Chandrakanta Patil Memorial
Eastern India Regional Health Assembly
9th July 2011, Kolkata

Organised by

Pratichi Institute, Liver Foundation West Bengal, Asian Development Research Institute, Patna and UNICEF Kolkata

Theme: Health, Social Justice, and the Democratic Deficit

The Eastern India Regional Health Assembly, held on the 9th of July 2011 and participated by 200 delegates, was presided over by Professor Amartya Sen and Sir Michael Marmot, who delivered the inaugural speeches and concluding remarks. The two panels in between brought together medical doctors, policymakers, development experts, academics, journalists, and civil society organisations from Eastern India, to discuss both socioeconomic and political inequities that influence the functioning (or non-functioning) of healthcare in India, and ways to address them. The Assembly was preceded by a review of health conditions in Eastern India by the Pratichi team, the findings of which were published as *Health Inequity and Democratic Deficit: A View From East and North East India*.

The Assembly was dedicated to the memory and ideals of Dr. Chandrakanta Patil, who died at the age of 24, attempting to rescue victims of the 2009 Bihar floods. It was supported by the Asian Development Research Institute (ADRI) Patna, Liver Foundation West Bengal, and UNICEF Kolkata. The team also received valuable assistance and inputs from Professor Achin Chakraborty and Dr. Subrata Mukherjee at the Institute of Development Studies Kolkata, Dr. Koninika Mitra of the UNICEF, Dr. Abhijit Chowdhury of the Liver Foundation West Bengal, Dr. A. K. Roy of Economic Information Technology, Mr. Dilip Ghosh and Mr. Shubhro Chakraborty of the National Rural Health Mission, and Mr. Kamal Pal of Riddhi.

Eastern India Regional Health Assembly: Objectives

The assembly focused on the relevance of the social imperatives of health as a tool for human development, thereby attempting to further the concepts in health beyond the prevailing narrow mechanistic domains.

It sought to bring together activists and academics, and organisations and Institutions of Eastern India together for building up a forum for exchange of experiences, empirical data and ideas on the intricate relationship between social disparities and health care, and on the need of treating health as an instrument as well as outcome of the paradigms of social justice existing in the contemporary society.

It also hopes to contribute to the genesis of research, thought, and plans through collaborative action amongst participants in the interface of Health and Social justice, and provide a conceptual framework for planning health care in the country by disseminating widely the deliberations.

Health Inequity and Democratic Deficit: A Glance

The text, based on the Pratichi health review, emphasised the following:

> There are many social determinants of health, including larger structural forces and socioeconomic inequalities. The question that motivates this study is how, even amongst these inequalities, the issue of health could be made a central democratic priority in India.
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> In view of the rather unenthusiastic public discussion and action regarding key health issues — a symptom of our democratic deficit —— we assert that to awaken ballot-box democracy to concerns of equity in health, we need to make the fullest use of the avenues of deliberative democracy. Hence is our focus on democratic dialogue in a public forum.[1]

For so many people in India, so central a capability is compromised due to a host of social conditions that produce poor health as well as health inequity, and the lack of adequate

[1] *Health Inequity and Democratic Deficit: A View from East and North East India*, "Introduction".

social action to combat those social causes of ill health. It is, therefore, essential to take a closer look at 'what makes good health so problematic for so many people in India'. To that end, *Health Inequity and Democratic Deficit: A View From East and North East India* aims to focus, above all, on socio—economic correlates of health, the importance of government action, and larger public participation and action to reduce social gaps in health. It also seeks to draw on positive lessons and experiences from within India, encouraging initiatives that prove better public health is achievable in this region and country, and stir our 'constructive impatience'[2] about not doing something that is within our reach.

The Assembly: An Overview

The welcome address was delivered, in succession, by:

Kumar Rana, Project Director, Pratichi Institute

David McLoughin, Deputy Representative, UNICEF India

P. P. Ghosh, Director, Asian Development Research Institute

Rana and Dr. Ghosh both emphasised the mediating role of society — and therefore social inequalities — in the delivery of health services in India. Ghosh mentioned that while both sectors were vital to the nation's progress, education gets more attention than health, but the biological body must prosper before the social body can assert itself. He also said the assembly would be a good platform to discuss untrained practices of medicine (the 'roaring practice of quacks' in villages and remote areas), and how the damage caused by it to the people, both medically and financially, may be addressed.

McLoughin emphasised the paradox of India's diversity. Its remarkable economic growth, he said, coexists with inequalities and such harmful practises as child marriage. Women and children suffer especially, and in different ways depending on the local practises of the region. These local diversities must be taken into account while planning a more equitable and universal health system for all.

