REPORT ON THE

Health and Healthcare in West Bengal Symposium

VENUE:
Amartya Sen Research Centre, Pratichi (India) Trust

DATES:
13th – 14th February 2026

Pratichi

O.P. JINDAL GLOBAL
INSTITUTION OF EMINENCE DEEMED TO BE
UNIVERSITY
A Private University Promoting Public Service

Table of Contents

Day 1: 13th February

Inaugural session

The symposium was formally inaugurated by the project in charge, Indranil Mukhopadhyay, who outlined the primary objectives of the presentation and discussed the preliminary research findings. In his opening remarks, he welcomed the collaborative initiative between Pratichi and O.P. Jindal Global University, underscoring the importance of joint academic engagement. He emphasized that the iterative nature of this research necessitates critical feedback from both academics and practitioners, which will serve to refine and strengthen the final outcomes.

In her welcome address, Antara Dev Sen, the Managing Trustee of Pratichi (India) Trust, Delhi, provided a socio environmental grounding for the health discussion. Drawing on local idioms such as *matha jhinjhin* (tingling head), *tonton byatha* (throbbing pain), *kaan kot kot* (ear discomfort), and *gaa myaj myaj* (general malaise), she illustrated the everyday Bengali experience of health. She highlighted a brewing crisis: air pollution in Bengal is worsening, with the AQI frequently hovering around 200, placing Indian cities among the top ten most polluted globally.

Figure 1: Antara Dev Sen delivering her inaugural speech

Sen further argued that universal healthcare lies at the core of Pratichi's mission, in alignment with Amartya Sen's vision. She emphasized that health deficits directly undermine human capabilities, productivity, and skill acquisition, thereby constraining both social and economic progress. She recalled that the Mid Day Meal scheme emerged from a vibrant debate facilitated by Pratichi, underscoring its role in shaping inclusive policy. Positioning Pratichi as a distinctive "stakeholder bridge," she highlighted its capacity to connect policymakers, academics, healthcare workers, and grassroots activists. While commending the Swasthya Sathi scheme for reducing catastrophic health expenditure and achieving broad coverage, she stressed that the ultimate goal remains the development of a robust primary healthcare system and the professionalization of frontline workers.

Building on Antara Dev Sen's emphasis on healthcare and stakeholder engagement, Professor R. Sudarshan, Dean of the Jindal School of Government and Public Policy, reflected on the pedagogical legacy of Amartya Sen at the Delhi School of Economics. He noted that Sen's hallmark was the ability to present complex economic theories in a simplified manner—a quality often missing in contemporary journals. He linked this clarity to the intellectual rigor of Bengali culture, citing Satyajit Ray's meticulous attention to detail as a benchmark for the present researchers.

Professor Rama Baru then situated the symposium within the broader framework of Indian federalism, stressing that health remains a state subject and cautioning that centralization often obstructs state level success. Drawing on David Mosse's concept of the "pedagogy of failure," she argued that studying failures is as vital as documenting successes. She challenged neoliberal claims that individuals "choose" private healthcare, referencing findings from the 42nd round of the NSS and citing T.N. Krishnan's assertion that true choice must consider the four A's: Accessibility, Affordability, Availability, and Acceptability. She observed that COVID 19 exposed massive market failures in the private sector, yet the current system continues to operate under fragmented public financing. In her concluding remarks, Professor Baru emphasized that the private sector is increasingly financialized and corporate driven, producing inequities that are morally unacceptable. She called for strengthening the public supply side and enforcing rigorous regulation of private healthcare to ensure equity and sustainability.

Figure 2: Esteemed guests of the inaugural session

After Professor Rama Baru's critique of fragmented public financing and inequities in healthcare, Dr. Monjur Hossain, Chief Field Officer, UNICEF, Kolkata, advanced the discussion by presenting four critical narratives. He began with normative systems, identifying persistent challenges in financing, information, and governance. He then highlighted the qualitative narrative, drawing on the work of the Commission for Global Health Systems. Third, he spoke about climate pressure, focusing on how systems adapt to environmental shocks. Finally, he addressed convergence, noting that the health sector often inherits failures from other social and economic domains, compounding systemic weaknesses. In this context, he called for the localization of benchmarks to align with the expectations of state and local governments. He argued that such tailored approaches are essential for building resilience, ensuring accountability, and fostering responsive health systems that can meet diverse regional health needs.

Figure 3: Dr. Monjur Hossain, Chief Field Officer, UNICEF, delivering his speech

Continuing the discussion, Professor, Achin Chakraborty traced the current work back to the 2005 Pratichi Health Report. He invoked Amartya Sen's *The Idea of Justice*, distinguishing between "Transcendental Justice," the pursuit of a perfectly just society, and "Comparative Justice," which evaluates real world alternatives and practical improvements. He urged the team to maintain analytical independence, cautioning that researchers are not present to "satisfy the personal beliefs or biases" of either the audience or the state. Instead, he emphasized the importance of rigorous, impartial analysis that can withstand scrutiny and contribute meaningfully to policy debates.

After the academicians and practitioners presented their views, Shri Narayan Swaroop Nigam, Principal Secretary, Department of Health and Family Welfare, Government of West Bengal, offered the policymaker's perspective and its dilemmas. He began his discussion by posing a philosophical question: *Is a woman in Bardhaman not receiving services an act of civil or criminal injustice?* According to his observation, societies evolve every 25–30 years, and while the state is progressing toward missions such as "TB Mukto Bangla," new challenges continue to arise. He further contrasted international models, comparing the United States' 17% GDP expenditure on health with Singapore's 4%, and questioned which path India should adopt. For Bengal, he highlighted innovations such as Suswasthya Kendras, with 2–3 lakh daily footfalls, and telemedicine services—largely accessed by women and older men with mobility issues—as strategies to address the doctor population gap. Additionally, he mentioned that under Swasthya Sathi, 96% of breast cancer patients completed their treatment compared to 60% among self funded patients. He also referred to another initiative taken up by the Government of West Bengal: Swasthya Bandhu mobile medical units (200 vehicles), which provide ECG, USG, and blood tests in remote villages, averaging 100 footfalls per vehicle per day.

