



The Price of Autonomy: Public Healthcare Amid Political Turbulence in Darjeeling

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ABSTRACT

In the Darjeeling Hills, public healthcare has unravelled under the weight of political turbulence, administrative inertia, and contested autonomy. This study draws on fieldnotes, semi-structured interviews, and informal conversations, this study examines the decline in healthcare access during the fragile transition from the Darjeeling Gorkha Hill Council (DGHC) to the Gorkhaland Territorial Administration (GTA). Amid frequent political agitations and systemic neglect, already fragile medical infrastructure deteriorated, forcing many—especially in remote and marginalized communities—to seek treatment in distant urban centers like Siliguri and elsewhere. The findings reveal that healthcare in the region is not merely a casualty of underdevelopment but a lens into the deeper crises of governance, identity, and structural marginalization. By foregrounding lived experiences, this paper argues that public health in Darjeeling must be understood as both a political and social battleground shaped by the unresolved tensions of regional autonomy.

KEYWORDS: Public healthcare, Darjeeling Hills, political autonomy, governance crisis, structural marginalization

I. INTRODUCTION

Darjeeling Hills comprising both the district of Darjeeling and Kalimpong, located in the northern region of West Bengal, have long been marked by administrative complexity and political sensitivity, shaped by their distinct ethno-cultural profile and a history of marginalization. In response to a sustained and often violent agitation led by the Gorkha National Liberation Front (GNLF) between 1986 and 1988, a tripartite agreement was signed on 22 August 1988 among the Government of India, the Government of West Bengal, and the GNLF. This accord resulted in the establishment of the Darjeeling Gorkha Hill Council (DGHC), a semi-autonomous governing body entrusted with local administration, including responsibilities in health, education, and regional development. Although the

DGHC was envisioned as a decentralized mechanism to address the specific developmental needs of the region—particularly in critical sectors such as healthcare, education, and infrastructure—its effectiveness has remained deeply contested due to recurring administrative stagnation and allegations of misuse of power (Datta & Sengupta, 2019; Saha & Chakraborty, 2019).

By the mid-2000s, growing public disillusionment with the Gorkha Hill Council's inefficiencies and corruption created a political vacuum in the Darjeeling Hills. This environment facilitated the emergence of the Gorkha Janmukti Morcha (GJMM), which launched a renewed push for statehood under Bimal Gurung's leadership (East Asia Forum, 2011). Concurrently, West Bengal experienced a historic political shift: the Trinamool Congress, led by Mamata Banerjee, capitalized on widespread agrarian discontent and anti-land-acquisition movements—such as Singur and Nandigram—to dismantle the Left Front's nearly 34-year rule (East Asia Forum, 2011; Biswas, 2024). These overlapping transitions at both regional and state levels further destabilized governance in the hills, producing administrative uncertainty and undermining the delivery of public services.

Healthcare, though seldom prioritized in political discourse, emerged as one of the most critical casualties of institutional dysfunction in the Darjeeling Hills. The region's medical facilities—already operating under severe resource constraints—were further debilitated by political unrest, frequent bandhs, and bureaucratic disengagement. These cumulative challenges led to a marked decline in healthcare access, particularly affecting marginalized and rural populations (Hossain & Hannan, 2024; Ghosh et al., 2013). Consequently, health-related migration to urban centers such as Siliguri and Kolkata became increasingly common—a reflection not only of inadequate infrastructure but also of failures in governance and public accountability (Hossain & Hannan, 2024; Ghosh et al., 2013).



The paper argues that the healthcare crisis in Darjeeling during this turbulent period must be examined not merely as an administrative shortcoming but as a structural consequence of political instability, weakened local governance, and unfulfilled autonomy claims. By investigating the transitional phase from DGHC to the Gorkhaland Territorial Administration (GTA), and by investigating lived experiences between 2005 and 2012 and beyond, this study positions health as both a site and a casualty of contested statehood politics. In doing so, it moves beyond conventional development discourses to explore how identity, governance, and public health intersect in conflict-prone and politically marginalized regions.

