method was used to elicit information regarding the social background of the owners. These interviews were conducted with the owners, managers in order to get details about the origin, ownership pattern and other related social and economic issues setting up the MCI.

2. *Interview schedule*

An interview schedule was build, which focused on certain specific aspects of the institution discussed earlier. Structured and semi-structured questions were combined. These were conducted after building a good rapport. Hence, the effort was to get details of perception and ambition of the owners. The qualitative and quantitative information gathered was helpful in constructing a picture of the present scenario of the private sector in medical care.

Getting appointment with the concerned people in the medical care institution took time. Only in very few cases the MCI authority agreed directly to give the interview. Phone calls and visits helped to build rapport and in certain cases reference from others helped to get the interview. Old, senior doctors willingly spared time compared to the young and middle-aged doctors.

Apart from this, a few medical practitioners were interviewed to get an overview of the growth process of the private sector in medical care. For the purpose of the study a medical practitioner is defined as a person with MBBS qualification in allopathic medicine.

3. *Historical and Secondary Data*

Other than the archival material, a range of sources such as officials and non-officials, press reactions has been identified and used. Data from the 'Health on the March' West Bengal, a publication of State Bureau of Health Intelligence of different

years has been used to understand the growth of private institutions and beds relative to the public sector. The 52nd (1955-96) and 42nd Round (1986-87) of the National Sample Survey is used to compare the utilisation pattern of out and in patient care across rural and urban areas. The data from (CBHI) Central Bureau of Health Intelligence provides an overview of the private hospitals and beds in the country.

4. Observations

While visiting MCIs, facilities, buildings and personnel were observed and the observations helped to cross check the information provided by the owners.

Data Analysis

The data collected for the study is divided into three sets. The first set of the data analyses the material gathered from the archival records, past journal. It explores the evolution of allopathic medical care institutions in Calcutta - rise of hospitals and critically examines the private interest within the evolving public sector and the emerging private sector prior to 1947.

The second data concentrates on the present medical care sector in the state of West Bengal and in Calcutta. The data projects the number of hospitals, beds, ownership status of the hospitals. Apart from this it also studies the reports brought out by the Subject Committee on Health and Family Welfare, Government of West Bengal.

The third set of data deals with the present private sector in Calcutta in Calcutta. It is based on the primary data collected. This concerns different types of MCIs, their services, structures, charges, staffing patterns, ownership, size etc.

Limits of the Study

1. Given the time limit, in-depth archival work on medical care service in Calcutta was limited.

2. It was realised that most private providers shared general information willingly but information on financial aspect and staffing pattern was not shared very willingly. Some private health personnel were reluctant to provide detailed information about their institution.

3. The reason for the closure of the nursing homes could not be identified.

Yet, the study provides insights into the specificity's of private sector in West Bengal and opens up areas for further research.

CHAPTER – III

MEDICAL CARE INSTITUTIONS IN CALCUTTA – THE PAST

In 1636 Shah Jahan, the then Moghul emperor allowed the Company to establish and trade from the soil of Bengal. In 1698 the Company obtained the right to rent three villages – Suttanatte, Calcutta and Gonbindapore. The new settlements began to take shape in the hands of Europeans (Kidwai, 1987). Thus the city of Calcutta was born with the advent of East India Company. During this period there was no regular allopathic medical establishment, except a few surgeons (Guha, 1951).

BEGINNING OF ALLOPATHIC MEDICINE

Between 1705 and 1707 Calcutta was afflicted with malaria and in one of the years, out of 1200 English soldiers no less than 460 died. The paper from Fort William Public Cons. of 16th October, 1707 read out: " *Having abundance of our soldiers & seamen yearly sick and this year particularly our soldiers and the Doctr representing to us, that for want of an Hospitall or Convenient Lodgeing...will be highly necessary....to keep the men in health* "(Crawford, 1913-14). In demand of the well being of the English soldiers, seamen, and those in Garrison and Company the first hospital came into existence towards the end of 1707 or early in 1708. The Company gave Rs. 2000/- towards the construction of the hospital. The money was collected from the ships coming to Calcutta dock and from the native zamindars and businessmen. In this hospital, Indians were not allowed for any kind of treatment. British soldiers, sergeants were charged for the services in the hospital. (Ibid.) In 1756 Sirajddaulah attacked some parts of the city in which the first hospital got destroyed (Ray, 1998). Thereafter in 1757 a temporary hospital not enough for the sick was started. Progressively the company was building up a regular medical service for itself. The medical officers of East India Company appointed apothecaries, dressers and hospital assistants as assistants (Ray, 1998). Juxtaposed to this the warfare between the English and French Companies in the time span of 1750-1754 and 1756-1763 necessitated the expansion and regularization of the existing medical establishment (Crawford, 1913-14). On 20th October 1763, the Bengal Medical Service was found and it was divided into military and civil service in 1766. During this time private allopathic medical practice was practically absent except

in a few places (Guha, 1951). The third hospital in the city came up in 1769, which was handed over to the Government. All these hospitals were under the British patronage and they were prohibited for the natives. These three hospitals were primarily meant for the Company's soldiers but Europeans were also admitted. The total cost of construction and maintenance of the third hospital was borne by Government (Crawford, 1913-14). Western medicine had not yet become popular with the natives.

By the Regulating Act of 1774, Calcutta became the imperial capital and the seat of power. With the expansion of the colonial power and control there was the concern to spread the western medicine among the Indians. Also, the military and civilian requirements were increasing. By the end of 1792 or the beginning of 1793 the first hospital for the natives opened with a subsidy of Rs. 600/- from the British Government. It had indoor and outdoor department and performed vaccinations (Crawford, 1913-14). It was for the indigent natives.

The Britishers did not intervene with the ayurvedic and unani medicine till the first two decades of the nineteenth century. In practice and content the indigenous medical system was not affected. Till the beginning of the nineteenth century in Bengal ayurvedic medicine was taught and practiced in the traditional 'Tol system'. In the Tol system Kavirajas of repute gave training to young aspirants to the science in their homes without demanding a fee (Gupta, 1976).

Table 3.1: The leading Schools of Traditional Ayurveda in Nineteenth Century Bengal

School	Special virtues of the School
East Bengal	
Savar	Preparation of herbal medicine
Matta	Techniques of examining patients, diagnosis &prescriptions
	Preparations of medicine s of Chemotherapy
Gaila	Healing many kinds of ulcers, fistula and piles
Chandsi	Treating insanity
Chittagong Khandarpara	Treating insanity and constructing temporary huts like temporary hospitals.
West Bengal	
Murshidabad	Reading pulse and diagnosis
Kumartooli	In medicine
Shrikhanda	General physicians who sold medicines in the open market and who published Ayurvedic textbooks

Source: Gupta, 1976.

The traditional ayurvedic schools of practice in the 19th century were primarily located in the eastern and western part of Bengal. Each school specialised in one aspect of ayurvedic medicine (table 3.1).

Rise of Hospitals in Calcutta

The nineteenth century Bengal made major advances in setting up allopathic medical establishments. In the first half of the century this process was scattered and slow. It was only in the second half of the nineteenth century that the medical care establishments began to grow in number and also expanded in Bengal. Dispensaries had spread faster than the hospitals in the beginning. Lord Auckland who appointed the Fever Hospital and Municipal Committee, believed that dispensaries were the cheapest and most effective way to provide medical care services. In the city there were doctors who favoured hospitals over dispensaries and claimed hospitals to be more effective. It is interesting to note that by 1880 under the British Government there were about 1200 public hospitals and dispensaries in India. This was twice the number by 1902 (Arnold, 1993).

Prior to 1787, there was a lunatic asylum of some sort in Calcutta. It was for the European insanes. From 1800 Europeans made efforts to gain popular support for the spread of western allopathic medicine. In addition, the inoculation programme allowed the Government to create an impact over the natives. For this programme the native 'tikadars' and brahmins were taken in large number and the district collectors were asked to assert their power and command in order to break through the native resistance. Kumar noted the influence of this force on the natives by 1840s. One section, especially the propertied and the educated class demanded greater usage of western medicine. He mentions about *Samachar Darpan*, 1834 and *Bengal Spectator*, 1842, which condemned the quacks and expressed the desire for the new modern medical institutions that would benefit the country (Kumar, 1997).

In 1811, leper hospital was established in Calcutta. The name of the asylum was changed twice. In 1814, the first Lying-in-Hospital was established. The first medical school in India for training the native doctors came up in the city in 1822. The students were taught in vernacular language and it functioned under the British patronage. Prior to this there were classes for training Europeans and Eurasians to form a sub-medical service for the army (Crawford, 1913-14). The Sanskrit and Urdu medical classes were located at Calcutta Sanskrit College and at Calcutta Madrassah respectively. In 1831, a small hospital was attached to the college with in-door and outpatient department (Gupta, 1951). This Native Medical Institution in Calcutta was a novel idea of the European scholars. They had done intensive research in Oriental art literature, science, philosophy and wanted Indian and Western medicine to be taught side by side (Kumar, 1998).

In response to the 'Language Controversy', that is in connection to the medium of instruction for higher education, Lord William Bentinck appointed General Committee of Public Instruction in 1833. The Committee inquired into the state of medical education in Bengal. It had suggested the establishment of a medical college for training in Western medicine and surgery through the medium of English Language. In the controversy waged, the Anglicists wanted to supplant the vernacular medium of instruction by

English and finally the decision of Anglicists prevailed over the committee. Following this the vernacular medical classes were abolished in Calcutta Madrasa and Sanskrit College. The decision to establish Calcutta Medical College in 1835 under the control of the Committee of Public Instruction was announced. English became the medium of instruction. It was also made the official language of India after Macaulay's Minute on Education (Kumar, 1998; Guha, 1951).

In 1835, the coexistence between the indigenous and allopathic medicine came to an end. On the recommendation of the Committee appointed by Lord William Bentinck the first medical college in Calcutta was started in 1835. It was victory of the Anglicists over the British Orientalists. In 1838, a hospital was opened with 20 or 30 beds and an out patient department was allocated to the medical college. The Fever Hospital and Municipal Committee appointed by Lord Auckland in 1836 dealt with a number of issues affecting the city and emphasised the need for a range of public health services as well as the establishment of hospital and dispensaries. These institutions were to treat a range of infectious diseases. Following this, the foundation stone for the new building of the Medical College Hospital was laid in 1848. The hospital began to function from 1852. From 1853 the college and the hospital expanded physically and as well as in terms of different departments. In 1857, the Medical College was affiliated to the University of Calcutta. Calcutta Medical College (CMC) comprised of a group of hospitals and dispensaries. In 1880, the Choony Lal Seal's Dispensary was built. Next year Eden hospital was built and it opened for the patients in 1882. The Ezra hospital was built in 1887 and began to function in 1888. The Shama Charan Lata Eye Hospital in 1891 and the Prince of Wales Surgical Block opened in 1911. In between a children's ward was added to the main hospital in 1886 and an outdoor dispensary was completed in 1898.

In 1867, the Government converted the Police hospital for the dying destitute into Pauper hospital. It was named as Campbell Medical School Hospital in 1873. It was for Indians and after Independence the name was once again changed to Nilratan Sircar Hospital. Calcutta School of Medicine, a private medical school, planted the seed for the present state Government R. G. Kar Medical College and Hospital's in 1886. Shambhu

Nath Pandit Hospital was opened at Bhowanipur in 1897. The cost for the hospital was borne by the Government, Calcutta Municipal Corporation and from the funds of the old Shambhu Nath Pandit outdoor dispensary. In 1885 with Dufferin Fund Lady Dufferin Victoria hospital was established for women. The Jatiya Ayurbijinan Parishad or the National Medical Council and the other Calcutta National institute were precursors to Calcutta National Medical College and Hospital.

The foundation stone of the School of Tropical Medicine and the hospital was laid in 1914 and 1916 respectively. The Government of Bengal had built the school building and the India Government provided the initial cost. Dr. R. Ahmed, father of Dentistry in India found the dental college in 1920. In 1923 Jadavpur Tuberculosis Hospital began its operation as a non-official enterprise. It was started by a medical student and was later developed by Dr. K S Ray. It obtained grants from the local Government, Calcutta Municipal Corporation and other public bodies. Another hospital for the women came up in 1926 named Chittaranjan Seva Sadan and was maintained by the local fund. Later on a separate Infectious Disease Hospital came up. This was in response to the influenza epidemic, which was occurring consecutively in the city. The Corporation of Calcutta took the initiative.

Medical schools and attached hospitals in Calcutta

The main objective of the medical school was to train the public service officers as hospital assistants of a lower standard than the Assistant Surgeons appointed in the Medical College (Govt. of Bengal, Report of Medical School Education, 1945). Besides training the students for lower level medical jobs in the Government service (Bala 1991), private practitioners were also trained in these schools (Jeffrey 1988). The Campbell Medical School in Calcutta and Dacca was founded in 1873-75. The Government recognized both the medical schools. About twenty years after the establishment of the two Government schools many private medical schools cropped up in considerable number. In 1886 private Calcutta School of Medicine was established in Calcutta. In 1898 a hospital was attached to the school land and was named as Albert Victor Hospital. In the early phase of the twentieth century Bengal province had 9 recognised medical

schools where about 3000 students received training (Govt. of Bengal, Report of Medical School Education, 1945).

Development of Medical Specialisation's

From the development of different branches of medicine in the then medical institutions it is evident that surgery was regarded as the main field. Other than surgery, specialisation's, which developed in these institutions, were ENT (ear, nose, throat), skin, dental, orthopaedic, fracture, neurology, psychiatry, chest, gynaecology, eye, venereal diseases and children's diseases. In terms of diagnostic facilities one can see the availability of X-ray and Electro-cardiograph facility. It is important to note that most of the allopathic institutions, which emerged then, were under the patronage of the state even if the funding was from the private sources. The system of private institution was not common though the doctors of these institutions freely practised in private.

Social Background of the Entrants into Medical System in Bengal

The State began to finance English schools from 1834 – 35 and by 1838 there were 6000 pupils in Bengal studying English. After the establishment of Calcutta University in 1857 the number of English schools for the natives increased. The medium of instruction in Government schools was converted to English by 1890s. The knowledge of English became compulsory to acquire western medical education. The elite groups of Bengali society could achieve the knowledge of English.

Table 3.2: Percentage of High Caste Hindus (Bhadralok) in Medical education

	Brahmin	Baidya	Kayastha	Suvarnavanik	Gandhabanik	Muslims
Male Literacy (%)	63.9	64.8	56.0	51.9	51.0	6.8
Male Literacy in English (%)	15.7	30.3	14.7	26.8	17.5	-

Source: Census of 1901, Vol. VI, pt. I, p – 297 - 303 as cited in Bala, 1991

Among the total population of Bengal only 10 percent of literate male population were from the medical background and of this only 0.9 percent were English educated. When we see the distribution of the literacy and English education in different castes of medical student then, we find that Baidyas and Brahmins were in equal proportion (64.8 and 63.9 percent). Kayasthas, Suvarnavaniks and Gandhabaniks then followed them (table 3.2). Brahmins though very visible in medical education, were proportionately less educated in English. It was Baidyas and Suvarnabaniks who were ahead of the other caste groups in English medical education (table 3.2).

Bala (1991) refers to the *elite group* in Bengal as the 'Bhadralok' community that includes the Brahmin, Baidya and Kayasthas of the Hindu society. Besides them any other caste group could also practice medicine provided they also had high economic status and adopt a specific lifestyle, which fell in line with the western culture. Second and third generation English educated Bengalis also demanded western education. Also, from landed gentry English education was demanded because of increased rent charges, which forced them to move away from agricultural jobs and acquire Government jobs (Bala, 1991). It was the propertied and educated class who could identify easily with the western medicine compared to any other class (Kumar, 1997).

In CMC in 1840s one third of the students were Christian. Some of them were either European or Eurasian (Jeffery, 1988). During this time Bhadralok Hindus, Europeans and Eurasians mainly dominated CMC (Bala, 1991). With the sanction of Government of India in 1858, paying seats were introduced for the primary classes for medical students in CMC. The primary classes in the following twenty years constituted more of paying students (Kumar 1998).

When we trace the ethnic composition of the students in medical schools and CMC in Bengal during the late nineteenth century interesting features emerge. Almost all European and Eurasians studied in Calcutta Medical College (CMC) except a negligible few in the medical schools during the late eighties of the nineteenth century. Thrice the number of Hindu students studied in medical schools than in CMC. In the

early nineties Hindu students increased in CMC but the strength in the medical schools increased by six and a half times. There were very few Muslim students in Medical College in comparison to the medical schools (table 3.3). Hindus were two and half-time more than Muslim students to receive medical education at medical schools. Bala however does not comment about the composition of the 'other students'.

Table 3.3: Ethnic Background of Students at Medical Schools and CMC, Bengal 1880-1891

Year	Europeans & Eurasians		Native Christians		Hindus		Muslims		Others	
	1	2	1	2	1	2	1	2	1	2
1880 – 81	-	39	4	-	230	84	100	-	5	-
1881 – 82	-	44	2	4	226	69	77	-	5	-
1882 – 83	-	51	2	2	346	68	77	-	12	5
1883- 84	-	34	3	2	474	76	126	-	2	5
1884 –85	-	33	4	3	533	86	130	1	5	9
1885 –86	-	59	4	4	509	80	82	3	5	6
1886 – 87	2	73	7	6	673	83	104	4	7	6
1887 – 88	-	80	7	7	615	70	100	4	3	2
1888 – 89	3	66	2	-	709	71	111	3	17	8
1889 – 90	2	58	8	1	714	87	122	1	21	3
1890 – 91	8	74	19	1	799	117	138	4	23	1

Source: Report on the Administration of Bengal 1880 – 1891 as cited in Bala, 1991.

