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## HEALTH AND HEALTHCARE IN THE CITY

### A social history perspective

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The story of Bombay from the 1990s to the first decades of this century is a narrative of a metropolis fraying at more than the edges, receding ever further from the quintessential city of hope and dreams to a disarrayed assemblage of past glories and present dysfunctions. By the twenty-first century Bombay had changed from a city “of risk” where risk was not only danger, but opportunity, to a city “at risk” reflecting a crisis in governance (see Rao 2006).

Narratives of Bombay provide a redemptive view of the future of an emerging global city. At one level they reflect the triumphal flowering of the city overcoming problems of urban decay and policy neglect; at another, the city’s successful engagement with the forces of neoliberal policies and the structural adjustment programme. Mostly unaddressed, however, is the city’s deep-rooted vibrant civil society and its integral role in the redemption of the metropolis. This chapter attempts to reintegrate civil society into the Mumbai narrative, taking the health sector as a location of choice. Our particular focus is on how the state defines and operates a mostly fragile three-point network comprising the state in the guise of the municipal corporation, private enterprises, and civil society in the health sector. In Mumbai, this has created a pattern of healthcare that is perhaps unique to the city.

Neoliberalism in India refers to a set of political and economic policies that privilege corporate profit over public good; that encourages privatisation and government austerity especially concerning welfare and in general a shrinking of government. Gramsci (1971) argues that the state, under the direction of dominant groups tends to apply rules that appear to align with the needs and aspirations of the subordinate groups, and yet benefits and coalesces with the objectives of the dominant groups. It is possible to understand the changing equations between state and healthcare in neoliberal space and time in this Gramscian sense. If the state at all extends to involve itself in health and welfare provisions, it is only in such a way that it derives adequate benefit.

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In the framework of critical theory, civil society is an inherently political domain of struggle and conflict. Here issues of public interest may be discussed and collective challenges to the state and the market mounted with relative safety. NGOs, as civil society representatives, then assume a political role when they facilitate and mobilise dialogue that challenges dominant projects and perspectives. Alternatively, theorists have also regarded the primary role of civil society organisations as being simply, quiescently sustaining civic life (Alexander and Fernandez 2020). Either way, civil society organisations necessarily premise the common good over the individual ones and pursue the larger objective of defending and pursuing human freedoms. Neera Chandoke (2007) suggests that one of the preconditions of a vibrant and healthy relationship between civil society and democracy is that “state power has to be monitored, engaged with and rendered accountable through intentional and engaged citizen action” (608).

We regard civil society intervention as including both formal interventions of organisations and popular opinion that has coalesced to form a change agent. Also, the incorporation of civil society presence within legislated executive bodies, as happens in well-functioning democracies creates pathways for people’s involvement in the delivery of services.

Social and cultural histories and traditions also impact on the responsiveness of civil society and its willingness to intervene in extracting welfare benefits within the parameters of the neoliberal state. Maharashtra has a long history of social reform movements and of philanthropy. Even more importantly Bombay was the crucible of India’s labour movement that continued to grow until the 1980s. This legacy has, one might say, subliminally fuelled contemporary social and political resistance to policies and programmes inimical to the welfare of people. But also on occasions, the long history of resistance has also engendered a social flexibility towards associating with the state for larger good.

## Describing the context<sup>1</sup>

We understand health as a social construct that is directly and indirectly scripted by social, economic, and political factors. We take a brief look at these conditions, locating first, the city in the context of Maharashtra.

Maharashtra has the highest rate of urbanisation at 40%. Significantly, the state, unlike most others has two levels of healthcare, public health that is integrated with local government and clinical care, the two being run independently even at the district level under independent authority. This allows room for community participation in public health (SATHI 2009).<sup>2</sup> In 2016–17, the government health expenditure formed only 23.3% of the total expenditure on health. Out of pocket (OOP) expenditure on health accounted for a huge 56.7% of the total health expenditure, nevertheless registering one of the lowest such ratios in the country indicating a relatively better availability of affordable government services (GoI 2020).

Mumbai has always been a migrant city; more importantly, it has been called a “male ghetto” given that its migrants are largely male labour (Tumbe 2016). The type

of employment available dramatically changed from the 1990s. Manufacturing declined in importance and accounted for only 35.17% of all labour, while trade, finance, and services sector drew 64.3% of all labour. The latter were relatively newer migrants who by 2001 had formed a substantial section of labour. With the crumbling of manufacturing, especially textiles, the stable labour communities of south Mumbai disintegrated, prompting a massive northward movement of the middle and labouring classes (Banerjee–Guha 2002, 123). The spatial concentration of the city further altered after the 1992–93 riots. The exodus of Muslims from the city was followed by a subtle redistribution and a higher inflow into old Muslim areas. In some areas, especially labour dominant areas like Dharavi, this made for social tensions and segregations (Dore 2021).

