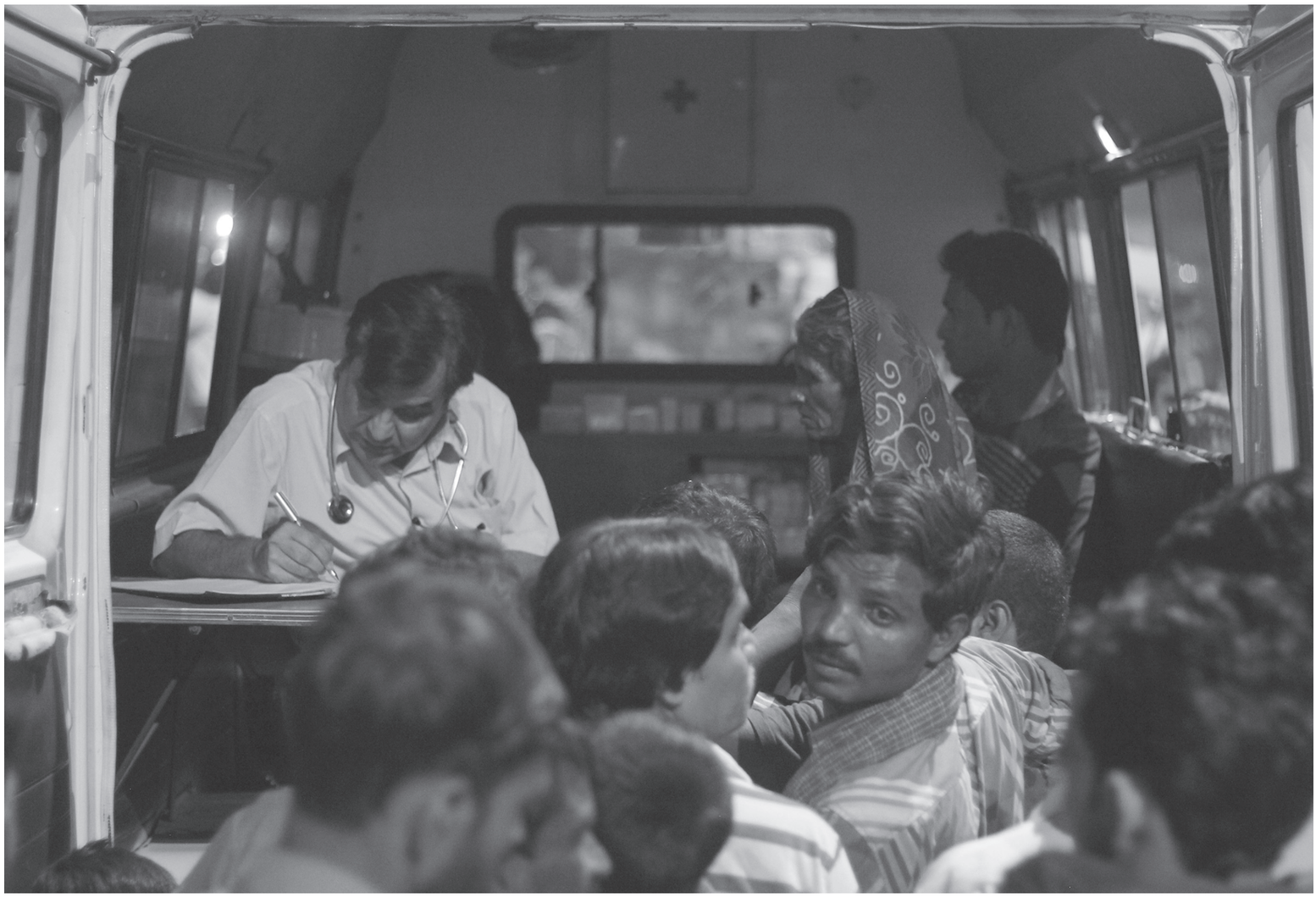

Photo courtesy: Atish Patel

‘Who cares?’

Urban Health Care and Exclusion

Devaki Nambiar, Prathibha Ganesan and Adita Rao[*]

Girish Motwani, Radhika Alkazi, Ganapathy Murugan, T Sundararaman and Dipa Sinha[**]

In 2015, Delhi experienced possibly the worst dengue outbreak the national capital had seen in the last 20 years—the official count reaching 14,889 cases, and 32 official deaths (44 unofficial) as of November 2015.[1] The heartbreaking deaths of young children in Delhi—and in one case, the double suicide of parents refusing to survive their neglected seven-year-old—trained the spotlight on the gross deficiencies of the health system: the shortage of beds, doctors, blood banks, and medicines in both the public and private sectors.[2] In response, the state government sprung into action, launching a 24-hour helpline to provide all relevant information about dengue and awareness campaigns through TV and radio advertisements.[3] The standard control measure of fumigation,belated and controversial,[4] was redoubled.[5] A number of beds were made available for treatment across hospitals[6] and limits set on prices for various tests.[7] News reports dubbed dengue the great leveller, an ‘equal opportunity’ infection that did not spare Delhi’s better-off.[8]

Such a claim is hard to substantiate. For the 32 official dengue deaths in Delhi from August through October of 2015, there were close to 500 deaths of homeless persons in just August and September.[9] Although it is not clear what proportion of these are attributable to dengue, many likely are, seeing as a large number of homeless persons interact with garbage on a daily basis (either for a living or to subsist) and have no choice but to sleep near stagnant pools of water, both risk factors for infection. Dengue is far from being a leveller for this population, for whom the deadliest month was June of 2015, when the toll crossed 3,500 in the capital city, according to a study published earlier in 2015.[10] As a pavement dweller from Eastern Delhi, Chajju Ram, conveyed to a reporter this fall: ‘At a time when the city is facing a dengue crisis, we are still living under the open sky. But who cares?’[11]

This question, about caring, is the heart of the matter in this chapter.

What is Urban Health Care?

As the dengue example amply demonstrates, there is a lack of both care and caring when it comes to health in Indian cities. Health, a state of well-being, is the embodiment of myriad factors: food and nutrition, water and sanitation, education, employment and social security, shaped by societal

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* Lead authors

** Contributing authors

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determinants. Conversely, as made plain in the People's Health Charter of 2000, 'Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people.'[12] Health is critically shaped also by health care, defined as 'a) appropriate infrastructure in the form of primary health centres with attendant basic facilities; b) skilled human resources like medical professionals and other health care and paramedical staff rendering required range of services; c) medicines and supplies which are basic and essential; d) emergency medical care; e) patient information, redressal and f) monitoring and professional accountability.'[13] Health care involves the provision of services—promotive, preventive,curative and rehabilitative—that may be delivered at the individual level (e.g., treatment for a disease) or to populations (e.g., screening for an illness) in communities, through specialised health facilities and other outlets (like pharmacies) and involve a complex mix of providers that may operate in the public and/or private sectors, for profit and not-for-profit, are formally accredited or informal, professional or non-professional, allopathic or from other systems and praxes of medicine, remunerated or voluntary.[14]

Health care, where we place our emphasis in this chapter, is necessary but not adequate for the health of populations. Yet, it is a critical starting point for the achievement of health equity,[15] which as per WHO is defined as 'the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically; thus, health inequities involve more than inequality—whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health—but also a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair.'[16]As Beauchamp (1976) indicates,

> The critical barrier to dramatic reductions in death and disability is a social ethic that unfairly protects the most numerous or the most powerful from the burdens of prevention…This is the issue of justice…Under social justice all persons are entitled equally to key ends such as health protection or minimum standards of income. Further, unless collective burdens are accepted, powerful forces of environment, heredity or social structure will preclude a fair distribution of these ends. While many forces influenced the development of public health, the historic dream of public health that preventable death and disability ought to be minimized is a dream of social justice.'[17],[18]

Thirty-two years later, the WHO Commission on Social Determinants of Health put it quite simply: 'social injustice is killing people on a grand scale.'[19] Health and health care are therefore a matter of redressing and averting the very embodiment of injustice.

Urban health care

According to the latest 2011 Indian Census, an urban area is defined as either all places with a municipality, corporation, cantonment board or notified town area committee, etc. or all other places which satisfied the following criteria: (i) a minimum population of 5,000; (ii) at least 75 per cent of the male main working population engaged in non-agricultural pursuits; and (iii) a density of population of at least 400 persons per sq km (these are just moderate deviations from prior definitions employed up till 1991).[20]

For the purposes of this chapter, urban health care is defined as affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative)—including all the infrastructure, human resources, supplies and diagnostics, provisions for emergencies, patient information/ redressal, and monitoring and accountability—for all populations living in areas defined by the 2011 Census as urban. There is a strong legal

and moral precedent for health care as a human right that the Indian state has the duty to respect, protect and fulfil. [21,22,23,24]

Why is urban health care a public good?

Health care, while it can be purchased on the market, can be argued in many ways to constitute a non-excludable and non-rivalrous public good. Take for example tuberculosis. No doubt those who can afford and access care have earlier chances of being diagnosed and treated, which in turn reduces the risk of everyone in the population getting this disease. The mechanism here is herd immunity, defined as an immunological benefit accruing to those who are not direct beneficiaries of a service.[25]

Many global health challenges and their solutions have the properties of global public goods. Aspects of health care as a global public good can be categorised into three broad areas: knowledge and technologies; policy and regulation; and health systems.[26] First, knowledge and technologies, particularly for vaccines and pharmaceuticals, may be commodified as private goods, but need to be clubbed with public infrastructure to ensure access. Second, policy and regulatory regimes in health (e.g., monitoring quality of care in facilities) are also public goods that apply to large populations. Health systems themselves are public goods that need to function effectively in order to ensure the wellness of populations.

Given its epidemiological dimensions mentioned earlier, health care is more accurately defined as a merit good.* A merit good is one whose consumption benefits us individually and the society as a whole, even as individuals and groups in society may not avail of health services of their own accord.[27] The state, then, in its paternalistic role, has the responsibility of paying for such goods. A typical example of this in the health sector is vaccination. While all may not want to get vaccination, the societal benefits of vaccination are such that most governments, including India's, offer them for free.

Another argument, building on a critique of the notion of 'goods', includes health along with protection, food, shelter, and basic resources that are seen together as 'commons', or that which we all share as human beings.[28] The view taken here is that exclusion from health is not an issue of the poor; rather, it is an issue demanding the solidarity and participation of all. As the Fourth Global Health Watch says,

> As neoliberalism has focussed exclusively on competition and flexibility, it has destroyed social relations and communities. This means that not only do individuals have to be protected, but so do societies. This collective dimension is particularly important when poverty is seen not as an individual problem of poor people, but rather as a social relationship. It can never be eradicated if the whole of society is not involved. This demands solidarity and the participation of all.[29]

The role of the state

Governance of population health in urban areas necessarily must fall within the purview of the state, both in the acute sense of providing emergency or ongoing care during ill-health and in the sense of creating an enabling environment for well-being. The arguments for this are many—legal, moral, and economic.

The Directive Principles of State Policy of the Indian Constitution explicitly state that the government is responsible for the determinants of citizens' health, including health care.[30,31]Following the 73rd and 74th Constitutional Amendment Acts

* We are grateful to DrIndranil Mukkhopadhyay for pointing this out.

Box A. Public Health Services in India: A Historical Snapshot

Independent India's first planning exercise was prefigured around health. Led by Sir Joseph Bhore, the Health Survey and Development Committee (1943) sought to expand the narrow, urban, elite-centric scope of health service delivery to the scale of an independent nation. In the years following, countries across the world set about establishing or expanding health systems using principles of welfare and the broad-based WHO definition of health . In India, at a systems level, growing emphasis on family planning and population control in the late 1960s began to deflect attention away from health, particularly among the vulnerable, while international donor aid for vertical, technology-driven disease control programmes further compartmentalised health into packages and pockets of care.

Internationally, however, the 1960s and 1970s were a watershed in the understanding of the limits to modern biomedical care and its approach. The landmark 1978 Alma Ata Declaration's definition of health was reinforced by subsequent high-level policy processes in Europe, , and most recently in the WHO Commission on Social Determinants of Health in 2008. In practice, however, various interests were setting a course away from this vision even as the ink was drying on the Alma Ata Declaration; the world seems to have only moved farther and farther away from this public vision of health.

The years following Alma Ata saw a debt repayment crisis, and concern moved from the provision of public services in individual countries to salvaging the international banking system (dominated by First World countries). This move was reinforced by Structural Adjustment Policies introduced the world over, and in India in the early 1990s. The terms of these policies included sharp cuts in public spending on education and health, removal of subsidies and lifting of price controls on food products (thus impacting nutrition) among others. Acquiescing to these terms, India reduced its allocation to health services by 20 per cent between 1992 and 1993. The groundwork laid at this time—part of the neoliberal Washington Consensus promoted the world over, has mostly endured: support for the private sector has shot up in the health sector in India; underfunding in the public sector such that it can no longer afford, adequately purchase or provide care—shifting this burden to the citizen, and the creation of a division between efficiency and equity (in a fiscal situation where the public sector would be guaranteed to under-perform).

The 1990s onwards marked a significant shift in the role played by the state in terms of its responsibilities to its citizens, and its positionality vis-à-vis the private sector, even in the design of ostensibly 'pro-poor' welfare. The mere fact of introducing reforms in 'mission' and 'scheme' mode (i.e., time-bound and therefore ever tenuous), introducing 'architectural corrections' to the system using ad hoc modes such as contracted labour, targeted programming, as well as demand-side and performance-based incentives are indicative of this shift. Such approaches are necessarily precarious in terms of financing. At the same time, there has been encouragement of Indian Foreign Direct Investment—Indian corporate hospitals franchising care across a host of other countries, thereby adding to their revenue, the amount of their capital and by extension, influence . As Bisht and colleagues have pointed out, the shift has occurred among these corporations from service delivery to medical education, consultancy, clinical research and other areas, allowing them wider and growing influence on the health sector in India overall. While public expenditure on health has stagnated since 2011, the private health care industry has burgeoned at a 15 per cent compounded annual growth rate—more than double that of all other services.

of 1992, Article 243G of the Eleventh Schedule and Article 243W of the Twelfth Schedule provides for municipalities to be endowed, by states, with powers to promote public health.[32,33] They have the mandate, therefore, to establish or maintain dispensaries, expand services, abate dangerous trades and practices, supply water, administer vaccinations, and dispose of waste, harmful substances, and control outbreaks.[34] A tall list of legislations concerned largely with regulation also place the state squarely in the role of steward of the health care system (these range from the Drugs and Cosmetics Act of 1940 to the Clinical Establishments Act of 2010).

Emphasising the public nature of health, whether we choose to call it a merit good or otherwise, is very important. It could be that for most commodities and services, the market forces of supply and demand would act simultaneously to bring some degree of control unless there is a clear monopoly. In health care, given the high degrees of information asymmetry, even where there is no monopoly, providers can price services on the principle of 'whatever the market can bear'. This is referred to, by Beauchamp, as market-justice wherein 'while society does prohibit individuals from causing direct harm to others, and has in many instances regulated clear public health hazards, the norm of market justice is still dominant and the primary duty to avert disease and injury still rests with the individual.'[35]

With increasing (uneven) urbanisation, urban poverty is becoming starkly visible. The peculiar features of urban areas have yet to be comprehensively considered in the design of urban programmes and schemes. It is more common for programmes to be replications of rural schemes. There is thus a situation where on the one hand, the urban is the site of growing populations of the vulnerable and also of dwindling provision of public services for all, including the excluded.

In India, the emphasis, that too, scant, of public provisioning by the state has been in rural areas, combined with a massive retreat from public provisioning of care in urban areas. This is further shaped by a most dramatic underfunding of health since the period of Economic Liberalisation from 1991 onwards, whereupon allocations to health were reduced drastically, and incentives for privatisation of health service provisioning were ratcheted up.[36] This paradoxical tendency of the state to eschew responsibility for providing health, and deregulate private provisioning has had results that are literally embodied in the ill health of urban populations.