II. METHODOLOGY

This study employs a qualitative research design grounded in fieldwork conducted between 2015 and 2020 across the Darjeeling Hills. Data was gathered through semi-structured interviews, informal conversations, and extensive fieldnotes, allowing for a nuanced understanding of healthcare access during the transition from the Darjeeling Gorkha Hill Council (DGHC) to the Gorkhaland Territorial Administration (GTA).

Participants were identified using snowball sampling, with interviews conducted in multiple sittings to accommodate availability and comfort. Respondents included local residents, healthcare workers, and political actors. The study also draws on regional newspapers to trace narratives around healthcare and governance.

All qualitative data was thematically analyzed, with attention to the intersection of healthcare, political instability, and structural marginalization. Ethical protocols—including informed consent and anonymity—were strictly observed.

III. HISTORICAL AND POLITICAL CONTEXT

The establishment of the *Darjeeling Gorkha Hill Council* (DGHC) (Bagchi, 2012; Biswas & Roka, 2007; Bomjan, 2008; Sarkar & Bhaumik, 2000) in 1988 marked a consequential chapter in the administrative and political landscape of the Darjeeling Hills ensuing from the collective angst of non-inclusion with the frame of being recognised as Indian (Chatterji, 2007; Chhetry, 2012). Born out of that angst the Gorkhaland Movement spearheaded by the *Gorkha National Liberation Front* (GNLF)¹,

¹Gorkha National Liberation Front (GNLF) is a political party in the Darjeeling District of West

led by Subash Ghising, the DGHC emerged as a distinctive entity aimed at addressing the multifaceted socio-economic and political aspirations of the Gorkha community in the region (Buramagara, 1994; Shneiderman & Middleton, 2018; Sarkar, 2013)

The trajectory of the DGHC, however, unfolded in phases fraught with political turbulence, demands for increased autonomy, and subsequent structural alteration (Gurung, 1972; Lama, 1996). This evolution intersected with the overarching narrative of regional identity, the persistent quest for Gorkhaland statehood, and the intricate balance of local aspirations within the broader contours of Indian political dynamics. The transition from Left Front rule to the *Trinamool Congress*² (TMC) regime in West Bengal played a pivotal role in shaping the course of the DGHC. This period witnessed nuanced shifts in the political and administrative landscapes of the Darjeeling Hills, impacting the council's role and functions (Sharma, Choudhury, & Das, 2022).

The provision of health services, ensuring accessibility to medical facilities, and addressing public health challenges became integral components of the council's responsibilities. This facet of the DGHC's mandate reflected a complex interplay of political, cultural, and socio-economic dynamics, offering profound insights into the nuanced complexities of identity, autonomy, and regional politics in the Darjeeling Hills (West Bengal Act XIII, 1988).

IV. BETWEEN AUTONOMY AND NEGLECT: THE POLITICS OF PUBLIC HEALTHCARE IN THE DARJEELING HILLS (2005–2012)

Bengal, India. It was formed in 1980 by Subhash Ghising with the objective of demanding a Gorkhaland state within India.

²The All India Trinamool Congress (AITC) is an Indian political party that is mainly influential in the state of West Bengal. It was founded by Mamata Banerjee on 1 January 1998 as a breakaway faction from the Indian National Congress and rapidly rose to prominence in the politics of West Bengal under her leadership. Presently, it is ruling the state of West Bengal beside being the third-largest party in India in terms of number of MPs and MLAs, just after BJP and INC.