Figure 4: Shri Narayan Swaroop Nigam delivering his speech

In the inaugural session, academicians, health professionals, and policymakers presented their perspectives on the overall health system in West Bengal, offering insights into both achievements and persistent challenges. Their contributions set the stage for a deeper exploration of systemic issues, ranging from financing and governance to frontline service delivery. Following these deliberations, Meenuka Mathew formally outlined the agenda for the two day dissemination symposium. She emphasized the importance of structured dialogue, collaborative reflection, and critical feedback in refining preliminary research findings.

Figure 5: Closing of inaugural session

Technical session I

West Bengal Health System Assessment

Chair: **Paramita Bhattacharya**
Discussant: **Nirmalya Das and Vandana Bhatia**

Speakers: Achin Chakraborty, Dibyendu Biswas, Debashree Paul

The first speaker of this session, Professor Achin Chakraborty, presented an overview of the health system in West Bengal, drawing on both anecdotal evidence and secondary data from the National Sample Survey. He discussed broad trends and standard indicators used to assess the system. He noted that while the Government of West Bengal's *Health on March* publication had earlier provided such data, it has not been available since 2018, making the current findings indicative and open to interpretation.

His presentation highlighted key features of both public and private healthcare, though it did not cover all aspects of the system. West Bengal performed well in outcomes such as infant mortality rate (IMR) and life expectancy, yet out of pocket expenditure (OOPE) remained high. Hospitalization rates were also higher compared to other states, reflecting a preference for private healthcare similar to families' reliance on private tuition in education.

His presentation further revealed that hospitalization costs in the private sector were significantly above the national average, while public sector costs were lower in West Bengal. OOPE was largely driven by outpatient care, especially for chronic and non communicable diseases. Based on the analysis, he mentioned that although Swasthya Sathi achieved wide coverage, its impact on reducing catastrophic health expenditure appeared limited.

Figure 6: Technical session I

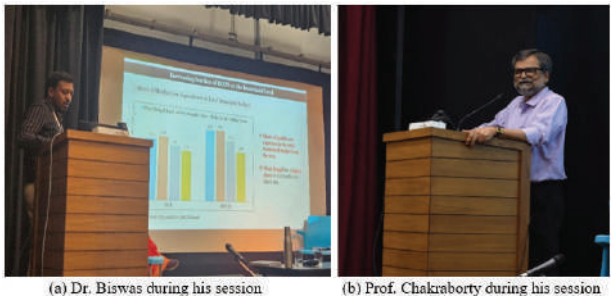
The discussion continued with the next speaker, Dr. Dibyendu Biswas, who built upon Achin Chakraborty's overview by further examining the structural gaps within the state's healthcare framework. He emphasized the need to contextualize rising OOPE within broader systemic weaknesses, particularly the limited reach of primary and preventive care. His analysis adopted a triangulation approach, using government reports and secondary data with descriptive statistics and comparative methods to examine the interrelationship of input, output, and outcome indicators across states and population groups.

Figure 7: Prof. Chakraborty during the session

The health system assessment report examined the reasons behind the rising per capita OOPE in West Bengal, which increased from INR 2,875 in 2019–21 to INR 3,219 in 2021–22 (at 2016 constant prices), despite the expansion of public insurance under Swasthya Sathi. The scheme achieved wide coverage—69.3% in 2022–23 compared to 24.9% nationally—yet its effectiveness in reducing OOPE remained limited. The primary reason identified was its hospital centric design, which excludes non hospitalization care. This category accounts for 90% of total OOPE, with medicines alone contributing 80%, thereby driving household spending upward.

Biswas also drew attention to the uneven distribution of healthcare infrastructure, noting shortages of specialists in Community Health Centres (CHCs) and inadequate Primary Health Centres (PHCs), which force patients to rely heavily

on district hospitals and medical colleges. He argued that while schemes like Swasthya Sathi have expanded coverage, their design remains hospital centric, leaving outpatient care largely unprotected. This mismatch, he suggested, explains why catastrophic health expenditure continues to rise despite insurance expansion.



(a) Dr. Biswas during his session (b) Prof. Chakraborty during his session

Figure 8: Technical session I presentations

Following the discussion, the next speaker of the session, Debashree Paul, presented her analysis of *public spending on health in West Bengal,* based on detailed budget analysis. She demonstrated that public health spending in the state remained low compared to both other Indian states and global standards. Her findings revealed an inverse relationship between public spending and OOPE, with West Bengal recording one of the highest OOPE shares despite limited public investment. She highlighted slow growth in health spending, skewed priorities toward tertiary care, and insufficient focus on primary services, which further confirmed the findings of Dr. Biswas and Professor Chakraborty.

The presentation was followed by a discussion, during which Dr. Nirmalya Das, one of the session's discussants, offered his critical observations on the dynamics of healthcare utilization in West Bengal. He noted that private healthcare use extends beyond large hospitals and includes smaller providers such as local chambers, nursing homes, and polyclinics. He questioned why OOPE remains high despite significant reliance on public tertiary care, suggesting that poverty and its effects on physical and mental health are key contributors to the growing burden of non communicable diseases.

Figure 9 Dr. Dr. Nirmalya Das discussing the session

Drawing on Michael Marmot's *The Health Gap*, Dr. Das emphasized the importance of social determinants of health in shaping outcomes. He observed that rising household health expenditure may reflect either increasing healthcare costs or insufficient public spending, while infrastructure gaps in the public system remain a continuing concern

On Swasthya Sathi, he highlighted that only 7.07% of admissions and just over 8% of claims occurred in government hospitals, underscoring limited public sector utilization. He also pointed out that outpatient footfall at many subdivision and block hospitals had weakened after being converted into medical colleges. His remarks reinforced the need to address systemic imbalances, strengthen infrastructure, and ensure that public investment translates into accessible and equitable healthcare..