Exclusions from Urban Health Care

Exclusion from public goods is dynamic and operates across multiple levels in the public and private spheres.[49,50] The relative position of an individual or group often narrows down to whether or not the person or persons are marginalised as a result of social, economic, political and community-level factors, which as Oommen argues, 'could be partial or complete'.[51] The partially excluded are recognised by the state, and benefit from policies and reform measures, while the totally excluded are invisible to, criminalised or otherwise denigrated by the state. While we recognise all these forms of exclusion to be deeply intertwined, our emphasis here is on exclusion where state intervention is desirable. In either case, the meaning and experience of social exclusion is necessarily relative,[52] and painfully more pronounced in urban areas: the most affluent neighbourhoods look over the most blighted; enclaves of prosperity, commerce and creativity abut ghettoes of poverty, exclusion and ostracism.

The most common and recalcitrant feature of urban exclusion in the context of health, is poverty. While agricultural labour is the primary occupation for a majority of the rural poor, the urban poor tend towards another extreme—falling into a

breathtakingly wide range of economic activities, often multiple, and mostly informal in nature.[53,54] This both reflects and perpetuates an altogether different set of conditions, capacities, and destinies for the urban poor, which the Planning Commission sought to understand in 2010. It constituted an expert group under the chairmanship of Prof S.R. Hashim to develop a methodology to understand urban poverty. The Hashim Committee Report, submitted in 2012, indicated three types of vulnerability that typify urban poverty: residential, social and occupational vulnerability.[55] Between 2013–14, this framework was used to understand the depth of exclusion by the Technical Resource Group (TRG)* supporting the newly launched National Urban Health Mission (NUHM), to understand urban vulnerability in relation to health. Notwithstanding its possible limitations, we apply this framework in our analysis.

Residential vulnerability arises in the absence of adequate shelter; this includes the lack of housing, precarious and illegal housing. The Hashim Committee report states,

> Swelling populations, fragile and insecure incomes and a legal and regulatory regime that is extremely hostile to the urban poor, combine to exclude poor people from safer, higher value sites in the city. Instead, they are crowded in precarious or illegal locations, such as open drains, low-lying areas, the banks of effluent tanks, the vicinity of garbage dumps, open pavements and streets….[56]

Urban centres exhibit distinct forms of settlements based on income and social categories. The urban poor settle mostly in slums or unplanned colonies that often go unrecognised by urban administration, posing a threat of eviction. These areas are typically located near waste dumps or treatment plants, having poor infrastructure, lacking space and provisions, thus having problematic access to drinking water and toilets, and increasing exposure to various forms of pollution. The National Sample Survey Office (NSSO) in its report on Key Indicators of Slums in India (2012) reports the poor conditions of living in urban slums.[57] In this survey, over a third of slum settlements had no electricity, while close to a third had no access to tap water, latrine facilities, drainage facilities, or garbage disposal arrangements. Only 23.9 per cent of the slums benefitted from any slum benefit scheme (such as the Jawaharlal Nehru National Urban Renewal Mission, Rajiv Gandhi AwasYojana, etc.). At the all-India level, out of an estimated total of 33,510 slums, 59 per cent were non-notified, accounting for almost 3.25 million slum households not officially recognised as slums by the government.[58]

In a highly cash-strained environment, some people have to live on pavements and streets to be able to save money for remittances.[59] Homelessness renders them more vulnerable to injuries, which often go untreated: a study in Delhi found that untreated injuries have resulted in lifelong disabilities, jeopardising the ability to work, further perpetuating homelessness.[60]

Social vulnerability is a result of exclusion of several groups on the basis of ascriptive or biological identities, impinging upon their livelihood, food and dignified living. Some of the socially vulnerable groups identified by the Hashim Committee are women, seniors without care, people with disabilities, the homeless, people living with leprosy, mental illness and AIDS, scheduled castes and tribes, children without adult care, street and working children, and children of destitute and stigmatised parents.[61] Generally speaking, urban women are more independent than their counterparts in rural areas; however, the extent of vulnerability they face

* Mr. Harsh Mander served as Chairperson of the Technical Resource Group of the National Urban Health Mission and Member of the Expert Group to Recommend the Detailed Methodology for Identification of Families Living Below the Poverty Line in Urban Areas (Hashim Committee).

varies with respect to other intersections of identity. This is to say, realities vary drastically, whether one is talking about elderly women, working women, slum dwellers, homeless women, women heading households, or single women.

Being socially vulnerable can serve as a deterrent to care. In Madurai, leprosy patients do not access public services fearing stigmatisation. This is all the more problematic for people with disabilities because their physical or mental restrictions are compounded by secondary health concerns. For example, children with cerebral palsy are at high risk of osteoporosis and fractures due to lack of medication, immobility and poor nutrition. Similarly, individuals with mental illnesses also have various co-morbidities with developmental disabilities.

Occupational vulnerability, stated by the Hashim Committee, comes about due to the 'fact that the large majority of the urban poor are trapped in low end jobs—insecure, low paid, low productivity with debilitating work conditions—mainly in the informal sector.'[62] Third party interventions in the job market based on commissions, lack of social protection at work, seasonal casual employment (like fishing) and so forth are major reasons for vulnerability. Some of the occupations falling under this category are noted to include 'daily wage workers, construction labour, petty traders, hawkers, street children, sex-workers, rikshaw puller[s], domestic workers, etc.'[63] Occupational vulnerability also arises due to health impacts and related illnesses from working in hazardous and exploitative work conditions, as was reported by almost all vulnerable groups during the work of the TRG of the NUHM. For example, heavy load workers experience severe spinal and back problems, while waste recyclers reported musculo-skeletal disorders, respiratory diseases and chronic fatigue. Vulnerabilities of work further stem from its seasonal nature. For example, the fisher folk community has a lean period when fishing is not allowed (3–4 months a year) at which point this community completely depends on state aid, which may or may not be offered in measure commensurate to need.

All these variations and combinations of vulnerabilities were studied at length in the work of the Techncial Resource Group of the National Urban Health Mission, convened by the Ministry of Health and Family Welfare of the Government of India. The NUHM-TRG carried out an extensive field-based policy recommendation appraisal of 31 Indian cities and towns and with over 40 different categories of the vulnerable, undertaken in 2013 by researchers, health officials and activists. It showed the stark and recalcitrant patterns affecting life and access to public services among the urban vulnerable, whose ailing health is the very embodiment of exclusion—at personal, community, institutional, and societal levels. We draw extensively on this experience for the India Exclusion Report placing emphasis on specific vulnerable groups that are being examined. These include women, Dalits, Adivasis, religious minorities (particularly Muslims), persons with disabilities, class-based disadvantaged groups (informal sector workers, migrants), and age-related disadvantaged groups (children and the aged). These populations face residential, social and occupational vulnerability in various combinations.

Women face vulnerability at an altogether different and more pronounced dimension in urban centres, placing them in the lowest stratum of society (economically and socially). All women work, whether in the home or outside it, performing both paid and unpaid labour. Their vulnerability stems from a lack of recognition of their work, under-payment, inequity in intra-household resource distribution, and the lack of power to claim equal resources in the family. In certain situations relating to health, vulnerability for women can be more pronounced in urban areas than in rural: sample survey data from 2014 show that while INR 40 more are spent, on average, for the treatment of rural females suffering from an ailment as compared to rural males, the relationship is inverse in urban

areas: at least INR 100 more are spent on average per ailing male as compared to an ailing female.[64]

The unequal nature of patriarchy comes into play also for women who are not in a typical family setting.[65] For example, single women, separated or widowed women, homeless women and women with mental disabilities, all face harsh and complex forms of vulnerability in the urban context for structural and societal reasons. Some women are trapped in spiralling vulnerability: escaping domestic violence, some may be cast into homelessness and penury, often supporting children through begging or other hazardous street-based work (including sex work, manual labour),[66] completely absent from the support structures of the state.[67] In Chennai, at a focus group discussion with nearly twenty homeless mentally ill women, all concurred that 'shelter from violence—verbal, physical, sexual—was the main recourse sought.' Estranged from families, these women lacked access to water, food, sanitation and saw no relevance of primary health care centres which in their experience were facilities only for pregnant women.[68]

Dalits: An important determinant of socio-economic inequities in spheres of well-being, is caste.[69] Landlessness leading to perpetual poverty and food insecurity motivates distress migration to cities, concentrating Dalits in slum areas. The 2011 slum Census reveals that 32 per cent of the slum population in Tamil Nadu and 39 per cent in Punjab is comprised of Dalits.[70] Nationwide, between 2001 and 2011, there has been a 37 per cent increase in the Dalit population within slums.[71] Three sets of challenges have been identified: 1) Dalit children face higher levels of mortality and malnutrition as compared to non-Dalits; 2) across age groups, Dalits suffer due to the low quality of health care they receive ; and 3) Dalits are forced to do hard labour for sub-standard amounts without any social security.[72] Typical occupations such as manual scavenging introduce vulnerability to an astonishing range of health issues, including poisoning, musculo-skeletal disorders, respiratory problems, leptospirosis, skin problems, etc.[73] Dalit populations tend to lack access to institutionalised care, suggested by the higher preponderance of home deliveries among Dalit families.[74]

Adivasis typically live in rural areas; their presence in urban areas is therefore usually because of desperation, often time-bound and cause-specific. For instance, the Narikkuravar community in Tamil Nadu comes to Madurai during the festival season to sell beads and ornaments near ThiruppuramKuntram Temple. Other tribal communities that migrate to the cities include those that are in search of casual labour, sometimes found in the most dangerous of occupations: Adivasi migrant workers in Gujarat routinely brave toxic exposure and death from Silicosis in the state's quartz crushing industry.[75] An ethnographic study found that 'whether for work on construction sites or stone quarries, for brick-making or digging cable trenches, the seasonal flow of Bhil casual labourers from upland villages has contributed directly to the physical expansion of the industrial growth poles in Gujarat such as Surat, Baroda and Ahmedabad.'[76] Officers in the labour department hold such migrants in contempt, thinking that the problems of Adivasis 'are of their own making, whose lack of care for their own welfare, ignorance and "bad habits" are embedded in their culture…they will not care to use (health) services...just go here and there.'[77]

Muslim minorities: Research suggests that both the resilience and the marginalisation of urban Muslims is not uniform across the country.[78] Analysis of the 2005–06 National Family Health Survey suggests that the reason that Muslims have a lower under-5 mortality rate as compared to Hindus (a feature earlier attributable to their greater urbanisation), is associated with maternal height, diet and son preference.[79] Yet, it is not consistently the case that greater access or uptake of resources is what accounts for this advantage.[80] Further, Muslim advantage is least visible in the East and Northeast,

where matriarchal societies prevail and the uptake of services is better overall in society (e.g., Assam and West Bengal).[81] Muslims have also been 'blamed' for the laggardly progress in eradicating polio in the country, accounting for about 16 per cent of the population and close to three-fourths of the cases. In a detailed study in Aligarh city, the vulnerability of Muslims to polio has been found to be the result of structural violence meted out as segregation following the Partition of India and Pakistan, differential development of Muslim areas, and lacunae of trust in the government apparatus, following several incidents involving the use of force.[82]

Other research suggests various cases and forms of deliberate marginalisation of Muslims from the social determinants of health, notably in the reach and provisions of the educational system,[83] housing,[84] and employment opportunities, as well as vulnerability to communal violence.[85,86] In recent years, a growing and occupationally expanding middle class of Muslims in urban India (from meat export, leather, Unani medicine to agribusiness, IT, pharmaceuticals and real estate) does not necessarily possess 'the capacity, or even the will, to contribute to the alleviation of their poorer coreligionists.'[87]

Persons with disabilities: In India, those living with loco-motor, blindness, low vision, hearing impairment, mental retardation, mental illness, leprosy cured, cerebral palsy, autism and multiple disabilities are legally acknowledged as persons with disabilities. An increasing trend of moving to urban areas among the population of people with disabilities in India (see Box B) has come to light in the comparison of Census data from 2001 and 2011. The percentage of persons with disability relative to the total population has increased from 2.13 to 2.21 respectively. The decadal growth percentage is significantly higher in urban areas (48.2 per cent) compared to rural areas (13.7 per cent).[88]

The largest groups of children and adults with disabilities lie in the category of loco-motor disability (20.3 per cent), followed by hearing impairment (18.9 per cent), and vision impairment (18.8 per cent). Children and persons with multiple disabilities constitute 7.8 per cent of the community. Further, though speech impairment is not an acknowledged disability as per the law, both the Census and the District Information System for Education (DISE) collect data on this impairment, which is the next largest group (7.5 per cent).[89]

The 2011 Census made a distinction between children and persons with mental retardation (5.6 per cent) and persons living with mental illness (2.7 per cent):[90] mental health issues are among India's most challenging.[91] Studies have also shown the higher burden even for caregivers of children with intellectual disabilities.[92]Although there are no studies, experience and discussions with families of children with disabilities living in the urban slums of Delhi suggest that they come seeking rehabilitation and access to education in urban areas, but as migrants, difficulties in establishing identity, barriers of language and navigating the city with a disability are added challenges. Even with a number of provisions existing for populations with disabilities including District and Regional Rehabilitation Centres, Institutes, Infromation Centres, and a National Policy all of which emphasise community-based rehabilitation, social exclusion is itself a major challenge faced by the persons with disabilities.[93]

Class-based disadvantage in occupational/ residential categories: The urban poor (the poor identified even with the crudest of stratifiers, such as income quintile) face a significant disadvantage compared to the average urban-dweller: Agarwal found that under-5 mortality (at 73 deaths per 1,000 live births) was almost double that in the poorest urban quintiles as compared to the remaining urban population (of 42 deaths per 1,000 live births).[96] In fact, data from the National Family Health Survey (2005–6) shows higher infant mortality, lower childhood vaccination, and comparable levels of anaemia among females when comparing the urban poor to the rural average.[97]

Box B. Spotlight on Disability and Exclusion

Apart from general healthcare needs resulting from poverty, living in difficult circumstances such as urban slums, children and persons with disabilities often have significant and multiple health care needs related to their impairments. Nearly 7 per cent of persons with disabilities belong to vulnerable social groups in the country. Census figures suggest that as of 2011, 2.45 per cent of the India's population with disabilities belongs to the Scheduled Castes while 2.05 per cent belongs to the Scheduled Tribes.

Urban areas are thought to have better facilities for most people, which in turn shapes health outcomes.

Parents of children with disabilities tend to seek information and rehabilitation of their child's condition at urban health facilities, but as is commonly assumed, the relative abundance of services in urban areas do not translate into better health care. For one, children and persons with disabilities face huge barriers in physical mobility as urban slums leave options such as the wheelchair totally unusable. Added to this, transport options in urban areas are inadequately accessible, leaving many children and persons with disabilities vulnerable in seeking adequate healthcare. Access may not always be assured even in clinical facilities, apart from which, patients and their carersare often pushed out due to the lack of knowledge in how to navigate and access their needs in facilities. Finally, disabled children and persons face vulnerability to violence and abuse when seeking all manner of services and entitlements. A 2014 study in Bangalore echoes many of these experiences, finding that communication barriers, lack of resources and back-up services hamper physicians while parents are challenged by financial constraints, stigma and beliefs related to disability.

Many women and girls with disabilities experience 'double discrimination', i.e., additional barriers in accessing health care services, particularly pertaining to reproductive health, or experiencing good health. Men with disabilities are also expected to experience additional barriers to good health.At present, Indian policies and programming have not begun moving away from impairment-based thinking to a more holistic and culturally competent understanding of disability.

