Journal of Law, Policy and Globalization www.iiste.org
ISSN 2224-3240 (Paper) ISSN 2224-3259 (Online)
Vol 2, 2012

Ailing Health Status in West Bengal Critical Analysis

P.K. Rana, B.P. Mishra*
Department of law , Reader, M.S.Law College, Cuttack , Utkal University, ODISHA, INDIA
* E-mail of the corresponding author: mishrabhabaniprasad10@gmail.com

Abstract

The State of West Bengal in India is at the crossroads in the field of health care delivery system. Nutrition, health and education are the three inputs accepted as significant for the development of human resources and the progress of the State of West Bengal in India during the last decade towards achieving these three inputs has been uneven. The main purpose of this article is to show the health facilities and challenges in West Bengal of India where the problem of providing effective health care services to the majority of its citizens has become an impossible task for the State of Government of West Bengal. Public Health expenditure under the State of West Bengal is so low that there has been hunger and starvation deaths in different districts of West Bengal. Different datas have been cited through different tables bringing into limelight of Infant Mortality Rate, Birth Rate, Death Rate and the facilities of Government of Hospitals of the State of West Bengal.This article has made a focus on the urgency of strengthening the implementation of all the rural and urban health care program and improve infant and child feeding practices among women. It is a challenge for the State of West Bengal in India to meet Millennium Development Goals by 2015.

Keywords: Ailing health status in West Bengal , Analysis

1. Introduction

The State of West Bengal where about three quarters of population live in villages, the remaining quarter living in urban areas and more than half reside in greater Kolkata is at crossroads in the field of health care delivery system. It is needless to say that the state economy rests on the health, ability and well-being of the people. The promotion and protection of right to health of the people of a state is essential for sustained economic and social development. These developments depend upon the satisfaction of an individual on his certain basic minimum needs for a healthy and a reasonably productive living. The enhancement of health is a constitute part of development and to give good health and economic prosperity tend to support each other.[1] Nutrition, health and education are the three inputs accepted as significant for the development of human resources and the progress of the state of West Bengal during the last decade towards achieving these three inputs has been uneven. An important feature to this has been the serious under-funding of the health sector and the poor performance of the public health delivery system is crippled by several constraints : vacancies and absenteeism of staff; urban/rich bias in the distribution and use of facilities; lack of drugs and other essential supplies at the field level and low staff motivation and management capacity. In 1978, at the Alma Ata Conference ministers from 134 member countries in association with WHO and UNICEF declared “Health for all by the year 2000” selecting Primary Health Care as the best tool to achieve it. Unfortunately that dream never came true. In many cases it has deteriorated further. But the Government of India claims that the country is on track to meet the Millennium Development Goals (MDGs) targets by 2015.[2] It argues that the number of people living below the poverty line has reduced. It claims that child and material mortality rates are reducing at a pace commensurate with its plans. The Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) has increased rural employment. The Sarva Shiksha Abhiyan (SSA), a national policy to universalise primary education, has increased enrolment in schools. The Reproductive and Child Health Programme (RCHP) II, the Integrated Child Development Services (ICDSs) and the National Rural Health

Mission (NRHM) have resulted in massive inputs in the Health Sector.[3] But due to inbuilt weaknesses and distortions, half-hearted attitude of Indian ruling classes and their governments, red-tapism, corruption, nepotism, delayed response, poor-motivation, poor work culture, lack of co-ordination and other faults NRHM has not been properly implemented like previous health policies and programmes.

2. Public Health Expenditure Under The State of West Bengal

West Bengal is one of the most fiscally stressed states of all the Indian states. The fiscal deficit has been between 7 and 10% of the state Gross Domestic Product (GDP) during the past few years, and state public debt has risen to 45% of GSDP. Interest payments now exceed 35% of revenue expenditure. This has forced the government to reduce the already inadequate outlays for health and other development expenditure. The Government of West Bengal is preparing a medium-term fiscal stabilization program, and is expecting Asian Development Bank's financial support in this effort. This is a major change for the Government of West Bengal, which has only recently fully acknowledged the seriousness of the fiscal problem, and has for the first time asked for external assistance to address it. Largely as a result of the fiscal crisis, the share of West Bengal's budget devoted to health has declined sharply, from 6.0% in 1999/00 to just 3.9% in 2003/04 (the share of non-interest' expenditure has been more or less stable). Health spending as a share of GSDP has also fallen, and was just 0.8% last year, which is the same as the all-India average. Finally, per capita spending on health is near the average for Indian states at Rs 176 per head (around US$ 3.50). Overall, the 2004/05 budget projects real expenditure 18% lower than in 2000/01. Department of Health and Family Welfare seems to have made expenditure cuts chiefly through allowing the number of staff vacancies to rise: officials estimate that 10% of all posts are now vacant. These vacancies are concentrated in rural and deprived regions, which are least able to cope with them, given low purchasing power and inadequate alternative (private) provision.[4]