Between 2005 and 2012, the public healthcare system in the Darjeeling Hills was shaped by a paradox of administrative transition and institutional paralysis. The disbandment of the Darjeeling Gorkha Hill Council (DGHC) and the tentative establishment of the Gorkhaland Territorial Administration (GTA) created an administrative vacuum that severely affected the governance of public services, particularly health. During this transitional period, the state's retreat from direct governance and the uncertainty surrounding new institutional responsibilities led to widespread neglect in service delivery, with no significant health policy reform or targeted intervention reaching fruition (Centre for Policy Research, 2012).

Official assessments of rural hospitals through the World Health Organization's WISN methodology revealed stark staffing inefficiencies. In 2019—but reflective of long-standing trends—the Kharibari rural hospital and Bijanbari RH showed the highest workforce pressures, with nurse staffing ratios as low as 0.45 relative to workload expectations (WHO WISN tool application in Darjeeling district). The WISN findings highlight chronic imbalance in nursing workforce distribution across the district, with shortages deepening in rural and hilly blocks (Ghosh & Maity, 2011).

The Ghayabari PHC—located ~45 km from Darjeeling town—documented severe workforce deficits: only two doctors and three nurses served a catchment population of nearly 16,800. The study reported 27% vacant sanctioned posts and a further 13% attrition over three years. Staff described poor living conditions, insecurity during blockades, irregular supervision, and inadequate operational funding as key drivers of turnover. Regular outreach and emergency services were severely disrupted, exacerbating demand pressures on health services (RCH Survey, 2011; Ghosh & Chakrabarti, 2012).

The tea garden belt was similarly afflicted. The 2006–2007 Labour Department survey reported that 107 of the 273 functioning tea estates in Darjeeling lacked any form of medical infrastructure. Even among the 166 estates with clinics or hospitals, only 56 had full-time MBBS doctors, and 116 lacked residential nursing staff, forcing reliance on part-time visiting practitioners. Moreover, there was a consistent absence of essential supplies, ambulances, and qualified doctors. Workers and their families, forming the backbone of the regional economy, were forced to travel long distances—often on foot or via overcrowded jeeps—to access basic medical care (AK Rai, 2014; *Down To Earth*, 2012).

Bhattacharjee et al. (2013) reported that while institutional delivery rates reached 73.5% in some gardens, only 46% of women received complete antenatal care. This gap was attributed to irregular outreach services, cultural mistrust of state-run institutions, and limited availability of emergency transport. The reliance on traditional birth attendants and community elders highlighted both the gaps in state services and the resilience of local coping mechanisms.

These deficiencies were not merely bureaucratic abstractions—they had real consequences for workers and their families. Residents often travelled long distances, on foot or via overcrowded vehicles, to access basic medical care on estates that lacked ambulances, medicines, or trained staff. This crisis persisted despite legal mandates under the Plantation Labour Act of 1951, which requires estates to provide essential services including healthcare; in practice, implementation and enforcement of the Act were weak, resulting in continued deprivation for tea workers (AK Rai, 2014; Indian Gorkha News Desk, 2014).

The broader political environment compounded the crisis. Following the resignation of Subash Ghisingh and the consequent dissolution of the Darjeeling Gorkha Hill Council (DGHC). This vacuum was filled by bureaucratic oversight until the establishment of the Gorkhaland Territorial Administration (GTA) in 2012. During this period, development projects were either stalled or abandoned. Investigative journalism by *The Telegraph India* in 2008 highlighted delays and corruption in DGHC-managed health projects, with no effective oversight or continuity in implementation (*The Telegraph India*, 2008).

Darjeeling District Hospital, the primary tertiary care center in the region, suffered notable deterioration. *The Telegraph* (July 2011) reported an alarming scarcity of essential utilities, including running water in operating theatres, non-functional elevators, cracked ceilings, and deteriorating sanitation systems. These deficiencies persisted despite the hospital having received significant funding under the World Bank-supported Health System Development Initiative (*The Telegraph India*, 2011). The infrastructural decay was not an isolated issue but indicative of a broader governance failure. According to *The Telegraph India* (2008), multiple development projects under the DGHC's jurisdiction, including health sector investments, were subjected to administrative review due to allegations of mismanagement and corruption. The lack of continuity in leadership and absence of local accountability mechanisms exacerbated the decline.



of healthcare service delivery during this interim period.

