Market Reform, Medical Care, and Public Service: Dilemmas of Municipal Primary Care Provision in Urban India

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ABSTRACT

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Studies across low- and middle-income countries document quality shortfalls in both public and private sector health care. They notably highlight a “know-do” gap in primary care delivery: doctors possess requisite medical knowledge but do not expend adequate effort to treat patients. In explaining low quality, researchers have largely emphasized transactional aspects of health care, viewing doctors’ actions as shaped by their skills and incentives to perform and arguing that the micro-institutions that drive doctors’ clinical behavior are faulty.

In contrast, in this project I analyze the social and political conditions in which public sector doctors deliver primary care in urban India. Viewing the doctors as both medical practitioners and state agents, I argue that health service outcomes depend on how doctors interpret policy mandates and relate to the communities they serve. I conceptualize their actions not just as medical transactions but also as social acts, shaped by the meanings they attach to their experiences and informed by the institutional history and social imaginary of state-provided care.

During a year of ethnographic fieldwork (2013-2014), I observed clinical and non-clinical encounters of doctors employed in municipal government clinics and hospitals in a midsize Indian city; interviewed doctors, other health workers, elected officials,
administrators, and staff of non-governmental organizations; and examined policies and administrative arrangements for urban health care since India’s independence.

I demonstrate that municipal doctors confront a trifecta of challenges: a legal obligation to deliver urban primary care from within an outdated urban governance structure; a largely unregulated private sector that residents widely prefer; and rising commercialization in medical practice, under which specialized medicine has crowded out primary care in popular ideas about “good” medical care. Unable to remedy the low legitimacy of their services, doctors circumscribe their actions, seeking, as one doctor put it, only to ensure the ordinary. My findings suggest that transaction-specific interventions to improve quality, such as focused on skills and incentives alone, may do little to circumvent these local effects of the policy neglect of urban health care.
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### Glossary of terms

<table>
<thead>
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<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>BSUP</td>
<td>Basic Services for the Urban Poor</td>
</tr>
<tr>
<td>CAA</td>
<td>Constitutional Amendment Act</td>
</tr>
<tr>
<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
</tr>
<tr>
<td>DNB</td>
<td>Diplomate of the National Board</td>
</tr>
<tr>
<td>GoI</td>
<td>Government of India</td>
</tr>
<tr>
<td>HLEG</td>
<td>High Level Expert Group</td>
</tr>
<tr>
<td>IIPS</td>
<td>International Institute for Population Sciences</td>
</tr>
<tr>
<td>IPP</td>
<td>India Population Project</td>
</tr>
<tr>
<td>JNNURM</td>
<td>Jawaharlal Nehru National Urban Renewal Mission</td>
</tr>
<tr>
<td>LMICs</td>
<td>Low- and middle-income countries</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine, Bachelor of Surgery</td>
</tr>
<tr>
<td>MCI</td>
<td>Medical Council of India</td>
</tr>
<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>NBE</td>
<td>National Board of Examinations</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>NSSO</td>
<td>National Sample Survey Office</td>
</tr>
<tr>
<td>NUHM</td>
<td>National Urban Health Mission</td>
</tr>
<tr>
<td>PMC</td>
<td>Pune Municipal Corporation</td>
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<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SDH</td>
<td>Social determinants of health</td>
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<td>UHC</td>
<td>Universal health care</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1 Introduction

1.1 Comparing public and private health care

Noting that India’s health system is among the world’s most heavily dependent on private health care—80% of all outpatient health care visits occur in the private sector—a group of leading health advocates and researchers charted a proposal to achieve universal health coverage (UHC) in India by 2020. In a 2011 series in *The Lancet*, they wrote:

The key characteristics of our proposal are to strengthen the public health system as the primary provider of promotive, preventive, and curative health services in India, to improve quality and reduce the out-of-pocket expenditure on health care through a well regulated integration of the private sector within the national health-care system (Reddy, Patel, Jha, Paul, Shiva Kumar, & Dandona, 2011, p. 760).

The proposal posits a place for the private sector in health care provision, but it also signals the continued relevance of public, i.e., state-provided, health care. This duality characterizes health systems in India and many low- and middle-income countries (LMICs), where both state- and privately-provided health care services have coexisted for decades (Bloom et al, 2008; Basu et al, 2012; Uplekar, 2000). A key point of debate on the future of health care services in these countries is the appropriate role of the public and private sector in providing health care (Mills, 2014; Forsberg, Montagu, & Sundewall, 2011).
The evidence base that underpins that debate includes a considerable effort to measure and compare the quality of public and private sector health care, particularly at the primary level of care\(^1\) (Berendes et al., 2011; Basu et al., 2012; Das & Hammer, 2014). Such measurements highlight quality concerns in both the public and private sector. They suggest the quality of medical advice in both sectors is questionable. They show that patients deem public providers as less personable and accommodating than private providers. They indicate a “know-do” gap among both public and private providers: providers do less than their medical knowledge suggests they can, and their low effort contributes to low quality of care (Das & Hammer, 2014). Evidence of reasons for this low quality is limited (Mills, 2014), but available studies tell us that material inputs, such as health infrastructure, medical equipment, and patient caseload, are weakly associated with improved quality of care, while behavioral factors, such as providers’ competence and incentives, are likely to improve quality of care (Das & Hammer, 2014). Researchers have tested behavioral interventions such as training, peer scrutiny, and financial remuneration, and found these can improve providers’ performance in controlled laboratory studies and specific field settings (Leonard et al., 2013; Das & Hammer, 2014; Mohanan, Hay, & Mor, 2016).

These studies have greatly advanced what we know about quality of health care, but they contain a crucial elision: available research on health care quality largely considers the clinical and managerial aspects of health care settings, but brackets or ignores the “politics and social relations that shape health systems” (Storeng & Mishra, 2014, p. 858). In much research on health care quality, researchers have emphasized transaction-specific aspects of health care provision, viewing providers as actors who deliver medical care in exchange for financial compensation or affective rewards, their actions shaped by their knowledge, skills,
and incentives to perform. A key problem researchers have aimed to resolve is that of asymmetries in information inherent to medical care, meaning differences in providers’ and patients’ knowledge about health and medicine. But as researchers have concurrently cautioned, providers’ pro-social behavior, and the probability that a provider’s greater incentives and ability (knowledge and skills) will translate to higher performance, are context dependent (Leonard, Masatu, & Vialou, 2007; Magrath & Nichter, 2012). That context remains little studied in LMICs. In particular, the political and social conditions in which providers deliver care remain under-examined (Forsberg & Montagu, 2014; Magrath & Nichter, 2012).

My project steps into that breach. It builds on the perspective that health systems are not only “delivery points for bio-medical interventions” but also “complex socio-political institutions” (Gilson, 2003, p. 1463). In contrast to a view of health care as a clinical exchange, I conceptualize health care provision as a social act, wherein providers’ actions are shaped by, and reinforce, the meanings they attach to their experiences and their relationships with actors (patients, communities, administrators, elected officials) (Sheikh, Ranson, & Gilson, 2014; Storeng & Mishra, 2014; Hall & Lamont, 2009). I argue that a transaction-specific view fails to account for public providers’ dual role as both medical practitioners and state agents, and overlooks the “social nature of [the] public goods” they provide (Reddy, 2015). In this dual role, public providers’ performance depends not only on their training and incentives, but also on the norms, ideas, and social relations that undergird the organization and functioning of state-provided health care (Sheikh et al, 2011) and medical practice more broadly (Zachariah, 2014). Attempts to measure, compare, and explain quality of health care ought to account for how these meanings and relations inform
providers’ actions. This includes examining how providers interpret their mandate, relate to communities, and resolve everyday dilemmas.

The health care encounter I present below, a vignette from my field observations, underscores one such dilemma. It illustrates a key theme in my findings, namely that public and private services may be incommensurable in a purported “health market.” For patients, public and private services may not be readily interchangeable or substitutable even when they concern the same medical treatment. For public providers, delivering medical care within state precincts is a distinct social act, informed by not only the material resources the provider has at hand, but also the social imaginary about the state’s provision of welfare. By the “social imaginary” I mean the shared meanings, common expectations, and underlying normative understandings that comprise “the ways in which people imagine their social existence,” that enable them to “carry out the collective practices that make up our social life” (Taylor, 2002, p. 106). The social imaginary comprises both factual and normative elements—it includes a shared sense of not only what is common and regular, of how things generally go, but also what is ideal or how things ought to be, of the practices that would violate the norm and the ideal cases that uphold it (Taylor, 2002). The social imaginary is a central construct for my study, one that I revisit in the next chapter where I elaborate my theoretical framework.

As the ensuing chapters will show, undertaking a social-scientific study of health care delivery, in particular conceptualizing health care as a social act, can yield alternative explanations for its quality. In turn, this evidence, specifically evidence about the state’s delivery of a basic service that the private sector concurrently supplies, helps us rethink
theories of the state and public goods provision. These findings and analyses are globally relevant, especially in liberalizing economies where debates about state versus private solutions to health care delivery count among the most pressing questions in health systems reform (Mills, 2014; Hanson et al, 2008; Mackintosh & Kovalev, 2006; Henderson & Petersen, 2002).

The following vignette draws on my ethnographic fieldwork in municipal government-run clinics and hospitals in Pune, India, conducted over 2013-2014. Pune is a city of three million located in the state of Maharashtra in western India. The vignette shows how the private sector can indirectly influence the quotidian workings of state-provided health care, creating a challenge for the public provider (here, the municipal doctor) that interventions such as improving skills and incentives may not circumvent.

1.1.1 The non-fungibility of public and private medical treatment

Dr Srinath briskly attended to a long queue of mostly poor patients in a municipal hospital one afternoon. Although he spent only a few minutes with most patients, he attempted pleasantries with each as they streamed by his desk in the outpatient consultation room of the municipal hospital. The patient now standing at his desk was a 12-year-old girl who had been bitten by a neighbor’s dog. The girl’s mother had brought her to the municipal hospital for post-exposure anti-rabies treatment, accompanied by the neighbor. Anti-rabies vaccine therapy was free at selected municipal hospitals, and this was one of several in the city that stocked the vaccine. Each dose of the vaccine cost around Rs 500 (US$ 8) if purchased
privately, more than a day’s pay for an unskilled worker. Depending on vaccine type, the post-exposure schedule prescribed four to five doses of the vaccine over several weeks.

The girl had already obtained two doses at a private clinic. Dr Srinath examined the girl’s medical records from the private clinic. He told the mother that the girl could certainly receive anti-rabies therapy at the municipal hospital, but would have to restart treatment. The municipal hospital offered intradermal rabies vaccinations, and these entailed a different schedule from the intramuscular vaccine the girl had received at the private clinic. Although Dr Srinath explained this several times to the mother, she seemed only to retain that they could not receive the vaccine here. Dr Srinath assured her the girl would receive standard post-exposure treatment. But the mother was reluctant to go ahead with the therapy at the municipal hospital. Mother, daughter, and neighbor stepped back from the desk and left the room to consult among themselves. Observed from a distance, their exchange seemed heated.

By the time the trio returned to his desk, about ten minutes later, Dr Srinath had seen four other patients. (Dr Srinath was quick but often genial with patients. Seated at a desk a few feet away, another municipal doctor saw as many patients in that interval but with less generosity of manner: he impassively examined patients, omitted to tell them what their illness was, and scarcely explained his prescribed treatment to them.) Back at Dr Srinath’s desk, the mother’s tone was now strident, though the neighbor was calm. The mother wanted to continue treatment at the private clinic. She wanted Dr Srinath to state they could not get the same injections here and would have to go back to the private provider where they had started the therapy. But that’s not entirely the case said Dr Srinath, repeating that it
was possible to obtain treatment here. He reassured the mother the vaccinations would be free here. He told her that private providers did not always properly maintain the cold chain (protocols for storing and handling vaccines) and that at the municipal hospital they followed all the procedures. He told her that one could not always trust the private sector, and getting the vaccine here would be good for the child.

But the mother fumed. The neighbor, on the contrary, seemed somewhat amused. Though neither of them said so at Dr Srinath’s desk, it was apparent that if the mother wanted the neighbor to pay for the girl’s treatment at the private clinic, she could not force the issue if the municipal hospital offered it for free. Watching them leave, the matter unresolved, Dr Srinath said, “Look at that. She doesn’t want to get the injections here.” He moved on to the next patient, who was already at his desk.

***

At first reading, Dr Srinath’s encounter with the mother underscores her steadfast preference for private versus public services: the mother insisted on private care for her daughter even though the municipal hospital offered equivalent treatment for free, treatment her daughter unquestionably and immediately needed. But the irony of a free-but-unwanted public service and a costly-yet-preferred private alternative is not what makes this encounter remarkable. Studies of health care-seeking behavior widely document people’s favor of private health care (IIPS & Macro International, 2009; Ergler et al, 2011; Seeberg et al, 2014). Substantial evidence suggests that people pay out-of-pocket for private services even when public services are available, because they deem private services more convenient to use and
private providers more responsive to their needs, offering a more satisfactory experience of health care (IIPS & Macro International, 2007; Bhatia & Cleland, 2001; More et al, 2011; Ergler et al, 2011; Barua & Pandav, 2011; Berman, Ahuja & Bhandari, 2010).

Neither is it notable that Dr Srinath cautions the mother about the uncertain quality of private health care. Studies commonly indicate that private providers may prescribe unnecessary or inappropriate treatments and maintain low clinical standards (Uplekar, 2000; Bhat, 1999; Barua & Pandav, 2011; Das & Hammer, 2007; Das et al, 2016).

Also unsurprising is the mother’s insistent preference for private services despite Dr Srinath’s caution. Studies find that public providers often conduct rushed consultations, as did Dr Srinath and his colleague (Das et al, 2012) (and as providers in other countries have been shown to do as well (Das, Hammer, & Leonard, 2008)). Although Dr Srinath was genial with patients, at least one of his fellow doctors exemplified the disrepute that public providers have earned. That doctor performed a perfunctory consultation for many routine primary care cases—a toddler with a common cold, a third grade student with a rash on his arm, a middle-aged woman who had trouble sleeping, a frail old woman with aching joints. All received a question or two about their symptoms, a hastily scribbled prescription, and a nod implying the consultation was over.

Thus, at first reading, the encounter corroborates well-known evidence about people’s preference for private versus public providers. But the encounter also evinces other, less commonly examined observations, which foreground the social and political conditions
in which public providers like Dr Srinath deliver care. I turn to this alternative reading of the encounter below.

1.1.2 Rethinking health care quality: Overview of inquiry and findings

I argue that Dr Srinath’s encounter is notable not for what it tells us about people’s preferences for private health care, but for what it suggests about the interplay between public and private health care. Dr Srinath’s predicament here entreats us to consider how an avid private sector may shape the ability and capacity of the public sector to provide health care. His exchange with the mother compels us to ask: under conditions where private providers conduct 80% of outpatient health care transactions, how do public providers understand their role as both medical practitioners and state agents? How does an expansive, largely unregulated private sector affect the terms on which public providers deliver basic primary care? How does it shape the ways they interpret their public service mandate, demarcate and articulate the scope of their medical expertise, and relate to the communities they serve? At a macro-institutional level, what policy developments help explain the dominance of the private sector and the generally low legitimacy of public sector services?

In this case, Dr Srinath was unable to deliver medical treatment to the mother. The reasons why relate not just to possible shortfalls in his competencies, i.e., deficiencies in clinical knowledge and behavior of which public providers widely stand accused, such as the brevity of their consultations, the brusqueness of their interactions, and the inaccuracy of their medical advice. The reasons also relate to the social imaginary of state-provided health care, specifically at the level of primary care. This social imaginary is evident, for example, in
the emphases of policy decisions, the organization of the state’s health care infrastructure, and the tenor and substance of everyday clinical exchanges in state-run health care facilities. The exchange between Dr Srinath and the mother illustrates not simply a point of user preference or an asymmetry in information. Rather, their exchange is fraught with both the material limits of and social meanings about state-provided services. It reflects the low legitimacy of bureaucratic institutions (Kaviraj, 2005), a product of historically inadequate state investment in basic public services. In India’s cities, state-provided primary care—its provision in cities being an obligation that falls to municipal governments—has been a particular casualty of state neglect.

This neglect stems from several factors. The factors include the rural focus of national health programs; the state’s developmental (rather than rights-based) approach to welfare; the power and un-ceded control of state-level governments over municipal governments; and the electoral and economic logic undergirding the state’s urban initiatives under liberalization. In that logic, the urban poor are both a needed informal labor force and a vote bank to be appeased, prompting the state to reactively deliver basic public services to some communities but not comprehensively upgrade services for all urban residents (Chatterjee, 2004; Weinstein, Sami, & Shatkin, 2014). Urban development programs have largely invested in infrastructure and real estate to make cities economically competitive, less so in basic services for the poor. Alongside forms and consequences of state neglect, municipal doctors’ practices are also shaped by developments in the field of medicine. There, medical educators and professionals have valorized and emphasized biomedicine, high technology, and clinical specialization, crowding out community-oriented, basic primary care
in both the practice of medicine and in the social imaginary about what constitutes “good” medical care (Zachariah, 2014).

Municipal doctors such as Dr Srinath therefore confront a trifecta of challenges: a legal obligation to deliver urban primary care from within an outdated urban governance structure, (2) an enterprising, largely unregulated private sector that residents widely prefer; and (3) rising commercialization in medical practice, in which specialized medicine holds value over primary care. In contrast to the marginal position of state-provided urban primary care, private health care has long coexisted alongside state-provided services and is especially dense and varied in urban India. It offers people a readily accessible (though costly) alternative to state services. For the urban poor, municipal health care is a crucial option given the cost of private services, but it is a derided choice. As a community organizer in Pune observed of the low-income informal labor groups with whom she worked, when confronted with choosing between public and private health care, they questioned: “Why would I do that [i.e., opt for the public sector] to someone I loved?”

Pune’s municipal doctors thus operate under not only tangible resource constraints, but also a combination of notoriety and need—low legitimacy of and peremptory claims on their services—a dilemma that private providers do not confront and that liberalization of India’s economy has intensified. This dilemma and related challenges comprise key themes in my fieldwork. I argue that the low quality of public sector health care is shaped in part by how public providers (here, municipal doctors) understand their mandate and resolve everyday dilemmas. I show how municipal doctors in Pune make sense of and negotiate the “intent of policy … and mangle of practice” (Hoag, 2011) that characterizes their everyday
work. My analysis suggests that private services—and the policies that directly or indirectly support them—can displace state-provided health care not only in quantity of supply, but also by subverting municipal doctors’ ability, capacity, and willingness to reach the urban poor. In the encounter above, Dr Srinath seemed willing to treat the young girl even if unable to deploy his expertise. But, as I will illustrate across the following chapters, in many encounters, municipal doctors practiced a restrained, abbreviated form of medical care.

To elucidate dilemmas they faced and to explain their responses, I present three themes: service, risk, and authority. Each theme contains multiple registers of meaning. Municipal doctors’ narratives about their mandate include ideas about service in the sense of public service (referencing their role as state agents) and patient care (reflecting their responsibility as medical professionals). Salient ideas about risk refer to not only the medical risk of clinical complication, but also the consequent social risks of patients’ aggression towards doctors, of inciting media scorn, and of receiving little support from administrative authorities. Notions of authority refer to nodes of power in municipal government and the force of public opinion about state-provided services. One is formal and manifest in doctors’ official relationships with municipal administrators and local politicians. The other is informal and evident in expressions of people’s entitlement to and disfavor of municipal health care. These registers of meaning show how municipal doctors, working at the level of primary care, made sense of evolving circumstances of welfare and medical practice in the city. The themes depict the strains bearing upon municipal primary care in an environment of private sector expansion. They portray the intangible conditions of municipal doctors’ work.
Partly in response to those strains, municipal doctors’ signature practice in primary care was a delimited medical consultation, often marked by few words, short duration, restrained professional opinion, and a referral to higher level of care. This practice suggests, I argue, something more or other than a failing of incentives and skills. It denotes, in part, doctors’ accommodation of their conditions of work. The accommodations reinforced the low legitimacy of state agencies and tenuous state-society relations (between municipal doctors and the communities they served), contributing to the low quality of municipal health care. In turn, the poor disengaged from limited though ostensibly more rational municipal services, exacerbating the adverse effects of inequality on health.

My findings suggest that enhancing public sector health care would require reconfiguring not only the micro-institutions (providers’ incentives and skills to perform) but also the macro-institutions (urban governance processes, the place of primary care in medical education and practice) that shape the material resources for and social meaning of the care that they provide. Advocates of the former have called for a pragmatic focus on micro-institutions given the long-term political change that the latter entails (Leonard et al, 2013). However, my findings suggest that incentives and skills alone may do little to transform the conditions under which public providers work and hence the quality of health care they deliver.

The remainder of this chapter proceeds as follows. I first describe relevant health system performance metrics (quality, access, responsiveness) and summarize evidence on the deficiencies in performance of both public and private health care providers. I highlight a need for greater analytical insight into low provider performance, in particular, analysis of
the political and social conditions in which health care providers deliver services. I then introduce my conceptualization of health care as a public good and as a social act. This conceptualization both motivates my focus on the effects of economic liberalization on the state’s provision of urban health care, and helps frame my analysis in subsequent chapters. I finally briefly describe developments associated with liberalization in India since the 1980s, specifically commercialization of health care and urbanization, which define the context in which the state plans, and state agents deliver, primary care in cities.

1.2 Global evidence and approaches to assessing the quality of health care

1.2.1 Defining terms: Health system, health care, and health care quality

I briefly describe here selected terms and metrics researchers use to evaluate health systems performance, which I use in this project as defined below.

A health system, as described by the WHO, comprises six core components or “building blocks.” These are: (1) service delivery, (2) health workforce, (3) health information systems, (4) access to essential medicines, (5) financing, and (6) leadership/governance (WHO, 2010). “Health care” and the “health system” are distinct though related terms. Their relationship is important to clarify, since it bears upon how researchers conceptualize, measure, and interpret health system performance (Nolte & McKee, 2011).
“Health care,” the focus of my study, includes population-level services (such as public health education and epidemic control activities) as well as personal services (such as curative care delivered through clinics and hospitals). The organization and operation of health care services is typically controlled by identifiable entities, in particular ministries of health (Nolte & McKee, 2011; Arah et al, 2006). A “health system” extends beyond these boundaries. It includes “all activities and structures that impact or determine health in its broadest sense within a given society” (Nolte & McKee, 2011, p. 54). This would encompass, for example, international trade agreements that affect the availability and prices of medicines, and government subsidies that enable the import of specialized medical equipment. Health system performance is therefore a broad concept that subsumes the organization and functioning of health care services.

Measures of access to and quality of health care are among a number of measures of health system performance. Measures of access encompass the availability, timeliness, and local accommodations of health care services (WHO, 2000, 2010). In a health system that offers accessible health care services, an appropriate range of services is available within physical proximity, services are adequately operated (in terms of timings that facilities are open or time required for receiving test results), and services are hospitable to users without “undue barriers of cost, language, culture, or geography” (WHO, 2010, p. 3).

Researchers commonly measure health care quality by the comprehensiveness of services offered and the efficacy, safety, and continuity of care (WHO, 2000; Kruk & Freedman, 2008). This includes providers’ diagnostic accuracy; adherence to management standards, such as following evidence-based protocols for diagnostics and therapies; and
client retention rate, as indicated by follow-up visits and completion of treatment regimens (WHO, 2000; Kruk & Freedman, 2008). In a health system that offers high quality health care, services are broad (with the required equipment, supplies, and personnel available at relevant points or facilities for service delivery), and providers are technically competent, follow established standards for clinical practice, and ensure continuity of care.

Closely related to both access and quality is responsiveness, a measure that is associated with the experiential aspects of health care: whether the system meets people’s expectations “of how they should be treated by providers” (WHO, 2000, p. 31), whether providers respect patients’ autonomy and dignity. Responsiveness is a relatively novel term in health systems research (WHO, 2010). Some researchers conceive of responsiveness as an aspect of quality and define it as health care providers’ behavior towards patients (e.g., Berendes et al, 2011). Other researchers conceive of responsiveness as an aspect of access and measure it in terms of patients’ experience of care (e.g., Ergler et al, 2011). Some monitoring and evaluation frameworks cast responsiveness as an outcome indicator, and access and quality as output or process indicators that together contribute to producing a responsive health system (WHO, 2010; Kruk & Freedman, 2008). Although definitions of responsiveness vary, each reflects an attempt to capture how, and to what extent, different elements of health care service delivery are “person-centered,” i.e., “organized around the person, not the disease or the financing” (WHO, 2010, p. 3). Their variety signalizes ongoing dialogue on how to conceptualize and measure constructs (Nolte & McKee, 2011; WHO, 2010).
In this project, in keeping with recent assessments of health care quality in LMICs, I conceive of providers’ responsiveness to patients as closely related to the quality of care. Unless they are responsive to patients, providers may not be able to ensure other, fundamental features of health care quality, such as continuity of care.

1.2.2 Evidence on the relative share and quality of public and private health care

Globally, use of private providers as a proportion of overall health care use ranges from an estimated 25% in sub-Saharan Africa to 63% in south Asia (Wagstaff, 2013). Private health care services in LMICs typically comprise a diverse range of providers, encompassing multi-sited corporate hospitals, neighborhood drug shops, and clinics of individual practitioners, who may be credentialed in allopathic or non-allopathic medicine or may hold no formal qualifications at all (Hanson et al, 2011; Bloom et al, 2008). Evidence suggests the poor are more likely to use the lower-quality end of this spectrum (Hanson et al, 2011).

The private sector is especially dominant in India, where it has accounted for over 75% of all outpatient care consultations since the 1980s; recent estimates place this at 80% (NSSO, 2006; IIPS & Macro International, 2009). Over the last three decades, the use of private hospital care has risen 50% in urban India (Duggal, 2011). Expansion of private health care and related industries (drugs, diagnostics, medical technology) are in part a product of India’s economic liberalization reforms beginning in the 1980s (Baru, 2006), a point I return to below.
Despite the prominence of the private sector, state-provided health care remains a crucial source of care for low-income households across LMICs. Global evidence shows that the poor commonly access multiple sources of health care, choosing variously from public sector clinics, private practitioners, traditional healers, and drug shops, sometimes for a single episode of illness (Das & Das, 2006; Geldsetzer et al, 2014; Colvin et al, 2013). Because of the diversity of sources of care, researchers caution that studies might overestimate the effective size of the private sector. They argue that if informal providers are excluded from the definition of the private sector, then the public sector remains a highly accessed source of health care (Basu et al, 2012). Estimates for India, for instance, suggest that over 60% of allopathic practitioners in rural areas and 20% in urban areas have inadequate or no medical training, with unqualified practitioners operating largely in the private sector (Rao, Bhatnagar, & Berman, 2012).

Given the importance of both the public and private sector, the evidence base that underpins UHC debates in India and other LMICs includes a considerable research effort to compare public and private health care provision along key metrics such as access to and quality of medical care (Mohanan, Hay, & Mor, 2016; Das & Hammer, 2014; Hanson et al, 2011).

Primary care, in particular, has received considerable attention in studies assessing public and private health care provision (e.g., Berendes et al, 2011; Das et al, 2012; Mills et al, 2004). Primary care is characterized by “first-contact care, ease of access, care for a broad range of health needs, continuity, and the involvement of family and community” (Kruk et al 2010, p. 904). Primary care refers to services delivered at the lowest tier of the health system,
ideally the first point of contact between people and the health system (Kruk et al, 2010). In many countries, the private sector has expanded significantly at the level of primary care through the rise in numbers of small-scale medical practitioners (Mackintosh, 2006).

Evidence widely documents deficiencies in primary care provision in both the public and private sector (Coarasa, Das, & Hammer, 2014). Data suggest that providers in both the public and private sector deliver medical advice of questionable quality (Das & Hammer, 2014; Basu et al, 2012; Berendes et al, 2011). A consistent finding in these studies is that patients deem private providers more responsive to their needs than public providers (Das & Hammer, 2014; Seeberg et al, 2014), and turn to private providers even when low-cost public facilities are available (Berman, Ahuja & Bhandari, 2010; Hanson et al 2011; Chuma & Maina 2012; Xu et al, 2007). In contrast, public providers appear to expend less “effort,” where effort is defined as “the exertion of mental or physical energy—for instance to determine what is wrong with a patient and to deliver an appropriate care package” (Leonard et al, 2013, p. 72).

Evidence from India affirms these findings. Studies assessing public and private primary care facilities show that providers in both sectors fall short on the quality of their medical advice (Das & Hammer, 2007; Das et al, 2012; 2016). National surveys as well as local studies of health care seeking behavior show that people prefer private sector providers for convenience of use (e.g. timings during which the facility is open), perceived efficacy of treatment, and a more satisfactory experience of obtaining health care (IIPS & Macro International, 2007; Agarwal et al, 2008; Banerjee & Duflo, 2009; Bhatia & Cleland, 2001; Gupta & Dasgupta, 2000; More et al, 2011; Ergler et al, 2011; Seeberg et al, 2014; Barua &
And evidence suggests that public providers spend less time with patients than private providers (Das et al, 2012).

1.2.3 Need for studies that explain, rather than document, quality shortfalls

Researchers highlight a need for greater analytical insight into the reasons underlying providers’ low quality of care. For instance, evidence suggests that low quality of care can stem from resource constraints, poor incentives, inadequate training, and lack of accountability mechanisms, among other factors (Berendes et al, 2011; Mills, 2014). However, research in a variety of fields, including on managing health workforce (Franco, Bennett, Kremer, 2002; Rowe et al, 2005); building trust in health systems (Gilson, Palmer, & Schneider, 2005); and involving communities in health service delivery (Freedman & Schaaf, 2013; Molyneux et al, 2012) has found that analysis of how these and other factors contribute to health care quality and overall health system performance remains limited.

Studies of interventions to improve health care provision, although on the rise, are relatively few (Forsberg & Montagu, 2014; Leonard et al, 2013; Hanson, 2015). As Mills (2014) notes in this regard, “the evidence of deficiencies is stronger than evidence of remedies” (p. 552). Berendes et al (2011) similarly find that “empirical evidence on the effectiveness of various approaches [to improve quality of care] is somewhat limited” (p. 7). Recent commentaries on health care quality in LMICs have called for greater analysis to explain, rather than only document, low outcomes in public and private health care (Hanson et al, 2011).
The limitations of the evidence are not only in quantity, but also in the kind of approach that defines much of this research. As Storeng and Mishra (2014) have argued of studies of health systems strengthening more generally, those studies emphasize “implementation and management structures within health service delivery, with little attention to the politics and social relations that shape health systems” (p. 858). Reviews of the health systems and policy analysis literature have concluded that studies that assess health systems performance are often more descriptive than explanatory (Gilson & Raphaely, 2008; Adam, Hsu, de Savigny et al, 2012) and illustrate an “imbalance of research on functional areas of analysis with a much greater body of knowledge on financing and payment issues than on organizational issues” (Bossert, 2012, p. 9). Studies of health system performance have tended to concentrate on one subsystem or one policy lever (Adam, Hsu, de Savigny, et al, 2012; Basu et al, 2012). In the process, they are “likely to miss the interactions among different subsystems changes that synergistically influence outcomes,” and inadequately account for the “underlying population and social processes underpinning those systems” that can influence health system performance (Bossert, 2012, p. 9).

1.2.4 Need for analysis of socio-political conditions in which providers deliver care

In studies of health care quality, researchers have often focused on transaction-specific aspects of health care provision, viewing providers as agents who deliver clinical care in exchange for financial compensation or affective rewards, their actions shaped by their knowledge, skills, and incentives to perform. For instance, a recent comprehensive review of health care quality in LMICs noted that,
[With respect to] market failures in the provision of primary care, … the key difficulty is (and always was) the transaction-specific nature of medical advice. Providers can do too much or too little (or both), and the extent of either depends on the specific patient and the specific disease (Das & Hammer, 2014, p. 525).

In the above approach, a key problem researchers have aimed to resolve is that of information asymmetry, i.e., the problem that patients have unequal knowledge relative to providers, are unable to judge the quality of goods and services they receive, and can potentially be exploited (Leonard et al, 2013). They have considered how micro-institutional determinants of providers’ behavior—skills, intrinsic motivation, remuneration, supervision, and accountability mechanisms, among others—influence providers’ performance. Researchers have tested interventions such as provider training, peer scrutiny, and financial remuneration, and found these can improve providers’ performance in laboratory and field settings (Brock, Lange, & Leonard, 2012; Lagarde & Blaauw, 2014). But these tests, as researchers acknowledge, do not account for the effects of social and political factors on providers’ actions outside specific sites or controlled settings.

Some researchers who recognize health systems as socio-political institutions have yet focused largely on the micro-level aspects of health care interactions. Leonard et al (2013), for example, note that “context” often determines provider performance. But their analytical focus is on the “micro” mechanisms of health service delivery and the possibilities to counter the information asymmetry inherent to medical care. The “macro”-institutional context, Leonard and colleagues (2013) argue, is difficult to change in the near term and should be regarded as a given. The interventions they identify to improve health care quality
include providers’ competence, effort, assurance of accountability for the outcome, and ways in which these are signaled in a health care transaction (Leonard et al., 2013). As inducements for shaping provider behavior, their suggestions include payments, supervision, training, and accreditation (Leonard et al., 2013).

Other researchers too have proposed remedies to improve providers’ performance, such as monetary incentives (compensation), nonmonetary incentives (e.g., supervision, peer scrutiny, encouragement, monitoring), and education (e.g., continuing education, professional accreditation, consumer education) (Berendes et al., 2011; Basu et al., 2012; Das et al., 2012). However, research on how and under what conditions such remedies work is incipient.

Financial incentive schemes, for example, have “become a popular form of intervention to boost performance in the health sector” (Magrath & Nichter, 2012, p. 1778). But there are few studies of the impact of these schemes on the health system, and available evidence does not much explain unintended effects of the schemes or how the effects vary according to their social contexts (Magrath & Nichter, 2012).

Enhancing providers’ accountability towards patients is another proposed intervention. Berlan and Shiffman (2012), who review evidence of accountability interventions in LMICs, identify two broad categories of ways to influence provider performance, namely structural factors (referring to the way the health system is organized, governed, and financed) and social factors (pertaining “to the way consumers and providers think about themselves, one another and their appropriate roles”) (p. 272). They find that
rural versus urban contexts, centralized versus decentralized health systems, and cultural norms and values, among other contextual factors, can influence the effects that are obtained and how mechanisms work (Berlan & Shiffman, 2012). However, data on the implementation and impact of strategies to enhance provider accountability in LMICs is generally thin, and the available evidence indicates little systematic study of how contextual factors affect provider behavior (Molyneux et al, 2012; Berlan & Shiffman, 2012).

Peer scrutiny and encouragement are further proposals to enhance providers’ performance. Peer-based interventions have been tested in laboratory and field experiments, with some positive results (Brock, Lange, & Leonard, 2012). Researchers have shown that an individual’s intrinsic motivation, generosity, and altruism—attributes that dispose them to “pro-social” behavior—can play a role in shaping providers’ responsiveness towards patients and quality of medical care (Lagaarde & Blaauw, 2014). Evidence also suggests that generous and non-generous providers alike can respond positively to peer scrutiny and encouragement (Brock, Lange, & Leonard, 2012). Yet, researchers caution that providers’ pro-social behavior, and the probability that a provider’s greater ability (e.g., knowledge and skills) will translate to higher performance, are context dependent (Leonard, Masatu, & Vialou, 2007).

In sum, researchers recognize that providers’ performance depends upon a range of interdependent factors, including providers’ ability and motivation and organizational dynamics and culture, and is conditional on the social and political context of the health system (Prashant et al, 2014; Rowe et al, 2005). But the existing data on public and private health care provision offers scant insight into how these factors interact and contribute to
shaping providers’ performance. In particular, it tells us little about how specific social and political conditions inform quality of health care.

1.3 Framing health care to comprehend its social nature

To study how social and political conditions shape providers’ performance, I begin, as noted above, by reconceptualizing health care. In this section I discuss how I frame health care, namely, that I conceive of health care as a public good (rather than a commodity with purely private benefits) and health care provision as a social act (rather than simply a clinical transaction). Since health care does not meet the formal definition of a public good, I present arguments about why it ought to be considered as such.

These arguments have important analytic purpose for my project. Once we establish that health care should be considered a public good, and recognize that the social nature of public goods affects how states, markets, and societies produce and consume such goods, then we can more clearly delineate the socio-political conditions in which providers deliver care. That is, arguments about why health care is a quasi public good illuminate reasons why states, and not solely private entities, should be and often are (to widely varying degrees, with varying public and private sector roles) involved in health care provision.15 The arguments support the idea that health systems embody and convey the nature of the social contract between state and society. They affirm the thesis that “health systems are part of the social fabric of every country,” and that a health system’s organization and operations, including its public-private mix, not only produce health care but also purvey “a wider set of societal values and norms” (Gilson, 2003, p. 1461).
A particular public-private mix in health care can, in turn, contribute to and reinforce shared or collective ideas about the state’s responsibility and capacity to provide health care. One implication of the “social nature” of health care is that state agents’ actions to deliver care may be stymied by people’s imaginary about the state, as Dr Srinath was in the opening vignette. For state agents such as Dr Srinath, delivering health care implies not only imparting medical advice, but also engaging in a social act, i.e., an act imbued with shared understandings and collective narratives about the state’s welfare role (Evans, 2009; Hall & Lamont, 2009). These meanings and narratives can shape agents’ behavior and the quality of their care.

Thus, whereas a transaction-specific view of health care draws our attention to the micro-institutions of clinical encounters, conceptualizing health care as a public good and its provision a social act expands our purview to the social relations, political imperatives, and normative bases that undergird health systems and shape public providers’ work.

1.3.1 Health care as a public good

Health care does not possess the formal properties of a public good (Karsten, 1995), and hence my characterization of it as such requires justification. A public good, formally defined, is non-excludable and non-rivalrous. A non-excludable good implies that people cannot be easily excluded from accessing the benefits of that good once the good is produced. A non-rivalrous good implies the good is inexhaustible in the sense that people can consume it without depleting or diminishing it for others to use. Put another way, a
good is non-rivalrous if, once the good is produced and one person uses it, making another unit of it available for each additional person has no marginal cost. A purely market-based supply of such a good would tend to lead to its undersupply (it would be difficult to get the private sector to produce a good that people can benefit from without paying for it) and to social welfare losses (it would be inefficient to exclude people from benefiting from a good when there is no marginal cost to additional people using or consuming the good). The state is therefore often the more appropriate entity to supply public goods.

Health care does not meet formal criteria for a public good. Health care is an easily excludable service, e.g., the cost of health care can exclude certain people from accessing it. And it is rivalrous, e.g., one person’s use of health care services—consultation time spent with a doctor, consumption of medical supplies—leaves less available for others to use. However, although health care does not strictly fulfill criteria for a public good, economists have proposed that health care should be considered a quasi public good (Karsten, 1995).

Arguments for why we should treat health care as if it were a public good—and hence bolster support for state provisioning and regulation of that good—take several related tacks. (I note some here.) One argument takes an instrumental view of health care. In this view, health care is one of many underlying, intermediate goods required to produce population health. Although health care is not formally a public good, some aspects of population health are public goods, such as population-level eradication of communicable disease (e.g., polio eradication) (Smith & MacKellar, 2007). Health care, as an “access good” necessary to achieve population health, should be considered a public good in its own right.
A second argument is based on principles of justice and the moral imperative to ensure equitable access to health care for everyone in a society (Karsten, 1995). This argument has a long history. It is reflected, for example, in Beauchamp’s (1976) case for the “public health ethic,” meaning an ethic grounded in the norm that all people are equally entitled to key ends such as health. Beauchamp (1976) proposes the public health ethic as a critique of market principles, which “legitimate a mindless and extravagant faith in the efficacy of medical care” (p. 7). In this view, the medical care industry, among other industries that can negatively affect health, should be subject to “policies and obligations” because market norms can fail to equitably allocate health care services to where they are needed (Beauchamp, 1976, p. 7).

A third argument is based on the externalities that private health care providers would generate in a competitive market. Given the information asymmetries inherent in seeking and delivering medical care, health care providers can “significantly influence supply and demand conditions, pricing and output decisions, excess profits, and also tend to generate inefficiencies” (Karsten, 1995, p. 135). Competitive markets would undersupply health care and lead to suboptimal consumption of health care (Smith & MacKellar, 2007). State intervention is thus warranted to correct market inefficiencies.

Taking that point further, another argument extends what we understand as sources of externalities. Externalities, proposes Reddy (2015), derive not only from characteristics of particular goods, i.e., from technologies associated with a good, but also from the social and economic structure in which goods are produced and consumed. On that account, the structure of the health care sector—including how and how much private versus public
entities provide health care—can generate positive or negative externalities. Health care should be considered a public good not only because the technology of giving medical advice is rife with information asymmetries (producing private losses and socially suboptimal outcomes), but also because macro-level arrangements in the health care sector and the social conditions in which health care services operate can result in social costs and inequities.

The above argument is, in a sense, an economic formulation of a social justice critique of markets. It echoes the critique that markets, which inherently tend to produce negative distributive effects, always operate under specific political and social arrangements. Under some of these arrangements, markets can “compound and reinforce systemic disadvantage” (Powers & Faden, 2008, p. 103). Powers and Faden (2008) further argue that markets can also produce nondistributive negative effects, such as where they “corrupt human relationships and human flourishing” by “undermining such things as mutual respect, respect for self and others, and the ability to form attachments” (p. 103). Among nondistributive effects, I would add that market structures, including combinations of public and private health care, can influence people’s ideas about state responsibility for health care.

In sum, health care is arguably a public good for instrumental, moral, market efficiency, and welfare reasons. Taken together, the arguments emphasize the social nature of public goods. They stress that providing a public good entails a weighing of social values and political decisions. They propose that externalities associated with a public good can arise dynamically from “social structures and institutional organization of an economy” (Reddy, 2015), including, I propose, its mix of public and private health care. That is,
different compositions of public and private health care services might result in different
distributions of individual and social costs and benefits, i.e., different externalities. Deciding
that mix of public and private entails not just technical assessments about social need, but
also invokes a politics of need, a reckoning with “the reciprocity and interdependence which
characterise community” (Robertson, 1998, p. 1419).18

In turn, a particular mix of public and private health care can potentially shape
individual and collective ideas about “family, market, and state responsibility for care
provision” (Levitsky, 2008, p. 551; Henderson & Petersen, 2002). That is, ideas about health
care, and not only incentives to act, can inform the behavior of both providers and users of
health care (a point I develop further in Chapter 2). Providers’ actions—and hence the
quality of their care—depend not only on the micro-institutions of clinical transactions.
They depend also on the society and economy in which providers operate, including the
prevailing social imaginary about state-provided health care.

1.3.2 Health care provision as a social act

How does the social imaginary enter into or inform the everyday workings of health care
services? To chart that inquiry, I conceptualize public providers as both medical practitioners
and state agents, embedded in the communities they are meant to serve, their behavior as
much social act as medical practice (I develop this point in Chapter 2). As Hall and Lamont
(2009) remind us, Max Weber long ago defined a social act as one that was meaningfully
oriented to others and stressed “the moral valence people attach to people around them …
that there is no action and social relationship without meaning” (p. 9). Building on that
insight, I conceive providers’ actions as shaped not only by their knowledge, skills, and incentives, but also by their relationships with other actors—patients, communities, administrators, local elected officials, among others—and the meanings they attach to their relationships and experiences (Sheikh, Ranson, & Gilson, 2014).

When doctors working in state-provided facilities deliver health care, they act not only on the basis of medical knowledge and incentives to perform, but also on the basis of their collective experiences and subjective interpretations about the state’s health care mandate. In India, ideas about health, poverty, development, and economic growth have variously shaped the state’s role and emphases in health care provision (as I will detail in subsequent chapters). In recent decades, India’s economic liberalization has affected that role. I focus on two developments associated with liberalization, namely, urbanization and commercialization of health care. These developments, evident in India and germane to other LMICs, set the stage on which health care providers work.

1.4 Economic liberalization in LMICs: Implications for urban primary care

Economic liberalization is significantly altering the political and social context in which states plan and deliver health care services (Mackintosh, 2006). My project considers two concomitant trends associated with liberalization: commercialization of health care (Mackintosh, 2006; UNRISD, 2007; Baru, 2003) and urbanization (Brenner, 2013; Roy, 2011; Baindur & Kamath, 2009). Both these trends shape the context in which public sector providers deliver health care, specifically at the level of primary care.
1.4.1 Commercialization of health care

Commercialization\(^9\) of health care refers to a rise in private provision, payment, and investment in health care, among other developments associated with market-oriented health policies (Mackintosh, 2006; UNRISD, 2007). In many LMICs, an early and dominant form of commercialization has been the growth of independent, small scale, and largely unregulated private providers of primary care, what Mackintosh (2006) calls the “informalization of primary care” (p. 395). Primary care is a critical component of a health system—global evidence shows that primary care can yield improved and more equitable population health outcomes than specialized medicine alone (Shi, Starfield, Kennedy, & Kawachi, 1999; Starfield, Shi, & Macinko, 2005; Kruk et al, 2010).

In India, commercialization of health care is widely evident—it increased during structural adjustment and stagnant public expenditure on social services in the mid-1980s and has intensified following subsequent economic liberalization reforms (Baru, 2003; 2012). Although the poor in India widely access a large informal private sector to obtain primary care, they are also the foremost users of state-provided primary care (IIPS & Macro International, 2007; 2008), which makes the quality of care that public providers deliver especially crucial for the poor.

Researchers have argued that the public and private sectors are not “separable” from one another; developments in one can affect the scope of the other (Koivusalo & Mackintosh, 2004, p. 13), thus shaping the social and organizational context in which public providers work. Market-oriented health policies can define, for example, the populations that
public providers serve and the services they deliver. Market competition under commercialization can segment health care provision, wherein where public providers serve the poor, while private providers serve those who can pay (Berlan & Shiffman, 2012; Kida, 2011). Market-oriented policies may restrict the expansion of public sector health care services, which can make it difficult for public providers to address health issues of low priority (e.g., mental health, disability) or of emerging prevalence (e.g., diabetes, hypertension) that are contingent on a well-functioning primary care set-up (Reubi, Herrick, & Brown, 2015). Certain popular perceptions about health care, such as the idea that exclusion from care on the basis of ability to pay is legitimate, can become more accepted under commercialization of health care (Mackintosh, 2006; Baru, 2012). Commercialization of health care can thus influence both the meanings and material capacities associated with state-provided health care.

Studies suggest that market-oriented policies in India are constraining the scope and reach of public sector health care (Baru & Nundy, 2008; Qadeer, 2013). In particular, Baru (2005) has commented on an associated trend of demoralization and felt loss of social prestige among public providers. However, “explorations of Indian doctors’ vulnerabilities in policy contexts are … rare” (Sheikh & Porter, 2011), and we know little of how public providers are responding, in their everyday practice, to the expansive private sector in India.

The private sector is especially dense in urban India. While public and private sector health care coexist in both rural and urban India (NSSO, 2006), estimates indicate that the density of qualified allopathic physicians—both public and private combined—is 11 per 10,000 population in urban areas, relative to 1 per 10,000 population in rural areas (Rao,
Bhatnagar, & Berman, 2012).

The majority (60%) of health workers—including physicians (practitioners of both allopathic and non-allopathic medicine), nurses, pharmacists, dentists, and other clinical staff—in India are located in urban areas. And in both urban and rural India, 70% of health workers are employed in the private sector (Rao, Bhatnagar, & Berman, 2012). In other LMICs, too, urban areas have higher provider-to-population ratios and availability of private providers than rural areas (Galea & Vlahov, 2005; Beogo et al 2014; Harpham et al, 2003; Harpham 2009).

Paradoxically, the density of health care in urban areas does not correlate with access to care or better health outcomes for urban populations. Rather, data show some urban groups, such as “the poorest migrants from rural areas and slum dwellers may have maternal, newborn, and child mortality rates as high as or even higher than the rural poor” (Matthews et al, 2010). Researchers have increasingly highlighted disparities in health status and access to care between the urban poor and non-poor in LMICs (Montgomery, 2009; Matthews et al, 2010), including in India (More et al, 2009; Agarwal et al, 2008; IIPS & Macro International, 2007). Urban contexts are thus significant to this study because of the density of health care provision in cities and, as I discuss below, the relationship between urban space and economic growth.

1.4.2 Urbanization

Urbanization refers, in part, to “a demographic and land change process” (Seto, Sanchez-Rodriguez, & Fragkias, 2010, p. 170), wherein the setting for human habitation is increasingly the city, although forms of the urban and processes of urbanization vary widely
across the globe (Montgomery, 2008; Brenner, 2013). Urbanization is of rising concern in health research and policy discussions in LMICs (Galea & Vlahov, 2005; Montgomery, 2009). Policymakers and practitioners, especially those in international development agencies, have typically stated this concern in terms of the size and pace of growth of urban populations and areas. A common declaration prefacing urban development policy and practice, for example, is that over the next four decades, most of the world’s urban population growth is slated to occur in the global South (Hildebrand, Kanaley, & Roberts, 2013; UN-HABITAT, 2008). Evidence does point to high growth rates. India exemplifies this trend: although India remains predominantly (70%) rural, over 2001-2011, India’s urban population grew by over 30%, over twice the rate of rural population growth (Ministry of Home Affairs, 2011).

But rather than begin by profiling the size and growth of cities, critical urban scholars emphasize the ways urban spaces are implicated in global, national, and local movements of people, capital, and culture. Brenner and Schmid (2014) contend that definitions of the urban that rely solely on territorial and demographic criteria “presuppose rather than examine or explain the historical construction and reconstitution of territorial boundaries” and subsume a “sweeping heterogeneity of settlement configurations and transformative processes” (p. 744, 748). Urbanization should instead be understood in terms of both “agglomeration” and “extension” processes that unfold differently across the world (Brenner, 2013). The analytical and practical challenge in the public health field is therefore not only how to respond locally to high urban growth, but also how to relate urban change to social, economic, and political processes at various spatial scales.
Researchers argue, for example, that while the growth of cities is a product of economic policies (among other factors) (Kramer, Khan & Jahn, 2011), cities are also, from the perspective of policymakers, drivers of economic growth (Baindur & Kamath, 2009). The production of urban space is “entangled” with flows of capital, including development and finance capital (Roy, 2011, p. 12). In India, urban development programs are closely entwined with national plans for economic growth (Baindur & Kamath, 2009) and urban public expenditure has been directed largely towards improving infrastructure to make cities economically viable, less so to improve basic services for the poor (Coelho & Maringanti, 2012).

This orientation of urban development towards economic growth is consequential for urban health care and crucial to defining the context in which public health care services are provided in cities. In India’s cities, the poor access a large informal private sector (Matthews et al, 2010), but the poor are also the foremost users of public sector primary care (Kroll, Butsch, & Kraas, 2011; IIPS & Macro International, 2008). Municipal governments in India are legally mandated to deliver primary care in cities, but upgrades to municipal health care facilities have been incommensurate with urban population growth (Dasgupta & Bisht, 2010; Duggal, 2011). Yet the relationship between liberalization and urban health care is under-examined: while health researchers concerned with urbanization have increasingly studied health outcomes (population health status and disparities) among urban populations, they have paid less attention to the structure and functioning of health care services in cities (Butsch, Sakdapolrak, & Saravanan, 2012) (I expand on this point in Chapter 4).
In sum, features of liberalization—commercialization of health care and urban development—define the social and political conditions in which public providers deliver primary care in India’s cities. These conditions ply municipal doctors with the task of delivering primary care to a growing population amidst a thriving private sector that the population widely prefers. As I discuss next, my fieldwork examines how providers in the public sector understand and negotiate the scope of their work. I attend to the meanings that public providers “produce and mobilize to act upon their environment” (Lamont & Small, 2008, p. 79). These meanings and actions shape how municipal doctors deliver primary care to city residents, and help explain its deficiencies.

In the next chapter (Chapter 2), I elaborate the theoretical propositions that guide my inquiry. Chapter 3 presents my fieldsite and methods. In chapter 4, I situate urban primary care in India in its historical and spatial context. In chapters 5, 6, and 7, I explore three themes that, I argue, offer insights into explaining provider performance, namely providers’ conceptions of their mandate, the risks that attend it, and the structures of authority bearing upon it, each of which circumscribe what providers do. I show how developments related to economic liberalization, specifically commercialization in health care and urban development, are manifest in each of these themes. In chapter 8, I offer concluding remarks, reflecting upon what my findings illustrate and imply for future inquiry into providers’ performance and health care quality. Chapter 9 provides a note on methods, charting the challenges and limitations of my fieldwork.
2 Conceptual framework and theory

In this chapter I present concepts and theoretical propositions to analyze how social and political factors shape public sector health care provision.

2.1 Conceptualization of health systems

I conceptualize health systems as “constructed and brought alive by social actors through the meaning they attach to (their interpretations of) their experiences” (Gilson et al, 2011, p. 2). In this view, health systems not only deliver health care using tangible inputs such as infrastructure, funds, staff, and supplies, but also embody and convey—through their organization and practices—intangible ideas and meanings (see Figure 2-1) (Gilson, 2003; Sheikh et al, 2011; Freedman, 2005). These ideas and meanings, in turn, “guide actions and underpin the relationships among system actors and elements,” and are as critical to shaping health systems performance as tangible inputs (Sheikh et al, 2011).

This conception of a health system emphasizes its “people centeredness,” meaning the sense in which social relations and personal encounters are “at the heart of a health system” (Sheikh, Ranson, & Gilson, 2014, p. ii1). It accounts for the values and norms that underpin interactions among health system actors—including health care providers, administrators, patients, elected officials, and non-governmental organizations—as a way to apprehend the organization and functioning of health care services (Biehl & Petyrna, 2013).
Figure 2-1 Health system as comprising tangible and intangible elements

A conception of the health system as above offers a scaffold from which to then devise an explanation of how its parts interact. To construct such an explanation, I next describe a set of theoretical propositions that guide my inquiry. I return to the above health systems framework in the methods section (see Table 3-1), where I describe how my research methods yield data on selected tangible and intangible elements of the health system.

2.2 Theory

My inquiry rests on a conception of the state that emphasizes attention to state practices—what frontline state agents actually do in the process of service provision—and to the potential for divergence between policy and practice. Beginning with this conception of the
state, I describe a set of propositions that draw on social scientific scholarship on the welfare state and welfare reform that refers largely to the experience of advanced industrialized countries as well as analyses of social and political development in developing economies. I present three inter-related propositions that each contribute to explaining how deficiencies in the quality of state-provided services may prevail.

Table 2-1 presents a schematic view of the conception of the state and the three inter-related propositions that drive my inquiry. I elaborate the conception of the state and three propositions in the paragraphs that follow.
# Table 2-1 Conception of the state and three propositions that guide my inquiry

<table>
<thead>
<tr>
<th>Conceptualization of the state</th>
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<tbody>
<tr>
<td>• The state is not a discrete entity, separate from society, although it may appear as such to actors within and outside it. Both state agents and social actors come to imagine the state—its bounds, powers, responsibilities—through everyday state-society encounters, such as in the course of welfare provision. State agents’ imaginary of the state, in turn, informs and enables their everyday practices</td>
</tr>
<tr>
<td>• Workings of and ideas about the state can vary over time and across space, e.g., the multiple levels, locations, and agencies of the state</td>
</tr>
<tr>
<td>• The state is thus manifold, comprised of parts that are not coherent or unified, reflecting the varied ways differently positioned state agents and social actors engage with and understand the state</td>
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### What does a conception of the state as manifold imply for analysis of state-provided services?

<table>
<thead>
<tr>
<th>Parts of the state</th>
<th>Workings of the state</th>
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<table>
<thead>
<tr>
<th>Three interrelated propositions to explain how deficiencies in state-provided services might prevail, involving different locations or parts of the state</th>
</tr>
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<tbody>
<tr>
<td>Social science theory suggests several explanations</td>
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<tr>
<td>Research questions based on social science theory</td>
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<table>
<thead>
<tr>
<th>Spaces of policy decision-making</th>
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</table>

<table>
<thead>
<tr>
<th>(a) Misalignment between policy design and social needs can result in mandates that don’t address or ameliorate conditions on the ground</th>
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<tr>
<td>(b) State agents at the frontlines of service provision grapple with the formal intent of policy vs. the mangle of actual practice. Their idea of the state—its bounds, powers, responsibilities—informs their practices. Their practices, in turn, shape policy (with recursive effect on working ideas of the state)</td>
</tr>
<tr>
<td>(c) The nature of social ties between state institutions and communities can shape how state agents see themselves and their role <em>vis-à-vis</em> society and can affect how they conduct their work</td>
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<th>Spaces of policy implementation</th>
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<tr>
<th>What is the state’s historical policy mandate for urban primary care? What conceptions of need undergird policies for and organization of urban primary care services?</th>
</tr>
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<tbody>
<tr>
<td>How do state agents understand their mandate and resolve everyday dilemmas on the ground?</td>
</tr>
<tr>
<td>How do state agents interact with, and interpret their social relations with, the communities they are meant to serve?</td>
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</tbody>
</table>
In early state-centric arguments for “bringing the state back” into social science analysis (Skocpol, Evans, & Rueschemeyer, 1985), analysts conceptualized the state as a discrete entity, an autonomous actor with clear boundaries from society. Scholars defended the state as an actor capable of contributing independently to the making of policy, formulating and pursuing goals distinct from the interests of political parties, social classes and groups, and business lobbies. Based on that conception, research on the state might concern questions of state power contra society, such as how the state consolidates rule or regulates the economy.

Countering that view of the state, other analysts have proposed that the state is not a discrete entity, a set of institutions set apart from society, but rather the state’s appearance as such is constituted through everyday social practices (Mitchell, 1991). These social practices include the practices of state agents and their encounters with others in the course of conducting the state’s routine activities (Sharma & Gupta, 2006). With such a conception of the state, the analytical problem is to understand how and with what effects the state comes to assume the power it does, what the state means to people in society, and how non-state actors—individuals, collectives, organizations—play a role in everyday processes of governance (Ferguson & Gupta, 2002).

My study builds on the latter view, which posits routine practices of state agencies as a crucial subject of analysis. It is through these practices that both state agents and social actors—workers situated inside state agencies, people receiving state benefits, and others—
come to encounter and imagine the state (Sharma & Gupta, 2006). Through these practices, “the state,” or an idea of the state, is produced and reinforced, as well as contested and sometimes destabilized. This process of construction and reinforcement of the idea of the state occurs not only across time, but also across space, i.e., the multiple levels, locations, and agencies of the state (Sharma & Gupta, 2006; Gupta, 2012; Kaviraj, 2005). Encounters and practices in one location of the state may differ from encounters and practices in another. The state is manifold, comprised of parts that are not necessarily coherent or unified, and state agents and social actors may variously understand, know, and engage with its parts.

Scholarship on the welfare state explicates this conception of a manifold state. One key approach in this scholarship is to conceive the state as a composite of policy-making and policy-implementing parts that are not always in sync (Haney, 2002). In this view, when making welfare policies, policymakers and state agents develop programs and services based on conceptions of population need. When implementing policy, state agents interpret individual needs at the point of service delivery. A study of state welfare services should recognize the state’s mandate as shaped by history, and also account for how state agents may differently understand the mandate and interpret social needs on the ground (Haney, 2002).

Based on a conception of the state as manifold, I next theorize how state-provided health care is variously rendered in policy and in practice. I devolve my inquiry into three parts, i.e., guided by three inter-related propositions, each of which theorizes how deficiencies in state-provided services may prevail.
2.2.2 Part (a) Misalignment of mandate and social need

Social scientists studying the welfare state have theorized that shortfalls in service provision can follow from welfare policies that do not address the reality of evolving social needs. A mismatch between policy mandate and social needs can occur in several ways. It may occur due to a conceptual shift: a reframing of commitments and understandings of need that alter the orientation and priorities of welfare services (Robertson, 1998; Haney, 2002). Or it can result from a failure to adapt policy to changing social needs. This can happen due to either general institutional constraints on policy reform or features specific to particular policies, both of which can delimit substantive changes to policy frameworks (Hacker, 2004). General institutional limits on large-scale policy reform exist where certain ways of seeing or material interests become entrenched in political institutions, and the status quo is difficult to dislodge given procedural rules and the distribution of decision-makers’ preferences (Hacker, 2004). Specific features of policies can facilitate “subterranean” policy adjustments, meaning less visible processes of adaptation that involve ground-level alterations to policies but leave the policy framework largely intact (Hacker, 2004; Thelen, 2003).

Examples of subterranean policy adjustments include “drift” (Hacker, 2004) and “conversion” (Thelen, 2003). Policy drift refers to a “shift in the context of policies that significantly alters their effects” (Hacker, 2005, p. 45). Policy drift occurs when social risks change, but existing policies remain stable and ill equipped to address or ameliorate them (Hacker, 2005). Policy conversion refers to changes in the use to which existing policy institutions are put, such as when policymakers might narrowly specify the strategies and target populations for an existing policy program, thus dissociating that policy from
addressing wider social structural factors and vulnerable constituencies (Thelen, 2003). In either case, a possible result is a mismatch between policy design and social needs.

Forms of misalignment between welfare policy and social need, which may be inadvertent or deliberate, create a chasm between what frontline state agents are mandated and enabled to do and what is actually needed on the ground (Hacker, 2004). Frontline state agents are thus implicated in subterranean policy adjustment, e.g., when their everyday practices do little to address changed social conditions on the ground (contributing to policy drift) or when they redirect their practices to alternate ends (contributing to policy conversion). One explanation for observed shortfalls in state-provided services may, therefore, be traced to the mandate from which their organization and functioning devolves. Understanding the scope of the mandate and its alignment or discordance with social need is thus the first stage of my inquiry.

The first stage of my inquiry is to delineate the state’s historical policy mandate for urban primary care in India—to situate the mandate in its temporal and spatial context. This involves examining relevant policy documents to discern policymakers’ intent and understandings of social need as depicted in policy design, i.e., the social problem they construct and attempt to solve with respect to urban primary care. Situating the state’s mandate temporally implies identifying the historical legacies and conflicts that mark the institution—the coming to be—of present-day policy design (Bourdieu, Wacquant, & Farage, 1994). Situating the state’s mandate spatially entails examining the organization of state institutions at local and extra-local levels through which policy is implemented in urban locales.
For this purpose, I examine the period immediately before and following Indian independence in 1947 given the legacy that colonial administrative institutions left on India’s service delivery apparatus (Chatterjee, 1997; Kothari, 1961). I specifically study a health report commissioned by the colonial government and published around that time, the Bhide Committee (1946) report, which significantly shaped, inspired, and set standards for subsequent development of health services in India (Amrith, 2007). I then focus on the decades following India’s economic liberalization beginning in the 1980s. The Indian economy, facing a severe crisis of external debt and foreign reserves in 1991, began to institute major market reforms that year. But some economists date the beginning of India’s economic liberalization to an earlier time the 1980s, when the state initially began to deregulate industry and relax trade restrictions (Deshpande & Sarkar, 1995; Panagariya, 2004). The state also took relevant measures to reform health care services in the 1980s—the central government published its first commissioned study on urban health in 1982. Thus, I cover the period from the 1980s onwards, noting that even though India’s major, systematic, historic economic opening began with its balance of payments crisis in 1991, its economic liberalization, and its attention to urban health and health care, began in the 1980s.

I should flag that my purpose here is not to analyze the politics of policy reform—it is not primarily to explain the actors, interests, and conflicts involved in producing mismatches between India’s health policy and the needs of its urban populations. Rather, my objective is mainly to glean, from policy-related texts and analyses, ideas about urban primary care that undergird the design of policy and the organization of urban health care services. These ideas represent the mandate that municipal health care providers are charged
with implementing, and this mandate can be weighed against evidence of urban health care needs as presented by demographic and health survey data and research reports. Whereas the first part of my study concerns the state’s mandate for urban primary care, the following two parts concern how state practices unfold on the ground.

2.2.3 Part (b) Interpretation of the mandate on the ground

Scholars have argued that social imaginaries influence the functioning of state institutions, including how state agents deliver services (Evans, 2009). The social imaginary “incorporates a sense of the normal expectations that we have of one another, the kind of common understanding which enables us to carry out the collective practices that make up our social life,” a shared sense of legitimacy (Taylor, 2002, p. 106). It comprises both factual elements (a shared sense of how things usually go, an awareness of common practices) and normative elements (a sense of how things ought to go and an identification of ideal cases and of practices that would violate the norm) (Taylor, 2004).

Taylor (2004) discusses the transformation of the social imaginary in Western society by the modern conception of the moral order of society, i.e., by a new vision of moral order initially stated in 17th century natural law theories. The concept of a ‘moral order’ is important here: the moral order refers not just to a set of norms by which we “ought to govern our mutual relations and/or political life,” but also includes an “identification of features of the world or divine action or human life that make certain norms both right and (up to the point indicated) realizable” (Taylor, 2004, p. 8). In modern social imaginaries, these features include, for example, the functional distribution of occupations we engage in,
the production and exchange of services and goods that serve our mutual benefit, the legal and judicial institutions we establish. These institutions operate in the here-and-now; in modernity, the moral order is imagined as achievable in the present, in ordinary human life.

Taylor (2004) discusses “three forms of social self-understanding that are crucial to modernity” and that each represents a transformation of the social imaginary in Western society (p. 69). Primary among these forms is the economy, reflected, for example, in the growing political power and status of the commercial classes, an understanding of the “economy” as a sphere separate from the polity (but interlocking with it in ways useful for the common good), and a sanctification of ordinary life in which production and exchange have a central place. (Taylor discusses two other paths to modernity through which the social imaginary is transformed in Western society: the public sphere and the outlook of popular sovereignty alongside practices of democratic self-rule.)

In India, the transformative processes that initiated a modern social imaginary were not primarily economic but political, with modern state institutions playing a definitive role. “Modernity came to India, and perhaps also in other European colonies, through the introduction of a new activity called ‘politics’,” writes Kaviraj (2009). This activity of “politics” expanded from being the engagement of Indian elites with British colonial rulers in the mid-19th century, to the mobilization of popular movements against colonial rule in the 1920s alongside the continued primacy of educated elites in national political participation, and broadened from the 1970s with the entry of lower-caste and lower-class politicians (Kaviraj, 2009). Modern state institutions—introduced by colonial rulers and used instrumentally by postcolonial leaders toward developmental ends—together with practices
of democratic representation have been central to this transformation in India, where a society based on a religious caste-based system, in which political rulers (including the Islamic rulers who governed large areas of India from the 11th century) were largely expected to uphold social norms and organization, was turned into a social order controlled by the modern state, by its laws, resources, functionaries, and “place in the ordinary people’s imagination” (Kaviraj, 2009). Even as the specific role of the state in social and economic life has evolved in the decades since independence, reflected, for instance, in the transition from state-led capitalist development to state policies to promote economic liberalization, the state has a central place in the social imaginary in postcolonial India (Kaviraj, 2005).

The contemporary background understanding or social imaginary about the state is crucial in my project, because this understanding informs frontline service provision and potentially shapes quality of care—it affects what state agents and citizens expect from one another and how state institutions function (Evans, 2009). Social imaginaries influence how state agents and citizens interact and how state agents make sense of their practices and their role in the state apparatus. In turn, interactions between state agents and social actors partly construct the social imaginary about the state, which includes a common understanding of the state’s powers and responsibilities (Gupta, 2005; Scott, 1998; Ferguson & Gupta, 2002). This dynamic suggests that to understand how shortfalls in state-provided services may prevail, we ought to study the social imaginary and the practices it enables.

People differently situated within and outside of state agencies—in the field of health care this would include policymakers, health care providers, health administrators, elected officials, and patients—may develop distinct meanings about state services based on their
position, concerns, and experiences (Morgen & Maskovsky, 2003). People “mobilize” these meanings “to act upon their environment” (Lamont & Small, 2008, p. 79). The social imaginary ordinarily subsumes these myriad meanings—it enables the collective practices of a society by incorporating the expectations people have of one another, how they make sense of their social existence and their relations with others (Taylor, 2002). Alternate repertories can coexist, such as what policymakers think the goals of state policy should be and what administrators perceive as infeasible or unethical on the ground.

My focus is specifically on the experiences and interpretations of those state agents who operate at the frontlines of service provision, i.e., those workers Lipsky (2010) termed street-level bureaucrats. Frontline state agents—in my project, these are primary care doctors in Pune’s municipal health service—routinely tackle the “intent of policy and … mangle of practice” that characterizes the everyday work of service provision (Hoag, 2011, p. 83). Charged with implementing policy, frontline state agents regularly interpret their mandate and its legal-administrative rules, as well as social needs and demands on the ground (Haney, 2002; Brodkin, 2012; Hoag, 2011). Their interpretations (Haney, 2002) as well as the discretion they enjoy in making decisions locally (Hacker, 2004) inform their actions and shape policy and its effects.

In this part (the second of three parts) of the study, I attend to municipal doctors’ narratives about their mandate to provide urban primary care and their practices in implementing this mandate. An analysis of narratives implies attention to the ways “people develop an understanding of themselves, their environment, and others that shape their actions” (Lamont & Small, 2008, p. 83). I observe how municipal doctors, in their role as
state agents, make sense of their mandate and how they articulate and resolve the dilemmas of their everyday work. A focus on narratives is crucial here, because narratives help make state agents’ practices comprehensible: they show that “action is not an automatic response to incentive,” but rather is mediated by, or “made possible within the context of narratives around which people make sense of their lives” (Lamont & Small, 2008, p. 84).

The third part of my inquiry considers, within these narratives, how state agents understand state-society ties and relate to the communities they are meant to serve.

2.2.4 Part (c) Relations between state and society

The third part of the study concerns social relations36 that connect state agencies and local communities, which evidence shows can shape the outcomes of state-provided services (Evans, 2009). The literature on health and social capital,37 in particular, suggests that social relations between individuals and “larger institutional forces,” such as state agencies, can have virtuous, positive effects for population health (Szreter & Woolcock, 2004a, 2004b; Evans, 2009; Swidler, 2009).

Szreter and Woolcock (2004b) invoke “linking” social capital to refer to social relations between a social group and an organization holding a position of power or access to goods or services. Linking social capital implies “norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalized power or authority gradients in society” (p. 655). Examples of such ties include relations between communities and “representatives of formal institutions,”
including “law enforcement officers, social workers, health care providers,” which affect people’s access to welfare (Szreter & Woolcock, 2004b, p. 655).

Linking social capital is especially important for public services delivered “through on-going face-to-face interaction, such as classroom teaching, general practice medicine, and agricultural extension” (Szreter & Woolcock, 2004b, p. 655). For frontline public service providers, linking social capital—the nature of their ties to the communities they serve—can affect how they conduct their work. As states’ efforts to address population health issues consistently demonstrate, successful efforts depend on how state agents see themselves and their relationship to society (Evans, 2009), e.g., in the state of Kerala in India (Heller, Harilal, & Chaudhuri, 2007), Botswana (Swidler, 2009), Brazil (Tendler, 1997), and France (Nathanson, 2007). Evans (2009) argues that achieving population health outcomes in times of crisis depends on more than state agents’ “responsible, judicious performance of duties;” it entails state agents’ seeing themselves not only as regulators and service providers but also as transformational agents who can foster and create the space for social change (Evans, 2009).

In sum, whereas theories of the state discussed above in (a) and (b) posit that service delivery outcomes are shaped by how state agents interpret policy mandates and social needs, theories of state-society relations in (c) emphasize that we ought also to consider how state agents interact with and interpret their social relations with the communities they are meant to serve. I elaborate my methodology in the next chapter.
3 Methodology, methods, and fieldsite

3.1 Methodology

3.1.1 The extended case method

The model for fieldwork that I follow is the “extended case method” (Burawoy, 2009). This is an approach to ethnography that connects observations about past and present conditions of “a case,” as well as about its local realities and their external influences, and reassembles the resulting picture using pre-existing theory. The approach ramifies the bounds of a case, with the potential to extend social theory.

The extended case method is apropos to my inquiry. Underpinning the extended case method is the precept that a specific case (in this case, state-provided urban primary care) is a product of past and present conditions, of local realities and extra-local influences. Similarly, the conception of the state I describe above emphasizes attention to the historical and spatial context of state practices, and to a potential divergence between policy and practice. The frames of reference evoked by the extended case method—past and present, local and extra-local—call attention to themes of inquiry suggested by theories of the state I delineate above, emphasizing history, spatiality, and everyday practices of state agents.

In my fieldwork and analysis, I shuttled between the present-day workings of municipal health care facilities and their historical institution; local policy implementation and extra-local policy decisions; and interactions between and perspectives of a range of
actors: municipal health care providers, administrators, elected officials, and NGO staff. The theoretical propositions described above guided my inquiry and analysis—they helped me organize my fieldwork and anticipate, interpret, and inter-relate my findings. Fieldwork involved multiple methods, including review of policy-related documents and administrative data, participant observation, and interviews. Findings and insights derived from one method helped inform investigations through other methods. Table 3-1 describes how specific methods help answer the research questions I identify based on social science theory (see Table 2-1 for a graphical view of theoretical propositions).

Table 3-1 Research questions, methods, and yield

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Methods and data sources</th>
<th>Yield</th>
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<tbody>
<tr>
<td>(a) What is the state’s historical policy mandate for urban primary care? What</td>
<td>Document review, drawing on policy texts: laws, policies, and budgets for urban health</td>
<td><strong>Tangible</strong> elements of health system: Organization of urban primary care services. Health care policy and urban development policy under market-oriented reforms in India. Administrative data on health infrastructure, staffing and budgets from Pune’s municipal government. <strong>Intangible</strong> elements of health system: Policymakers’ ideas about urban primary care.</td>
</tr>
<tr>
<td>conceptions of need undergird policies for and organization of urban primary care</td>
<td>care at national and local (city) level, around 1947 and then focusing on the period</td>
<td></td>
</tr>
<tr>
<td>services?</td>
<td>1980s onwards</td>
<td></td>
</tr>
<tr>
<td>(b) How do state agents understand their mandate and resolve everyday dilemmas</td>
<td>Participant observation in municipal clinics and hospitals, and informal and in-depth</td>
<td><strong>Tangible</strong> elements of health system: Actual resources available and in use in municipal clinics and hospitals <strong>Intangible</strong> elements of health system: Municipal doctors’ experiences, narratives, social relations associated with state-provided primary care in Pune</td>
</tr>
<tr>
<td>on the ground?</td>
<td>semi-structured interviews with health care providers and administrators in municipal</td>
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<tr>
<td>(c) How do state agents interact with, and interpret their social relations with</td>
<td>and state government and with staff of community-based NGOs.</td>
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<td>the communities they are meant to serve?</td>
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3.2 Relevant ethnographic traditions and anticipated practical challenges

I situate my methodology with respect to two relevant traditions in ethnography—organizational ethnography and political ethnography. Organizational ethnography has a long history particularly in anthropology and sociology. It espouses a multi-sited, multi-layered approach to inquiry (Yanow, 2010) that is aligned with the precepts of the extended case method. Political ethnography, too, has been conducted for decades, but in the margins of political science (Schatz, 2009b). Political ethnographers are especially concerned with the study of power in institutions or processes not typically conceived as “political,” such as local health care services, the focus of my project. I discuss these two ethnographic traditions to specify the general rationale for, yield from, and challenges inherent to ethnographic inquiry, i.e., to flag the “philosophical underpinnings … and practical challenges that particular approaches pose for the ethnographer” (Schatz, 2009a, p. 10). I discuss actual challenges I faced in the course of fieldwork in a later chapter (Chapter 9).

