(Kalpana Sharma)
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MEDICAL EMERGENCY

of the Urban Poor

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A man who works as a driver in Mumbai discovered recently that his wife, who complained of breathlessness, had a heart problem. She has a blocked artery and a faulty heart valve. Like others of his ilk, this man lives in a slum. His salary as a driver is not enough to rent, leave alone buy, an apartment anywhere in Mumbai. So he lives in a "regularized" slum, which cannot be demolished, and which is, ironically, located on the most expensive real estate in Mumbai, in the upscale neighbourhood of Malabar Hill.

This preferred location, however, makes little difference to him when facing a health crisis such as this. The choices before him are stark. If he does nothing, because he cannot afford to get his wife treated, then she will die. If he chooses to get her treated, then he faces lifelong indebtedness.

In a city with some of the most expensive and modern health care facilities, millions of lower income and poor people face the dilemma facing this driver. As opposed to their rural counterparts, even poor people living in cities are well aware of the medical interventions that are possible to prolong life and to deal with life-threatening conditions. But they also know that such interventions are out of their reach in an increasingly privatized health care market. The public health care systems that exist are simply not enough to meet the demand even for ordinary health conditions leave alone for specialised care.

Mumbai is actually better served than most other Indian cities with public health facilities. The Brihanmumbai Municipal Corporation (BMC) runs four teaching hospitals, five specialised hospitals, 16 peripheral hospitals, 28 maternity homes and several hundred dispensaries and health outposts. Out of the estimated 40,000 hospital beds available in Mumbai, around a quarter come under the BMC. In addition the state government runs one medical college, three general hospitals and two health units with a total of 2,871 beds. The Central government also runs one hospital.

Yet, despite the availability of these services, people who cannot afford to spend on private health care still do not necessarily see public services as the first choice. Several studies have shown that as many as 77 per cent in urban areas and 63 per cent in rural areas turn to private practitioners for outpatient care because the public facilities are either too far, or their procedures are too bureaucratic and take too long to access. Even amongst poor people who cannot afford private care, the percentage of those who use it is over 60 per cent.

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However, for in-patient care, the poor seek out public facilities, even if they are at some distance from where they live, because they are the only ones that are affordable. However, it is evident that these are inadequate to meet the demand. The overcrowding seen in every public hospital is a stark reminder of the shortage of affordable beds in a city where the majority of people cannot afford expensive health care. Furthermore, the big hospitals in Mumbai serve as referrals for people from across the state and other states.

Access to health care, however, is only one part of the larger story of health status of the urban poor, one of several hidden developmental crises. Compared to their rural counterparts, poor people living in cities should be better off. There are many more hospitals, many more doctors, running water that is reasonably potable, sanitation that is passable, electricity and public transport. Even the poorest can earn something in a city like Mumbai.

Unhygeinic conditions off the pavement dwellers

What is forgotten is that even if they do not suffer income poverty to the extent that people do in rural areas, the urban poor face other forms of deprivation that have a direct impact on their health. As most of the urban poor live in congested localities, often in flood prone areas, they are the first to succumb to water-borne diseases like typhoid and gastroenteritis. Every monsoon, the first cases of vector borne diseases like malaria and dengue are almost always reported from slum areas. Crowding and living in poorly ventilated dwellings also ensures the spread of communicable disease like tuberculosis. According to the latest data from the National Family Health Survey (NFHS-3), the prevalence of medically treated TB is much higher in Mumbai than in urban Maharashtra (590 vs 367 per 100,000). Also, predictably, within Mumbai, it is much higher among slum-dwellers than non-slum dwellers (690 vs 458 per 100,000).

The most telling comment on the health status of the urban poor is the nutritional status of children born and brought up in poor settlements. NFHS-3 has come up with disturbing data on the levels of malnutrition and under-nutrition amongst urban children. This data is indicative not just of levels of poverty, where families cannot afford to feed their children, but the prevalence of diseases, including repeated bouts of diarrhoea, which render children weak and unable to absorb even the little nutrition they do receive.