2.1 Collapse Of Health Status In West Bengal

The government health system in West Bengal has been on the verge of collapse vis-a-vis booming of private hospitals, nursing homes, clinics, diagnostic centres, insurance companies, Third Party Admiistrators, touts etc. Their beloved government even waived tax from these money and profit making organizations in the name of 'research'. Government has no will to thwart the unethical and corrupt activities of these private institutions like excessive and false billing, unnecessary investigations, negligence in patient care, irrational use of ventilator, ICU etc. There is resentment against the Medical Council also for their failure to take into task the grossly negligent doctors. Among Indian states West Bengal stood 19th in Infant Mortality Rate (lMR) and topped on anemia in children.

In West Bengal while the history repeats the same path resultantly whatever the benefits have come in West Bengal out of the land-reforms, reforms of education, reforms of health-cares, job-opportunities etc. have gone of its larger shares to the social hierarchies. Whatever the shares the Dalits and the religious minorities have got are very less in comparison to' the' population and definitely in violation of their constitutional rights.[6] The Government Hospitals by and large provide near about hundred percent of the health-cares to the Dalits in the state. At present the efficiency of treatment in the Govt. Hospital has gone to the poorest level. Anyone desiring satisfactory health-care is to depend on the private doctors or private hospitals. Since the charges of treatment in the private hospital is exorbitantly high and the deposit prior to admission needs minimum rupees ten thousands or more, it is now beyond doubt that the Dalits do not find any space of their treatment in the private capacity. Dalits are very often found to die of mal-nutrition and without proper treatment. In the tea-gardens of different places in North Bengal a few hundreds of the tribal people have died of the starvation just after the tea-gardens have been locked out. In a span of thirteen months in a particular tea-garden the death of 142 people occurred for scarcity of food only. In the NSSO (national sample survey organization) report published in February, 2007 it is seen that West Bengal is ahead of all the states in respect of the poor performance to provide full meal at least once a day through the month of the year. What the Bengal media generally do? They are very habitual to point out the weak points of the other states and very glamorously depict the starvation death of Kalanhandi in Orissa. The

above report mentions that 10.6 percent of the rural people of Bengal suffer from the food scarcity whereas it is 4.8 percent in case of Kalanhandi which stands second in the national gradation.[7]

3. Hunger, Starvation, Deaths

West Bengal, ruled by the Communist Party of India (Marxists) since 1977 faced widespread hunger and starvation deaths in 2005. The victims included the workers in the tea gardens in Jalpaiguri district of North Bengal, tribals in Amlashol in West Midnapur district and the villagers uprooted by land erosion by the Padma river in Malda and Murshidabad districts. The Supreme Court in its various interim orders in Writ Petition (civil) No. *196/2001 (Peoples Union for Civil Liberties Vs. Government of India & Ors.)* directed the government of India and the State governments/Union Territories to take steps to prevent hunger and starvation by identifying persons living Below Poverty Line (BPL) and making them beneficiaries of various poverty alleviation programmes of the government such as National Food For Work Programme. But the government of India and the State governments failed to effectively implement the Supreme Court orders.

3.1 Poor Economic Scenario: In Different Districts

On 15 March 2005, the then opposition Congress and Trinamul Congress legislators (now in power) walked out of the State Assembly of West Bengal in protest against the state government's "failure to stop starvation deaths" in different parts of the state.[8] In June 2005, the Supreme Court directed the West Bengal State Human Rights Commission to. investigate into the alleged starvation deaths in Murshidabad district.[9] The villagers were deprived of work although Murshidabad district had been declared as a backward district under the National Food for Work Programme.[10] which was launched in November 2004, in 150 most backward districts of the country, identified by the Planning Commission in consultation with the Ministry of Rural Development and the State Governments. A few families who were issued BPL (Below Poverty Line) ration cards did not get their rations properly as rice was not always available in the government designated ration shops. A few who got job under the National Food for Work Programme were not paid full wages. The workers were supposed to get five kilograms of rice and Rs 32 in cash but the CPI-M cadres deduct two rupees from each day's cash wage and 300 grams from the ration as donation to party fund.[11] On 2 April 2005, a 16-year·old girl identified as Rumpa Sharma hung herself from the roof of her mud house after three days of starvation at Dayarampur village in Murshidabad district.[12] On 9 September 2005, Hazrat Mollah died of starvation in Dayarampur village in Murshidabad district. He had been suffering from malnutrition for a long period of time.[13] The tribals in Amlashol of West Midnapore district were worst affected. Majority villagers of Amlashol, despite their acute poverty, were not enrolled as BPL families and only a few families had been listed under Annapurna Yojana. A few villagers had ration cards. The shop from which they were supposed to collect their rations was 35 kilometres away from the food storage. There was no medical facility.[14]