3.2.1 Organizational ethnography

Rationale

Organizational ethnography refers to the tradition of studying “organizations and organizational life,” the “quotidian experiences of people working in organizations” (Ybema, Yanow, Wels, & Kamsteeg, 2009, p. 1), and “understandings of meaning-making as a crucial component of organizational processes in organizations” (Sykes & Treleaven, 2009, p. 219). This approach is relevant for my project. As in the extended case method, historical context, interconnections between multiple sites and locations, and their effects on the local setting
are essential features of organizational ethnography (Yanow et al, 2012) and of critical, interpretive organizational research in general (Duberley, Johnson, & Cassell, 2012). The approach is premised on a conception of social reality as constructed and multilayered, where the researcher subjectively learns about people’s practices, perspectives, and sense-making (Ybema, Yanow, Wels, & Kamsteeg, 2009).

Yield

As the insights of Ybema, Yanow, and others suggest, an ethnographic approach can elucidate at least two aspects of health systems that other methods, such as surveys, interviews alone, or standardized patient vignettes, may not. First, ethnography can help make visible hidden dimensions of organizational life, including health care workers’ relative power, interests, and motives. I explore this point further in my discussion of political ethnography below. Second, ethnography affords sensitivity to “the interplay between actors and context” by alternating between subjective experiences and individual agency of actors and the broader historical context and social relations in which these are embedded (Yanow et al, 2012, p. 335). This point aligns with a theory of the state that views the state as constituted through the everyday practices of state agents and by its historical and spatial context (see chapter on theory above, e.g., Sharma & Gupta, 2006; Mitchell, 1991; Haney, 2002).

Practical challenges

The multi-sited nature of organizational ethnography poses several practical challenges, as it did in mine, notably those of access and positionality. Ensuring access involves traversing multiple sites within and across organizations, which not only makes high demands on time,
but also considerable demands of building rapport and maintaining relations across networked sites. It involves not just revisits to the same site, but performing the initial entry visit many times over at various locations, e.g., negotiating access at different government departments, offices within a department, and persons across levels of government, in each case working under the possibility that any of these sites might revoke access. Concerns about positionality require the ethnographer to be reflexive, including about her position in the field, and to present a “reflective transparency” about her access to people, places, texts, and parts of the organization under study (Yanow et al, 2012, p. 343). The researcher’s position in the field can affect what and how she learns, since the researcher is not primarily collecting neutral or objective data, but rather discerning people’s social worlds, their practices and perspectives. I explore issues of access and positionality I encountered in a later note on methods (Chapter 9).

3.2.2 Political ethnography

Rationale

Researchers have termed their work “political ethnography” to emphasize their use of ethnographic methods to specifically study politics, meaning “the exercise of power in its varying manifestations” (Schatz, 2009c, p. 306). According to some advocates of political ethnography, whether ethnography is recommended for a research project depends “less on the topic being studied and more on how the topic has been studied to date” (Schatz, 2009c, p. 305). A key concern of political ethnographers is to “uncover processes, discourses, and behaviors that generate a political dynamic” that has been largely invisible because the tools analysts have used thus far have not illuminated these politics (Schatz, 2009c, p. 305).
Analyses of health systems can be said to suffer from such a gap of sight and insight (Storeng & Mishra, 2014). That is, although social needs and state response are political constructs, their study in the health systems literature has been more technical-epidemiological and descriptive than informed by social science theory and critical analysis. As I have argued above, studies assessing health care quality in LMICs have tended to measure and compare providers’ performance in the public and private sector, with approaches often emphasizing the behavioral determinants of health care quality. Studies that take this approach have greatly advanced what we know about health care quality in LMIC contexts, where the state’s funding and regulation of health care are weak and population health literacy is low, making for conditions rife with information asymmetry, questionable medical training, and distorted incentives for providers. However, behavioral approaches can occlude the political and social significance of health care as a public good. They may overlook public providers’ role as state agents, whose actions are both clinical and social. That is, providers act not only on the basis of medical knowledge and incentives to perform, but also on the basis of collective experience and subjective interpretations, including ideas about the state’s mandate to provide care.

Yield

Ethnography serves my project because it can help render visible the political dynamics and social relations that attend the state’s provision of health care. By expanding “how we understand the boundaries of the ‘political’” (Schatz, 2009a, p. 10), ethnography can explicate state-provided health care as a site of politics. As Jourde (2009) argues, ethnography can contribute to the study of politics and power by expanding the repertoire
of what counts as a “political object” for inquiry. As the ensuing chapters will illustrate, municipal primary care services comprise spaces, processes, and encounters where people—specifically health care providers—exercise and experience “naturalized instances of power relations” (Pachirat, 2009, p. 147).

Attuned to the workings of power, political ethnography conducted from an interpretive, critical theoretical stance may help us devise alternative remedies to the problem of low provider performance, adding to or qualifying interventions such as training, certifying, and monitoring providers. Attending to power, as Flyvberg (1998) has argued, can help the researcher arrive at a “practical wisdom” gained from familiarity with the “contingencies and uncertainties of various forms of social practice embedded in complex social settings” (Schram & Caterino, 2006, p. 8). Remedies to improve provider performance could draw on critical assessments of norms, interests, and power structures that shape health care providers’ everyday dilemmas and decisions. Research that illuminates existing modes of power could be used, for instance, to conceive how health care workers might be enabled to “pursue interests and objectives excluded by dominant management discourses” (Duberley, Johnson, & Cassell, 2012, p. 24).

Practical challenges

Given their interest in the workings of power, a primary practical issue for political ethnographers is the challenge of “studying up,” or gaining access to organizations, processes, people, and spaces that hold or represent positions of power. Some researchers rail against the term “studying up” because, they argue, rather than reveal who does or does not have power, it presupposes a particular distribution or alignment of power between
researcher, researched, and groups within the researched. While the term was useful when ethnographers first began to call for more study of people in and positions of power (e.g., Nader, 1972), the argument goes, it is no longer a productive way to characterize the range of communities and questions ethnographers now research (Seaver, 2014).

Yet the point remains that the feasibility of studying groups in relatively closed organizations, such as banks, law firms, corporations, and state agencies, requires the ethnographer to rethink participant observation as immersion in the field, and to look afield at alternate venues, modes, and strategies, such as acquiring specialized skills, through which the researcher may engage with her subjects of study (e.g., Gusterson, 1997; Ortner, 2010; Ho, 2009). I explore challenges of access I faced, some similar to those ethnographers have commonly identified and others specific to my fieldwork, in a note on methods in Chapter 9.

3.3 Field site

3.3.1 Pune’s economy and population

I conducted one year of ethnographic fieldwork (2013-2014) in Pune. Pune has a population of three million, and is located in the state of Maharashtra in western India (Figure 3-1). Pune is not amongst the less developed of India’s smaller cities. To the contrary, it is considered a rising hub of economic activity, led by manufacturing and, more recently, information technology industries (Government of India & Bloomberg Philanthropies, 2016). Despite its economic growth, poverty persists in Pune: its slum population has remained over 30% of the total population since 1981 (Graph 3-1).
Pune’s combination of a growing economy, expanding population, and sustained poverty exemplifies the challenges that urbanization presents for public health in second tier cities in India and other LMICs. Pune is classified by the Census of India as a second tier or “million plus” city based on its population size, a tier below ‘megacities’ such as Mumbai,
which earn that paramount title once their population reaches the ten million mark (Government of India, 2011). There are 53 “million plus” cities in India, which together account for over 40% of India’s growing urban population (Government of India, 2011). The remaining 60% of India’s urban population resides in either a very few megacities or in numerous small towns.

Pune thus highlights an important aspect of urbanization processes unfolding in India and in LMICs generally. As demographers have alerted us for some time, cities other than megacities are primary sites of projected population growth in the developing world, but have so far been under-studied in health research (Montgomery & Ezeh, 2005). Like other second tier cities, Pune has enjoyed rapid population growth rate: over the decade 2001 to 2011, its population increased by more than 20% (Bhagat & Jones, 2013). Pune’s population growth rate was even higher in previous decades; over 1971-2001, its population grew by about 40% each decade. Pune is not among India’s smallest cities, but neither is it a megacity. Its particularities are typically off the urban health research map.

3.3.2 Challenges that urbanization poses for public health, with reference to Pune

Rapid urban growth presents at least three potential challenges for public health. One challenge is a shift in the burden of disease. Urbanization is globally associated with a dual burden of disease: i.e., the prevalence of noncommunicable diseases (NCDs) alongside continued challenges of infectious diseases (Stenberg & Chisholm, 2012). High rates of urbanization, along with “global integration of consumer markets, and advances in longevity in still-poor countries that lack sufficient health systems to adjust,” have been indicated as
driving the rise in NCDs in low- and middle-income countries (Daniels, Donilon, & Bollyky, 2014). Activities related to the prevention and treatment of NCDs—including health promotion, continuity of care, and well-functioning referral networks—all point to a greater role for the public sector, specifically to enhance primary-level health care services (Magnusson & Patterson, 2014). A dual disease burden is evident in urban India (Engelgau, El-Saharty, Kudesia, et al, 2011; Gupta & Ahuja, 2010).

A second challenge that urbanization poses for urban public health stems from the size and growth of city populations and economies, which may be out of step with the city’s public resources and governance structure. Pune is not amongst the smallest or poorest of Indian cities, but neither does it have the large scale and wide range of public sector health care services as exist in richer cities such as Mumbai. Pune is not so small as to be dependent entirely on central or state government funding and technical support. Unlike some cities, Pune’s municipal government manages and funds its primary care services out of its own budget. (Its budget is, however, subject to approval from the state government). Yet, despite enjoying some autonomy and capacity, Pune’s municipal health system is not developed enough, as is Mumbai’s, to offer its residents expansive state-run medical care services that span small, community-based primary care clinics to specialized, technologically sophisticated hospitals. Pune’s municipal health service runs no large, multi-speciality or teaching hospital, as does Mumbai’s.

Unlike higher-level health care, primary care is by law a municipal government obligation (see Sections 4.3.2 and 5.3 for details). And yet, although primary care is a legal municipal obligation, the capacity of Pune’s government to ensure adequate, comprehensive
primary care to all city residents is limited. A chief constraint here is the stalled
decentralization of responsibilities from state-level to municipal government, the un-ceded
power of state-level over municipal government (I explore the relationship between state-
level and municipal government in Chapter 4). Pune’s municipal government cannot set its
own budget or expand its employee roster without approval from Maharashtra’s state-level
department of urban development. Higher levels of government have generally provided
scant financial and administrative support to upgrade and expand urban health care (Duggal,
2011). The result is that Pune’s municipal health workforce and infrastructure are delimited
by both its own capacity and the controls of state-level government.

Based on administrative data from Pune and on estimated proportions of public,
qualified private, and unqualified or informal providers in urban India (Rao, Bhatnagar, &
Berman, 2012), Pune’s municipal government accounts for a small fraction of the total
number of medical practitioners in the city (see Graph 3-2). Moreover, the number of those
practitioners has barely changed in keeping with the city’s population growth. My analysis of
administrative data suggest that Pune’s municipal government has been constrained to
expand its medical staff to meet growing population needs, despite having submitted
multiple requests for such an increase. As Pune’s population grew over 1991-2011 from
roughly 1.7 million to 3.1 million (an 85% increase), the sanctioned number of doctors in
municipal employ grew from 78 to 110 (a 41% increase), even though Pune’s municipal
government submitted five staffing requests over that period (see Graph 3-3).

The steep rise in number of doctors after 2011 occurred in the wake of a H1N1
(swine flu) epidemic in India in 2009, in which Pune was the epicenter. According to several
of my informants, the public health crisis highlighted the paucity of Pune’s health infrastructure and eased the difficult path of obtaining state government approval to expand municipal medical staff.\textsuperscript{42}

Thus Pune, and other cities like it, hold a distinct middle position with respect to national health policy reform. Under recent developments in national health policy in India, the reach of and resources for urban public sector health care are poised to expand (MOHFW, 2014b, 2013c). In cities such as Pune, the future of urban health care will be determined by both the direction of national policy reforms in health and urban governance as well as the initiative of its local government. Studying the prospects for urban health care in India thus involves understanding the role played by each level of government, which together determine local health and health care outcomes in fast-growing cities like Pune.

![Graph 3-2 Estimated proportions of municipal, other public sector, qualified private, and unqualified private doctors in Pune](image)

*Source: Author's estimate based on administrative data from Pune municipal government and estimates of public and private providers in urban India from Rao, Berman, and Bhatnagar (2012)*
Source: Administrative data collected by author from Pune Municipal Corporation
*These numbers represent the number of sanctioned posts, which were mostly filled. The steep rise in the number of doctors' posts after 2011 occurred in the wake of a 2009 H1N1 (swine flu) epidemic in India, in which Pune was the epicenter. Several of my informants observed that the epidemic highlighted the paucity of Pune’s health infrastructure, prompting the state government to approve an expansion in municipal medical staff.

Graph 3-3 Staffing of doctors at the Pune Municipal Corporation, 1993-2013

A third challenge for public health in urban areas is the highly visible and unregulated market for health care in cities, which exists alongside public sector health care. While private health care services have grown in both rural and urban areas, private providers are particularly dense in cities (Rao, Bhatnagar, Berman, 2012). Patterns of health care utilization in Pune, similar to patterns observed in urban contexts across India and other LMICs, suggest that people access both public and private providers. National and local (city-based) surveys in India, including studies based in Pune (Kroll, Butsch, & Kraas, 2011; Kroll, Bharucha, & Kraas, 2014), highlight the relevance of the public sector as a source of health care, especially for the poor (Graph 3-4). According to a household survey conducted in Pune, approximately 10% of residents from middle class and upper middle class areas say that they use public sector clinics or hospitals, while a higher proportion of slum residents --
between 15% to 45% depending on the type of slum -- say they regularly use public providers (Graph 3-4).

Other cities in Maharashtra and at the national level, across urban India, utilization of the public sector is higher among those who belong to scheduled castes and scheduled tribes (who are historically disadvantaged and discriminated groups), than it is among those who do not belong to these groups (24%-30% versus 17%) (NSSO, 2006).

Source: Kroll, Butsch, & Kraas (2011); Kroll, Bharucha, & Kraas (2014)
Note: Hypertension prevalence is age-adjusted and based on self-reported morbidity. Survey size = 900 households = 3875 persons. One upper middle-class group omitted to simplify presentation; results for that group are similar to the upper middle-class group in the graph. Private sector = private hospitals and private practitioners.

Graph 3-4 Utilization of private and public sector health care in Pune and hypertension prevalence in Pune
Although the private sector appears to have the majority share of health care transactions, the public sector is an important source of care, particularly for the poor. People’s choice of public or private facilities has been shown to depend on the type of illness, the perceived severity of illness, and their perceptions of what they can afford to pay at the time of illness, among other factors (Geldsetzer et al, 2014). Rather than rely solely on public or private providers, people navigate a complex “local ecology of care,” as Das and Das (2006, p. 73) write of health care services in low-income neighborhoods in New Delhi. This ecology of care includes drug stores, informal providers, and, importantly, public sector clinics (Islam, Montgomery, & Taneja, 2006; Seeberg et al, 2014). Some researchers caution that estimates of the utilization of private providers might be over-stated: a recent systematic review concluded that if informal (i.e. unqualified) providers are excluded from the definition of the private sector, then the public sector remains an important source of health care for the poor (Basu et al, 2012).

Pune is therefore significant as a research site because it exemplifies critical urban health challenges: an evolving disease burden and unmet health care needs; a governance structure out of step with city growth; and a largely unregulated private health care sector. The policy and administration challenges that these factors present are under-examined in urban health research in India and other LMICs.

3.4 Ethnography: The method

Since ethnography refers to both method and text, in this section I discuss the methods I used, and in the next section how I organized my findings in this text.
3.4.1 Document review

To situate urban primary care in the history and organization of state-provided health care in India, I reviewed policy documents, administrative data, and policy and social scientific analysis relevant to urban health care at the national and local level. Policy documents dated from the time of India’s independence in 1947 and administrative data from the 1980s to the present. I studied how the texts envisioned and described the state’s mandate for providing health care, specifically primary care, in urban areas.

In addition, I reviewed literature on narratives of illness and health care-seeking in India, and interviewed staff of NGOs involved in health activism, health advocacy and communication, and community mobilization. I also examined popular perspectives about state-provided health care in newspapers. These ground-level accounts of health care seeking complemented the policy literature, because they provided a local view of social need distinct from assessments formulated at policy-decision making centres.

3.4.2 Participant observation

During a year of fieldwork (2013-2014), I observed the everyday practices of health care providers working in municipal primary care facilities in Pune and engaged them in discussions about their work. I sought to examine how municipal doctors made sense of their mandate, responded to dilemmas of their work, and related to the communities they
served. During participant observation, I observed interactions between patients and municipal health care staff, among staff, and between staff and administrators in 12 out of a total of 56 municipal health care facilities in Pune (Table 3-2).

Municipal health care facilities in Pune include hospitals and outpatient clinics located throughout the city. The majority of my participant observation was in outpatient consultation rooms of hospitals and clinics. Apart from outpatient consultation rooms, I also observed interactions between patients and health care staff and among health care staff in other locations within and outside health care facilities, namely waiting areas outside outpatient consultation rooms, pharmacies located within the facility, and community-based health camps held in low-income neighborhoods in the city. Each of these locations entailed different approach and scope of observation, as I discuss below.

Table 3-2: Typology of Pune municipal health care facilities visited

<table>
<thead>
<tr>
<th>Type of municipal health care facility</th>
<th>Number of facilities visited</th>
<th>Total number of facilities in Pune</th>
</tr>
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<tbody>
<tr>
<td>Outpatient clinics</td>
<td>4</td>
<td>38</td>
</tr>
<tr>
<td>Hospitals, including maternity homes</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Central medical store</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>

**Hospitals and clinics**

All hospitals offered primary care through outpatient consultation services. Maternity homes additionally provided inpatient ward facilities for childbirth and provide perinatal care and reproductive and sexual health. Some of the larger municipal hospitals had separate consultation desks for different branches of medicine, such as pediatrics, obstetrics-
gynecology, and general medicine. Patients who visited those hospitals were directed to consultation desks according to their ailment. Some hospitals offered the occasional services of private consulting physicians—doctors in private practice who were not employees of the municipal government—in pediatrics, obstetrics-gynecology, orthopedics, surgery, and other specialties, who would visit the facility for limited, specific times of the week to consult with patients pro bono. To maintain anonymity of informants, I do not specify the type or location of health care facility or the consultation room they worked in. I only specify it as a “clinic” or “hospital” to roughly indicate the facility size.

*Outpatient consultation rooms*

I spent most of my time in outpatient consultation rooms of clinics and hospitals, which is where doctors saw patients for primary care visits, during official weekday working hours (9am-5pm from Monday to Friday). In some facilities, outpatient consultation rooms were equipped with one or two desks. In other facilities, general outpatient services were delivered in a large hall instead of separate rooms; the hall would several desks. Some consultation rooms contained a medical examination table (which was often bare, lacking paper covers), although I rarely saw a doctor use the examination table for a general primary care visit.

It was common for two or three doctors to sit at a single desk, positioned at adjacent or opposite sides of the desk. Stools or chairs for patients were placed either next to the doctor’s chair or across the desk from a doctor. The photographs below are not taken from my project site, but they convey a sense of the outpatient consultation desks (Figure 3-2) and waiting areas (Figure 3-3) in the municipal hospitals and clinics I visited. Whereas the photograph below shows outpatient consultations held in an open-air hall or courtyard, all
interactions I observed were in a room with a closed door. As noted above, some of those rooms were large halls that accommodated several desks. In those cases a single doctor would be seated at each desk, but the desks would be a few feet apart.

![Photo credit: B. Velankanni Raj, The Hindu, October 12, 2012](image)

**Figure 3-2 Outpatient consultations with two doctors at a single desk on a busy day (not in Pune)**

Conversations between doctors or other health care workers and patients often could be heard by other workers and patients or by anyone in the room who cared to listen. Doctors acknowledged that the arrangement violated patient privacy and confidentiality, but the set-up of multiple doctors simultaneously seeing patients in a single room was not unusual in government-run health care and private facilities in Pune (or across India, as the photograph above shows).
It therefore proved uncomplicated to physically insert myself into the set-up, since both doctors and patients were used to the idea of having numerous people—other doctors, nurses, non-clinical support staff, patients, and relatives and friends escorting patients—present in the room or transiting through it. Once I had informed the doctors in a municipal clinic or hospital about my research and sought permission to observe their work, they typically provided me a chair in the outpatient consultation room. I sat near a doctor’s desk, observed and listened to exchanges, and took notes in a notebook. If there was a lull in the stream of patients, and if the health care workers in question were not engaged in other work, I asked them questions about what I had observed.

In some facilities, during slow afternoon hours, less than half a dozen patients would come by in the space of two hours. Doctor would spend some minutes with each patient. This left lengthy gaps of time when doctors were not occupied and yet duty-bound to remain at their desks. I used this time to engage them in longer discussions. In busy clinics or during busy hours, patients would stream in continuously through the working day. I would sometimes sit silently taking notes for a two-hour stretch.

Although doctors with specialized skills might be assigned to see medical cases related to their specialty, this was not always the case. Particularly in smaller hospitals and clinics, doctors handled all manner of cases: whichever doctor was assigned to the outpatient consultation room would see any patient who walked through the door. It could easily happen, for example, that a doctor with experience in pediatrics or in dermatology would see adult patients presenting with high blood pressure, an eye infection, or joint pain. This created contrasts between, one the one hand, doctors’ skills or interests and resources at the
municipal health care facility, and on the other hand, patients’ immediate needs. The contrasts opened a way for me to ask doctors to reflect upon their individual medical practice and the workings of municipal health care more generally.

*Waiting areas outside outpatient consultation rooms*

In waiting areas outside outpatient consultation rooms, patients sat in a moving queue while they waited their turn to consult a doctor (Figure 3-3). The patient first in line was seated nearest the door of the consultation room; when this patient was called in to see the doctor, the next person in line would move into her spot, and the whole queue would move up one space. In crowded hours, the queue could trail beyond available seats.

*Photo credit: Qamar Sibtain. Daily Mail.com India. June 13, 2014*

*Figure 3-3 Scene in waiting area of New Delhi public hospital*

My observation in waiting areas was difficult to sustain when support staff who sentinceled the outpatient consultation rooms and managed waiting patients disapproved of
my presence in the hallways. To the support staff, I was too closely associated with medical professionals to sit in the waiting area as a patient would, but not senior enough, as perhaps a supervising physician might be, to be able to violate the no-loitering rule. (I discuss further in Chapter 9 issues of access.)

Yet, each day that I visited municipal health care facilities, I observed goings-on in waiting areas outside consultation rooms, spending a few minutes to up to two hours there. Several times I witnessed breaks of order: angry waiting patients who thought a patient had sauntered into the doctor’s room out of turn, altercations between support staff and patients who felt they had been unfairly admonished for not keeping order or maintaining the queue in motion. The flared words revealed not only patients’ weariness at long waits, but also the nature of social relations between health care staff and patients. The waiting area provided opportunities to talk informally to support staff about patients and with patients about their views of municipal health care away from the doctor-dominated clinical visit.

Pharmacies

Besides outpatient consultation rooms and waiting areas, I spent some time in pharmacies located within municipal health care facilities. All municipal health care facilities had a window at which a pharmacist dispensed a selected range of drugs. Patients received, included in the cost of the consultation, which was Rs 5 (less than 10 cents), a free two-day supply of the drugs prescribed by the municipal doctor, provided the drugs were stocked by the facility’s pharmacy.
Stocks in each facility’s pharmacy were allocated, based upon formal requisitions that the facility’s doctor and pharmacist had to jointly file, from the central municipal medical store. Thus, while pharmacists in municipal clinics and hospitals managed and dispensed drugs to patients within facilities, pharmacists at the municipal government’s central medical store were responsible for purchasing and disbursing stocks of drugs to all municipal health care facilities in the city. Access to drugs was crucial for patients, since drug prices could be substantial in private medical stores (Bhargava & Kalantri, 2013). Drug costs make up a substantial proportion of health care costs—studies estimate that drug costs comprise 70% of out-of-pocket expenditure on health care in India (Garg & Karan, 2009), and over 80% of the cost of outpatient care (Shahrawat & Rao, 2012). Pharmacists therefore fulfilled an important function in municipal health care facilities. They worked closely with doctors yet at a remove from the medical encounter, and offered an alternate perspective on municipal health care.

*Participating as a patient*

I enlisted myself as a patient at municipal health care facilities in several instances. Twice I came in for minor ailments, for which I would have normally sought treatment from a private physician. In a third instance, I brought my four-year-old son, suffering from a cough and fever that refused to subside, to a municipal clinic. And lastly, I accompanied a domestic worker (who worked for my mother, in whose home I resided for the duration of my fieldwork) on her visit to a municipal clinic. Although these episodes were real—grounded in genuine discomfort and anxiety of real illness—I was aware that visiting municipal clinics and hospitals as a patient was out of the ordinary for most middle-class residents of Pune. For the middle-classes, availing medical care in state-run facilities was an uncommon
prospect, as survey findings from Pune and other Indian cities show (Butsch et al, 2011; IIPS & Macro International, 2007). Yet, the experiences afforded a patient-centric glimpse of municipal health care, in contrast to my regular perch on the side of municipal doctors.

Outside clinic walls

While the majority of my observation was within municipal health care facilities, I occasionally ventured outside their walls. Several times I accompanied community health workers on their rounds surveying communities; sat through health camps held jointly by an NGO and the municipal health department within low-income neighborhoods; and attended meetings that brought together some combination of local administrators, municipal health care providers, NGO staff, and community members to discuss local public service problems. These events enabled me to study relations between municipal health care providers and communities, to observe municipal doctors’ interactions with city residents outside the institutional boundaries of clinics and hospitals.

Besides my regular visits to municipal health care facilities, I made several visits to the main municipal offices where Pune’s department of health is housed, and which is the administrative and political headquarters of Pune’s municipal government. I visited local politicians’ offices in Pune. I met with state-level administrators, health researchers, national and city-based NGOs, academics, and policy research institutes, which took me across the span of Pune city and outside it to locations in Mumbai and New Delhi. In New Delhi, I attended a national consultation organized by a health advocacy group Jan Swasthya Abhiyan. The consultation, timed to precede national elections, aimed to stimulate debate on the need, program evidence, and policy options for universal health care in India.
Discussions there with journalists, medical students, and NGO staff from various parts of India, among others, further broadened my network and directed me to alternate views on the needs of India’s health system.

By traversing clinical and non-clinical, state and non-state spaces in the city and outside it, I observed multiple state agencies, non-state organizations, and levels of decision-making, and visited varied locations where people provided and received health care. This was vital for a relational ethnography such as mine, since it helped attune me to the dynamics between and among people and health-related institutions, and to the relations of power and meaning indicated by those dynamics (Desmond, 2014). However, traveling the geography of multiple sites to follow these relationships and expand the range of people and institutions with whom I engaged at times posed a challenge, namely that of achieving ethnographic depth (Desmond, 2014), as I discuss in the concluding note on methods (Chapter 9).

3.4.3 Interviews

I conducted a total of 102 in-depth, semi-structured interviews, typically in a mixture of Marathi and English, with a range of actors (see Table 3-3). The duration of interviews ranged between 30 minutes to 2.5 hours. In most cases of interviews with health care providers and paramedical staff, I knew the person through my participant observation at their workspace (i.e., municipal hospital or clinic) before the interview, had engaged in informal conversation with the person, and was familiar to them as someone who shared
and visited their space. Key informants aided my interpretation of findings; among these informants were health researchers and physicians formerly employed in the public sector.

Table 3-3: List of in-depth semi-structured interviews

<table>
<thead>
<tr>
<th>In-depth semi-structured interviews</th>
<th>Number of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>City level</strong></td>
<td></td>
</tr>
<tr>
<td>Medical officers (doctors working in health care provision and administration in the health department) in Pune</td>
<td>30</td>
</tr>
<tr>
<td>Paramedical staff (nurses, pharmacists, support staff) in Pune</td>
<td>15</td>
</tr>
<tr>
<td>Municipal administrative staff in non-health departments in Pune</td>
<td>4</td>
</tr>
<tr>
<td>Private sector doctors who also act or have acted as consultants in municipal public sector facilities in Pune</td>
<td>4</td>
</tr>
<tr>
<td>Local elected officials in Pune</td>
<td>3</td>
</tr>
<tr>
<td>Staff of NGOs and trade unions involved in urban community mobilization on health and health care in three cities</td>
<td>24</td>
</tr>
<tr>
<td><strong>State level</strong></td>
<td></td>
</tr>
<tr>
<td>Senior managers and senior bureaucrats in departments of health, urban development, and food and drug administration</td>
<td>6</td>
</tr>
<tr>
<td><strong>Key informants</strong></td>
<td></td>
</tr>
<tr>
<td>Senior staff of government and non-government research and policy development institutes</td>
<td>11</td>
</tr>
<tr>
<td>Academics</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total number of interviews</strong></td>
<td>102</td>
</tr>
</tbody>
</table>

I quickly found, after a few tentative questions about the possibility of audio recording, that municipal staff would not generally be comfortable with being recorded. I therefore did not request to audio record interviews and instead took copious hand-written notes, which I detailed and fleshed out (by hand in the same notebook) later the same day and subsequently typed up. I took all field and interview notes in English, translating the Marathi as I went along. I obtained authorization for the study from the Pune municipal government health department. The study protocol was approved by the institutional review boards of Columbia University and a Mumbai-based clinical ethics committee.
3.4.4 Who is a “doctor”

The term doctor encompasses a range of medical qualifications and, in India, does not presuppose a common body of expertise or knowledge set. In India, the basic medical degree in allopathic (modern) medicine is the Bachelor of Medicine, Bachelor of Surgery (MBBS) degree. There are also basic degrees in homeopathic, ayurvedic, and other fields of medicine, such as the Bachelor of Ayurveda, Medicine and Surgery (BAMS). Some doctors in Pune’s municipal health service held these alternative degrees and practiced alongside MBBS degree holders at the level of primary outpatient care. Maharashtra is one among few states in India that legally allow BAMS doctors to prescribe allopathic medicine (Dabhade et al, 2013).44

The majority of Pune’s municipal doctors were MBBS degree holders. The MBBS course takes five and a half years to complete and requires at a minimum high school completion. (The MBBS degree is roughly equivalent to the basic medical degree in the US, the difference being that it is not preceded by a four-year undergraduate course of study as in the US.) Following the MBBS degree, a doctor may pursue a two-year diploma or a three-year degree to specialize in a field (there are also further specializations). Specific post-MBBS three-year degree courses confer a Doctor of Medicine (MD) qualification. Doctors sometimes referred to those who held an MD degree as “physicians,” while an MBBS degree holder was never a physician, always a doctor. Only a handful of Pune’s municipal doctors hold MD degrees, while substantially more private sector doctors hold MD qualifications. The private and NGO-sector doctors I spoke to held MD degrees.
I have used pseudonyms for all informants and withheld or altered personal and situational details to maintain anonymity. I refer to doctors by pseudonymous first names, although the common way to refer to them would be by their last name, e.g., not Dr Radhika but Dr Gore, if I were a medical doctor. Since last names can potentially give away the person’s caste, religion, or community affiliation, I use (pseudonymous) first names to avoid having to either match or delink the person’s real ethnic affiliation with that of their anonymized identity.

Although doctors’ ethnic identity was not part of my research question, data collection, or analysis, I recognize that doctors’ caste and socioeconomic status can affect their education and employment opportunities, experiences, and practices. For instance, research on caste-based reservations (affirmative action) in India in public sector education and public sector employment indicates that caste and occupational choice are associated, although caste and social mobility are not associated except for specific sections of low caste groups (Bertrand, Hanna & Mullainathan, 2010; Howard & Prakash, 2008; A. R., 2013).

However, doctors’ ethnic identity may be less important in shaping their practice of medicine than more fundamental weaknesses in medical education (Rao, 2013). While the impact of caste-based reservations on quality of medical education and medical care has been a point of debate in the medical field, critics observe that concerns about reservations are misplaced. The real problem is corruption in medical practice and low enforcement of standards in medical education (Thomas, Srinivasan, & Jesani, 2006). Sujatha Rao (2013), former Secretary of the Ministry of Health and Family Welfare (MOHFW), has noted weaknesses in medical curricula, particularly in private medical colleges. Low standards in
medical education potentially affect doctors’ clinical skills and practices across the board, not only among specific social groups.

In this project, I do not examine the relationship between doctors’ socioeconomic position and their attitudes or practices in primary care. Yet, I acknowledge, and my findings affirm, these are valid questions for future study. For instance, in the chapter on Service (Chapter 5), I broadly consider how doctors’ social biases or prejudices (reflecting, for example, society-wide discrimination against caste or religious groups) might affect their clinical practice.

3.4.5 Analysis

My analysis draws on the following sources of data: (1) fieldnotes from participant observation, (2) transcripts from semi-structured interviews, and (3) administrative data and policy-related texts. I took hand-written notes to document observations and interviews. I typed up the fieldnotes within 24 hours. If typing notes within a day was not possible, I made extensive hand-written notes to comprehensively flesh out and supplement field notes within a day. In this way, I created detailed records not only of my observations, conversations, and interviews, but also of my thoughts and reflections about them.

Analysis was iterative, based on a reflexive relationship between theory and data. I brought relevant theoretical and empirical literature to bear upon my evolving data as I came to understand the issues, meanings, and themes generated from the data (Emerson, Fretz, & Shaw, 1995). I conducted preliminary analysis continuously throughout the project, which
greatly aided in refining data collection questions and methods each time I re-entered the
research field sites, planned for the next interview, and accessed policy and administrative
texts. I first identified themes that emerged from fieldnotes, interviews, and policy-related
documents. To identify and develop themes, I wrote initial memos on discrete topics and
categories. I referred to these memos as I collected further data, incorporating insights from
those memos to decide how to revise interview questions, allocate time to observe various
health care facilities or processes, and adjust whom I would meet. After I completed all
fieldwork, I re-read my data in light of the identified themes to further develop analytical
categories and connections that then formed the basis of the final ethnography. I continually
read theory and empirical literature to help make sense of data and organize themes and
analytical categories.

3.5 Ethnography: The text

3.5.1 Overview of chapters

Chapters 4, 5, 6, and 7 present the substance of my fieldwork and analysis (see Table 3-4
below). In Chapter 4, I show that both health and urban policy in India have neglected
urban primary care services. Chapters 5, 6, and 7 examine providers’ practices and narratives
about their mandate, the challenges of discharging it, and their relations with the
communities they serve. In part, the findings confirm the low quality of health care in India
and support the well-documented “know-do” gap in doctors’ performance (Das et al, 2012;
Das, Hammer, & Leonard, 2008; Mohanan et al, 2015). But the findings also extend what we
know about reasons for the persistence of that gap, primarily by highlighting the dilemmas that municipal doctors confront everyday and how they make sense of those dilemmas.

In each of the three chapters (Chapters 5, 6, and 7), I propose a theme to elucidate those dilemmas and municipal doctors’ response. Open-ended observations such as in my study afford an array of themes. I focus on three—service, risk, and authority—that are germane to current research and policy on the quality of state-provided urban primary care. Each theme comprises multiple registers, which reflect multiple dimensions of inquiry, drawing on various sources of data and attention to different parts of the state. The themes illuminate how municipal doctors make sense of and respond to evolving circumstances of medical practice, private sector expansion, welfare, and urbanism. In each chapter, I aim not only to help explain low quality of health care, but also reflect upon what the findings suggest about the workings of the state.

Table 3-4 Ethnographic text: Organization of chapters

<table>
<thead>
<tr>
<th>Theory: Explaining deficiencies in service outcomes</th>
<th>Findings</th>
<th>Organization of each chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Misalignment of policy design and social need</td>
<td>Chapter 4: Situating urban primary care in historical and spatial context</td>
<td>- Overview of chapter theme and findings</td>
</tr>
<tr>
<td>(b) Frontline state agents grapple with intent of policy vs. mangle of ground reality. Ideas of the state inform their practices</td>
<td>Chapter 5: Service</td>
<td>- For chapters 5, 6, and 7: Introductory vignette which illustrates theme and/or sets the stage for subsequent field observations</td>
</tr>
<tr>
<td>(c) Nature of social ties between state &amp; communities can shape how state agents perceive and conduct their work</td>
<td>Chapter 6: Risk</td>
<td>- Defining, theorizing, and presenting available evidence about main concept/theme</td>
</tr>
<tr>
<td></td>
<td>Chapter 7: Authority</td>
<td>- How my study applies or frames theory and how it contributes to available evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Findings and analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Conclusion: summing up main points and contributions of the analysis, particularly how it explains low quality of municipal health care and what it tells us about the workings of the state</td>
</tr>
</tbody>
</table>
3.5.2 Organization within chapters

I introduce Chapters 5, 6, and 7 each with a vignette and then present several other vignettes drawn from my field observations. Each introductory vignette frames a theme, namely service, risk, and authority. I provide a close reading of encounters and conversations. Taken together, the vignettes present a ground-level view of the workings of municipal health care. They show how a focus on frontline agents’ everyday practices, analyzed against the historical and spatial context of state-provided urban primary care, can help explain quality of care and identify challenges of ameliorating it.

My observations are not solely accounts of medical encounters between doctors and patients. Rather, by my being present before, during, and after the encounter, sometimes having observed the doctor in several different settings in the city, I am able to construct a picture of the situations, events, and narratives that precede and antecede the medical encounter, that invest it with attributes of what comes to be measured as the quality of health care. In this way, I aim to reduce the likelihood of committing the “attitudinal fallacy” of inferring “situated behavior from verbal accounts,” i.e., of conflating people’s self-reports of behavior with their actual behavior and assuming “a consistency between attitudes and action” (Jerolmack & Khan, 2014, p. 179). By both observing doctors’ actions in situ and discussing with them their intentions and explanations of events, I am better positioned to infer from their narratives an account of their practices.
I collect data across multiple situations, relying on what Tavory and Timmermans (2013) term “intersituational variation” to develop my analysis. This strategy involves “action and account triangulation within the field” (Tavory & Timmermans, 2012), in which I observe doctors acting in a group and alone, with varied patients, in different locations, and over time; request my interlocutors to reflect not only on their own experiences, but also on the actions and attitudes of their (anonymized) colleagues; and engage local experts to weigh in on my ethnographic observations. My purpose is to illustrate how “actors’—and not necessarily the same actors’—actions in different settings and situations,” which may comprise seemingly unrelated actions, “make sense as a single set” given my theoretical premise (Tavory & Timmermans, 2013, p. 692). The yield of this strategy is an account of doctors’ actions (verbal and otherwise) alongside their narratives of events and situations, thus drawing on multiple accounts to make doctors’ actions intelligible and my interpretation plausible.
4 Situating urban primary care in spatial and historical context

4.1 Introduction

In this chapter I show that urban primary care has long held a marginal place in both health and urban development policy in India. I examine policies, programs, and organizational structures to study how the state has described and responded to urban spaces, populations, and health needs. I focus on two historical periods: one around India’s independence in 1947, when the colonial administration and India’s independent government drafted influential blueprints for a national health service for India alongside plans for economic development, and the other following India’s economic liberalization, beginning in the 1980s. In the 1980s, the central government began to relax regulation of industry and trade, before enacting more far-reaching and systematic market reforms in response to India’s balance of payments crisis in 1991.

Evidence shows that India’s health policy has emphasized rural populations and rural health care, while urban development programs have sought to enhance cities as “engines of growth” (Banerjee-Guha, 2009, p. 97) rather than invest in basic public services. Both health and urban development programs show how the imperatives of economic growth under capitalism have “overdetermined” forms of state action (Sunder Rajan, 2013) and, in the case of urban primary care, forms of state neglect. The implications of this marginal position of state-provided urban primary care lie beyond the exclusions in health care they create and reinforce. I propose that the state’s inattention to urban primary care, coupled with
commercialization in health care since the 1980s, has contributed not only to denials of care for the urban poor, but also to a dampening of local collective action to improve urban health care.

In subsequent chapters I return to the themes I develop here, chiefly conceptions of development and health needs in health policy; the relationship between economic liberalization and urban space; the subordinate position of municipal government relative to state-level government; and the weak politicization of health in the social imaginary and in community action. I draw on these themes in the ensuing chapters, where I examine the street-level consequences of the state’s neglect of urban primary care and the concomitant expansion of private health care, and analyze how these factors shape the ways frontline service providers—primary care doctors in Pune’s municipal government—understand their mandate and confront its everyday challenges.

By drawing on the urban studies literature, my analysis extends urban health research in LMICs. Health researchers concerned with urbanization in LMICs have largely taken an epidemiological view of the urban and have mostly examined determinants of urban health, less urban health care. That is, urban health research in LMICs has often sought to explain how urban social and physical environments affect the health of urban residents and has less often examined the organization and workings of health care services in urban contexts. The “urban” in much health research depicts a physical site in which health care facilities happen to be located or a social and built environment that impacts individual and population health.
Urban studies scholars, by contrast, posit that the city is not a “container” of material assets, an arena in which people conduct social activities, or a background against which people contest interests. Rather, urban space is produced by and in turn shapes social, economic, and political processes at various scales (e.g., local, national, global). Importantly, the production of urban space is implicated in flows of capital and projects of development (Roy, 2011). This perspective guides us to relate the state’s provision (or neglect) of primary care in urban India to the liberalization of India’s economy. For instance, under liberalization, infrastructure and real estate have been among the foremost categories of public spending in cities, behind spending on basic public services (Coelho & Maringanti, 2012; Kundu & Samanta, 2011; Goldman, 2011). The urban poor lie outside the purview of development policy, which marks middle-class urban residents as the “representative citizens of liberalizing India” (Fernandes, 2006, p. xv) and has consequences for the organization and functioning of state-run health care services in the city. My analysis draws on these insights to explain the historical context of state-provided urban primary care in India.

This chapter is organized as follows. I first introduce selected concepts from critical urban theory. I discuss how these concepts guide my analysis of urban primary care in India and how my approach extends urban health research more generally. I next describe the organization of India’s health system and laws that govern state-level and municipal responsibilities. I then discuss health and urban development policy in India to identify their emphases, specifically the priority they accord to urban primary care. Finally, I discuss the implications of the state’s marginal attention to urban primary care, coupled with private sector dominance in health care, for the prospects for collective action to improve urban health care.
4.2 Applying lessons from urban theory to the study of urban health care

In this section I discuss lessons from critical urban studies that help guide my analysis of urban primary care in India in this and subsequent chapters. The present chapter especially elaborates on two ideas in these lessons. One is to approach the urban as a construct rather than an empirical object, and thereby discern how policy texts describe or “imagine” the urban. The other is to recognize that urban spaces are implicated in capitalism as a factor of economic growth, and thereby examine the relationship between the state’s provision of urban primary care and its economic plans.

4.2.1 Lessons from urban theory

One key lesson is to approach the urban as primarily a theoretical category rather than an empirical object (Brenner & Schmid, 2015). The “urban character of any site,” writes Brenner (2013), represents multiple realities (p. 95). It is overlaid with multiple histories, politics, and activities, and operates simultaneously at “local, metropolitan, regional, national, and global scales” (Kahn, 2005, p. 286). Because of their complexity and dynamism, urban sites are not usefully defined as empirical facts, but are more productively defined with reference to constitutive processes such as “capital investment, state regulation, collective consumption, social struggle” among others, “through which the urban is produced” (Brenner, 2013, p. 95). This prompts me to examine policy and administrative texts to
consider not just how the texts describe health care needs and services in urban areas, but also how they express imaginaries of the urban and reflect varied ideas about development.\textsuperscript{49}

A second lesson is that while particular theories about the urban reflect the time and space, or historical-geographic contexts, in which analyses emerged (Roy, 2009b), those contexts are intertwined: “conditions within local and regional contexts under modern capitalism have long been tightly interdependent with one another,” shaped by broader patterns of economic development (Brenner & Schmid, 2015, p. 164). To explain the urban, we need to both examine the distinctiveness of particular sites and undertake reflexive, relational, and comparative analysis that “draws insights from individual cities to understand how and why they vary” (Mollenkopf, 2008, p. 262). Although my project is not a comparative analysis of different urban sites, I employ, where possible, insights from other sites to more sharply render or qualify what I observe of urban health care in Pune.

Another lesson is that the urban is not a universal form; globally, urban sites include small- and medium-sized cities, sprawling megacities, and metropolitan areas, and are defined by varied demographics, infrastructure, and administrative structures (Montgomery, 2008). Urbanization—the process of becoming “urban”—is a variegated process.\textsuperscript{50} Using solely territorial and demographic criteria to define urban space can reduce urbanization “to a process in which, within each national territory, the populations of densely settled places (‘cities’) are said to expand in relative and absolute terms” (Brenner, 2013, p. 101).\textsuperscript{51} It can occlude the historical specificity, variety of settlement and administrative configurations, and diverse transformative processes that characterize urban conditions globally (Brenner & Schmid, 2014).
Pune represents a particular kind of urban site in India. As I note in a previous chapter (Chapter 3), the Census of India classifies Pune as a second tier or “million plus” city based on its population size (over three million), a tier below “megacities” such as Mumbai (population over ten million). There are 53 “million plus” cities in India, which together account for over 40% of India’s urban population (Government of India, 2011). The remaining 60% resides in either a few megacities or in numerous small towns. Differences in urban form imply differences in the organization and functioning of health care services across types of cities, as recent government reports on urban health care document (MOHFW, 2013c).52

Acknowledging that urban forms vary, my study offers not arguments about cities in general, but proposals for how to analyze urban health care, particularly to help explain quality of care in state-run urban health care facilities.53 One crucial theme concerns the connection between urban space and capitalism, which brings me to a fourth lesson I draw from critical urban studies, namely that processes of urbanization are centrally implicated in capitalism (Harvey, 1985, 2000), that urban space is not “the medium or arena” of capitalism but counts among “its means of production” (Roy, 2011, p. 12). In this perspective, urbanization is not simply a by-product of industrialization. Rather, urbanization processes reflect, and help us make sense of, new modes of “globalization of labor, capital and culture” (Soja & Kanai, 2007, p. 62). Study of the urban should therefore encompass an understanding of how the production of urban space is enmeshed in modes of capitalism.
The relevant mode of capitalism in my project concerns India’s economic liberalization. Liberalization has not only altered the state’s role in development, but also generated urban contradictions (Banerjee-Guha, 2009; Roy, 2009c; Goldman, 2011). Programs such as the Jawaharlal Nehru National Urban Renewal Mission (JNNURM), which the central government launched in 2005, arguably to transform cities into “engines of growth” (Banerjee-Guha, 2009, p. 97), are beset by conflicts between their purported aims, strategies, and narratives of development and the resistance they encounter on the ground.

For instance, Benjamin (2008) notes that “big business and lobbies” have captured “what used to be key elements of the progressive narrative,” namely, terms such as “civil society” participation in mega urban renewal projects (p. 725). Coelho, Kamath, and Vijaybaskar (2011) show how investors in such projects engage communities in a mere performance of participation in the projects. Roy (2009a) critiques the “politics of patience” espoused by some urban social activists, showing how some prominent social movements do not challenge the state’s vision of urban renewal but rather seek to change their terms of engagement with the state. Evidence also shows alternative examples of activist groups who resist such “negotiated development” (Roy, 2009a). I therefore consider both the state’s role in development under liberalization and instances of collective action to redress the state’s nominal attention to basic health care in cities.

These lessons from critical urban studies inform my analysis of the position of urban primary care in India’s health system, and, in subsequent chapters, analysis of Pune’s municipal doctors’ everyday work in delivering primary care. As I discuss next, health
research focused on the urban has largely concerned health outcomes (such as population health status and inequalities), but less explained urban health care services.

4.2.2 Extending urban health research

Unlike the global urban studies literature, which takes a political-economic view of urban public services, in much health research, analysts construe the urban as a physical site or environment that impacts population health. Some scholars expressly define “urban health research” as the study of how urban living conditions affect health outcomes (Freudenberg, Galea, & Vlahov, 2006). I argue below that although urban health research has advanced our understanding of health in urban areas, it has less examined the configuration and workings of urban health care.

A major contribution of urban health research in the past two decades has been to examine how cities expose the poor to unhealthy physical and social environments in areas of concentrated poverty and inadequate public infrastructure (Freudenberg, Galea, & Vlahov, 2006; Krafft, Aggarwal, & Wolf, 2003). Researchers have demonstrated an “urban penalty” in health, which refers to the negative health consequences of living in the city and inequalities in health care access among the urban poor55 (Ergler et al, 2011; Stephens & Satterthwaite, 2008). Growing evidence about the health risks of city living stands in contrast to previous research on urban health, which generally concluded that urban residents would tend to be “healthier than their rural counterparts as they had better access to health-related resources and services such as basic infrastructure and health care” (Ergler et al 2011, p. 327).
Along with showing that urban social and built environments could pose health risks, scholars of urban health have also advanced the conceptualization and analysis of urban complexity as it pertains to health. For example, some scholars have called for examining the city not only as a “center of disease, poor health and pervasive poverty,” but also as a “base” for medical cure, medical education, professional exchange, and public health innovation (Gusmano & Rodwin, 2005, p. 295). In other cases, scholars have posited how determinants of health operate at multiple, interacting levels—local, national, and global (Gruebner, Staffeld, Khan, et al, 2011; Galea, Freudenberg, & Vlahov, 2005). Based on a conception of urban contexts as complex, adaptive systems, groups such as the UCL Lancet Commission on Healthy Cities have recommended an urban planning approach that is incremental, sensitive to local circumstances, and forged through deliberation and consultation with communities (Rydin, Bleahu, Davies, et al, 2012).

Yet in these approaches, researchers view cities mostly as sites of exposure to disease, as locations with resources for health, and as physical places with measureable and modifiable attributes (e.g., area, population size, neighborhood income, transportation infrastructure). In conceptualizing urban complexity, researchers do attend to heterogeneity across and within cities and do refer to governance processes that affect the production of urban space. But their primary focus remains on how urban physical environments and communities can contribute to health. For instance, the UCL Lancet Commission based its recommendations on “case studies of sanitation and wastewater management, urban mobility, building standards and indoor air quality, the urban heat island effect (the difference in average temperatures between city centres and the surrounding countryside),
and urban agriculture” to show how urban planning policies could improve urban health
(Rydin, Bleahu, Davies, et al, 2012, p. 2079). In its aim to improve the planning and
management of city habitats, such work is less focused on analyzing the macro-politics of
urban health care services.

Stren and colleagues undertake a more expansive analysis of urban governance and
public services in an edited volume on urban population dynamics (Stren, McGee, Moser, &
Yeung, 2003). In their chapter, they present case studies of selected cities to review urban
governance challenges in developing countries.56 Their chapter covers a host of issues from
social diversity and urban violence to institutional fragmentation and political
decentralization. It notes (though it does not theorize or systematically analyze) the political
economy of urban public services, such as central governments’ reluctance to give autonomy
to municipal governments and metropolitan authorities’ difficulty with coordinating area-
wide development contra localized political attachments. Importantly, it calls for researchers
to move away from studying “social and physical change in the urban environment” and to
conduct greater comparative and interdisciplinary analysis of cities, “using analytical
approaches that link politics, administrative reform, and the other social sciences in the same
discussion” (Stren, McGee, Moser, & Yeung, 2003, p. 409).

This approach, i.e., one that analyzes not only social-environmental determinants of
urban health but also political determinants of urban public services, seems incipient in the
India-focused health literature, wherein researchers have indicated a need for greater
“academic introspection” into the urban health system (Dasgupta & Bisht, 2010, p. 18).
Researchers in fields of geography and planning, for example, have analyzed health in India’s
megacities, with attention to the transformations of urban social and political life that accompany economic development (Kroll, Butsch, & Kraas, 2011; Butsch, 2008). But these studies largely explain the effects of urbanization on health care utilization and health status, rather than the provenance and workings of health care services in urban settings.

In other India-based studies, researchers have proposed to examine both the social-environmental determinants of urban health as well as their converse, i.e., the impact of individual and population health on social and economic development, inequality, and human productivity, i.e., of “health … itself [as] an influencing factor in a complex and interrelated urban system” (Butsch, Sakdapolrak, & Saravanan, 2012, p. 27). Butsch et al (2012) recognize the importance of cities, specifically of the health of city residents, to the Indian state’s national development goals. They flag India’s diverse and unregulated private sector, stagnant public sector health care in cities, and need for “knowledge-based” planning to address urban health inequalities (p. 28). Their framework critiques urban health research as formulated by Galea, Freudenberg, and Vlahov (2005), terming this approach “unidirectional” and “focused only on health outcomes” (Butsch, Sakdapolrak, & Saravanan, 2012, p. 14). However, Butsch et al (2012) propose studying the impact of population health on “the characteristics of urbanization” (p. 13). Their alternative approach, although novel, concerns the dynamic links between the urban environment, population health, individual productivity, and income inequality. It is less concerned with examining the political economy of urban health care services.

Thus, largely absent in the study of urban health is a critical examination of the politics of urban health care, of theory and analysis to explain the provenance, organization, and
workings of urban health care services. My study offers such theory and analysis. Using India as a case, I show how imaginaries of the urban and the political economy of urban space shape health care services in cities. I begin by describing India’s urban and rural population and the current organization of government responsibilities for primary care in urban and rural areas. In subsequent sections, I analyze the politics that undergird health and development policy in post-independence India, and argue that urban health care services have received relatively little attention in both India’s health system and urban development programs. Apart from weakly empowered municipal governments and outmoded health care delivery infrastructure in cities, one consequence of India’s approach to public health has been a general lack of social awareness of health as an entitlement of citizenship. The analysis underscores how policymakers’ ideas about health, development, and social engagement intertwine to not only create a particularly configured health system, but also shape how people conceive of their claims on state services.

4.3 Urban population size, growth, and health care infrastructure

In this section I describe the size and growth of India’s rural and urban populations and the organization of health care services in India, focusing on laws and administrative hierarchy that govern state-level and municipal government responsibilities for urban primary care.

4.3.1 Size of India’s urban population and decadal population growth
Rural populations dominate in Indian politics, policy, and planning, as I will show in this chapter. On purely demographic grounds, this emphasis is unsurprising: the majority of India’s population has historically resided in areas designated “rural” (Graph 4-1). To qualify as “urban,” an area has to satisfy the following criteria: a minimum population of 5,000; at least 75% of the male main working population engaged in non-agricultural pursuits; and a density of population of at least 400 persons per sq. km. By those criteria, India’s overall population is almost 70% rural. Maharashtra is among the more urbanized states at over 40% urban (less than 60% rural) (Government of India, 2011).

Based on population growth rates, however, the state’s lack of emphasis on urban areas is more surprising. India’s urban population has grown more rapidly than its rural population ever since Indian independence in 1947 (Graph 4-2). I discuss in subsequent sections the state’s attention to rural and urban spaces in development policy and health services.

Graph 4-1 Percentage of population that is urban: India and Maharashtra (1951-61 to 2001-11)

Source: YASHADA (2014)
Graph 4.2 Decadal population growth rate: India and Maharashtra (1951–61 to 2001–11)


Source: YASHADA (2014)

4.3.2 Organization of and responsibility for health care in urban areas

In India’s federal system of government, local government institutions and health care services are both state-level responsibilities. That is, state-level governments hold oversight over local government institutions in both rural and urban areas. In particular, authority over urban local government (including municipal government) falls to the urban development department. State-level governments also oversee health across the state. In Maharashtra (see Table 4.1), the department of health oversees most health care services in the state, with one exception to the reach of its influence. In urban areas, the responsibility for primary care lies not with the department of health, but with the relevant municipal government. Municipal governments, in turn, are accountable to the department of urban development. Urban primary care therefore falls under the purview of the urban development department.
As Table 4-1 shows, the state-level health department manages primary care in rural areas and a hierarchy of facilities for higher tiers of care in towns and cities. In contrast, the municipal-level health service manages primary care in urban areas, and it operates under the administrative oversight of the state-level department of urban development, not health. Municipal health care providers, the chief protagonists in my study, are those doctors who provide primary care services through Pune’s municipal health care facilities, a responsibility that dates from India’s independence.

Table 4-1: Health care responsibilities of state-level and municipal government
Municipal governments in Maharashtra, among other states, draw their legal mandate to provide urban primary care from the Maharashtra Municipal Corporation (MMC) Act of 1949. The MMC Act stipulates municipal obligations and powers. I stress here that the MMC Act formally uses the broad term “medical relief” rather than the narrower “primary care” to define municipal obligations in health. Yet, several of my interlocutors—health care providers, administrators, elected officials—stated that the MMC Act encodes primary care as a municipal obligation. Central government reports also take the stand that primary care is a legal municipal government obligation. For instance, in its framework for implementation of a national urban health program, the Ministry of Health and Family Welfare notes that municipal governments are legally mandated to play a role “in the management of primary health care” (MOHFW, 2013c, p. 19).

While I find an apparent discord between the broad wording in law (municipal obligation as “medical relief”) and the more circumscribed interpretation on the ground (municipal obligation as “primary care”), for present purposes I hold the latter to be the case. That is, I describe primary care as a legal obligation of municipal government. (If anything, primary care is its minimum obligation.)

For Pune’s municipal health service, fulfilling that legal obligation has been partly constrained by the sanctioning power of the state-level department of urban development. For instance, my analysis of administrative data from Pune suggests that the numbers of its municipal doctors have barely kept up with its growing population (see Graph 3-3). As Pune’s population grew over 1991-2011 from roughly 1.7 million to 3.1 million (an increase of 85%), the sanctioned number of doctors in municipal employ increased from 78 to 110.
(an increase of 41%), even though Pune’s municipal government submitted five staffing requests over that period.\textsuperscript{62}

In sum, the department of urban development (which directs municipal governments) oversees urban primary care, not the department of health. In other words, the key arbiter of primary care in Pune is Maharashtra’s department of urban development, not its department of health. Although the central government can introduce policy directives that impact primary care services in Pune, historically the center has offered more concerted policy attention to rural than urban primary care services (Kapadia-Kundu & Kanitkar, 2002; Dasgupta & Bisht, 2010). I examine that spatial and political history of urban primary care in the sections that follow.

4.4 Rural versus urban in India’s health agenda

In this and the next section, I show that urban health care has received scant attention in India’s health system and urban development policy. I focus on the years around India’s independence in 1947 and the years following the state’s liberalization reforms beginning in the 1980s.\textsuperscript{63}

In the present section (Section 4.4), I examine the rural-urban focus of post-independence plans for development and welfare, for calibrating federal balance of power, and for establishing a national health service and priority national health programs. I begin by reviewing long-standing arguments that in post-independence India, the challenge that confronted the state was to reconcile the imperative to achieve economic growth with the
need to establish its legitimacy over and prevent conflict in a vast, heterogeneous population. The state’s program of development was interventionist rather than welfarist, focused on meeting basic needs rather than realizing rights. Development plans cast rural areas as backward, in need of upliftment, and health programs predominantly addressed rural populations, seeking to eradicate disease, control rural population growth, and ameliorate rural poverty. I argue that although urban spaces were not wholly ignored in plans, urban populations were not targets of development. Municipal governments were charged with providing health care to urban residents, but deprived of the capacity to fulfill this responsibility.

In the next section (Section 4.5), I examine imaginaries of the urban in the state’s approach to urban development from the 1950s to the 2000s. I show that under liberalization, the state’s view of urban spaces and populations, as evinced in urban development policy, shifted. India’s policies under liberalization have emphasized its cities as drivers of economic growth engaged with global markets. Ideas about modernity and technology-led growth that undergirded national development plans in newly independent India continued to do so under liberalization policies. But the state’s methods to achieve economic growth changed in the 1980s, allowing for greater private sector participation, and curtailing, for example, the state’s role in providing curative health care. The position of the urban poor in plans and narratives of development also changed. In urban development programs in recent decades, the poor are invisible. The new emblematic citizens of liberalizing India—middle-class urban residents—have taken centre stage in development policy.
4.4.1 Rural focus of models for development and welfare in independent India

The village in rural India has historically—in colonial and post-colonial nationalist thought, social science study, and policy—been the emblematic site of social and economic “backwardness,” in need of development (Thakur, 2014). The primary target of welfare programs has been the rural population. This is not to suggest that urban spaces have been invisible in national visions of India’s progress. To the contrary, as Chatterjee (1997) has argued, in the post-colonial “development model adopted in India, the ‘modern’ sector is clearly the dynamic element,” where the modern sector refers to spheres of activity involving industrialization and capital accumulation, in contrast to a traditional sector referring largely to agriculture (p. 288). For activists championing the cause of agrarian workers following India’s independence, modernity was concomitant with an urban, industrial India, but that vision of India stood in opposition to the traditional, rural, “‘real’ country of peasants and agricultural laborers” (Gupta, 1998, p. 80).

This tension between the rural, traditional sector and urban, modern sector was both a political and economic issue for leaders in newly independent India. That is, the problem of planning that confronted post-colonial leaders was to reconcile “[capitalist] accumulation with legitimation,” to enable an industrial transition while containing its effects on the “masses resident in India’s villages,” without “taking the risk of agrarian political mobilization” (Chatterjee, 1997, p. 283, 289). Its challenge was to stave off political conflict in a vast, heterogeneous society, while insuring a path to economic development.
Elections were one way that India’s post-colonial state sought to ensure the “representativeness” of democratic government and connect the new state to the people-nation. Alongside elections, the state reinforced its connections to the nation by “directing a programme of economic development on behalf of the nation,” a program in which particular interests could be subsumed for the good for society as a whole (Chatterjee, 1997). However, as Jayal (1994) argues, the intentions of this program were interventionist rather than welfarist. Its aims were not to correct or compensate for market-generated inequalities, as in welfare states in advanced industrialized countries. Rather, in post-independence India, “the assumption by the state of welfare tasks … paralleled the embarkation on a state-directed and essentially capitalist path of development” (Jayal, 1994, p. 18).

Jayal (1994) observes that the Indian state’s welfare provisions derived not from notions of entitlements (to a minimum wage, proper hours of work, and physical conditions of work as conceived in advanced industrialized nations), but from the political-economic project of state-led national development. While the post-colonial Indian state did assume some welfare functions, these did not reflect a state obligation to provide for people’s wellbeing as a right of citizenship. Instead, they were grounded in a compensatory, needs-based conception of welfare oriented especially to rural-agricultural populations. That is, welfare initiatives sought to redress inequalities stemming from ownership and use of land rather than from workforce participation in a modern, industrial economy (Jayal, 1994).

Although the post-colonial state’s claim “to care for the welfare of the Indian people, in a way that no colonial government could do, was central to constructing [its] legitimacy,” yet the state in that moment lacked both a bureaucratic tradition and the material
infrastructure to attend to public health—health care services in some places were “completely absent” (Amrith, 2007, p. 115). Besides institutional constraints, the state also inherited “currents of thought – both within and outside India – [which defined] ‘well-being’ exclusively in instrumental terms” (Amrith, 2007, p. 115). Debates in the Indian National Congress party’s National Planning Committee (NPC) brooked multiple, competing ideas about health. As Amrith (2007) shows, “within the thinking of the Congress Planning Committee health was, at once, a basic human right, a tool for the improvement of the ‘Indian race’, making it more efficient and more governable, and health was an instrument for economic development” (p. 117).

Dominant among these ideas was the economic value of health, which featured across the report of the (colonial government-appointed) Bhore Committee on health. The Bhore Committee’s findings, collected in the early-to-mid 1940s, anteceded NPC discussions about health in the late 1930s. Yet the NPC, in its report on health drafted by the Sokhey Committee (published in 1947), extensively cited the Bhore Committee report (published in 1946). As Amrith (2006) observes, the Bhore Committee’s “argument for the economic value of public health was the one which made the deepest impression on the shape of future debates on health” in independent India (p. 63). The Bhore Committee expressed the role of the state—as opposed to social reformers or volunteers—as essential to ameliorate health conditions in the nation. Congress leadership readily accepted the Bhore Committee’s argument about “health and economic efficiency” (Amrith, 2006, p. 63). The Committee’s ideas about health as state responsibility and health as instrumental to economic progress addressed the predicament that faced India’s post-colonial leaders: to establish legitimacy in the new nation; to subsume the interests of a complex, largely agricultural, demographically
rural society; to insure economic development and modern, industrial growth. In meeting these varied imperatives, the target of programs for health—health being a state responsibility and an instrument of economic development—was India’s rural population.

As I will next show, the Bhore Committee delivered a detailed account of the health status and health care needs of urban populations. Yet, the priority target of health and development programs in subsequent years was the rural population.

4.4.2  Bhore Committee report, 1946: Seminal proposal for a national health service

In 1943, to “make a display” of their concern for the nation’s welfare, India’s colonial government appointed a Health Survey and Development Committee—chaired by Sir Joseph Bhore and commonly referred to as the Bhore Committee—to survey India’s health needs and propose plans for its health system (Amrith, 2007, p. 116). Although the Bhore Committee’s recommendations were not all implemented—village-level community-based units for health planning, for example, were established in 2005 (MOHFW, 2013b)—yet, as researchers have widely observed (Murthy, Sarin, & Jain, 2013; Bajpai & Saraya, 2011; Amrith, 2007; Gangoli, Duggal, & Shukla, 2005), its report significantly shaped and inspired subsequent development of health services in India. As Amrith (2007) notes of its legacy, “In many ways [the term set by the Bhore Committee] remain the yardstick against which many commentators and health activists judge the government’s subsequent efforts to be wanting” (p. 117). Given its influence in shaping India’s health system at the moment of independence and beyond, I aim in this section to consider how the Bhore Committee conceived the rural and the urban in its report.
Emphasizing “the needs of rural India,” the Bhore Committee recommended a long-term strategy to complement village-level primary care services with a network of district-level health centres and more specialized medical care in hospitals in urban areas (GoI [Government of India], 1946b, p. 4). For the Bhore Committee, rural populations were of paramount importance for both health and development reasons. It was “the tiller of the soil,” wrote the Committee, “on whom the economic structure of the country eventually rests,” who gives the nation its food, provides raw material to India’s industries, contributes to India’s foreign trade, and suffers the most from “pestilence and famine” (GoI, 1946b, p. 5).  

Urban populations featured in two broad contexts in the report: as “industrial workers” who lived alongside “general” communities near or in urban centres, and as general communities resident in towns and cities. The report imagined the urban as a space of industry and population density and of associated social, environmental, and occupational health risks, especially for industrial workers. It noted that unlike in advanced industrialized countries, the industrial worker population was not stable in India (GoI, 1946a). Rather, the industrial worker in India was generally a rural migrant in an urban locale, who kept in touch with his rural home and was exposed to a more “congested and unhealthy” environment than he was accustomed to in his rural home. Not only did urban conditions provide the industrial worker with “temptations” when he was away from home, but overcrowded urban spaces were also conducive to the incidence and spread of infectious diseases such as tuberculosis and leprosy, which were then communicated to rural areas due to the continuous movement of workers between rural and urban centres (GoI, 1946a).
While the Bhore Committee observed that urban spaces posed rising health risks, it also noted that urban residents were far better served in terms of numbers of health care facilities and practitioners of modern medicine than rural populations. Urban centres were the location of the majority of India’s health care infrastructure and medical professionals (see GoI, 1946a, Chapter 3). And yet, when taking measure of the conditions of hospitals in urban areas, the Committee found major deficiencies: some outpatient departments did not “meet the needs of a modern hospital,” and had physical infrastructure that was “hopelessly out of date” (GoI, 1946a, p. 39). Numbers of private practitioners, the Committee noted, were greater in urban than rural areas, but accessing private medical care was financially out of reach of industrial workers. From its survey of selected industrial areas, it found health care services, whether provided by public or private medical practitioners or others, were “inadequate to meet the needs of both general and industrial communities” (GoI, 1946a, p. 75). Despite documenting a high concentration of medical institutions and practitioners in urban areas, it assessed that medical care provided to industrial workers—both within the factory (by owners as mandated under the Factories Act) and outside the factory (by town and city governments)—was inadequate to meet their health care needs.

Based on those findings, the Bhore Committee offered recommendations that referred to urban conditions generally—life, work, and government in urbanizing India—and specifically to needs of the industrial worker as the target of health services in urban areas. Across Volume 2 of its report, the Bhore Committee charted:
- A state-run “industrial health service” for occupational health,\(^{72}\) envisaging that industrial workers would access medical care available locally (state or private), as used by the general community, for other health care needs
- Town and city planning guidelines, including sanitation, housing, and land use (e.g., zoning, location of trade and industries)
- Special recommendations for health administration in urban areas with populations over 200,000. Depending on their financial situation, large municipalities could recruit and maintain their own health services rather than falling under the jurisdiction of the district health service, and could cooperate with district services to ensure efficiency of service provision.\(^{73}\)

In sum, the Bhore Committee surveyed both rural and urban health needs and reviewed health administration in both rural and urban areas. It reported severe deficiencies in quality of medical care in urban areas. Although it found services to be more plentiful in urban relative to rural areas, yet, noting the certain future growth of industry and population in urban areas, it found this quantity wanting. It proposed that large municipal governments could provide health services autonomously from but in cooperation with provincial governments to meet common health goals. For instance, for Delhi province, it proposed organizing health administration according to a “dual principle of encouraging the growth of local responsibility in health administration and of ensuring, at the same time, the maintenance of a reasonable level of efficiency” (GoI, 1946b, p. 445).

Despite the Bhore Committee’s attention to the plight of urban populations, health and development programs in the years following its publication in 1946 featured a narrow,
largely rural focus with low budgetary support for health and a fragmented administrative apparatus for health care service delivery. Reasons for the rural focus and overall weaknesses of the health system lay in both political-economic and pragmatic-financial factors. Politically, as leaders in the new state turned their attention to pressing questions of establishing legitimacy, national unity, territorial sovereignty, and industrial transition in independent India, they cast public health an inessential issue. They consigned health care, along with other welfare services, to a non-justiciable Directive Principle of State Policy rather than a Constitutional right (Amrith, 2007; Jayal, 1994). They left health primarily as the responsibility of state-level (rather than central-level) government “without the funding to match” (Amrith, 2007, p. 117). Pragmatically, they expressed concerns about the magnitude of budgetary resources implied by the Bhore Committee’s recommendations to reform India’s health system, long neglected under colonial rule (Amrith, 2007; Murthy, Sarin, & Jain, 2013).

The health system thus lumbered ahead without needed funds and with a meager bureaucratic and service delivery infrastructure. In policy deliberations, voices calling for the state to expend a guaranteed minimum amount of public funds on health were in the minority and had little support (Amrith, 2006). Amrith (2006) further observes that influential voices in the new state, such as Sardar Vallabhai Patel, “argued for a substantial retention of large parts of the colonial coercive and administrative apparatus. This meant, amongst other things, retaining the decentralized, fractured structure of the public health services” (p. 81). Retaining the colonial administrative apparatus also meant inheriting weak structures of municipal governance (Weinstein, Sami, & Shatkin, 2014). As I discuss below, municipal governments had low power and limited range of function in the colonial
administrative apparatus. This historically weak municipal government capacity, partly a result of the post-independence state’s pro-industry, pro-rural, and anti-local approach to development, implied low priority for urban health care.

4.4.3 State planning: Pro-industry and anti-local

As I have noted above, the new state faced both a political task of establishing legitimacy in the nation and an economic task of effecting growth and development. National leaders thereby confronted a challenge: to establish sovereignty and represent social particularities in a largely rural population on the one hand, and to embark upon a path of economic development led by industrialization on the other. I argue in this section that the strategies they took to address that challenge contributed to the marginal place of urban health care in India’s development plans. These strategies included, one, employing planning as a rational, apolitical instrument to enable and administer development in a heterogeneous nation (Chatterjee, 1997); two, aligning with business groups’ demands for state assistance towards, and not state ownership or disciplining of, industrial activity, so that a planned economy could accommodate private capital (Chibber, 2003); and three, consolidating central government powers in the federal balance, leaving municipal governments with the least planning autonomy and revenue-raising capacity (relative to central and state-level governments) (Amrith, 2006; Weinstein, Sami, & Shatkin, 2014).

State leaders beheld the Indian nation as diverse and heterogeneous, with “regional patriotism,” numerous monolingual and religious communities, the masses engaged in agriculture, with “petit bourgeois and peasants whose political horizons [had] never extended
beyond their region and its relatively local excitements” (Kaviraj, 2000, p. 151). For those leaders who espoused developmental ideology, the state was the “principal vehicle” of national development (Chatterjee, 1997). This role for the state posed a potential contradiction for its leadership: legitimacy of the post-colonial state derived not only from a political critique of colonialism, to be addressed through representative political institutions, but also from an economic critique of colonialism, wherein colonial rule had exploited the Indian nation and impeded its economic progress (Chatterjee, 1997). But people’s will, as they might express it through representative institutions, was not necessarily good for the wellbeing of the nation as whole. For nationalist leaders, it was in the administration of development, specifically processes of planning, that the state would be able to claim its legitimacy as the will of the nation, “pursuing a task that was both universal and rational,” in which particular interests could be subsumed in the well-being of the whole (Chatterjee, 1997, p. 279). National leaders saw planning, a rational and apolitical technique, as the key strategy to achieve economic development (Chatterjee, 1997).  

While an emphasis on planning implied a strong public sector, the state’s attention and interventions followed a mode of economic development defined by the cause of industry. That is, although leaders debated alternate models of economic development, their decisions ultimately bestowed a definitive but particular role for the state in fostering development and industrial growth. The planning of India’s public health services, Amrith (2006) reminds us, “took place alongside a range of other plans for ‘post-war reconstruction’ in industry, agriculture and social security” (p. 57). Competing visions for economic development included “the Gandhian Plan of Economic Development, the People’s Plan prepared by the Indian Federation of Labour, and the Bombay Plan representing the
industrial capital’s perspective” (Priya, 2005, p. 45). Each proposal purported specific roles for the state and ideas about the future of India’s health system—its organization, personnel, scope of services, and priorities for urban and rural areas.

Among these proposals, the Gandhian Plan took a people-centered approach, including community-based and -sourced care, with a focus on rural, agrarian India. The People’s Plan and the Bombay Plan stressed advancing health care through modern medicine, technology, and hospital-based care, and saw “doctors and nurses as the only legitimate providers of health care” (Priya, 2005, p. 45). The People’s Plan “was in tandem with the Gandhian Plan in emphasising the role of agriculture and health of the rural areas,” while the Bombay Plan advanced the cause of modern industry (Priya, 2005, p. 45). Drafted by a group of leading industrialists, the Bombay Plan saw a strong role for the state in developing health infrastructure and training medical personnel, but a limited state role in control over the private sector (Priya, 2005), coupled with an ultimately only rhetorical commitment to social justice and redistribution (Chibber, 2003).