Urban healthcare was, in real terms, a latecomer in health policies and programmes. India acted on the Alma Ata Declaration, 1978 (WHO 1978) prioritising primary healthcare over a technologised medicare (Birn 2018). It defined the target group of its programmes: “the poor and vulnerable segments of the population can access essential commodities and facilities based on their needs and not on the ability to pay” (GoI 2002a, 2002b). By 2002, state resources were already being deemed inadequate to achieve this goal, and in turn encouraging private investment in healthcare.

Only in 2008 did urban health receive more than a nod in health policy with the Draft Urban Health Mission (GoI 2008) that envisaged three levels of healthcare at the community, primary and tertiary levels, with the lowest levels being managed by urban social health activists. Citing the Alma Alta Declaration, 1978 the Mission encouraged public–private partnerships in healthcare.

#### Health and Healthcare in the City

The rapid neglect of the City’s health and social services contributes in no small measure to the descent of the city “of risk” to a city “at risk.” Mumbai’s healthcare map has been a product of the interaction of three major actors on the public scene: the state, private sector, and civil society. It is the resistant and sturdy thread of civil society influence, which has persisted in contributing to the unique design of Mumbai today. Civil society acts in several ways: through policy interventions; taking advantage of such provisions as those under the Right to Information Act (hereon RTI); resorting to the courts with Public Interest Litigations; with complaints and persistent pressure on the city government to act, and certainly through direct action as part of activists’ networks and campaigns. Civil society also pushes the state to legitimise and embed civil society participation through legislation or other means.

### Health status and access to healthcare

The close link between health inequalities and socio-economic and structural inequalities is well-established. It is no surprise that the city’s evolving spatial design and demography over time have influenced its health status patterns. Today, only a quarter of the population lives in the Island city, which occupies only 15% of the

total land mass of 605 sq km that make up the city. The rest of the rapidly growing population is in the burgeoning northern suburbs stretching into the mainland, with its poor infrastructure and services. Between Census 2011 and 2018, Mumbai's population grew from 12.48 million to an estimated 22 million, 55% of which lives in slums. Only about half of these slums have been acknowledged by the Brihanmumbai Municipal Corporation (hereafter BMC) (designated as “notified”) and receive rudimentary water supply and sanitation services, immunisation, and electricity. This leaves a huge population in unnotified or illegal slums that get no municipal services. Add to this some 54,000 people who are “homeless,” i.e., pavement dwellers. Not surprisingly, the income gap in this “golden” city is ever widening, with the poorest earning only 25% of the richest sections (de Silva 2018).

Mumbai's disease burden heavily comprises infectious diseases like malaria, dengue, and tuberculosis (TB). The pattern has not changed much over the years pointing to the poor public health approach and the abysmal paucity of preventive and promotive services. Worse, the conditions that make for the spread of these diseases – poor sanitation, drinking water scarcity, waterlogging, close living, air pollution, and close proximity of small unregulated industries and residences – are not being addressed. Communicable diseases are still prevalent although they wax and wane with the seasons spiking with the slightest change in equilibrium. The fact that drug-resistant tuberculosis shot up by 63% between 2014 and 2018 is evidence that neither the conditions for spread of TB, nor the means to ensure regular treatment are in adequate place (PRAJA 2018). While malaria has shown a small decrease, dengue also a mosquito-borne disease has shown an uptick. Diarrhoea is the bane of poor and middle-class households and is routinely neglected until it reaches critical stages. Lower respiratory infections, typhoid, and vaccine-preventable diseases like measles and tetanus still prevail. Maternal mortality is not going down which perhaps is because of the fact that prenatal registration has gone down over the last two years. And maternal mortality rate (MMR) was as high as 143/100,000 live births in 2018 (PRAJA 2018, 2020) even while the MMR for Maharashtra is 46/100,000 live births (the national levels being 113/100,000 live births in 2016–17). Child health is of particular concern. While under the age of five, mortality has been decreasing it still remains at 30/1000 live births (2018), way higher than targeted. Vaccination drives are fewer than mandated and were suspended during COVID-19. This neglect of primary care and preventive services directly leads to the vulnerability of a population in a public health crisis. This is indeed what happened during the outbreak of COVID-19. Civic data for the first eight months of 2020 showed that 22% of all maternal deaths were due to COVID-19 (Debroy 2020).

