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Concept Note

Urbanization, Inequity and Health in India: a Landscape

- Organising Team

Defining the Urban

In India an official definition of the term urban by Census is: over 5000 population; a population density of over 400 persons per sq km; over 75% of male workforce in non-primary activities.

According to the 2011 census, 30% of India's population lives in urban areas.

Visible Differences Between the Urban and the Rural

What would be the specific features of the urban that are immediately visible? Roads are relatively better, there is some drainage system that may or may not work very well. Some form of systematic centralized water supply occurs, badly or well, depending on availability. Often private suppliers make money in areas with water scarcity. Buses, trains, auto-rickshaws, cars, planes all may be part of the transportation system. Institutions like schools, hospitals, government offices are widespread. Physical access to essential services like health care and education is easier. Communication through phones or internet is much easier though in recent times the advent of mobiles have made things a little easier for the rural population.

Life in a city in India today is congested and unpleasant.

One characteristic aspect of the city is anonymity. It is possible to spend a whole day in a big city without encountering someone you know. It gives some privacy in the most public spaces, and at the same time it results in few social contacts that can be called on in times of urgent need.

The thing to notice is that the urban is automatically imagined in opposition to the rural. Without the idea that something is rural, the idea of the urban wouldn't exist. In many ways, from the urban perspective, the rural is the opposite of the urban. It is less congested, has fewer job opportunities, it lacks robust transport and communication systems, and there is no "privacy".

The Spread Between the Urban and the Rural

The opposition between the rural and the urban is an abstraction. In fact, there are over 5000 intermediate towns and 53 cities (with a million plus population). The metropolitan cities are six in number, and the broad details discussed here are largely with respect to these metropolises.

There is much literature on the growth and the weakness of small towns in India, and the existence or lack of dynamism in them. This is a picture that is too complex for a short paper of this type. However, we will broadly outline some differences with respect to smaller towns wherever we find ourselves competent to comment.

Urban and Rural: Economic Relationship at First Sight

It is a commonplace that the urban provides more avenues of employment given the intensity of agrarian distress in the rural economy – manifest as landlessness, lack of non-farm employment and the growth of mechanized agriculture. In contrast, urban employment options appear to be aplenty: white collar, blue collar, informal labour, self employed small businesses, delivery jobs, upkeep services of all kinds, rag picking, drainage cleaning, selling toys at street corners, watchmen, domestic work, sex work, collection agents for money lenders, strongman, etc. This differential has been theorized as the 'urban advantage' – which in the scenario we describe seems a misnomer for the complex survival tradeoffs that migrants make (See Rahul's contribution in this volume).

Yet, employment is often not tempting enough to make the rural population migrate lock, stock and barrel. There are economic ties to the village that remain a means to survival. Most important is food. "In my childhood", (Prabir Chatterjee says) "grain

would come from my village to the town I lived in every year. Even today, bags of rice come from the village to youth and migrant families to mitigate the cost of living. Many people like 'D' of SHRC, Chhattisgarh, live and farm in the village while using the cash from their salary to dig wells or buy seed or insecticide".

This fluctuating availability of different forms of labour opportunity results in a cyclical migration pattern where individuals migrate to the city on a seasonal basis, coming in for the available informal employment avenues, and returning during harvests, times of distress or to add to income using the NREGA as an opportunity (see Mithun Som 's contribution in this volume).

Yet, there is a desire among rural individuals and communities to come to the city for a better future. This leads to different kinds of migratory patterns, through family, community, occupation, caste, etc.

Broadly speaking, urban agrarian distress has been recognized as the covert engine of large scale migration to urban areas.

The Desire for the Urban, the Desire of the Urban

In spite of the extremely difficult life in the city, the desire for the urban is strong and nearly universal among the rural young. Wave upon wave of youth arrives at the city. While some youngsters succeed, many are marooned between an impossible dream that cannot be achieved and a life left in the village that cannot be fully returned to.

This unending desire is based on many perceptions. One, media, advertising, movies and television programmes promise a dream life in the city. The freedom, anonymity and individualism in urban areas are term for term opposed to the community constraint, constant recognition and submission that is experienced in traditional village communities. This desire is also set against an experience of social discrimination in an atmosphere of fully visible, known, community and caste relationships. The perception of rural discrimination is strengthened by dalit and oppressed caste movements and history. Further, those who come back to a village after a stint in the cities with their different clothing, increased confidence and liberatory ideas also lure more youth to the cities.

On the other hand, the urban dreams of the rural, its wide spaces, its idyllic life and peace. This dream is most vivid in cinema through the 1960s and 1970s. This is a romantic view that also draws upon a political history of praising the village and its resistance to the evils of modernity.