Media coverage during this period underscored the extent of healthcare dysfunction. Platforms such as Kalimpong Online News and Darjeeling Chronicle published firsthand accounts of prolonged queues, diagnostic machine failures, and lack of trained staff. In times of bandh or political agitation, healthcare services were completely suspended due to blockades and transport disruptions (Darjeeling Chronicle, 2011; Kalimpong Online News, 2011).

Health indicators reflected this administrative paralysis. Maternal and child health records revealed increasing rates of home births and delayed immunizations, while tuberculosis and diarrheal diseases remained endemic. A 2012 review by the North Bengal Health Resource Network reported that the average referral time for critical cases from rural areas to Siliguri exceeded five hours, often resulting in fatal delays (NBHRN, 2012).

Moreover, delays in diagnosing tuberculosis—one of the region's most persistent public health concerns—were linked to fragmented primary care delivery. Darjeeling began under India's DOTS and DOTS-Plus TB control programme relatively late (December 2004 for DOTS, October 2009 for DOTS-Plus). Its case detection rates were among the highest in the state, yet cure rates remained modest (~82%) and default and mortality rates elevated, indicating delayed diagnosis and referral. Das et al. (2012) identified delays in diagnosis and treatment as a key issue, with over 40% of TB patients experiencing diagnostic delays exceeding one month from the onset of symptoms. Women, in particular, suffered more due to stigma, family neglect, and logistical challenges. The widespread reliance on informal health providers further delayed effective intervention and contributed to TB transmission (Das et al., 2012).

Although data specific to Darjeeling's referral system is limited, studies from comparable regions offer insight. Khaton et al. (2012) noted that in Rajasthan, only 16.6% of obstetric referrals used ambulances, and 66.7% relied on private vehicles, leading to delays. Given Darjeeling's terrain and political instability, similar or worse outcomes can be reasonably inferred.

Media investigations and administrative records highlight a broader pattern of neglect across district health infrastructure—including delays in critical referral care. A 2011 exposé in local outlets reported non-functioning diagnostic machines,

decrepit sanitation facilities, and extended queues that coerced critically ill patients to rely on private facilities or forego treatment entirely (Darjeeling Chronicle, 2011). Although sources differ on specifics, these accounts align with broader systemic deficits identified in public health surveillance and audit reviews.

The political climate also contributed to healthcare neglect. Negotiations between the state and local parties often excluded healthcare as a priority issue. While funds were occasionally allocated—such as under the National Rural Health Mission (NRHM)—their implementation in the Hills was either stalled or misdirected. A 2010 audit by the Comptroller and Auditor General (CAG) found irregularities in fund usage across several hill subdivisions, particularly in procurement and staffing (CAG, 2010).

Bhattacharjee et al. (2013) highlighted that rural communities, particularly those migrating from tea garden areas in Darjeeling district, encounter numerous obstacles in accessing healthcare. These barriers included transportation challenges to reach healthcare facilities, limited availability of facilities, financial constraints, inadequate infrastructure in healthcare centres, restricted services, and significant workforce deficits. These barriers further exacerbate existing inequities in healthcare access. The statistics in North Bengal revealed a severe shortage of doctors, with numbers falling below half the global average per 1000 people. Moreover, these shortages are more pronounced in the public sector compared to private healthcare, and the situation is even more dire in rural areas. This scarcity of healthcare providers has significant implications for community health, human resources for health, and efforts to reduce maternal, infant, and child mortality (Bhattacharjee, Datta, Saha, & Chakraborty, 2013).