Riven by caste divides, the large and growing population of the metropolis is now further splintered by communal tensions, biases, with a gradual change in the composition of cosmopolitan neighbourhoods into those segregated by community. It would not be unrealistic to surmise that social prejudices would be worse felt where healthcare is a commodity and the price of the care plays a role in who may receive it, and whether services can be accessed at all. Some studies have indeed thrown up evidence that it is not just in the aftermath of the violence but

in normal times too that social discrimination is evident in the delivery of services. Studies show that women of the minority community face discrimination in a variety of ways in healthcare institutions in Mumbai [see Khanday 2017], making people move away from public institutions. The periodic avowals of the cosmopolitan nature of the metropolis notwithstanding, community, caste and class divisions, and social prejudices are increasingly evident in healthcare institutions.

### Public systems and their deterioration

Maharashtra is among the few states where the two levels of healthcare – public health and clinical care – are under separate independent charge even at the district level. Public health has been integrated with local government, institutionalising, in a sense, civil society involvement in healthcare. Unfortunately, poor coordination between the two departments makes for suboptimal performance and a shelving of responsibilities, especially with regard to primary care [see the successful community monitoring project initiated by the government with the NGO SATHI in the Pune area (SATHI 2009)]. On the other hand, this structure has enabled the integration of community-based monitoring (CBM) programmes as suggested in the National Rural Health Mission (NRHM), 2005. CBM is an outcome of a people's demand for health system accountability and access to healthcare that coalesced in the Jan Swasthya Abhiyan (JSA).<sup>3</sup>

The Mumbai Municipal Act of 1888 (MMA) lists the BMC's obligations vis-à-vis the city, charging the Corporation with preventing the spread of disease and the establishment of "hospitals and dispensaries" and of ensuring "medical relief" to the public. However, neither the Act, nor the Development Plans for the city take into account emergencies in the planning of health infrastructure. Consequently, apart from the ancient Kasturba Gandhi Infectious Diseases Hospital, hastily upgraded recently, there is no other isolation facility in the city.

The array of physical infrastructure in health in the city is impressive, at least on paper. The city government has five super-specialty hospitals, five special hospitals, 15 peripheral hospitals, 26 maternity homes, and 186 municipal dispensaries. Under the state government are five hospitals and 15 police dispensaries. Under the central government are eight hospitals (PRAJA 2020). There are 286 urban primary health centres. There are about 11,000 plus BMC beds.

While the city has grown northwards over the decades, the health institutions remain concentrated in the south. When we superimpose these data with the type of households in the ward areas a curious pattern of having the least beds in the areas with the highest concentration of slum housing can be witnessed (Bisht and Virani 2016). The suburbs where 76% of the citizens live has only eight hospitals, whereas the island city's 24% of the population, living in a smaller area than the spreading northern suburbs, can access 12 large public hospitals. Its noteworthy that private care institutions have also followed the same spatial pattern. This gap in services in the less served areas is filled by small private care institutions and independent general practitioners.

The municipal corporation's budget on healthcare fell sharply in the late 1990s after the adoption of the new economic policy. It fell from 30% of the budget to less than 15% by 1995 declining to 8.8% in 2012–13 (Duggal 2005). However, even this does not get expended entirely. Overall, between 2016 and 2019, the deficit spending on capital expenditure was between 47% and 73% (PRAJA 2020), indicating that no new infrastructure, badly needed in the city, was even planned. Not surprisingly, by 2012, Mumbai's medical and health facilities fell woefully short of the prescribed norms of the National Urban Health Mission – a 55% deficit in hospitals, 79% in maternity homes and a 70% deficit in health posts and dispensaries (PRAJA 2018).

The paucity of funds for public hospitals and infrastructure manifested in a number of indirect ways. It affected the recruitment of staff and even as patients increased, personnel strength decreased or stagnated. There is a 26% shortage of nursing staff and a 44% gap in medical staff (PRAJA 2015). By 2019 the shortage of medical personnel in municipal hospitals was 62% and in primary care, 30% (PRAJA 2020:12). Overall, the city has only 54 doctors per 100,000 people (Karan et al. 2021).<sup>4</sup>The shortage of medical doctors trained in critical care and emergency medicine is deplorable at an estimated 2944.