Another discussant of the session, Vandana Bhatia, focused on the relationship between budgeting and equity in the health system. She observed that spending on skilling and reskilling of the health workforce remained inadequate, with the quality of training requiring greater attention. She emphasized the importance of examining how Swasthya Sathi was being utilized across different types of care, including non communicable diseases, maternity services, and routine treatments in order to better assess its effectiveness.

Bhatia also highlighted concerns regarding human resource availability. Referring to WHO estimates, she noted that West Bengal's health workforce density stood at 2.2 per 1,000 population, well below the recommended 4.4 per 1,000 needed to achieve universal health coverage. She argued that progress should not be measured solely by the number of Health and Wellness Centres established, but by whether these centres were capable of delivering the full range of twelve mandated service packages effectively.

Figure 10: Dr. Paramita Bhattacharya, session chair concluding the panel

Her observations underscored the need for a more equitable allocation of resources, stronger investment in workforce development, and a sharper focus on primary care delivery to ensure that health system reforms translate into meaningful improvements in access and outcomes.

Technical session II

Hospitalization care

Chair: **Sabir Ahamed**
Discussant: **Debjani Barman**

Presentation 1: Analysing the Effectiveness of Publicly- Funded Health Insurance in reducing Fragmentation in Financing – Anandita Sharma

The first presenter of this session Dr. Anandita Sharma presented findings from a 2024 primary household survey that applied the Insurance Cascade Framework to evaluate the effectiveness of *Swasthya Sathi* (SS) in providing financial protection. Her analysis revealed a striking gap between high insurance coverage and actual financial protection. The survey findings reveals that 72% of individuals are covered by *Swasthya Sathi,* 3% by ESI and 8% individuals had dual coverage of SS and ESIS. Although, SS has the highest coverage in terms of utilisation only 16.6% of insured individuals reported using the scheme during hospitalization, pointing to a significant utilization gap. Some of the reasons reported for not using the scheme when hospitalised, apart from treatment taken in a government facility, include issues related to provider behaviour and supply-side issues such as hospitals denying service, hospitals not empanelled, service not covered by the scheme, and long waiting periods

The survey also highlighted a provider divide, with SS users predominantly accessing private hospitals, while non-users relied more on public facilities, suggesting that the scheme is closely tied to private care. A notable "OOPE paradox" emerged, as SS users often incurred higher out-of-pocket expenditure. In rural areas, mean OOPE was 23,694 for SS users compared to 17,920 for non-users, while in urban areas it was 22,722 versus 19,567. Median hospitalization OOPE for SS users stood at 10,500, rising to 19,500 when pre- and post-hospitalization costs were included, compared to 9,450 for non-users. Even after using SS, patients continued to spend significantly on medicines, diagnostics and transport.rt.

Analysis of catastrophic health expenditure (CHE) showed mixed results. CHE incidence was similar for SS-covered (36%) and non-covered (32.7%) individuals, but among actual SS users, CHE was higher at 43.4%, compared to 33.7% for non-users. Regression analysis revealed that SS coverage alone did not significantly reduce OOPE, though actual use reduced OOPE by 57% (ATET). In contrast, ESI demonstrated stronger financial protection, reducing OOPE by 70%. Overall, the study findings suggest that while SS can reduce financial burden when utilized, low uptake, reliance on private facilities and persistent spending on medicines and diagnostics limit its effectiveness in ensuring comprehensive financial protection.

Figure 13: Felicitating Dr. Bhattacharya

Presentation 2: Awareness and Utilisation of Health Financing Models – Sayantani Manna

Next presenter Sayantani Manna presented how awareness shapes healthcare utilization, moving beyond simple yes/no measures of insurance coverage by constructing an Awareness Score. This score was developed using nine indicators—surgery, transport, medicine, diagnostics, pre- and post-hospitalization, hospitalization charges, outpatient charges, and wage loss—with responses weighted according to depth of knowledge. The score was generated using principal component analysis (PCA) and applied to compare awareness of *Swasthya Sathi (SS), Employees' State Insurance (ESI),* and private insurance.

Her study findings revealed that awareness was closely linked to social position. It was higher among rural, poorer, and OBC households, suggesting effective outreach among target groups, but also high among urban, upper-income, and upper-caste households. Education showed mixed effects with primary education was associated with lower awareness, while education beyond secondary level increased the likelihood of awareness. The relationship between economic status and awareness was non-linear. For SS, middle and richest quintiles showed lower awareness than the poorest households, while for ESI, awareness varied unevenly, with second-quintile households showing

higher awareness but middle groups showing lower awareness.

Most importantly, the study findings ensure that higher awareness was strongly associated with scheme utilization. For SS, the awareness score was 0.29 among users, nearly double the 0.15 among non-users. For ESI, awareness was also higher among users (0.80 vs 0.75). Households that used SS or ESI for hospitalization were significantly more aware than those that did not. In her concluding remarks she mentioned that distributing insurance cards alone is insufficient. The state must focus on targeted literacy regarding scheme components such as transport and post-hospitalization coverage, ensuring that vulnerable populations are not excluded due to information asymmetry

Figure 14 Technical session II: Hospitalization care

Debjani Barman, serving as discussant, provided an important bridge between the empirical findings presented and the practical realities of West Bengal's health system. She commended the "Awareness Index" developed by Sayantani Manna, describing it as a valuable analytical tool that highlights why households, even when holding insurance cards, often fail to navigate the hospitalization process. Barman emphasized that awareness is a critical factor frequently overlooked in policy analysis and argued that the index offers a meaningful way to connect research insights with lived experiences. She further mentioned that the findings on caste, religion, and gender were not merely statistical observations but closely aligned with fieldwork and anecdotal evidence. Social identity, she stressed, continues to shape both the quality and frequency of healthcare use in Bengal, reinforcing the bi-directional relationship between social status and health outcomes for vulnerable populations.