Overlapping with the aforementioned categories of women, Dalits, Adivasis, Muslim minorities, the disabled, and those with class disadvantage are occupational and residential categories that policy documents have defined as being uniquely vulnerable in the urban context.[98] We discuss these briefly.

Construction workers: The construction industry accounts for nearly 44 per cent of urban unorganised workers, comprising more unskilled thanskilled labour.[99] Most construction workers are migrant labourers who move to different locations frequently. Construction workers form the floating labour force and are disadvantaged with respect to housing and often end up in rough shelters devoid of amenities like water, sanitation and electricity. Since the agricultural sector is declining and is unable to absorb the labour, tribal and other marginalised rural labourers turn to booming construction sites in large cities and towns.[100] A Self Employed Women's Association study on women workers in the construction industry of Gujarat notes that the problems shared by construction workers include lack of job security, accidents, lack of insurance coverage and loss of pay during periods of disability.[101] Alcohol abuse is rampant and 'construction workers are exposed to multiple physical, chemical and

biological agents, which make them vulnerable to various health problems that include injuries, respiratory problems, dermatitis, musculoskeletal disorders and gastrointestinal diseases. The work is hard physical labour, often under difficult conditions like adverse weather conditions and the nature of work, hours of work, low pay, and poor living conditions with lack of basic amenities and separation from family, lack of job security and lack of access to occupational health services make the situation worse.'[102] Moreover, the lack of supportive social networks among workers causes dependence on contractors, at whose hands they may additionally faceexploitation.[103] A Labour Bureau studyfound that employers violate a range of laws, including employing children and manipulating attendance to abjure fines, penalties and other obligations.[104]

Rickshaw pullers mainly come from poor socio-economic backgrounds, and have relatively lower educational attainment.[105] A small study in Delhi found that about 45 per cent of rickshaw pullers interviewed were illiterate, and another 40 per cent had gone no further than the 8th standard—a trend that likely holds across urban settings (although this population is relatively understudied).[106] Apart from extractive and exploitative relationships with rickshaw owners, the working hours for these workers are long, subjecting them to exposures to extreme weather conditions (heat in the summer and cold in the winter),[107] exacerbated by a common preference among indebted rickshaw pullers to live on sidewalks to save money on rent. Risks of developing heart ailments is reportedly high among rickshaw pullers as their heart rate does not reach a resting level following the 10 minutes of recovery period after pulling.[108] Studies have in fact also found DNA damage attributable to exposure to air pollutants and physical exertion by rickshaw pullers, a phenomenon only likely to exacerbate as pollution levels surge higher in Indian cities.[109] The TRG team in Agra learned of a range of morbidities, including malnutrition, drug abuse, and intense musculo-skeletal strain. Most rickshaw pullers avoided visiting health care facilities unless it is an emergency to avoid costs of both time and money. Their continuous mobility during the day keeps them away from primary health care facilities; instead, as we learned in Delhi, rickshaw pullers rely on rickshaw owners for their care, typically only in cases of accidents and injuries. Chronic health issues are therefore typically ignored, unless they interfere with labour.

Sex workers: It is estimated that India has close to 2 million sex workers, a large proportion of whom operate in urban areas. Sex workers in urban areas are usually dependent on intermediaries like pimps and 'madams', which compounds the stigmatisation of sex workers in society at large.[110] Violence against female sex workers by intimate partners or others in the workplace has also been reported.[111] A recent pan-India survey of sex workers found that they negotiate a range of other occupations in addition to sex work, often staying in this profession because of its liquidity relative to other informal work options, which are fairly narrow given that most in the profession have low levels of education.[112] In terms of health, research has focused on the sexual risks faced by sex workers: a meta-analysis has found that the odds of a woman of reproductive age who is a sex worker having HIV is 54.27 times that of any other woman in the same category not engaging in sex work.[113] Furthermore, studies demonstrate that access to basic health care (including in areas that the workers themselves prioritise: access to contraception, protection from violence and care for sexually transmitted diseases) is a major problem for sex workers because facilities are either lacking around red-light areas or under-equipped by way of drugs and facilities.[114] In addition, stigma serves as a major barrier for the effective dissemination of community interventions for the empowerment of sex workers.[115]

Children face many forms of exclusion in urban settings. A child's vulnerability is often due to factors that hinder the normal growth and functioning

of a child. This is further compounded by factors like homelessness, illegal status, disabilities, lack of social protection, and risk behaviours.[116] Some of the most vulnerable children include those in urban slums, those whose parents are migrant workers and street children. In a focus-group discussion conducted with homeless women with children in New Delhi, we learned that when carers/parents themselves are frequently ill, this affects their ability to provide and care for their children. We have found that children in urban areas face a variety of risks detrimental to their health; in almost all cases, they are socially vulnerable (so that is a given), but in some instances, also subject to additional residential and occupational vulnerabilities, which we outline briefly.

Slum children: According to the Ministry of Housing and Urban Poverty Alleviation, about 7.6 million children within the 0–6 year age group live in slums, representing roughly one in 10 children in Indian cities with slums.[117] A recent figure revises the number to over 8 million, residing in some 49,000 slums across the country.[118] The prevalence of underweight among under-5 children reported in urban slums in India is reportedly 52 per cent to 68 per cent, with Delhi peaking at 82 per cent.[119] A recent report finds that among children under the age of 10, urban children are 20 per cent more likely to be unwell as compared to their rural counterparts.[120] Slum children are heavily affected by the physical and social environment which in turn leads to school dropout and low educational status,[121] and a host of adverse nutritional, reproductive and mental health conditions.[122,123,124]

Street children: There are nearly 71 million street children in India. [125] It is estimated that 72 per cent of the street children are aged 6 to 12 years and 13 per cent are below 6 years of age, with typically boys outnumbering girls.[126] These children live in varying forms of precarity; UNICEF has categorised street children into three broad categories based on the place of living and their association with their families: 1) Street-living children (those who sleep in streets without their families); 2) Street-working children (those who work on the streets during day and return home at night); and 3) Children from street families (those who live with their families on the street).[127] Most children residing on the streets of Delhi according to a recent study were from Dalit backgrounds.[128] Whether with or without families, most street children engage in self-employment activities like rag picking, begging, and street vending. Some of them are also employed in hotels as porters, for example. These children are deprived of sufficient nutrition, sanitation facilities, drinking water and medical care, and are exposed to extreme climatic conditions. Outbreaks of measles, tuberculosis and other vaccine-preventable diseases are frequent. Street children are deprived of basic needs such as shelter, nutrition, medical care, education, recreation, and immunisation, and they have no access to water, bathing facilities or toilets (most of the time, these have to be paid for). Scabies, chronic dysentery, lung, ear, nose and throat infections are common, as are anemia and malnourishment.[129] In our primary fieldwork, we noted many instances of children suffering and dying from illnesses like pneumonia, diarrhoea, and simple hunger. Another scourge faced by street children, among the most visible, is the alarming rise in substance abuse: according to a 2013 report, one in three street children reported the use of inhalants and cannabis, while two out of three reported alcohol use of almost two weeks, and four out of five reported using tobacco (almost daily).[130]

Children from street families: One of the impacts of the rural-to-urban migration is that children accompany the adult migrants, thereby uprooting them from their hometowns. These children also engage in various small-scale employment activities like brickmaking, stone crushing, building construction, and rag picking. These children live in makeshift homes and under dangerous and hazardous conditions like lack of sanitation, water supply, and poor nutrition, all of which lead to a range of morbidities.[131] Common ailments that these children face are fever,

dysentery and skin diseases. According to a 2012 Aide et Action study in Odisha on children of migrant workers, 'since the family is temporarily uprooted from their habitation and social fabrics, they often get isolated from accessing government entitlements, social security, social assistance and government supported livelihood and poverty alleviation programmes. The family[,] including the child[,] become invisible at the destination due to lack of attention and support from the government department to include them into various government entitlements and citizenship right[s].'[132]

Child labourers: India is home to the largest number of child labourers in the world. According to the 2011 Census, there were nearly 44 million child workers in India.[133] Another study reports that as many as 12.6 million children are engaged in hazardous occupations.[134] Disaggregated data for urban child workers are unavailable, although some reference is made to occupations such as construction, work in factories, the service sector. Poverty and lack of social security are the main causes of child labour. A range of health sequelae are associated with child labour including orthopaedic ailments, injuries, stunting of gastro-intestinal, endocrinal and reproductive system development because of strain and exposure, and greater preponderance of substance abuse as compared to children who are not in labour.[135] More broadly, this kind of work robs children of their right to survival and development, education, leisure and play, and adequate standard of living, opportunity for developing personality, talents, mental and physical abilities, and protection from abuse and neglect.[136] Child line India quotes a study stating that 'Child labour is highest among Scheduled Tribe, Muslims, Scheduled Caste and other Backward Class children. The persistence of child labour is due to the inefficiency of the law, administrative system and because it benefits employers who can reduce general wage levels.'[137]

The elderly: Approximately 8 per cent of India's population, according to the 2011 Census, comprises the elderly, i.e., those aged 60 and above. This figure is projected to reach 158.7 million in 2025,[138] surpassing thereafter, the population of children below 14 years by 2050.[139] The most frequent ailments among the elderly are cardiovascular illnesses, circulatory diseases, and cancers.[140] A key physical barrier for accessing health services is that many elderly individuals require home-based care, a need arising from illness-related confinement following advancing age.[141] In both urban and rural areas, the confinement of the elderly population at home is very high. The lack of social and family support often leads to isolation of the elderly. Further, the chronicity and disabling nature of morbidities also causes economic shocks, resulting in financial dependency, loss of autonomy, in turn reducing social contact and often increasing isolation and loneliness.[142] There are various other vulnerable populations in urban areas (such as those living with chronic illness, affected by emergencies, survivors of violence), and micro categories of these populations that have unique burdens of ill-health (such as the elderly destitute or the disabled living in slums) whose life stories are humbling and whose health needs are poorly understood. As part of the TRG process, we began to understand these dimensions of exclusion and while we cannot explore these groups in further detail here, we do underscore the importance of using an intersectional lens to understand exclusion, and indeed, to respond to it.

Processes of exclusion in urban health

Drawing upon Naila Kabeer's work on social exclusion of women, a typology of exclusion emerges that sees exclusion as a dynamic process involving 1) social closure—the constraining of access to resources and opportunities; and 2) unruly practices, where there are big gaps between laws de jure and de facto; and 3) mobilisation of institutional bias, whereby a predominant set of values, beliefs, rituals and institutional procedures benefit or privilege certain groups over others.[143] With respect

to the state, Mander has developed a somewhat analogous typology whereby the state 1) invisibilises the vulnerable, or, 2) when it sees them, seeks to custodialise or otherwise impede their freedoms, and 3) in various ways, it stigmatises, illegalises, and criminalises them.[144] What we see through these processes is the amplification of vulnerability: the vulnerable may—due to various aspects of their actual and assumed identities—be subject to these processes in various combinations.[145] We explain how, below:

Unruly practices can be seen in the inadequate dispensation of schemes, services and programmes. Of course this is seen within urban policies and programmes in general (for more on exclusion in terms of Budgets, see Box C). In almost all of the 30 cities we visited, we learned that access to health care was constrained starting from the first point of interface with the system, the Primary Health Centre (PHC). The PHC is a 'point-of-first-contact' facility, where everything from immunisation to first aid, screening for a range of diseases and even deliveries should be carried out at no cost. Rarely are PHCs located at manageable distances from where the excluded live. Access is further constrained by the limited hours that PHCs are open and the long waiting hours that seeking care entails. In cities like Bhubhaneshwar, Delhi, and Kochi, seeking care at a PHC (or anywhere for that matter) usually requires taking a day off from work, thus losing that day's wages and trying to reach facilities in good time to obtain an appointment with a professional. In Muzaffarpur, we were told that many of the conditions and cases are referred to other facilities, which are a long distance away, and that a host of additional diagnostics may be prescribed, which then incur additional expenses and time. In general, PHCs are seen as a location only for the receipt of pregnancy-related care. Administrators across cities expressed the strong need for a broader range of services to be provided in urban health facilities at the primary level, including screening and wellness programmes for non-communicable diseases, injury, violence and substance abuse prevention, as well as needs specific to the urban context (e.g., occupational health and risk-related, seasonal health promotion in relation to communicable diseases, group-specific outreach and care, etc.).

We learned from the slumdwellers in Chennai that no services related to screening or treatment of diabetes or hypertension were available at the PHCs near their living areas, conditions that were now outpacing infections and other communicable diseases. Slumdwellers would instead have to spend INR 100 on travel to a tertiary care hospital. Most, from Dhamtari to Gangtok have resigned themselves to the fact that there will be out-of-pocket expenses involved in seeking care—that this is simply a feature of the system, and further that not only care, but also respect from health professionals, must be bought.

It has not been a surprise, therefore, that residentially vulnerable areas have been sites of major epidemics. As Dasgupta (2012) points out,

> The DDA set up 27 resettlement colonies for relocating slum populations from different parts of the city during the Emergency in 1975-77. These resettlement colonies were among the most-affected settlements in the 1988 epidemic, which was a landmark in the contemporary phase of the history of cholera in Delhi. The immediate cause of the epidemic is generally considered to be a breakdown in service provision during the transitional phase as these colonies were being handed over from the DDA to the Municipal Corporation of Delhi. However, there were several intrinsic deficiencies in the resettlement colonies that have not only rendered them vulnerable to the epidemic, but have meant that they remain endemic areas for cholera till date.[146]

The usually fragmented, often hostile and typically lonely experience of health-seeking among the excluded almost demands the advocacy and support of a good samaritan, someone who will root and

care for you. The onus of even this, in many cases, is put on the vulnerable themselves. In Thrissur, we learned from elderly day labourers that the onus of finding such a samaritan is not on the system, but on them, individually. In fact, government hospitals do not admit any patients without caregivers!

Institutional bias is evident for a number of vulnerable groups. Batliwala argues that 'the key feature of social exclusion processes is the "othering" and "bordering" of certain individuals and groups. This is achieved not through physical or structural barriers alone but through ideological constructions that justify this exclusion by defining who fits in the social mainstream and who doesn't.'[147] Women often bear the brunt of bias in the form of discrimination during delivery. A 2007 study found that as many as one in four women getting care at public institutions had 'some level of negative experience of care from nurse-midwives, with 10 per cent reporting that they felt their care was hurried or neglectful and an additional 15 per cent reporting that they were shouted at or slapped during labour.'[148] Similar experiences were reported by women going to private hospitals, albeit in smaller proportions. Across sectors, we found that women have been held at ransom; in Patna, we learned of cases where bribes were demanded for deliveries in facilities (which then issue certifications of institutional delivery, on the basis of which the government offers incentives) and for birth certificates, on pain of refusal of care.

Excluded groups including transgenders—hijras and kothis—have to face extraordinary humiliation, often regardless of the health issue or complaint they are facing. At a focus group in Pune, we were told harrowing stories of physical isolation and confinement of in-patients who were transgenders and that they felt as though they were treated like dogs. Flat denial of care is faced by those with physical disability, even in large metros like Delhi. Members of the Sikhaligad community in Pune told us how providers put on gloves even before seeing them,which they see as discrimination based on untouchability.