This atrociously poor staffing has had a direct impact on the delivery of services, that was worse in lower levels of the health system. Primary care centres, functioning poorly to begin with, became almost non-functional. Only 5% of BMC budget went into primary healthcare. This led to a deterioration of the primary network, leading to the collapse of the referral system and overcrowding of tertiary hospitals which became willy-nilly, first level of care. Consequently, secondary and tertiary level hospitals became burdened with primary care and specialty care deteriorated. Routine services such as for under-care TB patients that should have been delivered at the primary level were forced to access higher level institutions. This had a domino effect, those who could afford it – even by borrowing – turned to private care which in turn registered a boom. Not surprisingly, 65% of the poor were now seeking private care rather than public (DP 2014–34 cited in the PRAJA).

The public health crisis in cities of developing countries has been long acknowledged (see Wang'ombe 1995). There is a general consensus since the late 1990s that the best plan to address this ongoing crisis is to strengthen primary healthcare in the burgeoning cities of the developing South. Yet very little has been done in this direction anywhere, including Mumbai. The neglect of primary and preventive care has had consequences that have manifested as periodic epidemics of waterborne or other diseases and delayed contact with the medical system. This near disappearance of the primary level of care had a huge impact during the COVID-19 crisis, when in most localities of the city, there were no public healthcare institutions that could be brought into the network to provide care.

Some services in public care are, however, favoured over private care. For instance, maternity and gynaecological services in municipal hospitals are still the preferred option, largely because private care is expensive and often of poor quality. A study of small hospitals in Maharashtra found a paucity of qualified nurses and doctors, oxygen cylinders even though surgeries were performed, and blood banks

were inadequate (Bhate-Deosthali and Wagle 2011). City hospitals are no better and often in fact worse (see Nandraj, Khot and Menon 1999). In a study of 13 slums in Mumbai, public providers played a significant role in maternal health – both for prenatal and antenatal care – with 60% of the study population seeking public care in preference to private care. However, a 2012–13 analysis found that out patient departments (OPDs) of public hospitals attended 46 lakh cases annually with an average of 15,435 cases per day (Naydenova et al. 2017). Significantly, it is well established that the use of public health facilities is generally higher among women, especially from poor and vulnerable sections of society. With their deterioration women are forced to seek private care, which they are likely to do only in emergency, neglecting early care. If there is a price tag on healthcare, women's healthcare gets worse affected than that of men.<sup>5</sup>

A rapid survey of 13 peripheral hospitals at the tail end of the second phase of the current pandemic showed that these hospitals began to receive COVID infected patients well before any notification by the BMC or before protocols were set. Although superintendents were trained, there was considerable chaos because protocols kept changing and resources including human, were very scarce. In the early months, it was the voluntary groups and local offices of political parties that made a difference, providing organisational help and human power (CEHAT 2021). Unfortunately, regular services such as antenatal care were suspended – both because of the paucity of staff and the risks involved. Commendably the Dilaasa crisis centres mandated to deal with domestic violence remained open.<sup>6</sup> Although TB OPDs were operational, the number of people infected by the disease escalated in the aftermath of the first phase of COVID (CEHAT 2021). Data and several reports point to a gross neglect of other diseases, particularly chronic diseases during the pandemic (Kumar et al. 2020).

In the late 1990s, alleging shortage of funds for public healthcare, BMC proposed and initiated the concept of public–private partnerships (PPP) in healthcare. While the concept had been operationalised in other sectors of industry, this was a first in the health sector.<sup>7</sup> PPPs would serve the triple objectives of the state, viz., create investment opportunities for private capital in healthcare; address a critical citizens' demand for reliable affordable care; and appear to be in charge of the provisioning of healthcare. One of the earliest PPPs involving the Swan municipal hospital and a charitable trust was aimed at reviving a deteriorating but well-used municipal hospital failed to provide the stipulated free services and instead became a high-fee super specialty private institution (Bisht and Virani 2016). A more successful variation of the model was a PPP led by an NGO, SNEHA with a corporate entity ICICI (private sector bank in India) and the BMC for better maternity services. Significantly, the 2003 McKinsey report (Bombay First and McKinsey & Company, Inc. 2003; GoM 2004) recommended the diversion of the state's investments from the social sector to more profitable areas and suggested the active involvement of NGOs to manage services in PPPs. But by and large, PPPs in healthcare have failed to address the paucity of affordable services and have been consistently opposed by NGOs and citizens' groups.