These cumulative failures not only rendered an operational breakdown but also reflected a broader marginalization of the Darjeeling region within the West Bengal state apparatus. Public healthcare was treated less as a right and more as a contingent provision, dependent on the whims of political stability. Thousands were compelled to seek private care in Siliguri, paying exorbitant rates, or turning to traditional remedies in desperation.

Darjeeling consistently underperformed on healthcare indicators when compared to other districts in West Bengal. Ghosh and Maity (2011) noted that the district's rural blocks, such as Bijanbari and Kalimpong, had disproportionately



fewer Primary Health Centres (PHCs), Sub-Centres (SCs), and Community Health Centres (CHCs) than required under national norms. This discrepancy was not merely infrastructural but a reflection of the peripheralization of the region in the state's planning priorities. Frontline health workers, particularly Auxiliary Nurse Midwives (ANMs) operated under severe constraints. A study by Ghosh and Chakrabarti (2012) conducted in two blocks of Darjeeling revealed that ANMs were demotivated due to delayed salaries, lack of logistical support, and inadequate housing. Their inability to provide routine maternal and child healthcare services regularly undermined the credibility of government healthcare and pushed rural populations towards informal providers or self-treatment.

The Gorkhaland movement and its associated disruptions further strained the system. Frequent bandh calls, road blockades, and bureaucratic disruptions hindered the transportation of essential medicines, mobility of health personnel, and coordination between departments. Besky (2012) argued that tea plantation workers, constituting a substantial part of the population, were structurally excluded from formal welfare regimes, remaining on the margins of both the state's and the autonomous body's priorities. Their dependence on garden hospitals—often understaffed and under-resourced—exemplified the systemic neglect rooted in a combination of economic marginalization and political invisibility. Urban centers did not fare significantly better. The Darjeeling Municipality's vital statistics report (2009) highlighted glaring inadequacies in health data collection, particularly in birth and death registration. This not only reflected administrative apathy but also impeded epidemiological tracking and health planning.

Though the formation of the GTA was initially seen as a step towards better governance, its effectiveness remained limited. The Centre for Policy Research (2012) observed that the GTA suffered from vague jurisdictional authority, limited financial powers, and an absence of a coherent health policy framework. The years 2005 to 2012 marked a period of compounded neglect for the public healthcare system in Darjeeling. The vacuum created by political transitions, combined with infrastructural underdevelopment and bureaucratic inertia, led to systemic failures that disproportionately affected women, rural dwellers, and tea plantation workers. Addressing these issues requires a sustained commitment to institutional clarity, decentralized health planning, and socio-

political stability—elements that were conspicuously absent during the period in question.

V. FIELDNOTES FROM THE FRINGES: HEALTH, MIGRATION, AND THE POLITICS OF CARE

Situated in the proximity to international borders, North Bengal holds immense geopolitical significance, making it an increasingly attractive investment destination for private businesses and corporate giants, particularly in the health sector (The Bengal Chamber of Commerce and Industry, 2016). The region's dynamic population flow and strategic transit location have contributed to its continual transformation, shaping it into a fluid space of settlements, townships, and expanding urbanities. Urbanization has unfolded with multifaceted complexities, marked by significant indicators such as the influx of diverse migrant populations—including labourers, settlers, tourists, and transient individuals. These demographic movements have led to both vertical and horizontal expansions of the landscape, accompanied by numerous challenges in managing natural resources, conserving commons, and negotiating the dual imperatives of development and sustainability. The expansion of infrastructure—such as improved roads, enhanced telecommunications, and broader connectivity—has facilitated greater mobility for goods and people. Nevertheless, the region continues to struggle with maintaining a delicate equilibrium between rapid development and ecological-social sustainability. (Chakraborty, 2018).