Another major challenge in seeking care at government services, for people living with stigmatised conditions like HIV/AIDS, is the lack of privacy, and insensitive way in which they are treated. As a construction worker in a Delhi slum remarked,

> It is all right for the hoardings to be screaming about AIDS…you only know what happens when it happens to you. I got myself tested and they told me that I had AIDS. Only my wife knows…how can we tell other people…In the public hospitals you go to the AIDS clinic, and everybody will know you have AIDS. Sooner or later somebody will see you there…and then it is all over…and these people in these clinics…how they treat you…like diseased dogs in the street…like you a [sic.] criminal…so I prefer to go to the private doctor….[149]

A quantitative study of 100 patients of public hospitals conducted in Delhi found,

> social discrimination appears to be institutionalized within the public health facilities. Three fourth of the patients using public health facilities belong to lower castes or socially disenfranchised groups. Nearly 60 per cent of the patients asserted that the health care staff is not polite and respectful, which is partly the result of social discrimination based on caste, class and economic status. Among the workers or service providers, the survey shows that the same class and caste form the majority of the lower end workers such as ward ayahs, ward boys, safai karamcharis (cleaners), and so on, while the upper castes dominate the higher end. This caste break up is directly related to the level of exploitation as lower classes of workers are subjected to more discriminatory practices.[150]

Thus, there appears to be a cycle of discrimination that is meted out not just to patients, but to workers in the health system as well.

It is important to note that many of these

processes of exclusion are reinforced because of the overall monetisation and tertiarisation of health. Middle- and upper-class and caste denizens of urban areas, earlier received state attention;[151,152] now, in its waning, they simply buy their way out of these experiences and vulnerabilities. They have social networks comprising upper class and caste doctors, they live in health-promoting environments, and their work and living arrangements afford them the time and possibility of improving their health. The wealthy in urban areas are thus more visible to the system, always eligible, able to purchase as consumers their wellness and care, and also command respect and support when required. All of this over the past three decades has also meant the steady and near complete exit of the wealthy from the public sector and a kind of growing stigmatisation of the public sector itself (which as the afore-cited study suggests, may have caste and class antecedents). The resulting institutional bias towards privatisation is in fact another driver of exclusion in urban India. In Delhi, for example, even though the number of beds in the public sector is higher than in the private,[153,154] the latter is favoured over the former. In Kochi, a private construction company had made an arrangement with a private hospital to issue health insurance cards to migrant labourers directly recruited by the firm to work on their sites (their peers recruited by contractors could not avail of this system, nor had any access to the private hospital). While the efforts of the firm were to a degree commendable, the fragmentation of coverage, particularly in a situation where risks will not be similarly fragmented, is of concern. Had there been demonstrably greater, universal access for all migrants to public services, the company would have that as recourse for its labourers, but they hadn't yet thought of this as a possibility.

The private sector is itself notorious for eschewing any responsibility towards the poor, even when required. In another example, Krishnan points out,

> The Indraprastha Apollo Hospital was famously given fifteen acres of land in Delhi's SaritaVihar for a grand total of Rs 1, in exchange for the hospital providing a generous amount of free care to poorer patients—but the conditions of the lease, it turned out, were subsequently repeatedly violated.[155]

Encouragingly, following a High Court order, the Delhi government has recently taken to regulating and monitoring the extent to which private hospitals are fulfilling such obligations.[156,157]In Mumbai, by contrast, a highly dubious practice of a private corporate hospital—an 'Elite Forum for Doctors' offering them rewards for number of hospital admissions—was heavily remonstrated against by the Maharashtra Medical Council, following which the Brihanmumbai Municipal Corporation indicated that it had no municipal rule under which any action against the hospital could be taken.[158] Given this kind of a regulatory lacunum, regardless of how they fare, however, private hospitals in urban areas, continue to enjoy heavily subsidised land, infrastructure, water and electricity and tax rebates, even as they continue to ignore the most vulnerable or worse, exploit them for private gain.

Consequences of Exclusion

Consequences for health

The manifestations of marginalisation and exclusion are literally embodied in the illhealth of the urban poor. As we have earlier indicated, the urban poor and slum dwellers have poorer health outcomes than urban non-poor and non-slum dwellers, respectively.

India's health transition is typified by a double burden of communicable and non-communicable diseases; urban areas are also experiencing this trend in a more pronounced fashion. Latest data (gathered between January and June of 2014) from

Box C. Budgetary Exclusion*

India has a larger context of chronic underfunding of health and social services), such that only around 1.2 per cent of the country's GDP is spent on health, far lower than any other BRICS countries, and even neighbours like Sri Lanka and Bangladesh.[159] In 2014, after the new government came into power, it slashed the government budget on health, cutting spending by 20 per cent (INR 20,431.4 crore in 2014–15).[160] Prospects for the public health sector in general, thereafter, have been less than bright.

Our analysis of 2011–12 data from National Health Accounts suggests that the proportion of revenue expenditure on urban health and family planning services across all states was 1.47 times that of rural health and family planning services. Even having 50 per cent more funds appear not to have translated into relatively greater use of the public sector or better outcomes distributed across populations living in urban areas. Recent data suggests that while on average, as high as 52.5 per cent of hospitalisations for childbirth in urban areas are in private hospitals, this is skewed among wealthier denizens of the city.[161] Indeed, as against 80.4% of delivery hospitalisations among the richest quintile occurring in the private sector, the proportion among the poorest quintiles is 31.9 per cent.[162]

The shifts in the public sector pale in comparison with the sheer quantum of subsidy given to the private sector in health. The 1950 Public Charitable Trust Act has paved the way for corporatisation of medical care. The use of this Act increased manifold post neo-liberalisation in the 1990s in India, facilitated by other engines of growth in the private sector, such that setting up a hospital became a mechanism for profit-generation, even profiteering.[163] First was the growth of India's pharmaceutical industry which took on a globalised character. Second, the private sector close to doubled the number of medical colleges in the country. Finally, a trend towards the creation of elite hospitals that sought to market themselves as medical tourism destinations. What was given short shrift in the bargain was the corresponding requirement of the Public Charitable Trust Act for hospitals to provide 20 per cent of the beds at free and concessional rates to the needy. There has never been a solid monitoring mechanism for this, and the actual implementation of this provision is likely miniscule. Unsurprisingly, it is found that in 1992–93, the private health sector accounted for 2.5 per cent of the GDP whereas in 2004–5 it was 5.6% of the GDP, at a time when public health spending increased marginally from 0.74 per cent to 0.92 per cent of GDP.[164]

the National Sample Survey Office demonstrate that while 89 of every 1,000 of Indians in rural areas reported an ailment in the last 15 days, the number was higher (118 out of every 1,000 Indians) in urban areas.[165] Not only is this figure lower in rural areas than urban, the urban/rural difference appears to have grown over time. In urban areas, the gender gap is also significant, with as many as 135 out of 1,000 urban women reporting a recent ailment, against 101 for every 1,000 urban males. As can be expected, morbidity is concentrated among older age-groups,with ailments among the 60 and older age group being far higher among urban females as compared to urban males (inverse of the relationship seen in rural areas).[166]

Broadly, the health issues of the urban excluded can be classified into communicable, non-communicable and occupational illnesses. Communicable diseases are spread through

* We are grateful for the inputs and review of Dr Indranil Mukhopadhyay and Dr Ravi Duggal here.

pathogens and vectors that thrive in the unsanitary conditions that often plague these populations. Slums being underserviced by the municipal administration—with adequate drinking water supply, sanitation, and both solid and liquid waste management—serves as a major aggregate risk factor for the transmission of communicable diseases. Malaria, dengue and typhoid, for example, are therefore frequently reported among the urban poor populations. According to the TRG,

> in urban India, the infant mortality rate is higher by 1.8 times in slum as compared to non-slum areas. Diarrhoea deaths account for 28 per centof all mortality, while acute respiratory infections account for 22 per cent. Nearly 50 per cent of urban child mortality is the result of poor sanitation and lack of access to clean drinking water in urban slums.[167]

Non-communicable diseases are also common among the urban poor. Various behaviours, like alcohol and substance abuse, dietary habits, and physical inactivity, all increase the proximal risk factors for NCDs. While analysing the risk factors for NCDs among the urban poor population in Haryana,[168] it was found that the urban poor are particularly vulnerablebecause offactors like high alcoholism among the male population and unbalanced dietary intake. These have been substantiated by the focus group discussions during the TRG process as many vulnerable communities were found to suffer from various types of NCDs.

Apart from the more common health burdens among the urban poor, the TRG team observed some unique health burdens specific to vulnerable communities. These include injuries to rag pickers due to syringes, broken glass, metals, etc. in the garbage, stray dogs, specific occupational health burdens like spondylitis for head-load workers, high prevalence of sexually transmitted infections among sex workers, respiratory and other health issues due to toxic exposures among informal industrial labourers, and stomachaches among child labourers due to hunger. It was also noted in our focus group discussions that consequences varied over the course of the year: in an FGD with homeless elderly women in Delhi, we learned that during the monsoon, the area where the homeless shelter is located is flooded up to three feet. When asked how they manage during these periods, the response was, 'Road hai, zindabad!' (Long live the road!).

Consequences for health-seeking

As detailed at length in our prior work, exclusion from urban health services has dire consequences for the marginalised. Indeed the larger issue with urban health is that the health system in the public sector is not preoccupied with health more broadly. Instead, there is a focus on maternal health and family planning, while the private sector is preoccupied with illness management.

The central consequence of this is that health—sexual, reproductive, occupational, adolescent, elderly, cardiac, mental, environmental, etc.—is not a priority or a preoccupation of urban dwellers. Across cities that we visited, we found that health is simply ignored by the excluded for reasons ranging from economic (loss of a work day) and social (stigma, lack of essential documents) to institutional (lack of facilities or imperfect timings for consultation).

This neglect perpetuates a complex of intercalating and negatively reinforcing tendencies and techniques of managing illness: care will not be sought, sought in an ad-hoc fashion from inappropriate sources, too late, and/or in the private sector at massive costs.[169,170,171]

Among those suffering from an ailment in urban areas, it is found that although on average the tendency to not seek care is going down in India, the poorest fifth are more than doubly likely not to seek care as compared to the wealthiest fifth;

women are slightly more likely to have an untreated ailment.[172] For populations like the homeless, there is the onerous broader context of stigma that any kind of health seeking is unlikely. Many homeless persons we met in Delhi and Chennai were simply biding their time with illnesses and injuries. As we learned in Delhi, health is not even a priority for elderly homeless women who are desperately seeking pensions and dignified shelter. In many cases, homeless persons suffer from multiple morbidities (e.g., injury and mental illnesses or disability and chronic disease) and rarely do primary health care facilities have the ability to handle these combinations (especially mental illness and disability), so appropriate care is not even available. From what we learned of this situation even in the relatively better-performing cities like Chennai, receipt of care appears to be a matter of coincidence. In fact,we observed an almost complete dependence on charitable clinics, religious institutions, and donated foods and drugs. Further, prolonged homelessness itself is both a cause and consequence of ill health, perpetuating each other in a vicious chiasmus.

For those whom we spoke to in other cities, the preference was to self-medicate, involving the development of lay typologies of 'small' and 'big' illnesses. 'Small' illnesses typically involve the ad hoc administration of painkillers or generic medicines either suggested by an area pharmacist, neighbour, relative, or employer. Once the symptoms of a 'small' disease end, medication taking also ceases, again, based on a rudimentary logic of wellness that may have no linkage to true, clinical well-being (i.e.,'I feel better, so I can stop taking this antibiotic.') Only in the case of children do slum dwellers visit the doctor for smaller ailments as the parents think that children's ailments are important and only a practitioner can best help in overcoming them. For most other health concerns, especially those experienced by adults and the aged, providers were only visited for what were seen as long, drawn-out illnesses that interfere with work. This is borne out by a longer, more systematic ethnographic study in a Delhi slum, which examined 92 illness trajectories, the first resource was to a neighbourhood *daktar* who may not have the right qualifications [as opposed to a *bada daktar* (big doctor], who would cost something around INR 35 per visit, as opposed to at least double at private or government facilities.[173]

For larger ailments, or events like a delivery, injury, or other emergency, clinics and hospitals have to be relied on. For the poor, the government is the first port of call, but as a woman living in Jahangirpuri slum in Delhi made plain, 'sarkari aspatalon mein garib ki koi sunvai nahin.' ('Nobody hears/receives a poor person in a government hospital.') While there is obviously no caveat, the situation with which public sector health professionals must contend is palpably difficult; public providers are expected to deliver high quality care with the most unpredictable and inadequate of allocations, to gargantuan patient loads, all the while negotiating the temptations of the private pharmaceutical sector (by way of perks for referral, prescribing certain medicines and tests, and more). As appallingly revealed in a recent book by those in the profession, doctors are now more often businesspersons than health professionals, operating for private gain even from within the public sector.[174] Public maternity homes in the capital are so overcrowded that turned-away patients rely on non-registered private sector clinics, understandably of lower quality.[175] Transgenders must hesitatingly rely on non-registered practitioners in most cities for sex re-assignment surgery, knowing full well the serious health risks they must incur (Chennai is a noteworthy exception).[176] A recent study in Lucknow found that at least one in three parents of a poor urban neonate suffering from persistent diarrhoea sought care from a spiritual/informal provider.[177] Another provider that many excluded groups rely upon is the neighbourhood pharmacist. Ethnographic research in Mumbai has found that

informal providers and pharmacists alike are part of a complex 'unfree' market,[178] which is associated with practices of 'counter-pushing', self-medication and other practices that introduce, rather than reduce, risks to the population.[179]

Private hospitals and clinics dot the urban landscape, and are a major source of health-seeking, particularly in cases of emergency among the vulnerable. In urban areas, the proportion of in-patient care sought in the private sector has grown from 56.9 per cent in 1995–6 to 68 per cent in 2014, over a 10 per cent increase.[180] As can be imagined, the reliance on the private sector is skewed in wealthier income groups (as they can afford it), and yet, in 2014, private hospitals account for 52 per cent of hospitalised cases among the poorest urban quintiles in India, and 56.5 per cent among the second poorest.[181] There are a number of challenges related to seeking care in the private sector, including the ratcheting-up of costs for simple procedures and diagnostics, and the administration of unnecessary procedures to make money (rent-seeking). Most of these add morbidity and the toll on households by way of cost, time, and emotional anguish.

Sometimes, these patterns of harmful health-seeking run in sequence. In the case of a female resident of a Beggar Home in Mumbai, we heard a harrowing story of her experience in her hometown of Mathura. Given an injection from an un-credentialled doctor for a minor ailment, severe heartburn propelled her to spend INR 2,000 to travel to Agra and seek care. She is not even clear what was wrong with her (or if she is fully recovered) even though the private hospital charged her INR 1,30,000 for tests and treatment combined.

Finally, for the poor, many of whom in fact are or began as medical refugees in cities, for the express reason of addressing health needs, well-meaning schemes for financial risk protection offer no succour. For example, Delhi's Arogya Kosh requires three years of residency in the Union Territory to qualify for up to Rs 5 lakhs of financial assistance for treatment addressing kidney and liver ailments. In other cases, even with government support for treatments, the poor are billed for consumables and diagnostics.[182] Such costs are recurrent by their very nature and further dwindle their economic resources.