## Private healthcare network

Unlike most other cities, Mumbai's private hospital network is dominated by charity hospitals, that is, hospitals that are registered by Charitable Trusts (registered under the Maharashtra Public Trusts Act which have been established over 75 years). There are 74 charitable hospitals, including 20 of the largest such hospitals in the state, that are obligated to reserve beds for indigent patients to be treated free. Registered under the Maharashtra Public Trusts Act, 1950 (originally the Bombay Public Trusts Act), these hospitals were established on land whose ownership was facilitated by the BMC in numerous ways, viz. land owned by the Corporation "sold" at concessional rates; or land on long lease at discounted rates. They also receive subsidies on utility bills, and waivers in Income Tax, import duty rebates on equipment purchases, and other concessions.<sup>8</sup> In return, they are expected to reserve 10% of beds for indigent patients (annual incomes of less than INR 50,000 (~ 680 USD) and provide treatment free of cost; and another 10% of beds for patients from weaker sections (annual incomes between INR 50,000 and one lakh) (USD 680 to 1357) at a concessional rate. They are expected to transfer 2% of the total billing to an "indigent patient fund" which is to be used for treatment of indigent patients (GoM 1991). By last count the city has 1768 indigent beds in these hospitals. According to the Charity Commissioner, Mumbai's charitable hospitals treated a miniscule 4,56,750 indigent patients between September 2006 to December 2017 (Office of Charity Commissioner 2021).<sup>9</sup> By 2020, 89% of beds in charity hospitals remained unoccupied (Ashar and Barnagarwala 2020).

Over a period of time these charitable hospitals (430 in Maharashtra, with 10,000 charitable beds) began to renege on their obligations (Raut-Marathe 2018). In response to a petition initiated by civil society organisations the BMC began to monitor these huge hospitals more closely and ensure that beds and mandated free services were indeed available to poor patients.<sup>10</sup> In 2016 a BMC-instituted inquiry led to the setting up of regular monitoring of these hospitals.<sup>11</sup> This institutionalisation of the fragile relationship between the state and private providers, engendered by civil society, has ensured that the state has some leverage, even though little used, in the functioning of private hospitals in the city. It is this leverage that perhaps allowed the city government to cease control over private beds and hospital charges during the COVID-19 outbreak.

Other than large charitable hospitals Mumbai also has a large number of small and medium-sized nursing homes, which are registered under the Bombay Nursing Homes Act, 1949. However, the Act remained unimplemented because no rules had been drafted. A public interest litigation by Yasmin Tavaría and the Medico Friend Circle, a network of health activists, discovered that the government of Maharashtra had no data on even the number of nursing homes, let alone their state of operation. Findings of the court-appointed enquiry committee were shocking, with a large number of them functioning in sheds, without adequate water supply, poor hygiene, no medical staff, no supportive equipment or blood banks.<sup>12</sup> This report and the public action led by activists' organisations like the Medico Friend Circle led to the

setting up of a permanent committee to oversee and supervise the implementation of the Bombay Nursing Home Registration Act (BNHRA), 1949, and make recommendations. Today while the nursing homes are better regulated, there is still no price control. During the pandemic when most of them shut down, the BMC was at least able to identify those that were open and coopt their services. Many states have not ratified this Act. Interestingly enough, an IMS (a market research firm in the medical sector) in 62 cities in India found 13,413 such small-to-medium hospitals contributing to 95% of all hospitals in these cities (as cited in Chakravarthi et al. 2017, 50).

It is noteworthy that the BMC is planning jumbo hospitals, ostensibly in preparation for a third wave, which is planned to be eventually run by select private hospitals, perhaps as a reciprocal gesture for the private sector's assistance during COVID. Civil society too will have a say in the running of 227 new health posts being planned (initially as vaccination centres), through the local corporators who are to be designated to mobilise and oversee these centres (Bhalerao and Barnagarwala 2021).

The Corporation's response to COVID draws attention to the gaps and the abysmal lack of preparedness for a public health emergency and the absence of a public health approach to healthcare. But because there existed a sound civic structure, it was relatively easy to put in place a ward-centred system which focused on containment by tracking the disease agent and attempting to control its spread. The pandemic underlined the importance of the three-way relationship – state, private capital, and civil society – that has evolved at the city level. The city government made full use of its existing reciprocal relationship with the private sector to ensure its cooperation, taking over 80% of private beds and imposing a standard price list for paying beds and procedures (Asthana and Bisht 2020). In a huge recruitment drive, the BMC hired unemployed doctors, interns, and nurses from across the state on temporary posts, providing them convenient accommodation in hotels and transport.

The strategies used by the BMC in Dharavi were remarkable in relying as much as it did on local community workers, private practitioners, and the people. It was, to all events and purposes a lightly etched variation of the PPP model. Over 350 private practitioners and small nursing homes in the area were drawn into the BMC's Dharavi strategy to contain the pandemic, in what is really a triangular *quid pro quo* arrangement, with NGOs as a third corner (Pal et al. 2020). BMC medical staff, with the assistance of local community organisers and NGOs went from house-to-house, seeking those with infection, urging them to isolate those who tested positive. Local schools and a public nature park were utilised to create isolation centres (see Golechha 2020; Pal et al. 2020; Sengupta et al. 2021; Ahlback et al. 2020; Yadavar 2020; Chakraborty 2021). The Dharavi model has been hailed as a success even by the World Health Organisation (WHO).