1. *Students in Medical Schools*
2. *Students in CMC*

With the passing years, the medical schools were more sought after. The inclination towards the medical schools over the medical college was due to the increasing emphasis upon English and an increasing level of pre-requisite qualification. Christian students till the first two decades (1916 –17) of the twentieth century formed a significant part of the medical students body. In comparison to different fields of higher education in medical education Brahmins were fewer in number. From the medical education, in the nineteenth century Brahmins, Kayathas and Baidya obtained wealth,

status and power (Kumar 1998). In 1920s and 30s the number of Muslim students increased due to the reservation of seats (Jeffery, 1988). After World War I fee paying students in CMC grew rapidly and majority of them came from the privileged and well off sections of the Bengali society (Bala 1991). In British period other than the Europeans and Eurasians, Brahmins, Baidya and Kayastha castes practised western medicine. Orthodox Brahmins practised traditional vedic medicine.

In Bengal by the end of the nineteenth century medical profession had gained protection and support from the elite section of the society (Appendix II). Kumar has identified this section as the '*philanthropic elite of the Bengal*' who worked towards popularising western medical system among the natives by instituting many prizes and scholarship to the native Indian students besides donation (Kumar, 1998). 'Maharajas' of other province also contributed financial aid towards the growth and development of medical institutes in Calcutta. They were not necessarily educated in English. They were the aristocrat class for whom western medicine was a symbol of high social status (Harrison, 1994). This support gave medical institutions some special value in its work. There were also many from the upwardly mobile class who entered the profession and supported it.

There was yet another section, which comprised of established families of various castes – Brahmin, Suvarnabanik, Kayasthas, Tili, Basak and Kaivarta. They were different from the large income and land owning families but they belonged to forward castes. They controlled very little of capital or labour but, they dominated the public services, educational institutes and the top levels of administration and greatly influenced the decisions taken.

Thus, what was just a beginning in the eighteenth century became an established sector in the early phase of the twentieth century. The health sector in Calcutta attained its position and prestige not only with the support from the elite propertied class but also from those belonging to the forward castes and upwardly mobile class which gained power, prestige by means of English education.

Government Policy towards Private Practice

Public hospitals

Mention must be made about the Government medical officers doing private practice. The authority did not check this and the patients in the public sector were often not duly taken care off. The Government appointed a Committee (Hospital Committee of 1877) to look into the growing private practice by the public servants (Kumar,1998). The Committee expressed the difficulty in abolishing the private practice without increasing the pay of the Government Officers. A few officers in the Capital and other metropolis were barred from doing private practice like the resident surgeons, the health officers of the post and the Principal of the Medical College.

To make Indian Medical Service attractive, the Commission apart from recommending higher salary also called for allowing the recruited medical officers to have the privilege of private practice. It is apparent that the individual private practice was not objectionable except for a few. The public sector could not provide employment to every medical personnel produced (Report of the Commission on IMS, Calcutta, 1866).

The views of the inspector general of hospital of Indian Medical Department, 1870 gives us insight into the official attitude towards private practice:

"Private practice is advantageous alike to medical officers and their patients: it maintains and improves the professional knowledge, adds to the popularity of medical officers and consequent efficiency of dispensary and assist in spreading the knowledge of the value of English medicine. It is doubtful whether stringent practical rules can be laid down on this subject. Much will depend on the zeal, efficiency and discretion of a medical officer in the independent charge" (Murray, 1870).

Evidently private practice was considered as an additional benefit for the medical officers, who could enhance their skill and also seen as a strategy to popularise the usage of allopathic medicine among the natives. The rich patients used these private services

and paid for their own medical care thereby adding to the earnings of the IMS and the Government Doctors.

In the second decade of the twentieth century Government accorded the visiting surgeons of Calcutta Medical College Hospital to use the dressing drums for private use on payment of fee of Rs. 16 on each occasion (File Medl. 2M.16, progs 7 to 9, Last Order 10th feb 1925). The radiographers, professor and demonstrator staff of physiology, pathology were permitted to use Government material for the private examination of urine, blood etc by repaying to the Government 4 percent of their fees. A Professor at School of Tropical Medicine of Calcutta occupied with research work, drew an allowance of Rs. 500 per mensem in lieu of private practice. In the same way the Resident Physician and Resident Surgeon at the Presidency General Hospital, junior to the IMS officers were barred from private practice and were given a compensatory allowance. The medical officers of the dispensary could do private practice and could keep medicine for private supply to private patients where there were no drug shops or dispensaries. The Government found it difficult in regulating the compensatory allowances given to the medical officers given wholly or partly varied with position and thus could not be controlled by any uniform principal. This was due to the fact that the private practice allowed or forbidden varied in character. (File No. I-M-69, progs. 13-14 Dept. of Education, Health and Land, 1925).

The Government notified the general public about the fixed rates to be charged by the different classes of Government medical officers for visits to patients at their residences within the Municipal headquarter limit. The private patients were not entitled to free supply of medicines, dressings etc from hospitals. The scale of fee was to double the day fee during the night between 8pm to 6am. Government medical officers were not allowed to accept higher than the fixed fees. Presidency Surgeons and surgeons of similar standing were allowed to charge Rs. 24.00 if they visited the patients home otherwise Rs. 16.00 in the chamber. The rates were graded as per the designation of the doctor. The Civil surgeon could charge Rs. 8/-, assistant surgeon and sub- assistant surgeon charged Rs. 4/- and Rs. 2/- respectively (File Medl. No. 7M-38, progs. 1-3, 1949).

Paying wards in State hospitals

As early as in 1921 paying wards in the public medical hospitals of Calcutta and Bengal were introduced. In 11 hospitals there were total 191 paid wards (table 3.4). There were 52 paid seats in the Medical College. Medical College hospital, Eden hospital, Eye infirmary and Cottage hospital had paid seats. Calcutta Medical College hospital had the highest paid beds. Among the four Medical College hospitals Eden hospital had highest paid beds for the women. The charge for the paying ward was highest in Cottage hospital compared to other Medical College hospitals. It charged separately for the surgical and other medical cases. Surgical cases were charged more than the other medical cases. Other than the group of Calcutta Medical College hospitals, Albert Victor hospital, Presidency General hospital, Mayo hospital, Campbell hospital, Howrah General Hospital, Dufferin Hospital and Victoria Hospital in Darjeeling had paying wards. Presidency General Hospital and Howrah General hospital had the highest number of paying beds, 48 and 44 respectively. They had 16 and 27 percent of paying beds respectively for the female patients. In Mayo Hospital, there were only 2 paying beds and paying patients had to pay donation for one month at the time of admission. In Campbell hospital there were differential rates for the Europeans, seamen, Indians, attendants, Coolie department people. European wards were more costly than Indian wards. In Howrah General Hospital rates of the paying wards varied with type of ward viz. private room, railway ward and open wards. Rates in each ward varied with season. During winter the rates decreased. The maximum rate was Rs. 10.00.

Table 3.4: Hospitals with Paying Wards and rates of the bed – 1921

Name of the Hospital	Number of Beds		Total	Rates
	Male	Female		
Medical College Hospital	16	8	24	Rs. 2 per diem
Eden Hospital	-	13	13	3 turret rooms at Rs. 5 per diem. 10 cabins at Rs. 2 per diem.
Eye Infirmary	-	-	3	Rs. 2 per diem.
Cottage Hospital	-	-	12	Rs. 3 – 8 per diem for surgical cases. Rs. 2 – 8 per diem for medical cases.
Total Medical College			52	
Mayo Hospital	-	-	2	Rs. 50 for a month as donation for the hospital
Albert Victor hospital	5	5	10	Re. 1 – 8 per diem.
Presidency General Hospital	40	8	48	24 at Rs. 10 per diem 12 at Rs. 4 per diem. 12 at Rs. 2 per diem
Campbell Hospital	20	-	20	Rs. 5 to Rs. 7 per for the Europeans. Rs. 3 per diem for seamen from east India or Howrah Municipality Rs. 2 per diem Indian wards Re. 1 per diem Indians from Howrah Municipality or East Indian railway Re. 1 for European attendant per diem Re. 0 – 4 for Indian servants per diem Re. 0 – 12 for adult patients from Coolie Department Re. 0 – 8 for children from the Coolie department
Howrah General Hospital	32	12	44	**Private room**: For the summer Europeans, whole room – Rs. 8 – 4 Europeans, half room- Rs. 6 – 4 For the winter Europeans, whole room – Rs. 7 Europeans, half room – Rs. 5 Indian wards, whole room – Rs. Indian wards, half room- Rs.. **Railway ward** For the summer Employees of east Indian railway – Re. 1 – 8 Others Rs. 2 – 8 *Cont*

				For the winter Employees of east Indian railway- Re. 1 Others Rs. 2 **Open Wards** Employees of east Indian railway drawing less than Rs. 80 free For the summer Others Re. I –8 Female wards – Re. 1 – 8 Obstetric ward – Rs. 2 – 8 For the winter Others Re. 1 Female wards – Re. 1 Obstetric ward – Rs. 2 Confinements Private room Rs. 50 and Obstetric ward Rs. 25 in addition to the room charges Seamen (in the main Ward) – Rs. 2 – 8
Dufferin Hospital, Calcutta	-	11	11	2 beds at Rs. 10 per diem 4 beds at Rs. 5 per diem 5 beds at Rs. 3 per diem
Victoria Hospital, Darjeeling	-	-	4	1 bed at Rs. 2 – 12 per diem 3 beds at Re. 1 – 4 per diem
Total	**113**	**78**	**191**	

Source: 1 File Medl. No 1-H-9(1), progs. 30 to 31, June 1921.

User fee in State hospitals

In 1923, the Government abolished the distribution of free medicine and free treatment in charitable hospitals. Medicine in out door and in-door department was charged. The outdoor patients had to pay one anna per every 3 doses of medicine. Indigent patients were exempted from paying the user charge but later on medicine was not charged for the outdoor patients (Ray, 1998). Some of the well off patients in Calcutta, who could otherwise obtain treatment from the nursing home or by being at home, took the privilege of free treatment. The '*sick rich*' did this by giving a private call to the doctor in charge of the hospital or to one of the doctor in the Government health service. It created problems for the poor patients to get bed. Unless they paid the surgeon or the doctor previously the bed was not easily available to them. Several speakers raised

this issue of the poor patients facing the problem in getting accommodation in the Bengal Legislative Assembly (Ibid.).

The Government observed variations in the levy and disposal of fees from paying patients admitted to the state hospitals and dispensaries. The fees obtained from the patients were either credited in full to the Government or to the doctor for doing the operation or divided between the Government authority and the medical officer concerned. The Government of Bengal raised the issue that public authority which maintains the hospitals should get a part of the fees earned from the paying wards, otherwise the public medical officer is given an advantage over the private practitioner who cannot utilise the services provided by the hospitals. The Government took into care the interests of the private practitioner and nursing home unfair (*File Meld. No. 1-H-9(1), /progs. 30 to 31, June 1921*).

Operation fees in State hospitals

In Bengal presidency the patient in the paying ward of the Government hospital was not charged any special fee for the operation. Patient's fee covered all the hospital charges including surgical treatment. The public hospitals were primarily meant for the indigent patient. The paying beds were limited and fees charged are exceptionally low. It was found that patients seeking paid wards were not very rich. Only some among the patients could afford separate operation fees. The issue of realising fees from the patients for the operation in the Government hospitals was brought before the Public Service Commission from the standpoint of IMS, private practitioners and the private nursing homes. Governor-in-Council considered keeping the paying ward only. The Government felt that charging operation fees could create an outcry by the private practitioners who were already of the opinion that the presence of paying ward is unfair (Ibid.).

PRIVATE MEDICAL SECTOR IN COLONIAL CALCUTTA

Apart from the English education, press had also played a significant role in creating aspirations among the Bhadralok families for the white-collar Government job and associated them more with the western style of living. By 1816 the medical professionals among the *Bhadraloks* began to publish their own periodicals and in 1885 there were 96 periodicals in operation. Wealthy elites of Bengal supported the publication of these periodicals. Between 1857-85 various medical and science journals were published. In 1858 "*The Calcutta Journal of Medicine*" was started. It was started and edited by Mahendra Lal Sircar who was a western medical practitioners and his group also started the "The Calcutta Medical News". This was the emerging medical elite that became influential in the evolution of the private sector.

In the third annual general meeting of the Calcutta Medical Club Dr. B C Sen in his presidential address spoke about the presence of private medical practitioner even during the 1840s. There were many distinguished native practitioners like Dr. Doorga Churn Banerjee, Dr. Chunder Coomar Dey (first MD of CMC), and Dr Dwarka Nath Gupta, who attended aristocratic families of Calcutta. He pointed out the fact that many of the best graduates of the University declined Government services. The Assistant Surgeons were ill paid with heavy workload (The Calcutta Practitioner, 1904).

Prof. Goodeve in the opening address to CMC in 1855 – 56 mentions that in the first twenty years of its establishment 456 native doctors instructed went into public service. Among the 200 students of English class, 99 were in Government services. The native princes retained some of the other doctors as medical attendants. Another group of doctors was employed in the ship, which was quite profitable for the practitioners (Kumar, 1998). The Calcutta Medical College being one of the largest in the world failed to provide adequate number of native doctors for the public service. The Annual Report of the Director of Public Instruction, 1859 – 60, talked about many graduates going into private practice, as it was more profitable than the Government job (Ibid.).

The students from medical schools took up private practice. Majorities of the licentiates passing out from the Campbell Medical School were absorbed into the private practice in different parts of Bengal. It is recorded that men with some experience of work started independent practice with a qualified practitioner. From the Government medical schools the candidates after passing out were employed in these dispensaries and in a variety of subordinate positions in the hospitals. Some of them obtained private employment. Their services were in demand from the tea gardens. Some of them also took up independent practice in the more advanced villages, in the interiors and smaller towns (Govt. of Bengal, Report of Medical School Education, 1945).

Nevertheless, the employment scenario in the 1880s, tells that majority of the employment was in the Government sector – in the army, jail, railways. *The 1872 Census of Bengal lists 3769 physicians, surgeons, doctors, and vaids, hakeems numbering over 23,700.* The 'Bhadraloks' of the Bengali society were gradually moving away from the Government service towards the private practice (Bala, 1991). In the 1900s large number of medical graduates did private practice in the main towns and in this process began to draw patients from the hakims and vaids and also from the Government hospitals and dispensaries (Jeffrey, 1988). Jeffrey elucidates further how this shift to private practice was supported and perceived as an unavoidable result of the medical education policy by a few IMS officers in Bengal:

"The object of medical education was not merely to secure a constant supply of subordinate medical officers for the Government service... That private practitioners possessing the necessary qualifications should be able to compete with public medical charities, is a satisfactory result" (Bengal Administration Report 1885:306 – 307 as cited in Jeffrey, 1988).

The qualified doctors in Bengal practising allopathic medicine preferred to stay in the urban areas for better standard of living. The rural areas were starved of qualified allopathic doctors. Various newspapers like *Nihar (Kanthi), Amrita Bazar Patrika* noted the inadequate presence of doctors in the rural areas of Bengal (Ray 1998). In the late nineteenth century it was found that one quarter of the outpatient attendance in Bengal

was accounted by Calcutta hospitals and dispensaries. In the later years also among the total inpatients for Bengal Calcutta still dominated the scene thus reflecting the concentration of curative medical services in the urban area (Ibid.).

Private hospitals began to emerge in the city in the early twentieth century. As early as 1902 Marwari hospital came into operation in the city. Ramakrishana Sishu Mangal and Matri Pratishthan, special hospital for the women came up, maintained by local fund (Ray 1998). It started as a small maternity home in July 1932. It had an antenatal and postnatal clinic. It was started with financial aid from an American devotee Miss Helen Rubel (Sister Bhakti). In 1938 foundation stone of a permanent hospital building was laid and was completed as a 50 bed maternity hospital. Later on it gained wide recognition as a model maternity and Child Welfare Centre.

As early as 1914, that many nurses left Government job to take up private nursing because of poor scales and also to better future prospects (Triennial Working Report on Hospitals and Dispensaries, 1914-1916). But there are no clear statistics to tell us the exact number of private hospitals and nursing homes. The innovative scheme of honorary surgeons and Physicians was started in the year 1914. For this scheme none of the independent practitioners came forward for the outpatient department but many of them volunteered for the inpatient department. Private medical practitioners were appointed for a fixed period as house officers in medical colleges. The private practitioners used the public hospital facilities and enhanced their skills.

By the end of 1916 there were 22 civil hospitals and dispensaries in Calcutta. It was seen that during the war 1914 the state managed medical institutions were in better conditions. In 1922 out of 24 medical institutions 17 had indoor accommodation & the remaining 7 treated out patients only.

CONDITION OF THE HOSPITALS IN CALCUTTA

Joint Secretary of Indian Medical Association Dr. S. K. Ray wrote of the inadequate hospital bed strength for the poor patients and the need for new hospitals in the city. Medical care services were urban centred and commercialised. The Government hospitals in Calcutta were overcrowded. In 1927 the city was in need of 10,000 beds but had just over 3000 (Ray, 1998). The total number of beds in the important hospitals of the city was 2771, which reflects the degree of shortage in the city in 1932 (table 3.5).

Table 3.5: Number of beds in some of the Important Hospitals

Name of the institution	Total number of beds
Chittaranjan Seva Sadan	125
Eden Hospital	106
Dufferin Hospital	148
P.G. Hospital	235
Sambhunath Pandit Hospital	97
Chittaranjan Hospital (National Medical Institute)	105
Medical College Hospitals (Excluding Eden.)	583
Carmichael Medical College	330
Marwari Hospital	220
Mayo Hospital	107
Campbell Hospital	717
Total	**2771**

Source: Report of the Nursing Committee (1932) appointed by GB, MB, Medl.. N – 5, progs. A94 Feb. 1936 as cited in Ray, 1998.

Shortage of beds compelled the hospital authorities many times to refuse the admission of patients. The hospitals of Calcutta were lacking in the required number of trained medical and paramedical personnel. Diagnostic facilities were lacking in some of the important hospitals of the city (Ray, 1998). In June 1946, the compounders working in Government hospitals of Calcutta observed a strike as many unqualified compounders and doctors were engaged in these hospitals. Beside this, racial discrimination was prevalent and it was evident in the delivery of medical facilities (Ibid.). Ray (1998) in her comments upon the medical administration of Bengal accounts the lack of structural organisation and integrated medical service based on the needs of the people.