Additional consequences

The poor, just like any other urbanite, are willing to pay for care. The unit cost of services in a private facility can be as high as INR 2,213 per outpatient visit, while in a district hospital, the figure is INR 94, which can be the same amount as a day's wages for an informal urban worker. In private facilities, having to pay consultation fees means that not only is the income for the day lost (as one has to visit and wait in a facility inordinately), one also has to pay money to just be seen. This is just the beginning: the likely scenario that follows is that tests are required, and a follow-up visit, for which the quickest way is to pay out of pocket. The poor, furthermore, have less expendable income to spare even for such purposes: it is found that the monthly per capita expenditure of the poorest urban decile in 2009–10 was merely a tenth of that expended by the richest decile.[183] Multiple studies have concluded that in poor households compared to rich households, a far greater share of income is spent on health (even if in absolute terms this is less expenditure) given higher morbidity levels.[184] Significant spending is on outpatient procedures, which notably, are not covered by any pro-poor schemes. A 2011 study found that in urban areas, the poorest income quintiles were spending 70.3 per centand 73 per centof their total out-of-pocket expenditure on outpatient expenses and drugs, respectively,4–10 per centhigher than all other income quintiles.[185]

India therefore has the ignominious distinction of being a nation where out-of-pocket expenditures for health area cause of poverty. Data from the 61st Round of the National Sample Survey shows

an increase in urban poverty by as much as 2.9 per cent if out-of-pocket health expenditure is accounted for.[186] States such as Uttar Pradesh, Chhattisgarh, Kerala, Maharashtra and West Bengal have been shown to have high out-of-pocket health expenditures and demonstrate significant increases in urban poverty attributable to this.[187]

According to the 71st round of the National Sample Survey, the average total medical expenditure[188] per single ailment is much higher—i.e., INR 741 for males and INR 629 for females in urban areas, as compared to INR 549 and INR 589 respectively in rural areas.[189] Moreover, this survey found that expenditure in private hospitals as compared to public is much higher in urban areas (three times the expense in private than public hospitals for males and almost double for females) as compared to rural areas (1.9 times the expense in private than public hospitals for males and 1.6 times for females). All this results in a greater proportion of expenditure, on average, per person in urban areas as compared to rural (INR 639 as compared to INR 509). For the poorest fifth of urban dwellers, on average the cost to treat a single ailment in a single person is the same as over 10 months of household expenditure; costs are this high or even higher for those who use the private sector more. This trend has lasted at least a decade: analysis of the NSS 61st Round (2004–5) found that Dalit (SC), Adivasi (ST), and Other Backward Class (OBC households) were more likely to incur catastrophic out-of-pocket health expenditure than general-category households in urban areas (the margins were 27.8 per cent ($p<0.001$), 8.6 per cent ($p=0.06$), and 11.9 per cent ($p<0.001$) more, respectively.[190] Finally, urban household expenditure on non-communicable diseases (like cancer, diabetes, and heart disease), is higher compared to rural, by a greater margin among India's poorest income quintiles as compared to the richest quintile.[191]

Figure 1. Shri Baliah Memorial Urban Primary Health Centre for Senior Citizens, Rottler Street, Chennai. Photo Credit: Prathibha Ganesan.

Practices of Inclusion

Drawing from the TRG process and subsequent fieldwork in various cities, we have compiled the following examples of practices of inclusion that offer particular lessons in redress or prevention of exclusion from urban health. This was triangulated with visits to organisations in Chennai, Mumbai, Pune, Bhopal and Delhi to highlight inclusion in health care.

We would like to note at the outset, that strong public health systems, providing free services in clean facilities (as in Pimpri Chinchwad), timely surveillance, disease prevention and outbreak response (as seen in Chennai, Kolkata, and Madurai), and a strong community outreach component (as seen in Raipur) can go a long way to protecting the health of the excluded. Highlighted below are some examples 'practices of inclusion' that we feel could be quite feasibly scaled up or expanded. Rather than lay out the entire gamut of their work, we have chosen to emphasise only the practices that address the processes of exclusion (invisibilisation/ social closure, unruly practices, or institutional bias/discrimination). Our list of practices is not exhaustive and even the practices that are discussed may have their own flaws. Ultimately, we hope to encourage all stakeholders in the urban health sector to derive positive lessons from the work that is discussed below.

In Chennai, the Municipal Corporation has established primary and secondary health care facilities in an attempt to reduce existing inequalities and address two considerably excluded populations. The Shri Balaiah Memorial-Urban Primary Health Centre, exclusively for senior citizens, provides easy and affordable access to medicines and health facilities for common medical issues experienced by the vulnerable elderly population (see Figure 1).[192] The PHC, if scaled up and functional to its full extent, has great potential to deal with the physical and psychological health of the elderly. Similarly, an increasing number of standalone diagnostic facilities, such as the Valluvarkottam Diagnostic Lab in Chennai, under a public-private partnership between the municipal corporation and a private foundation, offer key diagnostics (x-ray, ECG, and ultrasound) at subsidised rates, blood and urine tests at one-third the market price, and dialysis free of cost.[193] Providing such diagnostic capacities referred from primary and secondary facilities improves the access and efficiency of the system and reduces out-of-pocket expenditures. Similar gradation of rates was seen for tests in PHCs in Bardhaman where discounts were also provided to those Below the Poverty Line who didn't have cards.

In Mumbai, the SNEHA (Society for Nutrition, Education, and Health Action) life cycle approach focuses on public health problems of urban slum populations—maternal and newborn health; child health and nutrition; sexual and reproductive health; and prevention of violence against women and children.[194] Working closely with the Brihan Mumbai Municipal Corporation and other government and private stakeholders, SNEHA has created referral networks of government hospitals to manage over 21,000 high-risk pregnancies, trained and improved the relevant skills of 3,000 staff at municipal hospitals, and connected slum-dwelling mothers and their families to professional health services for the various phases of pregnancy. SNEHA has addressed more than 4,000 cases of domestic violence, trained 4,500 police officers and cadets in Mumbai to deal with cases of domestic violence, and trained more than 2,100 public hospital staff to better identify patients who may be victims of domestic violence.[195] In partnership with University College London, SNEHA has developed a vulnerability scorecard to identify the most vulnerable amongst the informal settlements in the Mumbai area. This is a model for vulnerability mapping that has been adapted by the central government as well. The SNEHA model essentially couples projects to prevent negative health outcomes in mothers and their children, with educational programmes to help eliminate the cycle of ill health faced by several

of the most vulnerable populations within urban slums. Moreover, their work allows the urban slum dwellers to be more visible to the system, addressing issues of discrimination and institutional bias that the population usually experiences.

A self-governing cooperative in Pune of just under 3,000 waste pickers called the Kagad Kach Patra Kashtakari Panchayat (KKPKP), has created the SWaCH Coop (Solid Waste Collection and Handling), a unique model of addressing public health, while simultaneously ensuring the overall welfare of those in hazardous occupations. Following a law that required waste management instead of dumping, the Pune Municipal Corporation has facilitated door-to-door collection of waste in collaboration with KKPKP.[196] Now, waste pickers no longer have to sort waste (nor do their children), saving time and adding efficiency to waste management, and also saving the Corporation crores of rupees. Additionally, SWaCH/KKPKP members have been issued identity cards which assures them access to health services, checkups and diagnostics at discounted rates. They are also given protective equipment that helps avoid occupational hazards. The SWaCH model essentially brings together waste pickers in the city of Pune for the good of the collective itself, and cost-effectively manages

Figure 2. Behind the Sambhavna Trust Clinic's main building is a small plantation and area where staff members produce and use plants to manufacture the ayurvedic medicines that the clinic uses. Pictured here is Lalita, who is busy putting together packets of a powder that Sambhavna prescribes to patients suffering from constipation. The powder was manufactured at Sambhavna from the same plants that it grows. Photo Credit: Girish Motwani

a majority of the city's solid wastes. Membership also has powerful downstream effects on the overall livelihoods of card-holding waste pickers who are members. As such, the SWaCH Coop and KKPKP have both made significant progress in reversing the problem of exclusion of waste pickers from urban health resources, primarily by making this population visible but also by reducing the extent of institutional bias that these individuals normally face.

The Sambhavna Trust Clinic in Bhopal, located just metres away from the previously standing infamous Union Carbide factory, targets individuals who were either affected by the Union Carbide gas tragedy in 1984 or are currently suffering due to the ground water contamination in Bhopal. Through all of its activities, the Sambhavana Trust Clinic maintains an electronic medical record system. The clinic has found this system to be extremely useful in light of the fact that the medical care being provided to victims of either the gas tragedy or ground water contamination is not entirely evidence-based. Keeping the electronic records therefore enables Sambhavna to collect several data, which are then continuously analysed to better understand what approach for the care of these patients works best. By not relying only on individuals' ability to provide documentation certifying that they were affected by the gas disaster in 1984, Sambhavana has created a sense of inclusion to urban health resources for an estimated 50,000 people who otherwise may not have received the care that they needed in municipal hospitals (most of these 50,000) individuals are those affected by ground water contamination).[197] Through its research and political activism, Sambhavana has also secured greater recognition of its target population at municipal hospitals in Bhopal and has reduced the extent of the discrimination faced by these individuals (see Figure 2).

In the National Capital Region, the Aman

Figure 3. The Transit Care Centre (TCC), Adaikalam, of The Banyan offers its clients and residents facilities for several activities. Pictured here is a workshop for clients to practise art and create various crafts. Photo Credit: Girish Motwani.

Biradari Delhi Homeless Male Recovery Shelter, looks to provide shelter and access to facilities, to at least a proportion of the homeless population. With grave ailments like TB or even orthopaedic injuries, even if homeless persons can access public hospitals, they are discharged and advised to go home to rest and be cared for by their families. But if they have no homes and/or families, they simply are forced to forgo care, and in cases like TB risk eventual death, and in simple orthopaedic injuries, to risk permament disability. The shelter 'recruits' homeless men from across Delhi, to their shelter facilities, and helps them access public hospitals, providing necessary post-hospital care, creating a sense of inclusion for this largely ignored population. These individuals, who largely experience discrimination in medical institutions, due to the lack of relevant documentation, are advocated for, and stewarded through the process of getting identified by the system and receiving appropriate access to resources. Medical attention is provided by a doctor between 4 and 6 pm daily, and staff undertake outreach between 7 and 11am every day. There is no requirement of producing documentation, given that a large proportion of users of these services are migrants, and may not posess any. At intake, however, there is extensive documentation of the conditions and socio-economic profiles of men linked to the shelter to help the organisation better understand the types of populations it is catering to. Additionally, the shelter is linked to various TB speciality hospitals, such as Rajan Babu TB Hospital and Lok Nayak Jai Prakash Hospital, which help diagnose patients and thereafter provide medication, nutrition and sensitisation to the disease. In addition to serving as a recovery shelter while individuals undergo treatment (usually lasting atleast 6 months), as per the Revised National TB Control Programme, DOTS providers also visit the shelter twice a week to administer medication and carry out general checkups. Since the service began, over a period of 18 months (August 2013–February 2015), 18 TB patients residing at the Delhi Health Recovery Shelter have completely recovered from the disease. Within the population that the Delhi Health Recovery Shelter serves, several of the individuals fall into other categories of vulnerability as well: for example, disabled, mentally ill, and substance users. As such, by targeting issues of invisibility and institutional bias, the organisation tackles the problem of exclusion, making a portion of the male homeless population of Delhi visible to the government, and creates inclusion for individuals whomay be experiencing multiple levels of marginalisation.

The Adaikalam Transit Care Centre for women, a branch of the pioneering non-governmental organisation, The Banyan, serves as the largest shelter in India for homeless individuals with mental illnesses. Its multi-disciplinary team offers various social and clinical care interventions.[198] The Banyan provides services to those in need without any government identification; it works with the government to provide such indentification, which is necessary for them to have access to most government entitlements. Since its inception in 1993, more than 2,000 women have utilised Adaikalam (see Figure 3) and 1,275 women have been re-integrated with their families. Mentally ill, homeless people experience a strong institutional bias, therefore the organisation works to connect its clients to government entitlements, creating inclusion and alleviating bias and unruly practices faced by them.

It is noteworthy that the majority of organisations documented above are addressing exclusion by either making a given subgroup of individuals more visible to the government system and/or reducing the institutional bias faced by said subgroup. Most of the activities do not seem to tackle exclusion caused by unruly practices. To reiterate, unruly practices refer to the gaps in law (i.e., what is on paper) and reality (i.e., what is actually happening)—it is a problematic phenomenon when institutions are not doing what they are supposed to be doing. Generally speaking, exclusion is a problem particularly

because either there is no way for certain subgroups of individuals to be appropriately recognised by the state or because existing institutions are practising some discrimination against these subgroups. The most important priority for organisations and the Indian government should be to accept that certain definable groups are being excluded from accessing urban health resources and that more policies to reverse the problem of exclusion ought to be designed, implemented, and enforced.

Recommendations

The previous sections have attempted to describe the comprehensive and multifaceted exclusion of urban poor populations from either any kind of health-care services, or from services that are affordable, accessible, respectful and appropriate. This situation is unacceptable by any yardstick of basic equity, and calls for both the building and the sensitive restructuring of urban public health services.

The recommendations listed here are derived and reproduced from the TRG Report, validated and refined further by the fieldwork conducted to document both the overall state of exclusion from urban health resources and the practices of inclusion that currently exist, as well as as drawn from a recent publication by our partners in the TRG process.[199] We suggest an overall architecture for urban health care provision that is attuned to and directly addresses exclusion.

1. Map vulnerability, infrastructure, and access

Since exclusion has its roots in the invisibility of certain groups of vulnerable individuals, action ought to be taken to make these groups visible to the urban health system. It is only after these groups are made visible to the system that we can expect formal, systematic action to be taken. Therefore, it is recommended that cities make the effort to spatially and socially map various elements that would help locate and understand (1) where the socially vulnerable groups exist, (2) what facilities or health infrastructure are available, and (3) what the location of vulnerable groups, their exclusion, and available health facilities mean for issues of access to urban health resources. This effort would yield a map with three layers that should be updated at least once yearly.

The first priority should be to accurately locate the most marginalised groups. This can be done by mapping determinants of vulnerability (e.g., water and housing supply, and sewerage), and locations that concentrate the vulnerable (e.g., slums, resettlement colonies, clusters of homeless people, red-light areas, labour zones, wholesale markets, railway and bus stations). The determinants and locations could include linking information on categories and numbers of vulnerable persons.

Second, the map should indicate the location of existing institutions and organisations—public, private, and governmental—that deliver urban health services ('infrastructure mapping'). This includes, for example, outreach services, primary, secondary, and tertiary health services, inter alia CGHS, state government primary health units, community and district hospitals, medical colleges, ESIC hospitals and clinics, and ICDS centres.

Third, a more focused effort must be given to 'access mapping'. That is, the maps should depict clearly the relationships between the location of the vulnerable groups and health infrastructure, including the differently abled and elderly.

The final map would be the result of the superimposition of the three 'layers'—of vulnerability, infrastructure, and access—it could be used to make decisions about where to expand or improve services, where the risk of outbreaks and morbidity is high, and over time, how improvements are impacting health.

2. Organise services at the community level

The first institutional need for inclusion is to create primary health institutions that are physically, economically and socially accessible to urban poor populations. At the base of this health institutional structure proposed by the TRG is a facility that can be called a nursing station or a nursing station cum health sub-centre, comprising two female health workers, one male health worker, and five Accredited Social Health Activists (ASHAs)per 10,000 population. This exceeds the current NUHM Framework which provides for a single female health worker and five ASHAs per 10,000–12,000 population. The nursing stations must be located near the area of the population they wish to serve, and also at major transit points (like railway and bus stations) to provide drop-in centre care for the highly vulnerable.

More specifically speaking, nursing stations should provide all primary health care that does not require the presence of doctors—preventive and promotional health activities, health literacy activities, health and nutrition counselling, vaccinations, antenatal care, regular supplies of drugs, follow-up tests and counselling, and regular free medication for common urban ailments (for tuberculosis, mental health issues, leprosy, hypertension, diabetes, epilepsy, asthma, etc.) Nursing stations could also be equipped with the capacity to provide counselling services for substance abuse, disability, geriatric, palliative, and domiciliary care. Finally, to make the nursing station most accessible to the people it is serving, it would have to consult directly with them to determine its timings for mornings, afternoons, and evenings.

3. Establish primary health centres near poor and other marginalised populations

The majority of urban primary health centres must be deliberately established within or near (no greater than 0.5 kilometres away) settlements where the urban poor and other marginalised groups reside. This includes urban slums (notified and non-notified); slum-like habitations; other areas with either a lack of piped water supply, underground sewarage and drainage, and extreme overcrowding; urban villages; landfills; red light areas; factory worker and scavenger colonies; leprosy colonies; construction workers' camps; and impoverished inner-city areas. If and only if land cannot be found within these areas in any given city should urban primary health centres be constructed at a maximum distance of 0.5 kilometres from the area.