3.2 Some Burning Examples: Witnesses Of Death In Hunger

On 19 February 2005, a 30-year·old tribal woman Parbati Shabar died of starvation in Amlashol. Her family members stated that the deceased had nothing to eat for a month. But the Belpahari Block Development Officer (BDO) Subhashis Bej claimed that her death was due to illness and not starvation.[15] On 16 April 2005, 42-year-old tribal Lula Shabar died of starvation in Amlashol. According to Lula's nephew Rathu Shabar, Lula cried "bhat dey, bhat dey' (give me rice, give me rice) for three days before he died. But there was virtually nothing to eat in the family. The district administration, however, attributed Lula's death to tuberculosis.[16] Tea gardens also witnessed wide-spread hunger. In 2005, about 2000 tea garden workers had been reportedly facing stark starvation ever since the Potong tea estate near the Indo-Nepal boarder under the Mirik block in Darjeeling district was closed down in March 2000 by the Tea Trading Corporation India (TTCI) owned by the central government.[17]

4. Key Challenges For Meeting The Health MDG Targets

The key challenge of meeting the health (MDG)targets for West Bengal is to ensure that poor households — specifically women and children from scheduled caste, scheduled tribe and other disadvantaged social groups — are able to demand and access quality basic health care services. A recent study[18] comparing levels of access to health services across 16 states of the country places West Bengal in the lowest category alongside Rajasthan, Orissa, Bihar and Assam. It is worth noting that disaggregated data on health indicators by social groups is not easily available and accessible. The Health Monitoring and Information System (HMIS) which will ensure disaggregated data is generated on a regular basis and made readily accessible for evidence based policy planning. The other key challenge for ensuring equitable health outcomes is to priorities policy responses for the six poorest districts, which also have the poorest health indicators for West Bengal. The District Development Report for West Bengal[19] indicates that Malda, Uttar Dinajpur, Dakshin Dinajpur, Murshidabad, Purulia and Coochbehar have the highest levels of health services deprivation - i.e. the highest levels of children not fully immunised and non-institutional deliveries ... " This reflects the inadequacies of outreach of health services provided by the state, alongside poor quality delivery services. Children born in the poorest districts are less likely to survive than to children born in other districts; similarly, in these districts pregnant mothers are less likely to receive antenatal care and institutional support for deliveries, thereby making them more vulnerable.[20]

6. Conclusion And Recommendation

This paper has attempted to show the health facilities and challenges in West Bengal where the problem of providing effective health care services to the majority of its citizens has become an impossible task for the state Government of West Bengal. A huge section of the rural Bengal is succumbing to deaths which could be avoided to a great extent with safe drinking water, proper sanitation, may be with some very elementary medicines. Rural health services which form the backbone of public health system, is lacking in basic infrastructure, staff and essential medicines. The sufficient manpower is an important prerequisite for the efficient functioning of the Rural Health Infrastructure. Health indicators are very poor and the poor face financial ruin if visited by a serious health event. India is committed to the goal 'health for all' and in the last four decades, a wide network of primary health centres and subcentres has been created. Yet most of the states including West Bengal are far away from this goal. It can be easily apprehended from many surveys as well as NFHS-1 and NFHS -2 that either the services do not reach the disadvantaged sections of the society or people from those sections do not utilize the available services. Apart from economic condition, the social hierarchy or the system of social stratification existing in the society of West Bengal is likely to influence the health behaviour of individuals. Social stratification system determines the living conditions, privileges, obligations and cultural traditions surrounding the life of a person which in turn affect his perceptions regarding health, knowledge of health care and accessibility to health resources.[21] There is an urgent need to strengthen the implementation of all the rural and Urban Health Care programmes and improve infant and young child feeding practices among lactating women. However most of the patients in Government Hospitals have to wait hours after hours for treatment. Still a good section of the society is visiting these hospitals as they are financially crippled. Who is responsible for this dilapidated health structure of West Bengal ? This question echoes in the panorama of the broken health structure of the state of West Bengal.

Reference

1. National Health Development Report 2001, p. 64

2. K.S. Jacob : 'Millennium Development Goals and India', published in The Hindu, a news paper, dt. October 20, 2010.

3. *Ibid.*

4. www.webhealth.gov.in visited on dt. 30.08.2010 see also West Bengal : health Systems Development Initiative : Programme Memorandum, Govt. of West Bengal, Govt. of India, DFID, U.K. 15th January, 2005.

5. Gurub Roy : Manifesto of People's Health Movement in West Bengal, India, May 2009 available at Human Resource Development Report http:// hdr.org/en/reports.

6. http://www.dalitmirror.com/topic1.html.