Table 3.6: Expenditure on Public Health and Medical Services

Year	Expenditure on Civil administration in Rs.(%)	A Public Health Rs.(%)	B Medical Rs.(%)	A + B
1937-38	79222	3032 (3.82)	5287 (6.93)	10.50
1938-39	82780	4060 (4.90)	5596 (6.76)	11.66
1939-40	85959	3939 (4.58)	5633 (6.55)	11.13
1940-41	92812	3976 (4.28)	5635 (6.07)	10.35

Source: Statistical Abstracts for British India (1937-41) as cited in Ray,1998.

A very small portion of the money from the civil administration was spent on medical and public health services. Expenditure on medical care services was more then the public health. The margin between two decreased between the years 1937-38 to 1940-41 from 3.11 percent to 1.79 percent (table 3.6).

Table 3.7: Number of Civil hospital and Dispensaries in Calcutta - 1947

Class of civil dispensaries	No. Open on 31st Dec. previous year	No. opened during the year	Number closed during the year	No. transferred to other dept. or class	No. open on the last day of the year under reference
I State Public	7	1	--	--	8 (12%)
II State Special					4 (6%)
i) Police	1	--	--	--	1
ii) Jail	1	--	--	--	1
iii) Others	2	--	--	--	2
III Local & municipal fund (including union board & village)	30	--	--	--	30 (46%)
IV Pvt. Aided	16	--	--	--	16 (25)
V Pvt. Non aided	1	--	--	--	1 (2)
VI Railways	6	--	--	--	6 (9)
Total	**64**				**65 (100)**

Source: Annual Report of the Health of the Population of West Bengal, 1947

In 1947 Calcutta had a total of 65 hospitals and dispensaries. 18 percent of these hospitals were funded by the state (table 3.7). The state health department directly managed majority of the hospitals. A few were under the other departments of the state. Local and municipal bodies funded majority (46 percent) of the hospitals and dispensaries. However, they were small in size in comparison to the state hospitals and mostly catered to women and children. 25 percent of the total hospitals were state aided private hospitals. Hence we see that the state to a very large extent controlled the public and private hospitals even though private individuals primarily funded them. Thus we find that by the year 1947, the purely private MCI was just one (2 percent) in the total hospitals and dispensaries.

Literature and archival matter thus shows that the medical-care institutions such as hospitals and dispensaries were set up in colonial Calcutta much before the establishment of the first medical college. General and special hospitals for women, infectious disease, tropical disease and dental hospital had begun to operate under the state support, local and private bodies. People patronising modern medicine and providing the material help for its expansion belonged to forward caste. Some of them were from the propertied and upwardly mobile classes.

Calcutta was endowed with many good medical colleges, schools and hospitals by 1947. The state was supporting the hospitals that provided bulk of the service in the city and also had higher number of beds. With the birth of Indian National Congress many medical associations came up and one among them was Indian Medical Association (IMA). These medical organisations had already begun to ask for Indianization of the medical service whereby the Indian doctors could get higher pay and status. Medical practitioners who were part of the freedom movement in the 1930s and 40s had raised the issue of nationalised health service that would reach out to the population irrespective of the capacity to pay. The seed of state sponsored health service was in a way laid down in the city prior to 1947.

Before 1947 the private sector in medical care existed mainly in the form of private practitioners. Except a few Government medical officers, others were allowed to do practice privately. In addition many private practitioners were allowed to use the public resources. They concentrated in urban areas for better practice and scope of living. Many among them were not adequately trained and yet continued to practice. Private hospitals and nursing homes began to appear from the early twentieth century. As said by one of the contemporary senior private practitioners that, "*in those days the nursing homes were seen more as sites of practice for the doctors rather than as profit seeking medical care units*". Also inadequate bed strength, lack of trained personnel in large public hospitals triggered the emergence of private MCIs for those who could afford some extra charges and wanted private care. The medical services were confined to the city and the significance of traditional system of medicine had declined among the elite and upward mobile urban class began to patronise western medicine.

CHAPTER – IV

MEDICAL CARE INSTITUTIONS IN CALCUTTA – THE PRESENT

Before we examine the current scenario of the private medical care, it is important to see the post independence trends in medical care in West Bengal, particularly in Calcutta. This chapter therefore is divided into two sections. Section I looks at the medical care sector after 1947 and section II explores the private sector of today in Calcutta.

I

MEDICAL CARE IN CALCUTTA: 1947 – 2002

An Overview of West Bengal

A year after independence, in West Bengal there were 333 hospitals with total bed strength of 17461. In 1948, 75 percent (13,104) of the beds were under the State Government hospitals. Under Local fund there were a very few beds, only 2.72 percent (475) of the total. *There were nineteen private hospitals in the State with 7.14 percent (1247) of the bed strength* (table 4.1).

Table 4.1: Total Number of Hospitals and Beds in West Bengal - 1948

Classes of Hospitals	Total No.	Total Beds
1. State (Public)	216	10,825 (62)
2. State Special	52	2279 (13)
3. Local Fund	24	5475 (3)
4. State Aided	22	2635 (15)
5. Private (non-aided by State)	19	1247 (7)
TOTAL	333	17,461(100)

Source: Health on the March – 1948 –1969, West Bengal.

In the beginning West Bengal had two medical colleges and five medical schools. One medical school in Calcutta (Campbell Medical School) was converted to a full-fledged medical college. Two medical schools namely Calcutta Medical School and National Medical School were merged to form an under graduate Medical Institute. Bankura and Burdwan Medical Colleges were upgraded as under graduate medical degree colleges and Jalpaiguri Medical School was closed. In 1969 North

Bengal Medical College was established (Government of West Bengal, Twelfth Report of the Subject Committee, 1995).

In case of West Bengal the notion that the State would take the responsibility of the citizens' health, irrespective of their economic status predates independence. The Bengal Provincial Branch on Medical Education and Hospital Policy wanted nationalisation of the entire medical and health services (Guha, 1951).

With the partition of Bengal in 1947, the city of Calcutta lost its resource area and millions of refugees came to the city. The civic amenities faced intense pressure and were inadequate. In the trajectory of Calcutta's economy between 1918-1970 the Marwari community of the city was transformed into entrepreneurs with simultaneous fall of the small groups of Bengali entrepreneurs. India limited companies emerged with Marwari entrepreneurs. There was redistribution of the profits and incomes across a new set of elite as the control of capital and labour was shifting to the Marwari's. In the 1960s the Birlas, Goenkas, Bajorias, Bangurs, Kanorias, Kedias, Jalans, Dalmias, Poddars, Jhunjhunwalas and Jaipuria became the new economic elite of Calcutta (Goswami, 1990).

After the formation of the State, the Congress Government started with a mammoth and dramatic project of Damodar Valley Corporation and Durgapur Steel Plant. The successors of Dr. Bidhan Ray could not sustain the economic success. There was rapid decline in the level of real per capita public sector investment, and many firms moved out of the city with the low level of private sector investment (Ibid.). After the Congress Government in 1977, CPI (M) led Left Front came into power and it is now in power for the sixth consecutive term. The Left Front Government has continuously emphasised upon the qualitative transformation of rural areas by land reforms and operationalisation of Panchayati Raj. Though health is a state subject, after 24 years of the Left Front Government yet, there is no State Health Policy in West Bengal. The major part of the large health service infrastructure comes under the domain of curative medical system, which is hospital based and clinically oriented. The reality does not corroborate with the Left Front Governments emphasis on preventive and promotive health care.

Table 4.2: Pattern of Control over Hospitals in West-Bengal as on 31.3.2000

Number of Hospitals and Beds Under the Management of										Total	
State Government (%)				Central Government (%)		Local Fund (%)		Voluntary Organisations (%)			
Health Department		Other Department									
Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
131	38406	76	6307	51	5889	23	772	134	6701	415	58075
(32)	(66)	(18)	(11)	(12)	(10)	(6)	(1)	(32)	(14)	(100)	(100)

Figures in parenthesis are (%) from the total
Source: Health on the March West Bengal 2000-01

There are a total of 415 hospitals with 58075 beds in the state (table 4.2). The Health Department of West Bengal runs approximately 32 percent of hospitals in the state and controls 66 percent of the total bed strength. Though equal number (134) of hospitals are owned by voluntary organisations but these control only 12 percent of the bed strength. A little more than three fifth of the hospitals are under the management of different Government bodies (State, Local and Central). In the State among the eighteen districts Calcutta has the highest number of hospitals under the Department of Health and Family Welfare. Jalpaiguri district has the highest number (39) of voluntary hospitals in the state followed by Calcutta with 27 private or voluntary hospitals. Almost 46 percent (3050) beds of voluntary hospitals are in Calcutta. Therefore, we see that the state basically relies on public facilities. The 42nd NSS Survey shows that 77 percent and 73 percent of the hospitalised cases in rural and urban areas are treated in public hospitals.

'Health on the March' a State Bureau of Health Intelligence (SBHI), Government of West Bengal publication uses the term private and voluntary organisation synonymously. Therefore, to ascertain hospitals as profit and non-profit hospital from the list becomes difficult. From 1990 onwards the publication has clubbed the hospitals previously titled private aided and non-aided as voluntary hospitals.

Table 4.3: Management of the Hospitals in Calcutta as on 31.03.2000

Year	Management of the Hospitals under the under the different bodies																			
	State Govt.		State Special		Local Fund		Central Govt.		Pvt. Non aided		Pvt. aided		Pvt. voluntary organisations		A.G.& F.R.E		Railways		Total	
	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds
1970	15	7412*	6	656	8	397	-	-	10	400	20	2762	-	-	1	200	2	355	62	121382
1980	20	9209	8	912	5	184	4	759	6	499	23	2682	-	-	-	-	-	-	66	14195
1991	34	13067	-	-	8	329	4	840	-	-	-	-	27	3216	-	-	-		73	17452
2000	36	14502	-	-	9	374	5	1164	-	-	-	-	27	3050	-	-	-	-	77	19090

1970

*Including district hospital of 24 Parganas

State Special includes institutions by Police, Jail, forest, Labour (ESI) and irrigation department.

1991 & 2000

State Government includes State Special includes institutions by Police, Jail, forest, Labour (ESI)

Central Government includes Central Special hospital viz. Railway hospitals and Public Sector Undertakings

Private organisations include voluntary organisations. In 2000 – 01 Health on the March used Voluntary organisation as the heading replacing Private organisation.

Source: Health on the March: West Bengal – 1970, 1980, 1991, 2000-01; Directorate of Health Services, Govt. of West Bengal.

Hospitals in Calcutta

State run hospitals

There are now a total of 77 hospitals under the department of State Government, Central Government, Local fund and Voluntary Organisation with total bed strength of 19090. Almost 76 percent (14502) of beds are in State Government hospitals. A very small share of 2 percent (374) is in the local funded hospitals. Central Government hospitals have 6 percent of the total bed strength. The voluntary organisation hospitals own 16 percent of beds. The total growth of beds in the city between 1980 and 1991 was 18.66 percent and in the following decade it increased by 8.58 percent (table 4.3). A similar trend was observed for the State Government hospitals. Over the period 1980-1991, the beds increased by 22.54 percent and over the next ten years the increase was only 9.89 percent. These trends throw up two types of issues: i. the emergence of new hospitals ii. the conversion of private into state hospitals.

From early sixties to mid eighties one can trace the conversion of many private hospitals and a central Government hospital to state managed ones along with the starting of new ones in the seventies. These were primarily set up to reduce the pressure from the medical college hospitals. B. C. Roy Polio Clinic Hospital for crippled children started in 1954 was taken over by the Government of West Bengal 1957. Feeling the need for better teaching and treatment facility in the dental college, West Bengal Government took over the management in the early sixties and converted it to a degree and post degree college for dentistry under Calcutta University. Dutta family handed over Abinash Dutta Maternity Home and Charitable dispensary over to the state Government in 1969. Bangur Institute of Neurology formerly attached to PG hospital was established as a separate hospital for better understanding of Neuro-science by the state in 1969. Earlier Dr. B. C. Roy Memorial Hospital for children was a Central Government aided hospital. Now the State Government runs it. On a land donated by Late Biren Roy family (the Zamindars of Behala) Vidyasagar State General hospital was established in 1976. Three private

state aided hospitals[1] were also converted into State Government Hospitals in mid eighties.

By late 1980s, 30 percent of the paying beds were in the public hospitals. Free bed was allowed on the recommendation of Parliamentary or legislative members, Councillors, Panchayat members (representatives of the people) as per Government order. From 1st April, 2002 free bed is applicable to patients whose monthly income is less than Rs. 2000/- per month.

Over 1970s and 80s four tertiary level public hospitals in Calcutta experienced tremendous pressure from the city and it's surrounding area. Gradually the public institutions have begun to deteriorate and there is growing dissatisfaction among the users. Besides poor medical care, inadequate staff, indifferent behaviour of the hospital staff is helping in mushrooming of nursing homes (Govt. of West Bengal, Eighth Subject Committee Report, 1994-95). In the teaching institutes many instruments like X-ray machines are lying idle or are not installed. In some cases even after installation the machine is not functioning. The respective departments do not keep any track of the instruments purchased in different years. The conditions of the State General Hospitals are deplorable. Medical, nursing and paramedical staff and technicians have been sanctioned in an ad-hoc and arbitrary manner. Often technicians and radiographers are not available (Ibid.). The Subject Committee claims that the city hospitals and teaching institutes have adequate diagnostic infrastructure. In spite of this the patients are referred to private clinics and particularly for investigations like EEG, ECG, Ultrasound and CT scan. It anticipates that there is some kind financial deal between the private clinics and Health personnel in such institutions. Calcutta Municipal Development Authority (CMDA) independently carried out a study on the investigation on the rationality of ski gram for chest on the OPD and indoor patients of Medical Colleges. The study showed that 80 percent of the chest x-rays asked was unnecessary and the needy patients were forced to avail of private services. This points towards a link between public and private sector practitioners (Ibid.).

[1] Lumbini Park Hospital, Ramrickdas Haralka Hospital and Upendranath Mukherjee Memorial Hospital

Thus, the brief review shows that Calcutta being once the imperial capital was already endowed with good number of medical colleges, schools and hospitals. After the formation of the state in 1947, Calcutta benefited immensely from the pre-existing institutions. One of the veteran public practitioners said, "*in 1958 Lt. D.N. Chakraborty re-organised the health service in the state and he strongly believed that the medical care should be provided by the public sector. Left Front Government in Calcutta became more established by the eighties and it strongly believed that the health care should be provided by the public sector*". This is evidenced till the nineties in the public sector hospitals but thereafter growth of public hospitals and beds slowed down.

Restrictions and Ban on Private interest within the Public sector

In the non-teaching hospitals the doctors are more concerned with their private practice. This affects the patient care. In the teaching hospitals though the doctors are not allowed private practice, they clandestinely indulge in the private practice. The Government has separated medical education from the general service by introducing a separate cadre for medical education service. It has made the medical education service non-practising so that more time can be devoted to the improvement of medical education. Many senior physicians and surgeons have left teaching jobs or taken voluntary retirement. This has created a void in the teaching institutes. For the medical administration at all levels, a separate non-practising cadre has been introduced along with the full time non-practising cadre for medical education. Special privileges were provided to certain selected persons and to specialists working at district and sub-divisional hospitals. After granting this privilege to a few, the doctors in the medical profession close to political and administrative echelons gained the practice rights for a large number of clinicians in urban areas. The Subject Committee on Health and Family Welfare feels that doing away with the restrictions on private practise for the Government doctors would act as a positive incentive for the lobby of private doctors (Govt. of West Bengal, Twelfth Report of the Subject Committee on Health and Family Welfare, 1995-96).

The above facts show that in spite of the emphasis on public sector provision of medical care, the state of West Bengal has never been able to check the private

practice of the Government doctors. A large number of public sector doctors practised privately and this weakened the public services. The private interests within the State Health Department became apparent to the Subject Committee on Health and Family Welfare. Subsequently the Subject Committee made a sceptical comment upon the State Health Department: *"The Health Department appears to be unaware of an organised onslaught on the Department by various interested groups to vilify the Government Health Institutions. This is unfortunate that even some of responsible persons eulogise private entrepreneurs for their commercial endeavour to exploit ailing population in the name of superior diagnostic and treatment facilities. Thus inflicts upon them costly and often unnecessary investigations. In this process these private organisations have established an unhealthy liaison and link with the medical and paramedical personnel in the different categories of Government Hospital starting from Medical Colleges to the Block and Sub-block Level hospitals. This tendency of prescribing unnecessary sophisticated and costly investigation is jeopardising the functioning of the health department.* Further the Subject Committee remarks that: *"These irrational investigations create an artificial crisis, causes disbalance between demand and supply in the Government institutions. Patients are thus forced to go to the private clinics for such investigations. This has created an unhealthy nexus between those commercial diagnostic institutes and the medical personnel particularly those who are working in Government institutions* (Govt. of West Bengal, Eighth Report of the Subject Committee, 1994)."

Local Fund and Central Government Hospital

The bed strength and number of hospitals owned by local fund have remained static over the past 30 years. Except in 1980, when the bed strength reduced by almost half. There are five locally funded hospitals. Majority of them provides maternity service except one, which caters to the tuberculosis cases. The hospitals under Central Government ownership did not increase much in number, whereas the bed strength grew by almost 28 percent between 1991-2000. In the previous decade the growth was only 10 percent. Chittaranjan Cancer Institute, which was erstwhile State Government Hospital, is presently owned by Central Government.