Beyond this, a small number of Primary Health Centres could be located in middle-class areas, wherever possible, where the poor (e.g., domestic workers) tend to work. Another 5 per cent of the budgets should be allocated to the creation of Special Primary Health Centres for the completely excluded, i.e., homeless populations and street children.

Of all urban primary health centres, between 5–10 per cent should also have special services like mobile clinics (providing services similar to those found in nursing stations) and recovery shelters for homeless adults, street children, and temporary and circular migrants.

4. Ensure inclusion through specific measures

(i) No documents: Individuals seeking care are often denied health services because of their inability to produce documents certifying their identity. Therefore, 'no requirements of any identity proof' is a key institutional arrangement recommended for NUHM. For the purposes of tackling exclusion it would be more effective to design, implement, and enforce a policy that eliminates the requirement of identification proof for those seeking health services. Moreover, it would be even more beneficial, from the perspective of

reducing exclusion, if it is never required for an individual seeking urban primary health care to produce proof of address or citizenship or for s/he to have a caregiver.[200]

(ii) Mother's name: For intake/registration, all forms under the UHM should ask for mother's name only, instead of father's or husband's name, which can discourage or stigmatise children of single women or sex workers. Similarly, as is increasingly the practice, the option to register with one's transgender identity should also be permitted.

(iii) Changed timings: Urban primary health centres have been found to provide health services to patients during times where either they are at work or are busy with other activities in the day. The patients normally have to sacrifice a day's payment to avail the appropriate health services from the health centres. Thus, the operating hours of the urban primary health centres itself excludes populations—for example, domestic workers, self-employed individuals, and sex workers. Therefore urban primary health centres must decide their operating hours in consideration of the populations that they are serving. This typically means 3 to 9 pm daily would be a good time, with the exception of UPHCs in red-light areas which could operate in the morning hours.

(iv) Cashless services: The imposition of user fees for primary and curative care services at public/government hospitals, essential medicines, and diagnostics creates enormous barriers of access for individuals who are financially marginalised. The TRG suggests that all these services should be entirely free of cost for all individuals. Linked to this is compliance with legal directives to provide free beds in private hospitals to economically weaker sections.

(v) Special clinics: On a rotating basis, special clinics for the aged and differently abled could be introduced in existing facilities, that mobilise local youth volunteers and are specifically geared towards handling co-morbid conditions that these two populations often have. Creative allocation of space could also be considered in medical colleges' out-patient departments, which could serve as poly-clinic OPDs referred from Primary Health Centres.

(vi) Help desk: Providers of health services, particularly the urban primary health centres, should have a formalised help desk and counselling centre that is run by trained, professional medical social workers. These individuals would be responsible for advising and supporting patients, offer advice about preventive behaviours and promotional health such as the use and consumption of clean water, sanitation, breastfeeding newborns, child-rearing practices, and occupational health. Much like the professionals working at SNEHA Mumbai, such medical social workers should serve as the first point of contact for survivors of violence, children without adult guardianship, as well as for old and disabled persons.

5. Improve efficiency: make the continuum of care seamless and of standard, high quality

Moving beyond reproductive and child care, Primary Health Centres should be sites where vertical disease control programmes are integrated and linked to preventive and promotive services provided by the National Health Mission. This includes basic diagnostics; for more complicated tests, the Centre could serve as a sample collection site.

There is a need to make referral processes—from primary to secondary and tertiary care—more systematic, and therefore, more efficient. To facilitate referrals, for example, a system of colour-coded cards can be used. Patients needing immediate secondary or tertiary care can be given green cards from personnel at the urban primary health care facility, which would help them receive 'fast track' services through help desk staff at secondary and tertiary centres, receive quick access to the medications they need regularly, without having to make them wait in long queues.

In line with ensuring the continuity, efficiency, and quality of urban health care services, standard treatment protocols ought to be developed and followed carefully for the most common urban health ailments. It follows that the medications necessary for these standard treatment protocols be clearly listed, purchased by providers of urban health services, and sufficiently stocked up at relevant urban health centres. If services at all levels and between all levels are delivered with greater efficiency and with greater attention to standardised protocols, addressing exclusion from urban health resources becomes more manageable.

6. Integrate urban health services: towards a multi-disciplinary approach to service delivery

ICDS centres, which have been directed by Supreme Court to fully serve all slum populations, should be linked with the ASHAs, Multi-Purpose Workers, and the urban primary health centres to be able to provide slum dwellers and other such marginalised individuals with multidisciplinary services, focusing on, for example, (1) the nutrition and health of infants, young children, and expectant and nursing mothers (much like the work that SNEHA Mumbai is engaged in) and (2) the implementation of all national programmes such as those for tuberculosis, leprosy, mental health, and blindness prevention.

Urban primary health centres should also be equipped with referral linkages to supportive health care facilities. For example, primary health centres can be linked with designated public poly-clinics or specialised diagnostic clinics, free residential and outpatient drug deaddiction centres, free residential mental health care recovery centres[201] nutrition rehabiliatation centres, homeless recovery shelters[202] and palliative care centres.

7. Encourage community participation and transparency

Every urban primary health centre should have its own Jan Arogya Samiti (JAS), which is an empowered local health committee consisting of a local elected ward member, representatives from each of the occupational groups present in the health centre's catchment area, and chairpersons or representatives of the area's Mahila Arogya Samitis (MAS; existing committees of neighbourhood women who routinely meet and contribute towards promoting health in their communities). No more than one-fourth of the members of each JAS should be males; a minimum of one-fourth of the members of each JAS should be under 30 years of age; and a minimum of one-fourth of the members of each JAS should be above 60 years of age. Such a distribution ensures that the concerns of different, vulnerable age groups are voiced and addressed appropriately at the level of each urban primary health centre. The health centre's social worker should serve as an observer and help perform the secretariat function in the JAS. JAS should be made responsible for conducting annual audits of the social services that the urban primary health centres offer. These audits should be reported publicly and to the City and State Urban Health Missions, directing them to take corrective measures as and when necessary.

All JASs should have, at the very least, the following responsibilities: optimising the use of existing health services and suggesting ways of improving them and addressing the social

determinants of health (this is absolutely essential for community ownership of a given medical initiative); developing a community health plan after a careful assessment of the socio-economic profile (i.e., also the social determinants of health) of a given urban primary health centre's catchment area; conducting yearly social audits; working closely with the MAS and the ASHAs in a given area to recruit community health volunteers and peer educators, who, among other things, would be importantly responsible for improving the health literacy in the vicinity of the urban primary health centre.

8. Improve governance structures for convergence

Municipal health officers should be made responsible for continually monitoring the provision of public services that have a strong bearing on urban health. This includes disease surveillance, vector control, food safety, regulation of slaughterhouses, monitoring of air pollution, biomedical waste, rabies control, as well as linkages to schemes of other departments (Women and Child, Education/ School Health, Social Welfare, Urban Development, Food and Civil Supplies, Roads and Transport). As such, the health officers should be made in charge of implementing an improved surveillance system in their respective cities. City health centres should have a system through which they could report to municipal health offices about disease patterns, especially those linked to environmental causes like water contamination and overcrowding. This system would better enable a city to, for example, trace the source of a hepatitis or dengue outbreak to vector breeding and correlate increases in the incidence of asthma and acute exacerbation of chronic respiratory illnesses to air pollution, rabies and dog bite incidences to stray dog control, or road accidents to the lack of road safety measures. Appropriate corrective measures can be taken to prevent further health consequences if a powerful reporting and monitoring system is designed and implemented. For example, municipal health offices can respond to an outbreak of dengue with increased efforts towards vector control.

As is evident here, there is a lot to be said and as we found, a lot indeed that can be done about exclusion from urban health care in India. Ultimately, as was said repeatedly during the TRG session, if we can at least all face the correct direction, we can hope to have an answer to Chajju Ram's question, 'who cares?'

Endnotes

1. NDTV. Another Dengue Death in Delhi, Toll Touches 43. NDTV. 6 November 2015. http://www.ndtv.com/india-news/1-more-succumbs-to-dengue-toll-touches-43-1240951 (accessed 7 November 2015).
2. B.S. Perappadan, 'Fogging is ineffective in controlling dengue, says CSE'. The Hindu. 21 October 2015. http://www.thehindu.com/todays-paper/tp-national/tp-otherstates/fogging-is-ineffective-in-controlling-dengue-says-cse/article7785985.ece. (accessed 9 November 2015).
3. The Asian Age (2015), 'Fogging effective method to fight dengue: Centre'. 23 October http://www.asianage.com/node/433145 (accessed 4 November 2015).
4. The Indian Express (2015), 'With 10,683 cases in Delhi, 2015 dengue outbreak worst in last 20 years'. 13 October http://indianexpress.com/article/cities/delhi/with-10683-cases-in-delhi-2015-dengue-outbreak-worst-in-last-20-years/ (accessed 4 November 2015).
5. The Asian Age (2015), 'Fogging effective method to fight dengue: Centre'.
6. B.P. Shajan (2015), 'Hospitals to face action for denying treatments'. The Hindu. 16 September http://www.thehindu.com/news/national/other-states/

hospitals-to-face-action-for-denying-treatment/article7656828.ece (accessed 11 November 2015).

7. D.N. Jha (2015), 'Kejriwal government caps test cost at Rs 600, labs protest'. The Times of India. 17 September http://timesofindia.indiatimes.com/city/delhi/Kejriwal-government-caps-test-cost-at-Rs-600-labs-protest/articleshow/48992944.cms (accessed 11 November 2015).
8. A. Kelkar-Khambete (2015), 'How dengue has breached India's class barriers'. Business Standard. 9 October. http://www.business-standard.com/article/specials/how-dengue-has-breached-india-s-class-barriers-115100900196_1.html (accessed 11 November 2015).
9. A. Singh (2015), 'Dengue fears haunt capital's homeless'. The Statesman. 17 September http://www.thestatesman.com/mobi/news/delhi/dengue-fears-haunt-capital-s-homeless/90652.html (accessed 11 November 2015).
10. The Times of India (2015), '33,000 homeless people died on Delhi streets since 2004: Government report'. 18 October http://timesofindia.indiatimes.com/india/33000-homeless-people-died-on-Delhi-streets-since-2004-Government-report/articleshow/49442688.cms (accessed 11 November 2015).
11. Singh (2015), ' Dengue fears haunt capital's homeless'
12. People's Health Movement (2000), 'People's Charter for Health. Dhaka: People's Health Assembly'.
13. S.V. Joga Rao (2005), 'Fundamental Right to Health and Health Care' in L.V. Gangolli, R. Duggal, A. Shukla (eds) Review of Health Care in India, Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT), pp. 279–94.
14. G. Bloom, H. Standing and R. Lloyd (2008), 'Markets, Information Asymmetry and Health Care: Towards new social contracts'. Social Science & Medicine, 66(10): 2076–87.
15. B.S. Levy and V.W. Sidel (2013), 'The Nature of Social Injustice and Its Impact on Public Health' in B.S. Levy and V.W. Sidel (eds), Social Injustice and Public Health, 2nd edition. New York: Oxford University Press.
16. World Health Organisation. 'Trade, Foreign Policy, Diplomacy and Health Equity: WHO' http://www.who.int/trade/glossary/story024/en/ (accessed 11 November 2014).
17. D.E. Beauchamp (1976), 'Public Health as Social Justice' in D.E. Beauchamp and B. Steinbock (eds), New Ethic for the Public's Health, New York: Oxford University Press, Pp. 101–9.
18. Beauchamp (1976, pp. 102–3) contrasts social justice with market justice, in which 'people are entitled only to those valued ends such as status, income, happiness, etc., that they have acquired by fair rules of entitlement, e.g, by their own individual efforts, actions or abilities. Market-justice emphasizes individual responsibility, minimal collective action and freedom from collective obligations except to respect other persons' fundamental rights.'
19. World Health Organisation Commission on Social Determinants of Health (2008), 'Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health'. Geneva: World Health Organisation
20. Registrar General of India (2011), 'Provisional Population Totals: Urban Agglomerations and Cities'. http://censusindia.gov.in/2011-prov-results/paper2/data_files/India2/1.%20Data%20Highlight.pdf (accessed 2 April 2015)
21. People's Health Movement (2000), 'People's Charter for Health Dhaka: People's Health Assembly
22. Joga Rao (2005), 'Fundamental Right to Health and Health Care'
23. S.B. Shah(1999), 'Illuminating the Possible in the Developing World: Guaranteeting the Human Right to Health in India'. Vanderbilt Journal of Law, 32:435.
24. The right to health is guaranteed in the International Covenant on Economic, Social and Cultural rights, although details on actual state obligations are not given here or in other international treaties. In India, public interest litigation has been the avenue through which the Indian Supreme Court has allowed citizens to seek protection of their constitutional human rights, using its prerogative to interpret the fundamental right to life to include the right to have good health (Shah, 1999). The Court has thus directed states to provide citizens with basic health services and social conditions essential for the enjoyment of health. The Indian legal system is among the few in the world to have subjected social rights to this type of judicial scrutiny and litigative recourse.
25. L. Gordis (2014), *Epidemiology*, 5th edition, Canada: Elsevier, p. 27
26. D. Woodward and R.D. Smith, 'What may be a GPG in Health? Global Public Goods and Health: Concepts and Issues'. (ND). http://www.who.int/trade/distance_learning/gpgh/gpgh1/en/index10.html. (accessed 2 April 2015)
27. R.A. Musgrave (1957), 'A Multiple Theory of Budget Determination'. FinanzArchiv, New Series 25(1): 33–43.