7. *Ibid.*

8. Congress, Trinamul walkout of Assembly, The Statesman, a newspaper, dt.16 March, 2005.

9. Probe Starvation deaths, SC asks panel, The Tribune, a newspaper , dt. 4 June 2005.

10. The Inquiry report is available at http://www.masumindia.org/tribep.htm

11. Murshidabad : Nature's fury, hunger, death, apathy by Zafarul – Islam Khan, The Milli Gazette, 1-15 May, 2005, also available at http : // www.milligazette.com/dailyupdate/2005/20050501.htm

12. Hungry and Dying in Padma's lap, Tehelka dt. 18 June, 2005, available at http : // www.tehelka.com

13. HU-07-2005 : UPDATE (India) : Starvatron deaths continue despite government's commitment to provide food assistance in West Bengal, Asian Human Rights Commission, Hunger Alert, 16 Sept. 2005, available at http://www.foodjustice.net

14. "The Hunger Game – There is a law against everything, none against starving to death", by Bhaswati Chakravorty, The Telegraph,a newspaper, Kolkata dt. 26 April, 2005.

15. Woman dies, family blames hunger – Almasol death precedes CM visits to hand over houses, The Telegraph, a newspaper, dt. 25 February, 2005.

16. Starvation stench in Almashol again, The Telegraph, a newspaper, dt. 21 April, 2005.

17. Starvation looms over tea workers, The Statesman, a newspaper, dt. 16 July, 2005.

18. P. Samuel, et al 2004, State of India of India's Public Services : Benchmarks for the states, EPW Feb. 28, 2004.

19. B. Chatterjee, D.K. Ghosh, 2003, Towards District Development Report for West Bengal, SIPRD, West Bengal.

20. *Supra Note* 3 at 20.

21. SNM Kopparty (1994) : Social Inequality and Health Care, Northern Book Centre, New Delhi.

Table – 1

Comparing the Birth rate, Death rate and Infant mortality rate : West Bengal & India

	Birth Rate		**Death Rate**		**Infant Mortality Rate**	
	West Bengal	**India**	**West Bengal**	**India**	**West Bengal**	**India**
	Total	**Total**	**Total**	**Total**	**Total**	**Total**
1980	31.7	33.7	10.9	12.6	N.A.	114
1981	33.2	33.9	11.0	12.5	91	110
1982	32.3	33.8	10.4	11.9	86	105
1983	32.0	33.7	10.3	11.9	84	105
1984	30.4	33.9	10.7	12.6	82	104
1985	29.4	32.9	9.6	11.8	74	97
1986	29.7	32.6	8.8	11.1	71	96
1987	30.7	32.2	8.8	10.9	71	95
1988	28.4	31.5	8.4	11.0	69	94
1989	27.2	30.6	8.8	10.3	77	91
1990	28.2	30.2	8.4	9.7	63	80
1991	27.0	29.5	8.3	9.8	71	80
1992	24.8	29.2	8.4	10.1	65	79
1993	25.7	28.7	7.4	9.3	58	74
1994	25.2	28.7	8.3	9.3	62	74
1995	23.6	28.3	7.9	9.0	58	74
1996	22.8	27.5	7.8	9.0	55	72
1997	22.4	27.2	7.7	8.9	55	71
1998	21.3	26.5	7.5	9.0	53	72
1999	20.7	26.1	7.1	8.7	52	70
2000	20.7	25.8	7.0	8.5	51	68
2001	20.6	25.4	7.0	8.4	51	66
2002	20.5	25.0	6.7	8.1	49	63

Source : Health on the March, West Bengal, 2003-04

Vital Statistics

West Bengal's performance had always been better than all-India aggregates with regard to most of the vital statistics. Interstate comparison puts West Bengal in the middle position among the major 15 stats as far as vital statistics are concerned. In respect of Crude Birth Rate (CBR). West Bengal stands third with a value of 20.5 with the top slot occupied by Kerala at 17.2 in 2001. The state stands with respect to Death rate with a value of as against 8.4 for India.

This academic article was published by The International Institute for Science, Technology and Education (IISTE). The IISTE is a pioneer in the Open Access Publishing service based in the U.S. and Europe. The aim of the institute is Accelerating Global Knowledge Sharing.

More information about the publisher can be found in the IISTE's homepage:
http://www.iiste.org

The IISTE is currently hosting more than 30 peer-reviewed academic journals and collaborating with academic institutions around the world. **Prospective authors of IISTE journals can find the submission instruction on the following page:** http://www.iiste.org/Journals/

The IISTE editorial team promises to the review and publish all the qualified submissions in a fast manner. All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Printed version of the journals is also available upon request of readers and authors.

IISTE Knowledge Sharing Partners

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digtial Library , NewJour, Google Scholar