In drafting the Bombay Plan, leading industrialists had attempted to reinforce nationalist leaders’ model for national development led by state planning, while showing how private capital could lead the way to economic growth (Chibber, 2003). They had proposed to reconcile the imperatives that faced the new state, namely to satisfy subaltern demands for distributive justice within economic planning and establish sovereignty, legitimacy, and industrial transition based on modern science and technology, while also paving the way for private enterprise (Chibber, 2003). It was “an economic plan which used socialist language carefully” to present an essentially capitalist scheme (Amrith, 2006, p. 57). However, in 1945,
when the Bombay Plan was introduced in its entirety, business groups at large did not support it; even as they wanted state assistance to help industrial growth, they did not see the need to accommodate state-led discipline over or regulation of industrial activity⁷⁹ (Chibber, 2003). The business class rejected the Bombay Plan, and its initial proponents, too, distanced themselves from it. As Chibber (2003) explains, by 1945, British companies and assets were significantly retreating from India, leaving open a field of opportunity for Indian business. And since the influential “Old Guard” (including Patel) of the Indian National Congress was at its helm, industrialists expected it would steer the party away from its radical Left elements, under whom labor unions and social movements could disrupt business operations (Chibber, 2003).

By 1949, i.e., two years past independence, the Congress had positioned the state as mediator between labor and capital⁸⁰ and the rightward swing in the Congress had led to the “exodus of the Congress Socialists” (Chibber, 2003, p. 112). Industrialists continued to press for greater autonomy and greater state assistance for business, while rejecting conditions such as performance controls or minimum wage laws. For leading Congress members, an abiding principle of economic policy was to “nurture private capital” through “financial, technical, and logistical” support and to shield domestic industry from world competition (Chibber, 2003 p. 130-131). This stance was in the state’s interest for several reasons, among them to generate revenue and engender nation-building through industrial development (Chibber, 2003). For its part, the industrial class reaped the benefits of state assistance but resisted the state’s attempts to enforce discipline over industry, to extract reciprocal responsibilities from private capital.⁸¹
In this political-economic environment, the state’s assistance to cities, which state development policies described as spaces of industrial growth, extended to funding urban infrastructure to enable this growth (Priya, 2005). Concurrently, the state’s assistance to improve health care services extended to funding medical institutions and training personnel (Priya, 2005). The state neither exerted control over the private health care sector, nor allocated adequate public resources to build a national health system—the financial requirements for such a foundational investment in the public’s health vastly outstripped the political priority for health in the state’s budget (Amrith, 2007). Rather, state interventions in public health favored vertical, technocratic initiatives with a single-disease focus (see Section 4.4.4) (Amrith, 2007). These interventions largely targeted rural rather than urban populations as I discuss below, and this rural focus was apiece with the state’s general silence about urban questions in the initial decades of independence (see Section 4.5).

Alongside arguing for state assistance to nurture industry, business groups also argued in favor of central coordination of economic policy rather than dispersed policy-making power across provincial (i.e., state-level) governments (Chibber, 2003). In parallel to this industry-led push toward central planning, national leaders’ efforts to manage what they saw as the provincialism of India’s heterogeneous masses also resulted in an anti-local bias (Weinstein, Sami, & Shatkin, 2014). This anti-local bias was detrimental to municipal government powers and capacities, and it contributed to the neglect of urban health care. As Weinstein, Sami, and Shatkin (2014) argue, many of the delegates in the Constituent Assembly “believed that local power (in both villages and cities) was organized on the basis of communal sentiments, rather than on enlightened democratic principles. The less local the political system, the more inclusive many believed it would be” (p. 44). For Nehru,
Mehta (2010) writes, “villages entrenched practices that were archaic, anti-rational and sectarian in their prejudices,” which a modern, rational, democratic state stood to redeem. Partly due to their concern about regional fragments—religious, ethnic, linguistic—the framers of India’s constitution granted certain powers to regional units, “to hold the fragile union together” (Weinstein, Sami, & Shatkin, 2014, p. 44). But while nationalist leaders defined responsibilities for the central and state governments, they left the powers of municipal governments insubstantial, restricted, and ill-defined, as these had been in colonial times. This continuity was not just path dependence; it reflected the state’s purposive move to selectively decentralize power in the union (Weinstein, Sami, & Shatkin, 2014).

Under the colonial administration, the state’s public health operations were limited largely to preventing epidemics and responding to crises. The colonial state devolved responsibility for providing local health and sanitation services to municipal government bodies in the 1880s, which municipal governments shared with provincial governments by the 1920s (Amrith, 2009; Legg, 2016). Under colonial rule, municipal governments had been primarily service delivery units, operating under the direction of provincial governments. Municipal public health functions encompassed providing sanitation, street cleaning, and garbage removal services, and recording birth and death records (Weinstein, Sami, & Shatkin, 2014). Some large municipal governments recruited and ran their own health care services, but in most cases urban health care fell outside municipal responsibility to a higher-level administrative unit (e.g., district health service). As the Bhore Committee found, both private and public health care services were highly inadequate in India’s cities and towns (see Section 4.4.2).
In the post-colonial federal structure, this balance of powers remained largely intact. That is, state governments held the power to decide land use, raise revenue, define activities of municipal governments, and override or take over control from municipal government if they deemed it necessary (Weinstein, Sami, & Shatkin, 2014). The constitution categorized health care provision as a state government responsibility. This responsibility was split between the state-level urban development department for cities and towns, where a minority of population resided, and the state-level health department for the rest, the majority rural-dwelling constituency. As Table 4-1 shows, under the current division of responsibilities, primary care in urban areas falls to municipal governments, who answer to the state-level department of urban development.

We see therefore a mismatch between the needs of urban populations, the priorities of central and state-level governments, and the capacities of municipal governments that is evident even today. Partly because state-level governments’ primary concern is their majority rural electorate, and because central government interest in cities has focused on fostering their potential for industrial growth, the quality of municipal government has remained inadequate to the task of realizing urban public needs (Weinstein, Sami, & Shatkin, 2014). The state-level urban development department is mainly concerned with urban land use, transportation, sanitation, water supply, and other public works, not with health care. At the same time, central government efforts in health have been oriented to rural populations, as I next discuss.

4.4.4 Rural populations as primary targets of national health programs
As municipal governments remained tethered to their historically weak powers and limited mandates in the years following independence, the primary target of the state’s major health programs was the rural population. In the 1950s and 1960s, the state’s efforts in health focused dominantly on infectious disease eradication (malaria, tuberculosis) and population control, also known as “family planning” (Amrith, 2007; Rao, 2004). Both these programs had a rural bias. Both evince, as Amrith (2007) shows, the state’s view of health as instrumental to economic development, as a tool to foster a more productive labor force that was tied to the land and agriculture, tied, in other words, to rural spaces. “Spraying with DDT,” writes Amrith (2007) of the controversial insecticide used in malaria control, “was a means of making land cultivable and releasing labour for the modern industrial economy,” of “removing ‘natural’ obstacles to cultivation” (p. 118).

Population control, another instrument to achieve economic development, too, was a rurally focused endeavor. National leaders viewed population control as a more cost-effective alternative to malaria control in the goal of improving labor and land productivity and moving toward industrial progress (Amrith, 2007). Family planning strategies effectively strengthened the rural health system, adding staff and infrastructure in places where none existed (Rao, 2004). However, despite those intensive population control initiatives, state reports in the 1980s remarked on the paucity of population services for the urban poor.

The 1980s saw short-lived national attention to urban primary care, notably through the 1982 central government-commissioned Krishnan Committee report, which delineated norms and needs for health care infrastructure in urban areas (Kapadia-Kundu & Kanitkar, 2002). Following the Krishnan Committee’s recommendations, in 1983 a central government
scheme introduced “urban health posts”—community-level primary care facilities—in ten states, including Maharashtra (MOHFW, 2013c, p. 16). Although meant to enhance urban primary health care services, the posts “functioned chiefly to promote family planning goals” (Kapadia-Kundu & Kanitkar, 2002, p. 5088). The central government effectively discontinued the posts within three years when it withdrew remuneration (honoraria) for volunteer community health workers, leaving municipal governments to run the posts without assistance, which many failed to do (Kapadia-Kundu & Kanitkar, 2002).

In 1998, with World Bank assistance, the Government of India introduced health care services in urban slums in Chennai, Tamil Nadu, under the Fifth India Population Programme (IPP-V) (Van Hollen, 2003). In 1993, under IPP-VIII, the central government rolled out select urban health services in four cities (Bangalore, Delhi, Hyderabad, Kolkata) (Aggarwal, Pandey, & Talwar, 2008). The World Bank supported the IPP-VIII program for seven years in the four cities and extended some program features to 94 towns in three states (Andhra Pradesh, Karnataka, West Bengal) (World Bank, 2002). Yet it focused largely on reproductive and child health.

Recent health reforms reaffirm the dominance of the rural in policy and planning. The National Rural Health Mission (NRHM), launched in 2005, aimed to “provide accessible, affordable and quality health care to the rural population” (MOHFW, 2005, p. 5). A similar scheme—the National Urban Health Mission—was proposed in 2006 and drafted in 2008 to address health care needs of urban populations, but was launched only in 2013, eight years after the launch of the NRHM (MOHFW, 2013c; Dasgupta & Bisht, 2010).
In sum, through the decades following independence, improvements to state-provided urban health care depended on central government support and international aid and consistently lagged rural health care reforms. In the words of the Government of India’s tenth five year plan document (2002-2007), “unlike the rural health services there have been no efforts to provide well-planned and organized primary, secondary and tertiary care services in geographically delineated urban areas. As a result, in many areas primary health facilities are not available; some of the existing institutions are underutilized while there is over-crowding in most of the secondary and tertiary centers” (Planning Commission, 2002, p. 89). While national schemes failed to address urban health care needs, municipal governments too sidelined health care, as I next discuss.

4.5 Imaginaries of the urban in urban policy

4.5.1 1950s and 1960s: Urban spaces and populations in the initial decades of independence

In contrast to the central government’s substantial (although narrowly scoped) attention to health in the first decades of independence, “the center remained largely silent on urban policy questions” in those decades (Weinstein, Sami, & Shatkin, 2014, p. 45). Legally, both health care and urban governance were designated State subjects, i.e., constitutionally included on the list of state-level responsibilities in India’s federal balance of powers, and thus not primarily a central government responsibility. Yet the center contributed to building rural health care services through major national health programs (infectious disease control and family planning) (Amrith, 2007). Unlike those central government initiatives in health, in
the first two five-year plans (1951–61), the center adopted no concrete policies to address concerns of urban growth, land use, land prices, and housing, among other urban development issues (Shaw, 1996).

At least three factors undermined the state’s attention to and any attempts at urban development in the initial decades after independence. One factor was conflicting ideas about the urban, i.e., between the central government’s vision of urban development and the interests of local private actors (Weinstein, Sami, & Shatkin, 2014). For instance, private landowners’ speculative interests in real estate and preference for “the private provision of services” conflicted with municipal authorities’ efforts to plan land use and provide services, much as they had in the colonial period (Weinstein, Sami, & Shatkin, 2014). Also continuing from the colonial period was an idea of the urban among policymakers, administrators, and planners that hewed to ideals of “modern representation of town planning in 20th century Britain” (Shaw, 1996, p. 225). Municipal authorities’ attempts to plan urban land use tended to disregard “indigenous forms of spatial organization” and instead privileged order, hygiene, and “decongestion” (Shaw, 1996, p. 226). The obsessions of town planners, their “civilizing projects” (Weinstein, Sami, & Shatkin, 2014, p. 42), stood at odds with the predicaments of poor rural migrants in cities—the rising numbers of informal, self-employed, and casual labor in urban centers (Bhowmik, 2009). Not only the state’s attempts at urban planning but also its labor laws mostly sidelined these non-industrial workers’ needs, seeing them as an “aberration” contra a formal, industrial working class, even though they outnumbered the formally employed labor force (Bhowmik, 2009, p. 137).
A second factor was the emergence of a new ruling elite and the ironic persistence of patronage relations in cities, which resembled rural-agricultural class and caste relations. In the 1950s and 1960s, a new ruling elite—the wealthy and the middle class, landlords and professionals—dominated the city socially and politically, as Chatterjee (2004) writes of Kolkata in those decades. The new elite replaced colonial officials in local administration and elected party positions in cities. They established patron-client relations with the urban poor that were often “mediated by charitable organizations and proto-unions” (Chatterjee, 2004, p. 132). For instance, unions of the industrial working class—whose health care needs the Bhore Committee had detailed in its 1946 report—provided a link between the ruling “middle-class intelligentsia and the slum-dwelling workers” (Chatterjee, 2004, p. 132). The unions, in other words, effectively mediated between class interests, following old modes of sociality that resembled patron-client ties in India’s “pre-bourgeois” agricultural economy (Chatterjee, 2004, p. 132-134), rather than a reworking of labor’s right to the city.

A third factor that undermined state efforts in urban development were the methods and strategies the state employed to execute its initiatives. For instance, in the 1950s, the central government set up institutions for managing national urban affairs and master plans to model future modern cities, such as for Chandigarh, Bhubaneswar, and Gandhinagar (Weinstein, Sami, & Shatkin, 2014). But it appointed special committees, including international architects and planners and local bureaucrats, to manage these projects, and the master plans were standalone efforts that had little effect on municipal administration (Weinstein, Sami, & Shatkin, 2014). In the 1960s, the center formulated a national urban planning and land policy and made funds available for state-level governments to draft master plans and decide land use for cities (Weinstein, Sami, & Shatkin, 2014, p. 46).
However, the policy’s emphasis on land use, prices, and acquisition reflected its aim of “planned urbanization” or rationalization of urban space, i.e., “making the urban more amenable to control and management” (Shaw, 1996, p. 225). For plans for individual cities, it was “preoccupied” with hygiene and order and averse to congestion and crowds (as noted above) (Weinstein, Sami, & Shatkin, 2014, p. 46). Regionally, it sought to balance growth between large, medium, and small-scale industries and between rural and urban areas (Shaw, 1996). It proposed to align regional disparities through a “public enterprise location policy,” such as by establishing new industries away from major cities and “in industrially backward regions” (Shaw, 1999, p. 970). While these strategies did address regional disparities at least until the mid-1970s, they did little to improve municipal governance or basic services in cities.

4.5.2 1970s and 1980s: Just before and following liberalization

As urban populations grew rapidly and visibly in the 1970s and 1980s, piecemeal attention to health care featured in municipal government efforts, driven by what Chatterjee (2004) has termed the demands of “political society.” Municipal authorities acknowledged the frequently illegal status of the urban poor, such as when they squatted “on public land, traveled on public transport without paying, stole water and electricity, encroached on streets and parks” (Chatterjee, 2004, p. 135). The authorities supplied basic amenities to the growing ranks of the urban poor despite their illegal status, such as by providing water and electricity connections and health centers in slums. Their reasons were both pragmatic and political, a bid to both pacify a necessary labor pool and gain votes. Such efforts involved reactive, informal, case-by-case provision of selected services to certain groups of the urban poor, not
a systematic, universal upgrade of urban public services. In providing welfare selectively through constant negotiations with political society, municipal authorities made exceptions to rules, excusing or overlooking illegality or ineligibility of the city’s poor to receive benefits, rather than revising the rules to make the rules more just or inclusive or the benefits secure or permanent (Chatterjee, 2008). 

But high urban growth, with pressing demands of populations and partisan interests, only partly explains municipal governments’ reactive, selective, and ultimately inadequate efforts in meeting local needs. Another contributing factor was the imaginary of the urban that guided national urban policy. Weinstein and colleagues (2014) observe that in the late-1960s, after prime minister Jawaharlal Nehru’s death, support among India’s leadership for the modernist vision of the master-planned Indian city retreated. Instead, policy-makers backed populist plans whose proposals for urban development emphasized small and medium-sized towns (Weinstein, Sami, & Shatkin, 2014, p. 47). Urban development policies in three successive five-year plan periods (1966–1985) focused on drawing populations and economic activity away from major urban centers, even as they continued to fund infrastructure development in metropolitan cities and large urban areas “of national importance” (Weinstein, Sami, & Shatkin, 2014). The imaginary of the urban in urban development policy suggested two contrasting strands—the one populist, favoring the rural and smaller-town dwelling electorate, and the other promoting large cities as sites of economic growth—which had little effect on enhancing public services in urban areas of any size. 

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Health care featured as a minimal concern in central and state-level efforts in the 1970s to improve urban governance, efforts that in any case fragmented rather than strengthened urban governance. To address the weak capacity of municipal governments, central and state-level governments’ sought “substitutes for municipal institutions” instead of upgrading or reforming them (Weinstein, Sami, & Shatkin, 2014, p. 45). The substitutes took the form of regional development authorities and parastatal agencies, i.e., a range of statutory bodies appointed by state-level governments to undertake planning and development “of local infrastructure and services such as transportation, water supply and waste management, housing and electricity” (Weinstein, Sami, & Shatkin, 2014, p. 45). But since the parastatal agencies and municipal governments held overlapping jurisdictions (as they still do), these arrangements fragmented state decision-making in urban areas (Weinstein, Sami, & Shatkin, 2014).

The new administrative agencies did not, for better or for worse, address decision-making for state-provided health care in urban areas. While the new agencies complicated—overrode or conflicted with—municipal authorities’ control in core sectors of urban development, such as sanitation, water supply, transport, and housing, they did little in the realm of urban health care. In some cities, state-level and not municipal governments still manage and provide urban primary care, and under national health program guidelines might continue to do so if they deem this lies beyond municipal government capacity in those cities (MOHFW, 2013c).95

Beginning in the 1980s, the state’s view of urban spaces and populations, as evinced in urban development policy, shifted. India’s policies under liberalization emphasized its
cities and towns as drivers of economic growth engaged with global markets (Fernandes, 2004; Gupta, 1998). Ideas about modernity and technology had shaped national development plans in newly independent India, and they continued to do so under liberalization. But the position of the urban poor in those plans changed, along with the state’s methods to deploy to achieve economic growth.

As Fernandes (2004) writes, whereas early state programs “idealised poverty alleviation and asceticism” and “tended to depict [urban] workers or rural villagers as the archetypal citizens and objects of development, … mainstream national political discourses increasingly depict the middle classes as the representative citizens of liberalising India” (p. 2416). Whereas earlier planning had placed the state as central to lead and foster economic development, under liberalization the state’s role and political-economic agenda shifted. Its new agenda included reforms to deregulate and privatize industry, to invest in urban development and infrastructure, to decentralize political and bureaucratic institutions. These efforts “reshaped the terrain of urban land, as well as the constellations of political interests empowered to remake that terrain” (Weinstein, Sami, & Shatkin, 2014, p. 50). In that changing urban terrain, the state’s provision of health care, specifically primary care, gained little traction. I elaborate that point next, specifically discussing decentralization laws enacted in 1992 and their differing implications for rural and urban health care.

4.5.3 1990s and 2000s: Decentralization and urban renewal

The 73th and 74th Constitutional Amendment Acts (CAA) of 1992 sought to achieve decentralized, participatory local self-government in rural and urban jurisdictions respectively
(JNNURM, 2011; CAA, 1992). The CAAs empower central and state-level governments to transfer specific authority, to devolve administrative and political powers over certain functions and services to local governments, and aim to strengthen the role and workings of local government. The 73rd CAA concerns institutions and responsibilities of rural local government, while the 74th CAA concerns urban local government.

However, implementation of the CAAs has, to date, proceeded more effectively in rural than urban areas (Sivaramakrishnan, 2013a, 2013c). In urban areas, most municipal governments “still face resource constraints to even carry out their routine functions” (Kundu, 2014, p. 616). The reach of the 73rd CAA in rural areas has established working administrative and political institutions of local government, which national health programs have been able to use to align local health planning down to the village level. The National Rural Health Mission (NRHM), launched in 2005, strongly emphasized community involvement in the state’s delivery of and accountability for health care services (MOHFW, 2013a). It initiated planning and monitoring committees at various administrative levels—village, block, and district level—to engage people, politicians, local community leaders, administrators, and NGOs, so that local governments could “own, control and manage public health services” (Shukla, Khanna, & Jadhav, 2014). The feasibility of this aspect of the NRHM owed in part to the existence of institutions for village-level local government.

That correspondence between local government and community-level health planning has eluded urban areas, partly because the 74th CAA has barely taken effect there. A chief reason for the failure of the CAA to usher in reforms is the relative power of central and state-level government over municipal government in India (Murthy & Mahin, 2016).
The CAA gives state-level governments the discretion to devolve powers to municipal governments. It does not mandate such devolution, and imposes no penalties on either states or municipalities for “failing to implement decentralization goals” (Murthy & Mahin, 2016, p. 112). State-level governments have been reluctant to devolve powers to municipal governments, fearing a loss of control over the direction and spoils of urban economic growth, and arguing circularly that municipal governments have low administrative capacity to actually take on the task of delivering public services (Murthy & Mahin, 2016). (I further explore reasons for the failure of the CAA and its implications for sources of authority in Pune’s municipal health service in Chapter 7). The CAA thus remains incompletely implemented in urban areas.

State-provided primary care in urban India therefore has no comparably decentralized local government institutions to institute the kind of community-level health planning and monitoring the NRHM introduced in rural areas. While the NUHM envisages such community-based participatory health service delivery in urban contexts, it also acknowledges the low capacity of many municipal-run health services and suggests that state-level governments manage the NUHM in those cities (MOHFW, 2013c).98

Urban renewal reforms—specifically the Jawaharlal Nehru National Urban Renewal Mission (JNNURM), launched in 2005—aimed to address shortcomings of municipal governments, such as their insufficient fiscal powers and low administrative capacity to execute urban planning and service delivery (JNNURM, 2011). The JNNURM introduced initiatives to improve and modernize administrative processes and help urban local governments become self-sustaining.99 But progress has been slow and uneven (Kundu,
2014) and even perfunctory with respect to community participation and investment in basic services (Coelho, Kamath, & Vijaybhaskar, 2011). The JNNURM has largely emphasized upgrades to urban infrastructure such as roads and transportation, not improving basic public services or reforming municipal governance (Coelho, Kamath, & Vijaybhaskar, 2011; Coelho & Maringanti, 2012). Under the JNNURM, “inclusive” programs to reach the urban poor largely encompass targeted, subsidized provision of housing and specific basic services, notably under the Basic Services for the Urban Poor (BSUP) program (Coelho & Maringanti, 2012, p. 42). However, funding for the BSUP is segregated from and subsidiary to investment in “large infrastructure schemes with arrangements for private participation and user fees” for full-cost paying citizens (Coelho & Maringanti, 2012, p. 42). 100

While the JNNURM reflects the state’s shifting role under liberalization, in which the state enables private investment and improves cities as engines of economic growth101 (Jessop, 2002), its approach toward urban renewal also reflects and reinforces cultural shifts under liberalization. Notably, as Fernandes (2004) argues, India’s liberalization policies “have been accompanied by an array of images centred around consumption practices and wealth generated by the ‘new’ liberalising middle class” (p. 2415). That middle class is urban, i.e., the representative citizen of liberalizing India is an urban, middle-class consumer-citizen (Fernandes, 2004). Evidence shows that instead of upgrading basic services, urban renewal programs have largely implied upgrading infrastructure, sanitizing and beautifying neighborhoods, and creating “slum-free cities,” such as by resettling slum-dwellers under schemes of redevelopment. These state-led “spatial practices” of urban development produce “a vision of a liberalising India that centres on the visibility of the new Indian middle class” and the invisibility of marginalized caste and class groups (Fernandes, 2004, p. 100).
Reforms such as the JNNURM “remain consistent with the realization of state-level priorities, which have increasingly gravitated toward the promotion of pro-business and middle-class quality of life concerns” (Weinstein, Sami, & Shatkin, 2014, p. 54). Bhan (2014) articulates the aims and changing tenor of development policy as follows:

Claims to welfare within a national discourse of development in India have long been based on the idea that the vulnerable represent a majority of Indians – the sheer demography of impoverishment commanded priority in the allocation of resources. At the very least, accumulation had to be legitimized by its direct and indirect impact on poverty as part of the narrative of national development (p. 556).

Under liberalization, the state’s approach to development has shifted to the city as an engine of and resource for economic growth. The state must now “cater to a new set of elite ‘citizens’” who are “undeniably urban,” whose concerns lie afield from those of the vulnerable, impoverished populations who were previously prioritized in the “narrative of national development” (Bhan, 2014, p. 556). State-provided urban primary care, along with other basic services, appears peripheral to the concerns of the new urban elite.

While liberalization policies have sustained the marginal position of urban primary care, their consequences lie beyond the disparities in health and health care they produce. As I next discuss, by giving a fillip to private health care, liberalization policies may diminish prospects for collective action among urban residents to improve state-provided health care.
4.6 Consequences of liberalization on collective action for health

Private health care services have long dominated the health sector and have expanded following liberalization in the 1980s (Baru, 2006). I argue that this avid private sector may diminish the possibility that urban residents will collectively demand improved health care from the state, deepening the historically low social engagement in or collective voice for health care in independent India. Activism and debates about health have long been muted in popular discourse and civic engagement, a weakness that Amrith (2009) attributes to the post-colonial state’s emphasis on a state-led, technocratic approach to health. India’s new leaders diminished the role of self-help groups, voluntary or charitable organizations, and neighborhood associations in publishing and circulating “ideas about health and healthiness” (Amrith, 2009, p. 13). Such ideas and discussions about health were prominent in late-colonial society. But leaders of newly independent India substituted medical experts and an institutionalized, rational, planning-based approach for the individual charity and sympathy-based, unorganized efforts of elite interventions in health (Amrith, 2009). The state’s negation of civic engagement in health contributes to the current absence in the social imaginary about “health as a right and an entitlement of citizenship,” since, as Amrith (2009) writes, “the Indian state felt little need, after 1947, to communicate this to its citizens” (p. 13).

Yet the current scene of community activism for public services in urban India suggests that factors other than a historically weak social awareness about health may be simultaneously at work here. I argue that the organization of India’s health system—its dynamic, dominant private sector and its chronically under-resourced public sector—
reinforces a muted popular understanding of health as a right, of health care as an entitlement that citizens can and should claim from the state. As I show below, evidence suggests that community mobilization for a range of urban public services (water, sanitation, housing) is robust (if in some cases implicated in the politics of negotiated development), more so than for health care. One reason for weaker collective action for health is the ready availability of private health care. Private health care providers can resolve issues of access to health care (such as convenience, distance, timeliness, and responsiveness) for the urban poor, even if they deliver care of questionable quality and provide only temporary relief.

4.6.1 Private sector role in health care vs. water supply, sanitation, and housing

State investment in health care has been minimal, consistently short of population health needs (Deolalikar et al, 2008; Duggal, 2009; Marten, McIntyre, Travassos, et al, 2014; Bhaumik, 2015). Public sector expenditure on health dropped from 1.5% of GDP in the 1980s to 0.8% in the 1990s (Duggal, 2009) and hovered just below 1% through the 2000s (Duggal, 2009; MOHFW, 2009).

The private health care sector has long coexisted with and dominated state services in India (NSSO, 2006). Private providers have accounted for over 75% of all outpatient health care transactions in urban India since at least the late-1980s (NSSO, 2006; IIPS & Macro International, 2007). Health care has become more commercialized since the 1980s and the private sector has expanded its presence, assisted by factors related to liberalization beginning in the 1980s. These factors include the state’s policy to diminish its role in providing curative care (while keeping its focus on preventive care), the state’s
increasing use of varied technology in disease control programs, the entry of the corporate sector into health care, the entry of the private sector in health insurance, partnerships between the state and private providers, and the growth of private medical education (Duggal, 2011; Baru & Bisht, 2010). State monitoring (e.g., of accreditation, registration, standards) of private health care providers has been weak\(^{107}\) (Bhate-Deosthali, Khatri, & Wagle, 2011; Peters & Muraleedharan, 2008) and actively contested by private stakeholders (Sheikh, Saligram, & Hort, 2015; Srinivasan, 2013). As a result, people can purchase health care and related services (diagnostics, drugs, insurance) as commodities in a sizeable and largely unregulated market.

By contrast, the private provision of water supply, sanitation, and affordable housing has been relatively limited. Estimates suggest that over 90% of urban households in India have access to water supply, most of which is supplied by the state, although with significant problems of “poor quality of access, low reliability of supply, poor water quality, high loss levels, and low cost recovery” (Water and Sanitation Program, 2011).\(^{108}\) Informal water tanker markets have emerged in several Indian cities, but tankers meet only about 7% of the demand-supply gap in those cities (Srinivasan, Gorelick & Goulding, 2010).\(^{109}\) Formal private suppliers of water have been slow to gain a foothold in water supply markets in urban India (Water and Sanitation Program, 2011). Public-private partnerships for water supply began in the 1990s. But only an estimated 5 million people in urban India—a small number considering India’s urban population of 419 million\(^{110}\)—obtain water supply through “projects or institutional arrangements that involve the private sector” (Water and Sanitation Program, 2011, p. 6).
Sanitation services are wholly inadequate in urban India, but where services do exist they are largely provided by the state. India’s urban sanitation coverage, or percent of population with access to improved sanitation, is an abysmal 50% (Elledge & McClatchey, 2013). According to a survey conducted in selected Indian cities, including in Chennai, Delhi, Mumbai, and Kolkata, less than one out of every four slum-dwelling households use improved toilet facilities and about one-third to one-half of poor households in Delhi, Meerut, Indore, and Nagpur practice open defecation (IIPS & Macro International, 2007).

However, despite this gaping need for sanitation, the private sector has been slow to enter the sanitation market (Elledge & McClatchey, 2013). Private sector involvement in sanitation includes interventions to test new technologies and business models, including community-based and commercial approaches to operate and maintain public toilets in a bid to deliver sanitation services in India’s congested urban public spaces (Elledge & McClatchey, 2013). The non-profit Dasra (2012) identified over 160 organizations that offer “innovative, scalable models” to provide access to sanitation to marginalized urban communities (p. 36). As its report notes, these organizations and models are “poised for scale,” but they are not yet substantial providers of sanitation (Dasra, 2012, p. 36).

Affordable housing, too, “has traditionally been the purview of the state: it is only recently that the private sector has entered into building houses for the lower-middle and middle-class segments” (Gopalan & Venkataraman, 2015). Regulatory and statutory factors have constrained private sector participation in the housing market (KPMG, 2014). Land use in urban areas is poorly planned, and marketable land parcels are scarce, in part because state agencies such as the railways, ports, and defense authorities often own “large tracts of
centrally located urban land” (Gopalan & Venkataraman, 2015). The titling system—under which the state formally recognizes property rights and facilitates trade in land rights through a process of registration—is incomplete and weak (Gopalan & Venkataraman, 2015). Yet, the state is strongly enmeshed in land and housing development, without which private entities cannot legally invest in the housing sector.

Recent policy reforms encourage private sector participation in water supply (Ministry of Water Resources, 2002), sanitation (Ministry of Urban Development, 2008), and housing (Ministry of Housing and Urban Poverty Alleviation, 2007). However, in contrast to encumbered and belated private sector participation in urban water supply, sanitation, and housing, the private sector’s involvement in health care is notable for its magnitude, fervency, diversity, and history (Bhat, 1993; Baru, 2000; Baru & Nundy, 2008; Indian Chamber of Commerce, 2015).

4.6.2 Collectively action for health care vs. water supply, sanitation, and housing

Evidence suggests that collective mobilization for water, sanitation, and housing services is more robust than for health care. For example, researchers have documented the politics of inclusion in slum-dwellers’ collectives in Mumbai (Roy, 2009a); contestations around court-sanctioned slum evictions in New Delhi (Bhan, 2014); mobilization among the urban poor to collectively press for sanitation services in informal settlements in Mumbai (McFarlane, Desai, & Graham, 2014); and dissident responses of lower-middle-class residents in Bangalore’s periphery to market-oriented water reforms (Ranganathan, 2014).
In contrast, efforts by NGOs to mobilize urban communities for improved health care have been few and difficult to sustain (More et al, 2012; Agarwal et al, 2008). More et al (2013) report that while community mobilization among women in selected Mumbai slums was feasible—women were “able to articulate their experiences, identify problems and suggest local solutions”—yet community action was hard to achieve (p. 2). More et al (2012) note several challenges of collective action, including that women in socially and culturally heterogeneous settlements felt they lacked “the power to push their agendas with neighbors and health-care providers” (p. 2). Women also felt they lacked opportunities to participate, given that “urban life and time are intensely monetized” (More et al, 2012, p. 2).

But those challenges might apply equally to community mobilization for other public services. More et al (2012) note another challenge—one that especially distinguishes mobilization for health care versus other public services—namely that “access to health care is not limited by distance or scarcity” (p. 2). For the urban poor, private health care is easily accessible. I argue this can potentially obviate their need to raise demands for health care from the state.¹¹⁴

To place that argument on theoretical ground, I turn to the social-science scholarship on collective action. In that scholarship, questions of how and under what conditions people raise demands for public goods are central concerns (Mansuri & Rao, 2004). Researchers delineate several factors that explain collective action outcomes. They note that collective action is motivated and shaped by grievances (depth of discontent), individual incentives (material or affective inducements beyond enjoyment of the public good), and community characteristics (social heterogeneity, norms, and ties) (van Stekelenburg & Klandermans,
I argue that in the case of collective action for urban health care, the role of grievances—people’s sense of deprivation or injustice about a situation—is key to consider. That is, how people experience the deficiencies of health care distinguishes it from other public services.

A common assertion in the literature on collective action is that grievances are rarely sufficient to motivate collective action (van Stekelenburg & Klandermans, 2010). But some scholars highlight that we know relatively little of how grievances are constructed in the first place, prior to their being framed and mobilized towards collective action (Levitsky, 2008). I propose that grievances for urban health care are shaped in part by the structure of the urban health system, its configuration of state- and privately-provided services. The urban poor navigate a complex ecology of care encompassing public and private clinics and hospitals, individual private practitioners, alternative healers, and drug shops (Das & Das, 2006). They tend to use the less qualified, less expensive of private providers (Matthews et al, 2010; Hanson et al, 2011). The private sector enables the poor to avoid state facilities, thus deflecting their potential grievances against health care as an inadequacy in need of redress.

More than health care, the locus of individual and collective discontent, community action, and local political mediation is the routine urgency of everyday needs such as water, sanitation, and housing. Unlike those basic services, seeking health care is an episodic concern for the urban poor. Moreover, even if poorer communities are on the whole more exposed to risk of disease, their experience of illness is singular and individuated. That is, in the city, the care-seeking, caregiving, and economic burdens of illness are personal experiences rather than collective, community-wide concerns.
By contrast, in a poor urban community, access to water, sanitation, and housing is often an ongoing and shared trial. For instance, poor migrants in the city, for whom tenure of housing may be uncertain, if not illegal, may find they share little by way of language, religion, or custom with their neighbors, except the fact of their transient dwelling. Living in dense settlements, the urban poor experience the absence of some amenities collectively, together rather than individually: unmaintained public toilets, turned-off water pipes, an electricity outage, a slum eviction. These are not simply everyday inconveniences; they threaten life and survival in the city. But where health ailments prevail across a community, such as recurrent diarrhea among children, their prevalence may become normalized, subsumed “within the notion of the normal” (Das & Das, 2006, p. 76). And when minor or major acute illness strikes, there is no dearth of private providers to whom the poor can turn, even if at a cost and to uncertain effect. The urban poor use a diverse, largely unregulated private health care sector that adeptly caters to client needs (Ergler et al, 2011). These factors make the deficiencies of state-provided health care less amenable to collective action, a difficult issue around which to mobilize, a grievance that slips into the fold of the normal, that can be deferred, that is abstract until illness manifests, when it becomes privately catastrophic.

In sum, for the poor, securing services such as water, sanitation, and housing in informal or low-income settlements involves routine struggles and often compels engaging with state agencies. While access to those services entails degrees of complicity with bureaucratic, partisan, and private interests (Appadurai, 2002; Chatterjee, 2004), basic health care is readily obtained without recourse to the state. In this way, an expansive private sector
may forestall the possibility that people will collectively claim improved health care from the
state. In India, this weak politicization of health care reinforces a historically low social
engagement with health.\textsuperscript{119}

4.7 Concluding remarks on the marginal position of urban primary care

While cities have received attention in national urban development and urban governance
policy, this has done little to strengthen municipal governments’ capacity, role, and powers
to improve urban health care. National health reforms have primarily addressed rural areas.
Under India’s economic liberalization, decentralization has progressed weakly in urban areas.
Urban development programs have promoted middle-class concerns and economic interests
rather than the basic needs of marginalized groups. The result is extensive exclusion and
inequality in access to health care for the urban poor. These findings highlight the “social
nature of public goods” (Reddy, 2015). They show the imaginary of the urban that undergird
health and urban development policy, suggesting how national leaders’ ideas about
development, disease, poverty, and the city together shape the organization and workings of
state-provided urban primary care.

Another aspect of the “social nature” of state-provided primary care is the nature of
grievances it provokes. I propose that the state’s peripheral role in providing primary care
coupled with an expansive private health sector can constrain political mobilization for
urban health care. In contrast to the belated entry and relatively modest involvement of the
private sector in public services such as water supply, sanitation, and housing, private health
care has long coexisted with state services. It has, moreover, become increasingly
commercialized under liberalization. Whereas the urban poor have ready and direct access to private health care, their securing water supply, sanitation, and housing is typically fraught with local politics, often involving state agents, politicians, and private suppliers. Collective action for health care among urban communities appears as a relatively muted concern, deferred in light of other struggles in the contemporary Indian city.

I revisit these themes in subsequent chapters. I draw on the above analysis, specifically on the status of urban primary care in health and development policy, where I discuss how municipal doctors in Pune understood their mandate to provide primary care (chapter on Service), interpreted the risks of acting outside the notional purview of municipal primary care (chapter on Risk), and responded to sources of authority—administrators, local politicians, popular opinion—in their everyday work (chapter on Authority).
5 Service

5.1 Introduction to ‘service’

The previous chapter established primary care provision as a mandatory responsibility of municipal government and a marginal concern in national health and urban development policy. This chapter concerns the scope—the purview of service—of the municipal mandate for primary care. I examine how municipal doctors in Pune understood that mandate and confronted its challenges in their everyday work. I focus on an aspect of service central to primary care provision: responding to the social determinants of health (SDH). By social determinants I mean the “full set of social conditions in which people live and work” (CSDH [WHO Commission on the Social Determinants of Health], 2010, p. 9). Both global health initiatives (CSDH, 2010; Starfield, Shi, & Macinko, 2005; Metzl & Hansen, 2014) and India’s national policy (HLEG, 2011; MOHFW, 2013a; 2013b) affirm that primary care providers play a key role in attending not only to patients’ individual biomedical conditions, but also to the social circumstances of patients’ lives.

From that vantage point, I ask: how did municipal doctors understand the scope of their mandate, the place of SDH within it, and their ability and capacity to fulfill it in Pune’s urban context? How did they encounter and address SDH in everyday practice? How did they interpret and respond to SDH, and how did their interpretations and responses shape the outcomes of their work?
Addressing SDH entails addressing “relationships between underlying determinants of health inequities and the more immediate determinants of individual health” (CSDH, 2010, p. 9). As the WHO-CSDH observes, health systems and health care providers within them play important roles “in mediating the differential consequences of illness in people’s lives” (CSDH, 2010, p. 6). In a parallel formulation, researchers studying medical care in the US have recently coined the term “structural competency” to describe providers’ conjoined expertise in clinical medicine with knowledge of and action on socioeconomic factors that affect health (Metzl & Hansen, 2014; Reich, Hansen, & Link, 2016).

Providers of primary care (such as municipal doctors), in particular, are central to efforts to address SDH. Primary care, as widely conceptualized by global health researchers, implies “first-contact care, ease of access, care for a broad range of health needs, continuity, and the involvement of family and community” (Kruk et al 2010, p. 904; see also Rawaf, De Maeseneer, & Starfield, 2008). Global evidence suggests that improving primary care services can result in more equitable health outcomes, in part because primary care providers ideally focus not solely on the disease condition, but on the disease condition “in the context of the patient’s other health problems or concerns” (Starfield, Shi, & Macinko, 2005, p. 476). India’s health policies have long acknowledged the role of state-provided primary care in addressing SDH and have consistently promoted frontline health care providers’ role in this respect (HLEG, 2011; MOHFW, 2013a, 2013b). Thus, in theory and in policy, attending to SDH constitutes an essential aspect of providing primary care.

However, studies show that health care services in urban India neglect to attend to SDH in practice (Nambar et al, 2016). Researchers have documented how the urban poor
suffer from exclusions from health care, and how their experiences of seeking health care can “amplify their vulnerabilities” (Nambiar et al, 2016, p. 42; Planning Commission, 2011). But this research tells us relatively little about how providers encounter, interpret, and address those vulnerabilities in the course of clinical interactions (Ergler et al, 2011; Tharu, 2010). In other words, while we know that social discrimination in access to health care persists in urban India, we know less about how providers perceive and respond to it in their everyday work, and how their interpretations and actions might ameliorate or exacerbate it. My analysis in this chapter contributes to our knowledge and understanding of those less-known themes.

By focusing on how municipal doctors address SDH, my inquiry extends research on providers’ “responsiveness” to patients. In health systems performance assessments, “responsiveness” captures non-clinical aspects of providers’ performance and is meant to reflect a people-centered rather than disease-focused approach to health care (WHO, 2010; 2000). Studies of health care quality find that public providers score lower than private providers on responsiveness (Berendes et al, 2011). However, measures of responsiveness largely stress the “client orientation” (WHO, 2000) and “hospitality” (Basu et al, 2012) of provider’s behavior, including the time, dignity, and respect providers offer patients, and they gauge these attributes of providers’ performance from patients’ perspectives (e.g., Basu et al, 2012; Berendes et al, 2011; Das et al, 2012). While those attributes are important aspects of providers’ behavior, they tell us little about how providers address the “social, economic, and political realities” that can divest a patient of resources for health and recovery from illness (Kutty, 2010, p. 227), and about how providers experience and interpret the health care encounter. In contrast, my inquiry examines whether and how
providers addressed SDH—a key non-clinical aspect of primary care provision—in the

course of their everyday work.

In Pune, municipal doctors concurred that providing primary care was a municipal
obligation. They described primary care as services for reproductive and child health (RCH)
and minor illnesses (fever, coughs and colds, minor aches and pains). Within clinical
encounters, they focused largely on the immediate ailment that patients presented,
conducted summary consultations, provided mostly symptomatic treatment for basic
illnesses, and referred other cases. In sum, although India’s health policy has long espoused
an ideal of primary care with consistent attention to SDH, in practice, municipal doctors’
practices fell well short of that ideal. These findings align with other studies on the scope
and practice of state-provided (municipal) primary care across urban India, which similarly
show that RCH, minor ailments, brief consultations, and frequent referrals predominate that
scope and practice (MOHFW, 2014b, p. 53).

Unlike most of those studies, however, my findings present a narrative account of
providers’ perceptions and practices, their reasoning and interpretations. I show that
municipal doctors delivered treatment and referrals along with “counsel”—they variously
advised, admonished, or encouraged patients to follow a course of action. Municipal doctors
construed counsel as among the few options they had to address SDH. They acknowledged
health-relevant social conditions in the communities they served, but they applied counsel
sparsely or doubtfully and resignedly. The content and consistency of their counsel were
shaped in part by how doctors perceived the poor, the mutability of SDH, and the bounds
of their mandate. Operating largely without social relations with the communities they
served and without social support services to act upon patients’ social circumstances, doctors were generally unable to address SDH. In contrast, they were at times more readily able to facilitate patients’ access to the ubiquitous private health care sector. Doctors’ practices thus not only undermined the ideals of primary care, but also reinforced the dominance of the private sector.

My findings show how structural violence can unfold at the frontlines of service provision, where structural violence refers to the ways that the organization of social, political and economic systems can cause injury to individuals and populations, creating health inequalities that solely medical and public health interventions cannot address (Farmer, Nizeye, Stulac, & Keshavjee, 2006). They affirm the argument that routine procedures of the state can effect denials of care for the poor (Gupta, 2012). But they also qualify that argument. In Pune’s municipal health service, denials of care reflect not solely a failure of policy implementation. They also reflect the priorities and design of state programs and processes of social exclusion outside state-society encounters. These factors can shape how state agents understand their mandate and its challenges, relate to the communities they serve, and act to address SDH. The following vignette illustrates how municipal doctors’ encountered, understood, and responded to SDH in the course of their everyday work. It suggests that public providers who founder in their “responsiveness” may yet acknowledge and attempt to attend to the social conditions in which the poor live and work. That they are unsuccessful indicates not just an implementation problem. It reflects the institutional history of municipal primary care and collective narratives of poverty and social difference that undergird providers’ actions.
5.2 Against medical advice

Dr Amrita, a relatively recent recruit in the municipal health service, was the sole doctor in a municipal clinic one afternoon when a woman walked slowly in through its open doors, an emerald green sari draped closely around her thin frame, her hair in a tight, small knot. Her toddler son lay limp in her arms as she carried him in. The boy’s breathing seemed troubled. He wore a loosely buttoned graying-white half-sleeved shirt and khaki shorts, a public school uniform a size too large. A nurse directed the woman to Dr Amrita’s consultation room.

“He has a cold,” said the woman to Dr Amrita, requesting medicine for the boy’s cough and cold. Like all municipal clinics and hospitals in Pune, this one had an in-house pharmacy. Patients could consult a doctor and obtain selected drugs for free within the clinic. For the cost of the consultation, Rs 5 (less than US$ 0.10), patients would receive two days’ dose of drugs, on the municipal doctor’s prescription, from the clinic’s pharmacy.

Dr Amrita examined the boy as his mother held him. The boy was listless. Dr Amrita held her stethoscope to his chest. When she finished examining the boy, she told the mother to immediately take him to a hospital. A public hospital was located a short distance away, she reminded the mother. Dr Amrita listed aloud the boy’s symptoms so the mother could understand why this was urgent and necessary: the boy had difficulty breathing and a cough, his chest caved in when he breathed. At the hospital they could run tests and treat him, she informed the mother. She questioned the mother further, asking why the boy’s weight was so low. The mother replied he had a heart problem. Dr Amrita encouraged the mother to elaborate. The mother said doctors had told the family that the boy had a “hole in his heart.”
He has had this problem since he was a baby, said the mother. Her suspected diagnosis confirmed, Dr Amrita listened to the boy’s heart again and made further inquiries. What had doctors recommended about getting him operated? The mother replied that doctors hadn’t said anything about surgery, and added the boy was prone to getting colds.

Dr Amrita suggested again that the mother take the boy to a hospital. But the mother requested again that Dr Amrita prescribe cold medicine. Dr Amrita responded that cold medicine would not do him any good. He had a heart condition, and it could worsen. At the hospital they could run blood tests and other investigations. Doctors there could admit him to the inpatient ward if they thought it necessary to keep a watch over him. Dr Amrita stressed to the mother that none of that could be done here, at this clinic. She reminded the mother that at 5pm, she would lock up the clinic and leave. If the boy took a turn for the worse, who would attend to his condition then? Cold medicine might make him feel better temporarily, but he needed more than that. Why not take him to the hospital right away? And if she was not going to go, Dr Amrita added, then the mother should “sign here.” By “here” Dr Amrita meant a Discharge Against Medical Advice (DAMA) declaration, which she would imprint on the case paper. As her assistant prepared the case paper, here was more back and forth between Dr Amrita and the mother, the one reiterating the boy’s symptoms and the other deflecting the doctor’s entreaties.

Dr Amrita urged the mother to bring the boy to the clinic the next morning and to bring his previous medical reports as well. The mother agreed, but her “yes” was half-hearted. When Dr Amrita again suggested she visit the hospital, the mother fell silent. Dr Amrita couldn’t let the matter drop. She again referred aloud to the boy’s condition. “Can’t
you see,” she asked, “that he’s having trouble breathing?” Then, impatiently, in abruptly rising pitch, she demanded a response from the boy’s mother: “What am I saying? Do you understand what I am saying? Then why aren’t you going?”

The mother, unflustered, said yes, she did understand. She said the boy had always been like this, he has a heart problem, they knew, they have known since he was born. She had simply felt the boy had a small cold, and she would bring him in to the clinic to get a little help to ease his cold. After a pause, Dr Amrita again encouraged the mother, in quieter tones, to return the next day, to come prepared to be admitted to a hospital if required. The mother agreed and got up to sign the DAMA declaration and collect her cold medicine. She left the clinic seemingly unperturbed.

Dr Amrita, on the other hand, was frustrated at what she called the mother’s obduracy and ignorance, still in disbelief that the mother had left. Dr Amrita considered possible reasons the mother did not go to the hospital: she had paid for a consultation at the clinic, she would have to spend another amount at the hospital, and there would be queue in which to wait. I inquired if there was a way to reach the mother outside the clinic, if there were community health workers, as there are in the state government-run rural health system, who could visit the mother at her home. Dr Amrita shook her head, saying she knew of no community health workers linked with the municipal health department. The entire episode had lasted less than ten minutes, but Dr Amrita seemed exhausted.

Dr Amrita had hoped that mother and son would come back to the clinic the following day. But when I visited a few days later, the first thing she said, with regret, was
that the woman had not returned. In Dr Amrita’s narratives, her main challenge in this instance was getting the boy’s mother to respond to her counsel.

When I recounted the episode to other municipal doctors (anonymizing the scene, leaving out Dr Amrita’s name and the clinic’s whereabouts), they expressed little surprise at the mother’s refusal to take her sick child to a hospital. “Maybe she has taken the boy to a doctor in the past, someone told her how much treatment will cost, and since she cannot afford it, she decided not to do anything about it,” offered one doctor, who had long years of experience in the municipal health service. Another observed that children risked being neglected in poor households: “Maybe [the mother] has other children to look after, too. And in the end the sick child loses out.” She suggested Dr Amrita could have arranged for transport or accompanied child and mother to the hospital. But another municipal doctor cautioned that accompanying the patient to the hospital was only a partial, temporary solution:

Maybe the doctor could have done it once, but what about the next day? The next day, at home for the mother and child, things will be back the same as they were.

What can the doctor do? What more?

I inquired if Dr Amrita could have coordinated with a community health worker to visit mother and son in the community, a feasible option in state-run rural primary care. A long-serving municipal doctor demurred: “We are not allowed to leave the clinic. It says so in my job description, that I must remain within the clinic at all times. We are not allowed to make house visits.” I pressed her: But what if the community health worker made the visit,
not the doctor? The doctor said that no community workers were attached to the municipal clinic she managed. I asked: So there was no way to reach the mother in her home, outside the clinic? “No,” the doctor replied, conclusively.

* * *

Municipal doctors’ narratives suggest that they acknowledged social conditions affected patients’ health and recovery from illness. Doctors construed counsel—listening to and advising patients and their families during patients’ visits to the clinic—as one of few options, often the sole option, available to them to address those social circumstances. They felt constrained to respond to SDH partly because of inadequate resources, such as Dr Amrita’s lack of access to community-based health volunteers who might have contacted the mother at his home. But doctors also felt constrained by what they perceived as the intractability of the poor and the impassability of poverty. These themes underscore municipal doctors’ dilemmas in confronting SDH, and they animate my analysis in this chapter.

5.3 The mandate of service at the level of primary care

What does primary care comprise in India? How does health policy describe the scope of primary care? What is the mandate of service for municipal doctors? In this section I show that national health policies have proposed that a key task of primary care providers is to attend to social factors that affect health. This role for primary care providers has wide and longstanding support in health initiatives: both national policy and global consensus support
providers’ recognizing and responding to SDH as an integral aspect of primary care. Despite that policy thrust, in practice, health care services in urban India generally neglect to attend to SDH. Studies describe multiple vulnerabilities confronting the urban poor and the failure of state services to address them. But they offer little insight into the perspectives of health care providers, specifically municipal primary care doctors, who are supposed to be the first point of contact for urban populations when they access public sector health care.

In a subsequent section, I discuss how researchers have assessed providers’ response to SDH. I show how those assessments overlook what public providers might be attempting to do, namely to manage or overcome, as Dr Amrita in the vignette above, social factors that impede patients’ health and access to health care. I then present my fieldwork from Pune, discussing how municipal doctors addressed, or failed to address, SDH in their everyday work.

5.3.1 Primary care in national policy, municipal directives, and ground reality

In India’s three-tiered health system, primary care services constitute the lowest tier of care, the first point of contact between people and the health system. While state-level governments are responsible for managing primary care in rural areas of a state, municipal governments are responsible for providing primary care to urban populations. Primary care services in rural versus urban India thus have distinct governance structures.

However, national policies and programs for rural and urban health care, although separately drafted, have conceived of the scope of rural and urban primary care services in
similar terms, where “strategies, interventions and activities” designed initially for rural areas are to be “appropriately adapted and fine-tuned to meet the distinct challenges of urban settings” (MOHFW, 2013a, p. 35). The congruence of rural and urban primary care is clear to see in the Framework for Implementation of the National Health Mission (NHM) (MOHFW, 2013a). This Framework conjoins previously separate programs for strengthening rural and urban health care. According to that Framework and related national policy documents, in both urban and rural areas, primary care providers will ideally see patients for initial diagnosis and treatment for a broad range of illnesses, coordinate patients’ care with higher tiers of health care, and implement population-wide programs to prevent disease and promote health.

In practice, however, the actual content of primary care is uneven across types of services and service locations. Not all types of primary care services are available in equal measure. In practice, primary care services comprise largely infectious disease control and maternal and child health care, such as family planning, nutrition, and immunization programs for major diseases. These priorities reflect the emphases of primary care not just in India but across LMICs from the 1980s onwards, following events in the wake of the landmark Alma Ata Declaration. In 1978, India, along with other WHO member states, signed the Alma Ata Declaration at the WHO International Conference on Primary Health Care. The declaration called for states to “launch and sustain” comprehensive, community-based and -oriented primary health care, “providing promotive, preventive, curative and rehabilitative services” as part of their national health systems (Lawn et al, 2008, p. 918). However, countries subsequently whittled down the scope of services envisioned in the declaration, reducing them to select components that the “development
establishment" (Navarro, 1984) deemed strategic, feasible, expedient, and measurable (Reubi, Herrick, & Brown, 2015; Lawn et al, 2008; Navarro, 2008; Cueto, 2004). International aid and health agencies promoted a reduced package of services for maternal and child health and infectious disease control. Partly because of developments in global health priorities, these programs came to dominate primary care in many countries, including India (Banerji, 2008). Programs for non-communicable diseases, for example, are recent in India and are under-resourced relative to programs for RCH (Jose et al, 2013).

Primary care services are more extensive in rural areas. As discussed in the previous chapter, the Indian state’s initial (post-independence) commitment to public health stressed population control as a way to unshackle economic growth. The premise was that high population growth mired households in poverty, ill-health, illiteracy, and low labor productivity (Amrith, 2007; Mohan Rao, 2004). The main target of family planning programs was the majority rural population. Partly due to the state’s historical focus on the health of rural populations, primary care infrastructure is weaker in urban areas (MOHFW, 2013a, 2014b).

In urban areas, according to central government-issued guidelines, municipal governments are legally obliged to manage urban primary care services (MOHFW, 2013c, p. 14). For municipal governments in Maharashtra, that legal obligation derives from the Maharashtra Municipal Corporations (MMC) Act (Government of Maharashtra, 2014). The MMC was initially enacted in 1949 and remains unchanged in its delineation of the municipal health care mandate. But the MMC Act does not specify what primary care entails; it does
not use the term “primary care” at all (see Chapter 4). Rather, it stipulates obligatory health care responsibilities of municipal governments as the following:

The construction or acquisition and maintenance of public hospitals and dispensaries including hospitals for the isolation and treatment of persons suffering or suspected to be infected with a contagious or infectious disease and carrying out other measures necessary for public medical relief (MMC Act, Chapter VI, Section 63).

Operating under such broad terms as “public medical relief,”130 and without formal norms and standards to direct their health care-related work (Kapadia-Kundu & Kanitkar, 2002), municipal governments across Maharashtra and other parts of India vary in the organization, type, and range of health care services they provide (MOHFW, 2013c). In practice, municipal primary care in Pune and other Indian cities has historically encompassed mostly RCH along with few selected items described in national policy texts (IIPS, 2005; MOHFW, 2013c). In some cities, RCH is the sole focus of municipal primary care services (MOHFW, 2013c). In Chennai, for example, city residents considered state-run primary care clinics as facilities “only for pregnant women” (Nambiar et al, 2016, p. 36).

In sum, national policy texts describe a comprehensive scope and community-based focus for primary care.131 In national policy, primary care entails not just a program of medical care, but also community-oriented strategies to reach and engage local populations to prevent disease, promote health, and coordinate care with health-related service providers. In practice, however, primary care services in urban India cover mostly RCH and offer
limited community outreach. As I next discuss, both global initiatives (CSDH, 2010; Lawn et al, 2008) and India’s health policy (Narayan, 2008; HLEG, 2011) have advocated strengthening the community orientation of primary care, specifically to address SDH.

5.3.2 *Global consensus on primary care and the social determinants of health*

In contrast to uncertain meaning of primary care in India’s health policy, global health researchers have, as I pointed out, a widely shared conceptualization: “first-contact care, ease of access, care for a broad range of health needs, continuity, and the involvement of family and community” (Kruk et al 2010, p. 904; see also Rawaf, De Maeseneer, & Starfield, 2008). Primary care providers ideally deliver first-contact care “for each new need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere” (Starfield, Shi, & Macinko, 2005, p. 458). As such, providing primary care entails attending not only to patients’ individual biomedical conditions, but also to their social circumstances, such as their education, religion, income, social networks, and the neighborhoods in which they reside.

These social factors, among others, comprise “social conditions in which people live and work,” or the social determinants of health (CSDH, 2010, p. 9). Addressing SDH entails addressing “relationships between underlying determinants of health inequities and the more immediate determinants of individual health” (CSDH, 2010, p. 9). A key strategy toward that end is intersectoral action, involving policies and programs on multiple fronts beyond health care, such as food and nutrition security, education, urban development, agriculture, labor

My focus is on the role of the health system, particularly health care providers, in addressing SDH. According to the WHO, the health system “plays an important role in mediating the differential consequences of illness in people’s lives” (CSDH, 2010, p. 6). Health care services can, for example, be designed to account for the “differential exposure/differential vulnerability” of disadvantaged populations to health-damaging factors, and reduce the “unequal consequences of ill health and prevent further socioeconomic degradation among disadvantaged people who become ill” (CSDH, 2010, p. 52-53). Health care providers are therefore definitively implicated in efforts to address SDH.

Global evidence suggests primary care providers are central to and especially effective in such efforts. As Starfield Shi, and Macinko (2005) show, primary care doctors perform at least as well as specialists in caring for common diseases. They may outperform specialist doctors when quality of care is measured broadly (not only in terms of disease-specific outcomes). They and can obtain more equitable health outcomes, helping to narrow gaps in health between more and less socially advantaged populations. Primary care doctors obtain these superior outcomes in part because they focus not solely on the disease condition, but rather on disease “in the context of the patient’s other health problems or concerns” (Starfield, Shi, & Macinko, 2005, p. 476).

This connection between the work of primary care and the social circumstances of people’s lives has repeatedly featured in global health initiatives. The “content of primary health care—which interventions are included and which are priorities for universal access—
has shifted over time” and varies across countries (Lawn et al, 2008, p. 923). But the foundational idea that frontline health care workers, whether community volunteers or physicians, ought to provide “people-centered” and not disease-centered care endures among global health researchers, advocates, and practitioners (Rawaf, De Maeseneer, & Starfield, 2008; Sheikh, Ranson, & Gilson, 2014). A people-centered approach implies that the design and delivery of health care services account for community needs and foster the capabilities of health care workers to respond to those needs (Sheikh, Ranson, & Gilson, 2014, p. ii2).

Recently, researchers studying medical care in the US have conceptualized such capabilities as “structural competency” (Reich, Hansen, & Link, 2016). Structural competency expands the purview of providers’ knowledge, skills, and scope of action. It refers to providers’ competency not only to diagnose and treat clinical, individual-level medical issues, but also to recognize the “fundamental causes” of disease and engage with community-based interventions, social movements, and policy advocacy to address those causes (Reich, Hansen, & Link, 2016). As Reich, Hansen and Link (2016) observe, providers seeking to improve patients’ health through medical technology “without attending to their social and institutional settings may end up exacerbating, rather than alleviating, inequities in health” (p. 186).

5.3.3 Social determinants of health in national policy and in practice

Ideas about people-centered, socially attuned health care have long featured in India’s national policy framework for primary care. Recent health policy texts, state-commissioned
research, and state-supplied practical guidance for health workers and administrators also recognize a relationship between social conditions and health, and uphold health care providers’ role in recognizing and acting upon SDH. As the HLEG (2011) observes, “India’s approach towards health reform has historically endorsed a social determinants perspective, and continues to do so” (p. 280). The HLEG (2011) points to seminal blueprints for national health services in independent India, the Sokhey\textsuperscript{136} and Bhore\textsuperscript{137} Committee reports, as well as more recent policy texts such as the 2010 Annual Report to the People on Health. All acknowledged and prioritized social determinants.

Attention to the social animates the Bhore and Sokhey Committee reports not just as a broad idea, but in the details of health services delivery with a prominent state role.\textsuperscript{138} The Sokhey Committee, for instance, envisioned India’s national health service as an “organized, systematic, collective enterprise” attuned to the relationship between social conditions and health (National Planning Committee, 1947, p. 12). One member of the Sokhey Committee stated that “the individual and the society cannot be separated from their economical, educational, political, socio-religious as well as historical environment,” and the state had a role in ensuring that people’s conditions of work and life did not have health-damaging effects (National Planning Committee, 1947, p. 46).\textsuperscript{139} The Bhore Committee similarly discussed poverty and unemployment as root causes of disease, noting that the aim of the “modern public health movement” was not solely to prevent disease but to “[create] an environment in which each individual can develop his potential fully and completely” (Bajpai & Saraya, 2011, p. 220, quoting from Bhore Committee report).
These early plans envisioned a substantive role of health care providers in addressing SDH. Providers would attend not only to biomedical causes of disease, but also to social causes, including “[deficient] diet, … defective water supply, … lack of sanitation, … ignorance and superstition of the people or … social or economical causes” (National Planning Committee, 1947, p. 42).\(^{140}\) The Bhore Committee envisaged a “future medical doctor” skilled in “community and preventive aspects of medicine,” with knowledge of the social sciences as well as clinical medicine (Bhore Committee, Vol. 2, Chapter XVIII, p. 340-342).\(^{141}\) Thus, foundational policy documents that charted plans and blueprints for India’s national health service underscored the role of health care providers in attending to SDH.\(^{142}\)

Recent policies too have stressed health care providers’ role in addressing SDH. For instance, the central government launched the National Health Mission (NHM) in 2005 (known then as the NRHM) to provide health care services that are “accountable and responsive to people’s needs, with effective inter-sectoral convergent action to address the wider social determinants of health” (MOHFW, 2013a, p. 2). In specifying SDH-relevant strategies,\(^{143}\) the NHM proposes training frontline health care providers and community-based health workers in “critical areas of sanitation, safe drinking water, health and hygiene,” among other social and environmental factors (MOHFW, 2013a, p. 19). It terms gender a “major social determinant of health” and proposes “sensitizing providers and mid level managers to gender issues” (MOHFW, 2013a, p. 19). The HLEG (2011) similarly lists gender, religion, and language among other socioeconomic factors affecting health (p. 280), and recommends medical education include “[orienting] providers to the social determinants of health, including gender and equity issues” (p. 163). Thus, recent policies and
government-commissioned research as well emphasize acting on SDH and the role of health care providers in that effort.\[^{144}\]

In design and practice, however, health care services in urban India neglect SDH (Nambiar et al, 2016; Mander, 2004).\[^{145}\] Research widely documents that specific urban populations are excluded from health care based on place of residence, occupation in the city, and social status and identity (caste, gender, age, class, religion) (MOHFW, 2014b, 2013c; Nambiar et al, 2016; Planning Commission, 2011; Seeberg et al, 2014). For the urban poor, “social, physical/spatial and political marginalization” can affect their health by shaping their participation in political processes; freedom from violence, crime, and exploitation; and access to food, shelter, health care, social networks, and savings and credit (MOHFW, 2014b, p. 21).

Health care services contribute to negative health outcomes among the urban poor in at least two ways. One is due to the limited range and fragmentation of public sector primary care services, as they focus on RCH and link weakly to high levels of care (Nambiar et al, 2016). Another is due to social discrimination within health care institutions, i.e., processes of “othering” or “bordering” of specific groups, not only through “physical or structural barriers” to access and care (such as location, timing, cost, and formal and informal procedures to obtain services) but also through “ideological constructions that justify this exclusion by defining who fits in the social mainstream and who doesn’t” (such as transgender groups and people with disabilities) (Nambiar et al, 2016, p. 42). Thus, for the urban poor, the experience of seeking health care can “amplify their vulnerabilities” because the state either fails to see them, or, when it does see them, stigmatizes, “custodialise[s],”
“illegalize[s],” or criminalizes them (Nambiar et al, 2016, p. 42; see Mander, 2004; Mander et al, 2009).

This cited research paints a compelling picture of vulnerability among the urban poor and state failure to address it. However, it offers relatively little insight into those who implement policies at the frontlines—the perspectives of health care providers who are the first point of contact for urban populations when they access the public sector health system, and whose actions can reinforce or ameliorate vulnerability. We know little about how health care providers encounter, interpret, and address those vulnerabilities in their clinical interactions (Ergler et al, 2011). Although we know social exclusions affect health and access to health care in urban India, we know less about how providers perceive these social factors and about the everyday challenges they represent. We may anticipate, based on studies of health care-seeking among the poor, that the poor experience “bias and discrimination” in providers’ behavior and institutional norms (Batliwala, 2011, p. 22). But few studies document how providers—specifically doctors—construe their role and narrate challenges in addressing the social circumstances of patients’ lives, and how their interpretations and actions might ameliorate or exacerbate the effects of social factors on health (Zachariah, Srivatsan, & Tharu, 2010).

My analysis in this chapter contributes to those less-known themes. I next briefly review how researchers have analyzed providers’ attention to SDH. I specifically examine the concept of providers’ “responsiveness” towards patients, which studies of health care quality use to capture non-clinical aspects of providers’ performance. I critique and extend the concept of responsiveness.
Evidence from India suggests a mixed picture of how far health care providers wield SDH-related competencies in practice. Some researchers, examining patients’ narratives of illness, find that health care providers emphasize biomedical observations over patients’ social realities (Kutty, 2010; Das, 2006). Providers focus predominantly on “the body of an abstract ideal patient” and fail to consider “social, economic, and political realities” that can divest a patient of resources for health and recovery from illness (Kutty, 2010, p. 227).

Other researchers argue that providers do undertake “immensely demanding and risky intellectual, ethical, political and medical moves” in the course of encounters with challenging, “non-standard” patients (Tharu, 2010, p. 282). Tharu (2010) describes non-standard patients as those who appear, to the medical provider, as “unreliable, irrational, non-compliant, poor, underweight, illiterate, opinionated” (p. 282). She points specifically to the everyday medical care of general practitioners in India’s small towns, noting that they “consciously and subconsciously process the complexity” of patients’ living conditions, families, social networks, “individual economies, political issues, culture, history, and so on” (Tharu, 2010, p. 282).

Sociological evidence such as above is limited though important; I return to it later in this chapter. Apart from narrative studies of medicine and illness, evidence about SDH can be found in two other types of research: assessments of national policies and programs and global assessments of health care quality. Neither has so far attended to whether and how
providers address SDH in their medical practice. I next discuss what we may discern of providers’ perceptions and actions with regard to SDH in these two kinds of assessment and how my inquiry extends that evidence.

5.4.1 Evidence in national assessments of policies and programs on social determinants

Simply put, assessments of SDH are generally limited. As Cowling and colleagues (2014) observe, “despite the recognized importance of social determinants of health (SDH) in India, no compilation of the status of and inequities in SDH across India has been published” (p. 1). In their review of levels, trends, and progress on SDH in India, they highlight policies in nutrition, education, sanitation, water supply, gender equality, and employment, among other areas (Cowling, Dandona & Dandona, 2014). Their review does not cover how health care services and providers address SDH.

Nambiar et al (2015) provide compelling insights into “implementer’s narratives” about “convergent action” (intersectoral action across policy realms, welfare agencies, and community groups) to address SDH. However, they focus not on doctors but on the experiences\(^\text{148}\) of “research managers, policy makers, and funders” (Nambiar et al, 2015, p. 2), not doctors. While they detail challenges of intersectoral action to address SDH at policy and ground level, these studies tell us relatively little about doctors’ responses to SDH in everyday primary care practice.
5.4.2 Evidence in global assessments of health care quality

Assessments of health care quality encompass indicators of health care providers’ performance, including measures of the non-clinical aspects of performance. These are typically categorized as providers’ “responsiveness” to patients (Berendes et al, 2011; Basu et al, 2012). Responsiveness broadly refers to whether health care providers, and the health system they work within, respond to users’ needs, concerns, and expectations in relation to the health care encounter (WHO, 2010; WHO, 2000). According to the World Health Report 2000, responsiveness comprises “respect for persons” (respect for dignity, need for confidentiality, and autonomy) and “client-oriented attributes” (providing prompt attention, adequate quality of amenities, access to support from family and friends, and freedom to choose providers) (WHO, 2000, p. 1599).

While those aspects of responsiveness comprise important dimensions of patient care, they tell us more about providers’ communication skills, affability, and “hospitality” (Basu et al, 2012) than about whether and how providers address the social circumstances of patients’ lives. The WHO (2010) is explicit that its health systems performance monitoring framework is not designed to assess contributions of non-health sector activities towards improving health. It “does not take into account actions that influence peoples’ behaviours, both in promoting and protecting health and the use of health-care services,” or actions that “affect the underlying social and economic determinants of health (p. vii). Further, WHO’s monitoring framework “does not deal with the substantial and dynamic links and interactions that exist across each component” (p. vii). Its focus is intensively on health sector actions.
But this creates an interpretive problem. What we measure as providers’ responsiveness (or unresponsiveness) in health care service delivery might not be solely a response to people’s immediate health needs and concerns. Rather it might be intimately linked with and confounded by providers’ prior understanding of the social conditions of people’s life and work and prior perception of an appropriate response to those conditions. For example, as I show in vignettes below, providers might selectively conduct brusque, brief, clinical consultations with poor patients because they perceive “the poor” as difficult patients, unlikely to change their behavior given their illiteracy or irrational cultural beliefs. Providers may acknowledge patients’ affective expectations of the health care encounter, but may respond to something else: their comprehension of patients’ underlying social circumstances and of the possibilities for addressing those social factors.

In other cases, providers may not speak hospitably towards patients but may yet attempt to facilitate patients’ access to care. They may score low on responsiveness, but that low score belies their attempt to address patients’ health care needs, which may lie as much in the realm of the social as the biomedical. For example, as Dr Amrita’s encounter indicates, municipal doctors did try to guide patients in their health care-seeking decisions. While doctors at times interacted with patients in an admonishing and abrupt manner, doctors also displayed some understanding of how patients’ social and economic resources affected their health and access to health care. Measuring doctors’ “client orientation” may not capture whether they tried to address patients’ health care needs, broadly conceived.151
Terms such as “client orientation,” argues Navarro (2008), in his critique of WHO (2000) measures of responsiveness, suggest the influence of neoliberal ideology in WHO documents and terminology. Under that influence, “patients become clients” (Navarro, 2008, p. 153) rather than engaged citizens and social actors. When measures of responsiveness say little about providers’ response to the social determinants of patients’ health, they run the risk of evaluating only the extent to which providers satisfy patients’ demands and affective expectations of care. Such measures insufficiently consider whether providers strive for alternatives to improve patient health and access to care.

In that light, we ought to interpret cautiously the common finding in studies of health care quality that public providers score lower than private providers on measures of responsiveness (Basu et al, 2012; Berendes et al, 2011; Das & Hammer, 2014; Ergler et al, 2011). Those scores might suggest private providers are simply “pandering” to patients’ expectations rather than “working to identify better solutions for care” (Berlan & Shiffman, 2012, p, 275).

With that caution in mind, I discuss below two ways that measures of responsiveness can occlude our understanding of the reasons underlying low quality of care. The first concerns how researchers have measured responsiveness (key informants views, patient surveys), and the second concerns how the health care delivery context in which providers work (types of services provided, profile of populations served) might shape providers’ clinical interactions.
5.4.3 How measures of “responsiveness” can occlude our understanding of providers’ performance and quality of care

To measure provider responsiveness, recent studies have relied on surveys of patients’ perceptions of providers’ behavior (Berendes et al, 2011; Basu et al, 2012). Those measures tell us little about providers’ experiences with and narratives about SDH in everyday practice.


This suggests that an approach relying narrowly on specific informants can cast an incomplete, if not misleading, picture of responsiveness. (An approach exclusively focused on patients’ views too, I will argue below, may construct a partial and unreliable picture.) Specifically, where studies of responsiveness leave out providers’ perspectives, they may not illuminate dilemmas of risk, ethics, and politics, among other challenges, that providers confront in their everyday health care encounters with the poor (Tharu, 2010). And in the case of public sector providers, studies may not account for the state’s evolving ideas and
mandates for welfare, which can shape providers’ resources and approaches to providing care (Haney, 2002).^{152}

Haney’s (2002) study of gender and the welfare state in Hungary, based on historical and ethnographic fieldwork in welfare agencies and interviews with caseworkers, demonstrates the insights providers’ perspectives can yield. Haney (2002) analyzes shifting conceptions of need and of “the needy” in the Hungarian state’s welfare programs over a span of 35 years: from its early years of state socialism in the mid-1950s to the collapse of the Soviet Union in 1989. She shows that, in the 1950s, the Hungarian state sought to broadly reinstitute women seeking welfare into social and economic relations, assisting them to secure or reinstate employment, family ties, housing, and childcare. The state provided little financial assistance, but assigned each welfare recipient a single state worker who coordinated and looked into these all-round needs.^{153} By contrast, by 1989, the state construed “need” in material terms and delivered welfare in strictly monetary terms. The welfare system became increasingly “specialized, segmented, and punitive,” with a multitude of welfare state actors (caseworkers, home visitors, family experts) involved in “regulating poverty” (Haney, 2002, p. 4).

Haney’s (2002) insights into welfare policy and welfare practice suggest that state workers’ attitudes towards the poor may not entirely reflect shortfalls in their interpersonal behavior or hospitality. Rather, these attitudes can also derive from the state’s conceptions of need and its strategies to address poverty. Indicators of responsiveness described and measured in the WHO (2000) report elide how providers’ attitudes toward patients may reflect the state’s approach to welfare.^{154} By focusing on providers’ response to patients’
demands rather than to citizens’ social needs, they occlude what Reddy (2015) calls the “social nature of public goods.”

As a corrective, Navarro (2000) proposes using patient surveys rather than key informants interviews to measure responsiveness. Recent studies of health care quality (Basu et al, 2012; Berendes et al, 2011) and the WHO (2010) handbook on monitoring health systems do evince such an approach, i.e., they measure responsiveness by patients’ reports. Patients’ affective experiences of seeking health care can crucially inform their use of health care and shape health outcomes, and patients’ views contribute an important gauge of health care quality (Ergler et al, 2011). However, patients’ views of providers’ behavior are notoriously difficult to interpret, particularly in the context of primary care.