28. People's Health Movement, Medact, Medico International, Third World Network, Health Action International, AsociacionLatinomaricana de Medicina Social and Zed Books (2014), 'Social Protection: Reimagining Development'. Global Health Watch 4: An Alternative World Health Report. Cape Town/London/Frankfurt/Penang/Amsterdam/ Mexico City: People's Health Movement; Medact; Medico International; Third World Network; Health Action International; AsociacionLatinomaricana de Medicina Social; Zed Books;
29. Ibid, p. 186
30. R. Rao and P.R. Panchmukhi, 'Health and the Indian Constitution'. Centre for Multidisciplinary development research monograph seried No.7. (ND). http://cmdr.ac.in/editor_v51/assets/Mono-7.pdf (accessed 30 April 2015).
31. S.B. Ghosh (1954), 'Some Theoretical Implications of Welfare State in India'. Indian Journal of Political Science 15(4): 327–38.
32. The Constitution (Seventy-Third Amendment) Act of 1992, India. c2015 http://www.tnrd.gov.in/constitutionalprovision.html#1 (accessed 12 November 2015).
33. The Constitution (Seventy-Fourth Amendment) Act of 1992, India. c2015 http://www.tnrd.gov.in/constitutionalprovision.html#4 (accessed 12 November 2015).
34. B.S. Levy and V.W. Sidel (2013), 'The Nature of Social Injstice and its Impact on Public Health'
35. D.E. Beauchamp (1976), 'Public Health as Social Justice', p. 103
36. D. Banerji (2001), 'The Political Economy of Health and Development' in I. Qadeer, K. Sen and K.R. Nayar (eds), Public Health and the Poverty of Reforms, New Delhi: Thousand Oaks/Sage, pp. 37– 62.
37. L.A. Morenas(2010). 'Planning the City of Djinns: Exorcizing the Ghosts in Delhi's Post-Colonial Development Machine'. Unpublished Doctoral Dissertation. Troy, New York: Rensselaer Polytechnic Institute.
38. D. Banerji (2001), 'The Political Economy of Health and Development'
39. WHO (1986), 'Ottawa Charter for Health Promotion: An International Conference on Health Promotion, The Move towards a New Public Health'. 17–21 November, Ottawa, Geneva, Canada
40. Department of Health and Social Security (1980), 'Inequalities in Health: Report of a Research Working Group', London: DHSS
41. World Health Organisation Commission on Social Determinants of Health (2008), 'Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.' Final Report of the Commission on Social Determinants of Health
42. A. Sengupta (2012), 'Creating, Reclaiming, Defending: Non-Commercialised Alternatives in the Health Sector in Asia' in D.A. Mcdonal and G. Ruiters (eds), *Alternatives to Privatisation: Public Options for Essential Services in the Global South*, New Delhi: LeftWord
43. K. Sen (2001), 'Health Reforms and Developing Countries—A Critique' in Qadeer, Sen , Nayar (eds), *Public Health and the Poverty of Reforms*, New Delhi: Thousand Oaks/Sage, pp. 137–53.
44. D. Banerji (2001), 'The Political Economy of Health and Development'
45. A. Irwin and E. Scali (2007), 'Action on the Social Determinants of Health: A Historical Perspective'. Global Public Health 2(3): 235–56.
46. Ibid.
47. R. Bisht, E. Pitchforth and S.F. Murray (2012), 'Understanding India, Globalization and Health Systems: AMapping of Research in the Social Sciences'. Globalisation of Health 8: 32.
48. T. Sundararaman and V. Muraleedharan (2015). 'Falling Sick, Paying the Price: NSS 71st Round on Morbidity and Costs of Health Care'. Economic and Political Weekly L(33): 17–20.
49. B. Sivakumar (2013), 'Dalits form 32% of Slum Dwellers in Tamil Nadu'. The Times of India. 2 October http://timesofindia.indiatimes.com/india/Dalits-form-32-of-Tamil-Nadu-slum-dwellers/articleshow/23377468.cms (accessed on 2 August 2015).
50. J. Mathieson, J. Popay, E. Enoch, S. Escorel, M. Hernandez, H. Johnston and L. Rispel (2008), 'Social Exclusion: Meaning, Measurement and Experience and Links to Health Inequalities. A Review of Literature'. WHO Social Exclusion Knowledge Network Background Paper 1.
51. T.K. Oommen (2009), 'Social Exclusion and the Strategy of Empowerment' in H. Bhattacharya, P. Sarkar andAngshuman Kar (eds), *The Politics of Social Exclusion in India: Democracy at the Crossroads*, Routledge
52. In urban areas, complete and partial exclusion can be determined by the relative position of the community or individual in the society with respect to other factors. For example, while gendered forms of exclusion are very common in society, the impact of the gendered discrimination is different for, say, an educated housewife and a poor, uneducated

women working in an informal setting. The impact of exclusion is worsened in the case that the woman is homeless and mentally ill. While educated women experience partial exclusion, uneducated, poor women experience complete exclusion. Likewise, communities and individuals in urban areas experience social exclusion to differing extents and of differing natures.

53. A. Chakrabarti and A. Thakur (2010), 'The Making and Unmaking of the (In)formal Sector'. Critical Sociology 36(3): 415–35.
54. (Chakrabarty and Thakur, 2010) There is a problematic homogenisation of the informal sector in our current understanding of it, relative to the (hegemonic) logic of the formal sector, that both stigmatises the informal sector and charts a linear course favouring formalisation as the only required societal transition (ignoring other possibilities including better social protection for those in the informal sector, etc.).
55. Planning Commission (2012), 'Report of the Expert Group to Recommend the Detailed Methodology for Identification of FamiliesLiving below Poverty Line in the Urban Areas', p. 25 http://planningcommission.nic.in/reports/genrep/rep_hasim1701.pdf (accessed on 6 May 2015).
56. Ibid, p. 27
57. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2013), 'Key indicators of slums in India', New Delhi: Ministry of Statistics and Programme Implementation
58. Ibid.
59. K.C. Sivaramakrishnan, A. Kundu and B.N. Singh (2005), *Handbook of Urbanization in India*, New Delhi: Oxford University Press
60. V. Prasad (2011) 'A Study to Understand the Barriers and Facilitating Factors for Accessing Health Care amongst Adult Street Dwellers in New Delhi, India'. Unpublished Dissertation. University of the Western Cape.
61. Planning Commission (2012), 'Report of the Expert Group to Recommend the Detailed Methodology for Identification of Families Living Below Poverty Line in the Urban Areas', p. 28
62. Ibid, p. 30
63. Ibid.
64. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2015), 'Key Indicators of Social Consumption in India | Health'. National Sample Survey 71st Round (January–June 2014). New Delhi: Ministry of Statistics and Programme Implementation P 10.
65. J. Beall (1996), 'Participation in the City: Where do Women Fit In?' in C. Sweetman (ed.), *Women and Urban Settlement. Oxfam: Oxford*, pp. 9–16. http://citeseerx.ist.psu.edu/viewdoc/download?doi= 10.1.1.309.5830&rep=rep1&type=pdf#page=18(accessed 6 May 2015).
66. H. Mander and S. Jacob (2010), 'Homeless Deaths on the Streets', New Delhi: Centre for Equity Studies; http://centreforequitystudies.org/wp-content/uploads/2012/08/Homeless-deaths-on-the-streets.pdf. (accessed on 15 May 2015).
67. S. Choudhary, A. Joseph and I.P. Singh (2011), 'Homeless Women and Violence'. http://www.hic-sarp.org/documents/Homeless_Women_and_Violence_Shivani_Amita_Indu.pdf (accessed 15 May 2015).
68. Planning Commission (2012), 'Report of the Expert Group to Recommend the Detailed Methodology for Identification of Families Living Below Poverty Line in the Urban Areas', pp. 25
69. R. Baru, A. Acharya, S. Acharya, A.K.S. Kumar and K. Nagaraj (2010), 'Inequities in Access to Health Services in India: Caste, Class and Region'. Economic and Political Weekly XLV(38): 49–58.
70. Sivakumar. 'Dalits form 32% of Slum Dwellers in Tamil Nadu'.
71. Ibid.
72. S.J. Chander (2009), 'Defending the Health of the Marginalised'. http://www.sochara.org/sites/default/files/Defending%20the%20marginalised_0.pdf. (accessed 1 August 2015).
73. Rashtriya Garima Abhiyan. 'Manual Scavengers and their Health'. (ND). http://www.mfcindia.org/main/bgpapers/bgpapers2013/am/bgpap2013h.pdf. (accessed 1 August 2015).
74. K. Navneetham and A. Dharmalingam (2000), 'Utilization of Maternal Health Care Services in South India'. http://mobile.opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/3018/wp307.pdf?sequence=1. (accessed on 1 August 2015).
75. A. Baviskar (2008), 'Contract Killings: Silicosis among Adivasi Migrant Workers'. Economic and Political Weekly 43(25): 8–10
76. D. Mosse, S. Gupta and V. Shah (2005), 'On the Margins in the City: Adivasi Seasonal Labour Migration in Western India'. Economic and Political Weekly, 40(28): pp. 3025–38.
77. Ibid, p. 3030
78. L. Gayer and C. Jaffrelot (eds) (2005), *Muslims in Indian Cities: Trajectories of Marginalisation*, New Delhi: Harper Collins

79. P.M. Kulkarni, Himanshu (2012), 'Regional Dimensions of Inequalities', in Z. Hasan and M. Hasan (eds), *India Social Development Report: Minorities at the Margins*, New Delhi: Oxford University Press/ Council for Social Development,pp. 102–17.

80. S. Bhalotra, C. Valente and A. van Soest (2005), 'The Puzzle of Muslim Advantage in Child Survival in India'. Journal of Health Economics 29: 191–204

81. Sivaramakrishnan, Kundu and Singh (2005), *Handbook of Urbanization in India*.

82. R.S. Hussain, S.T. McGarvey, L.M. Fruzzetti and S. Helleringer (2015), 'Partition and Poliomyelitis: An Investigation of the Polio Disparity Affecting Muslims during India's Eradicaion Program'. PLoS One 10(3): e0115628.

83. A. Meha and R. Hasan (2006), 'Under-representation of Disadvantaged Classes in College'. Economic and Political Weekly XLI(35): 3791–96

84. S. Thorat, A. Banerjee, V.K. Mishra and F. Rizvi (2015), 'Urban Rental Housing Market: Caste and Religion Matters in Access'. Economic and Political Weekly L(26–27): 47–53

85. Gayer and Jaffrelot (eds) (2005), *Muslims in Indian Cities: Trajectories of Marginalisation*

86. N. Kirmani (2008), 'History, Memory and Localised Constructions of Insecurity' Economic and Political Weekly XLIII(10): 57–64

87. Gayer and Jaffrelot (eds) (2005), *Muslims in Indian Cities: Trajectories of Marginalisation*, p. 312

88. Census of India (2011), 'Disabled Population by type of disability, age and sec-C-20 Table'. http://www.censusindia.gov.in/2011census/C-series/c-20.html, Tables C-20, C-20 SC, C-20 ST (accessed on 20 July 2015).

89. Ibid.

90. Ibid.

91. K.S. Ganesh, A. Das and J.S. Shashi (2008), 'Epidemiology of Disability in a Rural Community of Karnataka'. Indian Journal of Public Health, 52:125–29.

92. A.P.C. Suresh, T.E. Benjamin, J.E. Crasta, M.T.J. Alwinesh, G. Kanniappan and S.M. Padankatti (2014). 'Comparison of Burden among Primary Care-givers of Children with Autism and Intellectual Disability Against Children with Intellectual Disability Only in a Hospital Population in India'. Indian Journal of Pediatry 81(S2): S179–S182.

93. S.G. Kumar, G. Roy and S.S. Kar (2012), 'Disability and Rehabilitation Services in India: Issues and Challenges'. Journal of Family Medicine and Primary Care, Jan–Jun; 1(1): 69–73.

94. Census of India (2011), 'Disabled Population by type of disability, age and sec-C-20 Table'

95. C.E. George, G. Norman, T.E. Benjamin and D. Mukherjee (2014), 'Barriers to Early Diagnosis, Intervention and Social Integration of Children with Developmental Disabilities: A Qualitative Study from Rural Villages and a Poor Urban Settlement of Bangalore, South India'. Disability, CBR and Inclusive Development, 25(4): 61–83.

96. S. Agarwal (2011), 'The State of UrbanHealth in India: Comparing the PoorestQuartile to the Rest of the Urban Population in Selected States and Cities'. Environment and Urbanisation 23(1): 13–28.

97. Urban Health Division, Ministry of Health and Family Welfare, Government of India (2008), 'National Urban Health Mission (2008-2012): Meeting the Health Challenges of Urban Populations especially the Urban Poor (With Special Focus on Urban Slums)'. Draft for Circulation. Pp. 31-32 http://www.uhrc.in/downloads/Reports/NUHM-Draft.pdf (accessed on 20 July 2015).

98. Planning Commission, 'Report of the Expert Group to Recommend the Detailed Methodology for Identification of Families Living Below PovertyLine in the UrbanAreas'. p.25

99. B. Jayakrishnan, B. Thomas, B. Rao and B. George (2013), 'Occupational Health Problems of Construction Workers in India'. International Journal of Medicine and Public Health 3(4): 225–29.

100. Editorial (2008), 'State Apathy towards Construction Workers'. Economic and Political Weekly 43(21): 5.

101. Self Employed Women's Association (2008), 'Labouring Brick by Brick: A Study of Construction Workers'. http://www.sewaresearch.org/pdf/researches/labouring_brick_by_brick.pdf (accessed on 8 June 2015).

102. Ibid, p. 228

103. D. Fernandez and G.D.B. Paul (2011), 'Social Networks of Migrant Construction Workers in Goa'. Indian Journal of Industrial Relations 47(1):65–77.

104. Editorial (1979), 'Plight of Construction Worker'. Economic and Political Weekly 14(39): 1630–31.

105. Gurnam Singh Virk (2013), 'Workers in Informal Economy: A Sociological Study of Rickshaw Pullers in Patiala'. Dissertation submitted to Punjab University, Chandigarh.

106. T. Kurosaki, Y. Sawada, A. Banerji and S.N. Mishra (2007), 'Rural-Urban Migration and Urban Poverty: Socio-Economic Profiles of Rickshaw Pullers and Owner-Contractors in North East Delhi'. Discussion

Paper Series. 205. https://hermes-ir.lib.hit-u.ac.jp/rs/bitstream/10086/13600/1/D06-205.pdf (accessed 8 June 2015).

107. Ibid.

108. S. Begum and B. Sen (2004), 'Unsustainable Livelihoods, Health Shocks and Urban Chronic Poverty: Rickshaw Pullers as a Case Study'. CPRC Working Paper.

109. A.K. Pandey, M. Bajpayee, D. Parmar, S.K. Rastogi, N Mathur, P.K. Seth and A. Dhawan (2005), 'DNA Damage in Lymphocytes of Indian Rickshaw Pullers as Measured by the Alkaline Comet Assay'. Environmental and Molecular Mutagenesis 47(1): 25–30.

110. F. Cornish (2006), 'Challenging the Stigma of Sex Work in India: Material Context and Symbolic Change'. Journal of Community and Applied Social Psychology 16(6): 462–71.

111. T.S.H. Beattie, P. Bhattacharjee, B.M. Ramesh, V. Gurnani, J. Anthony, S. Isac, H.L. Mohan, A. Ramakrishnan, T. Wheeler, J. Bradley, J.F. Blanchard and S. Moses (2010), 'Violence Against Female Sex Workers in Karnataka State, South India: Impact on Health and Reductions in Violence Following an Intervention Programme'. BMC Public Health 10: 476. http://www.biomedcentral.com/1471-2458/10/476.

112. R. Sahni and V.K. Shankar (2011), 'The First Pan-India Survey of Sex Workers: A Summary of Preliminary Findings'. Paulo Longo Research Initiative. Sangli: Centre for Advocacy on Stigma and Marginalisation/ Sampada Gramin Mahila Sanstha. http://www.sangram.org/resources/Pan_India_Survey_of_Sex_workers.pdf (accessed 8 August 2015).

113. S. Baral, C. Beyrer, K. Muessig, T. Poteat, A.L. Wirtz, M.R. Decker, S.G. Sherman and D. Kerrigan (2010), 'Burden of HIV Among Female Sex Workers in Low-income and Middle-income Countries: A Systematic Review and Meta-analysis'. The Lancet Infectious Diseases 12: 538–49.

114. G. Gangoli (1999), 'Unmet Needs: Sex Workers and Health Care'. Indian Journal of Medical Ethics 7(3). http://www.issuesinmedicalethics.org/index.php/ijme/article/view/1489/3242 (accessed 15 June 2015).

115. F. Cornish (2006), 'Challenging the Stigma of Sex Work in India: Material Context and Symbolic Change'

116. Childline (2015), 'Vulnerable Children'. http://www.childlineindia.org.in/vulnerable-children.htm. (accessed on 15 May 2015).

117. V. Deshpande (2011), 'Every Eighth Urban Child in India Lives in Slums: Report'. The Hindu. 15 October. http://www.thehindu.com/news/national/every-eighth-urban-child-in-india-lives-in-slum-report/article2541052.ece(accessed on 15 May 2015).

118. Price Water House Coopers and Save the Children (2015), 'Forgotten Voices: The World of Urban Children in India' http://www.pwc.in/assets/pdfs/publications/urban-child/urban-child-india-report.pdf. (accessed 20 May 2015).

119. S. Ghosh and D. Shah (2004), 'Nutritional Problems in Urban Slum Children'. Indian Pediatrics 41: 682–96.

120. P. Salve and S. Tewari (2015), 'Shut Out: India's Poor, Urban Children'. India Spend. 25 July. http://www.indiaspend.com/cover-story/shut-out-indias-poor-urban-children-part-i-72517 (accessed on 28 July 2015).