Private Sector in Medical Care in Calcutta

By the sixties, there were group of doctors in West Bengal who preferred the growth of private medical enterprise to meet the social needs. They wanted the Government to encourage the private medical institutions and the philanthropic activities in this field. In 1962 there were 64 state aided private institutions in West Bengal providing 27 per cent of the total hospital beds (7045 out of 29,474 beds). At that time there were 20,000 registered medical practitioners and out of them only 3,100 were in full-time employment under the Government including locally funded institutions. About five hundred doctors were employed by the state as part time and honorary medical personnel. Private medical practitioners contributed 75 percent of the ambulatory medical care service (Sarkar M N & Bhattacharya J K, 1964). There were more doctors employed outside the Government service.

In 1970, there were 30 private hospitals (20 state aided and 10 private non aided) with total of 3162 beds. The number of hospitals started decreasing in the 1980s and by 1991 it was 27. However, the beds marginally increased to a total of 3216 (table 4.3). In the next decade, the number of hospitals remained static and the bed strength decreased to 3050 (table 4.3). Among the 27 voluntary hospitals there are 19 hospitals, which receive aid from the State Government and the rest six are non-aided. Information about the remaining two hospitals could not be obtained. Though the Government report claimed to have 27 private or voluntary hospitals, the researcher on her personal visit to a few of the private or voluntary hospitals found that six of private aided hospitals were closed. In reality we see a decline in the number of state aided private hospitals.

These hospitals provide service for diseases of eye, chest, and tuberculosis, maternity and child-care service, orthopaedic, general surgery, paediatric and gynecological cases. They do not provide free of cost service. There are eight hospitals under the administration of religious bodies. R.K. Mission Seva Pratisthan and Assembly of God Hospitals and Research Centre have out reach programmes in the slums and in the nearby rural areas. Community health services include school health programme, antenatal and postnatal check-ups, immunisation, mobile clinics. Both these hospitals have a school of nursing.

There is growth of private nursing homes, clinics and diagnostic centres in the city. There are around 200 private medical establishments as per the list of private clinical establishments provided to the researcher by the state health department. But the list provided was an old one. The unofficial sources far exceed this number. They number around 1200 (Hazra, 2000). Many of the establishments are unauthorised. Apart from the different kind of clinical establishments, there are around 6000 doctors in the city (Ibid.). It signifies the presence of a large uncontrolled and unregulated private sector in medical care.

In the nineties, the city witnessed the rise of big business (table 4.4) in private medical care. In the early nineties, Peerless hospital and B. K. Roy Research Centre and Ruby General Hospital came up. Big corporate hospitals with professional management orientation started coming up. The promoters are from the forward caste and class, mostly Birla, Roy, Dutta, Neotia. Indigenous promoters with other business interests are entering in this sector. The promoter of Ruby General Hospital, Mr. S. Dutta is a graduate engineer and is an alumnus of Indian Institute of Management, Calcutta. He runs a successful business in India and USA and owns well-known brand names in the international retail markets. The present medical promoters are from the non-medical background with varied business interest. Apart from the indigenous business group multinational companies and non-resident Indians are investing in this sector. A non-resident Indian owning chain of hotels holds the majority share of Westbank hospital in Howrah, adjacent to Calcutta.

Table 4.4: Big Business in Medical Care

Sl. No	Name of the hospitals	Ownership Category
1.	B.M. Birla Heart Research Institute	Trust
2.	Calcutta Medical Research Institute	Trust
3.	Peerless hospital and B. K. Roy Research Centre	Public Ltd.
4.	Ruby General Hospital	Public Ltd.
5.	Wockhardt Medical Centre	Public Ltd.
6.	Duncan Gleangles Hospital Ltd.	Public Ltd.
7.	Bhagirathi Neotia Women and Child Care Centre	Trust
8.	Kothari Medical Centre and Research Institute	Trust

Out of the eight listed large hospitals five were started by the indigenous business groups (table 4.4). The elite class of the 1960s in Calcutta began to invest in mdical care. These investments became prominent by the 80s and in the later years as shown earlier by the entry of private capital (pg. 66). Looking at the present scenario, a Government doctor said that: *" now health care service is seen more as an industry, where health is a consumption good. Initially Birlas wanted to provide financial help for the public service organisation but later on we find them moving away from this kind of initiatives."*

The Subject Committee took up a study to understand the functioning of private hospitals, joint sectors, nursing homes and other clinical establishments of the state. Though the study could not be completed but it made a few valuable observations. The observation noted Government support to the private sector in the form of land, financial assistance, exemption of duty, receiving capital and recurring grants. The Government had negligible control over these institutions. Many nursing homes and clinical establishments hardly abide by the criteria laid down by the Health department. To a great extent Clinical Establishment Act, 1950 remains inactive. In the words of the Committee it has received lukewarm support from the political system. In fact there is an undercurrent of opposition from various types of health personnel and their organisations (Govt. of West Bengal, Sixteenth Report of the Subject Committee, 1999).

Total bed availability in the city

Seven hospitals with bed strength of 745 and above have more than 50 percent of beds in the city. Out of these, five hospitals are attached to the teaching institutes (table 4.5).

Table 4.5: Seven Major Hospitals of Calcutta

Name of the Hospitals	Bed Strength
Calcutta National Medical College and Hospital	1470
Medical College and Hospital	1718
Nilratan Sircar College and Hospital	1890
SSKM Hospital	1670
R G Kar Medical College and hospital	1200
ID &BG Hospital	780
KS Roy TB Hospital	745
Total	**9473**

All these hospitals are under the State Government Health department. There are eight locally funded hospitals that control only 2 per cent of the total bed strength. Their bed strength ranges between 1- 50. Central Government hospitals are medium sized with an exception of one. There are seven private/voluntary hospitals with bed strength of 1 to 50 and 101 to 200, 12 hospitals with bed size ranging between 51 to 100 and only one with 550 beds.

Table 4.6 Specialised Hospitals and Beds, Calcutta as on 31.03.2000

Cancer		Infectious disease*		Leprosy		Maternity		Mental		Children		Others**		Total	
Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds
2	32	7	2020	1	13	14	1014	3	486	5	616	4	320	36	4841

Hospitals include State, Central, Local body and Voluntary Organisations

**Including TB*

*** Others include hospitals for dental, eye, orthopaedic, polio etc.*

Source: Health on the March: West Bengal – 2000 –01; Directorate of Health Services, Govt. of West Bengal

Out of 19090 total beds only 25 percent (4841) are reserved for cancer, infectious cases, leprosy, maternity, mental, child and other diseases (table 4.6). Around 42 percent of beds in seven hospitals are kept for infectious diseases including tuberculosis. Beds for leprosy are negligible.

In the field of super speciality like neuro-medicine, neuro-surgery, cardio thoracic surgery, cardiology, urology, genito-urinary surgery, plastic surgery, endocrinology and gastro-enterology the services are limited to the city of Calcutta in the State. Super specialities exist in four under graduate Medical Colleges of Calcutta, as well as in Institute of Medical Education and Research (SSKM Hospital). Also, Bangur Institute of Neurology is the centre of excellence for Neuro Surgery and Neuro Medicine. Haemo Dialysis Units are in Calcutta Medical College and Sir Nil Ratan Sarkar Medical College Departments. Cardiology and cardio-thoracic surgery are situated in Kalyani Gandhi Memorial Hospital. In these hospitals 40 percent of the cases are referred from the surrounding districts. These institutes are faced with certain problems like inadequately trained doctors, nursing personnel, no co-ordination amongst the centres of excellence, and buying of superfluous instruments

(Govt. of West Bengal, Thirteenth Report of the Subject Committee on Health and Family Welfare, 1996-97).

Reforms within the Public sector

During the nineties, in West Bengal private initiative and capital began to play a significant role in medical care. The promoters of big business in medical care began to surface in the city. With the introduction of reforms in the country, the health reforms were actively initiated. World Bank supported State Health System Projects started in 1995 in the state and user fees were introduced in the public hospitals in the late eighties. The Left Front Government after 2001 election has reinforced this trend. A distinct change in the medical service policy became eminent when the Government for the first time gave importance to issues prominent to urban areas and enormous drive for industrialisation. In the 74th Annual General meeting of the Indian Chamber of Commerce, 2001, Chief Minister in his speech invited private investment to rejuvenate "*the pathetically managed state hospitals.*" It is a part of the *"new policy*" and he also said that: *"Besides tying up with government hospitals, the state will also encourage setting up of more private sector medical college in West Bengal"* (The Statesman, 30/08/2001).

Reduction of free beds in the State Government hospitals

In the public hospitals free beds are being reduced while paying beds are increasing in number. In the three medical colleges it is proposed to increase the paying beds from 30 to 33 percent and in SSKM it is to be increased to 85 percent. Previously among the four teaching hospitals out of 6374 beds, 26.40 percent (1683) were paying beds. Now it is increased to 46.65 percent (2974). The number of free beds will then decrease from 4691 to 3400. An official of the health department said that when the loan was taken from World Bank it was decided that the number of paying beds would be increased over the free beds in all the medical colleges and district hospitals. In 1999 an order was issued to increase paying beds from 30 to 33 percent. However none of the government hospital complied (ABP, 24/12/2001).

Increasing autonomy to the teaching hospitals in the city

The State health department plans to give administrative power to the five teaching hospitals in city to control the other Government hospitals. The department mooted the idea to reduce the rush of patients in the five teaching hospitals[2] (The Statesman, 21/12/2001).

Private Provisioning in the Public Hospitals

In two[3] medical college hospitals CT Scans are installed by private organisations and they will do the maintenance. State health department will not take any responsibility. For a section of the patients scanning will be done free of cost or at a lower price. The rest will pay at the market price (ABP, 7/01/2002). There are similar proposals in the pipeline. The World Bank has given an aid of Rs. 11 crore to two medical colleges in order to buy vital instruments for the intensive care units (ABP, 20/01/2001). This is an area of high foreign exchange and most of it will be done through private contracts.

Increasing the User Charges

The Left Front Government has increased the charges in state hospitals from 1st April 2002. The charges of operations, delivery, pathological tests, x-rays, dental and eye surgery, cardiothoracic surgery, therapeutic procedures, bed and cabin in all the teaching, decentralised, state general, district and sub divisional hospitals have been increased.

These are the ways of shifting the responsibility and the burden to the individuals. Reforms are being gradually introduced in the hope to improve the performance of the existing systems and bring about efficiency. The Left Front Government has introduced user charges, is privatising parts of services in the public hospitals like increasing the number of paying beds, contracting non-clinical services like food service, putting CT scan etc. It is encouraging the non-profit and profit groups, private physicians like retired professors or those who have taken early retirement to provide medical services. Recently Government of West Bengal has

[2] SSKM Hospital, NRS Medical College and Hospital, CMC and Hospital, Calcutta National Medical College Hospital and R. G. Kar Medical College and Hospital

[3] Calcutta Medical College and Hospital and Nilratan Sircar College and Hospital

signed a memorandum of understanding with IIT, Kharagpur to set up a medical research institute (The Statesman, 2002). In addition, professionally managed hospitals are now coming up in the city.

The challenge to reforms then is to assess whether private sector investments are providing care in a way that resources are i. released for the poor ii. strengthened infrastructure remains accessible to the poor and that iii. state priorities are not distorted by the demands of profit making. To assess these we present in the next section the characteristics of the private institutions today.

II

PRIVATE MEDICAL CARE INSTITUTIONS IN CALCUTTA – A SURVEY

We present here the trends emerging out of a study of 33 private MCIs in the north, north eastern and central part of Calcutta. This helps to grasp the reality of the private sector in medical care in the city.

Origin and Ownership pattern

Table 4.7 Year of Establishment of the Private MCIs

SL. No	Year of establishment	No. of MCIs	Ownership pattern				
			Sole proprietorship	Partnership	Pvt. Ltd.	Society / trust	Public ltd.
1	1925-1947	4 (12)	-	-	2	-	2
2	1948-1967	11 (33)	5	4	1	1	-
3	1968-1987	13 (40)	7	3	3	-	-
4	1988-2000	5 (15)	1	1	3	-	-
	Total	33 (100)	13 (40)	8 (24)	9 (21)	1 (3)	2 (3)

Figures in parenthesis are percentage

The MCIs under study reveal that between 1925 - 1947 only four MCIs were set up in our study sample. However, it is interesting that they were all private limited or public limited as far as ownership goes. Maximum numbers of MCIs were set up

between 1948-1987. While in the first 20 years after independence, the growth was threefold over the period 1948-1967. In the second twenty years this growth was only sustained, not significantly surpassed. After 1988 however, there has been a definite decline in growth of MCIs. The establishment of the sole proprietorship and partnership based MCIs dropped to only one from the late eighties. The overall growth is also slow in Calcutta with a decline over 1990s (table 4.7). What is interesting is the fact that between 1948-1967 and 1968-1987 the expansion was primarily through increase in ownership of sole proprietors and partnerships. The private limited MCIs increased primarily after 1968. In our sample the only trust hospital and the two public limited MCIs were both established prior to 1967.

As of today 40 percent of the MCIs are owned by sole proprietors. Only 24 percent of the MCIs were partnership based. There were very few medical care institutions under the trust and public limited ownership category. One of the MCIs was initially registered as a Public Limited Company (table 4.7). In the later years the ownership was changed and presently it is registered as a private limited organisation.

Among 13 sole proprietorship MCIs ten were owned by doctors. In the partnership MCIs there was at least one doctor among the partners. The partnership was not between husband and wives who were doctors. The team often included members from the owners' family, his or her close friends and also professionals. The shareholders the private limited MCIs also belong to the same family or were part of the extended family.

Table 4.8: Distribution of Beds

Sl. No	Ownership Pattern	No. of MCIs	Total No of Beds (%)
1	Sole Proprietorship	13	189 (20)
2	Partnership	8	170 (18)
3	Private Limited	9	293 (31)
4	Society /Trust	1	71 (8)
5	Public Limited	2	215 (23)
	Total	33	938 (100)

Figures in parenthesis are percentage

The total strength of beds in the surveyed MCIs approximately sum up to 938. Private Limited MCIs had the highest proportion (31 percent) of the city's overall bed

strength. Though single proprietorships constitute the highest proportion of MCIs in the survey, only 20 per cent of beds were under their control. There were only two Public Limited MCIs and that had 23 per cent of beds. One of the public limited private institutions had bed strength of 186 and the blue chip companies of the city are its shareholders. It provides the five star hotel like facilities (table 4.8).

It is evident from the distribution of beds that the number of beds under the private limited institutions and trust or public limited put together are the maximum and also equally distributed in the two categories, nearly 300 beds each. The sole proprietorship and partnership based MCIs though maximum in number cover only 38 percent of the beds.

Types of Private Medical Care Institutions

The bed strength varies from the minimum of 4 to the maximum of 186 in the study. As per the bed strength, MCIs have been classified into four types i.e. very small, small, medium and big (table 4.9).

Table 4.9: Type of Medical Care Institutions

Sl. No.	Type of MCI	Bed Strength								
		4-10	10-15	15-20	20-25	25-30	30-35	35-40	40+	Total
1	Very Small	11	-	-	-	-	-	-	-	11(33.33)
2	Small	-	4	3	-	-	-	-	-	7 (21.21)
3	Medium	-	-	-	3	1	4	2	-	10(30.30)
4	Large	-	-	-	-	-	-	-	5	5 (15.15)
	Total	11	4	3	3	1	4	2	5	33(99.99)

Figures in parenthesis are percentage

In the very small category the bed size ranged from 4 to 10, small category the bed size ranged between 10 to 20, medium category bed strength was between 20 to 40 and in the large category the bed size was 40 and above. In the very small category there were 11 medical care institutions with an average bed size of 7. The second largest proportion of 30 percent was of medium size MCIs with their average bed size

of 31. There were 21 percent of MCIs under the small category. There are 5 nursing homes with approximate bed strength of 426 and an average bed size of 85 (table 4.9).

Table 4.10: Ownership pattern of the MCIs

Sl. No	Type of MCI	Ownership Pattern					Total
		Sole Proprietorship (%)	Partnership (%)	Pvt. Ltd. (%)	Society/Trust (%)	Public Ltd. (%)	
1	Very Small	7 (64)	3 (27)	1 (9)	-	-	11 (100)
2	Small	3 (43)	3 (43)	1 (14)	-	-	7 (100)
3	Medium	3 (30)	1 (10)	5 (50)	-	1 (10)	10 (100)
4	Large	-	1 (20)	2 (40)	1 (20)	1 (20)	5 (100)
	Total	13	8	9	1	2	33 (100)

Figures in parenthesis are percentage

Majority of the very small and small MCIs were single proprietorship and partnership based. Drawing inference from the table 4.7 we can say that very small and small MCIs were established before mid eighties. Almost all the owners of very small MCIs were from the medical background. Therefore, these MCIs were for their direct source of earning. Half of the medium MCIs were private limited and 30 per cent were single proprietorship enterprises. Forty percent of the large MCIs were private limited enterprises and the rest were equally owned by partnership, trust based enterprise and public limited ones. Thus, there was a clear pattern of single proprietors and partnership owners largely having very small and small MCIs and the private limited, trust and public limited having the large and medium MCIs (table 4.10).

Types of Room Facilities

The MCIs were classified into three different kinds on the basis of the type of rooms, cabin, cubicle and ward. Their distribution and frequency is presented in table 4.11.

Table 4.11 Distribution of Room Types in the MCIs

Sl. No	General Bed/Room Types	All MCIs. (N =33) (%)
1	Cabin	1 (3)
2	Cabin +Cubicle	20 (61)
3	Cabin +Ward	3 (9)
4	Cabin +Cubicle +Ward	5 (15)
5	Cubicle	4 (12)
	Total	33 (100)

Figures in parenthesis are percentage

Majority (61 percent) of the private MCIs had cabin and cubicle facility. One medical care institution had only cabins. Among 33 medical care institutions surveyed, 15 percent had all three-cabin, cubicle and ward facility (table 4.11). In addition to the three types of room, these MCIs also had some special facilities. These special facilities comprise of intensive care unit, intensive cardiac care unit and star rooms (deluxe/Suite).