Turning to the structure of provisioning, Barman highlighted supply-side gaps that insurance alone cannot resolve. She pointed to unpanelled services and hospitals within the *Swasthya Sathi* network that refuse certain treatments, underscoring the limitations of current frameworks in addressing the growing burden of non-communicable and chronic diseases. Drawing on her work in maternal health, she observed that financial protection during childbirth remains fragile and suggested examining the role of schemes such as *Lakshmir Bhandar*, questioning whether cash transfers improve household liquidity and indirectly influence insurance utilization. In her opinion the usage gap identified in Sharma's presentation is likely driven by low awareness and supply-side rigidities. In the conclusion Barman called for a more integrated policy approach that considers social identity, strengthens regulation of private providers, and ensures that public insurance schemes deliver equitable and effective financial protection.

Figure 15: Felicitating Dr. Barman

Technical session III

Non-hospitalization Care

Chair: **Simantini Mukhopadhyay**
Discussant: **Rakhi Saha and Sashi Bhusan Mishra**

Presentation 3: Utilisation of Healthcare Services and Out of Pocket Expenditure for Outpatient Care – Dibyendu Biswas

The third technical session began with the presentation titled "*Utilisation of Healthcare Services and Out of Pocket Expenditure for Outpatient Care*" by Dibyendu Biswas. He explained the scope of the household survey, which covered 73 villages across four districts, and introduced the care cascade framework that identifies five possible pathways for seeking treatment: no treatment, self-treatment, and use of public, private, or mixed providers. The findings revealed that among those requiring outpatient care, 12% sought no treatment, 45% relied on self-treatment, 27% visited private providers, 9% accessed public facilities, and 7% used a mix of public and private providers. This distribution highlighted a heavy reliance on self-care and private providers, reflecting structural inequalities in access. Women, poorer households, and socially marginalized groups were more likely to forgo treatment or depend on self-care, while economically better-off households tended to use private providers.

The study found that the median out-of-pocket expenditure (OOPE) per episode was INR 300, but this varied sharply by provider type. Median OOPE was INR 1,300 for private providers and INR 1,060 for mixed providers, compared to INR 40 in public facilities and INR 140 for self-treatment. In 40% of cases, patients who initially sought care in public facilities could not obtain medicines or diagnostics free of cost, forcing them to spend additionally. The incidence of catastrophic health expenditure was highest among users of private (39.2%) and mixed providers (32.4%), while substantially lower among users of public facilities (2.5%) and self-treatment (2.2%). It was also significantly higher among poorer households (27.6%) compared to non-poor households (12%).

Overall, the study underscored that reliance on private healthcare and inadequate access to affordable public services substantially increases financial burden, making stronger public provisioning and financial protection mechanisms essential to reduce OOPE and catastrophic spending.

Presentation 4: Exploring the Dimensions and Extent of Unmet Healthcare Needs – Sonia Sebastian

The second paper of the session, "*Exploring the Dimensions and Extent of Perceived Unmet Healthcare Needs*", was presented by Sonia Sebastian. She began by defining healthcare needs as being met when individuals are able to access quality care without financial hardship, and explained that unmet needs include both situations where care was sought but not adequately received, as well as instances where care was forgone altogether.

Survey findings revealed that nearly 20% of households reported perceived unmet healthcare needs, with financial constraints emerging as the major reason. Unmet needs were found to be four times higher in Jalpaiguri and Paschim Barddhaman compared to other districts. Among 1,067 individuals who required care, 88% sought treatment, but access to proper and complete care remained limited. Only 39% received care from qualified providers, 17.5% obtained complete care but with financial hardship, and just 9% accessed complete care without financial hardship.

Different forms of unmet need were identified, including forgone, delayed, denied, and incomplete care, showing that even when healthcare was sought, it was not always adequate. Among hospitalised patients, financial hardship was particularly significant, with 36% receiving care but facing financial strain, while only 23% accessed care without hardship

Overall, unmet healthcare needs were more common among marginalised, poorer, elderly, and illiterate populations, underscoring persistent inequalities. She also highlighted supply-side constraints such as fragmented financing and low public spending, which continue to create barriers to equitable access. Her analysis emphasized that addressing both financial and structural barriers is essential to reduce unmet needs and ensure inclusive healthcare delivery.

Dr. Rakhi Saha, the discussant for this session, offered insightful observations on the two papers presented. She emphasized the need for a more

intersectional approach in analysing findings, suggesting that OOPE could be examined specifically for women from lower castes, Scheduled Tribes, or poorer households belonging to minority communities. Commenting on Dibyendu Biswas's paper, she noted that the relationship between socio-economic background and choice of healthcare providers is complex and multidirectional, requiring deeper exploration.

Saha also highlighted methodological concerns regarding the estimation of catastrophic health expenditure (CHE). She pointed out the limitations of the Budget Share (BS) Approach, arguing that it may not adequately capture household vulnerability. She recommended adopting the Capacity to Pay approach as a more robust alternative. Additionally, she raised concerns about using stringent thresholds to estimate "distanced care" in outpatient settings, suggesting that sector-sensitive thresholds should be applied to better reflect variations across contexts

Her observations underscored the importance of refining methodologies and incorporating intersectional analysis to ensure that research findings capture the layered realities of marginalized groups while addressing supply-side constraints in West Bengal's health system.