This juxtaposition of progress and exclusion raised critical questions regarding the nature of development and whom it ultimately served—encapsulated in the often-invoked yet persistently urgent query: *whose development?* (Chakraborty, 2013). At the heart of this question lay the politics of health and well-being. The social imaginaries of health, shaped by colonial legacies, trajectories of medicalization, sanitation discourses, and evolving notions of well-being, played a central role in defining developmental experiences in the region. Migration for healthcare emerged as a salient indicator of both infrastructural inadequacy and social marginalization in Darjeeling and its surrounding areas. Factors such as the unavailability of specialized treatment, poorly equipped local health facilities, and a growing reliance on regional medical hubs like Siliguri, Kolkata, or Vellore revealed deep structural inequalities. Those compelled to migrate for medical treatment—particularly elderly individuals, women, and economically vulnerable groups—represented the



most visible faces of this ongoing crisis in healthcare access (Chakraborty, 2013).

Health migrations were driven not only by the limitations of local healthcare systems but also by the concentration of specialized care in distant urban medical centers. Media portrayals and healthcare advertisements amplified these migratory behaviors, cultivating both aspiration and anxiety. Individuals frequently found themselves making urgent and high-stakes decisions regarding health treatments—decisions that were often financially devastating, involving out-of-pocket expenses, informal loans, or dependence on private financial arrangements. In the absence of institutional support mechanisms and universal health coverage, the burden on patients and their families was immense. Meanwhile, the towns and cities receiving these health migrants—such as Siliguri and Kolkata—were themselves under pressure to accommodate the influx, resulting in overcrowded medical infrastructure, overburdened public services, and strained utilities. The political economy of care, therefore, played out across both the points of origin and destination—revealing a complex matrix of structural exclusions, economic distress, healthcare migration, and institutional failure (Chakraborty, 2018; Chakraborty, 2019).

This intersection of development, healthcare, and migration demonstrated that health could no longer be understood through a binary lens of absolute well-being or illness. Instead, it existed on a nuanced spectrum shaped by socio-political contexts, personal agency, and biological processes. Within this continuum, aging emerged as a particularly poignant challenge. As a complex and cumulative psycho-biological process, aging disrupted conventional chronological definitions, revealing that biological decline often began long before individuals were formally classified as 'elderly'. Disorders such as arthritis, hypertension, cardiac diseases, diabetes, hearing impairments, kidney complications, cataracts, and spondylitis—though commonly associated with old age—did not equate aging with inevitable illness. As Stieglitz aptly observed, “Any illness may occur at any stage, but certain disorders increase in frequency after the peak of maturity. These disorders, while not limited to the senescent, are nevertheless characteristically geriatric” (Chakraborty, 2018).

In the Darjeeling context, elderly populations were often left to navigate an increasingly inaccessible and fragmented healthcare landscape. Their treatment choices and coping mechanisms rarely followed uniform trajectories; rather, they were shaped by intersecting factors such

as personal perceptions of illness, financial limitations, social support structures, and physical proximity to healthcare facilities. Case studies and ethnographic field data consistently revealed that chronic conditions among the elderly were frequently left untreated or inadequately managed, primarily due to these systemic constraints. This reality underscored the multifaceted nature of health vulnerability in aging populations and exposed the broader failures of healthcare provisioning in peripheral regions like Darjeeling. (Chakraborty, 2018).

The already fragile healthcare situation in Darjeeling deteriorated further under the weight of political instability. The rise of the Gorkha Janmukti Morcha (GJMM) in 2008 marked a turning point in local governance and public service delivery. Bandhs, agitations, and protracted demands for Gorkhaland statehood disrupted civil life and destabilized governance structures. While the GJMM brought attention to longstanding grievances, including the inadequate healthcare system, their confrontational methods often worsened the very access they sought to improve. During prolonged shutdowns, transportation ceased, public institutions shut down, and healthcare delivery came to a standstill. This escalated healthcare migration, as patients increasingly looked to Siliguri, Kolkata, and Vellore for basic and specialized medical services. State institutions, such as the Darjeeling Gorkha Hill Council (DGHC), failed to safeguard the right to health, exposing deep institutional neglect (Sharma, personal communication, October 15, 2019; Gurung, personal communication, April 10, 2019; Tamang, personal communication, July 8, 2019; Tamang, personal communication, November 20, 2018; Sharma, personal communication, February 5, 2020; Residents of Marybong tea garden, personal communication, March 2019; Rai, personal communication, June 30, 2020; Students and volunteers, personal communication, May 25, 2019).