Table 4.12 Distribution of Special Facilities

Sl. No	Special Room Types	MCIs (n =11)
1	ICU	2(18)
2	ICCU	3(27)
3	Star	1(9)
4	Star +ICU	2(18)
5	Star +ICCU	3(27)
	Total	11 (100)

Figures in parenthesis are percentage

Only 33 percent of the medical care institutions had special facilities. Two nursing homes have ICU facility. Star room was there in only one nursing home, but a combination of ICU and ICCU was there in 2 and 3 MCIs respectively (table 4.12).

Apart from the three kinds of special rooms there were other kinds of special beds like critical care unit (CCU), nursery, maternity room, air-conditioned day care room and suite, post operative critical care unit and intensive trauma unit. Critical care unit was there in two of the medical care institutions. Out of them one was a large MCI and the other one was a middle type of MCI. Nursery, a special kind of room for the newly born babies was present only in two large medical care institutions. Maternity room, A/C day care room and suite, post-operative critical care

unit was present only in one of the large private MCI. Intensive trauma unit was there in three MCIs out of which 2 were middle type of MCI and one was large type of MCI.

It is clear that the special rooms are not very frequent and are found mostly in middle and large medical institutions. Thus one can assume that they are very costly as they try to meet the hotel like facilities and services.

Nature of Facilities

Five kinds of services have been identified, which are provided by the private medical care institutions. They are indoor, outdoor facilities, bedside diagnostic facility, ambulatory diagnostic facility and diagnostic facilities and medical shops. Indoor facility is the commonest service provided by all the private MCIs. Many provide a combination of these services.

Table 4.13: Service Types and Type of Medical Care Institutions

Type of MCI	Service type							
	Indoor	Indoor + MS	Indoor + Bed Side Investigation	Indoor + O.P.D	Indoor + O.P.D + M.S	Indoor + O.P.D + DF	Indoor + O.P.D + M.S+ D.F	Indoo + D.F
	1	2	3	4	5	6	7	8
Very small	3	-	2	4	-	2	-	-
Small	2	-	1	3	-	1	-	-
Medium	1	1	1	1	1	1	2	2
Large	-	-	-	-	-	-	5	-
Total	6	1	4	8	1	4	7	2

OPD – Out Patient Department, MS – Medical shop, DF – Diagnostic Facility

All the private MCIs studied provided indoor facility. From the table among the 33 private medical care institutions surveyed, 61 percent had outdoor department, 40 percent of them had diagnostic care and medical shops were there in 24 percent of the cases. Bedside investigations comprised of very simple diagnostic facilities like blood sugar test, portable x-ray, ECG, differential blood count (TC/DC) and

haemoglobin percentage (Hb%). 12 percent of the MCIs rendered this facility along with indoor provision (table 4.13).

Almost 56 percent of the very small and small type of private MCIs provided ambulatory care. Only two very small MCIs provided diagnostic facilities but they were recently started. These MCIs provide such diagnostic facilities that bring in profits like ultrasonography, ECG, electrocardiography etc. Medium MCIs were distributed almost equally among all the categories of service. Seventy percent of medium MCIs provided ambulatory care and half of these offered diagnostic facilities. Therefore it can be said that diagnostics are one of the profitable areas after the ambulatory care. Large MCIs provided all the four combination of services (table 4.13).

On the basis of the above classification, the medical care institution (MCI) can be further narrowed down and classified into four types-

Type I - Includes Service Type 3 (Indoor & Bedside Investigation).

Type II - Includes Service Type 1 and 2 without any OPD and Diagnostic facility (Indoor & OPD).

Type III - Includes Service Type 4 and 5 with the OPD facility (Indoor, OPD with or without Medical Shop).

Type IV - Includes service Type 6, 7, 8 Diagnostic facility (Indoor, OPD, Diagnostic & Medical Shop Facilities).

In the following analysis the above classification of Type I, II, III, IV will be used to assess the range of clinical services provided by the surveyed MCIs. The range of service includes clinical services, diagnostic facilities and auxiliary services.

Table 4.14: Availability of Range of Clinical Service

S. No.	Clinical Service	Type I	Type II	Type III	Type IV	All MCI (n=33)
1	Gyn./Obstetrics	4	7	9	13	33(100%)
2	General Surgery	3	6	7	11	27(81%)
3	General Medicine	2	5	5	10	22 (67%)
4	Orthopaedics	-	1	4	9	14(42%)
5	ENT	-	1	3	5	10(30%
6	Urology	-	-	2	5	7(21%)
7	Eye	1	-	4	1	6(18%)
8	Cardiology	-	-	-	4	4(12%)
9	Plastic Surgery	-	-	2	2	4(12%)
10	Oncology	-	-	1	3	4(12%)
11	Nephrology	-	-	-	4	4(12%)
12	Neurosurgey	-	-	-	3	3(9%)
13	Neurology	-	-	-	3	3(9%)
14	Kidney Dialysis	-	-	-	3	3(9%)
15	Pediatrics	-	-	-	3	3(9%)
16	Laproscopic Surgery	-	-	-	3	3(9%)
17	Dentistry	-	-	-	2	2(6%)
18	Gastroentology	-	-	-	2	2(6%)
19	Dermatology	-	-	-	2	2(6%)
20	Cardiothoracic Surgery	-	-	-	1	1(3%)
21	Burn Unit	-	-	-	1	1(3%)
22	Pardiatric Surgery	-	-	-	1	1(3%)
23	Nuclear Medicine	-	-	-	1	1(3%)

Figures in parenthesis are percentage

The most commonly available clinical services among the surveyed medical care institutions were gynaecology and obstetrics (100 percent), general surgery (81 percent) and general medicine (67 percent). All the private MCIs provided gynaecological and obstetric services (table 4.14).

Type I service institutions provided a limited range of services. They had only a few bedside diagnostic facilities. Majority of the type II service institutions were very small and small MCIs and they also provided limited clinical services. Type III service institutions offered specialised clinical services like plastic surgery, oncology and urology. The type IV service institutions catered a wide range of specialised clinical services like cardiology and others following it in the table 4.14.

It is very clear from the table that gynaecology/obstetric, general surgery and general medicine are the three most profitable service areas. Specialised cases were available only where there were diagnostic facilities of a wider range (table 4.14).

Table 4.15: Range of Diagnostic Facilities

SI. No	Diagnostic Facility	Service Type				All MCI
		Very Small	Small	Medium	Large	(n=13)
1	ECG	1	-	3	5	9(69%)
2	Xray	1	1	2	4	8(61%)
3	Microbiology	-	-	2	4	6(46%)
4	Biochemistry	-	-	1	5	6(46%
5	Haematology	-	-	2	3	5(38%)
6	Histopathology	-	-	2	2	4(38%)
	Pathology	-	1	2	1	4(31%)

Figures in parenthesis are percentage

Among the 33 surveyed medical care institutions, only 13 medical care institutions had diagnostic facilities, which were not high-tech. In this range of facilities, ECG (69 percent), and x-ray (61 percent) were commonly available. It is clearly evident that diagnostic facilities were more frequently available in large MCIs, followed by small medium size MCIs (table 4.15). Very small and small size MCIs had very simple kind of diagnostic facilities like x-ray, pathology, ECG (table 4.15).

Table 4.16: Availability of Specialised Diagnostic facilities in different categories of MCI

Diagnostic Facility	Very Small	Small	Medium	Large	Total
USG	2	1	3	4	10
Echocardiography	1	-	2	3	6
Scope	1	-	-	4	5
Holter Monitonng	-	-	-	3	3
TMT	-	-	-	3	3
Cytology	-	-	2	2	4
Colour Doppler	-	-	1	2	4
CT Scan	-	-	-	2	2
EEG	-	1	-	1	2
Spirometry	-	-	-	1	1
ABG	-	-	-	1	1
Mammography	-	-	-	1	1

Ultrasonography, echocardiography and scopes were the three most frequently available specialised diagnostic facilities. The specialised diagnostic facilities are more available in the large MCIs. The last four specialised diagnostic facilities were very costly and were less frequently available (table 4.16). Smaller MCIs that provide the above facilities had recently diversified into these areas, as they were the profitable avenues.

Table 4.17: Availability of Auxiliary Services

Type of MCI	Auxiliary Services			
	Telephone	Food service	Ambulance	Blood bank
Very small	11	10	1	-
Small	7	7	-	-
Medium	10	10	-	-
Large	5	5	4	3
Total	33 (100)	32 (97)	5 (15)	3 (9)

Figures in parenthesis are percentage

Telephone and food service were the most commonly available auxiliary services. All the private MCIs provide these two services except one very small MCI. The nursing authority orders food from the near-by restaurant. They have a contract with the restaurant over a long period. Accessibility by telephone was viewed as an important indicator of health services. Only one of the small MCI had a medical shop. It is situated just outside the MCI. Except one large MCI, rest (80 percent) had ambulance facility. Sixty percent of large medical care institutions had the blood bank facility (table 4.17).

Cost of Various Services

Operation Theatre Changes

Operation theatre (OT) charges were classified for minor, semi major and major operations. In this section we try to look into the variations in rates across the different types of MCIs.

It was observed that the OT rates for minor operation in very small and small types of MCI did not vary much. The range was between Rs. 150/- per hour to Rs. 800/- per hour and Rs. 200/- per hour to Rs. 700 per hour respectively. Even the OT rates for major operation between the two were similar. But the average charge for the small MCI was around Rs. 200/- more than the very small MCIs. Very few reported the OT rates for semi major operation. All the MCIs charged for the extra minutes consumed during operation. However, the specifications for it were not mentioned.

The medium type MCIs gave very broad range of rates. One of them charged on the basis of hours consumed. Apparently, in the medium MCI the range of OT rates for minor operation seemed similar to very small and small MCIs. But case wise scrutiny showed that the rates were higher in this compared to the smaller MCIs. On the whole the OT rates of medium type were higher. The rate for the extra OT time was quite high (Rs. 300/- per hour). For emergency cases the charges were double the general rates. Under local anaesthesia minor cases were charged Rs. 250/- to Rs. 600/- per case, which was almost equal to the cost of minor operation in the first two types of MCIs. The labour room charges varied between Rs. 600/- to Rs. 950/- per case. In large private MCIs, OT charges purely depended on time and nature of the operation. Large MCIs had introduced *surgery packages*. They included the OT charges and therefore it was not reported separately.

Our data shows that the OT charges for different categories of operation are related to the MCI size and in case of large MCIs, the process of charging different aspects of operation is complex.

Surgery Packages in MCIs.

Provision of surgical package is a current phenomenon. There are different kinds of surgical packages available in the market. This is a kind of marketing strategy. In the medium and big nursing homes, surgical packages are very specifically designed. In case of small and very small nursing homes the surgical packages are not well defined and vary from case to case. There is no fixed rate and the concerned doctors decide it.

Table 4.18: Some of the available Surgical Package in the Medium and Large MCIs

Sl. No.	Surgical packages	Cost (Rs.)
1	Major Surgery Laproscopic Hysterectomy Abdominal Hysterectomy Vaginal Hysterectomy	25,000/-
2	Inter mediate Surgery	16,000/-
3	Minor Surgery	10,000/-
4	Total Knee Replacement	80,000/-
5	Total hip Replacement	60,000/-
6	Lap Choly	15,000/-
7	Other Lap Procedure	10,000/-
8	Anthroscopy	10,000/-
9	Permanent Pacemaker	55,000/-

These surgical packages (table 4.18) exclude the cost of medicine and the patient hardly gets to know the break up of different aspects of package. The facilities included in the packages vary over the medical care institutions. Other surgery package tends to include OT charges, cost of normal consumable, disposable, medicines and few days of stay. The cost of the same surgery package varies with the type of room and nature of surgery. In certain cases blood bank facility, medical, and nursing care, physiotherapy and diet is also included. Apart from surgical packages there are few *'profiles'* such as cardiac injury profile or diabetic profile, which comprise of tests, related to a particular kind of clinical test. These are offered to patients as and when they come.

Health Package

Health packages are different from the surgical packages. Health package comprises of a combination of check – ups, furnished primarily to the corporate sector or to individuals. All large MCIs in the study provided health packages, which are seen as preventive measures. They cater to different levels and age groups of people and are tailor made. The tests included in the health check-up package and its cost varies over the institutions. Only three of the MCIs provided details of Health check-up package.

Table 4.19: Kinds of Health Packages

Case 1	Case 2	Case 3
Pre–Employment Health Check-up • Routine Clinical Examination • TC, DC, ESR, Hb, Sugar – F& PP • Urine & Stool R/E • X-ray Chest Charges : Rs. 500/- Midlevel Executive Health Check-up for people between 30-40 yrs. All the tests of Scheme – 1 + Blood Urea & Creatinine, Serum Cholesterol & triglyceride, Uric Acid, ECG, Complementary Breakfast Charges : Rs. 1500/- 3. Senior Executive Health Check-up for people above 40 All the rests of scheme 1 and Scheme 2 + Electrolytes, lipid profile, Tread Mill ECG, Expert Evaluation + Complementary Breakfast. Charges : Rs. 3000/-	Executive Health Check-up – 2400/- *Complete Haemogram *Sugar F & PP *Urea , Creatinine *Uric Acid Cholesterol, Trigluceride HDL,.LDL,VLDL, Bilirubin, SGPT, SGOT. Alkaline, Phosphatase, Total Protein, Albumin ,GGT, Calcium, Phosphorus, Urine Routine, Stool Routine, Blood Group & Rh, VOR,L ECG, Chest, X-ray, Ultrasound Screen up, Clinical checkup, Dental checkup Pre-Employment Check-up - Rs. 600/- Complete Haemogram Sugar (F) Cholesterol Blood Group & Rh VDRL Urine & Stool R/E ECG Chest X-ray	Comprehensive Heath Scheme – It is designed for senior executive over 35 years. Actual Cost – Rs. 5,555/- Package Cost – Rs. 3,300/- Executive Package for executive under 35 years Actual Cost – Rs. 5, 155/- Package Cost Rs. 2,600 Package charges indicate the complete health plan rates. Actual charges denotes what the tests would cost outside the complete health plans. ***The exact contents of these packages were not provided to the researcher.***

The three case studies show that there are primarily two types of health packages *viz.* pre-employment and executive health package. The later one could be classified into mid-level, senior executive/comprehensive package. The cost of pre-employment package was around Rs. 500/- to 600/- per package and executive health package was within the range of Rs. 1500/- to 3300/-.

Surgery and health packages are signs of streamlining medical care with a technocentric approach. These packages are individual oriented, and formulated and projected as cost saving means of treatment.

Cost of different kinds of room

The different rates for rooms in the different categories of private MCI showed that they were organised according to the purchasing power of different segments of the society. Cabins were the costliest among the three general categories of rooms. The room charges included regular diet and general nursing of the patients. Very similar to the OT rates, the price range of cubicles and cabin in very small and small MCIs were almost the same. But the upper price limit of the cabin was higher in small MCIs. Marginally, the small MCIs were costlier than the very small ones. In the medium MCI, the starting rates for the three general categories of room were higher than the smaller MCIs.

Rooms in large MCIs were very costly. The charges for cubicle and cabin range between Rs. 300/- to1800/- per day and Rs. 100/-to Rs. 2500/- per day. This range was quite wide. In the large MCIs rooms where a family attended was allowed, an extra amount was charged and it varied for air conditioned and non-air-conditioned rooms. Meals for the companions were charged separately. The cost of A/C Deluxe and A/C suite seem to be similar and was about Rs. 1600 – 1700/- per day to 3200-3500/- per day. The minimum charge for cabin in large nursing home begins at Rs. 300/- whereas in medium, small and very small nursing homes it starts at Rs. 175/-, Rs. 135/- and 150/- day respectively.

Among the private institutions studied, only 24 percent could produce their rates. In one case, the researcher was only given the rate chart for the bed and diagnostic services. The rate charts did not follow any uniform pattern. They were in the brochure that gave general information about the private MCIs.

Service charge

Service charge is the amount, which is levied on the total bill of the patient. Even in the hotel industry a certain percentage is added to total cost for service rendered to the guest. We examine these charges for the different types of MCIs.

Less than half of very small MCI and almost 60 percent of other MCIs levied 10 percent service charge. In rare cases the service charge of 30, 20 and 15 per cent

was levied. It excluded the cost of medicine and was either imposed on the gross bill amount or only on room and operation theatre charge. In case of very small and small private MCIs, the system of advance booking was not formally laid out as it was in the case of medium and large type of MCIs. One of the managers' of a very small MCI had said: *"many patients party coming, have just the money for operation or even at times less than that. Therefore, we do not fix any minimum deposit money. If the patient party has the capability to provide for the deposit money then we ask for it other wise not."* Deposit money was based on the seriousness of the operation and on the size of the room. The minimum advance was Rs. 500/-. For pregnancy cases, the expecting family registers with the nursing home according to the advice of concerned doctors. This information ensures availability of a room three months later. Hence, at the time of delivery the MCI cannot reject the patient.

Booking in medium MCIs was normally accepted through medical practitioners. The patient's treatment was entirely the responsibility of their doctors under whom the patient was admitted. It was preferred that the advance is paid in cash with the application. At times seven days charge was taken as advance and later it was adjusted. In case of patients whose charges were recoverable from companies, MCI then straight away dealt with the company and so at the time of admission cash was not taken in these cases. The deposit money for medium and large MCI was quite high and well beyond the means of common person. In large MCI, for general bed the advance payment varied between Rs. 5000/- to Rs. 10,000/- and in case of ICCU/ITU/ Respiratory care unit the advance is Rs. 10,000/-.

Thus, we see that service charge do not vary much except in few cases. The advance-booking rates increase with the size of the MCI. This projects the hierarchical nature of private MCIs and the capacity to access these MCIs by the different class of people.

Charges for the Diagnostic facility

Only 13 medical care institutions had diagnostic facilities. Charges could not be collected from all the institutions, as the respondents were not willing. Some of them gave their rate charts directly. On closer scrutiny of the charts it was found that

some kind of diagnostics were not prevalent in all the institutions. It varied with the institution. Therefore, we take the average cost of the tests based on their frequency of availability. We have compared the charges levied by medium MCIs for diagnostic tests frequently done with that of large MCIs.