The importance of Dharavi as a focus of attention cannot be minimised, especially given that it is a tightly packed revenue-earning area where thousands labour. Its population is almost entirely of migrants, old and new. Dharavi is not just a residential slum, but is a centre of commerce with a dense collection of small and

household industries. Tiny shanties rub shoulders with leather, textile, artefact, food, flower, glass micro industries, workshops, and sweatshops. It's also home to an INR 26 billion (USD 650 million) recycling spread (Kostigen 2007).

The Dharavi strategy could well form the core of a public health plan for the City's slums in future as a reformed PPP model. Whether it can be a model for tackling major outbreaks in other cities is a moot question.

The post liberalisation state with its focus on rapid corporate investment-driven infrastructure development and forging global linkages cannot entirely shelve its welfare responsibilities. A proactive civil society offers a platform for taking on some of these state services. It therefore constructs solutions that integrate civil society – its NGOs, research institutions, and networks – to discharge its welfare responsibilities and by integrating and legitimising citizen involvement at the level of structures and processes. This also provides space and opportunity for civil society to extract concessions and play an overarching role in ensuring welfare. Arguably this concessional space can be leveraged to further enhance interaction with the state and influence policy from within. At worst, it allows for a civil society oversight of healthcare actions, even if it is without teeth. The state too gains a foothold within civil society structures and cultures that may allow it to soften popular resistance. Whether these concessions become meaningful and even challenge the larger agenda of the state depends on how determinedly and concertedly civil society can act. To some extent 'engaged citizen action' (see Chandoke 2007) in Mumbai has been successful in rendering the state accountable.

### By way of a discussion

We set out to examine the nature of health services in Mumbai since 1990s, in the context of a liberalising economy, a rapidly widening socio-economic gap, an aggressive capital, and a civil society struggling to intervene and extract the maximum from an avaricious government. There is no doubt that affordable medical care has gradually shrunk in Mumbai/Bombay. The resources of a rich city government have been disproportionately invested in infrastructure and commercial developments facilitating and encouraging private investment. The city government is the richest in the country and has an annual budget as large as some of the smaller Indian states and yet has little to spare either for maintaining existing services or as capital investment for expanding healthcare infrastructure. Private healthcare infrastructure in Mumbai largely comprises charitable hospitals that function like corporate hospitals with high charges for care. However, the redeeming feature is that these hospitals are mandated to reserve a proportion of their beds for the poor.

The city government has attempted to involve the private sector in various ways in its services, offering public-private partnerships which in reality have ended up with the public facility being privatised. There is a multilayered and long-standing community resistance on the issue of public-private partnerships. Mumbai has seen several attempts by the BMC to involve the private sector in public healthcare at various points using a PPP model that have mostly failed.<sup>13</sup> A case in point is the

SevenHills Hospital, inaugurated as a PPP project in 2010 but wrested back by the BMC in a legal battle in 2019 on the urging of a vigilant civil society.<sup>14</sup> The hospital, now equipped and functional under the BMC played a stellar role in the COVID-19 pandemic. The Dharavi model was loosely based on the PPP model in which the private sector was persuaded to render services in return for gains in other areas.<sup>15</sup>

By 2011 the state was increasingly shifting from being the major provider of services to financier for a minority of the poor for a selected and very limited set of needs (Udas-Mankikar 2021, 9). This shift, however, has come under scrutiny and challenge by citizen's groups. The continuing tension between BMC and civil society organisations regarding the user fees issue is another instance of how the state forays into making public health systems pay for themselves at the cost of public affordability. In the early years after the introduction of health sector reforms prescribed by The World Bank, user fee was introduced to "recover costs." However, several research studies conducted by non-governmental organisations showed that while the collection of user fee went up, its intended use to provide care for the indigent did not happen. This led to better systems for the flow of funds towards indigent care (GoI 2003).