2 Sen, Amartya, (2000) *Development as Freedom,* Oxford University Press, New Delhi.

Session I: Introducing the Theme of the Assembly

Abhijit Chowdhury of the Liver Foundation West Bengal introduced the people inaugurating the assembly. He gave us a brief introduction to Dr. Chandrakanta Patil's life and work, and spoke of carrying forward his mission of providing healthcare to the poor inhabitants of the remote and under-developed areas of the country. He also mentioned that during the assembly effort must be made to distinguish healthcare from medical care, because pathological care was only a part of healthcare, which included such preventive measures as access to nutrition, to clean water, hygienic surroundings, and so on. Dr. Chowdhury concluded by inviting Amartya Sen to deliver his opening remarks.

Sen, in his opening remarks, revisited the connection between education and good health, citing the instance of Thailand, where health systems are aided, critiqued, and added to each year by a national citizens' health assembly. Those wishing to participate write a letter to the government, and are included in the programme. Had they not had the capability of being aware of, and asserting their rights in writing, Sen said, the Thailand health assemblies would not be as participatory or democratic as they are, and Thailand's health systems would suffer as a result. He then went on to emphasise that markers of a nation's economic growth — such as its GNP — are not tangibly valuable to our daily lives. It is merely a means to an end, and this end is a richer, more fulfilling life of broader capabilities for every individual. If low life expectancy, infant mortality, poor nutrition *et al* continues, then the nation would rank very low on overall performance despite a robust GNP, as it is the role of the state to convert high GNP to better performances in these areas (and in education). He concluded by saying that demand for more equitable public services must be made audible.

Professor Marmot's talk, titled "Fair Societies, Healthy Lives", referred to Sen's point about economic performance and health services, emphasising that a state that does not perform well in health does not perform well overall, no matter how efficient its economy. He then went on to comprehensively demonstrate (with statistics available at http://www.marmotreview.org/) how local socioeconomic differences and inequalities affect health performances, and how therefore effective health services must always take the social gradient into consideration. The intervention needed in the poorer part of Glasgow, where average life expectancy (54) is lower than in India (62) will be different from the kind required at an urban Indian slum. Awareness of these details are vital to the success of

health policies and interventions everywhere. Good health is achievable, he concluded, for we have the knowledge and the expertise. The only thing that remains mobilised is political will. Civil society must act to influence political will, to enact vitally necessary changes in healthcare.

The final speaker for this panel was Manabi Majumdar, Director of the Pratichi Institute. Majumdar introduced and briefly discussed *Health Inequity and Democratic Deficit: A View From East and North East India*, the Pratichi publication that was unveiled at the assembly. She spoke of poor public health as a symbol of the democratic deficit in India, proof that democracy was not forwarding the interest of the common citizen. She said the social indifference towards issues of public health prompted this assembly, so that attention might finally be drawn and the deliberative process of democracy be put into motion for better health in India.

Session II: Panel Discussion: Equity in Health

The panel was chaired by David McLoughlin, Deputy Representative of UNICEF India, and Achin Chakraborty, faculty, Institute of Development Studies Kolkata. The speakers on this panel were:

A. K. Shivakumar (UNICEF) — spoke of the need to curb privatisation of the health sector, proposing state-sponsored primary and secondary care, 60 percent of which was to be earmarked for primary health care. He also advocated use of the health card system that UNICEF has been working on.

P. P. Ghosh (ADRI, Patna) — There are several levels of inequality in places like Bihar: caste, gender, class, religion. Private medical systems reinforce these inequalities because they are run by the privileged people. Those areas where public deliveries have improved saw improved attendance of rich upper caste people who previously only availed private care, but this move displaced the poorer people, tribals and lower castes from those hospitals, because it is still unthinkable in their society to share amenities across caste and religious barriers.

A. K. Roy (Economic Information Technology, Kolkata) — speaking of his current area of work, the North East, Roy said that unlike the rest of India, infrastructure is excellent in urban centres (but poor in remote areas because doctors refuse to go there). This area's three major health problems are alcohol, tobacco, and HIV/AIDS, and community awareness programmes et al have not helped curb these. He said a marketing/advertising intervention is what is required in relatively progressive areas (in terms of health performance) to devise effective anti-alcohol, anti-tobacco and anti-HIV/AIDS programmes.