For women, the urban opens out a new dimension of existence. The relative weakening of extended and joint family structures makes the urban space seem both more risky and free. The anonymity permits latitude of conduct that is wider than in the more closely supervised rural context. There is a constant necessity to go beyond the confines of the home in the urban context of an overcrowded public life. New relationships open out different worlds to women's experience of gender and its forms of freedom and inequity. (In rural areas, women who don't belong to the upper caste and class are seldom trapped at home. They have to go out on farm related activities, fetching water, taking care of cattle, bathing, etc. The difference is that rural women move in familiar territory whereas the urban women have to learn to deal with unfamiliar territory, strangers and public transport).

The small town provides a stepping stone for educated youth, in that their first step of college education usually takes place there. It is after the preparatory step of the small town that the major migratory step of the educated classes to the city takes place.

The town is also a place where the traditional power politics of the village clashes with the more democratic political imagination of a city. The first steps of politicization after the Tsunduru massacre in Andhra Pradesh (1991) took place in the town of Tenali after which intervention through civil liberties, legal and political bodies from cities like Guntur, Vijayawada and Hyderabad became possible.

Urban and Rural Economy: Deeper Structural Relationships

In modern India post independence, industrialization, the development of core industries like steel plants, fertilizer, cement, power stations, dams, machine tools, heavy equipment, etc., have been priority. They were the thrust areas of modernization, i.e., of urbanization and capitalist development. Rural and agricultural development was intended to provide cheap food for urban labour in national industries without losing self sufficiency in food production. Thus, for the first three decades the economy of rural India was planned by an administration that was essentially urban in its composition.

All forms of planned development in the rural areas such as development blocks, intensive agriculture areas, green revolution zones, etc., transformed the rural economy beyond recognition in the states in which they were implemented. Yet social change was slow to follow. To put it another way, the already uneven transformation of the rural economy was geared not to disturb existing relations of social dominance and oppression.

After the eighties, with liberalization, the erstwhile support for agriculture was gradually withdrawn, with fertilizer subsidies, grain purchase prices, stockpiling of grain coming under criticism from structural adjustment and neoliberalism. Decline

in rural bank branches and of agricultural credit resulted in increasing reliance on informal sources. Increasing health care and education costs also put people in debt. In this situation of distress, migration intensified, in turn vitiating scope for any sustainable livelihood in the rural areas. More and more villages in different parts of India are being abandoned, with people moving to the cities. Even more have mobile populations trying to eke an existence through a combination of survival strategies in both rural and urban areas.

Urban areas as economic and social spaces too have undergone a transformation. With neoliberalism, labour laws have been diluted. The influence and fervor of trade unions have become faint memories, eclipsed by the pervasiveness of contractualised, ad hoc labour arrangements. As the labour manager of the Jindal Steel Plant in Karnataka put it, by the early 2000s, their 'philosophy' was to use informal labour – to be precise, 30,000 informal labourers 'clothed' in rags brought in by trucks to the plant every day! This trend is also seen in government and public sector units where informal workers now dominate the lower cadres. Informal labour drives the worker to frantic extremes, forcing him/her to work long hours for a pittance, with complete lack of any legal protection or even any identity as belonging to the factory. Cash wages less debt repayments is the norm.

In relation to both caste and gender, new structural relationships have begun to emerge. Traditional caste patriarchy urbanizes itself as it struggles to keep control of the mobility of both women and dalits (e.g., medieval curfew timings in women students' hostels, a 'natural' shepherding of dalit men toward menial jobs). In addition, urban public labour requires a modern, industrial discipline and evolves new codes of conduct and forms of power.

The continued invisibility of unpaid labour vexes further the roles women play in the care economy in urban areas – their roles variably intermingled, replaced, challenged, and complemented with those in other class, caste, religious and occupational categories. Take for instance, four connected women: one is a mother who leaves her child in her mother's care, to care for the child of a professional nurse providing care to the elderly mother of a daughter who has forsaken being a mother for her career. These relationships and roles affect how women see themselves, each other, and understand their position and possible role in the world.

The contradictions of the rural and the urban in relation to caste and gender express their ugliest manifestations in the professions that relate to urban households: servants, cooks, drivers, etc. Verbal and sometimes physical abuse, subtle insult, everyday discrimination, sexual harassment and public humiliation are often the common language in the domain of the private – all this over and above a subsistence wage. The upwardly mobile middle classes plant their feet squarely on caste advantage to make the maximum of an urban life while paying a pittance to workers who take on domestic drudgery.

So while the urban dream is fostered and remembered with some fondness, the city becomes a space of ambivalent promise and struggle, deeply rooted in the emerging capitalist structure of the nation state.

It is in this broadly emerging scenario that we have to understand the recent idea of 'smart cities' in India. Clearly the idea is intended to provide structured markets for capital through streamlining and beautification of cities from the perspective of the better off. What does this mean for the lives of the dispossessed and expropriated? What does 'smart' mean? Do we rather not need 'wise and humane' cities?