Simple haematological, urine and stool routine tests ECG were compared. Haemoglobin percentage (Hb%) and ESR rates for large MCI were almost double that of medium MCIs. Urine and stool routine examination rates were marginally higher in large MCIs. The average cost for x-ray (1 plate), USG (whole abdomen) and ECG was Rs.127.50/-, Rs. 950/- and Rs. 225/- respectively in large MCIs. Diagnostic facilities were costlier in large MCIs in comparison to medium MCIs.

When the patients are asked to do range of tests they then approach diagnostic centres that suits their financial condition. As said by the senior practitioner and member of West Bengal Medical Council: *"From mid sixties diagnostic centres began to come up. This gained momentum in the 70s and 80s. They were built so that under one roof one gets all the facilities. Now diagnostic costs are very high. Many institutions add the word 'Research' to the name in order to get certain tax benefits. The state has also taken away many restrictions. This has benefited the diagnostic centres greatly. Like now a range of pacemakers are available at less cost. Apart from this, doctors ask patients to do a whole battery of tests and in the process* ***money changes many hands.*** *There is a deep commercial motive behind this also. CT scans and MRI instruments are very costly. To buy these, one has to take loans and pay back the principle with a substantial amount of interests. To get back the cost, charges are levied at a very high rate."* Hence, diagnostics have emerged as one of the profitable sectors in medical care. A few large and medium MCIs initially started by offering diagnostics.

Staffing Pattern of the MCIs

The staffing pattern of four different types of MCIs is studied here under three broad headings - administrative and medical Officers, doctors and paramedical and non-medical personnel. Large MCI is dealt here separately.

Administrative Officers and Medical Officers

In very small and small MCIs, majority of the owners were from the medical background. They worked as the administrative officer, resident medical officer and also provided the professional care. In case where the owner was from a non-medical background, medical officer was not appointed instead a doctor was called up when required. A proprietor of MCI said: *" even during the night it is not a problem as the doctors stay nearby. Few of the young doctors come on particular days during a fixed time of the day"*. In one case homeopathic doctor was a medical officer. In cases, where owner's spouses were doctors, they acted as the medical officer and partially shared the role of an administrator. Only where there was intensive cardiac unit, medical officer was separately appointed but only for the night.

In partnership firms, the shareholders of MCIs were employed as the administrative officers and they mostly belonged to the same family. In limited number of cases managers were appointed. Medium MCIs were comparatively bigger organisations and here though the owner took the final decision, for the day-to-day administrative work managers were appointed.

When asked about the medical officers the owners/managers were hesitant in discussing the issue. They worked on a shift duty basis for 8 hours a day. During an interview with a paramedical staff, it was found that the medical officers appointed, tend to give one full day (24 hours) to the MCI rather than coming for a stipulated time every day. This saved their time and they could also practice privately unhindered. These doctors were young and had just completed their M.B.B.S. or were doing M. D and needed to gain field experience. Some of them just came for two to three hours. Majority used it as a stepping-stone for their private practice. They were on contract and were either paid on monthly basis or on hourly basis.

As the owners of majority of the MCIs (very small, small) were doctors, they did not employ any doctor. The MCIs and the doctors charged separately. The patient's family paid the doctor's fee either directly or to the MCI along with the

nursing home charge. The doctors later on collected the fee from the MCI. Any doctor could admit their patients. The medium MCIs however, maintained a register for doctors who frequently admitted their patients. In some MCIs they were addressed as consultants. The doctors practising in the clinics within the nursing home were also allowed to admit their patients.

Paramedical Staff

Nearly, all the MCIs employed paramedical staff. On an average in the first two categories four nurses were employed on rotational duty. Around 45 percent of the very small MCIs had residential nurses. The working hours varied but in the majority of MCIs it was either 8 hours or 12 hours. In case of the residential nurse there was no stipulated working hour. Majority of the nurses were trained on the job. In few of the cases Auxiliary Nurse Midwives were employed. Since residential nurses stay for 24 hours in the nursing home complex, sometime extra manpower was not employed. Through them the need for extra hands was met and the cost of an extra worker was saved. At times they had to work continuously for one or two days when other nurses failed to come. It often over stressed them. The patients employ private nurse when required. They were called from nursing bureaus. Private nurses were paid Rs. 80 to 100/- per day.

As pointed out by one of the owners of medium MCI that, *" In Calcutta there is shortage of nurses. In majority of the MCIs nurses are not enough in number. Bengalis consider nursing still as a low profile job and as a result very few come forward for this profession. Still many nurses come from the south especially from Kerala. Few Bengalis who join, primarily belong to the low socio-economic class. Majority of them are not trained. They are trained on job."* Some of the reputed medium MCIs tried to keep a few trained nurses. Ayahs were mainly employed for doing unskilled jobs, which ranged from giving bedpans, cleaning and changing patients, holding the babies etc. 55 percent of the very small MCIs had employed ayahs. They also do other minor jobs of the nursing home.

Ward boys were not separately employed. It was often seen that the gatekeepers acted as ward boys in very small, small and few of the medium MCIs. They helped in taking stretchers, carrying oxygen cylinders etc. In one of the very small an OT boy worked as ward boy and in absence of the owner he admitted the patients. In MCIs with bedside diagnostic facilities, gatekeeper-cum-ward boys perform some of the activities like administering injection medicines, measuring blood pressure. However, this is not the scenario for medium MCIs.

Non-Medical Staff

Non-medical staffs comprise of cook, gatekeeper, sweeper, receptionist, accountant, electrician etc. In 78 percent of very small MCI, cooks and gatekeepers were employed not under any contract. In the first two categories of MCIs sweepers were kept on daily basis and electricians were called upon whenever required. Often nurses worked as receptionist and in some places receptionists were separately appointed. In the third type we find both permanent and contract staffs. Accountants, pathologist, few of the lab staffs were on contract in the third category. They appointed senior accountants or senior pathologist from the Government service on fixed honorariums.

In case of large MCIs, the staffing pattern of the medical, para-medical and non-medical personnel could not be mapped out very well. Only one of the MCIs discussed very briefly this aspect. The staffing pattern here was hierarchical. There was managerial, clerical and technical and class IV staff. Any doctor could not work in the MCI. It had a set of doctors who alone could admit their patients. They employed some doctors who were on the pay roll of the hospital and the majority were on contract basis. Usually junior in-house doctors were not allowed to put in their patients. Certain doctors there were allowed to separately charge the patients and it was fixed by the hospital. One of the large MCI had its own nursing school and hence drew nursing staff from there. After completion of their course they were bound to serve in the hospital for three years. During this they got a stipend and later based on their work performance they were either made permanent staff or stayed on contract. In the other MCIs the doctors were mainly attached as consultants who also

practised in the OPD. Only a very few doctors were on the payroll of the MCI like medical officer or in-house doctors.

We see then that, with the increasing size of the bed strength, staffing pattern in the MCIs became well defined, organised and hierarchical in nature. To reduce the liabilities, larger and medium MCIs tend to keep non-medical staff like sweepers, gatekeepers, and electricians on contract. There is greater casualisation of the staff in the last two categories of MCIs. In the smaller enterprises, majority of the paramedical staffs were not adequately trained.

The main trends that emerge from our data show that in Calcutta, there has not been any major expansion of large and hi-tech based MCIs. However, the ones that exist are costly, based on specialisation and offer hi-tech diagnostic facilities. They run a hierarchical organisation where consultants are fixed, heavily paid and the lowest staffs are often on contractual employment. The smaller MCIs provide primary and secondary care services with the medium MCIs offering a mix of services and wide range of support manpower. This set of MCIs cater to a range of lower middle and upper income groups and is linked to the public sector through consultancy, referrals etc.

CHAPTER – V

MEDICAL ENTREPRENEURS IN CALCUTTA – A SOCIO-ECONOMIC PROFILE

We have attempted to explore the social background of the owners of private medical care institutions. Information was elicited on the religious and caste background, demographic profile of the owners, educational qualification of the owners, professional background of the owners' parents, siblings and spouses. Information was also obtained on owner's place of origin, links with lands or with any own kinds of business the study also explored if the owners or anybody from the family stayed or studied or practised abroad and if so, how it was advantageous for the owners. The objective was to assess what kind of professionals opt for private practise and why, and also, to understand how they mobilised resources to establish their MCIs.

Religious and Caste Background

Table 5.1: Religious and Caste Background of the Owners

SI. No	Type of MCI	Religion				Caste		
		Hindu	Muslim	Christian	Others	FC	BC	SC/ST
1.	Very Small	11	-	-	-	10	-	1
2.	Small	7	-	-	-	7	-	-
3.	Medium	8	2	-	-	8	-	-
4.	Large	5	-	-	-	4	-	1
	Total	31	2	-	-	29 (88)	-	2 (6)

Figures in parenthesis are percentages.

Of the 31 owners (94 percent) were Hindus and only 2 (6 percent) were Muslims. Both of them owned only medium size medical care institutions.

Of the 31 Hindu owners, 88 percent belonged to the forward caste and 6 per cent belonged to the SC/ST category. Their distribution over types of MCI shows that, of the 10 owners of very small MCIs, fifty percent were Kayastas, forty percent were Brahmin followed by Vaishya, Banik and Sadgope. Among those owning small MCIs none of the owners were Brahmin. But those owning fifty percent of medium MCIs were Brahmin. Similarly, sixty percent of the Hindu owners of big MCIs were Marwaris who had shifted from Rajasthan, Uttar Pradesh and Agartala (table 4.1). The only SC owner who had a large MCI had free access to the resources of his family business. This reflects a relationship between the resource ownership that determines people's ability to invest in the business of medical care.

Demographic Profile of the Owners

Age Composition of the Owners

The age composition of the medical entrepreneurs show that around 51 percent of the owners were above 60 years, 40 per cent were between 40 to 50 years and only 3 percent were above 35 years. The age group of two owners could not be obtained.

In very small MCIs, 64 percent of the owners were in the age group of 60 and above and 4 out of 11 owners were 40 and above. While in medium MCIs, sixty percent of the owners were between 40 and 50 years and remaining 4 owners were 60 and above. Comparatively, the medium MCI owners were younger than the very small and small MCI owners. In large MCI only one owner out of five was 40 and above and three were 60 and above.

Gender Composition of the Owners

Historically, women inside and outside home, occupy subordinate status. Their position is less central and important in the hierarchy of organisational structure.

Table 5.2: Sex of the Owner

Sex of the Owner	Type of MCIs				Total
	Very Small	Small	Medium	Large	
Female/Male	2	4	4	--	10 (30)
Female	3	-	1	2	6 (18)
Male	6	3	5	3	17 (52)
Total	11	7	10	5	33 (100)

Figures in parenthesis are percentages.

The study shows that half of the private MCIs owners were men. One third of MCIs had men and women together as owners. Women were sole owners of only 18 percent MCIs. In very small MCIs 3 out 11 owners were women but the small had none. In case of medium and large MCIs sole women owners were 1 out of 10 and 3 out of 5 respectively. They were there mostly as partners. In the administration of the organisation, except for one woman, the others hardly played any prominent role. In

general, women partners took care of the non-clinical services like cooking, laundry or may not play any role at all.

Professional and Educational Background of the Owners

Professional background of the owners focuses on the founder's social and economic position and the ability to establish a certain kind of institution to deliver medical care.

Table 5.3: Professional Background of the Owners

Type of MCI	Professional Background of the Owners			Total
	Medical	Non-medical	Both	
Very Small	7 (64)	1(9)	3 (27)	11 (100)
Small	3 (42)	2 (29)	2 (29)	7 (100)
Medium	1 (10)	5 (50)	4 (40)	10(100)
Large	-	3 (60)	2 (40)	5 (100)
Total	**11**	**11**	**11**	**33**(100)

Figures in parentheses are percentages.

It is interesting to note that equal number MCIs had owners from the medical, non-medical background. Another 11 MCIs had owners from both the backgrounds. However, when we look at the professional background according to type of MCI we see interesting variations.

In very small type 64 percent of the owners were from purely medical background and only one was from the non-medical background. This shows that the professional owners were mostly concentrated in the very small MCIs, which were established in the first two decades after independence. This reflects a conscious choice for private practice rather than opting for Government service as the source of earning. In this study there were twelve owners with an MBBS degree along with specialisation. Such owners were found in the first three MCIs only. In very small MCI among the 7 owners with medical background, there were 5 doctor owners with specialisation. Another five specialists were owners of small MCIs. The rest two were owners of medium MCIs but they were in partnership with non-medical owners. Specialisation included diploma in cardiology, dermatology, MS/MD and FRCA or FRCS.

The investment from the non-medical entrepreneurs increased with the increasing size of MCIs. Half of medium MCI promoters and 60 percent of large promoters were from the non-medical background. Owners from medical profession solely did not invest into the large MCIs. They invested with partners from non-medical background in the study. Owners with non-medical background, show a range of educational credentials viz., simple graduate professional, master's degree and higher secondary (plus twelve). With increase in size of MCIs we find greater association of the owners with non-medical qualification.

This study shows that 18 percent of the entrepreneurs went abroad for their higher education. Whoever went abroad had gone to Britain to complete their higher studies. Except one owner of medium MCI, who stays abroad, majority did not work abroad or stay outside the country for some time so that foreign remittance could be invested towards the establishment of MCI. Most of these specialists who were trained abroad had opted to establish smaller MCIs. In the recent past some owners with medical background frequent abroad for seminars and other related works.

Land and Father's Background

Table 5.4: Land and Fathers background

Type of MCIs	Land Availability			Father's Occupation				
	Yes	No	N.A	Business	Doctors	Service	Land lords	NA
Very small	1	10	-	4(36)	4(36)	3(27)	-	-
Small	2	5	-	-	2(29)	3(43)	1(14)	1(14)
Medium	3	6	1	2(20)	3(30)	3(30)	1(10)	1(10)
Large	1	-	4	5(100)	-	-	-	-
Total	7(21)	21(64)	5(15)	11(33)	9(27)	9(27)	2(6)	2(6)

Figures in parentheses are percentages.

In the study 64 percent of the owners did not own land, land was owned by the 21 percent of entrepreneurs and for 15 percent of the owners the information was not available. Except one, other owners of very small MCI did not own land. Two owners of small MCIs owned land. Out of them one had land in his native place. It was a family property, which by mutual partition was given to the owner and presently it is used for fruit activation. At the end of the year, they receive a part of the money

earned from the land. Another owner of the small MCI belonged to the landed-gentry class. The family had land in Hooghly and Calcutta. The land available to the owners' family was utilised to establish different business and later on the MCI in the study was established on a piece of land owned by the owner. In case of medium MCI, the owners owning land were a little more in number than the preceding two categories (3 against 1 and 2). Thirty percent of medium MCI entrepreneurs owned land. Two of the owners' grandfathers were small zamindars in their native place. Among them one had started a native school, a welfare centre for the rural people and a subsidised health centre. The owners or the managers of large MCI did not want to discuss about this particular aspect. One of the large MCI maintained a park. It acted as a means of publicity.

Table 5.4 shows that 33 percent of owner's father had business, 27 percent were doctors and were in service respectively. Only 2 owners were from landed-gentry class. In the very small MCIs 36 percent of owner's fathers' were doctors. Among them in 3 cases owner's father had established the nursing home. Two who had established MCIs, one of them worked in State Government Health Service and another one private practised through out. Another 36 percent of the owners' fathers were from business background viz., textile shop, pharmacy shop and the remaining 27 percent were from the service background.

In small MCIs 43 percent of the owners came from families with service background. One of them was a schoolteacher and was the owner of the school. Almost 29 percent of owners' were from the professional background viz., doctor. It was found that in this kind of cases, generally owners' father establish the MCI. One of them was in State Government Health Service and also had private practice. The other doctor did private practice through out. Very soon he started with his own clinic and initiated a small MCI in 1969. After eighteen years of operating the MCI, he sold it away and started another nursing home. The present nursing home is located within his house. Lastly, among the 7 owners 1 owner's father was a landlord.

Three medium MCIs owners father were doctors. Among them one owner's father was a homeopath, another one was in defence medical service and the third practised privately. One parent belonged to the landed-gentry and two belonged to

business family. Rest of the nursing home's owners came from families with service and business background.

Therefore, the study shows that in the first three types of MCI very few were from the landed or big cultivator families. The business operated was not very big in nature except for the business owned by the medium MCI owner's family. Generally the owners fathers belonged to the medical profession and service background.

The owners of large MCI belonged to big business families. They had diverse range of business interests like jewellery export, trading, construction etc. In 1967, Late Shri. M.P. Birla established the Belle Vue Clinic. Seva Nidhi Trust, a Birla Foundation had set it up. It was built keeping in mind the global standard. It targeted the non-resident out patients to take advantage of the pathology, x-ray and pharmacy facilities. Now the founder's wife is the chairman of the M.P Birla Group of industries. Presently founders niece personally sees the administration.

Birla's belong to the Marwari community of Calcutta. In Calcutta the Marwari community was broadly divided into two parties. One was religious orthodox, largely anti-nationalist and controlled by the more traditional types of traders and agents, the 'banians'. The other was religiously reformist, often nationalist and sometimes involved in the beginning of new industry. Birla's are Maheshwari's by caste and belonged to the progressive group. At the turn of the nineteenth century, Birla firms began to emerge. They had interest in diverse kind of industries. In 1917, the Birla Brothers had established the first Indian office for the export of jute in London and rapidly became one of the 3 leading jute exporters. They had become the largest Marwari industrial group in India. They also had cotton mills. In Calcutta in 1921 Birla's gave support to the Congress party and contributed financially (Tinberg, 1978).

From 1951 to 1962 the assets of business houses among the Marwaris expanded. The rapid growth resulted in capital accumulation, which led to shift of capital into manufacturing field (Ibid.). In the late sixties, Birla's began to penetrate into the social sector like education, health and other welfare activities. Health sector was perceived as an industry. They invested into specialised curative care and high

technology. This shows the flow of capital from the trading to manufacturing sector and then into the social sector.