Dr. Simantini Mukhopadhyay, chairing the session, offered a cautionary note on the interpretation of findings related to unmet healthcare needs. She emphasized that while subjective assessments provide valuable insights into patient experiences, researchers must remain wary of relying solely on them. Mukhopadhyay stressed that subjective measures can introduce bias and may not fully capture the structural and systemic dimensions of healthcare access. She highlighted the importance of complementing perception-based data with objective indicators to ensure a more balanced and rigorous understanding of unmet needs.

Presentation 5: Situational Assessment of Primary Care Facilities –Vyom Anil

The fifth presentation of the day, "*Situational Assessment of Primary Care Facilities*", was presented by Vyom Anil, who examined the transformation of Sub-Centres and Primary Health Centres into Health and Wellness Centres (HWCs) under India's initiative to strengthen comprehensive primary healthcare. Drawing on a survey of 63 HWCs across four districts, the study assessed readiness in terms of service delivery, infrastructure, human resources, and medicine availability. The findings revealed significant infrastructure gaps, with 18 centres lacking water supply, 7 without toilets, and 19 without functional OPDs, all of which undermined service readiness. Human resources emerged as the weakest component, with scores ranging between 40–60 compared to 90–100 for service delivery, reflecting shortages that hinder effective functioning. District-level disparities were evident in medicine availability, with Murshidabad recording the lowest score (30) compared to Bardhaman (68) and North 24 Parganas (61). Utilisation patterns showed higher OPD volumes in urban HWCs, ranging from 250 in Bardhaman Urban to 2,500 in Jalpaiguri Urban, while rural facilities reported lower volumes. Accessibility was generally good, with a mean distance of 0.58 km, though some villages were up to 3 km away, and only 7 centres had functional Jan Arogya Samitis, indicating limited community participation. Overall, the study highlighted that facility readiness was strongly associated with utilisation, with better infrastructure and diagnostic capacity linked to higher service volumes, underscoring the need to strengthen primary care facilities to ensure equitable access.

Figure 17: Technical session III: Non-hospitalization care

Presentation 6: Role of Informal Care Providers – Manabesh Sarkar

The final paper of this session, "*Role of Informal Care Providers*", was presented by Manabesh Sarkar. Drawing on primary surveys conducted by Pratichi (India) Trust and secondary data, the study highlighted the continued presence of Unqualified Medical Practitioners (UMPs) in the healthcare sector and their influence on health-seeking behaviour. Sarkar noted that in a 2006–07 survey, 54% of respondents reported visiting UMPs, while in 2014 this figure was 44% in rural areas. The most recent survey (2024) shows that 28% overall and 32% in rural areas continue to rely on UMPs, underscoring their ongoing importance. These figures contrast sharply with NSS 2017–18 data, which reported only 6% in rural areas and 4% overall, possibly due to the omission of minor ailments or the tendency of UMPs to identify themselves as allopathic doctors despite lacking formal qualifications. Earlier estimates suggested that 42% of rural allopathic practitioners had no medical training.

The study observed that many traditional healers, once practising Ayurveda, now practise allopathy, often acquiring skills through apprenticeships or work in medicine shops. Vulnerable and marginalized groups depend more heavily on UMPs, as formal healthcare remains inaccessible. Even when not always cheaper, UMPs are embedded within communities, making them more accessible than distant public facilities, particularly during emergencies. Sarkar argued that this reliance reflects systematic neglect, where those with greater resources access better care, while poorer households remain dependent on informal providers. He concluded by noting the government's recent introduction of a Non-physician Clinical Cadre, raising the question of whether this represents a formalized version of the long-standing UMP phenomenon

Figure 18: Chair and discussants of technical session III: Non-hospitalization care

Dr. Sashi Bhusan Mishra another discussant for this session presented his opinion based on the last two presentations and highlighted the strong policy relevance of the papers presented, noting that the discussion was both timely and significant for health economics. He raised methodological concerns regarding the benchmark of 24 out of 30 essential medicines, questioning whether this threshold was arbitrary or based on a specific rule. He also suggested that the binary index used for assessing Community Health Officers (CHOs) could be refined by incorporating variables such as tenure or level of training, which would provide a more nuanced understanding of their role.

Mishra described the findings as stark yet actionable, pointing to the availability of expensive but underutilised infrastructure. He questioned whether current resource allocation patterns were efficient and equitable, suggesting that while efficiency may be achieved, equity remains a concern. He also noted the absence of functional telemedicine services, raising questions about missed opportunities in expanding access.

Figure 19: Felicitating the discussants of technical session III

Figure 20: Felicitating the chair Dr. Mukhopadhyay

Finally, he reflected on the reliance of poorer households on (UMPs), framing it as a rational choice. In his view, households were opting for what he termed a "second-best success" in UMPs, rather than facing the "first-best failure" of public healthcare, underscoring systemic gaps in formal service delivery.

At the conclusion of all presentations, the floor was opened for comments and suggestions, leading to a lively and relevant discussion. Several critical points were raised, and the presenters responded with counterarguments to the best of their knowledge, agreeing to incorporate the feedback into future work. Among the remarks from the house, participants questioned whether the SARA framework was appropriate for people on the ground and whether it matched community needs, suggesting that it may need reconsideration. Concerns were also expressed about the political culture in Bengal, particularly the politicisation of panchayats, which could explain why Jan Arogya Committees remain non-functional. Another important suggestion was the need for age-wise mapping of non-communicable diseases (NCDs) to strengthen management strategies. Finally, it was emphasized that further exploration is required using variables beyond social determinants to capture a more comprehensive understanding of healthcare needs and system performance.