The Other of the smart city is the much reviled municipal corporation that is expected to run and maintain the city today. These corporations struggle under budgetary constraints, administrative corruption through land mafia and real estate pressure, and in addition suffer a definite dimension of 'untouchability' that comes from their involvement in the often polluting task of keeping the cities clean and healthy. The political impasse for the poor arises between the barely functioning municipal corporations and the spectre of the smart city managements that threaten to replace them.

Urban Health

Urban health is a non-concept for the poor; it is only ill-health that surfaces rudely in the form of an emergency or catastrophe. The more common and regular concerns are around livelihood, which of course determines health in critical ways. Unsteady employment, self-employment and hidden unemployment lead to inadequate wages. The legal minimum wage is not adhered to. This leads to inadequate food and poorly balanced, unhealthy diets. Cramped and exorbitantly priced living spaces, dismal sanitation and unhygienic drinking water supply add to the risk. Savings are minimal, and informal daily wage labour makes any discontinuity economically crippling. Yet the cyclical pattern of migration to garner a livelihood and meet obligations make it difficult for these individuals to claim governmental benefits on the basis of identity documents, employee records, ration cards, etc.

In addition, the urban poor are also prey to instability and survival risk due to disasters, epidemics and conflict.

Minor illnesses like coughs, fatigue and inadequate bodily energy become chronic. The body's immune systems weaken, and tip the unfortunate over into disease – tuberculosis, infections of the gut, etc.

Accidents due to increasing traffic, disadvantageous living and transport conditions (like overcrowded buses and trains) also occur. The toll of worsening transport, pollution and fatigue on the body and mind cannot be overestimated.

Work in hazardous locations either as self employment (rag picking) with no scope of protection or in industries (metal plating, chemical, explosive) with criminal neglect on the part of employers adds to the heavy overload of risk. The heartlessness of employers in the drive for more profits is doubtless related to caste arrogance and a callous contempt for the working classes.

The double load of household/and paid labour outside on the one hand, and the characteristic self-sacrifice in food and well being on the other haunt and take their toll on married women in urban working classes.

Then the catastrophe that was waiting in the wings happens – illness, serious chronic conditions, accident – and access to a livelihood is threatened.

The highly excluded in urban areas – such as the destitute, face a unique toll, exposed to the physical and social brutality of cities and towns, living open to the elements and on the fringes of legality, the threat of violence, injury, insult, and exploitation. The toll of mental illness and substance abuse is high, just as the predictability of services and support – usually in the form of charity – is low.

Medical Treatment

At some point (often of desperation and last recourse), the urban-dweller seeks health care. A majority of the workforce isn't covered by the Employees State Insurance (ESI) scheme. Those who are may find that the employer hasn't paid the ESI share he was supposed to pay. However, it is the worker who is penalized through a lack of treatment at her most vulnerable moment. She finds that government hospitals treat her illness, but also treat her badly. She is abused, discriminated against and regarded as an unavoidable nuisance by many of the employees of the government health system.

The person finds that private hospitals often charge a fortune for tests, scans, to cure an illness that he can't understand. Everything costs money, which leads either straight to a debt trap, or to the complete pauperization through the sale of meager assets. Even schemes like the Rashtriya Swasthya Bima Yojana don't cover the bulk of costs that are typically incurred. Instead, he often first goes to the unqualified health providers where he may or may not get well. As Veena Das' contribution suggests, the informal medical system in the poorer urban areas is seen as unwanted, remains unplanned and chaotic, and is thus squandered as a potential resource for genuine health care.

Probably the biggest impact on the urban health care scene has been the entry of the corporates in health care from 1980s. This has been accompanied by the general belief that government health care is poor, while private health care is good. Another massive change has been the weakening of primary health care and the dominance of tertiary care. With these changes the disparities between urban and rural health care facilities/services has widened since the 90s. The tertiary health facilities and private facilities are full of both urban and rural consumers. But are they really looking after primary needs?

In actual fact, some primary health needs are better met in rural areas (e.g., can one get immunization, ORS or Paracetamol free in the town without standing in a long line?). Secondary Hospitals should have been in the districts and at the next stage in the blocks, but these are looked after by small nursing homes in small towns and cities as government secondary hospitals are poorly run.

The Woes of Government Hospitals and Urban Health Posts

The complexity of the urban is among the first features that preclude equitable and efficient service delivery. Authority is vested in state governments and municipal authorities (which are themselves sub-divided and furcated). Funding arrangements are deliberately tenuous and complex: including central, state, municipal, ad hoc and private funding. These are often linked, feebly, with various urban renewal and development projects and fragments or remnants donor-driven project components.

Government hospitals in urban areas are understaffed, underfunded and often chaotic. Sometimes, for various reasons, they fall into the cracks of the system and lose out on a proper source of supplies and funds.