In 1987, another group of Birla brothers were seen channelling capital into the medical care sector. The B. M. Birla Heart Research centre was named after Braj Mohan Birla. It is a super speciality hospital, exclusively for cardiovascular diseases. It is in assistance with the Cleveland Clinic Foundation Cleveland Ohio, U.S.A. It is accredited with ISO 14001 certificate for the highest standards towards quality heart care.

Another large private limited nursing home was established in 1986. It belongs to the Soni family. They are from Bikaner in Rajasthan. They shifted to Calcutta 40 to 30 years back. Among the family partners there is only one doctor who is an M.B.B.S doctor and was in Rajasthan Government service. The doctor was the owner's son. The owner lives partly in Calcutta and Bikaner and belongs to the Marwari community of Calcutta. The family is into jewellery exporting business. This MCI was their first venture into the medical care sector. One of the family members said that all the partners were not highly educated. A few of the partners could not even clear the secondary examination. Now the family wants to expand its business in the field of medical care and therefore, wished to conduct a survey on private medical care in Calcutta.

The other private limited nursing home was established in 1992. The partners were from Sharma family. A woman heads the board of director. Her brother-in-law is one of the board-of directors. The family originally belongs to Benaras, western part of Uttar Pradesh. Trading is their prime business. Their business is located in Burabazar area of Calcutta, one of the busiest business areas of the city. This is their first venture into the medical sector. They have another nursing home, located in middle Calcutta. There is no doctor in the family and started first by opening a diagnostic centre.

Another partnership based large MCI was started two years back. The partners were among the family members and close friends. The partners were from medical and non-medical background. The head of organisation was a doctor with a M.B.B.S

degree. Originally his family belongs from Agartala. He completed his medical degree in Agartala. Thereafter he started his private practice and opened a MCI there. Later on shifted to Calcutta for the private practice. He has two elder brothers who are also doctors and own two nursing homes respectively in Calcutta. Owner's father owns a business in Agartala.

The history of another large MCI can be traced back to 1947, when Bengal Chamber of Commerce and a few multinational companies of that period established a clinic. This was basically meant for the executives of these companies. In January 1958, Dr. B. C. Roy laid the foundation stone for the present building. The clinic has now expanded from a nursing home to a hospital.

Location of MCIs

The MCIs are mostly located within the residential compounds owned by the promoter. A part of the residence is used to accommodate patients and convert it as either a nursing home or a clinic (Baru, 1998).

Table 5.5: Type of Accommodation

Sl. No.	Type of MCI	Rented	Owned	Information N.A
1	Very small	5 (45)	6 (55)	-
2	Small	1 (14)	6 (86)	-
3	Medium	1 (10)	9 (90)	-
4	Large	1 (20)	2 (40)	2 (40)
	Total	8 (24)	23 (70)	2 (6)

Figures in parentheses are percentages.

Majority of the private MCIs under the small (86 percent) and medium (90 percent) were located in owned buildings. In the very small MCIs, 55 percent buildings were owned and the rest were rented and the owners paid a very nominal rent. Among the 5 large MCIs, only one building was rented and 2 buildings were owned. For the remaining 2 we could not elicit information. Almost 90 percent of the private MCIs in the study were located in owned buildings. Most of the very small MCIs were located within the residential premise of the entrepreneurs. Even among the rented ones, only two had their residences adjacent to the MCI. In the case of

small type, 67 percent had converted a portion of their house for the purpose of nursing home and clinic. Very few of the entrepreneurs of medium MCI had used their residence for this purpose.

An owned building of MCI does not necessarily mean that the owner's residence would be located in it. It is therefore, seen that only one third of the owners located the MCIs in their residential complex, thus saving on their establishment and other overhead costs.

Place of Origin

It throws light as to why the owner's family came to the study area, the motive behind establishing the nursing home or the hospital, and their other business interests.

Table 5. 6: Owners place of origin

Type of MCI	Place of Origin			
	Calcutta	Other districts of West Bengal	Other states	From Bangladesh prior to partition
Very small	3 (27)	7 (64)	-	1 (9)
Small	1(14)	3 (43)	-	3 (43)
Medium	2 (20)	4 (40)	3 (30)	1 (10)
Large	1 (20)	-	4 (80)	-
Total	7 (21)	14 (42)	7 (21)	5 (15)

Figures in parentheses are percentages.

A majority (64 percent) of the owners of the very small MCIs belonged to districts other than Calcutta. Amidst them 57 percent of the owners shifted to Calcutta for pursuing their higher studies in medicine. In the remaining three, the owners parent shifted to Calcutta. Yet, they had tie with their place of origin. Only one of the owner's place of origin is Bangladesh. His father shifted to Calcutta prior to partition and had started the MCI. In the small category almost 43 percent belonged to districts other than Calcutta. Forty three percent of the owners were from Bangladesh. They shifted before partition for pursuing their higher studies. It was interesting to note that in contrast 30 percent of the owners were outside the state in the medium type MCI.

One of the owner's families shifted to the city generations back and they now own one of the famous sweet brand name in the city. This private MCI was their first venture into the medical care. They have future proposals in the pipeline for setting up speciality hospital. Among the rest two, the owners moved to the city to continue their studies and settle down in the city. They came to the city in the late sixties and early seventies. Except one, the owners of the large MCIs hailed from other states (Rajasthan, Uttar Pradesh and Tripura). One of the owner's families shifted to the city many generations' back. Its history can be traced back to the nineteenth century.

Thus, we see that almost in all types of MCI, the majority of the owners came from other districts of West Bengal and only up to 21 percent were originally from Calcutta. Only in large and medium MCIs the ownership also belonged to people who did not originally belong to West Bengal.

Professional Background of the Spouse

We looked at the professional background of the owner's spouse in order to understand the role played by them as partners in ownership or as professionals or in other roles in relation to the MCI. A large percentage (58) of owner's spouse were housewives. Only in 27 percent case, the owners spouse were doctors. In circumstances where owners' husband was a doctor, he generally took up the major role in the administration of the MCI. Wives of the owners who were in service did not contribute to the work of the organisation in anyway. In medium and large MCIs the spouses owned business.

Professional Background of the Siblings

Thirty six percent of the owners of very small MCI had no siblings and in one case information was not available. In the rest of the case siblings were in service, small medical business (pharmacy shop), one engineer, one veterinary doctor and craftsmen. Two of the owner's siblings who owned pharmacy shop were not situated in the city or near the MCI. Very similar to the previous one, the small MCI owners' siblings were from identical professional background. The exception, which we found, was that three of the siblings were housewives and one was a gynaecologist

doctor owning her own MCI. In medium MCI 30 percent of the owners had siblings in business viz., medical shop, sweet shop, small trading. The medical shop was very closely located to the nursing home. Siblings in service were in Government jobs (banks, railway) and they were also shareholders of the MCI. Perhaps the Government link of the siblings helped the MCI in certain way.

Source of Capital

In smaller MCIs, almost all the owners had invested their own capital. Owner doctors contributed the capital raised through their private practice. In one very small MCI, where owner was a woman, there her relatives also contributed some amount of capital. In medium MCIs two out of 10 raised initial capital through issue of shares of public limited company and in another two partnership based MCIs partners contributed the capital in the beginning. Rest invested their capital. Among the five, one large MCI raised capital through the issue of shares. The rest of the four belonged to large business families and the initial resource may have come from their own capital. They did not give any details on their sources of capital.

Link with Public Sector

The private sector in medical care in India has grown and expanded with the direct and indirect support of the public sector. Hyderabad study (Baru, 1998) and Delhi study (Baru and Nanda, 1994) show that the owners of the large and small nursing homes had links with the public sector. Either the owners served in Government or had resigned early to pursue their private practice. The present study shows that in very small MCIs two owners were in Government health service and simultaneously practised privately. In another case, the present owners' father was in Government service and during the tenure of his service he started the private MCI. In very small MCIs where diagnostics were recently opened, Government doctors were attached as consultants.

The similar trend was also noted for the small MCIs. It was also noted that a Government medical officer started the enterprise in his wife's and son's name while he was on job. In few of the reputed medium and large MCIs, retired Government

doctors or those who resigned early were attached to it as consultants. In two medium MCIs they were included among the partners.

Here we draw some of the major characteristics of the owners of private medical care institutions. We can say that:

Majority of the MCIs in the study were owned by sole proprietors. Most of the owners were from forward castes and only two owners were Muslims. The owners went abroad primarily for higher studies. They did not work or stay abroad for long. As in Hyderabad study (Baru, 1998), many owners went to Middle East countries to work and accumulate capital, such trend is not noticed here.

Majority of the owner with specialised medical background had established very small and small MCIs. Half of the owners of medium MCI were from the non-medical background. Similarly, owners owning big business established three large MCIs. The owners of large MCIs show diverse range of business interests. Thus, we see that with the increase in the size of the private MCIs and complexity in the ownership form, there is greater involvement of people from the non-medical background.

Our study shows that very few owners were from the rich propertied background and the owners who owned land got it from their ancestral property which is located in their native place. A majority of owner's father had business. Father's of very small MCI owners did not operate very big business. Seventy percent of them had small-scale business. Equal number of owners belonged to medical and service background and only a few belonged to rich elite background. Equal number of the owners belonged to medical and service background with a few belonging to the landed-gentry background.

Around 42 percent of the owners belonged to districts other than Calcutta and 15 percent of them came from Bangladesh prior to partition. Equal percentage of owners' were from Calcutta and other states like Rajasthan, Uttar Pradesh and Tripura. In case of very small, small and medium MCIs majority of the owners shifted to Calcutta to pursue their higher studies. For them establishment of a private MCI was an avenue to augment their income and was a part of conscious choice process.

Almost all the owners of large MCI were from other states. They had shifted to West Bengal generation back and settled initially as successful business entrepreneurs in the non-medical arenas. In case of the smaller MCIs there was no significant capital shift from one sector to another, while in case of the larger MCIs the capital was diverted to the medical care sector.

Women owners in partnership MCIs and even as sole proprietors find less significant role in the administration of the institution. They mainly take care of the non-clinical services. In institutions where the owner's husband is from medical background, he plays important role in the management and takes all the important decisions for the MCI.

The MCIs in the study show that they had links with the public sector. Government doctors used private MCIs to practise privately and they referred their cases to the private MCIs in the study. This shows that the private practise of the Government doctors is unregulated even after the stipulations made by the state health department and that this unregulated practice is one of the factors that helps in the growth and expansion of private sector in medical care at the cost of public sector.

CHAPTER – VI

DISCUSSION & CONCLUSION

We have already seen the role played by the private sector in India's medical system. It is penetrating, expanding and catering to the needs of both urban and rural areas. In the context of Calcutta we see that the state owns more hospitals than the private sector and has continued to play a significant role at least till the eighties.

Historical evolution of allopathic medical care (public and private) in Calcutta shows that hospitals began to grow and expand by the second half of nineteenth century. State, local bodies and individuals in their own capacity had come forward to contribute towards the development of medical care institutions and reap the benefits of modern medicine. Entrants to the medical system during that time were from the elite upper caste and class and those willing to follow a specific life style. Those who rendered support to the medical institutions were not necessarily conversant in English. Yet, they considered adoption of western medicine as a status symbol.

During the colonial period we see the emergence of private sector in medical care mainly, through the presence of private medical practitioners. Private interests of the Government doctors within the public hospitals were evident in the permission to the Government employees to practice privately, user charges and private beds in the public hospitals. There was also conflict of interests between the Government doctors and private practitioners as reflected in the debate over operation charges (pg. 58). This reflects state support for the private sector in medical care. However, the state also tried to implement certain rules to regulate the private practice of the public medical officers as many patients in the hospital were neglected. Prior to independence, the socialist ideology influenced many doctors who were part of the national movement and the idea of public provisioning and funding of medical care for the people, irrespective of their ability to pay was mooted in Calcutta.

Calcutta saw the emergence of private hospitals and nursing homes in the early twentieth century. Yet, almost after fifty-five years of independence, the state owns more hospitals than the private sector and the private sector in medical care has only grown slowly. In the nineties however, the growth and expansion of public hospitals and beds slowed down while the private MCIs expanded at a faster pace.

Our study shows that very few private MCIs were established in the late eighties. The study indicated the dominance of sole proprietorship based private MCIs. Majority of the sole proprietorship were established in the early years. In the late eighties very few MCIs were registered under the partnership and sole proprietorship. Studies have shown that in other parts of the country private MCIs began to grow from the late seventies especially in agriculturally and industrially prosperous states. The trends emerging in our data differ from the all India trend. The most important factor, which can explain the slow growth pattern, can be the shifting of head offices of the industries to other parts of the country. Thus, the draining out of capital to other places hampered the expansion of the metropolis and investment of capital into other areas. Apart from this, in Calcutta till the nineties, emphasis was given to the public sector MCIs. Growth and expansion was evident in the public sector till that period.

The studies on the characteristics and profile of the private sector in medical care show that sole proprietors with medical background own still most of the small private MCIs. Over the past twenty years in contrast to this all India pattern, Calcutta did not show any increase in sole proprietorship or partnerships over the eighties.

Key trends in Private MCI Services

Private room facilities offered by MCIs have a large range. In smaller MCIs combination of cabin and cubicle is frequently found. Special room facilities are confined to the medium and large MCIs. Indoor facilities are available in all the surveyed private MCIs, followed by OPD and diagnostic facilities. As noticed earlier, ambulatory care is provided almost in half of the smaller private MCIs. It is primarily, because for the physician owners it is more advantageous. Very small, small MCIs provide more of primary and secondary level care. The medium MCIs offer a mixture of services. Tertiary level care is only limited to the large MCIs. Similar to the experience from other parts of the country, here also gynaecology/obstetrics, general surgery and general medicine are the three most frequently available services and therefore, can be called the most profitable services. Specialised clinical services are only limited to the large ones.

Diagnostic facilities are limited to the medium and large MCIs. Specialised diagnostic facilities are offered by large MCIs. Simple investigations are confined to the smaller MCIs. Recently, very small MCIs have diversified their services and began to provide diagnostic facilities like ultrasonography, that is profit making. Now there is a trend to invest first into diagnostic facilities and thereafter diversify the service in other areas of medical care.

Overall provision of facilities shows an inclination towards offering certain kind of clinical and diagnostic facilities and restricting others. There is greater availability of special and high technology based services along with shift toward complex ownership pattern and increasing size of MCIs. Therefore, epidemiological significant diseases and emergency cases are left under the public sector domain. A few of the MCIs specifically mentioned that they will not treat any kind of infectious diseases or treat police cases and in large number of MCIs it is an unsaid fact.

Private MCIs price various clinical and non-clinical services (OT charges, surgery packages, health packages, room and service charges) differently. The private MCIs can be thus categorised in a hierarchical fashion as per their levied charges. Therefore, they cater to different segment of the population. Majority of our MCIs were very small and small and they priced their services such that the lower and middle class could avail them. The medium and large MCIs targeted upper middle class and the rich. This is evident in the price differentials as discussed in chapter IV (pg. 89 to 95). The same services were provided at differential rates. While the smaller MCIs provided simple investigations at affordable rates the larger ones covered up the irrational prices by offering different surgical and health packages. Majority did not publish their rate charts nor did they put it up in their office for the public to know the rates of the commonly encountered services. None of the surveyed MCIs have any percentage of free bed for the poor patients. There is no formal system by which the indigent patents can avail any kind of free or subsidised services in the surveyed MCIs. It all depends on the recommendation of the doctor to the MCI authority and finally it depends on the authority's discretion. Formally, the private MCIs are less concerned with the problems of the poor people.

The family control over the organisation's staff is eminent. In partnership, private limited MCIs partners and staffs to a larger extent belong to owner's family or his or her extended family. The entry of management-oriented people is very slow. This trend is visible only in large MCIs that have come up recently in the city. Here lowest staffs are often on contractual employment. In the smaller MCIs there are less number of contractual staff than the ones that are large in size MCIs and those MCIs that are established in the recent years.

The *'group practise'* among the doctors is emerging in the larger enterprises. As one doctor said that: " *None of the medical departments are independent of each other. Doctors are contracted by the MCIs who will need each other and refer the patients whenever required. As a result in one of the newly opened MCIs whenever a patient gets admitted then he or she is referred to more than one doctor*". For this consultants are fixed who are on contractual terms with the MCI. The terms and conditions are fixed by the MCIs. Thus, our data shows the primacy of profits penetrating at all levels of the middle class that can pay and a lack of concern towards epidemiological priorities.

Even though we did not study all the dimensions of the quality of care provided the fact that through the use of fresh medical and postgraduate medical students, use of nurses for multiple responsibilities and use of gatekeepers and ward boys as medical assistants indicates the casualisation of the workers. It also shows that everything is not fine as far as the quality of care is concerned. The above traits undermine the professional ethics of work thereby affecting the quality of care.

Social aspects of Medical Entrepreneurs

The social background of the entrepreneurs presents certain interesting trends. Majority of the owners were from the forward castes with only two Muslim owners. Business families who shifted a few generations back from other states owned large MCIs. Very few of the owners owned land and their family links showed that they came from service, professional and small business background. A few had links with the landed gentry class. Marwari entrepreneurs had family links with big business. Entry into the medical care industry gave them prestige and status among their

community. The other business interests of the entrepreneurs were jewellery export, trading, construction, insurance, pharmacy shop etc. The range of business interests of the entrepreneurs was quite varied. Majority invested their own money from their private practice and business and a few raised resources from the issue of shares. In other words, tertiary care in Calcutta's private MCIs is a function of the capitals that's yet to diversify and yet, not a well thought out planned professional endeavour.

In the private MCIs women owners solely or as partners in the ownership do not play a significant role. They usually are assigned with less challenging roles or at times do not play any role at all. Their names are merely included in the list of ownership partners. This shows how the prevailing gender relations penetrate the institution of private medical care.