As Haggerty (2010) remarks, a “defining characteristic of primary care is the high degree of variety and variance, even within the practice of one doctor” (p. 791). Such variety and variance calls for prudence in interpreting differences in patient-reported satisfaction with care. Patient satisfaction scores may differ depending on when and how researchers seek patients’ views, such as closed-ended facility exit interviews versus open-ended focus group discussions (Schneider & Palmer, 2002). They may also differ based on features of local health care services: “in the absence of explicit and universal standards,” users may evaluate “providers against their experiences with other health care services available to them in their areas” (Schneider & Palmer, 2002, p. 32). Patient surveys are therefore an important but potentially invalid measure of provider responsiveness, particularly in the case of primary care providers. In urban contexts such as Pune, where private providers far outnumber public providers, patients may evaluate public providers based on their
experience of the (avid and unregulated) private sector rather than on “explicit and universal standards.”

This brings me to a second reason why measures of responsiveness tell us little about whether and how providers address SDH, and how this presents problems in assessing quality of care. Where studies of health care quality compare public and private providers’ performance, they potentially obscure the differing contexts of health care delivery—patient profile, kinds of health issues—that each confronts (Basu et al, 2012). The studies may therefore also obscure providers’ differing encounters with SDH. Public and private providers typically work under differing priorities, such as between achieving equity, universality, and profit (Herrera et al, 2014). They often differ in the type and volume of patients they regularly encounter and the scale and efficiency with which they discharge similar medical services. Public providers, for example, deliver immunization services on a more substantial scale and to a poorer patient population than do private providers (Basu et al, 2012).

Thus, although studies show public providers score lower than private providers on responsiveness (Basu et al, 2012; Berendes et al, 2011; Das & Hammer, 2014; Ergler et al, 2011), private providers’ greater responsiveness may not necessarily promote patient health or address SDH. Measures of providers’ responsiveness in terms of their hospitality alone, viewed solely from patients’ perspective, would not account for the “differing social and economic contexts of healthcare delivery” that characterize public versus private sector facilities (Basu et al, 2012, p. 10).
My study extends what we know of public providers’ performance and qualifies how we might interpret health care quality. In particular, to assess non-clinical aspects of providers’ performance, it looks not only to providers’ hospitality toward patients, but also to how providers recognize and respond to the social conditions in which patients live, work, and seek health care. It considers the public mandate and material and organizational resources under which providers work, and examines how providers understand that mandate and its challenges in the course of their everyday work.

In the sections that follow, I examine how municipal doctors perceived their mandate and addressed SDH in providing primary care in Pune’s urban context. Municipal doctors’ experiences and narratives show how they understood the scope of their mandate, encountered SDH, and responded to SDH (or failed to do so) in the course of everyday clinical encounters. My findings suggest municipal doctors felt constrained to address SDH partly because of inadequate resources, such as Dr Amrita’s lack of access to community-based health volunteers who might have contacted at her home the mother of the boy with the hole in his heart. Doctors also felt constrained by what they perceived as the intractability of the poor and the impassability of poverty. Thus, while doctors partly recognized aspects of SDH (as Dr Amrita’s encounter and other doctors’ narratives suggest), both tangible and intangible factors constrained doctors’ responses to SDH.

5.5 Municipal doctors’ perceptions of their mandate
This section shows that, first, doctors observed that primary care mostly constituted services for RCH\textsuperscript{156} and for the treatment of minor illnesses and injuries. Evidence of municipal primary care in other cities similarly shows it to be less comprehensive in practice than its policy ideal. Second, I show that doctors observed that municipal health care was a service for the poor, that the poor were its intended beneficiaries and its foremost users. Doctors’ perceptions of their scope of service and patient population set the stage for decisions and actions they took in everyday practice.

5.5.1 To provide RCH services and basic care for minor ailments

“Primary care is RCH only,” said Dr Priya, a long-serving doctor in Pune’s municipal health service. “Family planning. Immunization. These are primary care services,” she said. Other municipal doctors in Pune and administrators in both Pune and Mumbai confirmed that view. They stated that primary care was a municipal obligation, that if the municipal health service delivered anything other than primary care (such as minor surgeries), this was at its discretion. I asked Dr Priya about health concerns other than RCH. What about the treatment of minor ailments? The fevers, colds, coughs, aches, pains, and other everyday anxieties people daily presented in outpatient consultation rooms? “We treat those things, too,” Dr Priya said. “But those are subsidiary.”

Although subsidiary in Dr Priya’s perceived scope of work, minor injuries and illnesses contributed a significant volume of outpatient cases. The RCH program followed national guidelines and ran parallel to regular operations in municipal outpatient care. Some municipal doctors and nurses were assigned to RCH duties alongside other primary care
duties: basic first-contact care and referrals for patients presenting with a range of minor ailments. Municipal doctors in outpatient consultation rooms saw heavy traffic of such patients. In some municipal clinics, doctors handled nothing but minor ailments.

Despite the high volume of non-RCH patients, Dr Priya’s view of RCH as a core municipal health care service was common among doctors. Dr Atul, who had previously worked in state government health services, explained that RCH was a priority because it significantly contributed to reducing morbidity and mortality in India. Another municipal doctor stressed that RCH services covered mostly perinatal care and care for the first few years of a child’s life. She observed that this left out, for example, health care services for adolescents. Doctors noted the municipal health service scheduled periodic outreach visits to public schools, when doctors checked school children for basic health.

What about chronic illnesses, such as diabetes or hypertension, I asked Dr Priya. Here she was emphatic: “No, chronic illnesses are not included in primary care.” Another municipal doctor with long years of experience, when queried whether the municipal mandate covered chronic diseases, shook his head definitively. “No,” he said, “the main focus is on maternal and child health.” Dr Atul noted that Pune’s municipal government did not currently have the capacity to seriously deliver services for chronic diseases, although patients needing such care did frequently arrive at municipal clinics and hospitals.

Another senior municipal doctor was more ambivalent about care for chronic diseases. These, he reflected, were “a grey area” for primary care. He acknowledged the municipal health service was “falling behind” in attending to diseases such as diabetes and
cardiovascular disease, which, he said, were “no longer specialized diseases and were very prevalent in the population.”

Yet another long-time doctor said that expanding care to cover chronic diseases would have budgetary implications for the municipal government that went beyond its legal obligations. He questioned the economic and political feasibility of such a move, asking: How would the municipal government foot the bill for treating chronic diseases and under what charge? The municipal government was “not legally responsible for that,” he reminded me. Doctors stressed that although the municipal government provided some limited health care services beyond primary care, these services were not a legal obligation. For example, it offered certain minor surgical procedures at extremely nominal rates. The municipal government made these available at its discretion, doctors pointed out.

A final service doctors recounted was infectious disease control. They noted that municipal doctors helped implement national programs for the control of infectious diseases, such as tuberculosis and polio, in the city.159

In sum, municipal doctors construed the scope of their mandate as primary care, which implied largely RCH and basic care for minor illnesses and injuries. Services for RCH (perinatal and infant care) were guided and partly funded and staffed by central and state government. Services for communicable diseases control (tuberculosis, polio) were under central and state government control. Services for non-communicable diseases were, according to municipal doctors, outside the remit, organizational capacity, and budgetary
purview of municipal government; yet doctors did regularly encounter patients presenting with chronic illnesses.

Thus, the main types of health concerns municipal doctors encountered and treated without a national programmatic guide were minor ailments for patients of all ages and chronic illnesses. Of these, doctors considered only minor illnesses and injuries as falling within the scope of the municipal mandate to provide primary care. Their views align with evidence of the limited range of services municipal governments provide in other Indian cities (MOHFW, 2013c, p. 14-17). However, as I next show, their views went further than that technical scope, capturing not only which services they considered their mandate to deliver, but to whom.

5.5.2 To serve the poor

Municipal doctors impressed upon me that a de facto aspect of their mandate was to serve the poor population of the city. “It is for the slums,” said one doctor of the municipal clinic she managed, pointing in the direction of a low-income neighborhood near the clinic. “We treat the poorest here. Those who cannot pay,” said another municipal doctor. An activist for workers’ rights affirmed this view. She informed me that, based on her experience working alongside doctors in the public sector, including in Pune,

People who work in government hospitals ... have a general understanding that they and [activists] are working for the poor. ... It is only the poor and the absolutely
desperate who have exhausted other options who use public health care services. The image of the government hospital is such, [it is] seen as a service for the poor.

Dr Priya echoed that perspective, describing the patient profile at municipal facilities as follows:

The poorest will come to municipal hospitals and [other state-run hospitals in the city] and get treated. The ultra rich will go to private hospitals, anyway. It's the middle class that suffers – they have to pay to go to the [costly] private sector.

I asked Dr Mala if she had noticed any change in the profile of patients who came for outpatient care over her years of experience in the municipal health service. “No,” said Dr Mala. “We do get some middle class people, who have figured out that we do the same tests for blood pressure or blood that are done outside for hundreds of rupees, that we do them here for cheap, for very little. So they come just for just, to get their blood pressure tested.” But, Dr Mala noted, municipal health services were essentially for and mostly used by the poor.

In sum, municipal doctors observed that although no one was barred from accessing municipal health care, the poor were its main intended beneficiaries and its foremost users.¹⁶⁰

5.6 Responding to the social determinants of health in everyday practice
As Dr Amrita’s experience above and other vignettes below demonstrate, municipal doctors did recognize aspects of the social circumstances that affected patients’ health. They felt constrained, however, to respond to SDH. Both tangible and intangible factors undergirded their sense of constraint. That is, both inadequate municipal resources and doctors’ perceptions of the communities they served shaped their everyday practices.

These practices, specifically where they concerned SDH, took at least two tacks. First, municipal doctors resorted to counsel—advising patients. Dr Amrita’s failed attempt to convince the mother to take her sick child to a hospital is one example of how doctors encountered patients’ social circumstances and counseled patients to deal with those circumstances. Doctors perceived counsel as their main option for addressing SDH, even as they variously pronounced counsel a partial and uncertain measure. Counsel is the subject of this section. Second, municipal doctors took efforts beyond providing counsel or advice, such as attempting to help poor patients obtain access to health-related services like drugs and tests. I examine these efforts in the subsequent section.

My findings show that although doctors recognized (accurately or not) aspects of SDH, they did not or could not always follow either tack in responding to SDH. As a result, they in effect practiced a diminished version of primary care.

5.6.1 The resort to counsel: Advising patients as opposed to treating them

I submitted to municipal doctors that given their mandate to provide primary care chiefly to the urban poor, they confronted not only the clinical causes of illness, but also social causes,
such as poverty and unhealthy living conditions. Doctors agreed that patients’ social circumstances mattered for health, but they were ambivalent about their role and capacity to address these social factors. Some pointed to the circumscribed ambit of their tasks from a desk in an outpatient consultation room. “At most we can counsel patients,” said one municipal doctor with long years of experience in Pune’s health service. “But this is very limited. What can we do? Only give some advice.”

Evident in their (earlier reported) reflections on Dr Amrita’s encounter with the boy with the hole in his heart, municipal doctors perceived they had few feasible options to reach patients outside the clinic or to extend their involvement with local communities. For instance, one doctor suggested a doctor might pay travel fare for the patient or send someone from the clinic to accompany the patient to the hospital. But another cautioned this was a partial, temporary measure—the patient would be alone again the next day—and questioned what else the doctor could do. I suggested community health workers could be deployed for that task, but municipal doctors were doubtful, noting that few community-based workers were associated with the municipal health service. Some clinics had no such workers at all.

Municipal doctors who had worked in state-level health services were aware of the role community health workers could play in community outreach. One doctor recounted her experience in the Maharashtra state health service, where, she said, a network of health staff—nurses, childcare operators, community-based health workers—would pester parents to take action on behalf of their children: “If the doctor’s advice does not work, then
someone else reaches the household,” she said. “Not here. Here there is nothing,” she added.

Municipal doctors lacked those outreach measures. They had to often rely on counseling patients—listening to and advising patients about health and health-related matters during patients’ visits to the clinic—to address the social circumstances of patients’ lives, as the exchanges in the next section, from Dr Vineeta’s clinic, demonstrate. And counsel alone, Dr Vineeta’s experiences suggest, was often ineffective for the poor.

5.6.2 The ineffectiveness of counsel

As Dr Vineeta, a long-serving municipal employee, sat in a municipal clinic’s outpatient consultation room one afternoon, among the patients who visited the clinic was an old, bent-over man. He walked in slowly, leaning on a bamboo stick. He wore a loose white long uncollared shirt (jhabba) and loose white pants (paijama), clothes more commonly seen in rural Maharashtra than in the city. Dr Vineeta asked the man what he did for a living. He replied he was a laborer in gold metalwork in the city. He informed Dr Vineeta that, as instructed during his previous visit to this same clinic, he had gone to a public hospital, where doctors had told him they would need to conduct an ultrasound and then consider what was to be done next. Now he was back at this clinic because of his symptoms: he had trouble passing urine.

Dr Vineeta studied his case paper.164 “That was some time ago,” she said. “You’ve been coming here for over two months. Shouldn’t you go to the doctor [i.e., a specialist]?”
The old man restated his present pain. Dr Vineeta told him, matter of factly, that his problem would not be solved at this clinic. The man parried: “Give me something for now, for relief.” Dr Vineeta wrote him a prescription and repeated her advice that he had to see a “proper” doctor.

After the old man left, Dr Vineeta informed me that the man needed to get his prostate checked. She could not examine patients here, she said, since the clinic did not have an examination table, let alone any basic equipment or supplies she might require. She had requested for such equipment, she said.

Dr Vineeta observed that it was difficult for counseling alone to be effective. With limited medical facilities within the clinic, counseling patients—advising them about remedies and urging them to seek further care—was the only recourse left to doctors. But when patients were poor and bereft, counsel could achieve little. Poor patients could not afford private medical treatment for long periods. They could not pay for treatments that required repeated visits to the doctor or that were taken over a long time. When they had exhausted what they could pay for private health care, then they came here, to the municipal health service.

In that situation—where patients were poor and had few resources and the municipal health service could extend little treatment or support—doctors’ counsel was a meager solution, said Dr Vineeta. Her narratives suggested she recognized both patients’ social circumstances and the limits of what she could do to address them:
Social problems have increased in the city. We see so many old people in trouble. A lot of old people come here. They come because they don’t have the money to go anywhere else. We tell them to foment with hot water. They tell us that they don’t have water for a bath, to take a bath, so they cannot follow the prescription.

Several old people did indeed visit the clinic one afternoon, including three old women with ailments that, among them, included a cold, a cough, body ache, and joint pain. Dr Vineeta asked each what she did, where she worked. One old woman—thin, with a dark, lined face, complaining of body and joint pains—said she did housework. She worked in five different houses, a few hours a week in each house. Dr Vineeta told her that it was time to stop working. She told another of the women that she should take two days off from work, or else the medicines she was prescribing wouldn’t have an effect, that she needed to rest.

After the women left, Dr Vineeta remarked: “They are still working, they live alone, they have to work to support themselves. They don’t have much money.” She explained to me that doctors purposively asked patients what work they did or where they lived: “With that we know where they are living, if they are staying with their family, how they are living, what they must be eating, do they get home-cooked meals…” In this way, she said, doctors learned something about the patients’ lifestyle and social background. A doctor could then anticipate constraints that might impede a patient’s recovery from illness. Knowing these constraints, a doctor could perhaps appeal to the patient or her family to persist with medical advice or treatment.
Yet, doctors were unsurprised when their advice, however attuned to a patient's social situation, failed to obtain compliance or results. Across the city, in a municipal hospital, Dr Mala counseled a young father whose second child had been born not two days before at that hospital. The young man wanted to take the newborn and mother home. Dr Mala advised him against it.

It had been a difficult labor and delivery, Dr Mala reminded the father. The baby had been born prematurely. The mother had lost a lot of blood. Dr Mala asked the father, firmly, if he recognized this. The father, holding his firstborn (a two-year-old girl) and sporting a two-day-old stubble, said he did. Dr Mala warned him the baby did not have much strength. The baby weighed very little. How would he take care of the baby and the mother at home? Was he going to put the mother to work (i.e., housework, domestic duties) when they went home? The father shook his head to say no. Dr Mala told him that at the municipal hospital, nurses were present around the clock. When mothers slept, nurses picked up babies if they cried. How would the family manage this if they went home? Dr Mala encouraged him to let mother and baby stay longer.

But this was difficult for the family, said the father. There was no one to stay with the mother and newborn in the hospital. A neighbor was going to help at home, said the man. The neighbor, a young woman, had accompanied him to escort mother and baby home. Dr Mala relented. She told the young father that he had been cautioned about the risks to mother and child. She asked him and the neighbor to declare they knew the risks and were leaving against medical advice and to sign so on the case paper, which they did. Dr Mala gave them a few tips on caring for the baby, and with that they were off.
Dr Mala clearly recognized risks looming at home for the mother and premature newborn. Her strategy to address the social factors that potentially endangered mother’s and baby’s health was to heighten the father’s sense of danger. Dr Mala knew their home was not an ideal place for rest, care, and recovery. That her appeals to the father were unsuccessful only affirmed her earlier discussion with me about the limits of counsel when the central issues were not clinical but social: gender, poverty, and education. Dr Mala had described with frustration the situation of women and daughters in poor households, who were often “the last to eat” in a hierarchy of access to food and other household resources. In an earlier conversation, Dr Mala described the case of a patient, a pregnant woman, who Dr Mala suspected was being beaten at home:

There was a woman who came [to the municipal health care facility] in her seventh month of pregnancy, complaining of stomachache. I examined her, saw that there were welt marks on her back. She had been beaten. At first she denied it but then said that her husband had beat her, he had beaten her because, he said to her, ‘how come you have money to buy medicines but you don’t have money to give me.’ She was trying to explain to him that she got the medicines for free from the [municipal health care facility] and did not buy them. He was insisting that she give him money.

Dr Mala expressed her dismay at being unable to address unequal gender relations in low-income communities. She recounted that another woman’s husband, who did not work, used to beat her. The woman worked as a domestic worker. Dr Mala described the woman’s hardship after she finally left her husband taking her children with her and said she had encouraged the woman to find a safe location to live. The woman had eventually done so,
but this was an exceptional case, said Dr Mala. In general her counsel had not helped patients, she rarely saw change in their lives, she noted. In Dr Mala’s narratives, the problem of the social appeared as an impassable challenge. Like Dr Vineeta, Dr Mala commented on the limited reach of doctors’ advice when social circumstances constrained patients’ health and access to care.\footnote{166}

Other doctors observed that conditions of poverty and the stronghold of cultural traditions and irrational beliefs made it not only difficult for the poor to comply with prescribed regimens, but also unlikely they would easily change behavior. One doctor was categorical in casting the poor as intractable patients. He had joined Pune’s municipal service relatively recently, having previously worked in the state government health service. Recounting his experiences in rural areas with low literacy levels and limited access to health care, he starkly stated of the poor: “That’s just how they are.”

Dr Vineeta further informed me that counsel may not only be ineffective, but could also backfire. Patients might not only disregard doctors’ advice, but also hesitate to return to the clinic to avoid having to listen to more advice. This seemed imminent in the following encounter, where, for the municipal doctors, the patient’s medical condition seemed a lesser concern than his social circumstances.

\textit{5.6.3 Counsel as counterproductive}

A lanky boy of about 16 came in to Dr Vineeta’s consultation room. In a mild, low voice, he said he had a cough and cold. As she had done for other patients, Dr Vineeta asked him
what he did for a living, where in the city he lived. He said he had lived in Pune for a year. He was a migrant to the city, had moved here to find work. His family was back in his rural home district. Dr Vineeta asked him how far he had studied, how many years of schooling he had completed. He replied he had attended school up to eighth grade. She told him not to interrupt his schooling: “You can continue here, go to night school.” The boy nodded.

Then Dr Padma, another doctor with long experience in the municipal health service, who was seated at the end of the table, spoke. She told the boy it was not enough to have passed eighth grade, that he should complete at least tenth grade. She advised him to come back again to the clinic in a few days. She repeated before he left: “Make sure you come back!” The boy silently nodded again, took his prescription for cold medicine from Dr Vineeta, and left. Dr Padma restated that it was important he continue schooling. She reflected on an event just past:

Yesterday there was a man here, 35 years old, alcoholic. He was in a bad state. He does not have much education and he is just drinking. I can see the same thing (happening with this boy) … we counseled (the man), but at his age, there is nothing much you can do. You have to catch them when they are young, like this boy. He should study. What’s the use of only grade eight?

When I asked how patients responded to counseling, Dr Vineeta said, firmly, of the young boy: “He will not come here again. They think, ‘I get lectured at when I go there.’ They don’t like it when we tell them things.” The doctors recognized the boy’s vulnerability as an adolescent, a migrant, far from his family. They could foresee a probable fate for him
in the city, but their advice, though well intentioned, contained no tangible support for a 16-year-old alone in the city. To the contrary, they were certain he would stay away from the clinic to avoid their matronly remonstrations.

Other municipal doctors reasoned that invoking and engaging in patients’ health needs beyond the basic outpatient consultation could unsettle patients, driving them away when they needed medical attention. This presented not only a strategic problem of how to counsel patients, but also, specifically in the case of poor patients, an ethical dilemma of whether to counsel patients.

5.6.4 The ethics of counsel

Dr Sendhil explained how such dilemmas might arise. A doctor may realize a case before him was more medically complex than the symptoms the patient presented:

The parents of a child, if they are poor and uneducated, may not even realize that their child’s height-for-weight is not right. … Poor patients are often not aware of the development of a child, what it should be. They won’t recognize that their child is not developing properly. More educated patients will know that a child should be a certain height at a certain age, they will ask me where the child’s height should be, will ask if it is appropriate, and they will ask me to check it if they suspect it is not right.
This was in part a problem of asymmetric information, a routine problem in medical care. However, in doctors’ perspectives, the context of patients’ poverty demanded a considered response on both strategic and ethical fronts. With poor patients, medical advice and counsel could have unintended damaging effects on patients’ health. Patients might not seek treatment even for the condition for which they had initially sought care. Another municipal doctor (in a separate conversation) described a case that illustrated this point. The case involved an eight-year-old girl who lived with her family in a makeshift tent near a bridge. The girl's family brought her in to a municipal hospital because of her general weakness and symptoms of flu. Blood tests showed the girl was severely anemic. Municipal doctors urged the family to admit her to the hospital so they could administer blood transfusions. They arranged to subsidize the cost of the blood needed. They waived the cost of her stay at the hospital (which was already nominal). But, after some deliberation, the family did not stay.

The anemic girl was among the more extreme cases. In routine cases, as Dr Sendhil recounted, if children required unexpected diagnostic tests, their parents might repudiate or resist medical advice:

The parents think the child is ok to begin with, so they get upset with your suggestion that they should run tests. They do not see the value of the tests. They think that they came in for a simple health problem, and they were told to do much more.
Parents could thus feel faulted for neglecting their children’s health. In part this was a matter of doctors’ tact and sensitivity towards patients. But it was also, in Dr Sendhil’s narrative, a question of ethics. As he explained, if doctors instructed parents to conduct investigations that were unavailable at the municipal health service, parents would likely have to get them done privately. This posed considerations of effort and cost for parents:

Doing tests is costly when the patient is struggling to eat, dealing with basic things within his social strata. And just doing the test is not a treatment. We [in the municipal health service] don’t have infrastructure, we don’t have facilities – unless I have these things, I can’t begin to address the question of height-for-age. … If I point out that the child may not be of the right height for his age, the parent will get upset. And if I am not ready to counsel the patient [to help the patient follow through with my recommendations], then I can’t raise the issue.

Dr Sendhil’s narratives suggested that when the municipal health service offered limited facilities and the patient had limited personal and social resources, then in such cases, to receive and to give counsel could be, for patient and doctor respectively, a burden without redress. In a context where state resources were limited and patients were many and poor, if a family arrived with an underweight child suffering from a cough and cold, doctors might treat the child only for the cough and cold. Doctors might attend to the parents’ concerns and leave aside suspicions about the child’s low height-for-weight.

When I asked Dr Sendhil to reflect upon Dr Amrita’s encounter with the boy with the hole in his heart, he conjectured that had I asked him this question some years ago, he would have replied that the doctor should have personally gone with the patient to the
hospital. But now, he said, he could see a more complex picture, and that it was complicated to ask the poor to “take on larger struggles.”

Despite Dr Sendhil’s misgivings about municipal doctors’ capacity to serve the needs of a poor population, I found he was more accommodating with patients than his qualms suggested. Many other doctors I observed did not attempt to be sanguine or forbearing and appeared to scarcely register patients’ social circumstances during clinical encounters. In many such encounters, doctors summarily examined patients, barely explained their diagnosis to patients, and perfunctorily counseled the patient on follow-up actions. This supports studies of health care-seeking experiences of the poor, which report clinical encounters in public sector facilities as quick and terse (Ergler et al, 2011; Gurtoo et al, 2013). In the next section, I present a selection of those hurried encounters to understand them from municipal doctors’ perspectives. How did doctors make sense of brief interactions with patients? What do their narratives tell us about how they perceived the challenges of their mandate, specifically the challenge of responding to SDH?

5.6.5 Counsel as impractical

While Dr Sendhil suggested municipal doctors might abridge counsel on account of patients’ complex social circumstances, he also observed they might curtail consultations for simple, practical reasons. During crowded, busy outpatient hours, they faced long patient queues they had to “clear” before the hospital closed.167 When pressed for time, they rushed through patients. They might dispense with a full medical history and basic conversation, neglect to discuss or help patients resolve health-related concerns.
Another municipal doctor observed that doctors worried about irate patients outside the consultation room. Waiting patients might raise their voices to complain if they felt the doctor was spending too much time with any one patient. Doctors would then have to confront an angry, milling crowd of patients: “Here we have to move fast with each case because if we don’t, then the patients waiting outside the door, they will pounce on us!” Some municipal facilities saw a flow of more than 200 walk-in outpatient visitors a day.

Municipal doctors’ narratives suggest that, given the ineffectiveness of counsel, incurring such disruption among waiting patients had uncertain health payoffs for the patient being counseled. One doctor said she counseled a patient if she felt the patient was amenable to advice, otherwise she did not invest the time, since she felt it would be of little use. Another doctor said, slowly shaking her head: “Our emphasis is on the medical. There is no time … And patients don’t understand even if we did counsel them.” In such cases, doctors would provide the patient a written diagnosis and prescription, but likely not a conversation about health and recovery. Engaging with patients was simply impractical because of high patient volume. Doctors reasoned that patients often did not comprehend or comply with doctors’ advice in any case, making advising patients an especially lost cause during busy hours.

Pune’s municipal clinics and hospital outpatient consultation rooms were not always busy, however. The afternoon hours, in particular, tended to be slow. Yet, on these slow afternoons too, doctors would interact briefly with patients. As I next discuss, doctors explained that counsel was at times not just infeasible but also unnecessary.
5.6.6  Counsel as unwarranted

When I mentioned to some doctors that their consultations were often short even when the municipal facility was relatively empty, they observed that many patients seeking municipal outpatient care had trivial ailments that did not require a lengthy consultation. Counseling such patients was unwarranted. They explained that in processing a high volume of patients everyday, they learned to quickly assess patients’ illnesses, and many illnesses were, in any case, minor. Doctors assured me that, even when the outpatient queue was long, they did spend sufficient time with serious cases. And, they added, they could immediately identify cases that needed attention—cases of real need would not escape due care.

Municipal doctors’ views affirmed the critical perspective of a senior health researcher, who mentioned to me that, in India, the poor received attention in state-run health care facilities only when their condition was dire, close to death. In a similar vein, several municipal doctors noted that the majority of patients’ ailments generally received summary, “symptomatic treatment.” Cases that doctors deemed not urgent often earned short, practically wordless interactions, as the following encounters show.

Dr Ashish was one of several doctors on duty one slow afternoon in a municipal hospital. Before joining Pune’s municipal health service he had worked for several years in the state government health service. In telling me of his experiences there, he observed that after doctors see volumes of patients, they become practiced at spotting serious cases among the many routine, minor cases they encountered. Dr Ashish dispensed of the apparently
non-serious cases quickly. On that slow afternoon, a woman in her 30s, wearing an abaya (signifying she was Muslim), arrived at his desk in the outpatient consultation room. She told Dr Ashish she could not sleep at night. Dr Ashish asked her how long she had been experiencing this and at what times she felt sleepy. For eight to ten days, she replied. She felt sleepy in the morning, at 6 am. Until then, she lay awake. He inquired: “Do you feel fearful or anxious? Do you feel tired during the day?” The woman said no, no fear. She just lay awake at night. After each answer that she provided, Dr Ashish wrote in her case paper and asked another question. After two more questions, he returned the case paper to her.

The case paper now contained a record of the woman’s symptoms and Dr Ashish’s diagnosis and prescription. Dr Ashish did not mention to the woman what her condition might be, why it might be occurring, what remedies she could try, which medicines he had prescribed, or whether or when she should return for another visit. He simply handed back her case paper and nodded his head, signaling that she could now leave. For her part, the woman asked no questions. She took the case paper and proceeded to the pharmacy counter where drugs were dispensed.

Dr Ashish’s next patient was a two-year-old boy. The boy’s mother said he cried when he wanted to go to the bathroom to poop. He cried when he wanted to go, sometimes he cried for half an hour before he went, and even after he did it he cried. Dr Ashish asked the mother what the boy generally ate. She replied he did not eat well; he liked only milk and biscuits. “Stop giving him biscuits, he will be fine,” advised Dr Ashish. Mother and toddler were dispatched in under two minutes.
Dr Kailash, a relatively recent municipal recruit, attended to an old woman complaining of general aches and pains. He asked her a few questions, then wrote in her case paper and handed it to her without explaining anything. After the old woman left, I remarked to Dr Kailash that geriatric care seemed very limited in public sector facilities. He shrugged. The woman had minor problems, he said.

Dr Meena listened to a Muslim woman in her 30s list her symptoms: aching hands, arms, feet, legs. She then silently wrote in the woman’s case paper and handed it to her. I asked Dr Meena, whom I had previously observed spend ample time counseling patients, why she had not discussed anything with the woman. Dr Meena’s response suggested that she construed her actions partly as a pragmatic response to difficult social problems, namely poverty and gender, and partly as an appropriate medical response to a banal health issue:

Muslim women, at home, in their families, have to do a lot of housework. They are made to work a lot. They have to wait to eat, since their families eat first. And many of the other women who come here complaining of such aches, they work as domestic help, they work many hours doing that kind of physical work. They naturally have aches and pains …

We see so many patients in a day, a hundred patients per day, that after a while you get to know very quickly [what is wrong with them]. And if they come back – many don’t come back for three months – if they keep coming back frequently, then we know that something might be wrong. Then we would examine them more in detail.
When I asked Dr Meena if she might be missing something when she did not converse with patients, she observed that doctors lacked time to counsel patients. Many patients, in any case, did not present with major illnesses. In other words, the underlying problem was social (gender relations), its manifestation was nominal (body ache), and the clinical consultation (brief, terse) was driven by practical matters of time and efficiency. Dr Meena recognized the woman’s social situation as significant for her health, but thought her health issue easy to diagnose and undeserving of much attention, at least not in the midst of seeing a hundred patients a day.

Another doctor averred that urgent cases did receive priority. “If we can see that someone needs help and someone is at high risk, then we give them more time,” but many cases simply did not require intensive scrutiny, she explained:

Some patients, they just come to visit the hospital like a trip out, they leave the house and think, let’s go visit the hospital. Really! Many patients come with body ache; we don’t spend too much time on them. It is not possible to do that.

Dr Gitanjali echoed that sentiment. As I sat in the outpatient consultation room in the municipal hospital where she worked, a pair of abaya-clad women arrived, both in their early 20s, one holding an infant in her arms. They were here for routine vaccinations for the baby. After they left, Dr Gitanjali remarked that some Muslim women made trips to the municipal hospital without medical cause. She said Muslim women were so constrained by custom to remain indoors that they visited the hospital, a legitimate outdoor activity for them, as a way to escape their home for a few hours. They came with only the pretext of
illness. “Actually, nothing is wrong with them,” said Dr Gitanjali. Some women visited the hospital every few days, she added, and doctors did not invest time engaging with such patients.

In sum, the municipal doctors above explained the brevity of clinical encounters as a function of their patient profile, i.e., many patients they saw did not warrant counsel. According to these doctors, many patients presented with minor illnesses, and doctors saw patients in such high volumes that they learned to quickly assess a patient without an extensive, or any, examination. However, other doctors from the municipal health service derided the idea that a doctor could make a clinical assessment within moments or without examining patients and their case histories. One suggested that this idea prevailed among municipal doctors due to a lack of medical hierarchy in most municipal clinics and hospitals. Barring a handful of doctors who held specialist degrees, the majority of municipal doctors held a basic MBBS degree. Most municipal doctors operated without guidance from someone holding higher medical credentials, and their clinical diagnoses and treatments often remained unchecked.

My findings suggest municipal doctors’ diagnoses and responses to patients’ social circumstances also went unchecked. Doctors appeared to recognize, accurately or not, aspects of patients’ social, cultural, and economic realities. They seemed aware of how these aspects might affect patients’ health. Yet, doctors considered counseling patients to be infeasible under constraints of time and patient load, and in any case unwarranted given the trifling, elementary nature of patients’ ailments. They understood social factors as significant for health, but judged clinically serious ailments as meriting medical attention. To explain
their neglect of patients’ routine ailments, one doctor observed that most municipal doctors operated from a circumscribed and strategic scope of work: they sought simply to control patients’ symptoms, address patients’ complaints, and ensure patients “did not die,” because a patient’s death would lead to questioning from municipal authorities. Doctors thus (mis)recognized aspects of SDH, based their provision of medical care largely on clinical grounds, and demoted counsel in that care. I return to this point—the apparent disjunction between doctors’ observations of patients’ social circumstances and their delimited counsel—further below. First I discuss doctors’ actions beyond counsel.

5.7 Beyond counsel

Apart from counsel, municipal doctors at times used opportunities to directly facilitate patients’ access to care rather than only advise patients. In some cases, doctors skirted municipal norms, going beyond regular municipal operations. The examples below present, first, an ordinary effort within the scope of doctors’ mandate, and second, a potential breach of municipal norms.

5.7.1 Ordinary efforts

When a young, thin woman in her 20s visited a municipal hospital, Dr Devika, one of the doctors on duty, strained to comprehend her symptoms. The woman walked slowly, wore thick glasses, and spoke in low, unclear speech through her uncorrected overbite. Her hair hung in two schoolgirl braids, with dry wisps haloing her forehead rather than sitting oiled
down. She presented a slew of complaints, saying she had a heart condition, then adding she had a cold and a painfully sore throat. Dr Devika was unruffled. She rifled through the sheaf of stapled case papers that contained records of the woman’s previous visits to this hospital. Numerous case papers were on file, indicating the woman had made many visits here.

In a previous conversation, Dr Devika had informed me that this municipal hospital “had a slum area attached to it.” She had elaborated:

The middle class population, they don’t come here. Mostly slum patients come here, and they are very poor. Some patients can’t even afford to pay Rs 20 (US$ 0.30) for a pediatric syrup.

The young woman who stood at her desk counted among these poor. She could not properly describe what she felt, but it seemed her chief complaint was her cold and sore throat. After some inconclusive back and forth, Dr Devika eventually prescribed cold medication. The young woman got up. Dr Devika seemed unsatisfied as she saw the woman leave, but she had to turn her attention to the next patient at her desk.

Minutes after the woman left, a hospital security guard came in to the consultation room and informed Dr Devika the woman had tuberculosis. The guard had witnessed part of the interaction between Dr Devika and the patient. The guard was a sprightly young woman who regularly trooped between the main hospital door and the outpatient consultation room. Conducting these rounds was part of her duties overseeing the flow of patients through the hospital. She was familiar with households who used the hospital and
was acquainted with the patient’s family. Dr Devika immediately told the guard to hurry and catch the patient, to bring her back to the hospital and send her for a sputum test at the hospital lab. The guard ran out. Dr Devika began filling out the form she would need for the sputum test. She said, perplexed, that the woman had not mentioned tuberculosis and there had been nothing in her file about it.

In many ways this patient was like the hundreds municipal doctors routinely encountered: the patient stated symptoms of a cold, a minor ailment needing a standard prescription, which doctors would scribble and hand over without pausing to look up. But Dr Devika used an opportunity to leverage social networks between municipal workers and the neighboring community. Both she and the guard acted quickly to avoid losing the patient to the social world outside the municipal hospital. Patients’ non-adherence to treatment is a particularly significant challenge in tuberculosis control (Munro et al, 2007; Metcalfe, O’Donnell, & Bangsberg, 2015). Researchers have attributed this challenge to health system shortfalls, including the failure of health care services to account for the social and economic constraints the poor face in accessing medical care, drugs, financial resources, and caregiving support in times of long-term illness (Das, 2007; Nair, George, & Chacko, 1997; Fochsen et al, 2009). In this case, Dr Devika actions possibly helped prevent, however marginally, those social factors from determining the woman’s health.

And yet, Dr Devika’s effort here—calling the patient back to the hospital—fell well within the municipal mandate. This is notable not because it illustrates any extraordinary effort on Dr Devika’s part (it does not), but because she could take such an action at all. In this case, informal social connections between municipal workers and the local community
enabled the doctor to bring the patient within reach of public health services, to make the patient visible to India’s massive national tuberculosis program. Those social connections afforded Dr Devika an opportunity that generally eluded municipal doctors. Dr Amrita, for instance, while imploring the mother of the boy with a hole in his heart to visit a hospital, saw no alternatives to reach the mother, knew of no social connections between the municipal clinic and the community. When counsel failed, activating local social networks were a potential resource for municipal doctors to address SDH, but such connections were scarce, as I discuss in the next section. In contrast to Dr Devika’s ordinary effort, the following vignettes show how doctors risked transgressing municipal norms as they attempted to help poor patients access medical care.

5.7.2 Potential breaches of municipal norms

“Send us your patients, we will take care of them!” announced a neatly groomed man—trim mustache, crisply pressed shirt—to doctors in an outpatient consultation room in a municipal hospital. It was a slow afternoon; the doctors were not busy. He managed a private diagnostic testing center, and he was here to gain their business, i.e., to encourage them to send him their patients for tests that patients could not or did not want to obtain from the municipal health service.

The municipal health service offered some diagnostic tests at subsidized rates, but their range was limited and procedures to access tests were time-consuming. To obtain an ultrasound, for example, a patient might have to wait several weeks for an appointment and travel to a location across the city. To be declared clinically “fit” for surgery, patients would
have to visit specific municipal hospitals and brave long lines to see particular doctors in those hospitals who could certify their fitness for surgery, hoping to catch the doctors in the hours they were present and available for consultations in the hospital. To avoid this unpredictability and slow pace, or to access tests not provided by the municipal health service, patients would at times pay to get tests at private diagnostic centers.

Private diagnostic centers, competing for patients across the city’s public and private hospitals, sometimes directly approached municipal doctors, as did this manager. However, for municipal doctors, following up on the manager’s sales pitch could constitute a breach of municipal norms. Doctors informed me that municipal administrators insisted doctors refer patients to in-house services for drugs and diagnostic tests when possible, even though, in practice, access to those services was fraught with delays and runarounds for patients. In this situation, municipal doctors at times “worked the contradiction” (Bhattacharji, 2010), navigating “between systemic exigencies and people’s need” (Sheikh, 2013, p. 85), such as by negotiating with private actors to obtain discounts for patients.

The manager handed out his business cards, talking with each doctor in turn. One municipal doctor said she had a patient who needed a CT scan. “How much will you charge?” she asked. The manager inquired if the patient was an adult and was “affording,” referring to the patient’s ability to pay. The doctor said the patient was an adult and added, “No, he is not affording, that’s why I am asking, or I would not have asked.” The manager quoted a rate: “It will be Rs 3,500 (about US$ 52). For [child patients] it is Rs 2,500 (US$ 37).” He added that if the situation was truly critical, he could do it for Rs 3,000. The manager instructed her on how to get the discount applied to the case. The doctor nodded.
Another municipal doctor, who had not been present at the above incident, later explained how doctors’ requests for such discounts helped patients. “We negotiate a price with the private provider. If the cost [of a test] is Rs 600, we ask for 50% discount from the private center and we get it.” The patient enjoyed the lowered price for the service. The doctor simply facilitated the discount. When I remarked that a 50% discount seemed like a significant break in price, the doctor replied that private doctors asked for even higher reductions. In return for their continued referrals to a specific testing center, private doctors would ask for “cuts” of up to 60% of the listed price of the service. Patients would pay full price and the private doctor would pocket a portion of that amount. In contrast, municipal doctors asked for a lesser discount of 50%, a discount they secured for the patient and not a share they allotted to themselves. The diagnostic testing centers agreed to those smaller discounts, he said.

The doctor then turned to his colleague seated in the outpatient consultation room. He shared with her his experience of that form of corruption rampant in the health care industry, namely kickbacks for referrals. When he had recently telephoned and requested a discount for a patient, the private diagnostic center had asked if they should make the discount out to him, the doctor. He had told them to give the discount to the patient. “Why lose one’s reputation over Rs 500 (about US$ 8)?” he questioned, shaking his head, wondering aloud about municipal doctors who might be tempted to do so. The other doctor nodded in agreement.176
In another instance, a trio of doctors expressed a similar concern about their reputation. The doctors deliberated about a patient who needed specific drugs the municipal health service could not provide. The doctors considered whether they should approach a pharmaceutical company so the patient might obtain the drugs cheaply. One doctor suggested they call the pharmaceutical company representative who had recently visited the municipal hospital and ask if he could help. But the others seemed circumspect. In a previous conversation, municipal doctors had informed me that although pharma reps selling their brands courted them in municipal hospitals, such marketing practices were prohibited in state-run facilities. Another doctor cautioned that if they did too much for the patient, it might reflect badly on them. “We might be trying to help the patient, but it ends up looking like we are getting too close to the drug company,” he alerted his colleagues. “What if we just put the patient in touch with the rep, and say to both of them that all we are doing is putting you in touch with each other, and you can work it out from there?”

As these cases show, the dominance of the private sector was palpable across the municipal health service. At times, private actors were literally in attendance within municipal health care facilities. In contrast to evidence from LMICs showing how public providers might seek rents, such as by charging patients informal under-the-table payments in exchange for services (Berlan & Shiffman, 2011; Banerjee & Duflo, 2006), here municipal doctors helped patients pay less than ticketed prices for private services. Patients obtained lower rates on private costs they would inevitably bear, with discounts enabled by state agents.
But although state agents (the doctors) initiated the discounts, the state did not officially endorse such discounts. That is, when municipal doctors approached private actors to ease patients’ access to tests or drugs, they knew municipal authorities perceived such ground-level collaboration with the private sector as antithetical to the municipal mandate. Municipal administrators publically acknowledged that municipal services were meager and overstretched (Isalkar, 2012), but denounced doctors’ engaging with private entities (Satphale & Devikar, 2013). Administrators regularly lamented that there was only one official post for a sonographer (to conduct ultrasounds), who was to serve selected municipal facilities across the city (Isalkar, 2012). The sole sonographer visited those municipal hospitals on allotted days to conduct tests for patients at each location. Administrators had, in recent years, trained a few doctors to perform this service, but demand was greater than the municipal health service could meet. Yet, at the same time that administrators recognized these inadequacies, they could not formally condone doctors’ sending patients to private diagnostic centers for tests the municipal health service ostensibly offered in-house.

Consequently, in their everyday work, municipal doctors were wary of being “caught” in the act of referring a patient to a private center for an ultrasound. Doctors’ caution stemmed in part from local media reports of patients unable to obtain ultrasounds at municipal facilities and directed by municipal doctors to access the tests privately (Satphale & Devikar, 2012). Municipal administrators had denied knowledge of such practices (Satphale & Devikar, 2012) and, according to municipal doctors, had told them to desist from referring patients to private services for drugs or tests that were meant to be available from the municipal health service. Yet, for municipal doctors, engaging in small ways with the private sector in the course of their everyday work was inevitable, even as it invited
official sanction. (I take up the tenor and influence of local media upon the municipal health service in the next chapter, entitled Risk).

In sum, municipal doctors at times drew upon their networks with either local communities or private sector actors to help patients access medical services. While activating local social connections fell within their scope of service, this was a difficult strategy to systemically practice, since such connections were scarce and contingent on municipal facilities and city locales. On the other hand, negotiating with the private sector was a potential breach of municipal norms, but it was a ready option given the ubiquitous private sector in the city. On balance, however, neither doctors’ counsel nor strategies beyond counsel adequately addressed the social conditions of patients’ lives. I next discuss why these strategies fell short.

5.8 Explaining municipal doctors’ failure to address the social determinants of health

Both tangible and intangible factors constrained municipal doctors from addressing SDH. Tangible factors include material resources and community-oriented social support services. Intangible factors include doctors’ perceptions of their mandate and the communities they served. Together, these factors evoke three explanations for doctors’ failure to address SDH. One, the state’s neglect of urban primary care, which contributed to material and organizational inadequacies of municipal health care and doctors’ inability to reach patients outside the clinic. Two, an avid private sector, which contributed a covert though ready pathway for municipal doctors to facilitate patients’ access to (private) health care. Three, social and institutional exclusion of the urban poor, which contributed to doctors’
misrecognition of the workings and possibilities of responding to SDH. I discuss each of these in turn.

5.8.1 State’s neglect of urban primary care: Inadequate material and organizational infrastructure

National health policy has consistently espoused a role for health care providers to recognize and respond to SDH, especially at the level of primary care. But health programs have done little to support that role in practice, particularly in urban areas. Municipal primary care especially lacks organizational and material resources, limiting doctors’ capacity to reach the urban poor.

With respect to organizational resources, few community-based health workers are associated with urban primary care services (MOHFW, 2013c; 2014b), even though in rural areas the state has expanded their ranks (MOHFW, 2013a; 2013b). In Pune, community health workers in the municipal health service were attached to RCH services and were monitored by doctors in charge of planning and implementing these services. Municipal doctors uninvolved in RCH-specific activities did not draw upon these workers or their community contacts, which extended largely to pregnant women and new mothers. RCH services comprised a strong focus on antenatal care, as they do across Indian cities (MOHFW, 2013c). Women in Chennai, for instance, viewed municipal primary care services as being “of no relevance” to their needs, since “in their experience [these] were facilities only for pregnant women” (Nambiar et al, 2016, p. 36). Tangible social connections between the health service and the community were therefore limited in both the number and kinds of health issues and populations they engaged.
As a result, Dr Amrita could mobilize no community-based social network from her clinic to reach the sick boy’s mother at their home and could ensure no follow-up of any medical advice she gave the mother. Municipal doctors’ inability to reach patients outside the clinic limited their capacity to address patients’ social circumstances and uphold the idea of primary care, i.e., provide long-term, continuous care for families.

While municipal doctors were limited in reaching patients within local communities, they were also constrained to coordinate patient care and treatment with higher tiers of the health system. Doctors worked with few material resources: Dr Vineeta had no functional examination table at her clinic, and another municipal doctor had to refer an old man for a basic hearing test to a larger hospital. These limited resources made it difficult for doctors to follow up care for patients they referred. Moreover, inadequate treatment at the primary care level resulted in overcrowding in tertiary hospitals, a common situation across Indian cities (MOHFW, 2013c, 2014b).

In sum, limited material and organizational resources at the level of primary care impeded municipal doctors’ capacity to address SDH. Unable to either reach local communities or to provide appropriate medical care at primary level, municipal doctors were constrained in following up on both medical and non-clinical advice they gave patients. Dr Amrita’s entreaties to the mother to return the next day with the boys’ previous medical reports, or Dr Padma’s attempts to counsel the teenage migrant to stay in school, ultimately held little succor or substantive support for patients. They were well-intentioned appeals without ballast.
Where doctors tried to provide such ballast—took concrete actions to aid patients instead of providing only advice—their efforts were either contingent on chance social connections or else fraught with the risk of violating municipal norms. Doctors could seize opportunities to use fortuitous social connections between municipal health services and local communities, as Dr Devika did in bringing back to her hospital for further tests a likely tuberculosis patient. These actions potentially did more to ameliorate SDH than just counseling patients. Such social relations were not, however, wide and active. In contrast, private sector actors were readily accessible, though doctors’ attempts to connect patients with the private sector were furtive and risky, as I next discuss.

5.8.2 Commercialization of health care: Private sector as a resort to care

Private health care providers and suppliers of related goods and services (drugs, diagnostics) have expanded in urban India alongside the state’s marginal attention to urban primary care. Private providers are pervasive in cities, accounting for 80% of all outpatient transactions (IIPS & Macro International, 2007). Confronted with a range of services they could not expediently provide within municipal precincts—hearing tests, ultrasounds, CT scans—municipal doctors at times turned patients to private purveyors of those services. Among Pune’s municipal doctors, this was not, as far as I discerned in my fieldwork (and despite implicit suggestions in media reports (Satphale & Devikar, 2013)), a ploy for kickbacks but an attempt to aid patients (see endnote 176). When municipal doctors negotiated with private entities on patients’ behalf, they addressed one of the most significant social factors
impeding access to health care and recovery from illness: cost of care and its economic burden on the poor.

However, in negotiating with private actors, municipal doctors inadvertently set up an unofficial conduit between the state and private services. Their efforts blurred the boundaries between public and private services in a way that is less emphasized in the literature on public-private partnerships in health care. That is, researchers have described a muddying of borders between the public and private sector when, for example, public providers levy nonstandard, under-the-table fees for routine services, a practice common in LMICs (Leonard et al., 2013). Also, in India, official state contracts with private providers to implement national tuberculosis control programs obscure boundaries between the two sectors (Baru & Nundy, 2008). My findings suggest another way that such blurring may occur, namely, when public providers, working under constrained organizational resources, informally look to private providers to procure market concessions or quicker services for the poor. While this strategy benefited a few patients in Pune, it effectively reinforced the dominance of the private sector in the city and did little to shift the economic consequences of illness for the urban poor. Municipal doctors attempting to obtain relief for the poor at times facilitated people’s access to private services rather than reducing their resort to it.

As I discuss next, other reasons underlying municipal doctors’ failure to address patients’ social conditions lay not in the nature of municipal health-related infrastructure, but more fundamentally in doctors’ interpretation of those social conditions and of possible non-clinical responses.
5.8.3 Social and institutional exclusion: Doctors’ misrecognition of health of the poor

As I have shown, municipal doctors cited counsel—advising and directing patients—as one of few remedies they had to address SDH. But doctors widely perceived counsel as potentially ineffective, counterproductive, unethical, impractical, or unwarranted. They applied it doubtfully, sparingly, or not at all.

Doctors’ narratives suggest that while they acknowledged social factors could potentially affect patients’ health, they misrecognized—incompletely or wrongly conceived—the nature and workings of those social factors and the possibilities for addressing them. That is, patients’ problems arising from social circumstances, such as age, gender, poverty, and religion, did not always elicit a commensurately engaged response from municipal doctors. Dire social conditions could at times, ironically, diminish the attention patients received. For instance, deeming a poor patient unlikely or unable to follow their advice (e.g., about tobacco or alcohol consumption), doctors might abridge or withhold counsel. Understanding a married, middle-aged Muslim woman’s chronic body ache as unsurprising given her heavy housework load, they could judge the clinical consultation did not merit time or effort. Doctors might dispatch an old woman with over-the-counter pain medication, shrugging away her symptoms as standard and inquiring no further into her health. They might chide the parents of a sick child for not following medical advice, even as they knew their patients often needed economic and caregiving support.

How do we make sense of doctors’ apparent understanding (accurate or not) of patients’ social conditions and their summary interactions with patients that seemed at odds
with that understanding? One explanation would be to characterize municipal doctors’ abbreviated interactions with patients as a “coping mechanism” (Lipsky, 2010). As Lipsky observed, frontline service providers deploy a variety of coping mechanisms to psychologically and practically manage challenges resulting from overwhelming demand for public services and limited resources to satisfy the volume and substance of that demand.\textsuperscript{181} By this account, we might argue that, to adjust to their inadequate material and organizational resources, municipal doctors pronounced time as short and patients’ illnesses as non-serious, thus modifying their perceptions of their clients and simplifying and rationing their efforts (see, for example, Vedung (2015), Nielsen (2006), and Halliday et al (2009) for aspects of frontline workers’ coping mechanisms in varied settings).

But explaining doctors’ attitudes and actions as a coping mechanism, while relevant and important, is a broad and possibly incomplete explanation, for at least two reasons. First, it does not fully explain doctors’ delimited counsel during slow afternoons when there was no pressure of demand. Second, as Musheno and Maynard-Moody (2015) note, researchers have shown that frontline state agents regularly balance “competing demands” in “complex, multidimensional webs of accountability … the challenge for future research is to better understand how front-line workers operate within these webs of obligations, relationships and meanings” (p. 171). For instance, researchers have compiled much evidence on street-level bureaucrats’ “discretion.” But by framing discretion as the decision-making latitude that street-level bureaucrats activate in their role as “state-agents,” researchers have overlooked the intertwining of “culture, agency and structure” in frontline work, or the decisions that street-level bureaucrats make as “citizen-agents” (Musheno & Maynard-Moody, 2015, p. 169).
Taking that cue, I turn to three alternate reasons for municipal doctors’ actions of delimited counsel. These reasons suggest that while we may term doctors’ anemic responses to SDH as coping strategies given few municipal resources, we may discern, in their actions, other features of state-provided health care that constrained their actions. These explanations also point to varied strategies (other than improving health care infrastructure) for enhancing how municipal doctors address SDH in their everyday work. I next discuss these three explanations.

5.8.4 Doctors’ competencies to address social and institutional exclusion

One explanation lies in doctors’ weak communication skills and insensitivity to patients’ needs and expectations of care. It emphasizes their “responsiveness” to patients, i.e., non-clinical aspects of providers’ behavior (WHO, 2010; Berendes et al, 2011; Basu et al, 2012). Measures of responsiveness capture providers’ ability to interact with empathy and respect patients’ dignity, autonomy, and concerns in the course of providing medical care. (However, as I previously showed, measures of responsiveness do not entirely illuminate doctors’ understanding of or actions to address SDH; see section 5.4.3 for a critique of responsiveness).

Another explanation lies in doctors’ stigmatizing attitudes, i.e., knowing or unintentional “bias and discrimination … embedded in the minds of those implementing policies and laws” and “ideological constructions that justify [social] exclusion by defining who fits in the social mainstream and who doesn’t” (Batliwala, 2011, p. 23-24).
of stigma and discrimination in health care encounters abound in the India-focused literature. For instance, studies of poor women’s experiences during pregnancy and childbirth show how nurses mete out hurried, neglectful treatment and admonishments (Hulton, Matthews, & Stones, 2007). Studies document how providers might put on gloves before touching dalit (untouchable caste) patients or flatly deny care to transgender people or people with disabilities, as Nambiar et al (2016) report. When Pune’s municipal doctors dismissed as routine the pains of old women or characterized young Muslim women as seeking care without medical reason, their attitudes reflected their biases and conceptions about age, gender, and religion.

The above two explanations underscore doctors’ deficient interpersonal skills and social biases. They focus on the dynamics of the individual-level clinical encounter, on the exchange between provider and patient. Related solutions would strive to make that exchange humane, respectful, culturally appropriate, and emotionally satisfying for the patient. They would highlight, in particular, developing providers’ “cultural competency.” As Metzl and Hansen (2014) describe, cultural competency is the “rubric most often deployed in U.S. medical education for addressing the tensions of … clinical encounter[s]” that can result from “the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference” (p. 126). It involves training providers to identify “cross-cultural expressions of illness and health” and building skills in “communication, diagnosis and treatment” that take into account patients’ social identities, vulnerabilities, and cultural diversity (Metzl & Hansen, 2014, p. 126). Nambiar et al (2016) note, for example, efforts of the Mumbai-based NGO named SNEHA, which has “trained more than 2,100
public hospital staff to better identify patients who may be victims of domestic violence,” aiming to address providers’ biases and sensitize them to victims’ needs.  

A third explanation—apart from doctors’ interpersonal skills and social biases—helps elucidate municipal doctors’ narratives, specifically narratives where doctors acknowledged patients’ vulnerabilities but decided the situation was impassable or the patient intractable. Based on emerging approaches in SDH-related research, I argue that the discord between what doctors appeared to observe and how they decided to respond shows the limits of providers’ “structural competency” (Metzl & Hansen, 2014; Reich, Hansen, & Link, 2016). As discussed above (section 5.4), structural competency encompasses providers’ capabilities (knowledge, skills, attitudes) not only to communicate about, diagnose, and treat people’s individual-level medical concerns, but also to recognize and act upon the structural bases of people’s exclusions from health care (Reich, Hansen, & Link, 2016). Referring specifically to medical practitioners in the US, Reich and colleagues (2016) advocate for clinicians’ competency to address SDH within and outside the clinical encounter. This can be done, they note, through interventions ranging from collaborating with community organizers to assess patients’ exposure to health risks, to enabling patients’ access to basic needs and social support alongside medical care, to participating in policy advocacy to address the “fundamental causes” (Reich, Hansen, & Link, 2016) of disease.

On that account, municipal doctors’ narratives suggest they understood at least some structural impediments to patients’ health and access to care. For example, when doctors reflected on why the mother in Dr Amrita’s clinic did not take her sick child to a hospital, they cited possible economic and social barriers: she had other children to care for at home,
could not bear the cost of transport to the hospital, could not pay again for a case paper (for a consultation), did not have the time to wait in line at the hospital, already knew she could not afford the child’s medical treatment. Dr Padma projected how a 16-year-old boy alone in the city was vulnerable to health risks—she recalled the case of a 35-year-old alcoholic patient to illustrate the likely trajectory of the teenager’s urban migrant life if he abandoned his education. Dr Vineeta described how she took measure of patients’ social conditions: by inquiring what work they did, where they lived and with whom. In these instances, municipal doctors’ narratives suggest they understood how life and work in the city hindered the health of the poor.

Yet doctors did not address those urban conditions, citing counsel as a meager solution and recounting few options beyond it. Doctors’ spare, resigned, and doubtful approach to counsel suggests they saw those social factors as “timeless” and “immutable” rather than as amenable to change (Metzl & Hansen, 2014, p. 130). Doctors seemed to emphasize the “stickiness of tradition” rather than view the marginalization of social groups as “actively reproduced,” including through “modern, ostensibly ameliorative state practices” (Doshi, 2013). Doctors’ narratives suggest they fell short in realizing (or at least expressing) a core structural competency: to see how structural influences on health “reflect specific financial, legislative, or indeed cultural decisions made at particular moments in time … [and] are subject to various forms of intervention” (Metzl & Hansen, 2014, p. 130). In other words, municipal doctors painted a narrow structural canvas: they delineated, for example, financial constraints of the urban poor, but did not discuss fragmented (or supportive) urban social networks. Their narratives described their role as providing primary care as a medical intervention within the clinical encounter, not as a structural intervention that
engaged with actors and processes outside the clinic in fields other than health care, a core
tenet of social determinants-based approaches (CSDH, 2010; HLEG, 2011) going back to
Alma Ata (WHO, 1978). Municipal doctors failed to address SDH in part when they did not
connect their observations of patients’ social need with tangible resources in the city to aid
patients.¹⁸⁷

Municipal doctors’ counsel remained limited to behavioral advice to patients. This
underscores a need for the kind of medical education that Baru and Sivaramakrishnan (2009)
advocate for the India’s health care workforce, whereby doctors, “instead of focusing
excessively on behavioural modification at the individual level, … make their practice more
relevant by applying their understanding of the social context of health and ill health” (p. 33).
Such medical education would produce doctors who are “socially sensitive” and “well
informed and up to date with the current debates in public health” (Baru &
Sivaramakrishnan, 2009, p. 33).

Doctors so trained, however, would still require organizational resources within and
beyond health care services, including social relations with communities, to substantively
address population health. As Metzl and Hansen (2014) observe, “medical education is a
modest attempt,” a beginning, an initial move, “to promote new forms of coalition” to
combine biomedical knowledge and analysis of social systems to improve health. For state
agents to see themselves not only as service providers but also as transformational actors
who can foster the space for social change (Evans, 2009), they require not only social
connections with the communities they serve (Szreter & Woolcock, 2004a; Evans, 2009;
Swidler, 2009) but also institutional, intersectoral connections to multiple state agencies and
non-state actors, as SDH approaches recommend (Nambiar et al, 2015; Cowling, Dandona, & Dandona, 2011).

Evidence suggests such initiatives are feasible, although so far mainly NGOs and not the state have led the way for multidimensional, ground-level health care initiatives. One example is the intersectoral approach of the Mumbai-based NGO SNEHA. SNEHA not only sensitizes health workers to domestic violence issues (thereby developing their cultural competency) but also builds relationships with state agents—police officers and public health care providers—to improve women’s access to health care and legal assistance (SNEHA, 2014; Nambiar et al, 2015). These pathways enable public health care providers to not only medically treat victims of domestic violence (in theory with sensitivity, without stigma), but also refer them to legal aid and social support (Nambiar et al, 2015).

Interventions that do not provide multidimensional resources—that do not or cannot address social, economic, legal, and other barriers to care and support—can face challenges in reaching the vulnerable. For example, the Goa-based MANAS project integrates treatment of common mental disorders (CMD) in public and private primary care facilities (Chatterjee et al, 2008). The project trains and relies on low-cost, skilled lay mental health counselors who, “along with the existing primary care doctor, would detect and provide treatments for CMD with the support and supervision of a visiting psychiatrist” (Chatterjee et al, 2008, p. 40). While the MANAS project aims to reconfigure both “the human resources and the principles of care delivery in primary care” (Chatterjee et al, 2008, p. 40), evaluations show that doctors and lay counselors found it difficult to work with “patients with extreme social difficulties” for which they could offer no succor (Pereira et al, 2011, p.
5. According to the project’s doctors and counselors, some patients accepted life stressors as normal and felt that health care could not ameliorate those stresses, which affected their adherence to treatment and recovery from ill health (Pereira et al, 2011).

In Pune, municipal doctors generally lacked access to both social support resources for patients and active social relations with the communities they served. They were largely unable to address SDH within and outside clinical encounters. In contrast, as I note above, municipal doctors could more readily facilitate patients’ access to the ubiquitous, flexibly available private health care sector, as I note above. Forms of social and institutional exclusion not only resulted in low quality of care for the poor, but also potentially reinforced their reliance on the dominant private sector.

5.9 Concluding discussion about service

5.9.1 The municipal mandate for primary care: Policy, perception, and implications for practice

Although national policy texts describe primary care in comprehensive terms, municipal doctors in Pune understood its scope narrowly as mostly RCH (particularly antenatal care), infectious disease control, and some basic treatment of minor ailments. This disjuncture between national health policy and state agents’ interpretation of that policy on the ground reflects in part an inconsistency between policy statements and street-level programs in India. That is, despite espousing a broad scope of primary care in health policy texts, the Indian state has prioritized RCH and infectious disease control in its national health
programs. Central and state-level governments support those health sector priorities in budgets and organizational resources: to various degrees, they finance, design, and manage infectious disease control and RCH programs in both rural and urban areas. For frontline state agents such as municipal doctors, working at the level of primary care implies working under the aegis of programs for RCH and infectious disease. These programs shape what doctors perceive is the scope of primary care.

By contrast, treating minor ailments counts among those few aspects of medical care that the municipal government is obliged to provide and enjoys the discretion to decide how to provide. But state support for municipal health care (other than grants to implement national health programs) has been marginal, incommensurate with urban growth (see Chapter 4). Minor ailments were likewise marginal or subsidiary in municipal doctors’ interpretation of the scope of primary care. Municipal doctors’ narratives suggest a correspondence between tangible and intangible aspects of health care: both program priorities and the local imaginary of primary care indicate a limited mandate for state-provided primary care, even if national policies espouse a more comprehensive scope.

Thus, much as Haney (2002) charts Hungarian welfare policies and on-the-ground casework over decades of major political-economic change, we might trace India’s national health policies and on-the-ground urban primary care services over decades of liberalization reforms. A key contrast between these cases is that, in India, state-provided urban primary care has remained virtually unchanged since the 1980s. That is, like the caseworkers in Haney’s study, municipal doctors operate in a changing political economy. But unlike those caseworkers, whose resources and approaches to deliver welfare shift under evolving state
policy, Pune’s municipal doctors discharge a static remit of work. Municipal doctors’ narrow perceptions of their mandate reflect those bounds. Their practices reflect the strains of those bounds, i.e., the everyday challenge of managing the discord between health and social needs on the ground with an unchanged formal scope of work.190

How are we to address the health care implications of delimited national programs and the narrow local imaginary they can engender? A key challenge lies in breaking through state agents’ circumscribed notions of service provision, which can impede initiatives to extend services for under-served health issues such as mental health and chronic disease.

Evidence of this challenge comes, for instance, from task-sharing (also known as task-shifting) initiatives. These equip non-specialist medical practitioners and community health workers to identify and deliver basic, first-contact care for certain diseases (Patel et al, 2013; Beaglehole et al, 2008). A chief hurdle in such initiatives is that practitioners may operate under unclear roles and be unwilling to take on novel competencies and functions. Studies show their unwillingness stems partly from work overload and infrastructure constraints (Ngo et al, 2013; Mendenhall et al, 2014; Beaglehole et al, 2008; Patel et al, 2013). My findings suggest their reluctance may also derive from how they perceive the remit of their mandate. In Pune, municipal doctors took their cues from national health programs, which have long emphasized RCH and infectious disease control, and from the municipal mandate, which provides little formal guidance on the matter. (I explore this point further in the next chapter, entitled Rück, where I show how municipal doctors’ understanding of their mandate and the risks of stepping outside it constrained their response to treating chronic disease.)
5.9.2  Addressing the social determinants of health, the ideal of primary care, and the limits of “responsiveness”

Municipal doctors pronounced municipal health care as a service mostly for and used by the poor, and concurred that patients’ social circumstances affected their health and recovery from illness. Their perspectives aligned with national policy and related texts, which acknowledge the importance of addressing the social and not only the biomedical determinants of health (HLEG, 2011; MOHFW, 2013b, 2013c). However, municipal doctors stressed they were constrained in practice to address SDH. In this they diverged from the ideals of primary care encouraged in policy (although they reflect the paucity of state resources to address SDH on the ground (Cowling, Dandona, & Dandona, 2012; Nambiar et al, 2015)).

Municipal doctors’ signature clinical encounter was a brisk exchange with delimited counsel and a hastily written prescription. This approach belied the purpose and advantages of primary care. Studies suggest that, relative to specialists, primary care providers can produce as good if not better health outcomes for the treatment of common ailments, in part because of the comprehensive, continuity-of-care, community-oriented approach that is integral to primary care (Starfield, Shi, & Macinko, 2005; Kruk et al, 2010). In taking that ideal approach, primary care doctors can address co-morbidity (looking into multiple ailments at once, not only symptoms specific to a particular disease), detect disease in its early stages, and investigate not only disease-specific factors but also patients’ other related concerns (Starfield, Shi, & Macinko, 2005).
Municipal doctors squandered opportunities to provide that ideal of primary care. They focused largely on isolated, immediate symptoms that patients presented (common cold of an underweight toddler, body ache of an old woman) and hesitated or neglected to inquire into patients’ related concerns (a child’s developmental milestones, aging-related concerns ranging from nutrition to hypertension). They acknowledged health-relevant social conditions in the communities they served (gender relations in Muslim households, older adults living with little familial and economic support). But they applied counsel sparsely or with resignation, reserving intensive attention for cases they considered clinically urgent.

In sum, although India’s health policy has long espoused attention to SDH in primary care, in practice, municipal doctors’ brief consultations, symptomatic treatment, and limited counsel fell well short of that goal. In minimizing and routinizing their engagement with patients, doctors failed to inquire into the specificities of patients’ ill health, identify both social and biomedical risks for disease, and catch the beginnings of potentially serious problems. Operating largely without social relations with communities they served and without social support services to act upon patients’ social circumstances, municipal doctors were generally unable to address SDH. They were at times more readily able to facilitate patients’ access to the ubiquitous private health care sector. Doctors’ practices not only undermined the ideals of primary care, but also potentially reinforced the dominance of the private sector.

Those practices show that municipal doctors often foundered in their “responsiveness” (non-clinical aspects of service delivery) to patients as defined in studies of
health care quality, supporting the common finding that public providers do worse than private providers on this score (Basu et al, 2012; Berendes et al, 2011; WHO, 2000; 2010). I argue, however, that municipal doctors’ short, brusque interactions with patients may only partly be explained by poor interpersonal skills and cultural competency (see Metzl & Hansen, 2014). Rather, municipal doctors’ abbreviated counsel and minimal patient engagement reflect in part their (mis)recognition of patients’ social conditions and of their (meager) options to address those social conditions, i.e., their structural competency (Metzl & Hansen, 2014).

Researchers have proposed to enhance providers’ responsiveness via training and incentives (Das & Hammer, 2014). But my findings question the likely impact of these interventions if providers lack social connections with the communities they serve (Evans, 2009; Szreter & Woolcock, 2004a) and intersectoral, institutional support toward which they can direct patients (see Nambiar et al, 2015; 2016). That is, while the interventions might equip and motivate providers to speak more respectfully with patients, they may not enable them to aid patients’ access to care and recovery from ill health. Providers may score higher on measures of responsiveness, but even this improvement should give us pause. As Fountain (2001) argues of the US, principles of client orientation or “customer service,” when applied to state-provided service delivery, “may lead to increased political inequality (power differentials in society) even as some aspects of service are improved” (p. 55).\(^1\) For health care in LMICs, Fountain’s (2001) thesis resonates and merits further study. In Pune, municipal doctors’ experiences and narratives suggest that despite any probable improvements in their “responsiveness,” their incapacity to address SDH would undermine equitable and effective health outcomes for the poor.
5.9.3 Municipal mandates, the history of welfare, and the multilevel state

What do municipal doctors’ understanding of their mandate and responses to SDH tell us about the workings of the state? My findings concur with research showing how structural violence unfolds at the frontlines of service provision—how everyday procedures of the state can effect denials of care for the poor (Gupta, 2012). But my analysis qualifies that argument in several ways. First, in Pune, the denials the urban poor experienced in seeking municipal health care derived not solely or primarily from failures of policy implementation, but also from the priorities and design of state programs and from social discrimination outside of state-society interactions. Whereas Gupta (2012) attributes deficient development outcomes to modalities of state operations in India, my analysis suggests we ought to consider the emphases of state health programs as well as non-state sites of social exclusion, as lessons from development programs in India indicate. Those factors can shape how state agents interpret their mandate, resolve its challenges, and relate to the communities they serve.

Municipal doctors’ focus, for instance, on urgent medical problems rather than routine ailments, their seeking to ensure, as one doctor put it, mainly that the patient “did not die,” constitutes a stark denial of care that has parallels in the history of welfare in India. Critiques of India’s food policy similarly depict a wrenching refusal from the state of everyday succor for the poor. For instance, Amrith (2008) notes the state’s concern with starvation deaths rather than endemic hunger: “Starvation deaths’ are acutely sensitive in modern India; the political position of hunger has been more ambivalent and complex” (p.
In a similar vein, municipal doctors’ narratives suggest that, in Pune’s municipal health service, patients’ medical complications and death represented certain political peril (I explore this further in the chapter on Risk), but patients’ endemic sickness and poverty was a quotidian, indistinct concern. Doctors worked as though their task was to ensure the patient’s condition did not worsen, not to strive towards the patient’s health and wellbeing.

Municipal doctors’ restrained service delivery lies, I argue, in the discord between program priorities and population needs. Theirs was not simply a case of “bad implementation,” a charge that the media and politicians have often leveled against public officials responsible for administering food security policy in India (Sainath, 2001). The journalist Sainath (2001) observes that the media’s “exclusive focus on starvation deaths … disconnected from the larger canvas” of problems of widespread hunger and agriculture crisis, misrepresents the problem of food security (see also Mander, 2008). Although the media reports starvation deaths as a failure of implementation, blaming frontline state agents and administrators, the problem lies in the design of the Public Distribution System (for distributing subsidized food grains to eligible households), misallocation of public budgets, and a “gutted” public health system, among other policy failures (Sainath, 2001).

Gender-focused development programs provide another example of how social exclusion may inhere in policy design and thereby manifest in bureaucratic procedures (Doshi, 2013). If development programs fail to ameliorate gender-based social and economic inequalities, argues Doshi (2013), the reasons may lie not in state procedures, but more fundamentally in the ways programs conceive and naturalize women’s caregiving role. Similarly, municipal doctors’ practices of normalizing the ailments of the elderly suggest
something besides a street-level coping mechanism (Lipsky, 2010), such as stereotyping clients to manage overwhelming client demands against limited resources. Rather, doctors’ practices may also reflect social exclusions manifest in primary care services, which operate under anachronistic conceptions of (and make no concessions for) features of urban social networks and sources of economic and familial support for older adults (UNFPA & HelpAge International, 2012).

The low quality of municipal primary care thus indicates not just an implementation problem, where incompetent state agents (municipal doctors) corrupt, routinize, or deny the delivery of health care to the urban poor. Rather, it evinces the state’s neglect of urban primary care, among other urban public services, which has seen few upgrades commensurate with urban population growth and diversity, rising intra-city inequality, shifting disease burden in cities, and an avid, largely unregulated private sector (see sections above and Chapter 4). If municipal doctors conceived primary care narrowly, if they failed to address SDH even when they acknowledged that patients’ social conditions affected their health, then these street-level bureaucratic perceptions and practices indicate the debilitating effects of decades of “policy drift” (Hacker, 2004), not only modalities of state functioning (Gupta, 2012). (I explore this point further in Chapter 7, entitled Authority, where I analyze the effects of urban health and development policy on sources of authority in municipal health care).

The second qualification to the argument that state procedures explain the state’s denial of care concerns sites of social exclusion outside of formal state-society encounters. Gupta (2012) emphasizes that “uncaring” modes of state functioning apply to state
procedures, not to attitudes of state agents. However, I propose that attitudes of state agents towards the poor can matter intimately in their providing health care. For instance, municipal doctors considered it futile to address SDH in part because, as one doctor observed of the poor, “that’s just how they are.” To understand how municipal doctors arrived at and sustained this view would require studying doctors as citizens, in their social worlds, within and outside municipal-clinical settings.

Doshi (2013), for instance, argues that to explain how state procedures might sustain gendered violence, we may need to go “beyond bureaucratic encounters to unpack other apparently ‘non-state’ state-spaces ranging from the family to the neighborhood,” where forms of structural violence may be manifest. She calls attention to how “biopolitical programs … normalize the damage they inflict” on marginalized groups.196 This normalization occurs not just through explicit state practices, such as women’s empowerment programs that position women as volunteers and pay them minimum stipends. It also occurs invisibly in society-wide spaces (families, neighborhoods), which enable those programs to rely on and reinforce the “enduring trope of ‘motherly’ women as self-less and caring beneficiaries and workers” (Doshi, 2013).

Whereas Doshi’s (2013) point concerns how society at large, and vulnerable populations in particular, experience social norms and relations in non-state spaces, the point applies to state agents, too. That is, while state agents (here, municipal doctors) inhabit formal state spaces when they deliver state programs, they simultaneously inhabit society-wide spaces as citizens. If tropes of difference—part of the social imaginary of what is
marginal, normal, legitimate—pervade those society-wide spaces, they potentially influence the social worlds of state agents as citizens, which they likely carry into their work.