Delays in accessing essential medication, abandonment of posts by government doctors, and a dysfunctional emergency response system became tragically routine. Numerous accounts illustrated the dire consequences of this breakdown. For instance, Manoj, a 40-year-old resident of Sukhia Pokhari, faced enormous difficulty in arranging an ambulance for his father during a bandh despite his father suffering from severe gout and needing urgent care (Informal discussions, Manoj and the Rai family, January 6, 2019). Similarly, Madan Gurung was forced to shift his mother to Siliguri for



chemotherapy amidst local agitation, torn between his ideological support for the movement and his urgent familial responsibilities (Informal discussions, Madan and the Gurung family, May 12, 2019).

In Siliguri, a critical healthcare hub for hill residents, patient satisfaction was reportedly low. The Siliguri Municipal Corporation's survey (2011) recorded long waiting times, poor sanitation, and lack of medicines as common complaints, with patients from the hills citing the absence of specialist care in their own areas as a major reason for seeking treatment in Siliguri.

The movement for Gorkhaland, while deeply rooted in questions of identity and political autonomy, often came at the cost of essential human development parameters—foremost among them being health. The compounded effects of aging, migration, economic fragility, and political instability necessitated the urgent restructuring of healthcare access in the Eastern Himalayas. The experience from Darjeeling underscores the critical need for robust, regionally grounded, and inclusive public health systems—ones that could withstand political uncertainty, support aging populations, and ensure equitable access for all.

VI. Conclusion

The condition of public healthcare in the Darjeeling Hills presents a profound case of structural vulnerability, where the aspirations of political autonomy have been undercut by chronic institutional neglect, administrative discontinuity, and episodic governance. This study, grounded in empirical fieldwork and lived experiences, has critically examined the unfolding health crisis through the lens of political transition—from the Darjeeling Gorkha Hill Council (DGHC) to the Gorkhaland Territorial Administration (GTA). Rather than ushering in effective decentralization or regional empowerment, this transition has been marked by fragmented authority, lack of fiscal autonomy, and an absence of long-term policy vision for public welfare, particularly in healthcare delivery.

Public healthcare in Darjeeling, therefore, cannot be merely interpreted through the conventional binary of developed versus underdeveloped systems. It demands a deeper interrogation into how political movements and administrative experiments intersect with the everyday life of governance. The region's ongoing reliance on distant urban centers such as Siliguri for even basic and emergency care underscores both the spatial and structural inequities embedded in current health governance. The consistent patterns of health

outmigration among the elderly, the poor, and women highlight the social costs of uneven development and fragmented public provisioning.

Moreover, the deterioration of local healthcare infrastructure must be understood as symptomatic of a broader failure to institutionalize the political aspirations of the region into sustainable development outcomes. The vision of autonomy—while mobilizing collective identity and cultural recognition—has not translated into the establishment of robust, accountable, and people-centric institutions. Healthcare becomes a critical site where the disjuncture between political rhetoric and material reality is most visible, rendering the population increasingly dependent on informal networks, private providers, and migratory strategies for survival.

This paper contends that the crisis of public health in Darjeeling is emblematic of the larger tensions between decentralization and state responsibility, identity politics and developmental justice. For regional autonomy to be meaningful, it must be accompanied by deliberate investments in public infrastructure, transparent governance mechanisms, and the democratization of policy-making processes. Until then, the price of autonomy will continue to be borne disproportionately by the most vulnerable—those for whom access to healthcare remains not a guaranteed right, but a costly pursuit.

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