The elite class that emerged in the 1960s invested into this sector from the late 1980s and 1990s. As argued earlier in chapter IV, foreign investment from non-resident Indians began to come in this sector in the nineties. More number of indigenous business groups also began to invest in private medical care, offering specialised care like the Neotia's who have recently started the hospital, only for the mother and child. MNCs are also entering the private medical market in Calcutta, for e.g. – Duncan's Gleneagles, Wockhardt Medical Centre.

Our data shows that majority of the owners did not come from the rich elite backgrounds. Rather they came from professional, small business and service backgrounds. They had invested their own money. Very similar to Hyderabad (Baru, 1998) and Delhi (Baru & Nanda, 1994) study, it also shows that links with Government employees can act as a crucial factor in the proliferation of the private sector in medical care. Perhaps this is one of the reasons for the unregulated growth as by Government rules public sector employees are restricted to provide private service. The study also shows that private capital has now started trickling in to Calcutta where it is taking the form of hi tech tertiary level MCIs. It is here the non-medical and managerial control is becoming dominant. The fact that Calcutta had to wait for capital from outside is also perhaps a reflection of the problems of the economy of the state, slow rate of development and its relation with the centre.

Private MCIs in the context of Health Sector Reforms

The understanding of the present private sector in medical care in Calcutta will gain meaning in the context of analysis of macro forces, which are shaping it.

The state has made efforts to provide medical services through the public sector to poor and lower middle class. In the sixties, seventies, and eighties the state expanded the bed strength in the public hospitals, converted private hospitals into state sponsored hospitals and constructed new ones. It also provided aid to many private hospitals. Therefore, we see an accelerated pace of provision under the umbrella of the state from mid decade of the twentieth century. However, there is rural and urban spatial disparity in this provisioning system.

In spite of the efforts by the state, eighties onward we see that utilisation was not optimised. The infrastructure facilities could not meet the demand and were under pressure. Some sections were increasingly utilising the private sector. This began with the indifferent attitude of the health personnel, improper referrals to the tertiary hospitals and improper planning. The public hospitals could not also provide good care for the acute cases and the vested groups were also trying to build up alliances at different levels in the Government hospitals with the private sector. These above discussed factors weakened the public sector provision of medical care (Government of West Bengal, Eighth Report of the Subject Committee - 1994-95; Sixteenth Report of the Subject Committee – 1998-99). In addition, by 1996-97 the investment into health had come down to 0.9 percent of GSDP of West Bengal (Bhat, 2000). This was under the impact of health sector reforms.

Other than this the medical education in the state is largely curative, urban based, highly institutionalised, with sophisticated investigative and therapeutic approach. This kind of orientation does not encourage doctors to settle in rural areas. Often rural postings are circumvented. Rural areas are deprived of the adequate medical care facilities and doctors. Consequently there is pressure on the city hospitals.

Individual private practice over the years expanded without any state regulation. In the nineties, the slowing down of state intervention in the hospital sector and the introduction of user changes in the teaching and non-teaching state hospitals invited the private sector to establish medical care institutions. We also see withdrawal of state aid from the aided hospitals in the 1990s. In the public sector hospitals, the poor are exempted on the recommendation of the people's representatives. There are 30 percent of the paying beds in the public teaching and non-teaching hospitals and it is being now raised to 33 percent. Other than this, though hi tech facility is being brought in through private organisations, the poor are exempted from paying the investigation charges. To what extent these rules are exempted needs exploration.

The Government has accepted investment from the World Bank to strengthen the secondary level care in the districts. In 1995, the State Health System Project (SHSP) was started (Baru, 2001). It is expected that strengthening the block and district level hospitals will reduce the pressure from Calcutta hospitals. Also the public sector hospitals especially outdoor department is opened to private investment. However, the Government has put certain conditions so that the poor are not totally cut from the public services. Families below Rs. 2000/- income per moth can get free treatment. Nonetheless, the increasing user charges and pay beds can create problems for those just above the mentioned income bracket.

In the nineties, the corporate and big business investment in medical care began to appear in the city. There are now eight large size MCIs providing a combination of services, mainly tertiary and secondary level care. This has been possible with the direct and indirect encouragement by the state. The present Government in West Bengal is accepting these trends but at the same time trying to control the impact of privatisation. It does so by putting conditions on privatisation.

The private sector in medical care has been completely unregulated and uncontrolled in spite of the *West Bengal Clinical Establishment Act, 1950*. Recently the Government has brought out certain rules to regulate the private medical care institutions. The modified rules of 2001 lay down rules for space specifications for the indoor, out-door and other departments of clinical establishment. It also lays down

rules of free treatment for the poor. However, none of the MCIs surveyed provided formal free treatment to the poor patents. The general rule of the Act asks for, *"Free treatment facilities for 40 percent of the patients at Out – Patient Department that is, in Out-door and for 10 percent of the patients at in Patient Department that is, in In-door must be provided by the clinical establishment"*. Other than, this the new rules will now require the clinics in medical shop or at home to get registered and to renew this every year. This has met with strong resistance from certain groups of private doctor.

Thus, West Bengal is today at a critical juncture, where it cannot completely avoid the health sector reforms. Perhaps the state is trying to avert some of the negative implications of health sector reforms for the poor. Yet, it is clear that the professional lobby is operating its efforts. But the Government is trying to use some strategies to meet the challenges of health sector reforms. This is evidenced from the following facts:

- When we look at the total investment in health in West Bengal, it is noted that health expenditure is as low as 0.9 percent of GSDP in 1996-97. Yet, when we look at the efforts of West Bengal, the state takes to protect the poor through land reforms and land distribution, educational policy, food consumption and supply of food to PDS it has attempted to create conditions conducive to health.

- The State Government has invested in World Bank funds to strengthen the rural infrastructure. The assistance is accepted to revitalise and reorganise the hospital from the Block to the District level and reduce pressure on the tertiary hospitals, especially in Calcutta.

- In the state hospitals the Government is trying to control the manner of provision of services and charges by introducing different kind of conditions discussed above.

- Though it has encouraged private sector investment within the public sector hospitals it is largely in the primary and secondary level care. In this regard West

Bengal's effort is more like Sri Lanka where private sector operates at the primary and secondary level care.

- In addition to all these, the state continues to try to control and regulate the private sector.

These five trends reveal only a possibility that West Bengal can perhaps deal with the very serious and negative implications of health sector reforms. However, the Subject Committee has expressed its critical comment on the World Bank project saying that the expectation generated among the community and the health personnel by the SHSP has not been fulfilled. Rather the funds are not utilised properly (Govt. of West Bengal, Sixteenth Report of the Subject Committee, 1998-99). On the other hand the state Government has not been enable to control the private practice by the public sector doctors. This reflects the powers against which the state has to act in order to ensure medical care services for the poor.

The overall scenario of the private sector in medical care in Calcutta bears some resemblance with the early phase of privatisation in UK and US. Like the early phase of twentieth century in US, the proprietary MCIs of small size are more in number and they are very much related with the careers of their physician owners. The growth of corporate MCIs in Calcutta is at its infancy still and this growth is primarily due to the new investment from the indigenous business groups. Managerial aspects of medical care are given importance slowly in the large and medium MCIs.

As in the early phase of reforms in UK, in Calcutta too public provision of medical care is being restructured and the provision of private institutionalised care is increasing. In UK the reform is affecting provisioning, purchasing and private investment into medical care despite serious public criticism. In Calcutta there is private investment without much public opposition. The process of reform is not exactly similar in its pace. Nevertheless, profit-making motive is evident both within the public sector and private sector. Commercialisation of medical care is taking place but the pace is slow.

These issues are of significance to the State Government as larger macro forces are significantly pushing in pro-market strategies. It is a matter of further concern when the city is facing stagnation in growth, there is increasing unemployment and the overall degree of deprivation is very high.

We have already seen that there are very few specific studies on the characteristics of the private sector in medical care. Therefore, taking that into consideration the issues above-discussed presents us with certain insight for further research. An important question is how far the state successfully uses private capital implements in the public hospitals and still prevents the marginalisation of the poor. There is also a need to study the kind of conditionalities the state Government has implemented and whether it is at all able to enforce these on the private sector. At micro level one can further look into the staffing pattern in private medical care institutions, their volume of work and working conditions. Another interesting area for research is on the rates of the services offered, market strategies for it and how it influences the private medical market. Lastly, area of research, which has not been touched in this study, is the payment methods in the private medical care institutions and thus the functioning of the private physicians market.

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APPENDIX – 1

Interview Schedule

No.

Profile of the Nursing home/Hospital

1. Name of the Hospital & Address

2. Year of the establishment
3. Name of the Owner
4. Nature of ownership
   Single Partnership Pvt. Ltd. Society/Trust Ltd.

5. What are the various kind of clinical cases the nursing home/hospital deals with?

6. i. Do you have any OPD facility?
   (a) Yes (b) No
   ii. What are the general and different specialist medical facilities available in the OPD?

7. Does the nursing home/hospital has any diagnostic facility?
   i. (a)Yes (b)No
   ii. If yes, what are the facilities?
   iii. If no, where do you get your indoor cases investigated?

8. What is the type of preventive medical care provided & their respective charges?
9. Total bed strength of the hospital and the room types
   General ICU ICCU

Service Charges

1. Charges for the bed/room types.

2. Charges for the diagnostic facilities, if available.

3. What is the other kind of charges incurred by the indoor patient, undergoing an operation?

   OT Major
   Semi Major
   Minor
   OT Monitor
   OT medicine
   Anaesthesia

Oxygen
Dressings & bandages

4. How much is the service charge and for the advance booking how much is the deposit money?

5. Do you provide any kind of subsidy for poor patients?

Staffing Pattern

1.	Total No.	FT/PT/Shift Duty	Hrs. of wk.
a. Admin Officer			
b. RMOs			
in general &			
ICU			
c. Doctors			
d. Nurse			
e. Ayahs			
f. Male ward boys			
g. Lab Staff			
h. Class IV Staff			
i. Any Other			

2. Number of doctors in general medicine and in the specialised branches

3. Qualification of the nurse

Background of the owner/owners

1. Name Age Sex Caste Education Qualification

2. How many siblings the owner has & what is their professional background?

3. For how many years the owner/owners family has settled in Calcutta or on its suburban area?

4. Where does the owner's family originally come from?

5. Did you have family land there and is it still cultivated?

6. Father's occupation

7. Profession of the owner

8. Educational background of the owner/ owners
   Schooling College Professional Degree

9. Has the owner/himself or anybody from the family practised or stayed abroad?

10. Prior to owning the nursing home what was your profession?

11. What is the owner's spouse education and professional background?

12. Did you invest your own financial resource or take any loan for the nursing home?

APPENDIX - II

Some of the elite people from Bengal and outside Bengal who gave their support and provided financial assistance towards the establishment of medical care institutions and scholarships to the students in nineteenth century are as follow:

Medical College Hospital

1) Babu Ram Comul Sen gave assistance in establishing the hospital, dispensary & importing medical education.
2) In 1835 Babu Motilal Seal gave a large piece of land in the vicinity of the college for the construction of a large hospital.
3) Baboo Dwarkanath Tagore founded the yearly prizes to the total value of Rs.1000/- for the several classes and Government assisted in the same object.
4) From Baboo Ram Commul Sens fund (Dewan of the Bank of Bengal) a gold medal was to be awarded at the end of 3 successive sessions to the best student of Botany.
5) A gold medal was to be awarded every year to the best student in practical anatomy, out of the fund of Rustomjee Cowarjee Esquire of Calcutta.
6) In 1841-42 out of Goodeve endowment scholarship was awarded to the best student in midwifery.
7) Rajah Kissennath Roy donated to the college a sum of Rs. 700/-
8) Babu Dwarka Nath Tagore incurred the expenses of two students for sending to the college of England.
9) Babu Radhakant Deb was the first one to advocate publicly the need for female education in India
10) In 1884 Maharani Swarnamoyee donated a sum of Rs. 1.1/2 lakhs to the Government for building a hostel for Indian girls.
11) Maharajadhiraja Bahadur of Darbanga also donated funds.

R .G .Kar Medical College and Hospital

1) For Panna Lal Seal Out Door Dispensary in the Albert Victor Hospital Babu Monilal Seal gave a donation of Rs. 21, 000/- in 1899.
2) In the same year the Maharaja Monindra Chandra Nandy Babadur and Babu Bama Charan Blur gave generous donation for the construction of new buildings.
3) In 1909 to the Albert Victor Hospital Rani Kasthuri Manjuri (Rs.87,000/-) of the Pustha Raj Family & Babu Deb Prasanna Ghose (Rs.70,000/-) gave donations.
4) King George V & Queen Mary.
5) Government of India.
6) Rai Kailash Chandra Basu Bahadur donated Rs. 40, 000/- to create ward for Typhoid patient.
7) Dr.R.G. Kar gave his entire property to the patient.
8) Late Lord Sinha of Raipur and the Nizam of Hydrabad also rendered financial help towards the establishment.

Source ***Guha, P.K. ed. 1951:*** *The Bengal Medical Directory, 1951, Hopewell & Co.*
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APPENDIX – III

HOSPITALS IN CALCUTTA

Sl.No.	Name of hospital	Controlling authority	Beds
	State Government Health Department		
1	School of Tropical Medicine	SGH	150
2	Upendra Mukherjee Memorial Hospital	SGH	57
3	Vidyasagar State General Hospital	SGH	256
4	Vijaygarh State General Hospital	SGH	100
5	S.S.K.M. Hospital	SGH	1670
6	S.N. Rly Hospital	SGH	560
7	Nilratan Sarkar Medical College & Hospital	SGH	1890
8	R.G. Kar Medical College and Hospital	SGH	1200
9	Ramrick Das Harlalka Hospital	SGH	130
10	North Suburban Hospital	SGH	137
11	Patipukar T.B. Hospital	SGH	94
12	Medical College & Hospital	SGH	1718
13	Lumbini Park Mental Hospital	SGH	200
14	K.S. Roy T.B. Hospital	SGH	745
15	Lady Dufferin Victoria Hospital	SGH	274
16	Institute of Psychiatry	SGH	36
17	ID & BG Hospital	SGH	780
18	Indira Matri-o-Sisu Kalyan Hospital	SGH	30
19	Dr. R Ahmed Dental College & Hospital	SGH	**
20	Chittaranjan Seva Sadan & Sishu Sadan	SGH	324
21	Dr. B.C. Roy Memorial Hospital for Children	SGH	250
22	Calcutta Pavlov Hospital	SGH	250
23	Calcutta National Medical College & Hospital	SGH	1470
24	Bangur Institute of Neurology	SGH	70
25	B.C. Roy Polio Clinic & Hospital for Crippled Children	SGH	200
26	Bagha Jatin Sate General Hospital	SGH	100
27	Abinash Dutt Maternity Home & Charitable Dispensary	SGH	100
	TOTAL		**12791**
	Hospitals under other Government Department		
1	Presidency Jail Hospital	SGJ	170
2	Alipur Central Jail Hospital	SGJ	120
3	Alipur Special Jail Hospital	SGJ	280
4	Alipur Politce Hospital	SGP	18
5	Calcutta Police Hospital	SGP	300

Contd...

6	ESI. Hospital. Sealdah	SGL	250
7	ESI Hospital. Maniktala	SGL	500
8	Leprosy Vagrant's Home	SGV	13
9	New Vagrant's Home	SGV	60
	TOTAL		**1711**
	Calcutta Municipal Corporation		
1	Barisha Hospital	CMC	20
2	Boral TB Hospital	CMC	180
3	Champa Moniny Maternity Home	CMC	20
4	ChetLA Materinity Home	CMC	20
5	Garden Reach Maternity Hospital	CMC	20
6	Manashatala Hospital	CMC	4
7	Khidirpur Maternity Home	CMC	40
8	North Maternity Home (Baldeodas)	CMC	50
9	Maternity Home & Hospital	CMC	20
	TOTAL		**374**
	Central Government		
1	Centenery Hospital	PORT TRUST	160
2	Dock Hospital	PORT TRUST	20
3	Chittaranjan National Cancer Institute	CG	200
4	S.E. Rly Hospital	RLY	323
5	B.R. Singh Rly Hospital and Centre for Medical Education & Research.	RLY	461
	TOTAL		**1164**
	Private / Voluntary hospital		
1	Dr. M.N. Chatterjee Memorial Eye Hospital	PVT	100
2	G.K. Khemka Chest Clinic & Hospital (Unit No. 1)	PVT	98
3	G.K. Khemka Chest Clinic & Hospital (Unit No. 2)	PVT	67
4	Institute of Child Health	PVT	70
5	Islamia Hospital	PVT	200
6	J.N. Roy Sisu Seva Bhawan	PVT	84
7	L.N. Trust Maternity Home	PVT	26
8	Lohia Matri Sadan	PVT	125
9	Cancer Centre and Welfare Home & Research Centre	PVT	172
10	Marawari Relief Society Hospital	PVT	216
11	Matrimangal Pratisthan	PVT	150
12	Mohanananda Brahmachari Scvayatan	PVT	13
13	Ashram Bhiwaniwala Hospital	PVT	89
14	Assembly of God Church Hospital & Research Centre	PVT	150
15	R.K. Mission Sharada Mission Matri Bhawan	PVT	54
16	R.K. Mission Seba Pratisthan	PVT	550
17	Balananda Arogya Bhavan	PVT	58
18	Balananda Bramachari Sebayatan	PVT	94

Contd...

19	Bhagabandas Bagala's Marawari Hindu Hospital	PVT	35
20	Sri Sri Balananda Brahmachari Hospital	PVT	165
21	Sri Bishudhananda Hospital & Research Centre	PVT	121
22	S.V.S. Marwari Hospital	PVT	206
23	Student's Health Home	PVT	70
24	Society for Child Health & Community Welfare	PVT	12
25	Swadesh Bose Hospital	PVT	60
26	T.B. Relief Association Chest Hospital	PVT	56
27	Vivekananda Medical Institute & Hospital	PVT	9
	TOTAL		**3050**

** *14 Beds in C.B. Ward at NRSMCH*

Source: Government of West Bengal, Directorate of Health Services, 2000: Directory of Health Institutions, State Bureau of Health Intelligence, Calcutta.