Although exploring municipal doctors’ social worlds is beyond the scope of my present project, such an inquiry would elucidate how doctors confront, interpret, and “process the complexity” of patients’ living conditions, families, social networks, “individual economies, political issues, culture, history, and so on” (Tharu, 2010, p. 282), specifically in urban India. The effectiveness of SDH-related interventions I previously described—to enhance providers’ structural competency, to build their social relations with communities, to develop intersectoral initiatives across health care and other social services—will depend on how public providers relate to the communities they serve as both state agents and fellow citizens.
6 Risk

6.1 Introduction to ‘risk’

Despite espousing a narrow mandate for municipal primary care services, as the previous chapter discusses, municipal doctors did at times attempt to go beyond that remit. Municipal doctors did respond to patients’ health needs and social situations by venturing beyond dispensing treatment prescriptions and counseling patients. Their efforts, and misgivings about those efforts, illustrate how municipal doctors interpreted the challenges and risks of acting outside the notional purview of municipal primary care.

My discussion in this chapter explores further municipal doctors’ experiences of and notions about risk in the course of their everyday work. I conceptualize risk as denoting uncertain peril. In the health systems literature, risk has been studied largely in terms of trust (Gilson, 2003; Ozawa & Sripad, 2013; Ostergaard, 2015). As Gilson (2003) writes, relations of trust are premised on “an element of risk derived from one individual’s uncertainty regarding the motives, intentions and future actions of another on whom they depend” (p. 1454). One’s sense of trust in a person or institution (unlike, say, one’s confidence they will behave in certain ways) is predicated on the existence of risk in situations involving that person or institution.

Perceptions of risk and relations of trust are thus intertwined, and are especially pertinent in health care settings given the uncertainty and information asymmetry inherent in
medical care. From that standpoint, this chapter turns the analytical question away from trust to examine instead forms of risk that attend the work of municipal primary care in Pune. In this chapter, I ask: how do municipal doctors construe risk in the course of their work—what limits do they fear transgressing and what kinds of danger accompany ideas about risk? What do ideas about risk suggest about municipal doctors’ interpretations about their mandate—its scope and their role within it? How do municipal doctors respond to prospective risk and with what consequences for the quality of care they provide?

To investigate these questions, I focus on municipal doctors’ treatment of chronic disease, which highlights a rising unmet health care need in urban India. I show that municipal doctors in Pune assessed chronic disease as both beyond the scope of their professional medical expertise as MBBS degree holders, and beyond the scope of their public mandate as primary care providers in municipal government. In other words, municipal doctors’ narratives underscored their understanding of the limits of their expertise and mandate. I argue that their sense of limits illustrates indirect ways in which the state’s neglect of urban primary care, coupled with private investment in medical education and practice, inform municipal health services in Pune.

Municipal doctors invoked multiple registers of risk. In their narratives, the possibility of medical complication was a key risk, but it was shadowed by other possible dangers. They observed that should anything go wrong with a line of treatment, municipal authorities may not support doctors; patients or their relatives might become aggressive with doctors; and the media could direct negative attention on the mishap. Their reflections about treating medical conditions they deemed risky referred not only to the clinical and legal
aspects of medical care, but also highlighted its social and political dimensions, such as violence against doctors and unwanted media exposure. The bases of risk and sanction that municipal doctors narrated were a feature of municipal primary care, shaped in part by commercialization in health care in Pune’s urban context.

While here I focus on doctors’ various perspectives about the notional limits of municipal primary care, limits beyond which certain actions were ostensibly risky, their narratives suggest that related to their perceptions of risk were their perceptions of “authority,” which presented its own nest of dilemmas. Authority is the subject of the next chapter, which follows the present chapter on risk. I begin by presenting an encounter involving Dr Mahesh. Although a number of municipal doctors described their hesitation to treat chronic disease because this was “risky,” for some, like Dr Mahesh, the possibility of medical complication was a part of the job of being a medical professional.

### 6.2 Treating chronic illness

Dr Mahesh attended to an older woman brought in by her middle-aged daughter-in-law. The old woman looked frail and shuffled in with difficulty. The daughter-in-law spoke for her. They had visited a municipal clinic some weeks ago, she said, and some days before that they had visited a private provider, in both cases to address the problem of the old woman’s high blood pressure. The municipal doctor who they had last seen had asked them to bring the prescription for blood pressure medication they had obtained from the private provider. That municipal doctor had not prescribed them any drugs and they had lost the prescription
from the private provider, hence the old woman had taken no medication. She liked to get an injection, said the daughter-in-law: “Her mind feels lighter after she gets an injection.” In the village, the old woman’s usual rural home, she got an injection every 15 days. She was used to that. Could Dr Mahesh give her one now? requested the daughter-in-law.

Dr Mahesh questioned and examined the old woman and confirmed that her blood pressure was elevated. “You don’t need an injection, Aaji,” said Dr Mahesh gently, referring to the woman by the vernacular term for grandmother. He prescribed medication for hypertension and told the women they could not get the drug at the municipal clinic’s dispensary but could purchase it at any pharmacy. He instructed the patient to start taking the medication and to return the next day at the same time. He cautioned both the patient and her daughter-in-law that high blood pressure was a serious problem and could worsen if left untreated. When the daughter-in-law lamented that it was difficult to bring the old woman to the clinic, given that she had trouble walking and moving about, Dr Mahesh joked that he could hardly take the daughter-in-law’s blood pressure instead. The daughter-in-law smiled. The two women came to the clinic the next day at the same time in the afternoon, as Dr Mahesh had advised them.

According to Dr Mahesh, a key problem in some municipal health care facilities was doctors’ restrained approach to providing care. Doctors did not go far enough, they did not take risks, they wanted to push responsibility away from themselves. “In so many cases, doctors don’t even check the patient’s blood pressure,” said Dr Mahesh. And when doctors did check blood pressure and found it to be high,
They simply refer the patient out. Doctors just sit across the room from the patient and do not examine them. A person who comes with recurrent headaches, who has come many times complaining of headaches, his blood pressure is not checked … I saw a patient … his bp was 220/130. No-one had checked his bp. This patient had come seven times in seven months …. He had acidity, so he was told, and that’s all he was treated for. He was taking Brufen (Ibuprofen), that’s all. Acidity can cause headaches, but it’s not the only cause of headaches.

This reluctance extended to how municipal doctors managed the health care facilities’ medical supplies. Dr Mahesh observed that certain drugs, including ones commonly used to treat hypertension, were not uniformly stocked in municipal clinics even though they were available in the central municipal medical store. “If doctors want to, they can order these drugs,” said Dr Mahesh, implying that doctors could stock them and provide them to general patients in some measure, but did not usually include these drugs in their requests to the municipal medical store.

One pharmacist I spoke with concurred. He informed me of a memo informing all municipal health staff that new drugs available in the medical store inventory included drugs for diabetes and hypertension, which doctors could dispense, in limited amounts, to the general patient population. But some doctors were reluctant to order and prescribe these drugs. Other pharmacists, some with long years of experience, confirmed that doctors were generally unwilling to stock the drugs. In their view, doctors who worked in clinics located in the periphery of the city, where there were few large hospitals nearby, felt they could not ensure the patient would receive prompt attention in a medical emergency. (I found, however, that doctors who worked in more centrally located municipal clinics also
worried about the possibility of medical complications). To preclude being held responsible for any medical complications, they neither stocked these drugs in their clinics nor prescribed them, and instead referred patients to other health care facilities. If patients asked after the drugs, doctors would tell them the clinic did not have any stocks, and the patient would be compelled to turn to alternate sources of health care.

6.3 Theorizing risk

Municipal doctors explained their practices of referring patients (instead of treating or coordinating care for patients) in terms of the limits of their expertise as MBBS-trained doctors and the narrow remit of municipal primary care. They recognized these limits as evolving norms, not settled facts. Their narratives illustrate a dynamic between the tangible and intangible aspects of health systems (see Section 2.1). That is, the narratives show how health systems not only deliver health care using tangible inputs such as infrastructure and supplies, but also embody and convey, through their organization and practices, intangible ideas and meanings (Gilson, 2003; Sheikh et al, 2011; Freedman, 2005). These ideas and meanings “guide actions and underpin the relationships among system actors and elements” (Sheikh et al, 2011, p. 2), and are critical to shaping health care quality. In this chapter, I specifically analyze the interplay between tangible inputs related to chronic illness care, such as drugs and skills required to deliver that care, and municipal doctors’ ideas about risk related to treating chronic illness.

The stakes of this analysis are both practical and theoretical. Practically, it can help us ascertain ways to ameliorate risk and potentially enhance relations of trust. Theoretically, a
focus on risk—as opposed to trust—can more explicitly indicate the social bases of uncertainty in medical knowledge and practice (Kielmann et al, 2005, p. 1549). Although trust and risk are intertwined, studies of trust in the health systems literature do not so much examine risk as identify typologies, measures, and degrees of trust among health system actors. They cover trust between patients and doctors, among health care workers and managers, and between people and the health system at large (Ozawa & Sripad, 2013; Ostergaard, 2015). Studies of trust conclude, for example, that trust among workers and managers depends on factors such as “workplace collegiality” (Ostergaard, 2015, p. 9) and “perceived fairness of management practices” (Gilson, Palmer, & Schneider, 2005, p. 1427).

I argue that focusing on risk helps unpack those constructs and stipulate the sources and implications of dilemmas that health care providers routinely encounter. Focusing on risks that health care providers confront affords insight into why relations of trust may be compromised.

Evidence already suggests that people’s trust in public sector health care providers and institutions in India is low (see Chapter 1). Studies show, for example, that people use public sector health care as a last resort; are willing to incur high costs to avoid public providers; and deem public providers as less responsive than private providers. We have evidence of public providers’ uncaring conduct and lackluster effort—attitudes that do nothing to foster trust. But we know less about why public providers perform poorly on these accounts. As I will show below, attending to providers’ notions of risk gives us purchase on some of the reasons for their low effort, especially on ways that social and political factors external to the medical encounter enter into providers’ everyday decisions.
The existing literature on risk in medical care offers a limited guide for my inquiry. Apart from clinical studies of risk (e.g., biomedical risks associated with a procedure, drug, or health behavior), studies of medical risk often concern medical error and largely document medical practice in North America and Europe. The studies cover causes of medical error, consequences of medical error for patients and providers, and solutions to diminish medical error. Prominent themes in this literature include litigation, strategies of decision-making in health care, and patients’ right to information (Hunink, Glasziou, Siegel, et al, 2001; Vincent, Taylor-Adams, & Stanhope, 1998; Sohn 2013; Patel, 2014). Risk can also stem from policies or programs at the population level, e.g., nutritional recommendations that may have unintended, negative consequences at the population level in addition to their individual-level effects. Global initiatives in LMICs to reduce medical error illustrate concerns about risk similar to that in advanced industrialized countries. That is, they stress a concern with law, medical practice, and public safety, as seen in the World Health Organization reports on Guidelines for safe surgery (WHO, 2009) and The safety of medicines in public health programmes (WHO, 2006).

Risk as it pertains to the social and political dimensions of health care provision has been less studied. For example, Kielmann et al (2005), studying private sector providers in urban India, suggest that providers’ management of “testing and treatment of HIV patients reflect ways of dealing with the greater existential uncertainties around HIV/AIDS in the local socio-cultural, market and policy environments” (p. 1548). Kielmann et al (2005) argue that explorations of “uncertainty” have often been “restricted to a problem of gaps in evidence needed for decision-making,” and researchers should instead “more explicitly
acknowledge the social, moral and economic bases of uncertainty in medical knowledge, practice and the patient-provider dynamic” (p. 1549).

As I will explore in the rest of this chapter, undergirding municipal doctors’ concerns about the prospect of medical complication were two concurrent sets of limits: their sense of the limits of their expertise as MBBS doctors, and their sense of the limits of their obligations as municipal primary care providers. The first involved their capacity as medical professionals, the second their mandate as state agents. I take each in turn.

6.4 Risk of stepping outside medical expertise

6.4.1 Chronic illness treatment as specialized medical care

When responding to my questions about care for chronic illness in municipal health care facilities, municipal doctors indicated that treating chronic illness amounted to giving medical advice for which they were not qualified. Chronic illnesses, they argued, represented conditions that lay outside the expertise of MBBS-degree holding doctors, and this heightened the risks they faced should complications occur. Not all doctors agreed. As my discussion below will relate, the idea of chronic disease as lying outside MBBS-level expertise was a contested and arguably evolving view. It was a view forged in doctors’ understanding of medicine and the law, of the risks and consequences of medical complications, and of the conditions of medical practice in Pune’s urban setting, where specialists—MD-degree holders also known as physicians—abounded.
“We cannot give medicines for diabetes. These medicines can only be given by an MD physician,” stated one municipal doctor. Another municipal doctor elaborated:

Nowadays, diabetes is [approached as] a multi-organ disease, not a single organ disease. You need a physician to check and treat it. A physician would prescribe multiple drugs. It is better that the patient sees a physician. A physician will be able to better prescribe drugs than a MBBS doctor. It is better that a MBBS doctor does not prescribe and take risk. And if anything happens, the patient will file a complaint immediately, [such as] if there is renal failure. Diabetes concerns blood sugar, but it can also be associated with neuropathy … It used to be that MBBS doctors used to prescribe drugs for diabetes patients … and they still do in the outlying [rural] areas. But if anything happens, then the doctor is at risk.

Dr Latika, another municipal doctor, supported the position that chronic diseases were complex, and their treatment implied advanced medical care, beyond the pale for a MBBS doctor. She expressed both her lack of credentials as an MBBS doctor to administer treatments for diabetes and hypertension, which she considered required advanced skills, and the absence of relevant drugs and expertise in the municipal health service, which she said indicated that chronic illness lay beyond the municipal mandate. (I take up her latter point about the municipal mandate in the next section). Dr Latika observed that a physician, meaning a doctor who held an MD degree, was better placed to care for chronic illness:

The [municipal government] has a responsibility to provide basic medicines. But diabetes, blood pressure … medicines for these are considered advanced medicines
… To prescribe these, we need a physician… and we [in the municipal health service] do not have a full-time physician. We cannot treat these. We cannot treat a diabetes patient as an MBBS doctor. Which drugs to prescribe – we have to ask this to the expert physician.

I ask: MBBS doctors are not allowed to prescribe these drugs?

Dr: MBBS doctors can, but the physician is more of an expert. Why should I show shatapana [try to act too smart]? I will leave it to the physician, and since there are experts, they are the ones who should do it. Patient will get better treatment if he is seen by a physician. I will leave it to him.

Dr Manisha, a physician, countered the view that municipal doctors’ MBBS qualifications excluded them from treating patients with chronic illnesses. She affirmed that such efforts were in fact feasible given the MBBS skill set. Dr Manisha was an MD in private practice who held weekly pro bono consultation hours at the Pune municipal health service. She was thus familiar with the challenges and possibilities of medical practice in both the public and private sector, having been involved in both. If municipal doctors hesitated to treat chronic illnesses, said Dr Manisha, it was because “They don’t feel competent. They are on the defensive. An MBBS doctor can treat [specific chronic disease].”

I had observed outpatient consultation hours at municipal hospitals when specialist doctors (MD-degree holders) saw patients pro bono at municipal hospitals. Before the specialist was due to arrive for the scheduled consultation period, regular doctors working in that municipal hospital would keep aside in a stack patients’ case papers for those patients
whose illnesses, doctors felt, required an expert opinion. They would ask the concerned patient to wait for the specialist or to return on the specified day. The expert consultations were brief: the specialist might ask the municipal doctor or the patient a few questions about the case and prescribe medications and treatments, or inform patients they needed more intensive care. Patients were free to follow up with that or another specialist. During these rushed events, municipal doctors stood by, quietly guiding the specialist through the stack of cases as the expert took the lead on each medical encounter and assumed temporary charge of outpatient consultations.

According to Dr Manisha, the expert consultation did not have to end there. Over her years consulting with the municipal health service, she said, some municipal doctors had conferred with her for relevant medical cases outside of her regular consulting hours:

They can call me to ask about treatments, and in fact some doctors used to do this…they would get a [specific chronic disease] patient, they would call me, and over the phone I would advise them.

MBBS doctors could independently deliver standard treatment for chronic illnesses, and could refer to the expert where needed, Dr Manisha observed. Medical practice in rural areas relied on just such coordination with specialists at higher levels of medical care. Dr Atul, who had worked in the state-run health service, remarked that rural-based doctors did consult remotely with medical specialists when the case demanded it. When hospitals and specialists were geographically inaccessible to the rural poor, public sector primary care doctors liaised between patients and higher tiers of the health system. They undertook the
risk of treating the patient since simply referring the patient to a specialist was not a realistic option. In the state-run health service, primary care doctors in rural locations might take it upon themselves to telephone a specialist, prescribe treatment, and regularly monitor the patient.

Urban areas presented entirely different conditions. In urban areas, said Dr Atul, it was easy and preferable to send the patient directly to a specialist, who might be located literally around the corner from the municipal clinic. In the city, people would question why the MBBS doctor had attempted to treat the patient himself when there was a specialist right next door; municipal doctors would not take that burden upon themselves. Dr Atul allowed that in an emergency, the municipal doctor could at most stabilize a patient, but should refer the patient to a specialist. But Dr Atul’s view suggested that as a matter of routine, for an MBBS-trained municipal doctor operating in a city alongside abundant specialists, caring for chronic disease was unwarranted and carried unnecessary risk.

In Dr Mahesh’s reckoning, however, handling medical cases with standard therapies and standard expectations of medical complication was squarely a part of the job of the medical professional, a job that doctors in the municipal health service unduly shied away from fulfilling. “There can be complications,” said Dr Mahesh. “But that is the job.” He wondered how doctors who were “so scared to give patients a medicine like [drug name]” would ever reach for second-line therapies? “If you cannot do this, if you cannot prescribe these drugs, then you should leave your job. Yes, complications and side effects can happen. But you are trying to treat the patient.”
Other municipal doctors, however, offered examples where their supervisors asked them to do less than they felt they were capable of doing. For instance, I had asked one young municipal doctor to reflect on primary care services that she felt patients were denied in municipal hospitals and clinics. She identified and then explained denials of service in terms of the risk the services carried for doctors, namely the risk that should “something go wrong,” municipal authorities would not stand with the doctor:

Here, services are so minimal. We doctors can do stitches for injuries. Sutures. But I don’t take the risk to do that. When I first started working here, I did also do sutures. I had done them previously, in the private sector. But then my seniors [in the municipal health service] said, ‘Why do you bother? If something goes wrong, no-one will support you, back you up.’ We know that if something goes wrong, the patient will catch us, shout at us, so we don’t take that risk. Better not to do it at all.

I say: So even though there are supplies here to do sutures, and doctors know how to do them, sutures are not done here?

Dr: Some doctors do them. Dr X, Dr Y. [Both Dr X and Dr Y held some qualifications beyond MBBS degrees]. They do sutures. I don’t feel supervisors will support me.

The doctor’s narratives indicated the consequences of doctors’ violating the presumed limits of their expertise and role: that patients might “shout” at doctors, and authorities would not “support” doctors. I return to the point about patient aggression and authorities’ support further below, but note here that doctors’ ambivalence about treating
certain ailments was undergirded by a sense that providing such care was fraught with risk, namely the risk of medical complication and the public unpleasantness and censure that might follow. For Dr Mahesh, however, providing appropriate medical care was “not a ‘risk’” but often simply “a line of treatment.” According to Dr Mahesh, doctors were unduly worried about possible legal and administrative sanctions. The case paper, he said, included language that protected doctors if they prescribed a standard line of treatment.

But the growing concern among medical professionals and health activists about the legal and regulatory environment for medical practice suggests the challenges of designing and enforcing such protection. National laws to protect doctors and patients in cases of alleged medical malpractice and to ensure standards in medical care have so far proved largely ineffective and have sparked much debate about ethics and politics in the medical profession (Peters & Muraleedharan, 2008; Srinivasan, 2013; Phadke, 2010). Two relevant laws in India, which have not yet been legislated in all states, are the Consumer Protection Act 1986 (commonly known as COPRA) and the Clinical Establishments (Registration and Regulation) Act 2010 (CEA). Legal justice and monitoring of standards of care under the laws have been impeded by a slow and overburdened legal system and the power and political lobbying of the medical establishment (Peters & Muraleedharan, 2008; Srinivasan, 2013; Phadke, 2010; Bhat 1996; Bloom, Henson, & Peters, 2014; Ecks & Harper, 2013).

In my conversations with municipal doctors in Pune, few doctors cited the COPRA, but those who did displayed ambivalence rather than confidence in the law. They felt the COPRA has had the unintended consequence of creating fear and uncertainty in medical practice. Their views reflected evidence that for some medical professionals, the COPRA
represents not legal protection against allegations of medical negligence, but an opportunity for patients to cast failures of medical treatment as cases of doctors’ negligence rather than standard, expected, unfortunate risks of medical care (Kumar, Kumar, Dupare, et al, 2013).

One municipal doctor, Dr Mangesh, observed that the range of medical and surgical procedures municipal doctors routinely performed had diminished over his tenure in the municipal health service. Dr Mangesh attributed the decline partly to doctors’ hesitation given the COPRA, which he said, “made them step back.” Although Dr Mangesh’s remarks concerned medical conditions other than chronic disease, I discuss them here because they suggest how doctors interpreted developments in medicine and the law, and how these interpretations affected their practices.

6.4.2 Legal protection and the limits of medical practice: Obstetric care as a case in point

Procedures such as caesarean sections and abortions were no longer widely performed across Pune’s municipal hospitals, said Dr Mangesh, recounting his experience in past years:

Previously … MBBS doctors used to perform c-sections (caesarean sections). But now, the courts have passed a law, there is a new law, the courts have passed that order, that MBBS doctors cannot do c-sections. Same for MTP (medical termination of pregnancy, i.e., abortion). MBBS doctors are trained to do it, but not “allowed” to do it. … In the last 10-15 years you can see this mismatch between what you are trained for and what the law prohibits you from doing, or rather how the law does not protect you if you do it and it goes wrong.
Dr Mangesh’s misgivings about restrictions on doctors derived from what he saw as conflicts in medical training, law, and practice. My research suggested that the law has not entirely prohibited MBBS doctors from performing c-sections and abortions, but recent national guidelines stipulate training and experience before an MBBS doctors can perform specific procedures. Dr Mangesh’s views suggest doctors have interpreted the law defensively. Tongaonkar (2003), for example, writing in the Indian Journal of Surgery, enumerates legal developments in medicine that did either did not exist or had been weakly implemented for decades. In the absence of legislation and regulation, “The medical practitioner was only expected to follow the code of conduct and rules given by the respective medical councils” (Tongaonkar, 2003). In practice, in the absence of “explicit, written policies, guidelines, or rules,” doctors’ actions have also been guided “by social situations, the market, and other forces” (Mavalankar & Rosenfield, 2005, p. 201).

Documenting such social situations and forces in their research on obstetric care in rural India, Mavalankar and Rosenfield (2005) observed how unclear policy guidelines contributed to rural MBBS doctors’ uncertainty about what they could and could not do in emergency obstetric care. Unclear guidelines effectively restricted the range of procedures rural MBBS doctors performed, leading to avoidable maternal mortality (Mavalankar & Rosenfield, 2005). The MOHFW has attempted to clarify guidelines for clinical care and introduced skills training for MBBS doctors on emergency obstetrics care (MOHFW, 2010) and abortion care (MOHFW, 2010; Stillman, Frost, Singh, et al, 2014). However, the impact of these changes has been underwhelming. In rural state-run health care facilities ostensibly equipped with supplies and trained doctors, doctors have yet been wary to perform c-
sections partly due to “a tendency to avoid risk of treating a ‘risky’ case - a woman having obstetric complications” and the “fear of blame” (Mishra & Devadasan, 2012).

Incidents of municipal doctors’ referring patients with obstetric complications in Pune (Sayyed, 2014) have likewise highlighted municipal doctors’ fears and perceptions of risk. Although resource constraints exist in the municipal health service, such as the lack of anesthetists on staff at the municipal health service (and the need to rely on outside expert consultants), one municipal doctor observed that the municipal health service did not, in general, lack for supplies or equipment for delivering standard services. If doctors resisted doing procedures, he said, it was in part because they “face so much risk.” If something happened to the patient, the patient would not “apply logic,” said the doctor. Patients tended to blame the last doctor who saw them, to misattribute complications to doctors without proper evidence, he said. As a result, he said, municipal doctors referred patients out, they didn’t do procedures, they didn’t take risks.

These denials of service suggest how material resource constraints can co-exist with intangible aspects of health care, such as doctors’ sense of risk and fear of blame. They show how tangible and intangible aspects of health care can co-produce low quality of care. Although policy advances encourage MBBS doctors to perform obstetrics care, the policies sit in counterpoise to legal developments such as the COPRA, which doctors viewed as curtailing doctors’ actions. Doctors were also wary of the possibility of extra-legal sanctions, indicated by rising incidence of aggression against doctors, which I explore further below in this chapter.
Recent efforts to improve patients’ access to primary care recognize MBBS doctors’ tendency to refer rather than treat illnesses. One such effort, known as the “Refer Less Resolve More” Initiative, seeks to equip MBBS doctors with skills to become “multi-competent Family Physician(s) who could provide a single-window, ethical, and holistic healthcare to patients and families” (Velavan, 2012). To that end, it aims as much to update and deepen doctors’ competencies as to “empower” doctors to provide care, given that doctors currently “refer excessively to specialists and other clinical professionals” rather than treat patients themselves (Velavan, 2012). The initiative, which is run by the Christian Medical College (CMC) Vellore, confers a diploma in family medicine through a two-year distance-learning course (Velavan, 2012).

Another initiative is a 12-module on-the-job training program in diabetes management launched by the Public Health Foundation of India in 2010, where participants meet monthly in a classroom setting (CCEBDM, 2014). Minimum qualification for the course is a MBBS degree with three years of clinical experience, suggesting again that MBBS doctors can treat diabetes.²⁰⁸

Further evidence that MBBS doctors are not precluded from treating chronic disease comes from standard treatment guidelines issued by the MOHFW (2007). The guidelines indicate diagnostic and treatment options available to doctors operating in stand-alone clinics, and suggest points when doctors might refer patients to higher tiers of care (MOHFW, 2007). Advocates calling attention to the urgent need to improve care for
chronic disease in India have looked to models and experiments from a range of LMICs, including South Africa, Iran, India, and Pakistan, where non-physician health care workers may be trained to diagnose, treat, and refer patients with chronic disease (Mohan, Campbell, & Chockalingam, 2013; Abegunde et al, 2007).

However, a recent intervention designed to enhance diabetes care among primary care providers in a city in southern India found no effect on doctors’ treatment practices (Bhojani, Kolsteren, Criel, et al, 2015). The study included only private sector doctors, but its findings confirm that specialists appear to play a dominant role in caring for chronic disease. Doctors interviewed for the study noted that a specialist typically diagnosed and decided the treatment plan for diabetes, and the task of the primary care doctor was at most to prescribe refills for drugs.

In sum, recent initiatives to enhance primary care reflect the premise that MBBS doctors require both training and empowerment to encourage them to treat patients instead of referring patients to specialists. But, as I next discuss, some researchers have characterized doctors’ inordinate deference to specialists not only as a technical problem to be fixed through add-on empowerment or training programs, but as a more fundamental systemic, historical problem in Indian medical education.

6.4.4 Hierarchy of expertise in medical education and practice in independent India

Advocates for reforming medical education in India have called for addressing the neglect of primary care in India by correcting the overemphasis on specialist tertiary care in medical
education and practice (Zachariah, 2011, 2014). They have called attention to developments in medical education and health care in post-independence India, which privileged specialized curative medicine and technological solutions over a sociological understanding of health and health care (Zachariah, 2014; Amrith, 2007; Das Gupta et al, 2005).

In the decades following India’s independence, Indian doctors who trained and collaborated with international medical experts were instrumental in developing medical specialties in Indian medical education and practice—these specialties were modeled on systems in advanced industrialized countries (Zachariah, 2014). As those countries saw their population health challenges shift from communicable to non-communicable diseases, the “intellectual cutting edge” in the health sciences shifted from the improvement of public health systems to the improvement of “curative technologies and methods of health care financing” (Das Gupta, 2005, p. 5161). That change arguably affected developments in India’s health system. In India, within state-run health services, “qualifications in specialty curative skills became far better rewarded than public health qualifications” (Das Gupta, 2005, p. 5162). Doctors trained largely in curative medicine came to dominate senior positions in state-run health care (Das Gupta, 2005).

The high demand for medical expertise—specifically for specialized, biomedical knowledge as opposed to public health knowledge—in the medical profession and health administration aligns with what Amrith (2007) has called the “political culture of health” in post-independence India’s modernist, “high-Nehruvian” era (p. 117). This political culture, as evidenced by debates among national leaders at the time, was riven with competing narratives about health (Amrith, 2007). One was the redemption narrative, wherein science
would redeem the population from disease and poverty (Amrith, 2007). Another was the narrative of state power, technology, and sovereignty, wherein the state would deploy technology and promote personal discipline to enable national good health (Amrith, 2007). Both narratives privileged medical expertise, which played a definitive role in development planning.

For India’s modernist political leaders, planning represented a rational strategy to achieve universal development goals (Chatterjee, 1997) (see Chapter 4). But the planning and implementation of public health programs emphasized technological solutions over a sociological understanding of local context, voices, and needs. State-issued evaluation reports, written as early as the 1960s, recognized the weaknesses and neglect of local health care services in the state’s technology-driven vertical health programs, such as malaria eradication and tuberculosis control (Amrith, 2007).¹ In the modernist era of state planning in post-independence India, “As public health was turned, increasingly, into a simple instrument for the furtherance of the state’s broader ends, so questions of health retreated into the realm of expertise” (Amrith, 2007, p. 119).

The growth of medical specialties in medical education began in that moment, and the emphasis on academic specialization and curative medicine continued through the years of India’s liberalization (Zachariah, 2014). If state policy neglected what Mohan Rao (2004) has called the “unheard scream” of local voices and needs, by contrast, the market avidly responded to medical practitioners’ perceptions of “good” health care, defined by specialist, technologically advanced medicine (Deshpande et al, 2011; Zachariah, 2014).
The dramatic rise in numbers of private medical colleges in India, which are especially concentrated in urban areas, along with rising cost of a private education, is testament to this dynamic market response (Choudhury, 2016; Sabde, Diwan, de Costa, & Mahadik, 2014). Choudhury (2016) finds that from 1990 to 2014, “the number of private medical colleges increased by 405% (from 41 to 209), whereas the number of government-run medical colleges increased only by 72% (from 102 to 176), with an overall growth of 169% during this period” (p. 73). Studies in India and other LMICs suggest this market dynamism can inflect the medical profession, where students widely state a preference for lucrative clinical fields (Dossajee, Obonyo, & Ahmed, 2016; Khader et al, 2008; Kar et al, 2014), thus thwarting an appropriate mix of skills in human resources for health (Choudhury, 2016).

Alongside education cost and income potential, the culture of medical education and practice can reinforce the value of certain medical specialties for both doctors and patients. As Zachariah (2014) writes, if doctors view the profession of medicine through the “prism” of their medical education, then this prism comprises the “long period [spent] within the walls of medical colleges,” where students encounter a gradation of social and financial value accorded to a hierarchy of medical specialties. Doctors’ perceptions about medicine shape how they practice medicine and what society comes to expect of doctors and medical care. In other words, doctors’ views are “self-perpetuating,” because their perspectives and practices “profoundly influence society's own understanding of what constitutes ‘good’ health care” (Zachariah, 2014).
While the growth of medical specialties has been important for training experts, it does little to address “the realities of the local context and local problems” in India (Zachariah, 2014, p. 2). Medical specialties such as family medicine occupy bottom rungs of the hierarchy (Kumar, 2012). Family medicine is an interdisciplinary field, integrating the “biological, clinical and behavioral sciences” explains the Academy of Family Physicians of India (AFPI, 2015). Training in family medicine equips doctors to provide “comprehensive health care for people of all ages and continuing and comprehensive health care for the individual and family across all ages, genders, disease and parts of the body. [Family medicine] is based on knowledge of the patient in the context of the family and the community, emphasizing disease prevention and health promotion” (AFPI, 2015).

The substantive content and approach of family medicine are thus entwined with the definition of primary care, namely first-contact, continuous, coordinated, comprehensive health care for the family and community (Kruk et al, 2010). In contrast to specialized tertiary care, family medicine enables doctors to handle “a range of clinical problems, with understanding of the patient and the context” (Zachariah, 2014, p. 3). However, family medicine has not grown in stature, profile, or popularity among medical students and professionals in the medical field, despite policy efforts to effect some change in that regard, as the next section shows.

6.4.5 The low profile of family medicine as a medical specialty in India

A young MBBS municipal doctor barely in her mid-20s, informally conversing one afternoon during a lull during outpatient consultation hours, wrinkled her nose as she
recounted the prospects of a suitor her parents were encouraging her to consider in marriage. “He wants to do family medicine!” she said, disapprovingly. “Where’s the future in that?” she asked the other doctor, a married man in his 30s, seated in the room. The latter doctor dodged the question, turning the conversation to whether she should marry at all at her age. I met another MBBS doctor, enrolled in a graduate program in family medicine, who had taken the time to attend a national consultation organized by health advocacy group Jan Swasthya Abhiyan in New Delhi in 2014. The consultation aimed to stimulate debate on the need, program evidence, and policy options for universal health care in India, and had been timed to precede national elections. The young doctor unequivocally told me that had she scored high enough on qualifying exams, she would not have chosen the subordinate specialty of family medicine.

Family medicine has been a recognized medical specialty in India since 1983 (MOHFW, 1983), but it has occupied bottom rungs of the hierarchy of specialties in Indian medical education and practice. Since the 1990s, doctors have been able to pursue a post-MBBS three-year diploma in family medicine known as a Diplomate of the National Board (DNB), which is regulated by the National Board of Examinations (NBE) (Kumar, 2012). However, it wasn’t until the National Health Policy of 2002 that national health and human resource development policy identified family medicine as an important field towards achieving national health goals (Kumar, 2012). In 2005, with the implementation of the NRHM, fulltime family medicine residency training gained momentum (Kumar, 2012).

That momentum continued, at least in regulatory circles, through the 2000s. In 2009, the NBE issued a Bulletin of Information that outlined a new syllabus and curriculum for
the DNB family medicine specialty (NBE, 2009). The preamble to the Bulletin (NBE, 2009, p. 2), recognizing an unmet need for medical practitioners equipped to serve community health needs, stated that:

Preventive, promotive and rehabilitation aspects, which form an integral part of healthy living, have lost focus with most of the medical practitioners. More than 80% of our population comprises of either the rural or the urban poor. They are unable to get access to adequate medical care facilities from the existing hospitals. Moreover, to practice holistic medicine, the treating physician should also understand the social, cultural and economic conditions of the family.

Family medicine gained further impetus in policy, if not actively among medical students and practitioners, in 2012. Since 2012, doctors have had the additional option to pursue a post-MBBS three-year MD degree in family medicine, regulated by the Medical Council of India (MCI). However, as of May 2016, only one medical college in India offered the MD degree in family medicine and it had two seats for this program (Government Medical College - Kozhikode, 2016; MCI, 2016).

Although the DNB option is, in policy, equivalent to the MD degree, the two differ in what they entail for students in practice and perception, with the DNB being the less popular of the two. Medical students perceive MD programs as harder to gain entry into, more expensive to finance if not pursued in state-run medical colleges, but easier to pass (exit exams for the DNB are reputedly more difficult and have low pass rates) (OSMECON, 2014). Among the general public in India, the MD degree is more widely recognized as a specialist medical qualification, although internationally, the DNB diploma is regarded as a
more reliable indicator of graduates’ credentials and ability, and more readily enables Indian doctors’ entry into medical programs and practice (OSMECON, 2014).\textsuperscript{213}

These differences in preference and availability between the DNB and MD in family medicine have arguably further contributed to the overall low popularity of the family medicine specialty among doctors. Already reluctant to pursue family medicine given its low professional status and low earning power, MBBS doctors can in effect only pursue a DNB diploma in the family medicine specialty, an option to which they are less disposed than a MD degree.

A further serious and longstanding challenge for advocates seeking to raise the popularity and profile of family medicine in both undergraduate and graduate medical education derives, once again, from the privileging of tertiary care in medical education. The MCI does not recognize “community-based health facilities such as district hospitals, community health centers, family practices” as valid training or learning sites for doctors (Kumar, 2014, p. 2). If doctors practice medicine in community settings as opposed to tertiary care hospitals, this community-based work does not count as qualifying professional experience to fulfill eligibility criteria to teach at accredited medical colleges (Kumar, 2014).

Doctors who work in community-based primary care settings—which presents the foremost need and grounds for the practice of family medicine—are thus effectively “disenfranchised from professional, educational, and policy leadership positions” (Kumar, 2014, p. 2). (And, presumably, doctors who seek to pursue family medicine may also be disadvantaged in their marriage prospects.) Junior doctors and medical students can neither
learn about social medicine nor model their practice or approach from experts in family medicine.

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While some municipal doctors characterized their reasons for not treating chronic illness primarily in terms of deference to specialist expertise, others placed treatment of chronic conditions as beyond the municipal mandate altogether. I examine the latter point in the next section.

6.5 Risk of stepping outside the municipal mandate for primary care

6.5.1 Chronic illness as beyond the municipal mandate

Municipal doctors’ view of the dangers of treating chronic disease stemmed in part from their understanding of the municipal mandate. Some municipal doctors reasoned that although their MBBS education included chronic disease care, resources available in municipal primary care facilities precluded such care, and hence so did their obligations as municipal doctors.

   Dr Latika, for example, pointed out that while the municipal government had a responsibility to provide basic medicines, drugs for diabetes and blood pressure were “advanced medicines … To prescribe these, we need a physician… and we [in the municipal
health service] do not have a full-time physician.” For Dr Latika, the unavailability of drugs and expertise for chronic disease care in the municipal health service denoted that such care was outside its purview. (It’s important to note that while the Pune municipal health service did not, ostensibly, make these drugs available to the general population, a doctor working in the neighboring municipal corporation of Pimpri Chinchwad, a fast-growing industrial township that borders Pune, informed me that the Pimpri Chinchwad municipal health service did make a wide range of drugs available. It’s possible that municipal doctors there did not hesitate to treat chronic disease, or if they did, may not have cited drug availability as a reason for their hesitation).

Dr Priya observed that the municipal government did not include drugs for chronic illness in its drug list for general patients, which indicated that it did not expect doctors to treat them:

We cannot supply any drugs to patients to treat those illnesses. So we can’t consider that those are provided as primary care services… Drugs for those are only available for [government employees]. … What we offer in the clinics is what we are told to do, whatever we are given. If they don’t provide us the drugs, then what can we do?

Dr Madhavi, a relatively recent recruit in the municipal health service, also ascribed to the view that patients with chronic illness had to be referred to specialists, noting that treating them was infeasible for municipal doctors given the remit of municipal facilities. As I sat in her outpatient consultation room one morning, Dr Madhavi counseled a patient—a man in his 40s presenting with hypertension—to seek specialist care. It was not his first visit
to this municipal hospital for high blood pressure. He had come here before, and Dr Madhavi had examined him then too.

“The last time this happened, did you not go to [large public hospital]? Is it going to be ok if you get a heart attack?” she asked, scolding him for failing to follow her instructions. The man said nothing. “You need to get it checked out, to see another doctor,” she urged him. The man said, flatly, that it was expensive. (The public hospital to which she had referred him would charge nominally for a consultation with a specialist and medications. At a private sector specialist and private pharmacy, the costs would be far higher.) Dr Madhavi said, resignedly, “It’s up to you. If you want to continue like this…” The man seemed anxious to leave and asked for a medical certificate, a note stating that he had visited the municipal facility that morning so that he could apply for leave from his job. With certificate in hand the man was gone. Dr Madhavi observed:

The last time too he was told to go to [a large public hospital]. But they don’t go.
They want everything to be done here. But essentially this is a maternity home.

Dr Madhavi explained that municipal hospitals could provide care for reproductive and child health, not much more. Reproductive and child health services, doctors widely agreed, comprised the central obligation of the municipal health service (see Chapter 5). The question implied in both Dr Madhavi’s and Dr Priya’s reasoning was not whether MBBS-qualified municipal doctors were competent to treat diabetes and hypertension, but rather whether this task was part of their scope of work at all. Dr Priya elaborated:
MBBS doctors can [treat these diseases]; in the MBBS curriculum we are taught how to diagnose and treat diabetes, to prescribe drugs for it. But doctors don’t want to take the risk of treating it.

Dr Priya observed that since treating chronic disease was not an obligation of the Pune municipal government and not in doctors’ job description as primary care providers, why should doctors take the risk? “Why should they go out of their core tasks? They don’t bother doing it, they play safe,” she said.

In the words of another experienced municipal doctor, the practice of not treating chronic illness had become a “custom” in the municipal health service. This doctor noted there was no formal regulation or lack of training that barred MBBS doctors from treating diabetes and hypertension. Yet, municipal doctors abided by an unofficial protocol to refer rather than treat such patients:

It is…what do you say, it has become routine, it is the custom. MBBS doctors can do it, and in fact they can also perform minor surgeries, since they hold a Bachelor of Surgery. Doctors [holding MBBS degrees] in the private sector do treat these diseases. But here, the mindset is also a problem. Because population growth is a big focus, it is hard to shift focus away from population growth. Our doctors will not treat hypertension and diabetes. Doctors think it is not part of their job … if a doctor treats a patient for this, and if something goes wrong, then the authorities will not support that doctor.
In the above narratives, municipal doctors expressed a common perception that caring for chronic illness, though not outside the capabilities of MBBS doctors, was outside the notional remit of municipal primary care. Municipal doctors averred that municipal authorities would not support doctors who, against municipal norms, had taken it upon themselves to treat cases of chronic illness.

(Municipal norms for primary care, as described in municipal doctors’ narratives — see Chapter 5 — included mainly reproductive and child health and the treatment of minor ailments. I don’t analyze here the reasons behind the limited scope of municipal primary care. As I indicate in Chapter 5, the reasons are related in part to neglect of urban primary care in India’s health and urban development policy.)

As with doctors who cited the limits of their medical expertise (Section 6.4), here too, doctors worried about unsupportive authorities. Support from authorities was essential when medical care was risky: if complications occurred, doctors would be left on their own, left to face legal action or social consequences such as violence against doctors and negative reporting in the media. But in pitching the limits of their medical work in terms of their role as state agents (as opposed to their expertise as MBBS doctors), municipal doctors highlighted the distinct ways that these social consequences featured in the everyday work of state-provided primary care.

The social consequences of aggressive patients and negative news were particularly intense for municipal doctors relative to private sector doctors, since public opinion and the press were disposed to rail against the state. Conjoined with that public tendency was the
crush of public scrutiny in their frontline service delivery role: municipal doctors were mandated to provide state services to anyone who walked in to the municipal health care facility. Municipal doctors were accessible agents of the state, and in that role, they were both providers of care and bearers of all manner of state incompetence.

Doctors in the private sector, by contrast, had a wider range of options to enhance the services they provided or modulate people’s access to those services. As Dr Manisha, who ran a private practice and consulted pro bono weekly at the municipal health service, observed: “I know I have a way out, and that keeps me sane.” She had some leeway to either facilitate a patient’s access to care, such as by agreeing to see a patient on a Sunday, or else selectively decline to take on “problem” patients. But this could not happen in the municipal or any state-run health service, she said, because “doctors there are duty-bound. They cannot refuse to see a patient. This makes the doctor vulnerable and frustrated.” And their vulnerability and frustration found little succor in the tenor of public opinion.

In the sections that follow, I explore two vulnerabilities that municipal doctors narrated: the prospect of patient aggression and negative media attention.

6.5.2 The prospect of patient aggression

A municipal pharmacist asked me, after we had been conversing for three-quarters of an hour in the dispensary of a municipal hospital, if I felt “safe” within that health care facility. It was the end of the workday, there were no patients remaining in the facility, and staff were readying to leave. I was unsure what the pharmacist meant. I wondered if he implied if I felt
safe as a woman? As an outsider? I said I felt quite safe, not telling him that his posing that question had immediately made me feel less so. The pharmacist replied that he did not know, from moment to moment, whether a patient would become incensed, if at any instance an angry patient would create a disturbance. He operated knowing that violence was possible, that it was imminent.

The prospect of violence was a consistent theme in municipal doctors’ recounting of the social risks of medical complication. Their views reflected reports of rising incidence of violence against health care workers not only in India (Mishra, 2015; Bawaskar, 2014; Gupta, Kaur, & Gupta, 2016), but also notably in China (Huang & Ding, 2011; The Lancet, 2010) and other LMICs (WHO, 2014).²¹⁴ Reports show how patients and their families, stunned with the financial cost of care or deepening illness or death of loved ones, may resort to inflicting violence on individual doctors and vandalizing health care premises, both public and private.

One reported incident in Maharashtra involved family members of a three-year-old boy who beat doctors with wooden sticks and a metal stool following the boy’s death from dengue fever in a Mumbai municipal hospital (DNA, 2015; Barnagarwala, 2015). In New Delhi, doctors at a public hospital, who had treated a pregnant woman who had died from respiratory failure, “were attacked by a mob of about 50 of her relatives, who threw chairs, saline bottles and equipment at them” (Gowen, 2016). Another case involved policemen who beat a doctor in the city of Solapur, Maharashtra. The doctor had refused to interrupt his ongoing clinical work to attend to a patient the policemen had brought in and demanded he see immediately (Barnagarwala, 2014). In another case, a newspaper described a “mob” of
40 to 50 people who pelted stones on the glass facade of a private hospital in Pune and vandalized its premises following the death of a 19-year-old man in the hospital (TNN, 2013).215

Doctors in the public sector have called for state action to protect health care workers, but such protection has been minimal and attacks have continued. The Maharashtra Association of Resident Doctors (MARD), representing about 4,000 doctors working in state-run health care facilities, has responded to incidents of violence against doctors in Maharashtra and other states through strikes and demonstrations, demanding greater protection from the state for their personal security (Barnagarwala, 2014; DNA, 2014). MARD and the Indian Medical Association (IMA) have called for greater recourse to the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act 2009. Under this Act, violence against medical staff and medical establishments is a non-bailable offence. Offenders can be imprisoned for up to three years and made to pay damages. But enforcement of the Act has been impeded by low awareness about its provisions among the public and the police (Andhale & Pal, 2015; Isalkar, 2015b).

Yet, some municipal doctors highlighted another, more fundamental form of awareness that contributed to patients’ annoyance and could escalate to aggression: the attentiveness and sensitivity health care workers displayed, or failed to display, when they treated and communicated with patients. One doctor, for example, noted that some nurses chastised pregnant women who chose to visit particular municipal hospitals for antenatal visits if the hospital was located far from the woman’s home (as I had once myself
observed). A nurse might irately ask the woman why she had not visited the municipal hospital within her neighborhood, but there was no need for such questioning; the nurse's job was to provide care for any patient she is assigned who walks in the door.

The doctor recounted how a nurse had once got into an altercation with a patient instead of calmly communicating with the patient. The patient needed an intradermal test for iron, which a nurse was administering. This is a patch test, said the doctor, and the patient wanted to know why the test was not given on the arm, why it had to be done on the torso. A verbal fight broke out between the nurse and the patient. The doctor had had to intervene. He had to explain to the patient that the injection is given on the torso because it creates a *daag* [dark mark or spot] on the skin. It is usually given in a small amount and then in the full amount, and always on the torso. It was then that the patient relented and went ahead with the test, but “it took 15-20 minutes of fighting,” he said, resignedly. The problem of rude behavior from nurses was worse in the public sector, he acknowledged, in part because “in the private sector, the pay is lower and their jobs are not secure.” (For examples of curt consultations between doctors and patients, see Chapter 5).

Medical professionals and advocates have widely faulted the state of medical education in India for doctors’ insensitivity towards patients, noting that medical education curricula pay scant attention to interpersonal skills, medical ethics, and social aspects of health (Mishra, 2015; Ramaswamy, 2012). However, some have additionally questioned how far changes in medical education can fix problems created by commercialization in health care, which, they argue, trenchantly disposes doctors to flout ethics and dispense with sensitivity and care in their practice (Gupta, Kaur, & Gupta, 2016). In the latter view, the
compulsions of for-profit medical practice have eroded “academic and moral standard[s]” in medicine over the past three decades (Gupta, Kaur, & Gupta, 2016, p. 231).

Under compulsion to recoup high cost of private medical education and pressure to compete in the private sector, doctors have increasingly turned to “unethical practices” such as “conducting unnecessary tests and investigations, adopting unnecessary procedures and surgeries” (Gupta, Kaur, & Gupta, 2016, p. 231). In this environment of medical practice, patients experience neglect and delays in being attended to by doctors; having to pursue and pay for numerous investigations; requests for advance payments for treatment; or doctors’ withholding of a deceased body until the final bill is settled, among other factors of stress that can escalate to aggression and incite violence (Gupta, Kaur, & Gupta, 2016; Bawaskar, 2014). As for the counter charge that doctors in the private sector spoke “more sweetly” to patients, one municipal doctor responded that yes, they did, and “they charge you for it!” Speaking sweetly, he suggested, was also motivated by the profit motive, and was not a guarantee of responsible, effective medical care.216

Ironically, municipal doctors, who provided outpatient primary care within the narrow scope of the municipal health service, were not in a position to prescribe numerous, advanced diagnostic tests, care intensively for patients, or perform major surgeries. Yet the narratives of municipal doctors and other municipal health care workers—such as the pharmacist who related his sense of insecurity within a municipal hospital—suggested that the prospect of patient aggression had become a regular aspect of their work, even in the realm of basic primary care delivery. Compounding that danger was the prospect of negative media attention, to which I turn next.
6.5.3 Incomplete and consistently negative media reports

Media reports on medical and management mishaps in Pune’s municipal health service had a castigatory tone, exemplified by news stories with titles such as *Pregnant woman delivers on porch of hospital; baby dies* (Mascarenhas, 2012) and *Medical equipment worth Rs 1 crore [about US$ 150,000] lying unused* (Isalkar, 2013). The spirit of the stories reflected the role of the press in India as based on an “ideal of journalism as scrutinizing state powers,” conjoined in an enlightenment project of educating the masses, effectively “shaping a nation into making” (Rao, 2010, p. 75). The stories also reflected the particular vigor of vernacular newspapers in reporting the workings—more frequently the failings—of the state at the local level. As Gupta (2012) observes, vernacular newspapers in the rural districts he studied reported in excruciating detail abuses of bureaucratic power, such as by exposing names of specific state agents involved in alleged misdoings and documenting exact amounts of bribes. By so depicting the workings of the state, Gupta (2012) writes, the vernacular press provided citizens a way to see or imagine the state.

I similarly found that Marathi language newspapers in Pune sometimes reported stories that English language newspapers, even English editions of the same newspaper, did not carry. This was specifically true of news about everyday malfunctions and missteps in the running of municipal services. But municipal doctors in Pune were often disconcerted with the captious tenor and incomprehensiveness of news reporting about municipal health care, and it is their view of the news that I explore here.
News about Pune’s municipal health service—versions of which I read in English language newspapers dating from 2012 to 2014—included reports of an overfull elevator that crashed from the fourth floor injuring five people, an overnight eight-hour power outage, and newly purchased diagnostic equipment lying unused, all of which took place within municipal hospitals. One especially disturbing event was reported by the *Indian Express* under the headline *Pregnant woman delivers on porch of hospital; baby dies* (Mascarenhas, 2012). The event took place the year before I began my fieldwork. News reports stated that a pregnant woman had arrived at a municipal hospital in the morning. A municipal doctor had advised her to go home, saying her labor had insufficiently progressed. The advice of this doctor contradicted the advice of a more senior municipal doctor who had seen the woman earlier that day. The pregnant woman traveled home on a public bus. But her pains continued, labor progressed. The woman’s family returned to the hospital, this time by autorickshaw, but she delivered the baby sooner than they could make inside the hospital to the ward. The *Indian Express* headline suggested the baby subsequently died, but other stories noted the baby was stillborn (Isalkar, 2012; DNA, 2012). At least one story noted the municipal health service had issued a legal “show cause” notice against the concerned doctor (Mascarenhas, 2012), but I could find no further news about the case (in English language newspapers).

Municipal doctors felt the media’s accounts of medical mishaps portrayed a lopsided picture that did not report fully on the clinical facts and unfolding of a medical case, or too easily took patients, administrators, and political actors at their word. Many news reports exposed municipal misdoing by relying largely on testimonies of citizens and bystanders and official statements from state agents, without consistent independent verification of events.
During my fieldwork, one such incident particularly angered municipal doctors. A patient who had undergone surgery at a municipal hospital, left the hospital, developed complications, and then turned to a private hospital, had subsequently died. The press admonished the municipal health service, but, as municipal doctors noted, news reports did not accurately present all the facts. The patient had not revealed a prior medical condition to the municipal doctor, and the patient had left the municipal hospital against medical advice.

As one municipal doctor showed me on her smartphone as she scrolled down through a social network site, a spring of support had emerged among municipal doctors for their unfortunate colleague who had been lambasted in the press.

Some municipal doctors said the press did not go far enough in its reporting, and citizens could not appreciate the depth of administrative problems that beset municipal health care. For example, the local *Pune Mirror* had quoted Pune’s chief health officer as attributing a “dearth of specialists” in the municipal health service due to a lack of public response to the municipal health service’s “repeated attempts to hire pediatricians, gynaecologists, orthopaedics” (Sayyed, 2014). One municipal doctor pointed out to me that the same article absurdly went on to quote a “nursing orderly” as stating what appeared to be the official municipal government position. The news article reported the nursing orderly as saying, “We are waiting for a private college to send staff so that the hospital can run as a public-private-partnership” (Sayyed, 2014). The news article provided no supporting quotes, background, or facts to corroborate or explain the nursing orderly’s pronouncement of an impending move towards private management of the municipal hospital.
Another municipal doctor observed the media had not explained why specialists had not applied for jobs at the municipal health service. In previous years, stories such as *Few takers for specialist doctors’ post at PMC hospitals* (Mascarenhas, 2013) and *Seventeen civic hospitals, but not one has permanent gynaecologist* (Isalkar, 2012) had made the Pune news. But these intermittent reports cast the municipal health service as a broken entity. According to municipal doctors, newspapers did not provide reliable and sufficient evidence for the public to understand why the municipal health service remained broken and only highlighted cases of misdoing or errors.

Municipal health workers outside Pune also related their mistrust of the media. According to a manager at an NGO in Mumbai who had long experience with community-based health care services in that city, municipal health care workers in Mumbai harbored a “great, deep fear of the media. … When the media does write about the BMC [Brihanmumbai Municipal Corporation], it only disparages their work, does not write anything positive.” Municipal health care workers had once bitterly reminded the NGO manager about a past project that the NGO and municipal health care workers had jointly executed in a city neighborhood. When a newspaper had reported on the project’s aims and successes, it had written well of the NGO but had made no mention of the municipal workers or their contribution to the project. The municipal workers harbored this instance of media neglect as a grievance—it not only reinforced their mistrust of the media, but also hurt relations with the NGO.

The NGO manager observed there were “very few really good” municipal workers, i.e., frontline health care workers who persevered despite the constraints of municipal
services. But, she added, stories of those workers did not get published or known. To the contrary, “when something bad happens, then those [bad] things get exaggerated.” She went on to say she had “seen nurses sometimes pay for the services of patients, the ones who don’t have a change of clothes. Sometimes doctors and nurses contribute to pay for a poor person.” But neither the media nor the municipal authorities recognized and appreciated these deeds.

6.5.4 Dual role of state agent and medical practitioner: Which rules and calculations of risk prevail?

Attending to chronic illness was not only clinically perilous, emphasized Dr Priya, but also a risk that municipal doctors were not authorized to take under the mandate of primary care provision. Even if they held the requisite clinical expertise, their official status as municipal doctors obviated their responsibility to treat chronic illness.

To detail this point, Dr Priya observed that at entry level into the municipal health service, doctors were assigned a “medical officer” position. This position was designated as a Class 2 post; post ranks ranged from Class 4 at the lowest and Class 1 at the highest level within municipal government. Dr Priya then posed the following question: What if a Class 2 medical officer happened to be an MD degree holding physician and not an MBBS degree holder? Even then, said Dr Priya, such a doctor was “not officially able to treat those illnesses,” since the position of a Class 2 medical officer required the doctor to provide only the most basic primary care services.

Dr Priya’s comments suggested that doctors’ understanding of their mandate, administrative rank, and medical expertise could conflict. A doctor’s rank might be lower
than her medical qualifications should command. Or a doctor’s sense of his responsibilities might be incongruent with the notional description of his job. In their everyday work, doctors routinely weighed one against the other. In decisions other than clinical care, alternate calculations of risk could prevail.

The experiences and narratives of municipal doctors thus suggested that they variously confronted the notional limits of municipal primary care in several domains of work (e.g., clinical, managerial/administrative). The dilemmas of municipal doctors’ clinical work, as I show in this chapter, stemmed from their perceptions of the limits of their medical expertise and the municipal mandate. In citing these limits, doctors invoked the social consequences of medical risk. The dilemmas of their administrative work suggest a further set of constraints that informed municipal doctors’ practices, namely their concern about the social consequences of flouting “authority.” Authority is the subject of Chapter 7. It concerns the sources of social power—specifically municipal administrators, local politicians, and popular opinion—that shaped how municipal doctors perceived the quotidian challenges of their mandate and their relations to the communities they served. Chapter 7 will illustrate how municipal doctors experienced a lack of support and low legitimacy from municipal authorities and the public at large, and the effects this had on the everyday work of primary care provision.

6.6 Concluding discussion about risk
6.6.1 Transgressing medical expertise and the municipal mandate

Municipal doctors’ narratives generally suggested that in their reckoning, treatment for chronic illness carried a risk of medical complication that MBBS doctors were incompetent to handle and not clearly mandated to undertake. For these doctors, the risk of medical complication raised the possibility of legal repercussions, unsupportive authorities, negative media exposure, and an aggressive public, who might question why MBBS doctors had undertaken to treat chronic illness in a city where specialists abounded. The social consequences of medical risk thus outweighed the contrary idea that such risk was squarely a part of doctors’ regular work. Ideas about risk also outweighed the views of specialists such as Dr Manisha, who held that MBBS doctors could treat chronic illness, and doctors in the municipal health service had in the past remotely conferred with her to do just that.

Municipal doctors’ perceptions of the limits of medical expertise were evolving norms. Municipal doctors agreed that no formal regulation barred MBBS doctors from treating chronic illness. Yet some stated they would defer to specialists even if the MBBS doctor was trained in those aspects of care, and even if MBBS doctors used to provide that care in the past or still provided that care in rural areas. Doctors’ valorization of medical specialization draws attention to a systemic, historical problem in medical education and practice in India. Developments in medical education and practice—beginning in India’s post-independence period and intensifying under its economic liberalization—have emphasized the professional merit, social status, and financial worth of certain medical specialties over others. Notably, in medical education and practice and in national health
programs, curative skills and technology have often outweighed sociological approaches to understanding disease, local context, and local health services.

Since the early 2000s, health and medical education policy reforms have increasingly recognized the importance of family medicine and its comprehensive, interdisciplinary, community-oriented approach to health care. Initiatives to improve access to chronic care treatment have sought as much to empower as train MBBS doctors to treat rather than refer patients to specialists. However, opportunities for doctors to learn under and from family medicine experts remain marginal. Leadership positions in medicine, policy, and administration elude doctors who practice generalist, family-oriented primary care, especially in community-based settings as opposed to tertiary care hospitals.²²⁰

Trends in medical education and practice suggest the medical profession continues to value biomedical specialties. That is, the law, media, and popular opinion might cast a generalist MBBS doctor who is “caught” practicing certain aspects of medicine (typically when medical complications occur) as overstepping a threshold of knowledge and skill. If doctors’ perspectives and practices “influence society’s own understanding of what constitutes ‘good’ health care,” then these perceptions hew to an idea of specialized (bio)medicine as “good” health care (Zachariah, 2014).

Thus for some municipal doctors in Pune, treating chronic illness with the tools of a generalist MBBS skillset implied the risk of transgressing medical bounds: it wasn’t “good” enough health care. The violation of this bound implied a professional fault. It underscored both the presumptuousness of MBBS doctors’ attempt to provide what they considered
advanced medical care (“MBBS doctors can, but the physician is more of an expert. Why should I act too smart?”), and the negligence it implied (“People will say: why did the MBBS doctor try to do it himself?”) particularly in an urban context replete with specialist expertise.

For some municipal doctors, treating chronic illness implied the risk of transgressing municipal bounds: the limits of the municipal mandate for primary care. The issue wasn’t whether their skills were “good” enough, but that their role as a municipal primary care provider obviated their responsibility to treat chronic illness. If they transgressed that bound, they could not rely on support from municipal authorities if any medical complications arose. The prospect of medical complication, as before, raised the specter of patient aggression and negative media attention. Municipal doctors, relative to private sector doctors, experienced these social consequences more intensely. As state agents, municipal doctors could not escape the negative light in which the public and the media cast state services.

6.6.2 Commercialization, risk, and the quality of urban primary care

Evidence suggests that commercialization of health care has contributed to patient aggression and general public ire about the experience of seeking health care—neglect, delays, lack of communication from providers, high cost, numerous investigations. At least two mechanisms are potentially at play. One, commercialization of health care is associated with a skew in medical education towards specialized tertiary care and away from social medicine. This skew helps explain doctors’ poor understanding of ethics, social aspects of health, and interpersonal skills, which in turn shapes patients’ unpleasant experiences of
seeking health care. Second, commercialization of health care is associated with irrational and defensive practices in medical care—unwarranted treatments, numerous and expensive diagnostics, with untenable cost of care. These aspects also contribute to patients’ tribulations with seeking health care, which can escalate to aggression.

Although developments associated with commercialization have occurred largely in the realm of tertiary care and in the for-profit private sector, yet municipal doctors’ narratives suggest they have also inflected the work of providing basic, low technology, state-run primary care with a calculus of risk. In other words, commercialization has contributed to a pervasive sense of risk in the medical profession, which municipal doctors experienced in their everyday work as a fetter on the scope of their medical practice. Constrained on the one hand by the narrow mandate of municipal primary care, municipal doctors were also constrained by ideas about the limits of their expertise and the hazards of violating those limits, especially in Pune’s urban context. Their response was to defer to specialist expertise, to retreat into a contracted definition of primary care.

In sum, commercialization in health care not only poorly equips doctors to practice community-oriented medicine—the hallmark of primary care—in low-resource settings (Mackintosh & Koivusalo, 2005; Velavan, 2012), but also devalues, for both patients and doctors, the skills and knowledge that primary care providers are supposed to possess (Deshpande et al, 2011; Sethi, 2001; Kothari & Mehta, 1989). Coupled with stagnant investment in state-run urban primary care, these tendencies constitute a form of social discrimination in health care (Metzl & Hansen 2014; Zachariah, Srivatsan, & Tharu, 2011),
wherein doctors in the public sector, charged with serving the urban poor, are unable and unwilling to deploy their expertise.

6.6.3 Medical risk and the multilevel state

What do municipal doctors’ perceptions of and responses to risk tell us about the workings of the state? In the municipal health service in Pune, we can, as Gupta (2012) suggests, discern the workings of a state that systematically denies care to certain groups of people—in this case, those patients presenting with chronic illness. However, my findings lead me to qualify Gupta’s (2012) argument about the mechanisms by which this happens.

Gupta (2012) argues that the state’s “overt goal of helping the poor is subverted by the very procedures of the bureaucracy” through a “constitutive modality of the state” (p. 23). Gupta (2012) terms this modality “uncaring,” but emphasizes this is not “a psychological state of government employees,” but rather an aspect of state functioning (p. 23). In other words, the Indian state’s dismal welfare outcomes can be traced to the nature of bureaucratic functioning; they are “systematically produced by the very mechanisms which are meant to ameliorate suffering” (Gupta, 2012, p. 24). The poor largely experience these mechanisms through their interactions with the state at its local level. These mechanisms come to be “not only tolerated but taken as normal” by actors within and outside the state (Gupta, 2012, p. 23).

Gupta’s (2012) argument is based on fieldwork in rural areas, on the local implementation of development programs formulated under national policy. But if we define
the state as multilevel—differentiated in its operations at various locations, agencies, functions, and levels of government—we ought to consider that an alternate modality of state functioning may be at work in the case of municipal health services in an urban setting.

My findings suggest that, in the case of primary care delivered by municipal government, denials of care for the urban poor are not solely a result of bureaucratic procedure, i.e., where state agents, by following bureaucratic rules and normalized behavior, produce and reinforce a form of structural violence against the poor. Rather, state agents (here, municipal doctors) who operate in state agencies (municipal clinics and hospitals) confront not only bureaucratic constraints but also dilemmas arising from outside the state bureaucracy that circumscribe their actions. These dilemmas only partially stem from their role as state agents in municipal employ. They also crucially relate to developments accompanying the commercialization of health care, which are heightened in urban contexts, where the private health care sector is particularly dense, diverse, specialized, and accessible to the poor.

By their own admission, municipal doctors’ refusal to treat patients presenting with hypertension and diabetes is not prohibited by law. Rather, their refusal is an evolving norm, and it reflects the range of notions of service (Chapter 5), evaluation of risk (Chapter 6), and pressures of authority (Chapter 7) they confront in their everyday work.

Some elements of notions of service, risk, and authority reflect the social imaginary about the municipal mandate for primary care and doctors’ role within it. But other elements are rooted in the evolving political economy of medical care in India. That is, municipal
doctors respond to the nature of medical practice in India—the valorization of specialist biomedical expertise over generalist primary care, the ongoing lack of regulatory protection (for both doctors and patients) in the medical field—as much as to their role as state agents in municipal government. Unlike the state agents in Gupta’s (2012) ethnography, municipal doctors in Pune are not state functionaries dispensing a service that only the state provides. They are equally and simultaneously medical practitioners, trained and socialized in prevailing ideas about hierarchy, values, and, inevitably, risks in the medical profession.

Municipal doctors’ exposure to market forces distinguishes the work of these doctors from that of local officials whom Gupta (2012) studies in his finely observed ethnography (and also from state workers generally studied in ethnographies of welfare institutions, who deliver services such as food stamps and subsidized housing). The rural local officials whose work Gupta (2012) documents implement state-funded programs to provide rural employment, administer old age pensions, and operate nutrition and daycare programs for children. There is no for-profit private provider of these public goods, no market for these benefits. Under the recent “neoliberal moment” (Doshi, 2013) in development planning and programs, the state has increasingly involved NGOs in the delivery of these programs, as Gupta (2012) notes in discussing the Integrated Child Development Scheme (ICDS). But the scale of non-state operators of development programs such as the ICDS is far smaller than the scale of the private health care sector in India. The latter commands about 80% of all outpatient transactions (about 70% among scheduled caste groups) (NSSO, 2006) and out-of-pocket expenditure on health care constitutes over 75% of all health care spending in India (Berman, Ahuja, & Bhandari, 2010). By contrast, state-run ICDS centres for pre-school children dominate in rural India,
particularly among the poor (Woodhead, 2012). As a public good, the proportion of health care provided by the state is far outweighed by the proportion provided by (and sought in) the avid private sector.

The state is an especially marginal player in the provision of urban primary care. This brings me to another qualification of Gupta's (2012) argument. Gupta (2012) argues that the poor have long been included in national projects of sovereignty and development; the paradox is that the poor are nonetheless consistently denied care. However, in the case of urban health care in India, the urban poor have been consistently left out of programs for health care all together. Health reforms have long neglected urban health care, focusing instead on the need to develop rural health services (Dasgupta & Bisht, 2010). Cities in India, as elsewhere in the global South, illustrate the effects of liberalization policies that envisage cities as engines of economic growth (Jessop, 2002), urban governments as self-sustaining and corporatized (Roy, 2002), and urban populations as individuated, viable market subjects (Coelho & Maringanti, 2012). In this vision of urban development, “inclusive” programs largely encompass the targeted, subsidized provision of housing and basic services, such as the national Basic Services for the Urban Poor (BSUP) program (Coelho & Maringanti, 2012, p. 42). However, funding for the BSUP is segregated from and subsidiary to investment in “large infrastructure schemes with arrangements for private participation and user fees” for full-cost paying citizens (Coelho & Maringanti, 2012, p. 42). Evidence suggests use of BSUP funds towards upgrading urban health care services has been marginal (Action for Children's Environments, 2013).
Municipal doctors therefore implement a mandate that is already poorly designed and inadequately resourced to meet the evolving needs of growing urban populations. In addition, developments in the commercialization of medical education and practice discourage an expansive, comprehensive notion of primary care. Municipal doctors attribute the limited scope of their work to constraints of their expertise, their mandate, and its everyday challenges. Although their work is located within state precincts, yet municipal doctors’ practices are circumscribed not only by the state’s narrow remit in urban primary care provision, but also by the presence of a large, dynamic private health care sector operating right outside their doors.

Municipal doctors’ perspectives and practices suggest that health care should be considered a public good not only because the micro-level act of giving medical advice is inherently rife with information asymmetries (producing private losses and socially suboptimal outcomes), but also because macro-level arrangements in the health care sector, and the social context in which health care is provided, can result in social costs and inequities (see Section 1.3). Denial of care in municipal clinics and hospitals is one such social cost and inequity. Reasons for these denials lie not only in doctors’ incentives and training to perform, but also in the social context in which they practice medicine.
7 Authority

7.1 Introduction to ‘authority’

The previous chapter considered how municipal doctors perceived risk in their everyday work. It explored, in particular, municipal doctors’ conceptions of risk with regard to treating chronic disease. In this chapter, I ask how municipal doctors experience and respond to authority in the course of their work. Looking beyond clinical encounters, I consider a wider range of challenges in municipal doctors’ everyday work at the frontlines of public service provision.

I define authority as a “species of social power,” and analyze how authority operates from the perspective of those who are subject to it (McLaughlin, 2013, p. 54). Authority is “an effective capacity in human relations, the capacity of one person or body of persons to have an effect over another person or body of persons” (McLaughlin, 2007, p. 46). Authority thus “has an exigency that advice or requests lack” (Green, 1998). However, authority does not imply force or coercion, but rather that the subjects of authority recognize it and submit to it (Green, 1998; McLaughlin, 2007, p. 54). I elaborate this definition in sections below—a necessary elaboration since how I define authority guides how I study it.

Given the substantial literature on authority in the social sciences and humanities, I should flag that my aim is not to debate concepts, classifications, or evaluations of
authority. Rather, my aim is to describe and explain the workings of authority as a social phenomenon as it shapes municipal health care provision in Pune. In particular, I ask: how do municipal doctors experience authority? What effects does it have on the challenges and outcomes of their work? How can we explain the provenance of authoritative directives that we observe in the world of municipal health care provision in Pune? My approach is thus sociological rather than philosophical, although philosophical accounts of authority inform how I define and study authority, as I explain further below.

My inquiry departs from most studies of power in health systems in focusing on authority over rather than power of frontline agents in service provision. Analysis of power in general is limited in health systems research (Gilson, Schneider, & Orgill, 2014; Erasmus & Gilson, 2008; Storeng & Mishra, 2014). Within that analysis, researchers have considered some aspects of the discretionary power of frontline agents (Erasmus, 2014). By instead theorizing authority—a particular kind of power—over frontline agents (here, municipal doctors), my study extends analysis of power in state-provided health care.

To study the workings of authority over municipal doctors, I examine municipal doctors’ clinical encounters alongside non-clinical instances of their work such as their interactions with other employees, administrators, and local communities. The doctors’ experiences and narratives suggest at least three sources of authority over them: political, bureaucratic, and popular. These sources of authority reflect two forms of authority, i.e., two ways that authority operates. One form of authority is the “practical authority” (meaning authority in matters of action) of local politicians and municipal administrators over municipal doctors. Local politicians and municipal administrators derive their authority
from formally established positions or offices of the state (Anleu & Mack, 2015; McLaughlin, 2007). They represent political and bureaucratic sources of authority over municipal doctors.

A second form of authority is the social power of popular opinion, specifically the popular opinion of local communities. Popular opinion does not strictly constitute “practical authority” over municipal doctors in the sense I define here. Yet it does exert, through routes of accountability between state agents and the communities they serve (Molyneux et al, 2012; Standing, 2004), a rightful social power over municipal doctors. Some scholars refer to the authority of popular opinion as a legitimating force on the state (Sheehan, 2002; Furedi, 2011). Other scholars refer to the ways popular opinion, duly deliberated and mobilized, can exert pressure on those in formal positions of political power and on public policy (Neem, 2011). In articulating the views of “the people” (Neem, 2011), popular opinion operates as both a gauge of state legitimacy and an influence on state functioning. As such, it shapes the conditions and direction of work of municipal doctors. Although municipal doctors are not duty-bound to directly and immediately act according to the views of local communities, they are, as state agents, compelled to take those views into account in their everyday decisions and actions. In sum, I consider two forms of authority: the practical authority of local politicians and municipal administrators and the (indirectly authoritative) social power of popular opinion, both of which present pressures on municipal doctors’ everyday work.

As I will show, these are not pressures of performance—such as to achieve statistical targets or improve procedural efficiency—which much research on the discretionary power
(and powerlessness) of frontline agents has documented (e.g., Soss, Fording, & Schram, 2011; Mishra, 2014; Kielmann et al, 2014). In that scholarship, researchers have examined how performance pressures upon frontline state agents explain unanticipated outcomes or low quality of public services. The pressures I study stem instead from the silences of policy neglect in the domain of urban governance and urban health care in post-independence India. These silences amount to what Hacker (2004, 2005) has termed “policy drift,” wherein social risks change, but existing policies remain stable and, thus, ill-equipped to address or ameliorate them. Policy reforms have delivered minimal upgrades and resources to municipal health care relative to growing urban health care needs (Kapadia-Kundu & Kanitkar, 2002; Dasgupta & Bisht, 2010). Apart from inadequate resources for health care, municipal doctors face pressures stemming from the historical weakness of municipal governance (i.e., the organization and operations of municipal government in India’s federal system); the strength of ward-level politics (wards being electoral and administrative sub-divisions within the city); and popular disfavor of state-provided services (vis à vis the private sector).

Municipal doctors thus operate at the frontlines of material inadequacies of and a negative social imaginary about state-provided health care.

In that position, municipal doctors confront at least three sources of authority. One, they confront the authority of local politicians, for whom municipal doctors are levers through which to direct state benefits to select beneficiaries or causes. Two, they confront the authority of administrators, whose management practices suggest the confluence of few formal guidelines, limited managerial training, and complicity with politicians. And three, they confront the popular opinion of local communities, who arrive into municipal facilities
“disenchanted” with state institutions (Kaviraj, 2005), seeking and claiming services for which they have little regard.

These confrontations present a challenge for doctors delivering municipal health care, namely, the challenge of addressing the unmet need for low-cost health care among the urban poor on the one hand and the neglect and notoriety of state-provided health care on the other. The challenge contributes to everyday dilemmas of public service for municipal doctors in Pune, and doctors’ response sustains a low operational equilibrium in the municipal health service. That is, in a context of policy neglect, the effect of authority is not to direct municipal doctors to enhance their performance, but rather to impel them to accommodate irregularities of municipal operations and popular disfavor of the state’s welfare institutions. I begin to demonstrate this argument by introducing one such dilemma—an instance of the workings of authority in Pune’s municipal health service.