Achyut Das (Agragamee, Raygada, Orissa) — Mr. Das said that there is a systematic effort on part of the government in Orissa to depopulate tribal settlements in order to hand over the lands to mining corporations. Since they expect these tribal areas to be emptied of people soon, they do not want to invest in long-term programmes involving permanent infrastructure or doctors. The private economic agenda is being pushed by public healthcare planning. The common complaint about lack of funding or inability to set up health facilities quickly is completely untrue, given how quickly military and para-military settlements have been set up in the area, and provided with clean drinking water, running water, and medical facilities.

Sunil Kaul (Action Northeast Trust, Assam) — the effects of undernutrition have been normalised in our minds as ethnic traits. So Punjabis are expected to be tall, whereas Assamese are expected to be stunted. If the problem is made invisible like this, why would anyone look for solutions? The North East especially suffers from neglect: in Meghalaya several children die every year from something as curable as rickets, because the fact that rickets kills in this area goes unrecorded. Maternal mortality is very high in Assam, this is accepted as a 'historical fact'. But why should this continue to be a fact? This is why most sub-castes in Assam have chosen the language of violence to talk back to the centre, because democratic methods appear not to be getting any attention.

Anirban Chattopadhyay (the *Anadabazar Patrika*) — as the Pratichi report's chapter on media observed, media is driven by short attention spans of modern readers, and focuses on sensational individual cases of medical neglect. Perhaps the new Chief Minister's attitude of constructive impatience will compel the media to look into the deeper problems underneath and bring them into public discourse. We can certainly hope.

Binayak Sen (People's Union for Civil Liberties) — we mistakenly assume the state is benevolent and will actively work towards removing inequality, whereas it is the chief agent for extracting resources from the poor. If this is the state the poor must appeal to for universal coverage, the chances of success are very slim. We need more public platforms to debate and demand health rights, we need more awareness. From the infrastructural point of view, we need better information flow. Recording and sharing, on a national scale, the data of patients — especially birth and death — should be mandatory.

Session III: Panel Discussion: Rethinking Health Systems

This post-lunch session was chaired by Poonam Muttreja (Population Foundation of India). The speakers on this panel were:

K. Srinath Reddy (Public Health Foundation of India) — primary care failed in terms of coverage and quality across states and regions. Urban public health care is practically non-existent, which means the urban poor are almost completely excluded from health services. District hospitals have also been grossly neglected. District medical colleges will have to be set up to function as training hubs, strengthening district-level delivery of healthcare. Focus should now be on northern states since most training colleges are in South India and Maharashtra. Strong regulatory measures on the private healthcare industry are needed, especially on prices which have shot up beyond the reach of the average person. All essential drugs should be enlisted, and be provided free of cost via public healthcare centres.

K.S. Jacob (Christian Medical College, Vellore) — trend in medical training should be geared towards primary chronic disorders (common ailments) and be skill-based, instead of (specialised) knowledge-based. Current training is based in urban hospitals where students are made familiar with complex problems but not on such basic and widely-required skills as a delivery. These students, even if they are given incentives to go to rural areas, would not be useful. Our method of education also discourages critical thinking in both students and teachers — this is a big problem in both daily medical practice and research. There needs to be restructuring of the way medical students are taught and trained.

A. K. Sarkar (Additional Chief Secretary, Health and Family Welfare, Jharkhand) — healthcare cannot be improved without taking into account other factors such as purchasing

power, education level. Absenteeism in public servants results in services not reaching remote areas. Government might offer to pay part of the expenses of local private agencies which might undertake these responsibilities. Asha workers can be trained for emergencies and in delivering care for common ailments.

Dilip Mahalanabish — the top-down approach of delivering services has failed. What is needed now is the maximisation of available resources. Using government-owned or aided non-governmental agencies, the system must be made decentralised and autonomous so they can be more flexible to local needs.

Sanjay Sharma (Centre for North East Studies, Assam) — thirteen districts in Assam have very poor health service. There is no service on the islands on the Brahmaputra. There is not even a delivery mechanism in place. The current solution, aided by the government of Assam, is boat clinics. Such alternative and locally adaptable methods must be utilised in places where accessibility is difficult.

Punyabrata Gun (Shramajibi Swasthya Udyog) — health is the sum of physical, mental and social well—being. The state's withdrawal from the health sector will threaten this. While prices are rising outside, a by—pass surgery can be performed at the Howrah Shramik Hospital for Rs. 28000. Our drug policy needs to be rationalised as well, to cut back on money spent on unnecessary drugs. The state also needs to streamline infrastructure of medical delivery.

The evening concluded with presenting a felicitation plaque to Dr. Patil's bereaved parents, and Amartya Sen and Sir Michael presenting their concluding remarks to the press.