NFHS-3 shows that there is chronic undernourishment in 42 per cent of children in urban areas in Maharashtra, a state that is wealthier than India as a whole according to the wealth index used in NFHS. The survey found that 29 per cent of children in urban areas in Maharashtra are stunted (too short for their age), an indication of undernourishment over a period of time, 11 per cent are wasted (too thin for their height) indicating inadequate food intake or a recent illness and 21 per cent are underweight, signs of chronic and acute under-nutrition.

In the context of Maharashtra, and indeed the country as a whole, the data from Mumbai is important for a number of reasons. Twenty nine per cent of the urban population of Maharashtra lives in Mumbai, the wealthiest city in the state. Yet according to NFHS-3, the nutritional status of children under five years in Mumbai was slightly worse than in urban Maharashtra as a whole. The survey also found, not surprisingly, that the nutrition status of children under five living in slums was substantially worse than those living in non-slum areas. For instance, while 47 per cent of children living in slums were stunted, the percentage in non-slum areas was 42 per cent. Similarly while 36 per cent of children in slums were underweight, 26 per cent of their counterparts in non-slum areas were the same.

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The problem is not confined to a city like Mumbai where just over half the population lives in slums. Take Nagpur, the second most important city in Maharashtra, where 36 per cent of the population lives in slums. According to NFHS-3, both children and adults living in slums in the city were worse off in terms of their nutritional status than the non-slum population. "Among children age 0-5 years, the prevalence of stunting is 79 per cent higher and of underweight is 47 per cent higher in slum areas than in non-slums areas (48 per cent vs. 27 per cent children stunted and 42 per cent vs. 28 per cent children underweight)", states the report.

These figures fail to tell the full story. What is happening to the urban poor is a story not just of income poverty but many other forms of deprivation. People come to cities in search of a better future. But the absence of living

conditions that are conducive to healthy living is actually rendering these people worse off than if they had stayed behind in their villages.

A third problem that is only just beginning to crop up in some cities, and more specifically in Mumbai, is the rapid growth of an anti-migrant bias even amongst those making policy. This is rooted in the absence of a credible analysis of why cities fail to serve the needs of the people that live there. Instead of acknowledging that the reasons lie in the absence or failure of governance, increasingly city authorities tend to lay the blame on the stress of a growing urban population. The easiest and most convenient scapegoat when things go wrong are migrants, usually the poor and destitute who are forced to live in illegal settlements until they can earn enough to merge with settled populations.

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The latest scheme being contemplated by the BMC is illustrative of this growing paranoia against the so-called "outsider" in a city like Mumbai. Instead of seriously thinking through how to increase the number of hospital beds and medical facilities in the public sector, and to improve the efficiency of the facilities that already exist, the BMC is reportedly considering a proposal to restrict use of municipal health facilities to those who can produce proof of residence such as a ration card or an electricity bill. Such a precondition will automatically exclude the poorest, people living in illegal settlements, people with no address and no proof of residence. Yet, these are the people most in need of the free and affordable health care available in these public facilities.

Also, there are literally thousands of families who have lost much of their documentary proof during the floods of 2005 and in the many fires and demolitions that mark the disappearance of so many slum settlements. Such people, already disadvantaged by circumstances beyond their control, are going to be further penalised by such a rule. It is hoped that the provision will never see the light of day and will be challenged as being unconstitutional. But the very fact that it is being considered indicates the extent to which those who should be ensuring that public facilities are used for the public good are actually planning to limit access.

Whenever the government thinks of health care for poor people in this country, the usual focus is on rural areas. Understandably so as facilities in many parts of rural India are abysmal. Yet, although there are facilities in urban areas, they are inadequate and not always accessible. The cost of health care in cities through the private sector is placing an unbearable strain on millions of poor families, something that remains hidden and unaccounted. It is a medical emergency that must be recognised and addressed.