7.2 “Just take care of it”

Note: The vignette below and others in subsequent sections concern interactions between municipal doctors and lower-level employees. In these interactions, doctors seem to wield substantially less power over subordinate staff than we might expect they would. However, I do not mean to suggest that lower-level employees have authority over doctors; by the definition of authority I have laid out, they do not. Neither do I analyze doctors’ authority over lower-level employees, which is a relevant question of organizational behavior but not one that I study and discuss here. Nor do I analyze doctors’ expert authority over patients, which is an important question in medicine and ethics, among other fields, but is not my
interest here. My interest is primarily in authority over doctors. As will become clear, I present
interactions between municipal doctors and lower-level employees to illustrate the workings
of political and administrative authority, to show how authoritative directives wend their way
through the assertions of lower-level employees.

* * *

A man slouched by the open door of the outpatient consultation room of Dr Neerja’s
municipal clinic but did not enter the room. The rail thin man, who seemed to be in his 40s,
looked unwell and unkempt, his chin stubbled, hair disheveled. Dr Neerja observed him as
he walked slowly past the door. “Look at this man,” she said. “He’s one of our employees.”
His job was to sweep and clean the premises, but he could not do any work, explained Dr
Neerja. He was given to drinking. “He does nothing. They [the municipal administrators]
can’t let him go, they have to keep him on their payroll.” Dr Neerja said the man had
managed to get himself assigned a posting to this municipal clinic. “At first I asked them
[municipal administrators], ‘What do you want me to do with this person? He does not do
any work.’ They said, sambhalun ghyalo (take care of it). So that’s what I do, sambhalun ghe-to. We
just take care of it. Just let it be.”

Other municipal doctors had informed me that although Class 4 employees, such as
this man, ranked lower than doctors in the organizational hierarchy, in practice they seemed
to have power over doctors. The majority of municipal doctors were designated Class 2
officers, which was the entry-level rank of doctors in the municipal service, while a few
municipal doctors held administrative positions and were Class 1 officers. A lament I heard
repeatedly from doctors was that Class 4 employees enjoyed the patronage of local politicians, whose assent was necessary for municipal staff appointments, and who ensured that favored employees kept their jobs no matter how well or how much they actually worked. Municipal doctors were less likely to cultivate such political connections and more likely to suffer the irrational decisions and summary actions of local political figures.

Some time later, the “useless” employee entered the consultation room. In a few words and with a nod of his head, he informed Dr Neerja that he was leaving for the day. Dr Neerja nodded back. There was more than an hour remaining before the clinic officially shut. After he left the room, Dr Neerja said that it was difficult to tell Class 4 employees to do anything, to instruct them to work, to fulfill their job duties. “Look,” she said, resignedly. “He is leaving, and he doesn’t ask me, he just tells me.”

***

Dr Neerja thus faced the authority of municipal administrators, on whose orders she integrated into the clinic’s operations an employee who contributed little work. She acknowledged the authority of local politicians, at whose behest the said employee had likely secured this position. And as I will elaborate below, municipal doctors’ experiences and narratives show how they confronted the popular opinion of communities who sought and claimed municipal services even as they held the quality of those services in low regard. These influences on municipal doctors’ work help explain the low quality of state-provided urban primary care as observed in Pune.
7.3 Theorizing authority

Authority is a type of social power, “an effective capacity in human relations, the capacity of one person or body of persons to have an effect over another person or body of persons” (McLaughlin, 2007, p. 46). Unlike other forms of social power, authority involves a right to power: an authority claims a right to impose duties on subjects, who recognize that claim and accept an obligation to follow directives (Green, 1998; McLaughlin, 2007). In other words, we say an entity is an authority when its subjects recognize that entity as holding a rightful (or normative) claim to power and its subjects submit to its directives (Green, 1998). By contrast, an entity that holds raw coercive (or dominative) capacity may be able to get people to obey its directives, but has to rely entirely on threats and force. Coercion, while also a form of social power, does not impose obligations or duties on subjects.

This impels a question theorists have posed: how is authority binding on its subjects? How do subjects “surrender” their own private judgments when they confront authoritative directives? (McLaughlin, 2007, p. 57). In taking that line of questioning, theorists propose that to explain authority we have to explain not only how actors holding authority exercise, maintain, and justify social power. We also have to comprehend how authority operates from the perspective of those who are subject to it. Specifically, we need to understand not only how subjects recognize authority (how they believe or accept it as rightful—a question of the normative relationship between authority and subjects), but also how authoritative directives feature in subjects’ everyday reasoning about their actions (a question of private reasoning and judgment, akin to what sociologist Margaret Archer (2003) calls subjects’ ‘reflexive deliberation’).
A prominent philosophical answer to the question of how authority is binding on subjects is that an authoritative directive offers its subjects a “content-independent” reason for action (Hart, 1982). That is, authority requires its subjects to follow its directives irrespective of the content of that directive. The defining reason for action resides in the fact that the authority issued the directive, not in the content of the directive. This does not imply that subjects entirely deny their private, competing reasons for action. Rather, authority offers subjects a reason for action that pre-empts or excludes their private reasons for action (Raz, 2006). As appeals to reason, authoritative directives require some compromise of subjects’ autonomy, but not a suspension of private judgment (McLaughlin, 2007). Authority entails the power to secure conformity from subjects, but it does not suppose compliance, meaning that while subjects may follow a directive (rules, commands, norms), they may not be wholly guided, in their own practical reasoning, by all the reasons that authority provides (Perry, 2013).

This theoretical construction guides my analysis in this chapter. Specifically, it guides me to focus on the ways authority “figures in the practical reasoning of its subjects” (McLaughlin, 2013, p. 54). The subjects of authority in my project are doctors in Pune’s municipal health service. Entities holding authority include municipal administrators and local politicians, who derive their authority from the state offices they hold. In the vignette above, politicians exerted their authority by sustaining on the municipal payroll a lower-level employee who was unable to work. Administrators exerted their authority by directing municipal doctors to manage within their work his stray habits and scarce contribution to the clinic’s functioning. Municipal doctors experienced the authority of administrators and
politicians as directives to “just take care of” the delinquent employee and accommodate the political patronage behind his post in the clinic.

The popular opinion of local communities is a third source of authority over municipal doctors. Popular opinion exerts a social power over state agents that some scholars characterize as authoritative (Sheehan, 2002; Furedi, 2011). Popular opinion is arguably a rightful social power over municipal doctors because it represents citizens’ right to voice perceptions of and claims over state services, a right that citizens enjoy in a democracy. In a democracy, state agents are compelled to respond to citizens’ voices in a bid to maintain democratic legitimacy. That is, legitimacy in a democratic system rests not simply in counting votes as an expression of the “will” of the citizenry (Powers & Faden, 2008, p. 182). Rather, legitimacy requires that state agents’ decisions about public services are at least informed by citizens’ views and ideally also constrained by substantive considerations of justice (Powers & Faden, 2008, p. 184).

The manner in which state agents respond to citizens’ views may be slow and indirect, subject to local and extra-local collective deliberation and negotiation, put through technocratic and political decision-making procedures. These processes and the configurations of welfare services they produce can vary across time and place, yet the role of popular opinion is globally evident. Researchers have documented the historical foundations of and extensive variation in welfare states across both industrialized and developing countries (Mares & Carnes, 2009; Mares, 2003). Reasons for the variation include countries’ differing forms of class and partisan conflict and strategies of organized interest groups, along with differences in mass public opinion (Brooks & Manza, 2007). This
evidence suggests that popular opinion does influence state-provided services through electoral, social, and political processes. It affirms the social nature of public goods, which the state provides not simply at its behest or through technocratic decision-making, but also in response to the public’s expressed needs and preferences.

Frontline state agents, such as municipal doctors, may not (or maybe unable to) directly or immediately act upon popular opinion, but they cannot neglect to listen. They are duty-bound to take account of the views of the public in the course of executing a state mandate, even if they are not duty-bound to deviate from that mandate based on the public’s views, at least not without due institutional process.\textsuperscript{240} In other words, municipal doctors may not be duty-bound to comply with the directives of popular opinion—expressions of people’s wants, preferences, and claims—in their everyday work, as they are duty-bound to comply with the directives of administrators and politicians. Yet, the directives of popular opinion operate through routes of accountability of municipal doctors to the communities they serve (Molyneux et al, 2012; Berlan & Shiffman, 2012). These routes range from mechanisms for communities to monitor service providers and voice complaints, to channels for citizens to participate in local decision-making, to processes of “broader social and political change” (Molyneux et al, 2012, p. 542).\textsuperscript{241} Routes of accountability encompass not only technical means to overcome principal-agent problems in public service delivery, but also political processes through which citizens’ views travel across and shape policy implementation and decision-making. As I will show, municipal doctors recognize the authority of popular opinion, i.e., they recognize people’s claims over state-provided services, even if they rail against the misinformation that undergirds people’s perceptions of those services.
In sum, I examine authority as a form of social power that directs municipal doctors’ actions and potentially the quality of health care. In the health systems literature, there is growing interest among researchers in theorizing frontline service providers’ actions in terms of their discretionary power. By framing frontline service providers’ work as a response to authority—rather than as an exercise of discretionary power—my project complements that literature both theoretically and empirically. I first discuss prominent themes and approaches in that literature, and then argue how my project extends it in the next section.

7.4 Studies of power in health care settings

A limited body of research in the health systems and policy analysis literature in LMICs has addressed questions of the power and agency of frontline actors, such as health care providers (Gilson, Schneider, & Orgill, 2014; Erasmus & Gilson, 2008). (As far as I have found, nowhere in the health systems literature is the theory of authority an explicit topic of inquiry). Studies from India examining health care providers’ agency are also limited and have not conceptualized or theorized this agency with reference to the scholarship on power (Sheikh & Porter, 2011). Yet, there is an emerging interest in the construct of power, including in India-focused research (Storeng & Mishra, 2014; Mishra & Chatterjee, 2013).

Prominent themes in the India-focused literature are providers’ exercise of discretionary power and their vulnerabilities in the context of service provision (Sheikh & Porter, 2011; Sheikh & George, 2010). Studies have shown, for example, that practitioners in both the public and private sector infringe public health guidelines, flout regulations, and
violate protocols, all of which are instances of their exercise of “negative” power (Peters & Muraleedharan, 2008; Uplekar, 2000; Bhat, 1999). Other studies show how medical practitioners are constrained to voice their concerns in administrative processes or have their opinions and knowledge counted in policy decisions, leaving them unable to exercise “positive” power (Sheikh & Porter, 2011; Baru, 2005, 2009; George, 2009; Mishra, 2014).

Where programs rely on coordination among a range of public and private providers “who have different sources of legitimacy, power and willingness to contribute towards a shared goal,” health workers are compelled to balance personal ethics and commitments to patients with the goals and powers of more credentialed providers (Kielmann et al, 2014). The India-focused literature thus suggests that health system actors may resist following regulations and subvert program goals on the ground, and simultaneously face a lack of power and opportunity to contribute to program decisions and upstream policy processes.

Similarly concerned with power relations in health systems, Erasmus (2014) undertakes a synthetic review of studies that draw on Lipsky’s (1980) theory of street-level bureaucracy to explore how health system actors exercise discretionary power in the course of implementing new directives or emerging policy. The studies in that synthetic review, which are based outside India, suggest common themes of actors’ resisting authority in contexts of top-down policy processes. The studies suggest that health system actors may take either supportive or unsupportive stances towards new policies. Actors may cope by disregarding policy direction and breaching expectations, or by applying their own logic, derived from personal beliefs and values, to a situation (Erasmus, 2014).
Research on the discretionary power of frontline actors thus highlights a tension between what actors are expected to achieve in policy or program implementation and how they act in response. It suggests what we might expect to find at the frontlines of service provision: that health care providers face top-down administrative structures and processes that undermine their local knowledge, possibly conflict with their personal or professional principles, and disempower them from communicating their views. Providers nonetheless do exercise “negative” discretionary power, such as desisting from following formal guidelines. The literature offers few examples of providers’ exercising “positive” power, such as taking initiative and building further upon the directives given to them. However, as Gilson, Schneider, and Orgill (2014) conclude, although frontline actors’ practices of power seem to largely work “to obstruct policy implementation and undermine service delivery,” yet the absence of evidence to the contrary is not evidence of absence of this type of power.

7.5 How my project contributes to that literature

While my project explores power relations in the context of service provision, it extends research in this realm in two respects. First, my empirical focus is the everyday work of municipal primary care and not a specific, novel program or intervention. My project examines power relations that municipal doctors confront under regular conditions of work and the dilemmas of public service they create, untrammeled by new power relations that a novel program or intervention might introduce. Second, I theorize authority over municipal doctors rather than municipal doctors’ exercise of power. I identify the authority of entities in official positions (municipal administrators and local politicians) and the authority of popular opinion (views of communities that municipal doctors are meant to serve).
examine the nature and provenance of authoritative directives, what municipal doctors do in response, and how they reason their practices. I discuss these two points in turn below.

7.5.1 Studying social conditions of work rather than a specific program

Studies of power in health systems have frequently explored how frontline health system actors respond to an intervention, i.e., how they exercise discretionary power in the course of implementing a specific, often newly established, program or policy. Such an approach has to account for new sources of power that a new policy or program can introduce into existing power relations. As Gilson, Schneider, and Orgill (2014) remark, “Newly defined roles and responsibilities might represent a power source, e.g. as might the enhanced provider credibility, additional resources or new spaces of engagement with beneficiaries that a new policy might bring” (p. iii62). When a program introduces new actors into an existing system of governance—such as with “health visitors” new role in the tuberculosis control program that Kielmann et al (2014) study—the new actors affect the distribution of power among already present actors.

In contrast, my fieldwork examines how municipal doctors put into practice the regular, on-going municipal mandate for primary care, a decades-old municipal government obligation in Maharashtra. The Maharashtra Municipal Corporations (MMC) Act, which guides municipal government operations, dates from 1949 (Government of Maharashtra, 2014). While the MMC Act has been amended numerous times, municipal obligations in health care service provision remain unchanged within it. During the two-year period of my fieldwork, the municipal government undertook no significant reform of its primary care
services. National policy reforms in health and in urban development over the past three decades have barely affected the organization of or resources for municipal primary care services (Kapadia-Kundu & Kanitkar, 2002; Duggal, 2011). In sum, municipal health services have long functioned without what Hacker (2005) calls “compensatory interventions … to ameliorate intensified social risks” (p. 46). That is, despite demographic and political-economic transformations in urban India, policy reform of urban health care has been marginal (Kapadia-Kundu & Kanitkar, 2002; Dasgupta & Bisht, 2011). Thus, contrary to other studies, the power relations I observe do not derive from and are not contingent upon a specific or novel health policy or program.

Policy neglect, however, can create its own dilemmas. Municipal doctors did not labor under the “coercive power” of evaluative systems designed to enhance worker productivity (Brodkin, 2012; Soss, Fording, & Schram, 2011) or the imperative to meet top-down statistical targets that lacked sensitivity to ground-level social realities (Mishra, 2014). Yet, as I will show, municipal doctors were “rarely free to act as they wish[ed]” (Soss, Fording, & Schram, 2011, p. 230). Exploring how, in a context of policy neglect, authoritative directives created particular conditions of work for municipal doctors is a key aim of this chapter.

7.5.2 Theoretically interrelating power, authority, and subjectivity

Much research exploring power and politics in health systems, specifically in regard to medical practice, insufficiently applies theories of power and lacks “analytical detail” (Sheikh & Porter, 2011, p. 85). Sheikh and Porter (2011) argue that although many studies have
conceptualized medical practitioners “as exponents of different types of power,” the power relations examined in these studies have largely reflected medical practitioners’ power in the field of clinical medicine: power over the discourse of illness, the production and utilization of health knowledge, and barriers to entry into the medical profession (p. 84). Few studies in LMICs examine medical practitioners’ relations of power with respect to other health policy and health system actors (Sheikh & Porter, 2011). While the literature suggests broad themes, such as providers’ ability to resist authority, disregard program guidelines, and limit policy success, it offers little development of theoretical concepts, mechanisms, and hypotheses.

Echoing that point, Erasmus (2014) finds that studies applying theories of street-level bureaucracy to explore discretionary power examine some aspects of the conditions of street-level work, such as conditions of low resources, top-down administrative structures, and overwhelming demand for services. But the studies do not much explore “other conditions of work highlighted in the original theory [of street-level bureaucracy], including the often ambiguous, vague and conflicting goals of the organizations they work for and the fact that their clients are typically non-voluntary and not necessarily a primary reference group for street-level bureaucrats” (Erasmus, 2014, p. iii78). The studies well-represent street-level bureaucrats’ resistance of authority, but under-examine other behaviors, such as their “modification of their job conceptions and conceptions of clients” (Erasmus, 2014, p. iii78).

The problem that Erasmus (2014) identifies is not just an empirical lacuna, a “gap” in the literature. Importantly, it suggests an analytical oversight, one that theorizing authority
helps address. Power and authority are closely related but conceptually distinct. The yield of focusing on authority rather than on power, as I will discuss below, is that it gives us greater purchase on specifying “conditions of work” at the frontlines. By identifying entities holding authority, and examining how frontline actors experience, reason, and respond to authoritative directives, we may provide, with greater “analytical detail” (Sheikh & Porter, 2011, p. 85) an explanation for the quality of state-provided health care.

As discussed above, authority is a species of social power (McLaughlin, 2013). A theory of authority—of how authority operates, observed from the perspective of those who are subject to it—helps guide analysis of not only what municipal doctors do, but also how they reason their practices and which entities feature in their reasoning as constraints or enablements on their actions.

Power is a broader concept. It is both a relational phenomenon (involving interactions among people) and a structural phenomenon (inhering in environments and systems of social identities, laws, norms, and practices that are imbued with meaning) (Parker, 2011; Hayward, 1998; Lukes, 2005).246 Scholars have argued that we ought to acknowledge “a link between power and responsibility: that part of the point of locating power is to fix responsibility for consequences held to flow from the action, or indeed inaction, of specifiable agents” (Hayward & Lukes, 2004, p. 7). That is, in an analysis of power, we ought to identify entities who are in positions of power in order to attribute responsibility (praise or blame) for observed outcomes to specific agents (Hayward & Lukes, 2004). As my focus on authority makes clear, I take power to be both a relational and structural force. My primary interest in this study is how actors experience power relations
under particular structural conditions. The structural conditions here refer to the urban political economy, while specific relations of power among individuals derive from their positions in the municipal administrative hierarchy. The structural and relational factors are linked: the political-economic salience of cities influences the organization of municipal administrative hierarchies and responsibilities vis-à-vis state government, and hence affects relationships among individuals within municipal government and relations between state and societal actors in the city.

Focusing on authority enables us to distinguish, within the myriad forms and workings of power, entities holding rightful social power, whose directives enter into municipal doctors’ reasoning and shape their actions. Municipal doctors recognize the right of the entity to issue directives (or, in the case of popular opinion, to state claims), but may not agree with the content of the directives: such discordance opens a space for us to examine what doctors construe as constraints on and enablements for their actions. As I have previously pointed out, municipal doctors’ experiences and narratives suggest they are subject to at least three specifiable sources of authority, namely, political, bureaucratic, and popular. The authority of municipal administrators and local politicians derived from political and bureaucratic positions of power, and the authority of local popular opinion derived from relations of power between the state and citizens.

To depict how authority informs actions, I document municipal doctors’ experiences of and narratives about how authority constrains or enables their everyday work—I examine their experiences of and “reflexive deliberations” (Archer, 2003, p. 8) about authority.
thus seek to explain, with greater analytical detail than in most previous research on power in health systems, the low quality of municipal health care in Pune.

* * *

In sum, in this chapter I examine dilemmas that municipal doctors confront as they negotiate authoritative directives in their everyday work and the consequences it has on their practices. As the following sections will show, the workings of authority were evident in municipal doctors’ experiences of and narratives about (1) the assertions of lower level employees, (2) mismanagement of public resources, (3) patients’ use of political connections, (4) people’s expressions of their “ownership” of public services, and (5) people’s low regard for municipal services. Experiences and narratives under (1), (2), and (3) most clearly reference the practical authority of political and bureaucratic sources of power. Since doctors’ experience and reasoning of political and bureaucratic authority were closely entwined, I discuss them together in the next section. Municipal doctors’ experiences of and narratives about (4) and (5) reference the social power of popular opinion, which I take up in a subsequent section.

7.6 The authority of administrators and local politicians

In this section, I discuss how municipal doctors experienced the authority of administrators and political actors through (1) the assertions of lower level employees; (2) instances of mismanagement and misdirection of public resources; and (3) patients’ use of political patronage. Municipal doctors’ responses to and narratives about these experiences show
how authoritative directives served to circumscribe their actions and delimit quality of health care. In accommodating authority, municipal doctors effectively reinforced a low-effort status quo.

While these expressions of authority featured in the course of everyday municipal health care provision in Pune, they indicate characteristics of the state and politics in urban India more generally. Those characteristics, which I elaborate in subsequent sections, help explain why authority appeared as it did for municipal doctors: quotidian and informal, with calls to contain contingencies, rather than ordered and formal, with calls to elevate performance.

### 7.6.1 Assertions of lower level employees

On the morning that a municipal doctor was to conduct a health camp in a low-income neighborhood in the city, where she and two nurses would set up an immunization desk within the neighborhood, one of the nurses requested to be excused from her duties at the camp. The two nurses came together to see the doctor as she was preparing for the camp. The doctor questioned the nurses. The camp had been planned well in advance, she reminded them. All the nursing staff had been designated their roles, both in the hospital and for the camp, weeks ago. Why were they making this request to be excused from camp duties today? Why now, less than an hour before they were scheduled to depart?

The nurse requesting to be excused explained there was an event at her daughter’s school. The other nurse assured the doctor she had done this work before, she could
manage the camp on her own, and the two of them had worked it all out between them. The request was possibly sincere, yet it showed the nurses’ quiet strategizing to enable one nurse to remain inconspicuously absent from both the health camp and the municipal hospital in the middle of the workday.

Municipal doctors frequently faced such requests, voiced and unvoiced, from lower level employees: requests to make exceptions to rules, overlook shortcuts, or tolerate low standards of work. In municipal doctors’ experiences and narratives, these requests—effectively the assertions of lower level employees—underscored the authority of administrators and politicians, who condoned the requests. Administrators directed municipal doctors to make allowances for errant, “useless,” or grumbling employees, and politicians hinged doctors’ job transfers partly on doctors’ making such allowances.

In response, municipal doctors often ceded to the requests, or as this doctor put it, “adjusted” their own work accordingly. The doctor hesitated but did not deny the nurse’s request. “You have to adjust,” she later observed to me. “If you don’t adjust,” meaning accommodate such requests, “then it creates trouble for you later.” The “trouble” here stemmed from what some doctors termed the apparent reign of lower level employees, who held stronger connections to local politicians than did doctors. According to doctors, paramedical and support staff of the Pune municipal health service were used to being treated with leniency. As the doctor above put it: “Take a holiday here. Get off early there. Come late, leave early. If you try to be too strict with them, give them late marks and such, then they get together, go to the corporators [local politicians], and get you transferred.” One couldn’t afford to be that strict, she said. It didn’t work in the municipal health service.
Municipal doctors’ experiences suggested they most frequently confronted these assertions in small ways. Although doctors did not always acquiesce, these minor acts of resistance and presumption by support staff were a regular feature in their work. One such act of presumption by a lower level employee occurred under Dr Srinath’s supervision. An assistant (non-clinical worker) had come to Dr Srinath’s desk at 4:30pm, half an hour before the municipal hospital officially closed for the day. The assistant came bearing a ledger in which nurses recorded details of anti-rabies vaccine therapy the hospital had administered that day. Protocol required that Dr Srinath sign the ledger at the end of the business day, effectively declaring the day’s work done in that department. Dr Srinath joked with the assistant, asking if she intended to leave early. There was still half an hour to go before the hospital was due to close, he reminded her. As the assistant wordlessly walked away, Dr Srinath explained to me that had he signed the ledger, the assistant would have alerted the security guard to tell prospective patients the municipal hospital was not seeing any more dog bite cases that day. Patients requiring anti-rabies vaccinations would be turned away, he said, even though doctors were present and working inside the hospital.

Although the ledger-bearing assistant had not protested Dr Srinath’s sending her away without his signature, some support staff were vociferous in expressing demands. In another municipal hospital, two municipal doctors silently watched as an assistant noisily thumped down atop their desk a large fabric shopping bag containing drug supplies for the hospital’s pharmacy. The assistant was perspiring profusely. His eyes bulged with anger. He had just arrived from the central municipal drug store, from where he had picked up the regular replenishment of drug supplies for the hospital. “There are so many bottles [of
liquid] in here!” he exclaimed. “I have a blood pressure problem!” He seemed incredulous and indignant at the task he had to fulfill, to bring this heavy load back to the hospital, given his health condition.

The doctors said nothing in reply. After the assistant left the outpatient consultation room, the doctors calmly discussed what they considered his outsize reaction to a standard practice. “All the assistant has to do is travel there, present the requisition form, and come back with the drugs which the medical store people will place in the bag,” said one doctor. But this employee often complained he was unwell, talked up his high blood pressure, she continued. He had even said he would go to the local politician and complain. The other doctor jovially added:

Let him go, let him complain, let him ask for a transfer! But no, he wants to be posted only in this location, and he does not want to work. Why not take medical leave and stay at home? He wants to draw a salary and yet come to work and complain. I’m going to say to [the politician], either you transfer him, or you transfer me! I would like to be transferred, please transfer me from here, I will tell him!

They laughed. The doctors were unperturbed by the man’s behavior, even amused by his histrionics. But their humor and guarded response suggested they surmised this situation—of support staff who could not be pushed to work harder—to be beyond their control.251
7.6.2 Mismanagement of public resources

For municipal doctors, the assertions of lower-level employees were indirect expressions of authority of administrators and politicians. In contrast, the misuse of public funds or incompetence in management suggested direct expressions of authority. Municipal doctors had to either comply with directives that disrupted their clinical work, or leave unquestioned management decisions and practices that suggested incompetence or corruption. As one municipal doctor put it, observing municipal operations was like waiting and watching a train wreck as it happened.

One such wrenching spectacle that municipal doctors described concerned an intensive care unit (ICU) built at a municipal hospital. Constructed at great cost in 2012, the ICU lay unused (at least until 2015) in part because the municipal health service was unable to recruit appropriate specialized doctors and paramedical staff (Isalkar, 2015a; TGS News Service, 2015). By law, any expansion in staffing required approval from state-level government, and such approvals had been difficult to obtain. Local politicians could influence some public resources towards health care infrastructure, but were unable to create new staff posts without approval from state-level government. Another municipal hospital suffered the same fate due to lack of qualified staff: originally constructed in the 1940s, the municipal government had demolished and rebuilt the hospital over the past decade. It was now a multistory structure with the capacity for higher-level medical care. But without qualified staff to deliver that care, the hospital served largely as an outpatient primary care facility (Sayyed, 2014).
Municipal doctors perceived such investments in tertiary health care as indicating that politicians undervalued basic medical care. One municipal doctor observed he had been “stunned” by the impressive quality and sophisticated technology of a newly constructed operating theatre in a municipal hospital. But he was ambivalent about the purpose and effect of this spending:

For the last three years, no one has been using it. It is kept locked, because we don't have staff or supporting system. And no one has asked why this is the case. No one has tried to fix this. A huge amount of money was spent on building the operating theatre. And a good percentage of that went into the pockets of various people. But the level of care has not improved.

A local activist explained that such inexplicable expenditures were sometimes the result of politicians’ idea they could “do something for the system” (as opposed to helping individual voters case-by-case) by spending money on it (as opposed to improving its running). The municipal health service had once bought two dialysis machines, an expensive purchase, the activist informed me. But since they had no trained staff or budget to operate them, they gave the dialysis machines to a well-regarded private hospital under the condition that poor patients would receive treatment for free or at subsidized rates at the hospital. Public funds had buttressed a private facility, leaving unreformed basic outpatient services that were the core municipal mandate.
For municipal doctors, unwarranted public spending and unchecked daily operations in the municipal health service not only undermined health care as a public priority, but also the worth of municipal doctors’ daily work. As one municipal doctor recounted:

There is no evaluation. No-one checks the results of my treatment [of patients]. I arrive to the hospital in the morning at 9am and I leave at 5pm, and what I do in between, no-one is concerned. I get my payment no matter what I do in that time. … They [municipal authorities] just want to avoid making a noise. Avoid creating a situation of drawing attention [to the institution].

When I asked the municipal doctor if most people worked this way, he replied they did. Most people, he said, passed through the day “making sure nothing out of the ordinary happens.” He went on:

If I have enthusiasm, my enthusiasm is not supported by the system. … And we need staff. I mean, we have staff, overall the staff is very large, but the management of the staff is very poor. Their transfers are guided by political interests.

Another municipal doctor spoke of not only the apparently lackluster interest among administrators in improving efficiency, but also gaps in their competence to do so. This doctor recounted the challenges he had faced in obtaining from the municipal health department basic equipment and supplies for a hospital he had been charged with managing. Administrators had not put in place a plan for the hospital, said the doctor, and their responses to his requests suggested they had little idea of what such a plan would comprise.
Yet municipal doctors desisted from challenging irregular instructions from administrative quarters. In cases where an instruction or assignment concerned a political priority, they surmised they had little leeway to negotiate. In one instance, several municipal doctors had received orders to leave their clinical positions at municipal hospitals and begin an administrative assignment at the city’s birth and death registration office. The registration office was managed by the municipal health department. As part of that assignment, hundreds of thousands of the city’s birth and death registration records had to be urgently digitized. Stacks of thick, musty handwritten books containing several decades of records had to be transcribed before their ink faded and pages deteriorated. The information they contained had to be stored so it was easy to access, harder to tamper with.

Administrators had pulled municipal doctors from clinical duties and assigned them the task of supervising a fleet of data entry operators. The assignment was temporary but it was not brief: municipal doctors spent months checking data entry and making decisions about incomplete records of births and deaths.

I learned that the doctors had initially fretted about the assignment but did not protest the job transfer too strongly, that administrators had encouraged them to persevere for the arrangement—it was a necessary public service, one that fell squarely, legally, and urgently to the municipal health service. There was as well, in such cases, the question of maintaining good relations with municipal administrators, of carefully considering the requests one made to the administrators, noted a doctor who had not been transferred.

7.6.3 People’s use of political connections
A group of young men—one patient with four companions, all roughly in their early 20s—arrived at the door of an outpatient consultation room of a municipal hospital one afternoon and insisted on immediately being seen by the doctor. This occurred during a lull in the afternoon, just as three doctors were taking a five-minute tea break to drink steaming *cha* from a vendor had delivered, in shot-glass sized cups, to the outpatient consultation room. There had been no patients waiting to be seen. The group of young men arrived at that moment, attempted to enter the consultation room, and witnessed cups of tea on the desk, doctors leaning back in their chairs.

The events that ensued illustrate municipal doctors’ experience of the authority of politicians, specifically politicians’ power to direct doctors’ everyday work through the patronage they supplied to their electoral supporters. The young men seemed ready to call on this patronage, and municipal doctors were compelled to respond.

The young doctor in charge of the consultation room, who had joined the municipal health service relatively recently, told the men to wait for a few minutes, that they would be called right in. The men backed away from the door of the room, but seemed restless and hovered just outside it. The assistant in the consultation room (non-clinical staff), who had long experience in the municipal health service, was seated near the door from where she minded the flow of patients through the consultation room. The assistant realized what was about to happen when she saw the men had begun dialing numbers on their cellphones. She alerted the doctors the men were calling a local politician, urged the doctors to let the men in before there was a fuss, and motioned to the men to enter.
The doctor in charge was furious, but said nothing as she examined the patient and wrote a prescription. Intensely aware of how the scene had appeared—unfinished cups of tea on the desk, doctors chit-chatting in the afternoon—she bristled. Could the men not have waited for two minutes?, she wondered aloud after they left. “Could we not at least [be given time to] clear the cups before they came in? It does not look nice to have the cups there when patients are in the room.” The patient was not seriously ill, the doctor noted. He was on his feet; he had walked in comfortably. What was wrong, she questioned rhetorically, if she had asked them to wait? The assistant tried to calm the young doctor down, telling her to “Let it be. Let it go.” All the good work they did would come to nothing, said the assistant, if they let these small inconveniences turn into bigger incidents.

Tea breaks for doctors were not scheduled in regular outpatient hours, and the politician’s supporters had caught the municipal doctors in an awkward though relatively benign moment. The incident exemplified municipal providers’ sense that people would not hesitate to use the authority of local political figures to gain, even force, access to municipal health care services. In response, municipal providers had to either give in to their demands, or as in the example below, cautiously stand their ground.

One municipal doctor had to stand her ground during an overnight shift in the casualty room of a municipal hospital. The casualty room was severely limited in resources. It served largely as a first aid counter; doctors on duty referred most emergency cases to larger hospitals. Yet, as the municipal doctor recounted, a patient had once arrived at night in the casualty room and insisted on being treated for an injury. The patient’s companions had immediately telephoned a local politician when the doctor said she would be unable to
handle the case. The companions had asked the municipal doctor to directly speak with the politician on the phone. But the municipal doctor had refused to take the call, saying she was not allowed to do so. The municipal doctor noted that handling emergency medical cases was a relatively easy task—the doctor’s role was largely to manage the patient’s referral. Confronting politically connected patients, on the other hand, was far more difficult and unpleasant.

7.7 Explaining the provenance of political and bureaucratic authority and its effects on the work of providing municipal health care

7.7.1 The nature of authoritative directives: Quotidian, informal, contingent

From doctors’ perspective, expressions of authoritative power frequently entailed quotidian, informal requests, often to maneuver around or reconcile with contingencies: having to “take care of” a delinquent employee; having to excuse the absence of a nurse on the day of a camp; being asked to close a ledger before time; being temporarily pulled from clinical duty and assigned an administrative task. Authority appeared to demand that doctors sustain the status quo rather than transcend it. Municipal doctors noted that administrators did not formally evaluate employee performance. Recently recruited doctors informed me they had received no formal training or orientation to the municipal health service, as they had in previous jobs in the state government health service. The municipal health service seemed to run largely on praxis—learning through practice—with few checks on the rationality and reasonableness of those practices.
Where expressions of authority concerned allocating resources and managing operations, municipal doctors faulted administrators and politicians for transgressions of power or basic incompetence. Some transgressions were significant, such as an expensive ICU locked and unused for years. But the ICU not only reflected a mark against municipal government, raising questions about its misplaced health care priorities and misuse of public funds. It also reflected the abiding control of state-level government over municipal budgets and staffing, raising questions about the hierarchical relationship between the two. Smaller faults, such as basic supplies unavailable when needed, raised further questions about incompetence in municipal government.

What explains the nature of authoritative directives—their largely quotidian, informal nature—that we observe in municipal health care in Pune? What explains the apparently weak managerial capacity of municipal government and its fraught relationship with state-level government? To understand why the authority of administrators and politicians manifests in these ways, I turn to scholarship on the state and politics in urban India. Two themes in that scholarship are relevant here: the historical weakness of municipal governance and the importance of the poor in urban politics. As I elaborate below, the themes suggest why these expressions of authority prevail at the frontlines of municipal health care provision.

7.7.2 The historical weakness of municipal governance and the power of “poor people’s politics”
Institutions for municipal governance have remained largely unreformed since India’s independence. Reasons for the neglect of municipal reform include the rural focus of development policies in India, and the strong influence of central and state-level governments over the running of municipal government. Out of demographic and strategic-political exigency, leaders in post-independence India oriented national development efforts mainly towards rural development (see Chapter 4). Through the 1950s, where these efforts encompassed an urban focus, they aimed to foster new industrial townships and experiments in master-planned communities, not to strengthen existing urban centers or their governance (Weinstein, Sami, & Shatkin, 2014).

Over the 1970s and 1980s, instead of reforming municipal governance in rapidly expanding cities, central and state-level policies introduced alternative, overlapping, competing institutions that fragmented it (Weinstein, Sami, & Shatkin, 2014). Novel initiatives included metropolitan development authorities; satellite towns to deconcentrate metropolises; parastatal agencies for housing, area development, and roads; and legislation for urban land ownership (Wienstein, Sami, & Shatkin, 2013; Ruet & Tawa Lama-Rewal, 2009). These measures provided central and state-level governments some control over economic development in and around cities, but did little to address a growing need for urban public services.

From the 1990s, legislative efforts and urban development programs have aimed to improve governance of cities but without significant success. In particular, the 74th Constitutional Amendment Act (CAA) of 1992, designed to devolve greater administrative responsibility and political power to municipal government, has failed to usher in municipal
reforms (Murthy & Mahin, 2016; Sivaramakrishnan, 2013b, 2013bc). Scholars have proposed several reasons for its failure, a chief reason being the relative power of central and state-level government over municipal government in India’s federal structure, which the law did not overcome. As Murthy and Mahin (2016) argue, the CAA’s constitutional provisions do not mandate decentralization of powers from state-level to municipal governments, but rather give state-level governments the discretion to enact such devolution. Municipal governments must therefore “wait for such power” to be devolved to them by states (Murthy & Mahin, 2016, p. 113).

However, state governments have been reluctant to empower municipal governments, fearing a loss of control over the direction and spoils of urban economic growth, and arguing circularly that municipal governments have low administrative capacity to actually take on the task of delivering public services (Murthy & Mahin, 2016). State governments have been particularly reluctant to decentralize to municipal governments the power to raise their own revenue and manage their budgets (Ruet & Tawa Lama-Rewal, 2009). Thus, although municipal governments can plan and propose budget allocations, they cannot enact or implement these proposed budgets without the approval of state governments.

The 74th CAA thus remains incompletely implemented and toothless in its effects. Central government can only direct urban development through state governments, which continue to exercise strong oversight over municipal governments. For state governments, the concerns of rural populations—representing the majority electorate—have long been a greater imperative. State governments have paid little attention to the substance of urban
development, the quality of staff, and the relevance of operating guidelines to govern cities (Weinstein, Sami, & Shatkin, 2014; Kapadia-Kundu & Kanitkar, 2002).

This neglect of urban public services and operating guidelines for municipal government is especially true for urban health care. The central government first commissioned a committee to report on urban health care needs in 1982. The committee delineated guiding norms and needs for health care in urban areas, but these were not implemented (Kapadia-Kundu & Kanitkar, 2002). The National Urban Health Mission, a national program to reform urban health care, was initially proposed in 2006 and finally launched in 2013, eight years after the launch of its counterpart rural program, the NRHM (MOHFW, 2014b; Dasgupta & Bisht, 2010). Municipal administrators have therefore long operated municipal health services without uniform guiding norms, and cities across India vary in the types and extent of health care services they provide to urban residents (MOHFW, 2013c).

One program effort to encourage state governments to attend to urban development was the national Jawaharlal Nehru National Urban Renewal Mission (JNNURM), initiated in 2005, which imposed “conditions on states receiving grants” to enable “the modernization of accounting systems, improvements in property tax collection efficiency, a movement toward full cost recovery in infrastructure and service delivery, a more effective implementation of the 74th Amendment, and the repeal of the Urban Land Ceiling and Regulation Act, a 1976 act that had placed ceilings on private land ownership and had granted states the authority to acquire open land in excess” (Shatkin & Vidhyarti, 2014, p. 11). But state-level politicians “dragged their feet” on implementing the JNNURM to retain
their privileges and powers and not cede control over funding to municipal governments (Shatkin & Vidhyarti, 2014, p. 11). The impact of the JNNURM has been largely in the realm of urban infrastructure (such as roads and transportation) and real estate, not improving basic public services or reforming municipal governance (Coelho, Kamath, & Vijaybhaskar, 2011; Coelho & Maringanti, 2012).

At the same time as states remain powerful vis-à-vis municipal governments and municipal governance remains largely unreformed, ward-level politics have become more vital and dynamic within cities. This has not, however, occurred in ways that have enhanced the overall quality of municipal planning or administration. “Wards” are electoral and administrative sub-divisions within the city. Several electoral wards may comprise a single administrative ward. As Baud and Nainan (2008) describe of Mumbai, electoral wards are the smallest unit of municipal government, while administrative wards refer to the next largest unit and delineate areas for managing public services. The 74th CAA calls for municipal governments to decentralize political participation to the level of the ward. This includes holding regular elections for ward-level political representatives, devolving specific functions and budgets to them to serve their constituencies, and establishing “ward committees” to include citizen voices in local administration (Weinstein, Sami, & Shatkin, 2014; Baud & Nainan, 2008). According to the 74th CAA, ward committees\(^2\) are to include elected officials, ward-level administrative officers, and representatives from local community-based groups or NGOs (Weinstein, Sami, & Shatkin, 2014).

However, the 74th CAA left decisions regarding the composition, powers, and procedures of the ward committees to state-level governments (Sivaramakrishnan, 2007).
Studies in some cities—Mumbai, Chennai, Bangalore, and Delhi—show that ward committees and related institutions, such as Resident Welfare Associations, have begun to operate at the ward level (Baud & Nainan, 2008; Weinstein, Sami, & Shatkin, 2014). But their effect has been largely to function as “‘invited spaces’ for participation in which middle-class groups and other self-appointed representatives shape local policies by appealing directly to state and municipal administrators” (Weinstein, Sami, & Shatkin, 2014, p. 52).

Overall, efforts to expand formal political participation in cities have not improved municipal planning or administration. In Pune, the municipal government initiated participatory budgeting at the ward level in 2007, though questions remain about its popular awareness and transparency (Menon, 2013). Studies from other cities suggest that middle class groups have predominantly (though not solely) used these opportunities to influence urban development to their ends (Coelho & Venkat, 2009). Informal coalitions built on personal social networks constitute the main form of political participation in Indian cities (Sami, 2013). As Sami (2013) describes of Pune, “Power structures in Pune are based on social relations: kinship networks, caste and community relations and personal friendships” that encompass actors at city and state level (p. 160).

While wealthier urban residents and propertied classes use social relations and political negotiations to lobby for their interests, studies of “poor people’s politics” in urban India show how “seemingly marginalized groups” also “assert their centrality and make political claims on the state” (Weinstein, 2009, p. 401). Both the politics of the poor, conducted on the terrain of “political society” (Chatterjee, 2004), and the politics of the minority bourgeois class (“civil society”) depend upon what Roy (2009c) terms the state’s
informality in urban planning. Wealthier classes may be better equipped than poorer groups to claim, obtain, and direct state resources to their ends using formal, legal state channels, but these channels too are paved with informality. Thus, both wealthy and poor classes may resort to informal channels to access state benefits.

The urban poor, often marginalized from formal access to basic state benefits on account of their illegal, transient, or tenuous status or due to their lack of capabilities, are more likely compelled to use informal channels to access benefits, to find “temporary, contextual and unstable arrangements” in lieu of legitimate access to public services (Chatterjee, 2004, p. 57). They advance their causes through negotiations with politicians and bureaucrats and recourse to extra-legal means. Local politicians, in turn, “depend on support from the urban poor” as an electoral constituency (Weinstein, 2009, p. 420), whose demands they cannot afford to ignore. Thus, political negotiations, whether enacted by wealthy classes involving city- and state-level actors, or by the urban poor at street- or ward-level, can thwart the possibility of municipal plans and management. And while such political negotiations reinforce the patronage of local politicians within city neighborhoods, they can deny politicians a voice in urban development at large.

In sum, municipal governance and politics in urban India are dominated by state-level governments who “guard their power over cities even as they have little political incentive to focus on an urban development agenda” (Weinstein, Sami, & Shatkin, 2014, p. 40); propertied urban residents and businesses who impose on urban planning and policy-making efforts (Weinstein, Sami, & Shatkin, 2014, p. 40); and the urban poor, who represent a “vital constituency” for local politicians as an electorate (Weinstein, 2009). These factors
help explain the historical weakness of municipal governance and underscore the importance of the urban poor in local politics in urban India.

As I next show, in this political context—where patronage relations and priorities of higher levels of government strongly influence urban politics—local politicians and municipal administrators, limited in both power and facility, could hardly enact systematic, formal, expansive change. Evidence suggests that politicians were likely to ally with extra-local actors or use their influence within neighborhoods. Municipal administrators, who worked in a system locked out of governance reforms, were often ill-equipped to manage municipal health services, or were at times complicit with local politicians in its omissions. As a result, municipal doctors experienced expressions of authority that tended to be quotidian, informal, and mired in contingency. Authority regularly disordered in mostly small but impacting ways municipal doctors’ everyday work, ultimately diminishing the quality of municipal health care.

7.7.3 Local politicians: Power and patronage in the neighborhood

As I waited to meet a local politician who I learned had shown interest in health care in the city, I observed a young woman seated next to me, her hair tightly plaited, her long dark fingers clutching a folder of papers, looking tense as she also waited. One of the politician’s staff, one of several young men who worked from a desk outside his office, called out to her when it was her turn. After a few minutes, as the young woman exited his office, her visit apparently complete, his staff instructed me to enter it.
I had just introduced myself to the politician when the woman reappeared at his office door with one of his staff, apparently with new information concerning her situation. The politician turned to me to say he would take care of this business before he and I could resume our conversation, but he did not ask me to leave. He called a number on his phone and related the woman’s case to the person on the phone. He said she was “one of us,” that she was Maharashtrian, Hindu, Marathi-speaking. (I am also Maharashtrian, Hindu, Marathi-speaking, and this undoubtedly made it possible for me to witness the phone call). He said she used to work at a private company and noted its owners were Muslim. The woman had been recently fired from the company and needed a job. The politician said he had looked over her resume and it seemed she had experience and skills. He asked the person on the phone to help the woman get a job, to employ her if they could, as he ended the call. The phone conversation was brief and to the point. The woman beamed. She said a deep thank you to the politician and left the room with palpable levity. He had won her vote, I thought to myself. He had possibly won the vote of her neighbors and friends and relatives too, of people who depended on her income and wellbeing.

By dispensing these kinds of favors, local politicians in urban India are powerful within city neighborhoods, especially in disadvantaged neighborhoods (Weinstein, Sami, & Shatkin, 2014; Ruet & Tawa Lama-Rewal, 2009). They may be drawn into powerful coalitions that “mediate the distribution of land, housing, and services” across the city (Weinstein, Sami, & Shatkin, 2014, p. 40). But such coalitions typically span extra-local networks (Sami, 2013) and carry the influence of state-level government upon local urban development priorities (Murthy & Mahin, 2016). As a result, local politicians are likely to hold substantial power within city neighborhoods to obtain benefits for their constituents,
but possibly less power to exert influence through extra-local networks for city-wide projects or through formal channels of the federal government hierarchy.263 For instance, the politician above told me of the numerous times Pune’s municipal government had applied, without success, to the state government for increases in the strength of the municipal medical staff, including recruiting specialists to run the infamously unused ICU. He was irked that people questioned why the ICU was built but did not ask why it was not yet operational.

While state-level government can curtail plans devised by municipal government actors, the latter have stronger influence at ward level (Ruet & Tawa Lama-Rewal, 2009), where “the urban poor exercise their capacity to deploy their votes in protection of claims to urban space” (Weinstein, Sami, & Shatkin, 2014, p. 56). One type of mediation that local politicians often and possibly more effectively engage in involves not processes of planning and policy-making but forms of patronage—procuring benefits for individuals, building and expressing power case by case, voter by voter.

In Pune, municipal doctors thus experienced the authority of local politicians through, for example, the assertions of lower level employees and the demands of patients, both braced by politicians’ support. Lower level employees counted among those poor, disadvantaged groups staking claim to state benefits through the mediation of local politicians. Securing a job as a municipal employee was one such benefit. Maintaining that job even when one was incapacitated, such as the underperforming employee in Dr Neerja’s clinic, was another. For patients, political connections helped them obtain services faster, outside of regular channels.
For municipal doctors, expressions of authority disrupted everyday work: support staff who expected a doctor to sign a ledger much ahead of closing time; patients who were quick to call a local politician if they were dissatisfied. Yet in municipal doctors’ reasoning, they were obliged to follow. Doctors’ narratives showed they recognized their frontline (and hence end-of-the-line) position in the municipal hierarchy, and were aware that politicians could unsettle the tenure and terms of municipal doctors’ employment. Doctors’ narratives—their contention that municipal doctors couldn’t afford to be strict with lower level employees, the young doctor’s indignation at being “caught” drinking tea mid-afternoon—were fraught with the restraint and caution municipal doctors had to exercise while handling employees and patients.

Municipal doctors reasoned the authority of local politicians as a base condition of the work of delivering municipal health care. Municipal health care was not only a public service for urban residents, but also a conduit for delivering promises to voters. As frontline state agents, municipal doctors found themselves implicated in the imperatives of local electoral logic, which contributed to diminishing the quality of municipal primary care. Expressions of authority disrupted municipal doctors’ everyday work and sidestepped basic material inadequacies in outpatient care.

### 7.7.4 Municipal administrators: To be seen but not heard

Municipal administrators were often incapable to plan and unable to challenge urban political priorities, such as claims made by powerful coalitions to direct city-wide
development or claims by middle-class residents for neighborhood- or individual-level benefits. The perspectives of one NGO manager in Pune suggested that municipal administrators were to be seen but not heard.

The manager described the nature of municipal budgeting and planning proceedings. He informed me that municipal administrators did not volunteer information in budgeting and planning deliberations. Administrators only stood up to speak if they were asked, and only answered questions they were asked. The manager had attended general body meetings, i.e., regular meetings of all elected officials (local politicians) in the municipal government. His description of what transpired during the meetings showed how elected officials could push issues such as health care to the sidelines. When an issue was tabled for discussion, elected officials might collectively agree to defer the topic to the next meeting, or to return to it after they had discussed other more “important” topics. So the topic would get pushed forward or delayed, said the NGO manager.264 Or else they might say they needed more information to proceed, which the concerned administrator was supposed to provide but would not have ready. The elected official might arrange with the administrator beforehand that the latter should say, if she was asked, that she had to investigate the matter and would produce the information at the following meeting. Municipal administrators enjoyed “informal friendships” with politicians, said the manager, but were subordinate to them.

When I asked another politician in Pune if municipal administrators could do anything to improve municipal health care services, he immediately dismissed the idea.265 This politician explained that health care was of low quality and inequitable largely because of the unregulated private sector and lack of public investment. The low- and middle-classes,
he said, might use private health care services. But private providers exploited people, who eventually visited the public sector when they were unable to meet the cost of private health care. However, people did not receive good services at the public sector either, since government at all levels had underinvested in health care. The politician’s prescriptions for enhancing health care lay in the realm of policy reform rather than improving public service delivery:

Main thing is, you have to change the policy. You can see that the policy is currently not for the poor, because it just neglects them, just lets the private sector continue.

I asked him about the administrative staff of Pune’s municipal government. Could they make a difference? He shook his head: “No, no. They have no voice.” I pressed him to explain. Recalling municipal doctors’ narratives about the limited scope of their mandate (see Chapter 5), I asked the politician if the problem lay in the reach of municipal administrators’ tasks—perhaps they did their work but did not or could not take account of the wider social challenges the poor faced? The politician said, “Yes. They can’t do anything.” His answer remained short, attesting little confidence in municipal administrators’ capacity to improve health care services.

Having dismissed the effective capacity of administrators, the politician again stressed the real challenge lay in the design of policy, specifically at national level. Using the example of India’s food security bill to make his point, he described how, under faulty provisions in the bill, a household living on a paltry daily subsistence wage would be
ineligible for food security benefits. “The policies look good on paper but in practice they don’t make sense,” he said.  

Staff and supplicants began to re-enter his office, marking the end of our conversation. The office contained the large desk at which the politician sat and a dozen chairs in rows before him. As people began to re-occupy the chairs, I reflected on the case he had handled before we began our discussion, which I had witnessed while waiting my turn to see him. The case illustrated the kinds of requests local politicians appeared to routinely encounter, which municipal administrators were then tasked to follow through.  

In this case, a man from the politician’s constituency said he’d been asked by the municipal housing department to stop construction on a building project. The first question the politician asked the man was whether he had a permit for construction. The man did not. The politician was prompt and unequivocal: “Then what do you want me to do?” he asked. The man fell silent. The politician told the man government wasn’t a free-for-all. “For now, stop building. Apply for a permit,” he advised. If the man filed the paperwork, made the formal application, then they could discuss further. “I will help you,” said the politician. But breaking the law was not ok, he informed the man. The man agreed to stop construction and file for a permit. The politician’s allowance here—the political negotiation—was to pardon a transgression already committed, a law already broken. And administrators from the housing department, I imagined, would eventually be told, down the chain of command, to excuse the transgression, to make an exception.
Administrators not only appeared to have little voice at decision-making levels, such as in municipal planning deliberations, they also seemed to have limited and a specific kind of discretion in routine service delivery tasks. That is, administrators were often called upon by politicians and their constituents to make exceptions in service delivery or piecemeal fixes, not to comprehensively enhance it. As Chatterjee (2008) has argued of “political society,” when disadvantaged groups call on state agents to claim benefits, their claims entail requests to exempt, rather than reform or recalibrate, existing rules and laws (Chatterjee, 2008). In responding to such demands, state agents were compelled to make political (rather than legal or rational-bureaucratic) decisions, to declare an exception to the administrative rule or law rather than apply or reform a rule or law (Chatterjee, 2008, p. 61).

When municipal administrators confronted such claims, routed through and insisted upon by politicians, they had to diverge from regular municipal operations. Regular municipal operations were already mired in decades of policy neglect. Administrators in Pune have long run the municipal health service with sparse guidelines inadequately revised for contemporary urban conditions, a problem endemic to urban India (Kapadia-Kundu & Kanitkar, 2002). Central government reports show that cities across India vary in the type, extent, and quality of health care services they provide to urban residents, contributing to inequalities within and across cities (MOHFW, 2013c). In Pune, municipal administrators’ work seemed directed by minimal formal guidelines and quotidian informal requests for exceptions to rules.

Pune’s municipal doctors, in turn, encountered irregular or faulty management of the municipal health service, which they had to entertain or incorporate in their daily work. Such
faults included administrators’ neglecting to evaluate employee performance, shifting doctors from clinical to clerical tasks, and seeming unfamiliarity with running a hospital. As one municipal doctor cynically narrated, health workers performed as though their overarching mandate was to do nothing out of the ordinary, to not draw attention to the municipal health service. Not drawing attention meant containing the informality of service delivery—accommodating a delinquent employee, a non-clinical job posting, a politically connected patient. Authoritative directives enforced and reinforced that de facto mandate. Doctors reasoned that challenging authority could misfire; an act of protest could undo the general good work municipal doctors did everyday. For municipal doctors, that “good work” entailed keeping things running despite working at the frontlines of material inadequacies and political disruptions.

In sum, expressions of authority directed municipal doctors to maintain their work at even keel despite gusts of irregular managerial and political demands. As medical practitioners, municipal doctors were meant to provide health care, but in their simultaneous role as state agents, their task was as much to anticipate and manage the informality of municipal service provision.

7.8 The authority of popular opinion

Municipal doctors in Pune largely encountered popular opinion through their everyday interactions with communities. In these interactions, doctors confronted a diffuse sense of people’s wants, preferences, and perceptions. While these myriad views did not directly or
immediately influence administrative processes or policy, they did present, for doctors, a form of social power of citizens over state agents.

Municipal doctors did not deny this social power was rightful. That is, municipal doctors recognized that a core objective of the municipal health service was to serve the city’s poor. The service was “for the slums,” said one municipal doctor, pointing outside her clinic windows in the direction of a low-income neighborhood. An NGO worker in Pune informed me that, based on her experience of working with public sector workers, “People who work in government hospitals ... have a general understanding that they and [NGO staff] are working for the poor.” For municipal doctors, the poor were not only the foremost users of municipal health services, they were also its main intended beneficiaries. Citizens’ claims to municipal services were not a point of contention among municipal doctors.

What municipal doctors did rail against, however, were the misinformation about health care and misplaced value for private health care that undergirded people’s claims. From the doctors’ vantage point, while people sought and claimed municipal health care, people yet held its worth in low regard.

That discomfiting contrast evokes Kaviraj’s (2005) argument that, in India, the idea of the state as ultimate arbiter of assistance remains strong in the public imagination, but the legitimacy of bureaucratic agencies is diminished. A similar irony defined popular opinion about municipal health care in Pune, and it compelled accommodations from municipal doctors. In particular, it implied that municipal doctors inure themselves against (what they considered to be) people’s misinformed views about the state in general and their work in
That is, doctors’ narratives suggest that expressions of popular opinion disposed them to refrain from extending themselves for the communities they served, given that communities seemed both uninformed and disinclined to take a considered, fair view of municipal doctors’ work. Although popular opinion was not homogeneously negative—some municipal doctors narrated positive experiences with and responses from patients—it was fragile, prone to sour.

The provenance of popular opinion lay not only in people’s encounters in seeking municipal health care, but also in people’s discouraging experience of the state at large. Moreover, popular opinion reflected to municipal doctors not only the community’s sense of their work and its worth, but also the community’s favorable valuation of private health care.

If the success of efforts to improve population health depends on how state agents see themselves and their relations to society (Hall & Lamont, 2009; Evans, 2009), then in Pune the prospects for such efforts seemed unpromising.

In the sections that immediately follow, I discuss the content and tenor of popular opinion as municipal doctors encountered it—how it featured in municipal doctors’ experiences and narratives.

7.8.1 People’s expressions of “ownership” of public services: Public health care as an entitlement, private health care as paid exchange

As most mornings, the waiting area of the municipal hospital was full with patients queuing up for an outpatient consultation. Then, above the steady buzz of people streaming in,
finding their way, and going about their work, an altercation erupted between a seated patient and a security guard. The guard was one of several directing people and minding the queue of seated patients. Since municipal hospitals took no appointments, all visits were on a walk-in basis. Hospitals did not issue numbered tokens or record patients’ names in the order in which they arrived, so patients’ position in the seated queue marked their turn to see a doctor. Patients played a sort of musical chairs: everyone got up and re-seated themselves one seat closer to the consultation room as the patient closest in line to the consultation room entered it.

For the security guards and assistants who oversaw the waiting room, ensuring patients maintained their relative positions as the queue staggered forward was crucial to keeping order. Fights would break out occasionally over patients’ alleged skipping turns or giving their seat to someone out of turn, fights among people already weary and anxious with illness. But the fight I witnessed that morning occurred between a waiting patient and a security guard.

The patient in question was tall young man with a trim moustache, dressed in long-sleeved shirt and pressed pants as if on his way to an office job. He was standing up amid a row of seated patients. He addressed the security guard in a raised voice, angrily telling the guard not to talk to him this way. Then an older woman seated in another section of the waiting area, who seemed to know the young man, called out to him and told him to calm down, reminding him that he was in a hospital. The young man sat down but declaimed, irately, “This is not a private company! This is a sarkari (government) hospital!”
The young man repeated several times that this was not a private company. He said he had stood up because he did not want to sit too close to the woman ahead of him, he was giving her room, he insisted. From their exchange, it appeared that the security guard had asked the man to either sit down, or to move on up, to occupy the next seat, and not to loiter (it was difficult, from a distance, to fully hear their argument). A discussion ensued between the guard and the young man about ways of waiting in the waiting area. The guard said, for the benefit of entire room, that everyone had to stay seated at all times and had to move up in line when it was their turn. Other patients watched the fracas from their seats, seemingly undisturbed.

Later I asked Dr Nina, who had not witnessed the incident, what the man possibly meant when he said, “This is not a private company.” Dr Nina grimaced. “Yes, that’s typical. That is what they think, that because this is a sarkari hospital, they can behave as they like, as though they own it because it is the government.” I asked her if people interacted differently in private and public sector facilities. Dr Nina said yes, they did, and reasoned the difference as such:

In the public sector, we can’t tell them to go, we have to see everyone who comes, we have to treat them, we can’t tell them to leave. In the private sector, the patient would never speak that way to the doctor, and if he did, then the doctor would just tell the patient to leave, because it is his personal clinic. But we can’t tell them that.

Dr Nina’s account described a distinction between patients’ perceptions of and behavior in public versus private health care. Other municipal workers corroborated this
view. A few days after the incident, I spoke with two security guards from that hospital about that morning’s incident in the waiting area. I said I was trying to understand why there seemed to be frequent interruptions of order in public sector hospitals, and whether tempers flew as fast in the private sector. Both shook their heads. “No. Because people are paying for the service there,” said one guard. The second guard happened to recall the incident of the irritated young man. “I remember that patient,” she said. “I told him to not be upset. … He was asked to move. He got upset.” The first guard added, “People behave better in private hospitals.”

For municipal doctors, patients visiting a private sector doctor were in that doctor’s private space at the behest of that doctor. By contrast, patients in a public sector hospital, as citizens, owned that public space, in which the municipal doctor, as state agent, happened to practice medicine. This distinction—which the irate young patient had explicitly articulated—illustrated the nature of social relations between municipal doctors and the communities they served. For municipal doctors, the unruliness and unpleasantness of delivering health care within state precincts was partly a product of how people perceived and behaved in public versus private sector facilities.

Dr Nina provided an example of this point, reflecting on events of a vaccination camp she had conducted. At one point during the camp, mothers had thronged her desk, pushing to get in front, breaking the queue Dr Nina had tried to orchestrate into order. “They crowd my desk, they come so close,” she pointed out. “And then they say they don’t get any privacy in a government hospital. But they would not act this way (pushing, crowding) in a private hospital.”
Dr Biren affirmed that view. “People think ‘we pay taxes, and you get your salary from my taxes,’” said Dr Biren, adding that although the poor did not pay income taxes, they were aware the state was obliged to provide services to citizens. People then behaved as though municipal doctors were their “servants.” Dr Biren was careful to note this attitude did not apply to everyone: “Not all, maybe 60-70% of them, their attitude is such,” he estimated.

Dr Manisha (MD in private practice who held pro bono consultation hours at municipal hospitals) agreed that “[People] see public sector doctors as servants. In the private sector, they need to pay to see the doctor.”

Municipal doctors’ narratives suggest that in a private hospital, the irate young man would have likely tolerated a security guard’s admonishing tone, or at least responded with less overt irritation, because he did not own the space. By contrast, in municipal health care facilities, people sought and at times asserted their claims to state-provided services, and by extension, to the dispensations of municipal doctors. And yet, as I show next, municipal doctors surmised that people simultaneously held the worth of municipal health care in low regard.

7.8.2 People’s low regard for municipal health care

In reams of surveys across India, people say they prefer private health care and hold state-provided health care to be an inconvenient, unreliable, unpleasant option (see Chapter 1). The vignettes below illustrate how municipal doctors in Pune encountered, in the course of their everyday work, people’s low regard for the services they provided. In particular, events
at Dr Nina’s vaccination camp show how municipal doctors who encountered such negative views might assume defensive positions against the communities they were meant to serve.

The vaccination camp was conducted in a community space in a low-income neighborhood. When she arrived, Dr Nina and health workers assisting her repositioned the furniture in the room. They arranged the paperwork and supplies so Dr Nina could first examine a child and determine the vaccinations the child needed and a nurse could follow through. Soon mothers holding infants began to line up. By mid-morning, the camp was in full swing.

Dr Nina checked each child’s vaccination card—a paper record the mother must keep with her—before a nurse administered the shot. She talked to the mothers about their child’s growth. Some mothers had failed to keep up with the immunization schedule. Dr Nina reprimanded them, saying their negligence had consequences for their babies’ immunity. The mothers typically said little in response. Some mothers had lost their vaccination cards. Dr Nina listened to their reasons why. One mother said she had separated from her husband—the child’s vaccination card had been left behind, and her husband had refused to give it to her. Dr Nina paused briefly in her work to stress to me, with a shake of her head, that in the chaos of domestic strife, the one-year-old child had been neglected. The child had missed several vaccinations, she informed the mother.

Throughout the morning, Dr Nina fielded questions from the nurse administering the vaccines. The nurse was about to vaccinate one infant girl, who had diarrhea though no fever. Should they wait until the baby was better? Dr Nina told the nurse to wait, and
instructed the mother to take the baby to the municipal hospital as soon as the baby was better, not to delay. The mother had applied a heavy smear of *kajal* (kohl) around the baby’s eyes, a common tradition. Dr Nina paused to ask the mother if she had bought the *kajal* in a store or made it at home. (It was homemade; commercially made kohl is likely to contain lead). She told the mother *kajal* was bad for the baby’s eyes. The mother giggled, amused at this advice. Several other children were unwell and could not be vaccinated that morning. Dr Nina repeated firmly to their mothers not to wait until next month’s camp. “Just go to the hospital and get the child vaccinated!” At one point the line collapsed and the crowd thronged Dr Nina’s desk. She told them to move back. “When it is your turn, you want the doctor to spend full attention and time with your child, don’t you?” she asked the room.

When the time neared 12:30pm, Dr Nina had to wrap up. She could not examine the latecomers, she mentioned to the staff of the NGO with whom the municipal health service had planned the camp. Dr Nina again informed the mothers that although she was closing the camp, they could always visit the municipal hospital located a short distance away.

I later conversed with an NGO staff member, who recounted to me the challenges of getting the community to attend such camps let alone travel to the municipal hospital. Local residents preferred the convenience of visiting local private providers, she said. It took them more time and effort to travel to the nearest municipal hospital. Private providers charged fees marked to what the community could afford. And community members widely held that municipal hospitals were unpleasant and untrustworthy, said the NGO staffer. She elaborated: people had misconceptions about the public sector. They felt that if they used public hospitals they could acquire infections, if they got their child immunized there, the
child could “get a knot” at the spot where the injection was administered. When the NGO had started the camp in this community, it had been difficult to get people to attend. The NGO staffer was encouraged by the increased attendance.

When I met Dr Nina again in a few days, she informed me with great dismay that a community organizer had later criticized her behavior at the camp, that the mothers she had urged to arrive early for the camp had interpreted her directives as disrespectful. She explained that according to immunization protocols, after health care workers had administered the last vaccination, they had to remain in the locality for at least half an hour in case a child had an adverse reaction to the vaccine. Mothers who arrived late would think the camp was still running, but could not get their children immunized. Community members had not understood that, and Dr Nina was perturbed that they had not voiced their concerns to her directly and had misperceived her efforts: “She said that I did not speak properly to patients, that I didn’t examine patients, that I didn’t give injections…”

The charges against her ran contrary to her attempts that morning to bring structure and order to the makeshift room; to advise and counsel mothers about their child’s health, noticing details such as a baby’s *kajal*-lined eyes and pausing to dispense advice; to maintain offsite vaccination protocols. She said: “… I feel there is no point in working so hard. I thought I was really doing my best there.”

Dr Nina thus experienced popular opinion as a debilitating, dampening effect on her initiative. By her own measure, Dr Nina was trying her best to conduct the vaccination camp under less than ideal circumstances, yet she felt the community hardly noticed her efforts.
and moreover misconstrued the intent of her actions. She experienced popular opinion as a
gauge of her effort towards and social relations with the local community. In this case, that
experience conveyed to Dr Nina only low regard for her work, potentially straining her
future encounters with the community.

7.8.3 Municipal doctors’ response to popular opinion at the frontlines of service provision

Events at the vaccination camp depict how, for municipal doctors, providing basic primary
care involved grappling with complex social conditions of urban poverty, using limited
material resources, and serving a community that mistrusted them. The challenge they faced
was to both manage the delivery of health care and accommodate the community’s
perceptions of their work. This challenge entailed as much a technical task as a social act. A
social act, as I define in the introductory chapter, underscores “the moral valence people
attach to people around them … [T]here is no action and social relationship without
meaning” (Hall & Lamont, 2009, p. 9). Municipal doctors’ actions are shaped not only by
their knowledge, skills, and incentives to perform, but also by their relationships with
actors—patients, communities, administrators, local elected officials, among others—and the
meanings doctors attach to their relationships and experiences (Sheikh, Ranson, Gilson,
2014). A transaction-specific view of health care emphasizes asymmetries of information
inherent to the giving and receiving of medical advice, but health care also involves, for both
doctors and patients, engaging in a social exchange.

As a social exchange, the success of Dr Nina’s task at the camp depended on
prevailing social relations between the community and the municipal health service. Those
social relations were steeped in the community’s disfavor of municipal services, which individual municipal doctors had to confront and overcome in their frontline role.

Municipal doctors’ narratives suggest their response was to accommodate negative popular opinion as a base condition of work, i.e., to expect it as routine rather than actively address and counteract it in the course of everyday work. Dr Biren, for example, pointed to the difficulties of building a reputation for oneself as a municipal doctor. Dr Biren said he told his “nieces and nephews to go into engineering,” to avoid medicine altogether. In his estimation, most people who took up medicine today were those who could run a practice privately, whose families already had a business and who could take over that practice. They had an established name to carry forward, which was difficult to forge from scratch. Dr Biren stressed the importance of developing a name for oneself in order to be successful in private practice. By contrast, he said, building a reputation for oneself as a good doctor seemed irrelevant and practically impossible in the municipal health service. “Here … no-one asks my name! Not even by mistake!” he said. He continued: “And if I get transferred, which happens regularly, what difference does it [i.e., my hard work] make? Patients come, and each time they come, they see a different doctor, new faces, anyway.” Dr Biren’s narrative indicated the infeasibility of building a reputation as a doctor while one worked for the state, since patients who frequented state-run facilities had little opportunity, and possibly little inclination, to get to know a particular doctor.

Dr Biren’s misgivings might be well addressed by Leonard et al’s (2013) suggestion that incentives (such as compensation and appreciation) to improve health care providers’ effort are better supplied by the organization they work for rather than by users of the
service. That is, as Leonard et al (2013) report, “Organizations have a greater ability to observe and reward the performance of their staff than individual users of the service do. Because of information asymmetry individual users do not always know when they are being badly served” (p. 78). And, municipal doctors would likely stress, neither do users always know when they are being well-served. To inform users of quality, or “signal” to users a “commitment to quality,” Leonard and colleagues place organizations as better suited than individual practitioners to provide such signals: “Because facilities have a physical and continuous presence they are much more visible to the public and more subject to public discussion than individual practitioners within them” (Leonard et al, 2013, p. 78). Particularly in LMICs marked by poor governance and “pervasiveness of patronage,” few public sector organizations have invested in “establishing a reputation for institutional quality” (Leonard et al, 2013, p. 78).

That lack of investment marks municipal health care in urban India. In the present case, the public sector organization (Pune’s municipal health service) neither rewarded performance of health care providers (municipal doctors), nor signaled a commitment to quality to communities (see sections on policy neglect of municipal health care in this chapter and Chapter 4). Although national health reforms have established institutions for community participation in rural village-level health care decision-making beginning in 2005 (MOHFW, 2013a), such institutions elude urban India (MOHFW, 2013b). Collective action for urban health care is scarce in Indian cities, giving communities few opportunities to deliberate health care needs and deliver collective appeals to municipal governments (see Chapter 4). Given the paucity of institutional mechanisms by which Pune’s municipal health service might signal commitment to and apprehend concerns from communities, municipal
doctors’ individual actions were effectively the only signals of quality communities received. And deserved or not, as frontline state agents, municipal doctors bore the brunt of negative popular opinion about municipal health care in the course of their individual encounters with communities.

For Dr Nina and Dr Biren, among other doctors, responding to negative popular opinion entailed a retreat to circumscribed personal effort and initiative. The potential effect of such a retreat was to reduce the services they provided to minimal, technical tasks, whereby doctors fulfilled essential clinical duties but were wary or unwilling to forge social relations with communities.

However, not all municipal doctors in Pune encountered negative popular opinion in their work, as warranted at it might have been for municipal services in the aggregate. This heterogeneity in popular opinion, which I examine in the next section, opens questions of how popular opinion might vary and change. If some among the community had positive views, then could municipal doctors reorient the dominant imaginary of the municipal health service as an unresponsive purveyor of services? I address questions about the provenance of popular opinion and the possibility of changing it in the section below.

7.9 The provenance of popular opinion about municipal health care and the challenges of changing it

The vignettes above suggest that, in municipal doctors’ experiences and narratives, people generally held low regard for municipal services. But this low regard was not universal.
Rather, popular opinion seemed heterogeneous: not all patients had unfavorable views of municipal doctors, and not all municipal doctors reported patients’ lack of appreciation. Heterogeneity of views is characteristic of popular opinion—as Neem (2011) describes, although popular opinion reflects views of “the people” who collectively legitimize the state, it contains myriad voices, positions, and identities, evolving and expressed in varied intensity. Popular opinion does not reflect a singular, static “will” of the people; rather “all claims to popular voice [are] partial and creative” (Neem, 2011, p. 271). How, then, might a particular view come to dominate? How might it shift?

I focus here on heterogeneity in popular opinion, how it might sour, and why municipal doctors might be constrained to shift it. As I will show, municipal doctors’ constraints derived partly from an “uncaring” (Gupta, 2012) mode of state functioning and the popularity of private health care, which together did little to redress municipal doctors’ tenuous social relations with communities.

7.9.1 The heterogeneity of popular opinion, and how opinion might sour

To emphasize how deeply popular opinion was turned against state-provided health care, a community organizer in Pune observed that when people had to choose between public and private services, they asked themselves: “Why would I do that (opt for the public sector) to someone I loved?” But this was not the only view people held. The incident below shows that some people assessed state-provided services favorably, yet people’s encounters in seeking municipal health care could lay the ground for popular opinion to depreciate.
In a municipal hospital early one morning, I had briefly conversed with a young family—parents and their baby daughter—as they sat outside an outpatient consultation room, waiting for the doctor to arrive. The doctor was late; it was almost 15 minutes past opening time. But the young parents seemed unperturbed. The baby, the parents told me, was due for scheduled vaccinations. She looked rosy, alert, and calm in her mother’s arms. The parents were here with a well child, not a sick one, and they were happy to chat. When I asked if they generally visited public sector hospitals, the father conveyed, to my surprise, his preference for public health care. “It’s the best,” he declared in halting English, adding he didn’t trust the private sector. The family had recently moved here from Mumbai, and there they visited only public sector hospitals.

The father then recounted his experience of negligence and exploitation in the private sector. He was a carpenter and supervised a small team of carpenters for a construction company. One of his workers had once suffered an injury, a wound in the hand that needed stitches. The worker insisted on going to a private facility. The private doctor sewed the worker’s wound, but did not apply a malam (ointment) that would have prevented the bandage from sticking to the wound. When they tried to remove the bandage, the skin was stuck to it. They had to keep going back. Instead of being able to take care of it in one go, they had to keep paying the private doctor for many visits. Each time the private doctor would do something and charge for it, said the father.

When I offered the contrasting view that I usually heard, namely that people preferred the private sector because they were treated nicely and got more attention there, the father did not concur. He said that one had to respect doctors for their knowledge and
expertise. If the doctor sometimes spoke roughly with a patient, as they might in the public sector, the patient “had to take it.” The father’s observation illustrated a common fact—the fact of curt consultations that often transpired when the poor visited public sector facilities. But it also displayed the uncommon stance, uncommon at least among health advocates and activists, that patients should accommodate doctors’ rough behavior.

That stance seemed set to change. It was the family’s turn to see the doctor. I entered the consultation room a few minutes after they did, and observed the municipal doctor, the baby’s vaccination card in her hand, scolding the parents. She asked the father why they hadn’t put a sweater on the child, noting the baby was wearing a sleeveless cotton frock on an early February morning. (Temperatures in the winter months drop in the night, but they rise as the sun rises high; I too was wearing a sleeveless kurta that morning). The municipal doctor snapped at the alleged errors of their parenting: The child’s skin was cold! How had they taken the child outdoors like this? The father looked subdued. He said they had rushed out of the house and hadn’t had a chance to put on layers on the child. (Neither parent was wearing any warm clothes.) The doctor shot back, pointing out the mother had neatly combed her hair. “She found time for doing that, didn’t she?” the doctor asked sarcastically. The father did not reply. The baby received her vaccinations and the family left, waving bye to me. I could not imagine the family would be back here, or that encounters such as this would not erode their view that the public sector was “the best.”