Panel Discussion

Health System Challenges in West Bengal

Panellists: Ajay Tandon (World Bank), Thomas Hone (Imperial College London), Marine Mukherjee (Child in Need Institute), Biswajit Das (Bartaman newspaper), and Fuad Halim (Jan Swasthya Abhiyan)

Chair: **Dr. Dipa Sinha**

The panel discussion brought together diverse perspectives on healthcare delivery and financing in West Bengal and comparable contexts. Ajay Tandon (World Bank) noted that while progress has been made in areas such as under-five mortality, non-communicable diseases (NCDs) like cancer and diabetes remain poorly managed and addressed. He emphasised prioritising prevention over curative care and highlighted the burden of Out-of-Pocket Expenditure (OOPE) for ambulatory NCD care in low- and middle-income countries. Poor quality care, he argued, harms both health outcomes and financing sustainability. Tandon advocated for accessible, good-quality, no-frills healthcare for the poor and stressed that Universal Health Coverage (UHC) should encompass financing and quality service delivery, not merely insurance

Thomas Hone (Imperial College London) praised the study's multifaceted findings and observed that fragmented health financing is a global challenge reflected in India. He underscored that awareness of schemes such as Swasthya Sathi and ESI is crucial, as utilization remains low despite high coverage. High OOPE for diagnostics and medicines persists worldwide. He commended cross-state comparisons and suggested cross-country learning, noting similarities between India and Mexico

Figure 22: Ajay Tandon (World Bank) delivering his lecture

Marine Mukherjee (Child in Need Institute) provided field-level insights from remote and vulnerable regions. He raised issues of persistent infrastructure gaps, behavioral challenges, early marriage and motherhood and varied NCD patterns between rural and urban areas. Maternal and child health gaps included incomplete antenatal care, poor postnatal documentation and lack of BMI data. He emphasised community engagement through Panchayati Raj Institutions and self-help groups and highlighting continuing infant mortality concerns.

Figure 23: Thomas Hone delivering his lecture

Journalist Biswajit Das questioned the disconnect between policy discourse and ground realities. While noting reduced OOPE, he stressed the need for ambulance coverage and prioritising healthcare access before quality improvements. Finally, Dr. Fuad Halim (Jan Swasthya Abhiyan) presented some alarming trends: rising dengue deaths, a reversal in maternal mortality decline, and slowing progress in infant mortality reduction, suggesting neglect of public healthcare. He concluded by observing that while quality healthcare remains absent in remote areas, ultra-processed food and injections are ubiquitous.

Figure 24: Panel discussion on health system challenges in West Bengal

Day 2: 14th February

Technical session IV: Market failures in healthcare

Chair: **Mousumi Dutta**
Discussant: **Rama Baru, Amrita Bagchi, Subhashis Ray**

Presentation 7: Trends and Patterns in Private Health Expenditure and Health Insurance Coverage in India – Akarsh CO

In the context of contested claims regarding the reduction in OOPE for India, Akarsh's presentation examined trends in private health expenditure and health insurance coverage in India from 2018 to 2023, with a focus on pre- and post-COVID-19 dynamics. Using CMIE data, descriptive statistics were employed to trace expenditure patterns across socio-demographic groups, alongside econometric analysis to identify the pandemic's impact. Inequality measures, including the Gini coefficient, revealed a rise in expenditure inequality in the post-COVID period.

A sharp decline in OOPE is observed in 2020 using CMIE estimates, contrasting with National Health Accounts data, which surprisingly indicate an increasing trend—highlighting critical gaps in national estimation. Findings pointed to the limited effectiveness of insurance schemes in both access and utilisation. On one hand, access remains heavily skewed, with persistently lower coverage among lower-income quintiles. On the other, insured individuals are found to consistently incur higher OOPE (399.68) compared to the uninsured (288.21). Thus, coupled with significant urban–rural disparities in coverage, the study called into question the extent to which insurance schemes have enhanced equitable access and financial protection during the study period.

Figure 25: Akarsh CO during his session

Broadly four sets of comments were received. First was on the possibility of bringing in federal power relations to OOPE analysis. The role of pandemic preparedness in bringing down OOPE growth rate is suggested to be explored, in the context of subnational welfare regimes. Also, exploratory potential on role of private sector in state level analysis related to OOPE was indicated. Third was regarding whether 2020 would qualify as covid break year as pandemic had multiple waves. Fourth was regarding whether to use Difference in Difference instead of Fixed effects Model for regression analysis. Finally, possible explanations for increased OOPE of insured were flagged by different commentators; core ones being moral hazard, illegal co-payments and inapt OPD timings.

Presentation 8: Continuum of Care and Caesarean Childbirth in India - Dr. Montu Bose

Dr Montu's paper examined the Continuum of Care (CoC) in maternal health and its relationship with Caesarean deliveries in India. The CoC refers to receiving antenatal care, childbirth and immunization services from the public facilities, and NFHS-5 data show this occurs in 56% of births. However, Caesarean deliveries account for 27% of all births, with around 16% c-section cases in public facilities—exceeding the WHO's recommended 15% threshold. The study found that when CoC is maintained and the first birth is a C-section, the likelihood of a repeat C-section declines. Logistic regression results indicate that prior C-section history significantly increases future C-section probability, while CoC reduces the likelihood across all wealth groups. Yet beyond the median wealth quintile, income and education play a dominant role in increasing C-section rates. A Random Forest model revealed around 70% gap between predicted and actual C-section rates, suggesting that over 60% of procedures may be unnecessary and avoidable.

Figure 26: Felicitating Dr. Bose after his session

In her comments, Professor Rama Baru highlighted the need to examine the share of institutional deliveries covered by public health insurance and raised concerns about physician-induced demand, especially in profit-driven private facilities. She emphasized the importance of post-natal care; the role of informal practitioners and inequities linked to caste and social gradients. Remarks from the house noted concerns about unnecessary vaccinations in private care, suggested prescription audits to detect induced demand and proposed analysing delivery timing patterns. Dr. Fuad Halim observed that private facilities tend to schedule C-sections during daytime hours, unlike public hospitals, which may indicate systemic differences in practice dynamics.