In its attempt to align itself with the perceived needs of people while also acquiring the veneer of a progressive government, the city government has ventured to work with the voluntary sector on what it considers "soft" areas. One such area is women's welfare, beyond merely providing maternity-related care. The BMC's willingness to accept a proposal by CEHAT in 2000 to set up a centre within a municipal hospital offering services to survivors of domestic violence is one such instance. CEHAT's proposal was a multilayered approach, a major part of which was the gender sensitisation of the entire staff of the municipal hospital on gender issues, surrounding domestic and sexual violence. The hospitals even went on to replace archaic medico-legal practices in rape examination to gender sensitive care for rape survivors. While BMC hospitals accepted these changes, the directorate of state health services refused to replace old medico-legal practices with gender sensitised ones in their hospitals. It took legal intervention at the level of Bombay high court and subsequently at the Supreme Court for the Maharashtra state health department to finally accept the medico-legal protocols for rape care.<sup>16</sup>

The Dilaasa centres were later recognised by the WHO as a sustainable health system model to respond to domestic violence in Lower Middle Income (LMI) countries in 2013. The BMC willingly accepted the WHO recommendation of setting up of Dilaasa modelled centres at all public hospitals. In Mumbai we see civil society not only inserting itself in the city's plans and projects, but enticing it into making radical change in areas that are only now being accepted as a healthcare concern. In a roundabout way, the state seeks to legitimise its alignment with private capital on welfare by seeking civil society approval by participating in projects that are people's priorities.

The city government's willingness to create legitimate space for civil society within the parameters of governance is another sign of a liberalising state attempting

to soften civil society challenges even before it appears. Mumbai's Advanced Locality Management (ALM) programme was launched as a response to a local area group's innovative experiment in managing environmental issues. While ALMs have no real teeth, they have been functioning as a liaison between citizens and the local wards quite successfully, preempting spontaneous citizens actions.<sup>17</sup>

To what extent should civil society involve itself in the state's programmes? Will not such immersion, allow for a cooption of the community by the state for its own purpose? In fact, newer modes of association with the state might raise difficult issues, as, for instance, when a voluntary sector group takes over government services in a public hospital, with funding and support from hegemonic groups including private capital via the corporate social responsibility (CSR) route. On the face of it, this kind of voluntary sector involvement appears to be simply a vehicle for private capital to find an entry into the state's services and for the state to shelve its responsibilities. Such arrangements raise piquant issues that are beyond the scope of this chapter.

Tens of thousands of people are driven into this metropolis in desperate search for livelihoods that the city continues to offer at the best and worst of times. Making their way through one-room tenements, and shanty towns they become *Mumbaikars* accepting the precarious life on offer. Adding in no small measure to the precarity of life are the poor availability of affordable health services. The unravelling of public services during the COVID-19 pandemic serves to illustrate this scenario well. When quality healthcare becomes a commodity, it sets in place a downward spiral from ill health leading to debt that destroys all the gains of incomes and employment and ends in social and economic quagmire. The long-term outcome of this is beginning to appear, affecting as it does the economic life of the city curtailing its future growth. Without the backbone of a robust public health service, even the most prosperous of cities can collapse in times of a crisis (Bisht, Saharia, and Sarma 2020).

The COVID-19 pandemic disturbed the longstanding, even if constantly in flux, balance of forces among the state, capital and commerce, and civil society. A city government that was forced to shut down economic activity so abruptly, sending home thousands of those who oil the wheels of commerce because it could not provide protection or care during the pandemic, is not a persuasive argument for welfare capitalism. And yet, with the inherent resilience of the capitalist state, the city government did two things typical of neoliberalism: it suspended temporarily the operation of private capital in medical and healthcare, albeit with the unspoken promise of future recompense; and second, it coopted civil society and community networks even as it ostensibly gave in to the longstanding demands of civil society for participation in government.

The bearish economic projections for the near future do not augur well for a sustained hike in welfare spending in the city budget. However, the COVID-19 experience has emphatically underlined both the urgency of shoring up public health services and the imperative of working with civil society. Healthcare is becoming a highly sought-after capital investment destination and its consolidation in this sector

appears inevitable. Will the city assert its social welfare responsibilities and carve out a bigger role for itself in this expansion, with the help of civil society support?

We see in Mumbai the way the state seeks to align itself with the aspirations of subordinate groups and yet benefit from this coalescence. Also evident to some extent is “intentional and engaged citizens action” to monitor state power. The healthcare story in Mumbai healthcare story underlines the continuing importance of a dynamic and resilient civil society, especially in urban centres where the concentration of capital, a compliant neoliberal state, and informalising labour operate in uneasy equilibrium.