The example shows that while popular opinion about municipal health care was not a universally negative or foregone conclusion in the community, yet people’s experiences with seeking municipal health care were likely to do little to bolster positive opinions about
it. Municipal doctors’ uncharitable behavior (as in the example above), and operational lapses, such as unavailability of basic drugs and supplies (as previous chapters have documented), challenged positive views of municipal services. Dr Nina’s behavior at the vaccination camp too was not above reproach. Although well-intentioned, Dr Nina was at times short and paternalistic with mothers at the camp.

Positive encounters—such as Dr Mahesh’s gentle treatment of an old woman with hypertension (see Chapter 6)—would likely generate more salutary popular opinion, at least of individual municipal doctors if not the municipal health service as a whole. Dr Amrita, who had failed to persuade a mother to take her ailing toddler to a hospital (see Chapter 5), had been frustrated with that particular case. But Dr Amrita had also noted to me the satisfaction of patients’ returning to the clinic; when she had once been on leave, patients had come asking for her and been willing to await her return, she said, beaming.

Dr Priya said patients did acknowledge doctors’ good work, and stressed this gratification as one of the main reasons she did this work at all. Patients sometimes traveled across the city to visit a particular municipal doctor if the doctor was transferred to another location, said Dr Priya. When I suggested that people’s mistrust and under-appreciation—in addition to municipal authorities’ irregular directives—could impair municipal doctors’ ability to perform effectively, Dr Priya disagreed. Her own experience ran to the contrary: municipal authorities may not recognize doctors’ efforts, she said, but individual patients did, and the latter recognition represented a vital reward.
Individual municipal doctors could thus potentially enhance their social relations with community members. But municipal doctors’ narratives suggest this forging of social relations was not an institutional norm supported by the state. Rather, where it occurred, it was grounded in the personal capacity and willingness of individual municipal doctors. Doctors’ individual capacities are certainly important for health care outcomes—in a transaction-specific view of health care they are central to improving health care quality. From a transaction-specific view, we might propose interventions to train and incentivize municipal doctors to increase their individual responsiveness to patients. But the state’s functioning at large—its mode of bureaucratic procedure—would remain, as Gupta (2012) argues, “uncaring” (p. 23), enacting a form of structural violence on the poor and conditioning their unfavorable views of the state.

Gupta (2012) stresses that the term “uncaring” describes a mode of state functioning, not attitudes of state agents. In previous chapters I provide examples of such modes of functioning in Pune’s municipal health service: doctors’ reluctance to treat certain illness; absent or inconsistently available medical supplies and equipment; and doctors’ conducting, as a matter of routine, summary outpatient consultations with patients (see Chapters 5 and 6). People’s experience of these modes of state functioning is not wholly direct. Rather, as Corbridge et al (2005) argue, people form an idea of the state “with close regard for past memories, accounts that circulate in the public sphere, and how [they] see other people getting on and being treated” (Corbridge et al, 2005, p. 8). As I discuss in a previous chapter, municipal doctors lamented the local media’s negative portrayal of municipal services, with newspaper articles that frequently highlighted and castigated the municipal government’s misdoings and errors (see Chapter 6).
Besides modes of municipal health care operations, other areas of the state’s welfare operations also likely contributed to people’s wariness about seeking state-provided services. As Corbridge et al (2005) show, people’s “sightings” of the state can vary—differently placed people can have different encounters with state agencies, and can experience different processes and outcomes from their exchanges. Yet, despite differential impress of the state, in aggregate the state “fails poorer people on a regular and predictable basis” (Corbridge et al, 2005, p. 4). Select state initiatives have enhanced formal spaces for political participation, one example being India’s Right to Information (RTI) Act, 2005, which enables citizens to query and gain access to information held by state agencies (Corbridge et al, 2005). However, evidence shows these spaces coexist with people’s ongoing, routine attempts to obtain access to state services using informal and paralegal means. Not only for state services but for livelihoods too, especially in the informal economy that is the mainstay of the urban poor, the poor engage with a vast “shadow state,” meaning networks of brokers, gatekeepers, advisers, and contractors, among others who surround the “official state” (Harriss-White, 2003; see Anjaria (2011) for an account of the shadow state drawn from experiences of street hawkers in Mumbai). If people’s various experiences of state functioning inform how people understand the state, then it is unsurprising if people come to anticipate state agencies as spaces of denial and tribulation.

One such discouraging example of state functioning—involving an agency other than Pune’s municipal health service—was evident in Dr Mala’s narratives. Dr Mala observed that people equated municipal health care to the subsidized rice in ration shops. Ration shops or fair price shops are the end point in India’s state-run Public Distribution
Evidence shows the PDS has had “chronic management shortcomings,” including “poor quality food grain, harassment of consumers at the point of client interface, and exclusion of large numbers of the poor from the system entirely, either through incapacity to process their claims or outright disqualification despite clear evidence of need” (Jenkins & Goetz, 2002, p. 3). If people indeed compared municipal health care to ration shop rice, then the comparison indicates the intensity of negative popular opinion about municipal services, and underscores how people’s encounters with one facet of the state may inflect people’s (not entirely wrong) presumptions about other aspects of state functioning. (I return to the ration shop rice comparison below).

In sum, although popular opinion about municipal health care was heterogeneous, it seemed unlikely to systematically improve through the efforts of individual municipal doctors. While individual doctors could forge positive social relations within the scale of their clinical work, they were unlikely to be able to reorient negative popular opinion of the municipal health service in general. Municipal doctors appeared aware of that challenge. Their narratives offer examples of how popular opinion about municipal health care was informed not only by people’s experiences of seeking municipal health care but also by people’s encounters with state agencies more widely. An “uncaring” mode of state operations at large and the social imaginary of the state it engendered disposed people towards a negative opinion of municipal health care.

But modes of state functioning were not the only hurdle to municipal doctors’ ability to build local social relations. As I explore in the next section, municipal doctors’ narratives suggest that people’s view of private health care, specifically what doctors’ felt was
misinformed overvaluation of private health care, could further frustrate social relations between municipal doctors and communities.

7.9.2 The contrast with favorable popular opinion about private health care

“It’s like the ration,” explained Dr Mala, as she contrasted people’s perceptions of municipal and private health care. The Public Distribution System sells subsidized rice, she elaborated, and people think the rice you get in the ration shops is not of good quality. She added it was true to some extent the rice in the ration shops was indeed of low quality. But people “think the same way” about health care at state-run facilities, she observed. “They think the government doctor means a free service means that he or she is bad. [They think] if you pay, then you get better services.”

Reflecting upon the high use of the private sector among the urban poor, several municipal doctors noted the poor were more accepting of the inconveniences of seeking health care at private doctors’ offices—they tolerated long waiting times, they assented to medical fees. Not so at municipal health care facilities, where people were quicker to complain, become confrontational, and call local politicians to mediate conflicts between doctors and patients. Dr Mala portrayed the censure under which municipal health care providers labored:

Patients ask for reports, for example, for sonograph reports. They come and say, ‘so the sonograph is done, so where is the report?’ In the private sector, they would pay Rs 700-800 and wait to get the reports, even if they were told to come later in the
day, they would wait. But here, they want the reports instantly. The mentality has become: if you pay more, then you get better service. If you get something for free, then it is not as good.

In municipal doctors’ narratives, popular opinion held that health care obtained in a municipal facility did not simply cost less, it was also worth less than that obtained in a private clinic. Given its low worth, state-provided health care was an option of last resort. When patients arrived to avail services in a municipal health care facility, said another municipal doctor, it was because they had already visited the private sector and had exhausted they could afford there. Out-of-pocket payments for treatments that required repeated or regular visits, such as for chronic illness, imposed a particularly high burden on the poor.

In some cases, the expenses people incurred in the private sector were unnecessary, but “the way it is in India,” explained one young municipal doctor, people felt “proud” to visit a private doctor, to say they could afford to pay for private medical care. The municipal doctor pointed to a baby he had just evaluated: the baby had a cough and some chest congestion. If the baby had been evaluated in a private hospital, said the municipal doctor, it’s possible the parents would have been told to admit the baby to the private hospital’s inpatient ward. Then the parents would have realized they could not afford it, and they would have arrived at the municipal hospital. But the baby did not need to be admitted, he observed.

Municipal doctors chafed at the misinformation that fueled people’s determination of the low quality of municipal health care. For instance, responding to my observation that
some people chose to obtain routine vaccinations for their children at substantial private cost when these were free in municipal clinics, Dr Mala replied:

People want to go to a nice pediatrician’s office, with nice colored walls, a nicely set up office. We distribute vaccines; we get our stock and distribute the same stock to the private providers also. But when people get the vaccines here, they think ‘government ka maal’ [a government product]. They don’t want it. … Patients want you to open a new vial of the vaccine each time they come in. They will say, ‘why are you giving me vaccine from the same vial?’ Actually, for tetanus, the vaccine comes in a 10-dose vial. It’s not meant for a single dose. In the private sector, they will open a new vial for you and charge you for it; here we don’t do that.

A nurse at a municipal hospital, discussing people’s mistaken overvaluation of the private sector, averred that in the private sector, providers did not uniformly follow protocols and patients had little knowledge of the criteria that constituted sound medical practices. She gave the example of vaccination practices in public and private sector facilities:

When you open one (multi-use) vial, you can only use it for so many days. In the private sector, the doctor might use the same bulb for (many) days, he will poke it once, uses one dose, put it back in the fridge, then use it again. You can’t say how long he uses it, you cannot guarantee quality. We don’t do that. We use a fresh bulb on each vaccination day. We maintain the cold chain, we check the temperature of the fridge every morning and evening. We do all this. But the patient does not see this, does not know this. They don’t know all the work that we do. Patients think that doctors in the private sector speak nicely to them, so they are satisfied.
Municipal doctors acknowledged that people preferred to visit private providers because the experience of seeking health care there was more pleasant, that private doctors behaved more agreeably towards patients. But municipal doctors suggested that this could be misleading. One doctor, for example, agreed that in the private sector, doctors spoke “more sweetly” to patients, but added that, “In the private sector they charge you more, a price for speaking sweetly!” One nurse noted that private providers not only behaved nicely with patients, but also spent more time with them. “Doctors in the private sector can give patients 15-30 minutes of time per patient,” she said. But given the crowds in municipal hospitals, she said, doctors could not give each patient as much time. Private providers were likely to cater to patients’ requests even when those requests were costly for the patient and medically unwarranted.

In sum, in municipal doctors’ perspective, popular opinion about municipal health care was grounded in people’s misinformation and misplaced overvaluation of private health care. Municipal doctors perceived private providers as profit-driven and unscrupulous, terms similar to those reported in a study of public providers’ perspectives in Bhopal (De Costa, Johansson, & Diwan, 2008).²⁷⁵ Another study reported that according to public providers in Chennai, people considered public health care as “undesirable” relative to the private sector because it “served poorer residents” and was beleaguered with outdated equipment, among other resource shortages (Ergler et al, 2011, p. 331).²⁷⁶ In Chennai, public providers “spoke of recent improvements in treatment [in the public sector] and pointed to a reinforcing and stigmatizing discourse of low quality care provision, which the public sector has yet to overcome” (Ergler et al, 2011, p. 331).
Municipal doctors in Pune similarly encountered popular discourse that municipal services were “undesirable” relative to private health care. Researchers have debated whether competition from the private sector can improve public providers’ performance, if it can make public providers more responsive to users (see Hanson et al., 2008; Berlan & Shiffman, 2012). But few studies have documented such an effect. Instead, researchers caution about private providers “pandering” to users to attract them, and “private sector provision creating unequal systems of care,” with “responsive” private providers catering to the wealthy and “unresponsive” public providers serving the poor (Berlan & Shiffman, 2012, p. 275).

My findings suggest that private sector expansion may not only create unequal systems of care but also, without reforms to public services, deepen social rifts between public providers and the communities they serve. As Dr Manisha observed, if the poor were aggrieved, so too were municipal doctors. It was “not rewarding” for municipal doctors to treat poorer patients, said Dr Manisha, because they had to “run after the patient.” Municipal doctors “give medical advice but don’t see change, they don’t see the results they would like to see in the patient,” Dr Manisha explained. (See Chapter 5 for a discussion of how municipal doctors viewed the urban poor, their main patient population). That dynamic diminished quality of care:

So you have two groups of frustrated people coming together on a common ground. You don’t get good results from this union. Each group wants something different. The patient wants a different treatment or experience and the doctor wants the patient to behave differently. So you have a communication gap. And this
gap leads to distrust. That leads to a vitiating atmosphere. And that leads to no
growth and no dynamism in the organization.

In the private sector, the terms of the contract differed, said Dr Manisha. There was an understanding that either patient or doctor could break the relationship. Patients could leave a doctor for another doctor, or doctors could choose not to take on a particular patient. There was room for doctors to compromise: patients could accept the doctor’s way of working, including long waiting times, and doctors could meet the patient’s needs, such as setting an appointment on a Sunday or reducing the price of treatment. As a doctor in private practice, Dr Manisha observed: “I know I have a way out, and that keeps me sane.”

A context of policy neglect, with few upgrades to municipal governance and public services, left municipal doctors few options to forge relations with communities. For the doctors, the contrast between people’s low regard for municipal health care and preference for private health care indicated a distance between what municipal doctors provided (or thought they provided) and what communities appeared to value. That distance eroded state-society relations, where municipal doctors felt undervalued and communities felt underserved. It was on that unhappy meeting ground that municipal doctors delivered their mandate.

7.10 Concluding discussion about authority
I set out in this chapter to explain the workings of authority over municipal doctors. In particular, I considered the authority of local politicians and municipal administrators and the authority of popular opinion.

My findings show that municipal doctors frequently encountered the authority of politicians and administrators as directives to accommodate irregular operations stemming from the entwined effects of local politics and weak management. Such operations included politicians’ promoting high cost, high technology medical facilities that lay unused, and patronizing voters by imposing political influence in everyday patient-doctor interactions. They included administrators’ seeming unfamiliarity with running a hospital, neglecting to evaluate employee performance, and summarily transferring doctors from medical posts to non-clinical duties.

As one municipal doctor put it, municipal health care employees worked as though their overarching mandate was to do nothing out of the ordinary, to not draw attention to the municipal health service. This entailed conforming to authoritative directives to accommodate a delinquent employee, a non-clinical job posting, a politically connected patient. Municipal doctors reasoned that challenging authority could misfire: they might need access to administrators for reciprocal requests, and protesting directives could undo perceptions of the good work they did everyday.
Municipal doctors thus negotiated the effects of urban politics and weak municipal governance on everyday state functioning. As frontline agents, their task was as much to deliver health care as to anticipate and manage the “informality” (Roy, 2009c) of municipal service provision (Weinstein, Sami, & Shatkin, 2014). The latter task (managing urban informality) constrained the former (providing health care) in tangible and intangible ways. Tangibly, the informality of municipal services disrupted municipal health care priorities and everyday management, constraining municipal doctors’ efficacy as medical practitioners. Intangibly, it contributed to a social imaginary of municipal government as badly managed and riven with politics. This constrained municipal doctors’ capacity to build social relations with communities, to forge positive popular opinion about their services, as I discuss next.

Municipal doctors encountered the authority of popular opinion through expressions of people’s entitlement to and disfavor of municipal health care, which they reconciled as a condition of everyday work. In serving a population that simultaneously claimed and discredited their services, municipal doctors averred they weathered a more irascible attitude from patients than did doctors in private practice. Several doctors noted the contrast with private health care, saying patients misguidedly overvalued private health care and behaved better within private facilities, partly because it entailed a paid exchange rather than a free entitlement. The tragedy of the contrast was that in municipal doctors’ view, by the measure of popular opinion, their services did not simply cost less but were also worth less than private health care. As Ergler et al (2011) observe, public providers in Chennai similarly reported “a reinforcing and stigmatizing discourse” of the low quality of their services, a discourse “the public sector has yet to overcome” (p. 331).
Popular opinion about municipal health care thus tended to reinforce tenuous social relations between municipal doctors and the communities they served. Although some municipal doctors reported positive interactions with and appreciation from patients, the dominant “uncaring” (Gupta, 2012; see also Corbridge et al, 2005) mode of functioning of the municipal health service and other state agencies, alongside an avid private sector, stood to negate doctors’ individual efforts to reorient popular opinion. Social relations were strained by frustrations on both sides: the urban poor, aggrieved by livelihood struggles and hurdles to access state services, and municipal doctors, constrained to practice medicine by inadequate resources and incapacity to secure compliance and appreciation from patients.

7.10.2 Authority, state-society relations, and the quality of health care

In the context of policy neglect that beleaguered municipal health care, authoritative directives largely undermined quality of care. Politicians’ priorities often concerned high profile investments and ward-level politics. Administrators operated with no training and few upgrades to guidelines and rules to manage the everyday running of municipal health care. Popular opinion indicated communities’ unmet need for health care, wariness about seeking it from the state, and paucity of opportunities to deliberate and appeal its reform. For municipal doctors, this meant that the authoritative directives they received were largely in the realm of quotidian requests to “adjust” to non-ideal conditions of work. Overtly and implicitly, municipal doctors were frequently directed to accommodate political priorities over, weak management of, and low popular regard for their services.
Under those circumstances, improving the quality of health care was a secondary aim, even a moot concern for municipal doctors. Administrators and politicians rarely appeared to demand and enable enhanced performance from municipal doctors, and communities largely did not appear to comprehend and value their services. In response, municipal doctors’ narratives suggest they felt disposed to retreat to a minimal, technical version of their mandate. Such a retreat implied not taking risks, not extending themselves, striving only to ensure they did nothing out of the ordinary.

Municipal doctors’ disposition to such a retreat had the potential to subvert their social relations with communities and damage prospects for improving health care quality. Providing health care is a social act—for frontline state agents it is necessarily implicated in the “mangle of practice” (Hoag, 2011) and social embeddedness (Evans, 2009; Szreter & Woolcock, 2004a; Hall & Lamont, 2009) that welfare service delivery entails. Evans (2009) argues that population health outcomes depend not only on state agents’ judicious performance of duties, but also on state agents’ seeing themselves as transformational agents who can foster and create the space for social change. In Pune, the force of popular opinion, along with directives of political and administrative authority, conveyed to municipal doctors a sense that such transformation was barely on the horizon, hardly an achievable objective.

And yet, even if municipal doctors chose not to extend themselves in virtuous interactions with local communities, they could not entirely disengage from the social world in which they were embedded. That is, municipal doctors might be disposed to fulfilling only technical aspects of their work, but in practice this was effectively infeasible given their position as frontline state agents. As I show in previous chapters, municipal doctors’
signature practice in primary care was one of delimited counsel: a medical consultation marked by few words, short duration, restrained professional opinion, and perhaps a referral to higher level of care. This practice reflected a norm to expediently dispatch patients and conform to regular municipal operations. But as delimited the practice may be, it entailed a social act, imbued with social meaning for both doctors and patients. Particularly at the level of primary care, municipal doctors routinely encountered and recognized the social circumstances of patients’ lives, even if they felt constrained to address them.

In practice, instead of disengaging from the social aspects of health care, municipal doctors altered the nature of their engagement with their social world: their delimited counsel reflects a resigned accommodation of their conditions of work. The accommodations were municipal doctors’ response to authoritative directives, which stemmed from urban politics, weak municipal governance, and people’s experience of consistent failures of state functioning at large. The accommodations reinforced tenuous state-society relations between municipal doctors and the communities they served, and contributed to low quality of municipal health care. Municipal doctors’ accommodations, as I discuss below, were not a response to pressures to elevate or rationalize their performance as street-level bureaucrats but rather to contain contingencies of state functioning, to manage at street-level the policy neglect of urban health care.

7.10.3 How a study of authority extends research on power in health systems
Rather than broadly examine power relations at the frontlines of service provision, I inquired specifically into authority over frontline state agents. This move affords several novel perspectives on the workings of power in health systems.

First, focusing on authority enables me to identify entities holding authoritative power over frontline state agents. As defined above, authority implies rightful social power—subjects of authority recognize it as rightful and submit to its directives. From this definition, it follows that lower level employees—some of who seemed impervious to doctors’ commands and contrived to secure their demands over doctors’ wishes—did not have authoritative power over doctors. NGO staff too did not have authority over municipal doctors. NGO staff may have the capacity to inform a community’s views or complain to an administrator against a doctor, but it was the authority of popular opinion and municipal administrators that influenced municipal doctors’ actions.

Defining authority thus enables us to distinguish between different relations of power. Studies of power might show a multitude of crisscrossing relations of power, such as among health volunteers, public officials, private physicians, and patients in Kielmann et al’s (2014) study. However, defining authority enables us to clarify and specify power relations among the “broad range of actors who have different sources of legitimacy, power and willingness to contribute towards a shared goal” (Kielmann et al, 2014, p. 987). By delineating which of frontline agents’ actions are an obligatory response to authority, and which are responses to other forms of power, we may better specify “conditions under which street-level bureaucrats work and the reasons for their actions” (Erasmus, 2014, p. 78).
In reviewing evidence on “conditions of work” of street-level bureaucrats, Erasmus (2014) points out that health systems research has little examined “the often ambiguous, vague and conflicting goals of the organizations [street-level bureaucrats] work for and the fact that their clients are typically non-voluntary” (p. 78). Findings from Pune illuminate both points, showing the dilemmas municipal doctors labored under. For instance, municipal doctors served a mandate to provide primary care to the city’s poor (a legal obligation of municipal government), but confronted authoritative directives that subverted that aim, such as summary transfers of doctors from clinical duties to clerical work.

The “non-voluntary” status of their clients contributed another conflict. Municipal doctors observed that the poor reluctantly arrived into municipal clinics and hospitals after having exhausted their ability to pay for private services. For the poor, municipal health care was an entitlement to state-provided services they had a right to seek and claim, but it was also simply one option among many, and an option of last resort at that. Municipal doctors were thus compelled to serve a patient population that sought and claimed their services, but held those services in low regard. Patients’ low regard was not only a measure of consumer satisfaction; it also had the force of authority of citizens over the state. As state agents, municipal doctors were obliged to respond to popular opinion, but limited in their ability and capacity to do so.

Second, focusing on the nature of authoritative directives, i.e., the forms and provenance of directives and how subjects experience them, provides a basis to compare workings of authority across time and space, i.e., across locations, levels, and agencies of the
state. For instance, George (2009) illustrates, based on fieldwork in a rural Karnataka district, how informal relationships can override formal arrangements for accountability and disciplinary action. Administrators and health workers may enact formal accountability measures (such as by recording minutes of disciplinary action taken against a health worker), but may also negotiate informally amongst each other (paying a bribe to obtain a job transfer) (George, 2009). In a conceptual framework based on authority, we may identify formal and informal authoritative directives as well as directives that abuse authority, and study subjects’ reasoning as they conform to directives. In contrast to workings of authority in the rural Karnataka district, in Pune’s municipal health service, informal directives predominated. Few formal directives, even if nominally enacted, appeared to guide everyday operations of municipal health care.

The above contrast suggests that frontline state agents endure a distinct experience of authority in state institutions in urban versus rural settings. That is, municipal doctors’ experience of authority shows how the “informality” of urban planning in India (Roy, 2009c) versus more extensive reform of India’s rural administrative institutions may contribute to distinct street-level effects in urban public service provision. For instance, evidence shows that some health outcomes among the urban poor are no better than rural averages, despite greater density of health care providers in urban areas (Subbaraman et al, 2012). One explanation for this paradox may be the workings and consequences of authority for frontline state agents in urban areas, where municipal governments are mired in weak governance and strong ward-level electoral politics (stemming from, e.g., state-level control over urban development, incomplete decentralization, and the rural emphasis of health care reform).
Third, describing how authority works—examining the nature, provenance, and subjects’ experience of authoritative directives—helps us see how organizational structures feature in frontline agents’ “reflexive deliberations” (Archer, 2003) and shapes their actions. Such an approach is aligned with studies of street-level bureaucracy where researchers analyze how “organizational routines, tools, norms, incentives, … and categories of understanding function as mechanisms of social control” that shape frontline agents’ use of discretionary power (Soss, Fording, & Schram, 2011, p. 230). However, a study of authority potentially offers additional traction over a study of discretionary power, because it opens the space to evaluate the de facto, de jure, and moral legitimacy of organizational structures over frontline agents (McLaughlin, 2007, p. 59). That is, rather than contend (as I do here) the authority of state office-holders is legally legitimate and then proceed to analyze the nature and effects of their directives, a philosophical approach (which I leave for future study) would more critically question the legitimacy of authority.

Particularly in LMICs where governance is weak (Leonard et al, 2013), an approach grounded in theories of authority may proffer novel insights into “categories of understanding” that circulate in organizations (Soss, Fording, & Schram, 2011, p. 230), and that can help explain power in health systems. For instance, health systems research shows how both public and private providers exercise “negative” power, e.g., by infringing health guidelines, flouting regulations, and violating protocols (Peters & Muraleedharan, 2008; Uplekar, 2000; Bhat, 1999).²⁷⁸ An approach that discerns the de facto and moral legitimacy of authority-holding entities may suggest why providers so frequently seem to resist directives.
It may also clarify where providers’ actions reflect not an exercise of discretion but a failure of authority. 279

7.10.4 Authority, policy neglect, popular opinion, and the manifold state

What does this study of authority in municipal health care tell us about workings of the state at the frontlines of service provision? My findings affirm the argument that for the poor, denials of care from the state derive from an uncaring mode of bureaucratic procedure (Gupta, 2012). Frontline state agents may not be personally uncaring—Gupta (2012) stresses the term applies to modes of state functioning and not attitudes of state agents—yet, as findings from Pune’s municipal health service suggest, state agents can be inadvertently complicit in producing denials of care. In Pune, municipal doctors’ apparent complicity derives in part from their responding to authoritative directives. Authority, in the present case, is untrammeled by any specific health policy or health intervention. Rather, it is configured by India’s urban political economy, including its neglect of basic services. 280 My findings show how this policy neglect can create dilemmas for municipal doctors, which, in their resolution, result in denials of care for the poor.

But my findings also lead me to extend that argument. They suggest that under liberalization, frontline state agents confront dilemmas that stem not only from bureaucratic dysfunction, but also from the advent of the “consumer-citizen” (Harriss, 2007) in an unchecked private sector. That is, in examining the authority of popular opinion, I show how Pune’s municipal doctors encountered people’s sense of entitlement to municipal health care, low regard for municipal health care, and preference for private health care. People’s
conjoint sensibility as citizens and preferences as consumers recalls what Harriss (2007) describes as the “ideal subject of the post-liberal state, ... the notion of the ‘consumer-citizen,’” (p. 2717). My findings illustrate the challenges and consequences for frontline state agents in confronting consumer-citizens’ claims without either the material or normative means to address those claims.

Harriss (2007) characterizes consumer-citizens as self-regulating and entrepreneurial subjects, encouraged by the state and global development agencies (such as the World Bank) to develop the capacity to make choices and transform choices into actions (p. 2716). They “submit to the discipline of the market,” e.g., obtain information about market choices, negotiate with providers, and make individual choices, and they also “accept the duties of citizenship,” e.g., participate in collective decision-making and hold institutions accountable to principles of efficiency (Harriss, 2007, p. 2717). My findings suggest that the imperatives of consumer-citizenship create distinct challenges for frontline state agents, particularly those agents, such as municipal doctors, who provide a service the private sector dominantly supplies.

Pune’s municipal doctors worked alongside an avid private health care sector. They confronted evidence of both consumer choice favoring private health care and citizens’ claims on state services. But municipal doctors were constrained to respond—authoritative directives stemming from policy neglect disposed them to accommodate irregularities in everyday municipal operations rather than elevate quality of care. Municipal doctors accommodated, too, negative popular opinion about their services, accepting this as a base condition of their work.
Those routine accommodations are, I argue, doubly detrimental: they not only result in material denials of care or bureaucratic disentitlement of the poor, they also unsettle in the social imaginary the idea of the state as a viable option of care. That is, under liberalization—specifically developments in the political economy of urban space and of health care—the private sector may secure not only consumer market share, but also space in citizens’ collective narratives as a preferred purveyor of services. Expansion of private health can thus displace state-provided services on both tangible and intangible accounts. At the frontlines of service provision, this displacement can frustrate social relations between state agents and the communities they are meant to serve, further compromising the quality of state-provided health care for the urban poor.
8 Concluding remarks

I opened this dissertation with a call to rethink how we explain health care quality, particularly the well-documented low quality of public sector health care in LMICs. The key moves we should make, I argue, are the following: to frame health care as a public good and its provision a social act, to conceptualize the state as manifold, and to theorize the workings of the state at the frontlines of service provision. In those theories, I attend specifically to how the social imaginary and local state-society relations shape the organization and operations, the policy and practice, of state-provided health care. Empirically, I field these theories in urban India, where, under liberalization reforms since the 1980s, the state’s provision of primary care has been a clear casualty of policy neglect and commercialization of health care has intensified. In this concluding section I reflect on the following: How do these findings help us rethink theories of power, the state, and the social imaginary? What insights does the approach offer to explain the low quality of state-provided health care? What does it say about the role of public and private providers in India’s health system?

8.1 Reflecting on power, the state, and the social imaginary

8.1.1 How authoritative power over frontline state agents shapes their actions

My exploration of power centers on theorizing “authority,” which denotes an actor’s rightfully-held social power over others, who accept to follow its directives. I observe providers’ actions through this lens, viewing their actions as a response to authority over
them. By studying authority’s workings—its nature, provenance, and effects—I show how organizational structures feature in frontline agents’ “reflexive deliberations” (Archer 2003) and shape their actions.

The approach I take is aligned with research on how “organizational routines, tools, norms, incentives, ... and categories of understanding function as mechanisms of social control” that shape frontline agents’ actions (Soss, Fording, and Schram 2011, p. 230). However, by theorizing authority, my analysis distinguishes between agents’ discretionary acts (e.g., the adaptations they make to their practices and their conceptions of their tasks and clients to “cope” with often impossible-to-meet work objectives under time constraints, limited information, and high caseload (Lipsky, 2010)) and their obligatory responses to authoritative power. Both can lead to low-quality public services. Both involve, for agents, a subjective tension between ideal and practical service delivery. But the deliberative calculus differs in each. The former entails agents’ volitional efforts to “salvage service and decision-making values” (Lipsky 2010, p. xv). The latter entails compulsory replies to practical commands, a giving up of autonomy in action even if not in private judgment. Crucially, then, although the structural constraints of their work everywhere shape frontline agents’ practices, the reflexive interaction of structure and agency takes a distinct course in situations involving particular forms of authoritative power over agents.

This particular reflexivity, i.e., between how providers interpret directives, act, and make sense of their actions, demonstrates that authoritative actors directed Pune’s municipal doctors to maintain their work at even keel despite gusts of irregular administrative and political demands. In their concurrent roles as medical practitioners and state agents, the
doctors’ mandate was as much to deliver health care as to anticipate and manage the informality of municipal operations, to negotiate, at street-level, the state’s historical inattention to urban health care. If population health outcomes depend not only on state agents’ judicious performance of duties but also on their seeing themselves as transformational agents who can foster and create space for social change (Evans, 2009), then municipal doctors’ experience of political authority conveyed to them a sense that such transformation was barely on the horizon. Instead, doctors perceived their work as a public service of low political priority (in policy reform terms) but high political utility (in street-level political calculations)—an entitlement that, when claimed by city residents, municipal authorities upheld. Overtly and implicitly, doctors were directed to reconcile the disordered management and peremptory political use of municipal health care services.

In these conditions, improving health care quality was a moot concern for municipal doctors. They pressures they faced, namely to contain everyday contingencies stemming from the state’s long-standing policy neglect of urban health care, were unlike those prominently documented in research on frontline state agents, such as to achieve statistical targets or improve procedural efficiency (Mishra 2014; Soss, Fording, and Schram 2011). Municipal doctors’ retreat to a minimal version of their mandate suggests not solely a coping strategy but a routine response to authoritative directives, which they experienced largely as quotidian calls to “just take care of” or let be the systemic deficiencies in urban primary care.

8.1.2  Encountering the social imaginary about the state at the frontlines
There is another sense in which doctors’ narratives suggest their actions are something other than or in addition to coping strategies to manage work burdens. Municipal doctors certainly grappled with the dilemmas of public service delivery under chronic resource constraints. But doctors also operated within and daily confronted the prevailing social imaginary about the state. Their narratives denote the social and economic conditions of their work, conditions that frustrated their already tenuous social relations with the communities they served and diminished their willingness to provide improved care. These work conditions suggest the transformative power of liberal economic principles on the social imaginary and the challenges it presents for frontline state agents.

To apprehend these changes, it is useful to consider, as analysts of urban politics have observed, that economic liberalization in India, as in other countries, is “intimately associated with transformations in the role of the state” (Harriss, 2007, p. 2716). Formulations of a drastically marginal role for the state in the economy and society under 1980s liberalization policies have been replaced in recent years by the idea that the state has a distinct role to play in establishing “the institutional conditions that are necessary for a successful market economy” (Harriss, 2007, p. 2716). This mode of government alters the terms of citizenship; it encourages, in particular, a kind of participatory self-government, where the ideal subjects are self-regulating and entrepreneurial “consumer-citizens” who make informed, negotiated choices and hold state institutions to account to principles of efficiency (Harriss, 2007, p. 2717). This mode of government is undergirded by the idea of partnerships between public and private actors and between government and citizens. It relies on mobilizing “the interests and aspirations” of urban subjects who are empowered but also self-disciplined, who may, for example, resist their displacement in the city (such as
due to economic forces) but do so in ways that comply with “top-down forms of rule,” such as by exercising patience, negotiating with rather than radically confronting authority, and committing to rather than disrupting the authoritative vision of the city (Roy, 2009a, p. 160).

Yet alongside this turn to consumer-citizenship there is the continuing low legitimacy of the state’s service-provision agencies. State policies may be shifting toward establishing conditions for a market economy, but the state’s service-provision role and institutions for urban primary care remain unchanged. Also unchanged is the wide unpopularity of the state’s welfare agencies; municipal doctors’ social relations with communities are fraught with poor people’s experience of state agencies as spaces of denial and tribulation. Municipal doctors seem to perceive urban residents as consumers keenly attuned to market operations, who, when purchasing health care privately, follow disciplined behavior (e.g., informed choice, negotiation for mutual benefit), but when accessing municipal health services do so as citizens in a stance not of market-inspired discipline but of impatience, mistrust, and confrontation. Doctors thus appear to experience their work conditions as fraught with historically tenuous state-society relations, hobbled by resource constraints, and additionally challenged by recent liberal-market shifts in the terms of citizenship. These combined challenges reflect not just bureaucratic work burdens, but tensions between changes in the economic sphere and continuities in the social imaginary about the state.

The economy as an organizing principle of society is a relatively novel feature in India. In India, the transformative processes that facilitated a modern social imaginary were not primarily economic, as in Western societies, but political (Kaviraj, 2009). Modern state institutions—introduced by colonial rulers and used instrumentally by postcolonial leaders
toward developmental ends—enabled a new social self-understanding in Indian society, wherein modern society was centered around the political authority of the state rather than traditional or religious social constructions (Kaviraj, 2009). Together with the extension of practices of democratic representation, state control over economic (e.g., state-led capitalist development) and social life (e.g., social surveillance and reformist projects) was a key process through which a modern social imaginary developed in India. This transformative process shaped citizens’ strong expectations of welfare from the state, even as the state consistently failed to deliver universal, equitable welfare.

By contrast, in Europe, the rise of the “economy” represents a key process by which the modern theory of moral order gradually came to infiltrate and transform the social imaginary (Taylor, 2004). People came to see the economy as a system of production, exchange, and consumption with its own laws and dynamic, distinct from the polity. The economy came to refer not only to the management of collective resources by those in authority, but to define “a way we are linked together, a sphere of coexistence that in principle could suffice to itself” (Taylor, 2004, p. 76). Dimensions of social existence other than the political thus became comprehensible and legitimated, with human activity directed to realize their integrity.

In India, such an idea of the economy as a legitimate organizing principle of society is a relatively recent feature in the modern social imaginary, one that, my findings suggest, intensifies municipal doctors’ fraught social relations and low legitimacy. Municipal doctors can neither fulfill their public mandate as state agents nor compete with private providers in health care; their inability to act compounds already weak state-society ties. Municipal
doctors’ experiences and narratives suggest the difficulties of meeting the terms of frontline public service in a time of economic liberalization.

8.2 Explaining health care quality

With regard to empirical insights into health care quality, I reiterate here my main argument: that meanings associated with the provision and seeking of health care can shape public providers’ actions and thereby the quality of their care. Specifically, my findings show how municipal doctors’ perceptions of their mandate, notions of risk in transgressing that mandate, and everyday experience of authority (bureaucratic, political, popular) all served to circumscribe their practice. When doctors abbreviated their clinical interactions—delivered brief examinations and curt diagnoses—this reflected, in part, doctors’ accommodation of their conditions of work. Doctors worked under conditions of a narrow mandate, heightened sense of risk, and irregular authoritative directives. For instance, they desisted from treating patients based not only on perceived clinical risk, but also on associated social risk, such as scathing media attention and lack of support from administrators.

These work conditions stemmed from macro-level factors, i.e., the social and political context of state-provided health care. They reflected the weak power of municipal government vis-à-vis state-level government; weak local state-society relations; low legitimacy of state-provided services in general; high popular preference for private health care; and high value of specialized medicine (relative to primary care) in medical education and professional practice. These factors subverted municipal doctors’ ability and willingness to reach the poor. A key dilemma doctors faced was that of both the low legitimacy of and
peremptory claims on their services, claims that, as state agents, they could neither fulfill nor ignore. Liberalization intensified this dilemma by diminishing both the material resources for and the social imaginary about state-provided care. Municipal doctors thereby circumscribed their actions, seeking, as one doctor put it, only to ensure the ordinary.

Enhancing doctors’ skills and incentives could improve their performance. But the efficacy of such micro-level interventions will depend on the social and political context of health care delivery. In urban India, that context offers scant symbolic value, inappreciable social relations, and meager material resources to support the state’s frontline agents. For instance, municipal doctors could be trained and incentivized to treat patients with chronic disease at the level of primary care. While such training would address clinical aspects of treating hypertension and diabetes, accompanying interventions would need to disrupt popular ideas that such treatment lies in the purview of specialized medicine. As another example, administrators could devise peer-monitoring programs to encourage municipal doctors to conduct more respectful, attentive clinical interactions with patients. To be viable and sustainable, such a program would have to tackle endemic prejudice across ethnic and class lines. It would also have to concretely link health care services with social services to address patients’ other needs, such as for social protection (for unemployment, old age, disability) or legal aid in the city. That would possibly require coordinating a slew of basic social services, which urban development programs have not so far prioritized. If municipal doctors failed to respond to incentives and training and did not obtain higher quality of care, their failures may be a product of the social and political contexts in which they operate rather than the design of the micro-level interventions. Micro-level interventions on their own may achieve insignificant or unsustainable results.
8.3 The public-private mix in India’s health system

With respect to the public-private mix in India’s health system, I argue that the relative prominence of public and private health care services shapes the social imaginary about health care and the state’s role in providing it. Leading health practitioners and policy analysts propose to “strengthen the public health system” as well as regulate and integrate “the private sector within the national health-care system” (Reddy et al, 2011, p. 760). My analysis suggests that health care outcomes from such integration would depend not only on the role each sector separately plays, but also on the interplay between the two.

In particular, the social and economic structures in which goods (such as medical care) are produced and consumed can contribute to both tangible social inequities (e.g., health disparities) (Reddy, 2015) and nondistributive negative effects (e.g., diminished sense of interdependence or mutual respect in a society) (Powers & Faden, 2008). Those social and economic structures include the composition of public and private services. In India, commercialization of health care, entailing a shift towards for-profit, private provision of health care, has diminished the prestige of and knowledge about basic family- and community-oriented primary care in medical education. This regard for specialized medical expertise is not new in India; it may be found in India’s post-colonial health and development policy, which emphasized the redemptive, instrumental power of science and technology to improve the nation’s health and alleviate poverty.
Although ideas about social medicine have long graced India’s health policy texts, they have eluded actual practice on the ground. Instead, medical educators and practitioners have valorized medical specialization and biomedical technology. In sum, commercialization in health care may not only poorly equip doctors to practice primary care in low-resource settings, but also denigrate, in both patients’ and doctors’ perspectives, the skills and knowledge that primary care providers are supposed to possess. In urban India, these tendencies accompany stagnant state investment in primary care. My analysis suggests that inadequate state upgrades of urban primary care coupled with avid private expansion renders a form of social discrimination, wherein municipal doctors, charged with serving the urban poor, are unable and unwilling to deploy their expertise.

For India’s contemporary national leadership, anxieties about urban development lie elsewhere. In 2015, Pune won second place in the national Smart Cities Challenge, an award cofounded by the Government of India and Bloomberg Philanthropies.\textsuperscript{282} The award funds winning municipal government proposals to foster economic growth, jobs, and quality of life in the city. Health care is not a priority in the Smart Cities’ vision. As India’s urban development minister observed, “housing, transporting, and employing [India’s future urban] generation will be the great global urban test of our age” (Venkaiah, 2015).

Perhaps Indian cities should heed another former mayor, whose advice concerns inequities generated in cities under policies that stress growth rather than social justice. Enrique Peñalosa (2013), mayor of Bogota, Colombia, from 1998-2001, proposed that, “An advanced city is not one where even the poor use cars, but rather one where even the rich use public transport.” Peñalosa posits a clear and substantive role for the state to create a
more democratic society, for more concerted state action to create and sustain excellent public services that everyone would want to use, not just to maintain mediocre or deficient services targeted to the poor. The point would apply to the domain of health care, too, particularly under its unremitting commercialization. It suggests that a substantial state role in providing, upgrading, and regulating primary care for India’s cities—and not only in devising transaction-specific fixes in clinics—could afford a democratic, equitable solution to improve quality of care.
9 Note on methods

In this chapter I reflect on practical challenges and opportunities that shaped the scope and day-to-day logistics of my fieldwork. I discuss how my physical and social location within the state institutions I studied informed what I could observe and interpret. I structure my reflections in three parts: (1) negotiating access, (2) being present, and (3) traversing multiple sites.

9.1 Negotiating access

Ethnographers have charted the challenges of negotiating access to specialized, inscrutable, or closed organizations and groups such as nuclear scientists (Gusterson, 1997), Wall Street bankers (Ho, 2009), Hollywood actors (Ortner, 2010), and state agencies (Hoag, 2011; Brash, 2011a; Yanow et al, 2012). In these cases, access often involves two elements. The first is obtaining permission from the group or organization, such as through figures of authority within it, to conduct a social scientific study involving its members, spaces, and processes. The second element is gaining visibility, i.e., to see and experience events and processes of interest to the study. That is, once inside the institutional space, the researcher still needs to get close enough to happenings and to people to observe the workings of the group or organization. Access in these cases is continually negotiated, and formal permission is not a guarantee of informal access.
That continual negotiation is compounded in an ethnography of the state theorized as manifold, its parts not necessarily coherent or unified (Sharma & Gupta, 2006). The multiple layers and sites of the state can complicate what is and is not visible to the researcher: even state agents may have only partial access to and understanding of the state (Hoag, 2011). Hoag (2011) notes that bureaucratic “rules and hierarchies are often clearly spelled out, and yet bureaucracies are always at some level opaque, inscrutable, and illogical to both ‘insider’ and ‘outsider’ alike” (p. 82). In effect, state functionaries “become gatekeepers, with control over the flow of information and resources” (Hoag, 2011, p. 82)—and yet their partial access implies that the researcher has to not only contend with blocked or hidden views, but also continually contextualize partial perspectives as she navigates myriad state spaces.

In my project, formal access, or permission to study the workings of municipal health care services in Pune, was a lengthy though straightforward process. I first sought out a health researcher in Pune, known to certain administrators in the municipal health department, who agreed to speak to an administrator and vouch for me. I then introduced myself to relevant staff in the municipal health department in person, who asked that I submit a formal letter. I drafted such a letter to present my bona fides and describe my project, which I sent to faculty at Columbia University. I received from them the letter printed on official letterhead and signed by two Columbia faculty members, which I submitted to the municipal health department. About a month later the letter was ready. It was now stamped “Approved” and signed by the chief executive of the municipal health department. This letter of authorization secured my formal access to the municipal health service and subsequently to individual health care facilities and staff as well.
I carried the letter (in original and several copies), with its official municipal stamp and signature, with me at all times, since municipal doctors expected to see a written warrant for my presence in clinics and hospitals. Among the first things doctors asked me was whether I had written documentation about my study and whom I had met at the municipal health department. Once I produced the authorization letter and named specific administrators, the doctors appeared satisfied and moved on to ask other questions. What exactly did I want to know? Which facilities was I planning to visit? How long would I be here? They would then instruct me as to where I could sit in the outpatient consultation room and would procure a chair for me if needed.

On two occasions, municipal doctors queried me on my methods. Each of the doctors had substantial experience and seniority within the municipal health service. What were the parameters of my research? they wanted to know. What conclusions could I possibly draw from such a study, since it seemed to comprise subjective impressions I alone would gather, a collection of my opinions? What exactly was my research question? These were tense moments, in part because of my discomfort, in my initial days in the field, with having to explain interpretive ethnographic methods to doctors whose professional expertise lay overwhelmingly in the biomedical sciences, in fields whose methods and aims are orthogonal to that of ethnography, and whose contact, in India, with the humanities and social sciences is practically nil.

While I was discomfited about having to justify my methods on the spot to senior medical professionals, I was far more worried that they would deem my research irregular
and not meriting approval, that my dissertation fieldwork, newly begun, would quickly end. A badly designed project was at least redeemable. Based on their questions, it seemed the doctors would even help me fix it. But an incomprehensible project might be entirely out of the bounds of permission. Could they, if they chose, have my formal letter of authorization retracted? Did they have the ear of health department administrators, of the chief health officer? Fortunately, one doctor dropped his questioning once I discussed my research strategy and methods. The other doctor’s skepticism was not easily appeased. She said she would think it over. But a few days (and, for me, sleepless nights) later, she agreed to let me observe the outpatient services she managed. Although unconvinced about the merits of my project, she reasoned I had already secured approval and begun the project.

Once I had gained access from the supervisor of a facility, I then had to request and gain access among individual doctors who managed outpatient consultation desks. I faced no instance of being refused access to a health care facility or to outpatient consultation desks. While some health care staff might have privately perceived the terms of my entry into their workplace as an imposition, most were welcoming. Even those few who were reticent or short in their answers to my queries had arguably little reason to change their behavior in my presence for at least two reasons. One, I was never the only person in the room. Doctors often sat two or three to a room, sometimes at a single desk, and often there were multiple patients in the room. The outpatient consultation room in some hospitals doubled as an administrative office: clerical staff might sit at another desk in the same room. Two, the door of the consultation room was never closed during working hours. Nurses and other paramedical staff freely entered and left. Patients waiting to be seen lined up right up to the door of the room, sometimes across its threshold. Local politicians and municipal
administrators strode or sauntered in without warning. In short, while patients had no privacy, neither did doctors have any retreat. Their work was thoroughly public: conducted not only in a public sector institution and thus subject to public scrutiny, but also physically in an open, common space within state precincts. My presence added another set of eyes on their work, but their work was, in any case, already in full display.

Rather than being uneasy, most doctors seemed neutral about my study. Those who expressed more than a passing interest in it were either eager to share their experiences or else nonplussed about my methods and choice of research question. Some were, as I have mentioned above, curious and skeptical about what they referred to as the unclear parameters and vast agenda of my study. One doctor asked why I had chosen to study a topic with such dim prospects for reform and volunteered suggestions of what he considered more productive topics of research in more dynamic cities: community-based health care in Mumbai, for instance. Another doctor cynically said that it would make no difference if she shared her experiences with me, since whatever report I produced would “end up in a trash can” by an official’s desk. Yet, despite their doubts about the approach and potential impact of my research, doctors did not object to my being in the room. Their lack of conviction that anything would change was, of course, part of the social imaginary, their collective narratives about their public mandate, that I was aiming to discern.

Brash (2011b) argues, drawing on his study of urban planning in New York City under Mayor Bloomberg, that when studying organizations and elites within them, issues of access might be less insurmountable than they seem, in part because “power operates in plain sight … the powerful operate in a world that is almost completely self-justified, thus
rendering obscuration and dishonesty unnecessary.” The ethnographic study of power
requires not access to its “secret workings,” but rather an understanding of “the terms and
production of its self-justification” (Brash, 2011b). What this seems to imply is that power
operates in ways that are not so much hidden as invisible, in need of illumination rather than
unveiling. In the municipal health service, many power relations were explicit. For example,
doctors occupied positions of power in clinics and hospitals vis-à-vis patients and supporting
staff, and doctors were in turn subject to the authoritative power of municipal administrators
and local politicians. These were not secret or hidden relationships but professional, official,
or widely acknowledged power relations. My task was not so much to uncover but to
understand them.

“Access is a sliding scale, not a binary…. The political ethnographer strives for the
nearest possible vantage point to study a given problem,” notes Schatz (2009c, p. 307). By
that measure, my formal access to municipal health care in Pune was satisfactory. What was
trickier than formal access was informal access to people, spaces, and processes. Before
beginning fieldwork, I had expected that apart from observing encounters in municipal
health care facilities, I would also explore alternate venues and settings in which to interact
with municipal doctors and other informants. I thought I would engage with doctors outside
clinics and hospitals, perhaps over shared meals or recreational activities (e.g., Gusterson,
1997) or come to know the municipal administration by “attending events in which the
closed institution presents itself to ‘the public’” (Ortner, 2010, p. 211). These are strategies
ethnographers have used to “study up.” But such “polymorphous engagement” (Gusterson,
1997, p. 116), or engaging with informants outside of their workplace, was infeasible in my
project primarily for reasons of time and geography, as I explore in the sections below. As I
also explore next, within the workplace, constraints of time and social and organizational norms sometimes impeded interactions, limiting how much I could actually observe even when I was physically present in municipal health care facilities.

9.2 Being present

I conducted my observation largely in the outpatient consultation rooms where doctors saw patients for primary care visits, during working hours, i.e., 9am-5pm from Monday to Friday, and 9am-1pm on Saturday. I have already discussed how the open, public setting of the outpatient consultation room made it possible for me to observe encounters without drawing attention to myself. I discuss below spaces and situations that were more inconvenient to enter, where my presence was more conspicuous and difficult to sustain. I also discuss how my social position afforded advantage or disadvantage in my fieldwork.

9.2.1 Non-clinical interactions in municipal facilities

I was generally unable to lurk for long in waiting areas. Support staff who sentinelleled the consultation room and managed the waiting patients sometimes did not approve of my sitting in the same chairs and benches that were used by patients. Neither did they like my standing around in the hallway. To the support staff, I was too closely associated with the doctors to sit in the waiting area as a patient would, but I did not have the seniority to violate rules that applied to patients, such as the no-loitering rule.
My in-between status had implications for the spaces I could occupy, who I could interact with, and how. That in-between status was at times overtly established by doctors I met, as I discuss below. It was partly a function of my apparent age (locally, I appeared younger than other women my age). It was also partly a product of the limits of linguistic capability and the social informality I could achieve in Marathi. Although I grew up in a Marathi-speaking household, I was schooled in English and have lived outside India since I was four years old. I am therefore more proficient in English than in Marathi. My interlocutors openly remarked on my linguistic ability. For instance, when I first approached a long-serving municipal doctor, she was avuncular and disarming but also keenly attuned to my organizational rank. After I described to her my project and requested permission to stay and observe encounters in the clinic she managed, her first remarks were about my identity: she said that although my name was clearly Marathi (a communal affiliation), my Marathi (language) was halting. By directly commenting on both the sufficiency of my background and deficiency of my ability, she immediately created the space that I would occupy in the rest of our conversations: that of a subordinate observer, legitimate in my presence as a researcher but junior in position and age. This in-between role meant that I remained the tentative, inexpert novice among municipal doctors even as I formulated increasingly educated questions about their organizational life.

That in-between status was evident again when several municipal doctors visited a municipal hospital for a health service-related event for a few days. During an afternoon break I conversed informally with one senior visiting doctor, whom I had previously met in another location, in a mix of English and Marathi (more English than Marathi). We sat in a room that nurses in the hospital used to conduct administrative work. The room regularly
doubled as a registration and record-taking area for the lines of pregnant women who arrived on designated days for antenatal care, but on that day, that afternoon, it was empty of both patients and doctors. Only a few nurses went about their non-clinical duties. As it happened, teatime fell during the course of our conversation. A nurse brought both the senior doctor and me cups of tea, and we continued to converse. Yet, on the following day, during lunchtime, the visiting doctors left together to lunch at a nearby restaurant, while I sat instead with the nursing staff to share their tiffin of homemade rice, dal, and vegetables. The nurses did not formally invite me to join them. Rather, without saying a word, the nurses simply made room for me to sit down with them in the room where they ate lunch, at the same large desk where the previous afternoon I had had tea alone with the doctor.

The two afternoons showed that while I was able to socially interact with the senior doctor, to talk to him in English, I still held a subordinate position within the organization as a junior outsider. My social status as an visitor from America, as someone with an elite enough background to speak English more fluently than Marathi, who could talk at length and informally with a senior doctor, all of this did not supersede my simultaneous status as a young person, a student, someone who held no organizational clout. This in-between position was a mixed advantage. On the one hand, I could continually play the naïve, information-hungry questioner that I often was, asking basic, exploratory questions. On the other hand, my evident traversing across the organizational hierarchy might have made some municipal doctors nervous about what I might say to whom.

Had I been a medical doctor myself, had my Marathi been more colloquial, or had I enjoyed more free time outside my own home responsibilities (a point I discuss further
below), it is possible I might have developed friendships with a greater number of informants than I did. Other small cultural distinctions cropped up occasionally. For example, during lunch breaks, doctors would either leave the clinic or hospital or else have lunch right at the desk in the outpatient consultation room. This varied from facility to facility and from day to day. If they remained at their desks, I would join them. Lunchboxes were typically shared: people sampled food from each other’s tiffin and I learned to bring more than I could eat myself. The type of homemade food I brought with me sometimes set me apart. Doctors never, for example, brought sandwiches as I had once hurriedly packed. The sautéed vegetables I ate (which my mother prepared) were far less spicy than theirs; some doctors found my food bland. I would bring food cooked in styles from other parts of India (such as thin, small phulka in the Gujarati style of making flat bread, rather than the layered, thick poli in the local Marathi style), which they would find curious since I was Marathi.

On the other hand, I found that my seriousness and formality—my polite but persistent intrusions into their daily working life—encouraged informants to be thoughtful and serious in return. In one case, an assistant (a non-clinical worker who managed patient flows in outpatient care, a long-time employee who knew the politics of the organization and had worked across it), enabled my access to doctors and spaces and made a point to include me in their group social activities because, in her own words, she said I had good swabhav, meaning nature, temperament, demeanor. In another case, a senior doctor, after having spotted me in multiple municipal hospitals, once remarked loudly to the room that it seemed I was “studying the anatomy, physiology, neurology … everything about [the municipal
I took this as a compliment, a reckoning of the breadth and doggedness of my research.

### 9.2.2 Working hours

Being present in municipal facilities during working hours was no guarantee that I would observe health care staff at work, and my availability outside of working hours was limited by family responsibilities. Empty time during municipal working hours (when facilities were closed or unattended) and my own busy time outside them limited the events I could observe.

Municipal health care facilities closed for lunch between 1pm to 2:30pm, and closed for the day at 5pm. If the doctors left the health care facility for lunch, I either remained in their vacant consultation room until working hours began again at 2:30pm, or I left to conduct other meetings, to observe at another municipal facility, or to record my observations in detail. But some facilities had erratic *de facto* hours of operation. A doctor at a clinic may not arrive until 3pm post-lunch, even though official working hours began at 2:30pm. Or the doctor I was hoping to engage with may have left the hospital in the middle of the working day, even though he had previously informed me he would be present. He may not return for the rest of the afternoon.

At day’s end, doctors would hurry to begin their homeward commute, as might workers in any highly populated, sprawling city with bad traffic and unreliable public transportation. Several young women doctors had substantial housework at home, with
waiting in-laws who expected their working daughters-in-law to keep up with the cooking. I too was anxious to return to my two children at home, who were one and four years old at the time. “Home” was my parents’ home, where I stayed throughout the course of my fieldwork. During the day, my mother helped look after the one-year-old with the aid of a sitter. My four-year-old attended daycare, but had to be dropped off and picked up; often I did one of those commutes. My father was diagnosed with a form of dementia the same time that I began my fieldwork. He was unable to walk steadily, was sometimes disoriented, and could not be left alone. My mother was tied up in his care-taking, something that no-one had anticipated when I had initially planned my fieldwork. His illness meant that I could rely on her less than I had hoped to do. For these reasons, neither the young municipal doctors nor I could reasonably linger beyond 5pm. We each had families to return home to.

It was crucial, therefore, that I used my time during official working hours expeditiously, that I was ready to engage them with a question or to offer an observation to elicit their reflection whenever an occasion arose, partly because it was practically difficult to meet with health care staff outside of the clinic.

9.2.3 Municipal doctors as Weberian state agents

My access to doctors on social ground was additionally complicated by their steadfast role as state agents. The scope of my project, an exploration of the challenges of state-run urban primary care provision, provided me access to state institutions and, by extension, to doctors in state employ. But while it soon became routine for me to engage doctors in questions about their patients, local communities, and the deficiencies of state-run health care, I could
not get very far in conversations about doctors’ early experiences in medicine or of working for the city. I found it difficult to engage them in conversations about their career or educational trajectories or to gain oral historical narratives about how the municipal health service operated in the past. When I attempted to understand what it was like for doctors to work in the municipal health service or other health facilities or to attend medical college a decade or two ago, I received mostly short answers in response.

For the most part, municipal doctors engaged with me and answered my questions about their everyday work in their capacity as municipal employees. Their attitudes suggested they implicitly took a Weberian view of themselves in this regard: they were neutral state agents, rule-bound bureaucratic actors whose personal predilections or histories had (or should have) no place in how they carried out their tasks. Discussions about a point of interest—such as why lower-level employees were difficult to control, how politicians interfered in health service-related decisions, or how medical graduates decided between public or private practice—foun-dered when I tried to shift the conversation to what these situations were like a decade or two ago.

In part, the maneuver to the past or to the personal was difficult to execute because of the location and staccato flow of our conversations, which largely took place within state precincts. We sat in the shadow of state structures, grounded in physical institutional spaces. At other times the maneuver was difficult because doctors had to attend to patients and other regular work during working hours, which interrupted the flow of our conversations. Had I been able to spend more time over the duration of the project, both within and
outside of municipal facilities, I might have navigated that shift from the current and the institutional to the past and the personal more effectively and more often.

Ethnographers who “study up” suggest researchers find alternate avenues to approach and observe a closed institution (Ortner, 2010; Gusterson, 1997). Yet barriers of informal access may persist even when the researcher gains formal access to spaces, events, processes, and people in a closed institution. In an ethnography of the state, when people interact with the researcher largely in their capacity as state agents, the researcher confronts the time-honored challenge of establishing rapport with individuals, complicated here by the multiple roles—organizational and social—that individuals simultaneously play. Addressing that challenge might require framing the study as one concerning the medical profession rather than only about the state. I propose that within such a project, apart from spending additional time in the endeavor, the researcher may additionally frame questions in terms of the values and ethics of a situation. As Weber noted, even bureaucrats may be moved, when confronted with matters of substantive justice, to reject “the formalism and the rule-bound and cool matter-of-factness of bureaucratic administration” and look instead to emotions for answers (Weber, Roth, & Wittich, 1978, p. 979-980).²⁸⁵

9.2.4 Participating as a patient

Apart from being present in municipal facilities as an observer, I also enlisted myself as a patient at municipal health care facilities in several instances (described in the methods section). Although availing medical care in municipal facilities was an uncommon prospect
for most middle-class residents, yet, I encountered some of the same things that might confront the average patient in municipal facilities.

For instance, one municipal doctor, with whom I had had several conversations, prescribed antibiotics for my medical problem without informing me what he was recommending or why. I later learned the condition did not warrant antibiotics. My clinical encounter with him presented a similar experience as befalls many patients. I received incomplete information about my medical condition and its cause, and a prescription based on a cursory examination.

In another instance, I was sent away at the door of a municipal diagnostic lab when I arrived seeking routine blood tests. The municipal staff monitoring the lab categorically informed me, with no explanation, that the lab was closed, even though I was there during regular working hours. I later learned that it was not formally closed, but they were sending patients away to attend to internal work. Like many patients, I left perplexed but without pressing too far for answers from the curt municipal employees who stared me down. I was already ambivalent about having blood tests done there and discomfited by illness.

Early in my fieldwork, when I asked municipal doctors how poor, illiterate patients navigate municipal hospitals given, for example, that signage within buildings is limited and confusing, doctors shrugged at the question. They replied that patients learn to cope, and reasoned that any new space would be disorienting at first. Although I was able to counter my disorientation with my ability to read and capacity to question figures of authority, my visits as a patient nonetheless yielded glimpses into the structural violence of institutional
spaces and bureaucratic procedures. My socioeconomic status did not render me entirely immune to their potentially negative health effects and the unpleasant affective experiences they tended to offer. I had greater social and cultural capital to rebut potential denials of care, but I was subject to them nonetheless. This provided first-hand insight into the plight of poorer patients who visited state-run facilities.

9.3 Traversing the extra-local: Accessing the state’s multiple sites

The geography of cities—Pune, where I conducted participant observation; Mumbai, the capital of Maharashtra and Pune’s metropolitan neighbor; and New Delhi, India’s capital and hub of policy institutes and NGO headquarters—shaped the overall scope of my fieldwork as well as its day-to-day logistics. Guided by a theory of the state as manifold, comprised of multiple locations and levels, my fieldwork necessarily entailed traversing multiple spaces: clinical and non-clinical, state and non-state; municipal government and higher levels of government; in the city and outside it. This multiplicity of site and vantage is vital in a relational ethnography (Desmond, 2014). However, physically traveling the geography of multiple sites to follow organizational relationships, effectively extending the range of people and institutions I studied, at times meant a compromise of ethnographic depth (Desmond, 2014). That is, in spending the time and effort in pursuing a range of informants, encounters, and institutions, I was unable to spend great amounts of time in any particular site. The challenge was compounded by conditions of urbanism in India.

In navigating travel to and within these cities, in particular within Pune, I ran up against the travails of urban living in India, where cities have rapidly grown dense as well as
geographically expansive without commensurate transportation infrastructure. I also confronted the reputed unreliability of government services: it was not unusual that people and spaces I hoped to visit would be unavailable—shut, absent, or otherwise occupied—without warning or obvious cause, or else require persistent, in-person efforts to gain formal access. This meant that I had to strategize my travel within Pune every day, sometimes recalibrate my plans several times a day. It meant that I had to simply trust that people in Mumbai (three- to four-hour bus journey from Pune) and Delhi (two-hour flight) would keep appointments I had made with them days or weeks in advance.

Pune was settled (some accounts place its beginnings in the 8th century AD) at the confluence of two rivers. Municipal health care facilities are denser at the centre of the city, where the rivers meet, and spread out across the outer neighborhoods. Trawling the sprawl of the city for useful ethnographic data could be time-consuming and logistically difficult. For instance, based on traffic conditions, it could take me over 75 minutes to arrive at a distant health care facility. Making the return journey from such a location every day was not an efficient use of my time: I could not be sure that doctors would be available or that I would have a reasonable amount of time to spend in the facility when I visited that location.

Three factors fueled my uncertainty about the usefulness of crossing the breadth of the city as a regular research practice. One factor was that some municipal health care facilities sometimes had erratic de facto hours of operation. A doctor at a clinic may not arrive until 3pm post-lunch, even though official working hours began at 2:30pm. Or a doctor might have to leave the hospital during working hours, even though he had mentioned to me
that he would be present. That unpredictability made long journeys across the breadth of city sometimes unproductive. I had to have ready alternative plans and people to meet.

Another factor was that communication about scheduled or impromptu events in the facilities was not easy to obtain. I would show up at a facility only to learn that they are to close an hour early due to a staff training exercise, leaving only 45 minutes before they packed up and locked the doors. Or I would find upon arriving at a facility that a staff meeting I was to attend, the main purpose of my visit that day, was cancelled. Staying abreast of such events would have required me to call daily to check ahead with the clinic, an intrusion that would have made my presence there annoying and overly conspicuous. Telephoning municipal facilities was not always easy: the phone numbers of some clinics were missing from the official municipal telephone directory, and were unknown even to telephone switchboard operators at municipal headquarters when I inquired.

A third factor was that health care staff were posted to and transferred between health care facilities with little warning. For example, a doctor might receive an early morning phone call that she had to report to a different clinic from the one she is regularly posted. I could not be certain to find the same doctor in the same clinic from one day to the next. While this unpredictability complicated the logistics of my fieldwork, it was an intrinsic aspect of municipal health care services in the city. Indeed, my experiences confirmed the popular complaint against public sector services, namely that seeking health care in municipal clinics and hospitals took too long, seemingly without reason, and without dependable results. Just as patients found themselves stranded and bewildered by what they
expected to find and what they actually encountered in health care facilities, so did my research progress in surprising fits and serendipitous starts.

Unlike the lot of patients, of course, for my purposes the unpredictability had some uses: chance conversations with other health care staff, whom I may not have otherwise approached, did at times prove productive. And importantly, my ethnography was not primarily focused on individual doctors’ practices, but on the workings of the institution as a multi-sited object of analysis. If individual doctors were present one day and absent the next, this was data: a part of my record of the field. Examining why it happened, and how doctors made sense of it, was part of the analytical task.

However, the prospect of traveling to a distant location and returning empty-handed generally implied high opportunity cost: I would not only lose time, transportation expense, and energy, but also the chance to schedule other meetings, attend other events, observe at other facilities. I tended to plan my commutes to cover middle-range distances, where I could make frequent visits and observe for longer periods within a facility, and I kept ready alternate plans should a doctor abscond for the day or a meeting be summarily cancelled.

Although this strategy could potentially diminish the range of neighborhoods and types of institutional spaces in which I conducted my observations, yet it was not, I contend, ultimately damaging for at least two reasons. Firstly, while I did not venture to some peripheral parts of the city, where municipal health care facilities were newly established and neighborhoods more recently settled, yet the facilities I did visit were located in disparate, diverse neighborhoods. Secondly, the unpredictability of workers’ postings and transfers also
meant that, since doctors moved around, it was not unusual to encounter the same doctor in multiple facilities, sometimes in locations within a specific area of the city. By visiting a selected number of facilities, I was able to observe some of the same doctors in different clinical settings. By visiting various facilities and observing some of the same doctors in multiple locations, I was able to achieve a degree of “intersituational variation” to develop my analysis, sufficient to illustrate how actions of various actors, observed in different situations, “make sense as a single set” given my theoretical premise (Tavory & Timmermans, 2013, p. 692).
Endnotes

1 Primary care refers to basic care for illness and injury delivered at the lowest tier of the health

2 Leonard and colleagues (2013) use the term “health market” to denote the combined supply and use of public and private health care services.

3 Drawing on Taylor (2002), by the social imaginary I mean “the ways in which people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations … It incorporates a sense of the normal expectations that we have of one another, the kind of common understanding which enables us to carry out the collective practices that make up our social life” (p. 105-106).

4 The municipal hospital’s use of intradermal rabies vaccine was aligned with World Health Organization (WHO) recommendations. “The reduced volume required by intradermal vaccines, in comparison to the intramuscular vaccine, results in cost savings of 60-80%. Intradermal vaccination may be a more cost-effective option for high-flow clinics where the disease is endemic.” Retrieved on Oct 23, 2015 from: http://www.who.int/rabies/en/

5 Responsiveness measures the extent to which providers meet people’s expectations within a medical encounter, including whether providers treat patients with respect, autonomy, and dignity (WHO, 2000, p. 31).

6 Evidence also suggests that, on average, public providers’ medical advice is of no better quality than that of private providers even though private providers are likely to hold lesser medical credentials (Das & Hammer, 2007; Das et al, 2012). In this case, contrary to that evidence, Dr Srinath’s advice to the mother was on target.

7 An alternate, more clearly specified formulation of this definition is one that decomposes “access” into five distinct subcomponents: accessibility in terms of geographic location; availability in terms of the range of services offered and their appropriateness to population needs; adequacy in terms of how the services are operated (e.g. timings that facilities are open); affordability given users’ resources and ability to pay; and acceptability to users of the experience of care (Obrist et al, 2007; Ergler et al, 2011; Penchansky & Thomas, 1981).

8 In LMICS generally, precise estimates of the size of the private sector are hard to come by because of the heterogeneity and informality of the private sector (Hanson et al, 2011). In India, according to official estimates made just before India’s independence in 1947, the private sector maintained about 8% of all hospitals and clinics in India (GoI [Government of India], 1946a, 1946b). By the mid-1990s, the private sector accounted for around 60% of all hospitals and clinics (Planning Commission, 2002). If we include rural state-run community-based health care facilities in the aggregate number of state-provided health care facilities, the share of the private sector would still account for almost 40% of all health care facilities in the mid-1990s, up from 7% as of 1946 (Planning Commission, 2002).
Responsiveness measures the extent to which providers meet people’s expectations within a medical encounter, including whether providers treat patients with respect, autonomy, and dignity (WHO, 2000, p. 31). Provider responsiveness captures the extent to which health care provision is “organized around the person, not the disease or the financing” (WHO, 2010, p. 3).

Out-of-pocket expenditure for outpatient care can be cumulatively catastrophic for household finances. Studies from India show the substantial economic and caregiving burden of illness, to the extent that out-of-pocket health care expense is a major cause of household debt (Krishna, 2006; Dilip & Duggal 2004; Bhat, 1999; Bhojani et al, 2012). Despite the high cost of private health care, people often turn to private providers, suggesting the extent to which they deem public sector health care to be inaccessible and of low quality.

Leonard et al (2013) note that information asymmetry is heightened in conditions seen in many LMICs, namely that of “mixed markets” (where public and private sectors coexist), poverty, and weak governance, since these factors can increase the likelihood of exploitation.

In their review, Berlan and Shiffman (2012) acknowledge that “macro-political factors such as the degree of responsiveness of the political system to citizen demands for quality health care, and the extent to which the system is oriented toward social equity, ultimately may have great influence on provider responsiveness” (p. 272). But, in their review, they focus on patients as consumers rather than citizens, considering more narrowly the “direct interactions between consumers and providers and the factors that immediately surround them that may influence these interactions” (Berlan & Shiffman, 2012, p. 272).

To be clear: I am not saying that health care is a public good because the state does or should provide it. To the contrary, states typically provide a good or service because the good or service meets the formal criteria of a public good.

A lighthouse is the classic example of a public good: people cannot be prevented from benefiting from the illumination it beams, and one person’s use of the light does not leave any less light available for others to use.

According to the OECD (2003), externalities refer to “situations when the effect of production or consumption of goods and services imposes costs or benefits on others which are not reflected in the prices charged for the goods and services being provided.” Helbling (2010), writing in an IMF publication, notes that “consumption, production, and investment decisions of individuals, households, and firms often affect people not directly involved in the transactions. Sometimes these indirect effects are tiny. But when they are large they can become problematic—what economists call externalities. Externalities are among the main reasons governments intervene in the economic sphere” (p. 48).

In a related point, Reddy (2015) notes that state regulation may not only help markets become more perfect, but also redress distributional effects due to negative pecuniary externalities. Externalities formally refer to technological or “direct” costs and benefits (e.g., pollution from a factory affects the local community). However, as Reddy (2015) observes, externalities should also include negative pecuniary effects, i.e., effects of price changes and resulting welfare losses, which would not be offset in incomplete markets or in the presence of asymmetric information (e.g., migration in-flows to a city increase prices of real estate for local residents). In the realm of health care, state regulation of pharmaceuticals and state funding of research and development can help ensure that drug prices do not negatively impact those who are less able to pay for medical care.
17 As Reddy (2015) writes: “the presence of an externality … is in basic respects a consequence of the specific social structure and institutional organization of an economy and not only of prevailing technology. Whether externalities can be said to arise or not is a consequence, for instance, of ownership relations …”

18 In standard economics theory, a maximizing “social planner” arrives at the efficiency condition that identifies the optimal public and private provision of the public good, corrects externalities, and restores market perfection (Reddy, 2015). From the perspective of such a planner, public and private health care might be substitutable services. But the standard view “evades the discussion of … detailed aspects of the structure of an economy” and the “social nature of public goods” (Reddy, 2015).

19 Mackintosh & Kovalev (2006) define commercialization of health care as: “the provision of health care through market relationships to those able to pay; investment in and production of those services for the purpose of cash income or profit; health care finance derived from individual payment or private insurance” as opposed to the state (p. 388). My analytical focus is on health care provision, meaning the organization and functioning of health care service delivery, which comprise a subset of policy reforms under commercialization in the health sector.

20 Accounting for unqualified practitioners—those doctors practicing allopathic medicine but without relevant credentials—brings the density of allopathic doctors down from 13 to 11 per 10,000 in urban and from 3 to 1 per 10,000 in rural areas, reflecting the higher proportion of unqualified physicians in rural areas (Rao, Bhatnagar, & Berman, 2012). Most unqualified practitioners are in the private sector (Rao, Bhatnagar, & Berman, 2012).

21 India seems exceptional in the extent of its private sector in rural settings, but accounts of the number and distribution of providers should be read in tandem with estimates of unqualified providers. Unqualified providers make up over 60 percent of providers in rural areas and 20 percent in urban areas; the concentration of qualified private providers is therefore still relatively high in urban areas (Rao, Bhatnagar, & Berman, 2012).

22 Evidence from other Asian countries and sub-Saharan Africa shows a similar picture of greater availability of health care, especially private health care, in urban areas. In Indonesia, for example, the physician to population ratio as of 2007 was 36 per 10,000 in urban areas, compared to 5 per 10,000 in rural areas (Rokx, Giles, Satriawan, et al, 2010). Moreover, the number of physicians employed in private practice increased by over 50 percent in urban areas over 1997-2007, whereas in rural areas it rose by about 20 percent (Rokx, Giles, Satriawan et al, 2010). In sub-Saharan African countries, privately provided health care is typically concentrated in cities: Ouagadougou houses 60 percent of Burkina Faso’s private sector health care facilities (Beogo et al, 2014). In Nigeria, there are four times as many private sector doctors in urban areas relative to rural areas (Dutta et al, 2009). In Ghana, urban districts sport a higher proportion of private providers (over 80 percent in the district of Tema and Aishman) than rural districts (about 30 percent in Manya Krobo) (Bitran, 2011).