121. N. Juneja (2001), 'Primary Education for all in the city of Mumbai, India: Challenge set by local actors'. Indian Institute of Educational Planning, UNESCO. http://datatopics.worldbank.org/hnp/files/edstats/INDpub01.pdf (accessed 15 May 2015).

122. National Commission for Protection of Child Rights (2013), Assessment of Pattern, Profile and Correlates of SubstanceUse among Children in India. New Delhi: National Commission for Protection of Child Rights. http://www.ncpcr.gov.in/view_file.php?fid=17 (accsesed 14 October 2015).

123. Ministry of Labour and Employment (2011), State Wise Details of Working Children in the AgeGroup of 5-14 Years as per Census 2001 and Census 2011. http://labour.gov.in/upload/uploadfiles/files/Divisions/childlabour/Census-2001%262011.pdf (accessed 15 May 2015).

124. K. Srivastava (2011), 'Child labour issues and challenges'. Indian Psychiatry Journal. Jan–Jun; 20(1): 1–3.

125. N.K. Behura and R.P. Mohanty (2005), *Urbanisation, Street Children and their Problems*, New Delhi: Discovery Publishing House.

126. A. Chatterjee (1992), 'India: The Forgotten Children of the Cities.' Italy: UNICEFhttp://www.unicef-irc.org/publications/pdf/is_india.pdf. (accessed 1 August 2015).

127. Childline India. 'Street Children'. (ND). http://www.childlineindia.org.in/street-children-india.htm. (accessed 1 August 2015).

128. Save the Children (2011), 'Surviving the Streets: A Census of Street Children in Delhi by the Institute of Human Development and Save the Children'. http://resourcecentre.savethechildren.se/sites/default/files/documents/5332.pdf. (accessed 2 August 2015).

129. N. Reddy (1992), 'Street Children of Bangalore: A Situational Analysis'. Noida: National Labour Institute.

130. National Commission for Protection of Child Rights (2013), 'Assessment of Pattern, Profile and Correlates of SubstanceUse among Children in India'.

131. Aide et Action (2012), 'Access to Education, Nutrition and Protection of Children of Migrant Workers'. http://www.aea-southasia.org/uploads/unicef_study.pdf (accessed 15 May 2015).

132. Ibid, p. 42

133. Ministry of Labour and Employment (2011), 'State Wise Details of Working Children in the Age Group of 5–14 Years as per Census 2001 and Census 2011'.

134. K. Srivastava (2011), 'Child labour issues and challenges'.

135. K. Goel, S. Ahmad, R. Bansal, P. Parashar, B. Pant B and G. Goel (2012), 'The Social and Occupational Problems of ChildLabour: A Challenge the World is Facing'. Indian Journal of Community Health 24(1): 53–57.

136. V V Giri National Labour Institute. 'Magnitude of Child Labour in India: An Analysis of Official Socurces of Data (Draft)'. (ND). http://www.vvgnli.org/sites/default/files/publication_files/Magnitude_of_Child_Labour_in_India_An_Analysis_of_Official_Sources_of_Data_Draft_0.pdf. (accessed on 27 May 2015).

137. Childline (2015), 'Child Labour in 'India'.

138. United Nations Department of Economic and Social Affairs, Population Division (2008 Revision), 'World Population Prospects'. http://esa.un.org/unpp/index.asp?panel=2. (accessed 26 May 2015).

139. S. Raju (2000), 'Ageing in India: An overview', in M. Desai and S.Raju (eds), *Gerontological Social Work in India: Some Issues and Perspectives*, New Delhi: BR Publishing; as quoted in S. Dey, D. Nambiar, J.K. Lakshmi, K. Sheikh, K.S. Reddy (2012), 'Health of the Elderly in India: Challenges of Access and Affordability.' http://www.ncbi.nlm.nih.gov/books/NBK92618/ (accessed 27 May 2015).

140. S. Dey, D. Nambiar , J.K. Lakshmi, K. Sheikh, K.S. Reddy (2012), 'Health of the Elderly in India: Challenges of Access and Affordability', in J.P. Smith and M. Majumdar (eds) *Needs to Meet the Challenges of Aging in Asia*, Washington (DC): National Academics Press (US) http://www.ncbi.nlm.nih.gov/books/NBK92618/ (accessed 27 May 2015).

141. Public Health Resource Network (2010), 'Lesson Three: Urban Health – Policies, Programmes, and Delivery Structures'. Book 16: Issues in Urban Health. New Delhi: Public Health Resource Network, pp. 36–78.

142. S.I. Rajan and S. Aliyar(2011), 'Population Aging in India' in S.I. Rajan, C. Risseeuw and M. Perera (eds), *Institutional Provisions and Care for the Aged: Perspectives from Asia and Europe*, London: Anthem Press.

143. Naila Kabeer (2000), 'Social Exclusion, Poverty and Discrimination: Towards an Analytical Framework', IDS Bulltein, 31:4

144. H. Mander, 'The State, Marginalised People and Justice'. Unpublished Presentation. (ND).

145. Steering Committee on Urbanisation, Planning Commission (2011), 'Report of the Working Group on Urban Poverty, Slums and Serivc [sic.] Delivery System'. New Delhi: Government of India http://planningcommission.nic.in/aboutus/committee/wrkgrp12/hud/wg_Final_Urb_Pvt.pdf (accessed 3 August 2015).

146. R. Dasgupta (2012), *Urbanising Cholera: The Social Determinants of Its Re-Emergence*, Hyderabad: Orient Blackswan, p. 266

147. Srilatha Batliwala (2011), 'Unpacking Social Exclusion: A Primer for Marginalised Women', CREA, pp. 17-37 http://www.countmeinconference.org/downloads/background_papers.pdf

148. L.A. Hulton, Z. Matthews and R.W. Stones (2007), 'Applying a Framework for Assessing the Quality of Maternal Health Services in Urban India'. Social Science & Medicine 64:2083–95.

149. N. Barua and C.S. Pandav(2011), 'The Allure of the Private Practitioner: Is this the only Alternative for the Urban Poor in India?' Indian Journal of Public Health 55(2): 107–14.

150. Hospital Employees Union, Jobs with Justice and Society for Labour and Development (2007), 'India's Health Care in a Globalised World: Health Care Workers' and Patients' Views of Delhi's Public Health Services'. New Delhi: Society for Labour and Development, p. V.

151. R. Priya (1993), 'Town Planning, Public Health and Urban Poor: Some Explorations from Delhi'. Economic and Political Weekly 28(17):824–34.

152. Public Health Resource Network (2010). 'Lesson Three: Urban Health – Policies, Programmes, and Delivery Structures', pp. 36–78.

153. R. Kaul (2015), 'Five Remedies to Save Delhi's Hospitals'. Hindustan Times. 11 July. http://cjr7.com/five-remedies-to-save-delhis-hospitals/. (accessed 11 July 2015).

154. This ratio is perhaps somewhat exaggerated as the

public sector includes beds provided by the Railways, Army, and the Employees State Insurance Scheme. These facilities are not be accessible to all populations. However, it can conversely be argued that while these facilities restrict access based on eligibility criteria, private facilities restrict it on purely financial grounds, i.e., the ability to pay. Further, public facilities are also known to specifically cater to the poorest populations.

155. V. Krishnan (2015), 'Private Practice'. The Caravan. 1 Feb http://www.caravanmagazine.in/reportage/naresh-trehan-medanta-private-practice?page=0,10#sthash.pSnmTAkA.dpuf (accessed 14 February 2015), p. 4

156. P. Kaushika (2015), 'Govt Cracks Down, Will Monitor EWS Admissions in Private Hospitals. The Indian Express. 19 March. http://indianexpress.com/article/cities/delhi/govt-cracks-down-will-monitor-ews-admissions-in-private-hospitals/(accessed 3 Aug 2015).

157. B.S. Perappadan (2015), '30% Beds for EWS Patients Lie Vacant'. The Hindu. 5 August. http://www.thehindu.com/news/national/other-states/30-beds-for-ews-patients-lie-vacant/article7500824.ece (accessed 5 August 2015).

158. M. Kanchan (2015), 'Business of Hospitals'. Economic and Political Weekly L(30): 25–27.

159. High Level Expert Group on Universal Health Coverage (2011), 'Report of the High Level Expert Group on Univeral Health Coverage'. New Delhi: Public Health Foundation of India.

160. Editorial (2014).'Facing Health Crises, India Slashes Healthcare'. India Spend. 25 December. http://www.indiaspend.com/cover-story/facing-health-crises-india-slashes-health care-57629(accessed 3 August 2015).

161. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2015), 'Key Indicators of Social Consumption in India | Health'

162. Ibid.

163. R. Duggal (2006), 'Health Tourism or Reengineered Brain Drain'. Health Action 19(3).

164. Ibid.

165. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2015), 'Key Indicators of Social Consumption in India | Health'

166. Ibid.

167. Planning Commission (2012), 'Report of the Expert Group to Recommend the Detailed Methodology for Identification of Families Living Below Poverty Line in the Urban Areas'. p. 28

168. K. Anand, B. Shah, K. Yadav, R. Singh, P. Mathur, E. Paul and S.K. Kapoor (2007), 'Are the Urban Poor Vulnerable to Non-communicable Diseases? A Survey of Risk Factors for Non-communicable Diseases in Urban Slums of Faridabad'. National Medical Journal of India 20(3):115–20.

169. M.K. Ranson (2002), 'Reduction of Catastrophic Health Care Expenditures by a Community-based Health Insurance Scheme in Gujarat, India: Current Experiences and Challenges'. Bull World Health Organ 80(8): 613–21.

170. K.D. Ramaiah, H. Guyatt, K. Ramu, P. Vanamail, S.P. Pani and P.K. Das (1999), 'Treatment Costs and Loss of Work Time to Individuals with Chronic Lymphatic Filariasis in Rural Communities in South India'. Tropical Medicine & International Health 4(1): 19–25.

171. J.F. Levesque, S. Haddad, D. Narayana and P. Fournier (2007), 'Affording What's Free and Paying for Choice: Comparing the Cost of Public and Private Hospitalisations in Urban Kerala'. International Journal of Health Planningand Management22: 159–74.

Sivaramakrishnan, Kunduand Singh (2005), Handbook of Urbanization in India.

172. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2015), 'Key Indicators of Social Consumption in India | Health'

173. N. Barua and C.S. Pandav (2011), 'The Allure of the Private Practitioner: Is this the only Alternative for the Urban Poor in India?'

174. A. Gadre and A. Shukla (2015), *Voices of Conscience from the Medical Profession*, New Delhi: Oxfam/CEHAT.

175. Ibid.

176. V. Chakrapani, Y. Singh, A. Aher, S. Shaikh, S. Mehta and J. Robertson (2013), 'Issue Brief: Transforming Identity – Access to Gender Transition Services for Male-to-Female Transgender People in India'. http://www.allianceindia.org/wp-content/uploads/2014/07/2014_AllianceIndia_Transforming-Identity-Access-to-Gender-Transition-Services-for-Male-to-Female-Transgender-People-in-India.pdf. (accessed 21 July 2015).

177. S. Awasthi, N.M. Srivastava and S. Pant (2008). 'Symptom-specific Care-seeking Behavior for Sick Neonates among Urban Poor in Lucknow, Northern India'. Journal of Perinatology, 28: S69–S75; doi:10.1038/jp.2008.169.

178. A. George and A. Iyer (2013), 'Unfree Markets: Socially Embedded Informal Health Providers in Northern Karnataka, India'. Social Science and Medicine 96:297–304.

179. V.R. Kamat and M. Nichter (1998), 'Pharmacies, self-medication and pharmaceutical marketing in Bombay, India'. Social Science and Medicine 47(6):779–94.

180. Urban Health Division, Ministry of Health and Family Welfare, Government of India (2008) 'National Urban Health Mission (2008-2012): Meeting the Health Challenges of Urban Populations especially the Urban Poor (With Special Focus on Urban Slums)'

181. Ibid.

182. K.D. Ramaiah, H. Guyatt, K. Ramu, P. Vanamail, S.P. Pani and P.K. Das (1999), 'Treatment Costs and Loss of Work Time to Individuals with Chronic Lymphatic Filariasis in Rural Communities in South India'

183. Sivaramakrishnan Kunduand Singh (2005), *Handbook of Urbanization in India*.

184. K.D. Ramaiah, H. Guyatt, K. Ramu, P. Vanamail, S.P. Pani and P.K. Das (1999), 'Treatment Costs and Loss of Work Time to Individuals with Chronic Lymphatic Filariasis in Rural Communities in South India'

185. S. Selvaraj and A.K. Karan (2012), 'Why Publicly-Financed Health Insurance Schemes are Ineffectivein Providing Financial Risk Protection'. Economic and Political Weekly XLVII(2): 60–68.

186. I. Gupta (2009), 'Out of Pocket Expenditures and Poverty: Estimates form NSS 61st Round'. Paper presented for consideration of the Expert Group on Poverty, Planning Commission. Delhi: Institute of Economic Growth. http://planningcommission.gov.in/reports/genrep/indrani.pdf (accessed 12 June 2015).

187. Ibid.

188. This applied to the average total medical expenditure for non-hospitalised treatment per ailing person suffering from only one ailment at various levels of care.

189. National Sample Survey Office, Ministry of Statistics and Programme Implementation (2015), 'Key Indicators of Social Consumption in India | Health'

190. R. Pal (2012), 'Measuring Incidence of Catastrophic Out-of-pocket Expenditure: With Application to India'. International Journal of Health Care Finance and Economics 12: 63–85.

191. M.M. Engelgau, A. Karan and A. Mahal (2012), 'The Economic Impact of Non-communicable Diseases on Households in India'. Globalisation and Health 8:9.

192. The Hindu (2009), '2 Health Centres Coming Up Soon for Senior Citizens'. 2 October. http://www.thehindu.com/todays-paper/tp-national/tp-tamilnadu/2-health-centres-coming-up-soon-for-senior-citizens/article153267.ece (accessed 2 March 2015).

193. R. Sujatha (2010), 'Corporation Health Centres to get Semi-auto Analysers'. The Hindu. 8 August. http://www.thehindu.com/news/cities/chennai/corporation-health-centres-to-get-semiauto-analysers/article558181.ece (accessed 17 March 2015).

194. Society for Nutrition, Education and Health Action. Organisation Brief. Mumbai: SNEHA. (ND). http://www.snehamumbai.org/

195. Society for Nutrition, Education and Health Action. SNEHA: About Us. http://www.snehamumbai.org/about-us/about-sneha-mumbai-ngo.aspx (accessed 5 August 2015).

196. SWaCH. What is Swach? http://www.swachcoop.com/about-swachpune.html (accessed 7 August 2015).

197. The Bhopal Medical Appeal. Sambhavna Clinic. http://bhopal.org/about-us/sambhavna-clinic/ (accessed 7 August 2015).

198. The Banyan Projects – Adaikalam. http://www.thebanyan.org/html/adaikalam.html (accessed 7 August 2015).

199. R. Gopinath, K. Richter, K. Srivastava and G. Plotkin (2015). 'USAID/India Health of the Urban Poor Program Final Evaluation Report (AID 386 TO 15 00002/ AID 486 1 14 00001)'. New Delhi: USAID.

200. An urban homeless recovery shelter in the Yamuna Pushta area of New Delhi, The Banyan in Chennai, and the SWaCH Cooperative in Pune are all examples of organisations that are facilitating the identification acquisition process for their patients and residents, clients, and members. Certainly other organisations functioning in the urban health sector, though they themselves might not be requiring identification for individuals to access their services, should similarly facilitate the identification acquisition process.

201. The Banyan has shared living accommodation available for its clients whohave been duly treated at The Banyan but still need some level of long-term care.

202. The Aman Biradari programme has a functional model of linkages between health care facilities and their recovery shelter, which is an important, and often only recourse for those who cannot continue or complete treatment specifically because of their vulnerability.