Presentation 9: Financialization of Healthcare Services in India- Dr. Satyaki Roy

Dr. Satyaki Roy's presentation examined how the hospital 'industry' is evolving under neoliberalism, where healthcare is increasingly integrated into market processes and global finance. Drawing on Paul Starr's work on corporatization, two trends were identified. The first is vertical consolidation, where non-profit and government hospitals, along with insurers and care providers, are absorbed into corporate structures. The second is horizontal consolidation, where smaller hospitals are taken over by large corporate chains. This reflects a shift from non-profit and independent hospitals to large, profit-oriented corporate enterprises. The study analysed the trends in private investment and profits in the healthcare industry with primary focus on the hospital sector during FY2000 to FY2024 using mainly two databases, namely CMIE Prowess IQ and Venture Intelligence (private equity and venture capital investments and mergers & acquisitions). The findings point to increasing monopolization in the healthcare market wherein the top 15 hospitals account for a major share of both profits and private investment. Dr. Satyaki concluded the presentation by relating the process of financialization to what Michel Foucault calls 'responsibilization' where the individuals are encouraged to act both as consumers of healthcare and participants in financial systems.

Figure 27: Felicitating Dr. Roy after his session

The discussant Prof. Amrita Bagchi provided an historical perspective to corporatization in the particular context of Kolkata. She explained how the healthcare landscape in Kolkata shifted from small nursing homes run by individual doctors during the 1950s-70s to large corporate hospital chains in 2000s came to dominate the sector, a process she described as "Manipalisation." With respect to remarks from the house, Fuad Halim made reference to Japan wherein private hospitals are not allowed to list in the share market and in USA, nurses are striking in protest against the selling of hospital land to surrogate companies. Concerns were raised to ensure public control over corporates as a necessary means to restrain the adverse impact of corporatization.

Figure 28: Felicitating expert discussant and chair of the session

Technical session V

Social Health Protection: The case of ESI

Expert Discussants – Mayukh Roy (ESIS West Bengal), Nandakishore Alva (ESIC West Bengal), Akshay Kala (Former ESIC) and Leena Chatterjee Basu (All India Trade Union Congress)

Presentation 10: Contribution of ESI to the West Bengal Health System: Preliminary Findings - Dr. Dipa Sinha and Meenuka Mathew

Dr. Dipa Sinha and Meenuka Mathew examined the Employees' State Insurance (ESI) scheme in West Bengal, drawing on the West Bengal Household Survey and ESI annual reports, with a focus on access, coverage, expenditure and compliance.

The presentation found that while ESI offers extensive formal coverage and meaningful financial protection, utilisation remains uneven. All 23 districts are covered, with 3.84 crore insured persons and 14.9 crore beneficiaries enrolled nationally in 2024–25; women insured persons rose from 0.79 to 0.83 crore. ESI-covered households use the scheme at a markedly higher rate (59.4%) than Swasthya Sathi, and in both schemes' covered household, ESI is strongly preferred (52.9% vs. 10.6%).

Financially, ESI reduces mean out-of-pocket expenditure by Rs. 15,801 per hospitalisation episode, with the greatest relief in private settings. OOPE in public facilities, however, remains comparable for ESI and uninsured users. System capacity is under strain: overall doctor vacancies stand at 20.6% — rising to ~59.5% for hospital doctors excluding contractual staff — and bed occupancy averages 76.8%, exceeding 130% in some facilities. Per capita medical spending in West Bengal (Rs. 4,873) surpasses the national average, with ESIS consistently outspending ESIC. Employer registration grew by 53%, yet compliance fell from 44% to 38%, leaving nearly two-thirds of registered employers non-contributing by 2024–25.

Figure 29: Meenuka Presenting the ESI Study

Key Informant Interviews with ESI Corporation and West Bengal state officials revealed deeper structural challenges: access divides across gender, caste, religion, and geography; staffing shortages; fragmented procurement; stalled infrastructure; and specialty care concentrated in select hubs, forcing patients to travel over 100 km.

The panel consisted of ESI officials from the West Bengal State and the Corporation, and representatives of the trade unions, who discussed the scheme's potential alongside the governance and implementation constraints limiting its delivery. Stakeholders agreed that any expansion to informal or other sectors must address existing capacity, financing and legal gaps rather than assume they can be absorbed.

Figure 30: ESI expert panel

Panel Discussion

West Bengal Health System in Transition

Panellists: Pradipto Roy (Calcutta Heart Clinic & Hospital), Bishan Basu (Jhargram Medical College), Arun Sinha (Advisor, Department of Health), Anup Roy (NRS Medical College)

Final panel was focused on the systemic shifts in healthcare delivery, moderated by Manabi Majumdar.

Pradipto Roy (Calcutta Heart Clinic & Hospital) addressed the "boom of therapy culture" and the growth of the healing business, noting that mental health services in India are now almost entirely private and largely unregulated. He pointed out that the public mental health system is deteriorating, with medicines that are at least two decades behind current research. He warned that this is creating a two-tier system, similar to schooling, where high-quality private care is available only to those who can afford it, while the public system remains neglected.

Bishan Basu (Jhargram Medical College) argued that the state's healthcare transition is taking place in a "top-down" manner rather than emerging from grassroots needs. He criticised the role of high-powered government committees, which often include representatives from for-profit institutions. According to him, this has promoted a market-oriented approach in which public hospitals are undervalued, making schemes like Swasthya Sathi necessary for their functioning rather than supplementary.

Figure 31: Panellists of West Bengal Health System in Transition

Arun Sinha (Advisor, Department of Health) highlighted the risks posed by mergers and acquisitions in the healthcare sector. He noted that around 40% of doctors now work in the private sector, and increasing corporate concentration could raise healthcare costs by up to 20%. Using the example of the Jarwa tribe, where mothers and newborns are kept together, he criticised corporate hospitals for separating them for administrative and billing convenience.