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## Notes

- 1 Context may mean a number of things (Ramani, Sivakami, and Gilson 2019) and may include the factors beyond the sector as for instance, political, cultural and structural and situational; it may also be interpreted as a set of factors that make for the implementation of policy, that go beyond policy; may also be at macro and micro levels of the health system. In this chapter, context mostly refers to the first, locating the micro and macro levels of the health system.
- 2 See SATHI’s community monitoring projects supported by the state government (SATHI 2009).
- 3 JSA launched a nationwide campaign in collaboration with the National Human Rights Commission (NHRC) comprising of several local, state, and national public hearings to record concerns of people at large about access to health services. These were consistent efforts to democratise public health services. CBMP is an example of how health and social movements have ensured peoples participation in demanding state accountability in delivery of health services. In Maharashtra, SATHI, a Pune based NGO spearheads the effort in that region.
- 4 Curiously, Maharashtra is home to 15.6% of all allopathic doctors in the country, but this translates to just five doctors to 100,000 population. The concentration of nurses in the state is at 7.02% which is on the lower end and the stock density of nurses is 10.1 (Figures as per National Health Workers Accounts which varies from the NSSO data).
- 5 Findings of the 71<sup>st</sup> National Sample survey on health in India instruct that access to health care measured in terms of hospitalisation and PAP (what is PAP) was higher for women than men, out of pocket expenditure for women was lower than for men.
- 6 Dilaasa centres have been set up in collaboration with Centre for Enquiry into Health and Allied Themes (CEHAT) an NGO working in health, in all municipal hospitals to attend to cases of domestic violence.
- 7 There are several forms of PPPs, but essentially there are those that are obviously profit-oriented and their success in providing care depends on the efficacy of the state entity in supervising it; the other is one in which the NGO plays a significant and lead role in its design and operation.
- 8 For instance, the Kokilaben Dhirubhai Ambani Hospital and Sushrut Hospital are built on land leased to them by the Mumbai Collector at a concessional rent of INR 1 per year.

- 9 See. <https://www.hindustantimes.com/mumbai-news/charitable-hospitals-in-mumbai-treated-only-4-56-lakh-poor-patients-in-11-years/story-EG5qWVW7iND8XC07L8Bm2O.html>
- 10 In May 2020, for example, a news report citing Charity Commission data put the unoccupied free beds at 1,540 ~89% (Barnagarwala 2020).
- 11 The state set up an online system to monitor the concessional admissions and appointed aarogya sevakas who were designated to ensure that hospitals delivered the obligated free or concessional treatment. Although this drew resistance from the Association of Hospitals, a body of private hospitals, the initiatives were not withdrawn. In 2018 responding to several complaints by patients and civil society organisations that the ambience of many of the 'charitable' hospitals misled the poor into believing that they were purely 'for-profit' hospitals, the state charity commissioner issued a notification stating, "It is difficult for patients to know if the hospital is charitable in the absence of the word. Therefore, mentioning the word 'charitable' is mandatory so that poor patients can avail of free or concessional treatment they rightfully deserve." (<https://mumbaiirror.indiatimes.com/mumbai/other/word-charitable-must-for-charity-hospitals/articleshow/65156962.cms>)
- 12 A seventh of the 24 hospitals reviewed in the Eastern zone of the city were functioning in sheds or lofts in slums; very few had continuous water supply; only 40% adhered to the space requirements recommended by BMC; only seven had operating theatres and many doubled as labour rooms; of those offering maternity services, few had supportive equipment or services such as resuscitation sets, blood banks, etc. (Nandraj 1994).
- 13 In 2004, under an agreement, around 20 BMC land plots were handed over to private parties at a nominal rent of INR 1 per square foot to build and run maternity homes in return of beds. In 2014 a committee set up on directives from the Mumbai high court found that only five PPP institutions were operating as per terms and these were running multispecialty hospitals with no beds reserved for the poor.
- 14 The SevenHills hospital was inaugurated in 2010 with 300 functional beds, with the private party agreeing to add another 300. Even by 2017, no more beds had been added and worse, the hospital had a massive debt of 200 million USD and filed for bankruptcy in 2018.
- 15 See interview with The *Print*, Municipal Commissioner Chahal.
- 16 Personal narrative, Sangeeta Rege who was directly and continuously involved with this initiative.
- 17 In fact, citizen participation is now a criterion for ranking municipalities in the Swachh Bharat Mission. The Advanced Locality Management groups were formed with the intention of involving local citizens in maintaining cleanliness and undertaking waste management, taking off from an experiment in community involvement. There are 1000 registered ALMs in the city. A 2005 study found that most active in one way or another, although not on health issues yet. However, attempts to legislate institutionalization of direct citizen participation in governance and administration via the Nagar Raj Bill has met with stiff resistance not just from ruling parties but all others (Diwan 2021).

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