The logic of salaries tends to run against the dominant free market pattern without adequate ideological support or mobilization. Thus, to take one example, urban government doctors in one state get 35,000 Rs per month, 10,000 less than rural government doctors who also collect hardship pay. While this is a useful motivator for rural postings among the young, only retired and senior doctors with a private practice opt for urban postings. They devote barely 2-3 hours to the government clinic per day. In other places, doctors are given free accommodation by the private pharmacies in return for what may be called 'preferential prescription rights'.

Medical supplies to government medical posts are irregular and follow complex organizational routes that lead to the familiar unavailability of drugs. Facilities thus depend on diverse and sometimes irrational authorities for their disbursement. Staffing and administrative patterns are chaotic. The queues

to see the doctor are inevitably long, and the patient is often seen by the pharmacist. Medicines are given for three days at a time, forcing a loss of wage labour every three days for any systematic treatment.

As Ravi Duggal puts it in his paper, primary healthcare facilities in the public sector are grossly inadequate in urban areas. The administrative expectation is that municipal governments should pick up the tab or urban healthcare should be left to the mercy of the market, especially the rapidly growing private health insurance market – in fact the defunct NUHM policy document actually suggested that!

And yet, urban health care does provide some basic minimal care with all the limitations it suffers from. There are many of both private and public practitioners of medicine who work with commitment towards alleviating morbidity among the poor. Government hospitals in urban areas in particular are beacons of hope to many migrants – especially the disabled – whose health needs drive them into particular cities and towns.

The chaotic and amorphous structure of governmental urban health care is the outcome of a complex struggle between economic forces that push the state to liberalize the economic agenda completely on the one hand, and a disorganized, yet sturdy resistance by some wings of the state apparatus to maintain some autonomy and responsibility to the people on the other.

Privatized Medical Care and Insurance

Although the origins of privatized medical care go far back, the last decade has seen the profusion of insurance models for catastrophic illness functioning through corporate hospitals. Schemes like Rajiv Aarogyasri are designed to provide the poor free medical care for catastrophic illness, but de facto serve the purpose of using the illness of the poor as a vehicle for transferring government funds to private corporate hospitals. In this system of health care, appropriate, timely and economical treatment of illnesses with minimal medically induced trauma is replaced by expensive, delayed and completely outlandish forms of treatment. Even though this is purportedly free, it ends up extracting from the patient out of pocket expenditure often exceeding what he or she would have paid without insurance.

The net effect of the steady erosion of the primary health infrastructure and the power of the corporate hospitals is that the poor have no memory or comprehension of timely, appropriate, low cost (including loss of wages), easily accessible and genuinely useful medical care. They only know that when the catastrophe occurs, the government pays the bill (and the poor pay a quite large sum too, but don't realize it). This results in a false and completely unjustified sense of gratitude towards the programme and the corporate hospitals who earn their profits through them.

Invisibilised thus are the commitments that such hospitals pledge, of providing free care to economically weaker populations, in return for prime land (at throwaway prices) on which their medical "cities" are built. In rare cases these requirements are actually met, and rarer still are they monitored by the government.

As a further twist and as an extension of the urban dominance over the rural, corporate hospitals through the vehicle of privatized insurance are using primary health camps to attract fee paying patients to their tertiary hospital setups in the city. Thus the privatized urban health care system now begins to prowl the countryside to fulfill its thirst for profits.

Conclusion

Between the collapsing public health care systems and the zeal for profit of corporate hospitals, the urban ill encounter an impasse. Any choice (public, private, alternative care) will lead quite often to a situation where a rational recovery of 'full' health is impossible (this is of course presuming they had full health in the first place). As an earlier essay by Lakshmi Kutty[1] on the urban poor in the old city of Hyderabad has suggested, the poor know the impossibility of their predicament and try to make the best of a hopeless situation – a kind of 'pragmatic agency'. They seek some form of palliation in an endless struggle to live and sustain their bodies.

And yet, there are some small but important possibilities of change: Using the informal network through strengthening its resources (as Das' paper for this meeting and others earlier have suggested); experimenting with new kinds of community self-help organizations that draw on available public and private resources; depending on 'new' actors, for instance, women, as described in the essay Siddharth Agarwal, et. al. have contributed to this meeting; advocacy to improve and implement existing strengths. It is up to a kind of democratic inventiveness to find new ways of engaging with these complex problems. Before we dismiss this as applying a band aid on a problem that needs more radical intervention, let us remember that having a participatory democratic process, however small, is perhaps the most radically transformative step of all.

[Inputs from Prabir Chatterjee, Dhruv Mankad, Devaki Nambiar, Adithya Pradyumna, Sheela Prasad, and R Srivatsan]

[1] *In Towards a Critical Medical Practice* (Hyderabad: OBS, 2010)