Anup Roy (NRS Medical College) discussed the "de-professionalization" of the medical workforce. He observed that mandatory attendance in medical colleges, once strictly followed, has weakened due to private coaching and the outsourcing of staff through agencies. He also noted that 8,000 doctors applied for only 1,200 posts in a recent recruitment drive, arguing that the issue is not simply a shortage of doctors but systemic problems in recruitment and referral structures.

Figure 32: Dr. Majumder summarizing the session

Summary of the Session

1. Insurance coverage under Swasthya Sathi is failing to reach its potential because the supply side (public infrastructure) is being neglected or outsourced.

2. Regulation must move beyond registration to actively control induced demand (e.g., C-sections) and merger-and-acquisition-driv en price hikes.

3. The success of Telemedicine and Swasthya Bandhu units should be scaled, but only as a bridge to not as a replacement for permanent PHC staff.

4. Public sector funding must be diverted toward modernizing psychiatric drugs and creating dedicated research institutes to break the private monopoly on mental wellness.

5. A bottom-up administrative shift is needed to restore public faith in state-run hospitals and reduce dependence on private insurance.

Figure 33: JGU team members

Figure 21 Participant during discussion session

Figure 35: Participants of the symposium

Figure 36: JGU and Pratichi team members

AGENDA

Day 1 | 13th February 2026 (Friday)

9:30 am –10:00 am	Registration
10:00 am- 11:15 am	Inaugural Session
Welcome address	Antara Dev Sen, Pratichi (India) Trust
Opening Remarks	R Sudarshan, Dean, OP Jindal Global University
Inaugural address 1	Shri Nigam, Principal Secretary, DHFW, Gov WB
Inaugural address 2	Prof Rama Baru
Health system challenges in WB	Prof Achin Chakraborty
11:30 am - 12:30 pm	TS-I WEST BENGAL HEALTH SYSTEM ASSESSMENT
12:30 pm to 1:30 pm	TS-II Hospitalisation Care
	1. Hospitalization Care
	2. Awareness of Schemes in WB
1:30 pm – 2:30 pm	Lunch
2:30 pm - 4:30 pm	TS- III NON-HOSPITALISATION CARE
	3. Out-patient care
	4. Unmet Need
	5. Facility Survey
	6. Informal Providers
4:30 pm - 5:00 pm	Tea break
5:00 pm - 6:30 pm	PANEL DISCUSSION: HEALTH SYSTEM CHALLENGES IN WEST BENGAL

Day 2 | 14th February 2026 (Saturday)

9:30 am – 11 am	TS-IV: MARKET FAILURES IN HEALTHCARE
	7. Facility Survey
	8. C-Section
	9. CMIE-OOP post covid
11:00 am -11:30 am	Tea break
11:30 am - 1:00 pm	TS-V: SOCIAL HEALTH PROTECTION: THE CASE OF ESI
	10. Presentation of Findings Panel Discussion: Mayukh Roy (ESIS West Bengal), Nandakishore Alva (ESIC West Bengal), Akshay Kala (Former ESIC), and Leena Chatterjee Basu (All India Trade Union Congress)
1:00 pm - 2:00 pm	Lunch
2:00 pm - 3:30 pm Valedictory Session	PANEL DISCUSSION: WEST BENGAL HEALTH SYSTEM IN TRANSITION

PARTICIPANTS LIST

Panelist:

1. Antara Dev Sen, Pratichi (India) Trust
2. R Sudarshan, Dean, OP Jindal Global University
3. Shri Nigam, Principal Secretary, DHFW, Gov WB (TBC)
4. Rama Baru, Professor, JGU
5. Dr. Monjur Hossain, Chief Field Officer, UNICEF
6. Achin Chakraborty, Professor, IIT Kharagpur
7. Ajay Tandon, World Bank
8. Thomas Hone, Imperial College London
9. Marine Mukherjee, Child in Need Institute
10. Biswajit Das, Bartaman newspaper
11. Fuad Halim, Jan Swasthya Abhiyan
12. Mayukh Roy, ESIS West Bengal
13. Nandakishore Alva, ESIC West Bengal
14. Akshay Kala, Former ESIC
15. Leena Chatterjee Basu, All India Trade Union Congress
16. Pradipto Roy, Calcutta Heart Clinic & Hospital
17. Bishan Basu, Jhargram Medical College
18. Arun Sinha, Advisor, Department of Health
19. Anup Roy, NRS Medical College
20. Indranil, JGU

Chair and Discussant:

21. Paramita Bhattacharya, MANT
22. Sabir Ahamed, Pratichi (India) Trust
23. Simantini Mukhopadhyay, IDSK
24. Mousumi Dutta, Presidency University
25. Dipa Sinha, Azim Premji University
26. Manabi Majumdar, Pratichi (India) Trust
27. Amrita Bagchi, Bethune College
28. Nirmalya Das, AHSD
29. Vandana Bhatia, UNICEF
30. Debjani Barman, Consultant
31. Rakhi Saha, University of Calcutta
32. Sashi Bhusan Mishra, Aliah University
33. Subhashis Ray, JGU

Presenters

34. Dibyendu Biswas, JGU
35. Debashree Paul, JGU
36. Anandita Sharma, JGU
37. Sayantani Manna, JGU
38. Sonia Sebastian, JGU
39. Vyom Anil, JGU
40. Manabesh Sarkar, Pratichi (India) Trust
41. Akarsh CO, JGU
42. Krittika Roy, JGU
43. Meenuka Mathew, JGU
44. Montu Bose, TISS
45. Satyaki Roy, ISID

O.P. JINDAL GLOBAL
INSTITUTION OF EMINENCE DEEMED TO BE
UNIVERSITY
A Private University Promoting Public Service

CONTACT

PI – Health Financing Study India,
O.P. Jindal Global University
Sonipat, Haryana

Email: health_fragmentation@jgu.edu.in
LinkedIn: https://www.linkedin.com/company/healthfragmentation
YouTube: @HealthFragmentationStudy