23 Agglomeration refers to the concentration of population, infrastructure, and investment over a densely settled territory. Extension refers to ways in which agglomerations dynamically transform through “circuits of labor, commodities, cultural forms, energy, raw materials, and nutrients” across the rest of the world, “via dense webs of relations to other places, territories, and scales” (Brenner, 2013, p. 102).
In such an approach, scholars conceived the state as a collective of state institutions (military, police, civil administration, and others), coordinated by a central executive, and showed this entity as relatively insulated from or capable of countering the pressures of socioeconomic circumstances and social groups (Skocpol, 1985). Mitchell (1991) argues that Skocpol (1979) narrows the definition of “the state proper” to its “organizations” to distinguish it from the overall “political system” within which states operate (the political system includes, e.g., institutions through which social interests are represented in policy-making or nonstate actors participate in policy implementation). But, Mitchell argues, Skocpol is unable to concretely draw those boundaries in her empirical analysis, to separate, for example, “the state proper” from the “political power of the landed class” in her analysis of revolutionary France, Russia, and China (Mitchell, 1991, p. 87).

According to Mitchell (1991), researchers should view the porous boundaries between state and society not as a problem that seems to elude definitional accuracy, but rather to view the porous boundaries as containing “clues to the nature of the phenomenon” of the state (p. 78).

Kaviraj (2005), writing on the “enchantment of the state” in India’s intellectual culture, notes that “The boundaries and contents of the idea of the state are likely to vary between intellectuals and common people, and also between literate and illiterate actors in the political world, between elites and underprivileged populations. All this can be gathered together into something like a ‘political imaginary’ or a state imaginary” (p. 263).

Historical legacies and ruptures, including transformations in the national economic and political landscape, can shape and re-shape the objectives and design of welfare policies (Haney, 2002). These same legacies and ruptures can also unevenly, across the policy-making and policy-implementing centers of the state, condition state agents’ conceptions of need and citizens’ expectations about services (Haney, 2002).

I recognize that measures of “social need” are inherently political and are “always located within a particular historical and cultural context” (Robertson, 1998, p. 1421). Defining, gathering, reporting, and acting upon evidence of need are all political acts.

Hacker (2004) writes: “As institutionalists have long argued, opportunities for policy change are systematically shaped by the distribution of decision-makers’ preferences regarding the status quo and alternatives to it, as well as by key institutional features of political systems, particularly the degree to which procedural rules create a status-quo bias” (p. 247).

Hacker (2004) writes that policy drift may be inadvertent, a result of “failures of foresight or perception,” or it may be deliberate, due to “efforts by political actors to prevent the recalibration of social programs” in the face of evidence of changed social circumstances (p. 246). In other words, policy drift is mediated by politics where opponents of state intervention block “compensatory interventions designed to ameliorate intensified social risks” (Hacker, 2005, p. 46).

Some economists argue that India’s departure from its post-independence planned economy began in the 1980s, with important (though unsystematic) reforms, when the state started to relax the regulation of industry and trade, laying the foundation for more extensive reforms in the 1990s (Panagariya, 2004). In the health sector, in the 1980s, the state gave concessions and subsidies to the private health care sector, such as for imports of medical equipment, and curtailed public expenditure on social services (Baru, 2003).
This common understanding in modern times in the Western world, argues Taylor (2004), includes a particular “moral order” that derives from Grotius’ and Locke’s natural law theories. This new theory of moral order refers to a sense of the natural rights that all individuals hold, the responsibilities we have toward each other, and the features of the real world that make those rights realizable, as far as possible, in the here-and-now. The modern social order is one in which society exists for the mutual benefit of all—a “political society” in which each one agrees to incorporate or to make into one body; to invest a “government” with the power to make, adjudicate, and execute laws; with the ultimate aim to act for the common good of all. The theory of individual rights (and it was an intellectual theory before it became prevalent and widespread in society) and norms of equality and reciprocity thus ended up “spawning a dense web of limits to legislative and executive action via the entrenched charters” that feature in contemporary government (Taylor, 2004, p. 5). The modern moral order—as it shifted from being a theory used to legitimate modern political authority to being a pervasive understanding among contemporaries of the ties that exist among and sustain them—thus re-organized both imagined relations and actual institutions that mediated between the individual, society, and the state.

A key element that distinguishes modern from premodern social imaginaries, says Taylor (2004) specifically with respect to modern society in the Western world, is that these identifying features of the world are not themselves normative and fixed but are contingent and may be variously organized. They are not a goal in themselves but rather simply a means to achieve the moral order, which is premised on individual rights and mutual benefit, chiefly benefits of security and prosperity, which pertain to the ordinary life of all humans as lived in the here-and-now as opposed to, for instance, ideals and virtues attainable only to a small minority such as a community of saints.

The term street-level bureaucrat refers to state agents, such as teachers, police officers, and social workers, who engage directly with the public, implement policy, and deliver services. Michael Lipsky’s book, first published in 1980, which popularized the term, recognized that street-level work confronts its practitioners with what he called “dilemmas of the individual in public services.”

By “narratives” I mean the stories that actors tell; these stories would have formal properties of a narrative, involving a central character or subject, a sequence of events, and a causal explanation for the events (Gupta, 2012).

I take social relations to be manifest and expressed in individuals’ social actions, i.e., social relations prevail both in individuals’ interactions with others and as abstractions in individuals’ structures of thought and feeling, in the meanings they attach to their interactions with others (Hall & Lamont, 2006). As Hall and Lamont (2006) note, Max Weber long ago “made the point that there is no action and social relationship without meaning. Building on this insight, recent network analysts have observed that the social connectedness of a society is not specified simply by the structural properties of networks, such as their density or even the instrumental functions they serve, but by the meanings those networks produce and convey” (p. 9). Weber referred to social acts as actions meaningfully related to the behavior of others: actions in which the individual interacts with others, attaches subjective meaning to her behavior, and this subjective meaning takes account of the behavior of others.

Social capital is “the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (Bourdieu & Wacquant, 1992, p. 119). Two constitutive elements define the social capital an individual or group holds: “first, the social relationship itself that allows individuals to claim access to resources possessed by their associates, and second, the amount and
quality of those resources” (Portes, 1998, p. 3). Individuals and groups can deliberately construct social relationships that can then be used as a resource. Political and economic systems can contribute to the particular form that social capital takes in a society, for example by instituting the ways that collective resources are distributed in society—Bourdieu gives the example of labor unions and political parties as institutions that account for variations in the “shape of social space” in different societies (Bourdieu & Wacquant, 1992, p. 119).

38 Its growing significance in recent years signals pushback in the discipline of political science against the dominance of the positivist paradigm and concerted interest in the value of a plurality of methods to understand and explain politics (Schatz, 2009b; Schram & Caterino, 2006).

39 See discussion between Seaver (2014) and Anderson (2014) in Ethnography Matters. (http://ethnographymatters.net/blog/2014/03/10/studying-up/).

40 For example, if we refer to research on professional technology developers (e.g., software programmers) as studying 'up', we obscure their differential relative power vis à vis the ethnographer, other technology professionals (who may hold relatively more power than the programmers), and the technology-consuming public (Seaver, 2014).

41 Montgomery and Ezeh (2005) note: “Whereas in 1950 less than 20% of the population of poor countries lived in cities and towns, by 2030 the figure will have risen to nearly 60%. Within a few years, according to these forecasts, it will no longer be possible to speak of the developing world as if it were mainly composed of rural villages” (p. 202). They go on to state that “the majority of developing-country urban residents will probably reside in much smaller settlements” than megacities. “The largest share of the increase will be absorbed by urban areas with fewer than 1 million inhabitants” (Montgomery & Ezeh, 2005, p. 203).

42 Another informant asserted that Pune’s municipal government obtained the increase in medical staff positions not due to the H1N1 epidemic, but because it championed a better put together, more compelling proposal than in previous years. I was unable to obtain a copy of the proposal.

43 In both Mumbai and Nagpur, cities in Maharashtra, a greater proportion of residents residing in slums, as opposed to those not residing in slums, say they use public sector facilities (25% vs 21% in Mumbai, and 22% vs 18% in Nagpur) (IIPS & Macro International, 2008).

44 Recent estimates suggest that of all doctors, roughly 77% are allopathic and 23% are ayurvedic, homeopathic, or unani (Anand & Fan, 2016). Maharashtra has a particularly high concentration of ayurvedic doctors: althoughts it accounts for 9% of the national population, it has 23% of the country’s ayurvedic doctors (Anand & Fan, 2016).

45 According to Thomas, Srinivasan, and Jesani, (2006), writing in the Indian Journal of Medical Ethics:

Protestors … incorrectly equate [test scores] with “merit” and are afraid that caste-based reservations dilute academic standards, thereby reducing the quality of medical care that is available to the public. While the system of reservations may lower entry requirements to permit less-privileged people to enter higher educational institutions, the exit requirements—the assessment of performance—remain the same. The questions the public must ask in this context are: how well does the medical examination system evaluate the quality of graduates? What is done to prevent corruption and maintain high standards? (p. 82).
I found it easier to immediately write in a notebook than to wait to type on a laptop. Once I returned home from fieldwork, I was often pulled into the vortex of family life and sometimes would not have time to return to my laptop until late the next day. On occasion I sacrificed morning hours to transcribe notes, but, as I discuss in the methods note in Chapter 9, I had to make municipal working hours count, and using those morning hours hunkered down at home was not the best use of time. To ensure that details of field observations and interviews would not go unrecorded, I resorted to the following: after reaching home but before entering it, I would silently sit outdoors and spend between 30-45 minutes or more writing in my notebook while the fieldwork was still fresh. I then typed these into my laptop a few days later.

According to Tavory and Timmermans (2013), in using this strategy, the researcher examines different situations involving, for instance, different actors, events, and spaces. The researcher discerns how a specific aspect of a “meaning-making process” (e.g., how municipal providers interpret their public mandate) might variously configure, transform, or produce different effects in these different situations but yet make sense as a whole.

As Sunder Rajan (2006) argues, while capitalist “political economic formations do not directly or simplistically” lead to the emergence of specific state operations or social life, yet they can “disproportionately set the stage within which the latter take shape in specific ways” (p. 6).

For example, research, policy, and practice communities may diverge in their conceptions of the urban. Their debates and conflicts are consequential for how urban sites develop: contradictory frames and visions of the urban in urban planning and policy shape how urban landscapes are configured (Brenner & Schmid, 2015).

Rather than “a singular urban form, ‘the’ city, we are instead confronted with new and varied processes of urbanization that are bringing forth diverse socioeconomic conditions, territorial formations and socio-metabolic transformations across the planet” (Brenner & Schmid, 2015, p. 152).

As Brenner and Schmid (2014) argue, programs and pronouncements of the UN, the World Bank, and other international organizations have routinely announced an “urban age” based on the planet’s having crossed a statistical threshold, where over 50% of the world’s population live in cities.

For instance, in documents outlining the framework for implementation of the National Urban Health Mission (NUHM), the MOHFW (2013c) reported that at least two models of primary care provision prevailed in urban areas. “In states like Uttar Pradesh, Bihar and Madhya Pradesh health care programmes are being planned and managed by the State government; the involvement of the urban local bodies is limited to the provisioning of public health initiatives like sanitation, conservancy, provision of potable water and fogging for malaria. In other states like Karnataka, West Bengal, Tamil Nadu and Gujarat the health care programmes are being primarily planned and managed by the urban local bodies. In some of the bigger Municipal bodies like Ahmedabad, Chennai, Surat, Delhi and Mumbai the Medical/Health officers are employed by the local body whereas in smaller bodies, health officers are mostly on deputation from the State health department” (p. 18-19).

That is, I propose constructs, themes, and relationships that help explain how municipal health services operate and factors that sustain low quality of care. I expect these constructs, themes, and
relations are analytically generalizable across other urban sites, although they may play out differently in alternate sites.

54 They work in a mode of collaboration rather than confrontation, acting as “governable subjects,” simultaneously “civil and mobilized” (Roy, 2009a, p. 160-161).

55 As Harpham and colleagues (2003) clarify, there is no clear, conclusive evidence of an urban health penalty, whereby urban children are definitively at greater risk than rural children. There is, however, evidence that “the urban poor are generally worse off than the urban nonpoor and in several cases may fare worse than rural children” (Harpham et al, 2003, p. 279). One striking example of urban health inequality comes from an illegal settlement (slum) known as Kaula Bandar, built on unused state-owned dock land in Mumbai, India. Rates of childhood immunization in Kaula Bandar have been shown to be lower than in Mumbai’s legal slums (which enjoy, by government mandate, access to basic utilities such as water supply and electricity), lower than Mumbai overall, and similar to rates in rural Maharashtra, the state in which Mumbai is located (Subbaraman et al, 2012).

56 The authors examine urban challenges along five dimensions: “capacity (with a focus on urban services and service delivery); financial resources (with emphasis on generation of local revenues); diversity (in particular, issues of inequality and fragmentation, often leading to violence and a failure to regulate social conflicts); security (involving crime and violence, and approaches to the preservation of public order and the alleviation of violence); and authority (with a focus on decentralization and distribution of powers, local jurisdictional configurations, and political participation)” (Stren, McGee, Moser, & Yeung, 2003, p. 363).

57 Butsch et al (2012) define urbanization as the population growth of cities, and cities as “manmade surroundings in which interacting humans shape environments according to their needs” and which “need ecosystem services” (p. 16). Their definition of the city underscores its territorial, demographic, and ecological aspects, but appears to less account for urbanization as a process of extension, that is, characterized by diverse social, cultural, political, and economic connections between urban sites and “other places, territories, and scales” (Brenner, 2013, p. 102).

58 Health care is a state-level responsibility, but other health-related responsibilities are variously divided and shared between levels of government. For instance, state governments independently manage hospitals and dispensaries within a state. Responsibilities such as population control (family planning), epidemic control of major diseases, medical education, and quality control of drugs are shared between state-level and central government. See endnote 85 for more on the division of health responsibilities between levels of government.

59 A contemporary document, the Bhore Committee (1946) report on health care infrastructure and needs in India, published around the same time the MMC Act was enacted, uses the term “medical relief” to imply medical care in a broad sense. When the MMC Act originally denoted, in 1949, that obligatory duties of municipal governments included providing “public medical relief,” the term possibly implied all manner of health care—primary care and higher tiers of care as well—just as it was used in the Bhore Committee’s writings.

60 The MMC Act, I hypothesize, does not restrict legal municipal obligations in health care to primary care. Although policymakers and administrators seem to hold this as the standard interpretation of the MMC Act, the wording of the Act cautions against accepting that popular view. According to the Chapter VI Section 63 of the MMC Act, obligatory duties of municipal corporations include
the construction or acquisition and maintenance of public hospitals and dispensaries including hospitals for the isolation and treatment of persons suffering or suspected to be infected with a contagious or infectious disease and carrying out other measures necessary for public medical relief (MMC Act, 1949, p. 65).

The obligatory duties, as listed above, do not seem to explicitly exclude levels of care beyond the primary level. The discretionary health-related duties of municipal governments, as described in Chapter VI Section 66 of the MMC Act, include

the organisation, maintenance or management of institutions within or without the City for the care of persons who are infirm, sick or incurable, or for the care and training of blind, deaf, mute or otherwise disabled persons or of handicapped children; [and] … the organisation, maintenance or management of maternity and infant welfare homes or centres (p. 67).

The discretionary duties, to the contrary, seem to cover reproductive and child health, which municipal doctors and administrators viewed as their obligatory mandate.

I was unable, in this project, to trace the history of the MMC Act and how its definition of obligatory and discretionary functions has shaped state policies for urban health care, or to identify any other legislation or policy that clarifies the meaning of “medical relief” as intended in the MMC Act. I therefore maintain, for present purposes, that state agents widely understand and practice primary care as a municipal obligation, but I propose that this interpretation of the MMC Act requires further study.

61 The literal wording in the MOHFW (2013) report is that urban primary care as a municipal responsibility is a “Constitutional” mandate (p. 53), which is an odd statement to find in a government report for at least two reasons. Firstly, in the Constitution of India (Government of India, 2012), health care is not a mandatory legal obligation of the Indian state. Rather, the Constitution discusses the state’s approach to provide health care in a section entitled “Directive Principles of State Policy,” which lists principles to guide the making and implementation of national and subnational policy (see Constitution of India, Part IV). Secondly, the Constitution does not explicitly say that municipal governments are responsible for urban primary care. Rather, the constitution says that the provision of health care and oversight of municipal government are both state-level government duties (see Constitution of India, Seventh Schedule), and that state-level governments may enact laws to devolve certain responsibilities to municipal governments, among them the responsibility for “public health” (see Constitution of India, Part IXA). Public health services (e.g., immunization, epidemic control, promotion of healthy behavior) overlap with but are not the same as health care services (e.g., individual curative care), a distinction that is well established in health policy and research in India (Das Gupta et al, 2010). The constitution lists public health along with “sanitation conservancy and solid waste management” as matters of concern for municipal governments, but does not use the terms primary care, health care, or medical relief (see Constitution of India, Twelfth Schedule).

This suggests a difference between what the law encodes and what state agents espouse in practice, in part exemplifying the discordant, out-of-sync workings of a multilevel state (Sharma & Gupta, 2006). In part, the broad wording of municipal government obligations in the constitution reflect the incomplete, ambiguous scope of powers that framers of the constitution accorded to local governments. That is, while they delineated a division of responsibility between first and second levels of government (central and state-level), they left the third level (local government) unspecified,
partly due to an anti-local bias in development planning at the time (Weinstein, Sami, & Shatkin, 2014). I explore that point further below in this chapter.

There was a steep rise in number of doctors after 2011, which occurred in the wake of a H1N1 (swine flu) epidemic in India in 2009. The swine flu crisis highlighted the paucity of Pune’s health infrastructure and prompted the urban development department to approve expansion in Pune’s medical staff. However, my informants presented alternate explanations for how the Pune health service obtained that increase in staff. Some attributed the increase to the glaring shortcomings the H1N1 epidemic revealed; others attributed it to a more compelling proposal for the staff increase than had been put forward in previous years. I was unable to obtain a copy of the proposal (the concerned municipal department did not have or did not share copies of any of the proposals they had made for such staff increases).

As I note in the previous chapter, although the Indian economy, facing a crisis of external debt and foreign reserves in 1991, began to institute market-liberalizing reforms in the 1990s, some economists date the beginning of India’s economic liberalization to the 1980s (Deshpande & Sarkar, 1995; Panagariya, 2004). They argue that India’s departure from its post-independence planned economy began in the 1980s, with important (though unsystematic) reforms, when the state started to relax the regulation of industry and trade, laying the foundation for more extensive reforms in the 1990s (Panagariya, 2004). In the health sector, in the 1980s, the state gave concessions and subsidies to the private health care sector, such as for imports of medical equipment, and curtailed public expenditure on social services (Baru, 2003; Jalan, 1991).

Such thoughts are evident in nationalist debates in the 1930s, when the National Planning Committee (NPC) of the Indian National Congress party considered plans for a future health service for yet-to-be independent India. The NPC’s plans contained visions for a well-regulated, state-led amelioration of health conditions in India, but they also contained ideas about poverty, population, and disease that complicated that vision (Amrith, 2007). One idea concerned poverty: undergirding the NPC’s vision for a national health service was a notion of poverty as a “natural” condition in India and as a root cause of disease, which in turn weakened the vitality of the population (Amrith, 2007, p. 115). This idea attributed the low vitality and short life span — and hence low productivity — of the Indian people to their destitution and ill health (Amrith, 2007). A second idea concerned social reform: in the NPC’s discourse, the ignorance of the Indian people, their social customs, religious prejudices, and poor diet, were all causes of ill health that required social reform and not only medical care (Amrith, 2007, p. 115). A third idea concerned the quantity and quality of the population, i.e., concerns about over-population as well as upper-caste anxieties about reproduction of “defective types” (Amrith, 2007, p. 116).

The Sokhey Committee was the sub-committee on health appointed by the Indian National Congress NPC. Although the Sokhey Committee met in the late 1930s, its report, along with reports from other subcommittees, was finally published in 1947. That final publication drew heavily from the Bhore Committee report and repeated and cited its recommendations. However, it was not identical to the Bhore Committee report. Researchers have observed that it had a less top-down and more pluralistic, “people-centred,” bottom-up vision (Priya, 2005). Both reports advocated universal access, comprehensive preventive and curative services, and modern medicine (as opposed to traditional systems of medicine) as the basis of the health system. However, unlike the Bhore Committee, the Sokhey Committee suggested, for example, that “youth in every village be trained in primary health tasks and that those who perform well be trained further to become doctors, including those who were already practicing indigenous systems” (Priya, 2005, p. 44). Ultimately, it
was the Bhore Committee’s recommendations that came to shape health care services in independent India (Duggal, 2005; Priya, 2005).

The Bhore Committee was globally comparative in its approach: along with consulting international medical experts who were invited to visit India for the task, the Committee intensely scanned plans for post-war health services in the UK, the US, Canada, Australia, and New Zealand (GoI, 1946a). The report of the Bhore Committee, published in 1946, referred to the development of Soviet health services in the 1930s and was explicitly influenced by the 1942 Beveridge report, which centrally shaped the form of welfare state in the UK.

The long-term strategy was termed the “Three Million” plan, referring to the arbitrary population of an average district. The Bhore Committee report stressed its proposals would have to be tailored to each region, and specific norms were guidelines for local governments to adapt. The short-term strategy focused on primary care at sub-district and village level.

The report appeared apologetic about investing substantially in “teaching, training, and ancillary centres which, perforce, must be located in urban areas,” stating that this was necessary only to accomplish “a tardy measure of justice to the medical needs of the rural areas” (GoI, 1946b, p. 5).

A chapter entitled The health of the industrial worker described the health needs of industrial workers—a category that included workers in factories, construction, transportation (e.g., railways, tramways), restaurants and hotels, and commercial plantations (e.g., tea, coffee, cotton, rubber) (GoI, 1946a, Chapter 8).

Noting that industrial centres were typically located within or near large urban areas, the Bhore Committee sought to estimate if general health care services provided by local governments were adequate for industrial workers (GoI, 1946a, Chapter 8). Drawing on specific examples—industrial centres of Ahmedabad, Cawnpore, and Hooghly—the Bhore Committee found these areas had grown rapidly (e.g., Cawnpore had increased from 200,000 population to 800,000 over the war years due to an influx of industrial workers) but “medical relief” provided by local governments had remained constant.

Such workers “must depend mainly on the out-patient and in-patient departments of hospitals and on the dispensaries maintained by the public authority or on institutions provided by employers” (GoI, 1946a, Chapter 8).

To ensure proper conditions of work, prevent occupational health risks, promote safe and healthy behaviors among workers, and provide emergency medical care and rehabilitation associated with industrial work, the Bhore Committee recommended an ‘industrial health service’ (modeled on a 1945 plan drawn up in the UK), which it envisaged would be administered jointly by the ministry of health and ministry of labor (GoI, 1946b, Chapter 10). For their general (non-work-related) medical needs, industrial workers would access the same health care services that the general community accessed (GoI, 1946b, Chapter 10). These services would likely be those provided by local urban governments, given that industrial growth was occurring in or near urban centres.

Such municipal bodies would have to provide the same level of services as in the Three Million plan, and would be “deprived” of those health functions in which they could not meet technical efficiency and standards (GoI, 1946b, p. 310).

One of the Committee’s aims in introducing new health services was to “not supplement and not supplant those which are already in existence in the areas concerned” (GoI, 1946b, p. 439).
From this motive, and noting that some large municipal governments already ran some measure of health services, the Bhore Committee report suggested that Provincial Governments could authorize “large municipalities with populations of 200,000 and over to recruit and maintain their own health services, provided the general plan and level of efficiency recommended by us for such services are duly kept up” and that the “two types of services are so integrated as to enable them to function in the closest possible co-operation” (GoI, 1946b, p. 440). The Bhore Committee proposed to organize health services for large urban areas such as Delhi province according to a “dual principle of encouraging the growth of local responsibility in health administration and of ensuring, at the same time, the maintenance of a reasonable level of efficiency appears to us to be essential to the comprehensive program of health development we have advocated” (GoI, 1946b, p. 445).

74 Amrith (2006) notes that in the proceedings of India’s Constituent Assembly in the late 1940s, there were barely any mentions of public health. “In striking contrast with the centrality of health to earlier nationalist discourse, by the time the Constituent Assembly embarked on its discussions, almost every mention of ‘health’ was in connection with the ‘health of the body politic’; with ‘healthy’ and opposed to ‘unhealthy’ criticism of the state; with ‘healthy’ national sentiment” (Amrith, 2006, p. 80).

75 See, for example, analysis of food security and famine codes (Mander, 2013; Amrith, 2008; Hall-Matthews, 1996) and labor rights in India (Agarwala, 2006). In recent years, an activist judiciary has reassessed the nature of these rights.

76 In other words, to administer and promote development across the nation, the state instituted processes of planning and an extensive bureaucracy (Chatterjee, 1997). Planning and bureaucratic functions were meant to be rational and apolitical, residing outside the domain of politics, so that they could help the state achieve universalist goals.

77 Although planning was meant to be apolitical, yet the functioning of the state’s administrative apparatus—its planning process and implementation of plans—became implicated in “modalities of power,” used as “instruments of politics” by a variety of actors (Chatterjee, 1997, p. 279). Actors both within and outside the state, including those who were ostensible subjects of state power, came to use the state’s planning authority as an object of power (Chatterjee, 1997).

78 The Bombay Plan was a proposal in two parts, released in 1944 and 1945, signed by five of India’s leading industrialists at the time (Chibber, 2003). It was not, as popularly understood, a proposal that shows how ready capitalists were to support state-led economic planning in India. As Chibber (2003) argues, this interpretation of the Bombay Plan sets up the follow-on argument that the failure of the Indian state to become a successful developmental state is the fault not of capital-owners but of the state’s managers. Chibber shows that the Bombay Plan met with much hostility among business people at large, who were strenuously opposed to a disciplinary state controlling industrial activity and who instead wanted state decontrol of tariffs and prices, among other regulatory measures. The original proponents of the Bombay Plan had aimed not so much to “launch” a planned economy but to “maintain legitimacy in the face of the most massive popular upsurge in India during the century,” namely, the Quit India movement in 1942-43 (Chibber, 2003, p. 86). They had intended to “promote the image” that the business class, too, “was committed to the project of social justice,” while at the same time to set the terms of the critical debate about India’s economic future by espousing capitalist rather than socialist planning. They designed the Bombay Plan to both “make subaltern demands for distributive justice” part of the Plan design, and to then focus attention on how a capitalist economy could meet those demands (Chibber, 2003, p. 97).
The Bombay Plan, introduced in its entirety in 1945 and accompanied by a (colonial government-issued) Statement of Government Industrial Policy based on the Plan, was rejected by the business class as a whole (Chibber, 2003). The Bombay’s Plan’s original proponents went silent on the Plan, with some dissenting, along with the general business class, against state disciplining industry such as through setting wages and prices, setting the exchange rate, issuing licenses for starting new businesses, and determining quality control and performance standards (Chibber, 2003). Chibber explains that even as the business class wanted state assistance to help industrial growth under import-substituting industrialization (e.g., protectionist tariffs), they did not see the need to support state-led discipline over or regulation of industrial activity (e.g., minimum wage laws).

The state did this by passing a labor law, the Industrial Disputes Act, under which the state would arbitrate and settle disputes between labor and capital rather than labor unions confronting capital through collective bargaining (Chibber, 2003). The Indian National Congress party also launched a new labor union federation that was “explicitly committed to the party’s labor policy,” the Indian National Trade Union Congress (INTUC), with the idea that unless labor was aligned with the resolutions and directions of the Congress, labor-capital relations would be inimical to the national interest (Chibber, 2003, p. 123-124).

The industrial class was able to resist state discipline in part because of the weak political support within the Congress party for disciplinary planning (i.e., state-led planning where private capital was not only provided state assistance but was also to be held to account for these benefits), and because of demobilization of labor outside the party, with a split in the labor movement and the state’s de-escalation of labor conflict by forming a labor federation through which it channeled labor disputes (Chibber, 2003).

Malaria and tuberculosis control programs in the 1950s and 1960s exemplify this focus, and the failures of these programs underscore the stark neglect of basic health care services and people’s lack of confidence in those services (Amrith, 2006).

The debate over the roles and powers held by and/or shared between central, provincial, and local government in India has a long history. One important point of this debate is encapsulated by “dyarchy,” a term used to describe the intent of the Government of India Act of 1919. Dyarchy referred to the devolution and division of government functions between central and provincial units, where the provincial functions were further subdivided into reserved and transferred categories (Legg, 2016). According to the Act, control over functions was also split based on imperial, executive, and administrative control. For example, the (mostly) British officials of the Indian Civil Service at the central level retained control over “reserved” functions such as foreign affairs, while elected Indian officials at the provincial and local levels held control over “transferred” functions such as health and education (Legg, 2016). A third category of function (e.g., finance) was to be negotiated between central and provincial/local administrations.

Thus, dyarchy implied both a vertical hierarchy of power and a horizontal hierarchy of responsibilities (with provincial and local governments holding matters of lesser national importance and governmental complexity). Setting the appropriate division of these functions along both dimensions involved reconciling colonial imperial authority with nationalist demands to devolve power to the public (Legg, 2016).

After the 1919 Act, the next major constitutional reform came under the Government of India Act of 1935, which purported to guarantee autonomy to the provinces to contest direct elections and run the provincial government (Elangovan, 2012). The 1935 Act seemed to concede to nationalist demands, but its provisions—such as veto power retained with a British-appointed provincial Governor, the Viceroy’s central control, and the ultimate responsibility lying with British
Parliament and not the Indian Parliament—“made the 1935 Act an embodiment of imperialism represented in a constitutional form” (Elangovan, 2012, p. 46). The process of implementing statutory reforms to bring into force the 1935 Act stirred debates between British authorities in Britain and in India, specifically the British Parliamentary Counsel and the India Reforms Office, about the distribution of powers and functions across central and provincial levels (Elangovan, 2012).

What these Acts illustrate is that the federal question has involved a sustained debate over not only a vertical scale of responsibility (between central, provincial, and local governments) but also a horizontal scale of salience (based on the kind of function or power deemed less or more complex or critical). In independent India, business groups added to these debates their arguments for centralizing specific powers such as economic planning and industry control, but not necessarily other functions such as health care services. State governments came to hold responsibility for providing health care services in rural areas, and municipal governments for health care in urban areas (see endnote 85 for the current division of responsibilities).

Yet the overriding vision was one of an “indestructible” Union, Mehta (2010) writes, quoting Ambedkar, i.e., the country may be divided into states, but these were only for administrative convenience, according to Ambedkar.

In India’s federal system of government, there are three lists that stipulate legislative responsibilities of government: the Union list, the State list, and the Concurrent list. The Union list includes items such as defence forces, currency, income tax, and foreign trade, which are the sole responsibility of central government, that is, only the central level Parliament has the authority to legislate on these items.

Both central and state-level governments can legislate matters of health. Their responsibilities for health are stipulated in two lists: the State list and Concurrent list, the former being items that each state covers on its own, while the latter being items central and state-level governments undertake jointly (Bhandari & Dutta, 2007).

The State list for health includes items such as hospitals and dispensaries within the state. The Concurrent list includes items such as population control, epidemic control of major diseases, medical education, and quality control of drugs. For items on the Concurrent list, the central government provides the overarching policy framework, and states are expected to mobilize the majority of funds and infrastructure to implement policies (Kanango, 2013). For example, national reforms of health care services, such as the National Rural Health Mission (NRHM), launched in 2005, are led by central government and implemented by state-level governments, with financing split between centre and state. Financing was 100% central government funding at the start, and the share of central government funding was phased down to 75% by 2012, higher in North-Eastern states and special category states (MOHFW, 2005; 2013a).

Among other items on the State list is the responsibility for local government, that is, “the constitution and powers of municipal corporations … and other local authorities for the purpose of local self-government or village administration” (see Constitution of India, http://www.constitution.org/cons/india/shed07.htm). State-level governments thus run health care services and oversee municipal governments. In Maharashtra, these functions fall under two agencies: the department of public health and the department of urban development (https://www.maharashtra.gov.in/).

Another reason, according to Weinstein and colleagues (2014), is that most public administrators prefer more prestigious and higher paying positions in central- and state-level governments rather than municipal governments.
For malaria control, at the height of the program (1959 to 1963), the budget for the program “took up nearly 70 per cent of India’s budget for communicable disease control, itself accounting for nearly 30 per cent of the overall health budget under the second plan” (Amrith, 2007, p. 117, citing Roger Jeffery, 1988). For the national population control program, as of 1966, “family planning was granted almost as much in funding as the entire public health service of India” (Amrith 2007, p. 120, citing Mohan Rao, 2004).

As Rao (2004) argues, the entire public health infrastructure was “suborned” to the cause of family planning (p. 45). The “state admits as much,” observes Amrith (2007), noting that the health ministry itself reports, in 2002, that for health programs that do not have a separate vertical structure (such as infectious disease control programs do), there is virtually no service delivery system at all (p. 120). That situation persists with dramatic effect in urban India, where a recent health ministry report found that municipal health care services were practically nonexistent in some cities, save for reproductive and child health care (MOHFW, 2014b). Although a major national health program sought to expand and rationalize rural health infrastructure beginning in 2005, similar reforms for urban health care were approved only in 2013.

Urban neighborhoods were often mixed in terms of class, language, religion, or ethnicity and mingling between classes occurred in neighborhood-wide events (religious, cultural, sports) (Chatterjee, 2004). Yet class distinctions were maintained in specific contexts: “middle-class houses would invariably hide crowded slums at the back where the service population would live. The industrial areas of the city, of course, contained huge slum-dwelling populations” (Chatterjee, 2004, p. 132). Ethnic groups tended to group together, and associational life was “caste-like,” organized along intra-ethnic networks.

The location decisions were not free of political pressure, Shaw (1999) points out.

Municipal governments undertook welfare distribution based on a logic unlike the theorized relationship between the state and its rights-bearing, legitimate citizens, argues Chatterjee (2004). Civil society, comprising largely the “urban middle classes, is the sphere that seeks to be congruent with the normative models of bourgeois civil society and represents the domain of capitalist hegemony” (Chatterjee, 2008, p. 57). The other domain is that of political society,

which includes large sections of the rural population and the urban poor. These people do, of course, have the formal status of citizens and can exercise their franchise as an instrument of political bargaining. But they do not relate to the organs of the state in the same way that the middle classes do, nor do governmental agencies treat them as proper citizens belonging to civil society. Those in political society make their claims on government, and in turn are governed, not within the framework of stable constitutionally defined rights and laws, but rather through temporary, contextual and unstable arrangements arrived at through direct political negotiations (Chatterjee, 2008, p. 57).

According to Chatterjee (2004), the authorities’ decision to do so was both pragmatic and political. They did not expect the city’s poor to easily obtain legitimate housing or afford public services, but neither could they stand by as the poor, who provided necessary labor in the city and were an important electoral constituency, routinely faced unmet basic needs and denials of care.

In this way, “entitlements, even when recognised, never become rights” (Chatterjee, 2008, p. 58).
Chatterjee (2004) argues that “the politics of governmental administration of welfare schemes for the poor” in the 1970s and 1980s produced a new field of mobilization for political parties and effectively diminished the political significance and power of trade unions (p. 138). As the poor began to organize to obtain welfare benefits from the state, to negotiate their demands as political society, old structures of patron-client relations were transformed. Industrial cities like Bombay and Calcutta saw a “decline in the effectiveness of trade unions organized around the factory and the rise of organized movements centered on the slum” (Chatterjee, 2004, p. 138).

The central government-issued framework for a national urban health reform program (known as NUHM) acknowledges the weak capacity of municipal authorities (MOHFW, 2013c). It notes that while municipal governments in “mega cities, namely Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmedabad” may implement the NUHM, in other cities, the state-level “health department would be the primary implementation agency for NUHM,” and may decide, at its discretion, to hand over that task to municipal authorities (MOHFW, 2013c, p. 46). This undermines municipal governments’ role in health care, leaving urban primary care in state-level hands, contributing further distance between the state’s manifold priorities for and sites of health care practice, management, and policy-making.

As Ganti (2012) observes: “Although the current Indian state replaced a Nehruvian-style development agenda with a neoliberal one—preliminarily in 1985 and more aggressively since 1991—it has not abandoned its obsession with “catching up” with the West. While the methods may have changed, a teleological ideology of modernization still undergirds state economic and social policy” (p. 19). The official rationale for a major national urban renewal program launched in 2005—the Jawaharlal Nehru National Urban Renewal Mission (JNNURM)—characterized India’s urban spaces as such: “Since cities and towns in India constitute the second largest urban system in the world, and contribute over 50 per cent of the country’s GDP, they are central to economic growth. For the cities to realise their full potential and become effective engines of growth, it is necessary that focused attention be given to the improvement of infrastructure (JNNURM, 2005, p. 4).

The NRHM mandated community-oriented structures such as Village Health, Sanitation and Nutrition Committees (for planning and monitoring village level health care services) and Rogi Kalyan Samitis (comprising mainly health officials and elected representatives to ensure patient welfare and utilization of funds) (Shukla, Khanna, & Jadhav, 2014).

Lags in decentralization reforms in urban areas raise questions about how community-based participatory institutions will work there. Besides municipal governance structures, other factors likely to constrain community participation in urban areas include social ties, livelihood struggles, and housing, as I discuss.

Initiatives included providing financial support to catalyze investment in urban development, assist “urban local bodies” (ULBs) to prepare and submit city development plans to obtain JNNURM funds, and facilitate public-private partnerships (JNNURM, 2005). JNNURM reforms also included aiding ULBs to improve public budgeting, community participation, and public service delivery. ULBs’ receipt of investment funds was conditioned on their implementing reform measures, such as adopting modern, accrual-based double entry accounting, reforming rent control, introducing e-governance systems (e.g., GIS and MIS), earmarking funds for “basic services to the urban poor” (BSUP), and enacting a community participation law and public disclosure law (Planning Commission, Steering Committee on Urbanization, 2011, p. 379).
Three years after the launch of the JNNURM, funds for the BSUP had either not been released by the JNNURM or not been utilized by local governments, indicating “a deep structural anomaly … between the modern infrastructure and gentrification projects on the one hand, and the BSUP on the other” (Banerjee-Guha, 2009, p. 99).

The JNNURM also reflects the central government’s interventionist role in urban affairs, where the center intervenes to resolve or circumvent conflicts between state-level and municipal government with a view to enable its liberalization agenda to proceed.

As Weinstein et al (2014) describe, state-level policies acquired an urban focus in the late 1990s, even though most of those urban policy recommendations remain proposals on paper. While some state-level governments “have greater incentives to concentrate investments in rural areas, this is not always the case” (p. 52). For a variety of reasons—industrial growth, weakness of the agricultural sector, political strength of the urban middle classes—urban politics is finding a place in the political mainstream. By contrast, at the local level, a variety of groups have challenged state-level urban development plans. Among those groups are private landowners, farmers on the fringes of cities, and “low-income urban residents on whose land much of this infrastructure and real estate will presumably be constructed” (p. 52).

Urban renewal programs such as the JNNURM are, argue Weinstein et al (2014), a measure to intervene in cities directly. The JNNURM stipulates that states who participate in the JNNURM first submit city development plans (CDP). The CDPs are meant to outline the city’s urban development priorities and describe how JNNURM funds would be spent. Central government has to approve the CDPs, and its issuing of funds is further tied to certain state-level policy reforms.

Central government control over urban development implies that the priorities and claims of poorer, less advantaged urban residents, including claims for improved health care (which do little to support the national liberalization agenda), are likely to get short shrift as states compete for funds. The configuration of power that the JNNURM reflects supports Murthy and Mahin’s (2016) argument that India remains a highly centralized state.

Those “spatial practices” promote a “sanitized vision of the economic benefits of globalisation” (Fernandes, 2004, p. 2416). Fernandes (2004) argues that the process of producing a “sanitized vision” of economically liberal, globally engaged India is both a political and discursive process, which involves both dominant societal and state actors, and is challenged by “politically mobilized marginalized caste and class groups.” That is, those groups contest the efforts of “dominant social groups and political actors who attempt to naturalise these processes of exclusion by producing a middle-class-based definition of citizenship” (Fernandes, 2004, p. 2416). My fieldwork suggests that in these contestations, discussions about the state’s role in providing basic services such as primary care are possibly marginal. This is not because health is unimportant to people’s lives, but because concerns of health are overwhelmed by routine struggles for livelihood, shelter, water, and security, and because people can more easily access health care without recourse to the state. I discuss this briefly in the concluding section of this chapter.

In his analysis of judicial framing and ordering of slum evictions as acts “in the public interest” in Delhi, Bhan (2014) observes how the courts imagine the public and define who is a citizen. He finds that in case law on evictions, the emblematic citizen resides in legal and legitimate neighborhoods in the city, not in slums or slum-resettlement colonies.

This includes amounts spent by central, state-level, and local governments. Municipal governments’ contribution to health expenditure is miniscule. As of 2005, when public sector spending was about 20% of all health spending in India, local governments’ spending on health comprised less than 1% of that 20% (MOHFW, 2009). Of the rest,
about 78% came from private sources and just over 2% from external sources. The majority of that private spending was out-of-pocket spending by households. (To be precise, 71% of all health spending in India came from households spending out-of-pocket).

By contrast to India’s 20% public sector spending, Duggal (2009) notes that, as of 2007, in Sri Lanka, Malaysia, Thailand, Cuba, Chile, and Costa Rica, public sector spending accounted for between 46% and 88% of total health spending.

105 According to NSSO (2006) estimates, the proportion of outpatient ailments treated by public providers dropped from 24% in 1986 to 19% in 2004 in urban areas. (The proportions are even lower for urban Maharashtra: 15% in 1986 to 11% in 2004). Nationally, private providers account for about 80% of all outpatient transactions.

106 While the size of the private sector is difficult to estimate given its heterogeneity and informality (see Hanson et al, 2011; Hanson & Berman, 1998), data on health care utilization show that over 1987-2004, the use of private hospitals increased by 50% (Duggal, 2011). Whereas the public-private mix in hospital utilization was 60% public and 40% private as of 1987, by 2004, this mix had shifted to 38% public and 62% private.

107 Maharashtra is one of eight states in India that has a law regulating registration and standards of private hospitals, namely the Bombay Nursing Home Registration Act (BNHRA), enacted in 1949 and amended for the first time in 2005 (Bhate-Deosthali, Khatri, & Wagle, 2011). But the state has barely implemented the Act. Rules to detail implementation of the amended BNHRA were formulated through a consultative process including NGOs, researchers, and health practitioners in 2006. But the state-level government has not finalized the draft rules which has hindered implementation of the Act (Bhate-Deostalis, Khatri, & Wagle, 2011; CEHAT, 2006).

108 Globally, too, a minority of urban dwellers received water through informal private water suppliers (Kjellen & McGranahan, 2006).

109 Household spending on water supplied by water tankers is significant, but water tanker markets constitute “a relatively small fraction of the water supplied overall” (Srinivasan, Gorelick & Goulding, 2010, p. 254).


111 An improved sanitation facility is one that “hygienically separates human excreta from human contact” (WHO, 2015c). Improved sanitation facilities include flush/pour flush (to piped sewer system, septic tank, pit latrine), ventilated improved pit (VIP) latrine, pit latrine with slab, and composting toilet.

112 Reports suggest further dismal facts: “Where sanitation access is available, many urban residents use toilets that are not connected to underground sewerage networks. It is estimated that 75–80% of water pollution by volume is from domestic sewerage. Only 160 out of nearly 8,000 towns have both sewerage systems and a sewage treatment plant, and only 13% of piped sewerage is currently treated. Additionally, treatment capacity is highly uneven, with 40% of India’s total treatment capacity located in just two cities—Delhi and Mumbai. Even when there are sewerage networks, much of the waste fails to reach wastewater treatment plants” (Elledge & McClatchey, 2013, p. 1).
113 These include regulations governing the real estate sector, cumbersome approval procedures of central government agencies, and insufficient tax and non-tax incentives to encourage private investment in housing (KPMG, 2014).

114 As noted in introductory chapters, across urban India, some 80% of all outpatient health care transactions occur in the private sector (IIPS & Macro International, 2007). Surveys show that people prefer to pay for private health care than use public sector facilities, citing the greater convenience and more satisfactory experience of seeking private health care (IIPS & Macro International, 2007; Ergler et al, 2011; Butsch et al 2012). Yet this dissatisfaction does not appear to readily translate to collective demands for improved health care services in urban contexts.

115 As noted in the introduction, studies show that people prefer private sector providers for convenience of use (e.g. timings during which the facility is open), perceived efficacy of treatment, and a more satisfactory experience of obtaining health care (IIPS & Macro International, 2007; Agarwal et al, 2008; Banerjee & Duflo, 2009; Bhatia & Cleland, 2001; Gupta & Dasgupta, 2000; More et al, 2011; Ergler et al, 2011; Seeberg et al, 2014; Barua & Pandav, 2011).

116 I base my arguments here on my discussions with NGOs and reading of secondary literature on health care seeking behavior among the urban poor. I did not conduct extensive interviews with community members.

117 I thank Ramnath Subbaraman for his thoughts and discussion of these arguments.

118 Studies suggest that associational life and social support systems are more fragmented in urban versus rural contexts (Bhide, 2009; More et al, 2012). However, some researchers have noted that we know little about changing family structures in urban India (Shah, 2013). For instance, the scholarship on caste in India has remained largely village-based, and there is little research on caste-based networks within cities or on the complex relationship between caste, urban poverty, and ties to rural homes (Shah 2013). Popular perceptions about the “joint” or extended family living together in a household are that the number of such families and ties within them have been weakened by urbanization. Yet, according to recent Census data, the percentage of households with two or more married couples in urban areas has risen (Shah 2013), calling for more research on the nature of living arrangements and social support systems in urban areas.

119 This low social awareness about health as a claim on the state is a general picture across India, but some Indian states show the counterfactual. In Kerala, notably, where local institutions for social and political mobilization have been strong, built alongside and interconnected with the state bureaucracy, there is both greater civic engagement and greater state response to community demands and evidence of better health and other development outcomes (Amrith, 2009; Singh, 2015; Heller, Harilal, & Chaudhuri, 2007).

120 The case paper is the formal record of the patient’s visit containing the doctor’s report, which is filed and stays in the municipal health care facility.

121 India’s central government has funded and promoted health reform initiatives in both rural and urban areas. The National Rural Health Mission (NRHM), launched in 2005, boosted rural health care infrastructure and institutions, and the National Urban Health Mission (NUHM), launched in 2013, proposed to do the same for urban areas. In practice they differ partly because of dissimilar governance structures in rural versus urban areas: institutions for participation government are more
functional and active in rural than in urban areas, and community-based health planning and monitoring committees are likewise more evident in rural versus urban areas.

122 Primary care services encompass the items listed below as per the NHM Framework (MOHFW, 2013a) and related texts, such as the framework for urban health care services (MOHFW, 2013c, p. 57-58), and guidelines for managing non-communicable diseases (MOHFW, 2010) and community health workers (MOHFW, 2013b).

- Reproductive and child health (RCH) (including pregnancy care, newborn care, programs for immunization and nutrition, diagnosis and treatment of childhood illnesses)
- Control of communicable and non-communicable diseases (screening, detection, prevention, treatment, referral where required, and follow-up)
- Emergency and trauma care (first aid for minor injuries, stabilization and referral for major injuries, prevention and treatment of animal bites, stings, and poisoning)

123 Navarro (2008) notes that the Alma Ata declaration was in part the product of “great social agitation – not only in the developed, but also in developing countries – agitation that started in the middle 1960s and continued during the 1970s” (p. 152). That agitation was a response against growing inequality within and across countries and against priorities the “development establishment” had espoused in the 1960s and 1970s, namely population control, technology transfer from richer to poorer countries, individual self-care, and community self-reliance (Navarro, 1984). By “development establishment” Navarro (1984) means the “body of internationally minded individuals who are active in major Western aid agencies or who are their champions within Western political circles” (p. 468).

Social movements called for a “new economic order,” for a change in the very foundations and assumptions guiding development (Navarro, 1984, p. 469). The response of the development establishment was “to agree that some changes needed to be made in the worldwide distribution of resources, but to insist that change should be based on cooperation rather than confrontation” (Navarro, 1984, p. 469).

Navarro (1984) argues that the Alma Ata declaration itself is not free of the influence of the development establishment, whose priorities infused its text. However, he later clarifies the declaration was nonetheless “a step in the right direction” (Navarro, 2008, p. 152).

124 Note the distinction between primary care, which is the focus of my study, and “primary health care” as described in the 1978 Alma Ata Declaration. In the declaration, the term primary care implies frontline or first-tier health care, a level of care (Lawn et al, 2008, p. 921). The declaration describes “primary health care” in similar terms to mean: “the first level contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (Lawn et al, 2008, p. 919).

However, in the declaration, the term primary health care not only refers to a “level of care,” but also reflects an ideology or approach to designing, planning, and running health care services—it describes “a wider construct of social justice based on the Alma-Ata philosophy” (Lawn et al, 2008, p. 921). As Navarro (2008) describes, the “ideological basis that sustained [the Alma Ata] report was Primary Health Care, based on not only medical, but also social interventions governed by the communities and by the citizenry” (p. 152). That ideology included, for example, strategies for intersectoral, coordinated action across non-health state agencies on social factors that affected health, such as water supply, sanitation, education, housing, and livelihoods (Lawn et al, 2008).
Primary care and primary health care are therefore closely linked. Primary care, as people’s first contact with the health system, is integral to realize the objectives of primary health care.

125 By “development establishment” Navarro (1984) implies the “body of internationally minded individuals who are active in major Western aid agencies or who are their champions within Western political circles” (p. 468).

126 As Fee and Brown (2015) note:

[The Alma Ata declaration] was received with considerable skepticism by many staff members at WHO. It was likewise resisted and undermined by important outside agencies, even by some United Nations agencies. The biggest disappointment came when UNICEF switched to a “selective” approach to primary care. The International Monetary Fund and the World Bank played particularly deflective roles in the 1980s.

Alongside lack of support from the WHO and UNICEF, the International Monetary Fund promoted Structural Adjustment Programs in the 1980s, which advocated the privatization of health care services in many LMICs (Fee & Brown, 2015). This undercut the Alma Ata vision of state-supported comprehensive first-level health care services (Lawn et al, 2008).

As I noted above, Navarro (1984) argues that the text of the Alma Ata declaration, while “a step in the right direction” (Navarro, 2008), yet contains the priorities and ideological and political positions of the development establishment. Those priorities—population control, technology transfer, self-care, and self-reliance—appear to persist in post-Alma Ata initiatives, including proposals from aid agencies for a reduced package of selective primary health care.

127 Cueto (2004) details how primary health care was reduced to a few selected initiatives. He describes the Bellagio Conference organized by the Rockefeller Foundation in 1979, a year after the WHO conference at Alma Ata. That 1979 conference, entitled “Health and Population in Development,” was attended by a small number of international development and aid agencies, notably the World Bank and USAID, among others. Its purpose was to “examine the status and interrelations of health and population programs;” its organizers were “disturbed” by signs of declining interest in population control and family planning issues, which they had promoted since the 1950s (Cueto 2004, p. 1868). The outcome of the conference was a set of strategies that would offer a purportedly more realistic, achievable package of services with clear, measurable targets, known as Selective Primary Health Care. Over the next few years, that package was reduced to four interventions: child growth monitoring, oral rehydration techniques, breastfeeding, and immunization.

128 That is, population growth was deemed the independent variable, and economic growth the dependent variable.

129 In the late 1960s, funds for family planning programs constituted the largest portion of the budget of India’s health service (Amrith, 2007, p. 120).

130 As noted in Chapter 4, a contemporary document might help clarify the meaning of “public medical relief.” The Bhore Committee (1946) report on health care infrastructure and needs in India was published around the same time that the MMC Act was initially enacted (1949). The Bhore Committee report uses the term “medical relief” to imply medical care in a broad sense, not solely the lowest tier of the health system. When the MMC Act originally denoted, in 1949, that obligatory
duties of municipal governments included providing “public medical relief,” the term possibly implied all manner of health care, i.e., primary care and higher tiers of care as well, just as it was used in the Bhore Committee’s writings.

131 To reiterate, national policy texts describe the scope of primary care to include RCH; screening, detection, prevention, management, and referrals for communicable and non-communicable diseases; and emergency and trauma care extending to first aid, stabilization and referrals for major injuries, and prevention and management of animal bites, stings, and poisoning.

132 As discussed above, one significant such initiative was the 1978 Alma Ata Declaration, which called for states to provide comprehensive, community-based primary-level health care, “providing promotive, preventive, curative and rehabilitative services” (Lawn et al, 2008, p. 918).

133 As noted above, the actual content of primary care services in LMICs has not been comprehensive, but has tended to emphasize maternal and child health and infectious disease control (Reubi, Herrick, & Brown, 2015; Lawn et al, 2008).

134 Fundamental causes of disease refer to socioeconomic status-related resources such as “knowledge, money, power, prestige, and beneficial social connections,” which people may deploy “flexibly … in different places and at different times to garner a health advantage” (Reich, Hansen, & Link, 2016, p. 186). Fundamental cause theory proposes that as a result of people’s “differential access” to socioeconomic resources, health gradients in a population can persist along inequalities in those socioeconomic resources (Reich, Hansen, & Link, 2016, p. 186). Those socioeconomic factors are “fundamental causes” (in contrast to biomedical causes) of disease, because they “affect health even when the profiles of risk and protective factors and diseases change radically,” and lead to the “re-expression” of gradients in health based on socioeconomic status across time and place (Reich, Hansen, & Link, 2016, p. 186). Fundamental cause theory compels a people-centered rather than disease-focused approach to health care, one that is attuned to the social determinants of people’s health.

135 Examples include the National Health Mission (NHM) Framework for Implementation (MOHFW, 2013a), the report issued by the High Level Expert Group (HLEG) on universal health care appointed by the Planning Commission (HLEG, 2011), and National Health Systems Resource Centre guidelines for community processes (MOHFW, 2013b).

136 The Sokhey Committee was one of several sub-committees appointed by India’s National Planning Committee in 1939, the decade preceding independence, which issued its recommendations on health and health services in India in 1947 (National Planning Committee, 1947).

137 The Bhore Committee was appointed by the colonial government around the same time as the Sokhey Committee. Its report preceded the Sokhey Committee report.

138 The Sokhey Committee report, published within two years of the Bhore Committee report, was modeled on and reaffirmed much of the Bhore Committee’s recommendations; the colonial British government had commissioned the former, while the Indian National Congress had commissioned the latter. The Sokhey Committee report stressed “the obligation” of both state and society, “with an industrial population, with its congregation of large numbers in a few centres, to provide not only the necessary means for curing disease when it occurs, but also preventing it” (National Planning Committee, 1947, p. 11). Strategies to do this included “bringing about an environment and
conditions of living which would prevent the germs of disease taking hold and eradicate them gradually, improving at the same time the resistance capacity of the people concerned” (National Planning Committee, 1947, p. 11).

The report stated that “commonly considered as part of an un-co-ordinated individual enterprise, like suitable housing, adequate and healthful food, proper clothing, sufficient leisure for exercise and other demands of employment and living, are coming more and more within the general control regulation, and co-ordination, if not actual direct provision, by the state” (National Planning Committee, 1948, p. 12).

The Sokhey Committee recommended “health officers” trained in medicine and holding additional “special training in … social function of medicine” be in charge of rural “district centers,” (serving a rural population of 50,000) (National Planning Committee, 1947, p. 24).

The Bhore Committee recommended such a doctor would be trained in a university (not community) setting, which would facilitate knowledge of fields outside of medicine, including “the natural and social sciences” (Bhore Committee, Vol. 2, Chapter XVIII, p. 342)

Relative to the Bhore Committee, the Sokhey Committee emphasized a keener ground-up, community-based health system, e.g., by training health workers “selected from villages,” selecting them based on and developing their “missionary spirit” and imparting to them, apart from knowledge of first aid and recognition of common ailments and simple remedies, also knowledge of “social implications of medicine as a science” (National Planning Committee, 1947, p. 22). India’s political leadership eventually followed the Bhore Committee report to develop a national health service, “marginalizing” the bottom-up, community orientation of the Sokhey Committee (Priya, 2005, p. 45). Yet both the Sokhey and Bhore Committee stressed that medical education should include serious attention to the social: the former stressed “social and economic implications of the science of medicine” (National Planning Committee, 1947, p. 23), while the latter stressed “community and preventive” aspects of medicine and knowledge of the social sciences gained in a university setting (Bhore Committee, Vol, 2, Chapter XVIII, p. 342). Both stressed that health care services should be state-led and comprehensive, covering both preventive and curative services (Priya, 2005, p. 45).

The NHM states that, “action on social determinants will occur at many levels” (MOHFW, 2013a, p. 19). One is grassroots level coordination through village-based committees for on health, sanitation, and nutrition issues; a second is district and city level health plans; and a third is state- and central level coordination for policy reforms to address social determinants (MOHFW, 2013a, p. 19).

Critics have argued that recent policy initiatives present a more dilute version of those ideas and less transformational role for public services than policy texts drafted in the initial years of India’s independence (Bajpai & Saraya, 2011). However, evidence undergirding that critique largely assesses the state’s efforts to address SDH in areas outside of health care services, such as in education, water and sanitation, environment, and labor market and employment, among other public policy fields.

According to Bajpai and Saraya (2011), recent policies such as the NHM (launched in 2005) focus on technocratic details of strategies to reach the poor, rather than emphasize, as the Bhore Committee report did, poverty and unemployment as root causes of disease. The Bhore Committee was expansive in discussing poverty, stating that the aim of the “modern public health movement” was not solely to prevent disease but to “[create] an environment in which each individual can develop his potential fully and completely” (Bajpai & Saraya, 2011, p. 220, quoting from the Bhore
Committee Report). In contrast, the NHM mentions poverty largely as a demographic indicator, using the poverty line to establish target populations for state benefits (Bajpai & Saraya, 2011).

Notwithstanding that critique, researchers have noted that “relevant, and in some cases long-term, public policies” have indeed sought to address the social determinants of health in India (Cowling, Dandona, & Dandona, 2014, p. 10). The problem, Cowling et al (2014) highlight, is the “persistence of ... challenges” to meet that aim despite decades old policies to ameliorate conditions of water supply, sanitation, food security, education, gender violence, and child labor, among others, that affect health. Cowling et al (2014) largely assess progress on public policies other than health care.

This disjuncture between policy and practice is evident not only for urban health care, but also for other urban public services. For instance, Mander (2004) writes that the Indian state began to acknowledge urban poverty as a singular problem, related to but distinct from rural poverty, from the mid-1980s onwards. The state issued related policies, such as housing policy to address shelter rights of the urban poor, but actual experience on the ground shows “abysmally low investments, misdirected subsidies, high reliance on skewed market forces, and a legal and regulatory regime that is extremely hostile to the urban poor” (Mander, 2004, p. 198). Mander (2004) observes that the policies “cannot even be described as aspirational, because the actual experience belied … modest objectives and suggested little political will or priority for their realization” (p. 198).

Mander et al (2009) write about the discord between policy and practice with regard to the Indian state’s “massive” programs to provide food, livelihoods, and social security to support vulnerable groups, programs that extensively breach their theoretical universality and inclusion. The programs are not only ravaged by “corruption, leakages, errors in selection, delays, poor allocation and little accountability,” but also “discriminate against and exclude those most in need” (p. 27). Through those programs, the state effectively not only marginalizes people on account of gender, age, caste, ethnicity, religion, and disability, but also is hostile to “urban poor migrants, street and slum residents, and unorganised workers” (Mander et al, 2009, p. 27).

Mander et al (2009) go to say that public policies and much civic action and mainstream academia do not address the “precarious, lonely, humiliating and uncertain existence” of the poor (p. 27). Instead, state programs and society at large tend to assign blame for destitution to the poor, treating destitution as a malaise (Mander et al, 2009). They tend to either neglect to see the poor altogether, rendering them invisible, or else, where they see them, they devalue, socially isolate, stigmatize, disenfranchise, and even “illegalize” the poor (Mander et al, 2009, p. 27).

According to Mander (2004), examples of how the state might render the poor illegal are evident in poor urban neighborhoods, where a “permanent state of illegality” exists among the urban poor, who are either constantly in conflict with public authorities because they often seek livelihoods (sex workers, petty traders, hawkers, child workers), or because they obtain public services (water and electricity supply connections, shelter on sidewalks) through extra-legal means (p. 216-217).

As Kutty (2010) puts it, “how the medical system imagines the patient” appears to diverge from “how the patient actually is” (Kutty, 2010, p. 227).


In other words, providers’ responsiveness indicates whether they treat patients with dignity and respect and whether they respond to patients’ preferences and expectations “of how they should be treated by providers” (WHO, 2000, p. 31; see also Berendes et al, 2011; Basu et al, 2012).
The WHO (2010) health systems performance monitoring handbook observes that quality of care is a “multidimensional” measure, where “care is said to be of high quality if it is effective, safe, centred on the patient’s needs and given in a timely fashion” (p. 13). It defines person-centredness as the following: “Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own health care” (p. 3). In the WHO (2010) handbook, responsiveness is a central measure of health system performance not only in the service delivery component but also as an overall goal across all core components or building blocks of a health system (p. vii-viii).

The WHO (2010) handbook describes six core components or health system building blocks which contribute to strengthening health systems in various ways: service delivery, health workforce, health information, access to essential medicines, financing, and leadership/governance (p. vi-vii). For each component or building block, the handbook describes attributes that would characterize a good component or building block, such as characteristics of good service delivery, and then presents suggested indicators or measurement strategies for related aspects of service delivery.

In its own words, the WHO (2010) handbook “identifies a parsimonious set of indicators and related measurement strategies. This handbook does not address the measurement strategies and indicators across the entire results chain of the common monitoring and evaluation framework. Rather, it focuses on systems ‘inputs,’ ‘processes’ and ‘outputs’ as they relate to each of the six building blocks of health systems” (p. vii).

The handbook focuses on quantitative indicators, but recognizes that qualitative information is also important to chart the performance and impact of a health system.

This suggests that to enhance the quality of care of providers deliver, specifically to improve their “responsiveness” to patients, interventions such as training or incentivizing providers would be incomplete if they focused only on providers’ interpersonal skills and client orientation. Interventions would need to incorporate an education in, and on-the-ground institutional support for, providers to address the social determinants of health, so that they may address patients’ health-related needs and concerns. I return to this point further below.

For example, the WHO (2000) states that in many countries “a common complaint about public sector health workers” concerns their “rudeness and arrogance in relations with patients” (WHO, 2000, p. 31). But without accounting for public providers’ conceptions of public need (and the related political-economic context of and social understanding of welfare), we may attribute the problem to their interpersonal skills and caring attitudes, when the problem might also lie in the task they (perceive they are) mandated to fulfill and the resources they have to fulfill it.

Haney (2002) shows that in the early years, state programs viewed women seeking welfare assistance as needing all-round institutional support to find employment, stable housing, childcare for their children, and familial support. The state did not provide financial assistance, but assigned welfare workers—a single worker assigned to individual cases—to (re)institute women into myriad social and labor relations. Two decades later, conceptions of need shifted. The state focused predominantly on a woman’s role and identity as a mother, and did not seek to assist her find employment or mobilize her extended kinship relations. Later still, the state’s conceptions of need shifted under a “welfare regime aimed at the bureaucratic regulation of poverty,” wherein women’s needs were seen in strictly monetary terms (Haney, 2002, p. 3).
Extending this line of critique, I would add that indicators of responsiveness in the WHO (2000) report not only elide such conceptions of need, they expressly focus on user demand rather than need. The WHO (2000) report critiques the primary health care movement for failing to attend to people’s demands and focusing “almost exclusively on [people’s] presumed needs” (p. 15). According to the WHO (2000), “people’s demand for health care … is greatly influenced by perceived quality and responsiveness,” which, along with private finance and private provision of care, the Alma Ata declaration omitted to discuss. “Responsiveness,” then, in the WHO (2000) report, is meant to correct an omission of user demand and focus on peoples “presumed needs” in the primary health care approach. Responsiveness, for the WHO (2000), is a corrective measure to assess whether health care services meet people’s demands and expectations of health care services as consumers.

A later WHO document, namely, the WHO (2010) handbook on monitoring health system components, is explicit that its proposed framework does not account for “the underlying social and economic determinants of health, such as gender inequities or education, and also does not deal with the substantial and dynamic links and interactions that exist across each component” (p. vii). Presumably, any assessment of health system performance should use this framework in conjunction with other analyses, such as of social policies that affect SDH (say, the review of SDH-relevant policies in education, gender equality, nutrition by Cowling et al (2014)). However, indicators of health care providers’ performance should arguably tell us whether or not providers recognize patient’s social and economic needs, else those indicators run the risk of measuring providers’ efforts to “pander” to patients’ demands “rather than working to identify better solutions for care” (Berlan & Shiffman, 2012, p. 275).

Schneider and Palmer (2002) found, based on research in South Africa, that closed-ended facility exit interviews and open-ended community-based focus group discussions yielded different users’ views for the same set of primary care providers. In their study, focus group discussions yielded more negative views and more “dramatic” representations of everyday interactions. Importantly, they found that, “in the absence of explicit and universal standards, users evaluated providers against their experiences with other health care services available to them in their areas. Responses were thus highly context specific, dependent on the particular configuration of services in each site” (Schneider & Palmer, 2002, p. 32).

Municipal governments do not independently design and fund the entirety of their RCH services. Rather, they deliver RCH services under the auspices of the National Health Mission (NHM), which, beginning in 2005, boosted funds and organizational support for RCH services. Under the NHM, in most states, the central government initially funded 75% of expenditures for specific health care programs and state governments funded the remaining 25%. Municipal governments too received resources for RCH from higher levels of government. However, the central government progressively phased down funds for RCH over 2005-2010 (Government of Maharashtra, 2012), leaving municipal governments to operate RCH services using more of their own budgetary sources. Under a recently approved urban RCH component approved in 2013, municipal governments will receive additional funds from the central government for RCH-related activities (MOHFW, 2013c). These funds will partially cover the cost of RCH services, which remain prominent in Pune’s public budget and health care services.

Although municipal doctors attributed the importance of RCH services partly to high maternal and infant mortality and high fertility, yet recent evidence about the burden of disease and causes of morbidity and death suggest an alternate picture. RCH does deserve attention: surveys show that, in India, approximately 43% of children under age five were underweight and 36% of women in the 15-49 years age group had body mass index below normal in 2005–2006 (James, 2011). Data suggest
improvements in the rate of immunization and acceptance of maternal health services have slowed in the last decade (James, 2011).

But India’s epidemiological and demographic transition is having significant effects on patterns of mortality and morbidity (Yadav & Arokiasamy, 2014). According to the WHO, as of 2012, although poor maternal and neonatal health and nutritional factors were the leading causes of disability-adjusted life years, yet maternal, neonatal, and nutritional causes contributed about as much to DALYs as did cardiovascular diseases and diabetes (WHO, 2015b).

Yadav and Arokiasamy (2014) studied India’s epidemiological transition by “exploring the structural changes in pattern of diseases and progress in mortality transition” (p. 1). They found a modest decrease in the burden of communicable diseases in India and that noncommunicable diseases (NCDs) have emerged as a major cause of death. “Among urban populations, the major changes in disease patterns were caused by infectious and parasitic diseases, which declined steeply by 10% during 1975–1995, and diseases of the circulatory system, which increased asymptotically to the highest share and engrossed the largest share of 21% of total burden of diseases in 1995” (p. 7). According to WHO (2015b) statistics, the leading causes of death in India are ischemic heart disease, chronic obstructive pulmonary heart disease, and stroke, followed by diarrheal disease, lower respiratory infections, and preterm birth complications. However, as Dr Atul’s remarks suggest, municipal health services remain tied to RCH services and do not reflect the above data.

The doctor pointed out that under the RCH program, pregnant mothers received free iron supplements to treat anemia. But there were hardly any services, the doctor said, for adolescent girls or young women before they got pregnant, to ensure girls are healthy before they become mothers. (National health programs announced expanded services and resources for adolescent health in 2014 (MOHFW, 2015a; 2015b)).

The design, management, and funding for national communicable disease control programs are undertaken by central- and state-level government agencies. See, for example, the national program for tuberculosis control (MOHFW, 2012)).

Evidence confirms that the poor do use municipal services more than other classes (Kroll, Butsch, & Kraas, 2011). See also Chapter 4.

Doctors’ use of terms such as “counsel” and “giving advice” has been documented in a recent study of patient-provider interactions in urban India. Notably, Ghoshal et al (2014) report, based on interviews with public and private sector obstetricians in Mumbai, that providers viewed “communication” with patients not as dialogue but as one-way “counseling, guiding, or talking to patients” (Ghoshal t al, 2014, p. 1). Their analysis suggests that providers were attempting largely to get patients to adapt to modes of curative care, not to adapt treatment for patients’ social circumstances (Tharu, 2010; Ghoshal et al, 2014). I mostly concur that terms such as counsel and giving advice imply “talking to” rather than dialoguing with patients, although I argue doctors’ intentions, at least as the level of primary care and care for a range of minor ailments, seem more complex than a singular focus on providing biomedical treatment, as municipal doctors’ narratives in this chapter suggest. I should emphasize here that my aim is to delve into municipal doctors’ understanding of and responses to SDH. While I acknowledge that doctors’ engaging in a two-way dialogue with patients is critical to that response, my primary interest is in doctors’ recognition of the social conditions of patients’ lives and attempts to reflect upon and address those social conditions, even if their manner of communication belied such reflection on their part. As I will show, doctors’ communication skills and listening to and respecting patients’ concerns and needs during clinical encounters are important, but not the only relevant, features of doctors’ response to SDH.
National health policy has championed their role and expanded their numbers in rural primary care in recent years (MOHFW, 2013b). The municipal health service did have some community-based health workers, whose task was to assist with RCH-related activities.

Some newly recruited municipal doctors had worked alongside such volunteers in the rural state-run health service, but were unaware they existed in the municipal health service.

Each municipal clinic archives case papers. As long as the patient holds on to their case paper chit, a 1 inch by 2 inch piece of thin, pink paper on which is printed their case paper identification number, and presents the chit at the clinic, the clinic can retrieve the patient's records of prior visits to that particular clinic.

When a patient is admitted to a public sector hospital, someone close to the patient is compelled to stay with them for a good portion of the time. There may be nurses day and night, but medical supplies and aides are limited. If the patient requires a specific drug, or if the doctor orders a particular size of gauze for dressing a wound, or if the patient has to bathe, then the patient's escort has to be present to run errands, say, to purchase drugs or materials from shops outside the hospital or to help the patient move around the ward.

Studies in LMICs suggest similar themes, indicating how social, economic, and cultural factors interact to shape how the poor access care and follow treatment. Considerations of convenience and cost, beliefs about spiritual versus biological causes of diseases, and affective elements such as the emotional experience of the medical encounter, can all direct people's use or non-use of therapeutic options (Colvin et al, 2013; Seeberg et al, 2014; Geldsetzer et al, 2014; Ergler et al, 2011). Das and Das' (2006) study in New Delhi found that people's perceptions of what degree of ill health could be “absorbed within the notion of the normal” intersected with individual and household economics to shape when people sought health care, from which sources, and with what degree of compliance with prescribed treatment. However, as I discuss further below, municipal doctors painted over these complexities with broad strokes, occluding nuance, specificity, and tractability of patient cases. They emphasized the “stickiness of tradition” (Doshi, 2013) rather than its mutability and its active social reproduction.

The municipal health service took no appointments. All outpatient visitors were walk-ins. Municipal doctors had to clear the queue of outpatient visitors before the clinic or hospital closed for the day. In some municipal facilities, groups of doctors in outpatient consultation rooms saw over 200 patients in a day. The workday ran from 9am-1pm and 2:30pm-5pm. The patient load was generally heavier in the mornings.

As I will explore further below, critiques of food policy in India similarly highlight the state's concern with starvation deaths rather than endemic hunger (Amrith, 2008; Sainath, 2001).

As it happened, the two young Muslim women arrived again two days later, and that time I briefly conversed with them. They were there again for the baby. I discovered they were unhappy with their experience of the municipal hospital. The baby’s mother had been registered to deliver at this hospital. But days before she was due, doctors had informed her that she had better find another hospital for the delivery. They were worried it might be a complicated birth. She had been disappointed and frustrated, since this was the closest hospital and least expensive option for her. She did eventually deliver at another hospital, but the delivery had been entirely normal.
What was it, then, that doctors inscribed on patients’ case papers and prescribed to patients who, in their professional estimation, barely qualified as ill? I observed one doctor as she attended to a woman in her 40s. The woman complained vaguely of pins and needles and generalized body aches and pains. The doctor examined her and asked a few questions. She then wrote a prescription and instructed the woman to get the drugs at the clinic’s pharmacy window. She explained nothing to the woman. After the woman left, the doctor remarked to me that the woman had no illness and had visited the clinic several times in the past few weeks. “She’s fine. But just … she’s getting medicines for free from here, so she makes a trip here to get medicines.” What did the doctor prescribe, I inquired, if there was nothing wrong with the patient? The doctor responded drily: “Multivitamins. Balm. This kind of thing.” In a previous conversation, this doctor had discussed how doctors often had to placate patients who presented with no substantial symptoms. For example, she said, there was no need to take drugs for a cold, but doctors could not say this to the patients. “If we tell them they can give their children kadha (an infusion of spices and roots) to soothe a cold, they will think we don’t know anything about medicine!”

Medical hierarchies in clinical settings—medical interns, residents, fellows, attending physicians, and so on—reflect apprenticeship models of learning in medicine (Walton, 2006). Medical institutions depend on and continually grapple with managing the hierarchy of expertise in clinical settings (Walton, 2006; Srinavasan, 2013; Schocken et al, 2013). In Pune’s municipal health service, there were very few educational opportunities for medical students. Although hierarchy of administrative authority does exist in Pune’s municipal health service, essentially no hierarchy of medical expertise exists across its clinics and hospitals. This is not for lack of trying. The Pune municipal health service had been unable to obtain approval from the Maharashtra department of urban development to increase its specialist medical staff (Isalkar, 2012). For example, the municipal health service had proposed, in 2008, 15 new staff positions for gynecologists, but the urban development department approved none (Isalkar, 2012).

Although some municipal doctors held post-MBBS two-year diplomas in fields such as child health and obstetrics-gynecology, the municipal health service had, as of 2012, positions for one pediatrician, one pathologist, one radiologist, and no gynecologist. The rest of staff positions for doctors stipulated a minimum qualification of a basic medical degree (Isalkar, 2012).

A few private sector specialists held consultation hours in municipal clinics and hospitals and were paid a nominal honorarium. But these sessions were usually held once a week, and my fieldwork showed they could be rushed affairs, at times lasting less than 30 minutes.

I return to this point further below in this chapter. In subsequent chapters, I examine doctors’ perceptions of medical complications and their political consequences as well as the workings of authority in the municipal health service.

I did not confirm what kind of CT scan. According to the price list of a private hospital in Pune, the price of a CT scan could range from Rs 2,100 to Rs 8,400 (roughly US$ 30 to 125), depending on the type of scan.

I did not investigate corruption, if or how it existed, in Pune’s municipal health service. While evidence suggests that various forms of corruption in health care exist in both the private and public sector across India, yet corruption at the small-scale level of doctors accepting informal payments seemed less prevalent in Pune’s municipal health service. For instance, studies report doctors (mostly rural-based, state government, and private sector doctors) taking kickbacks for referrals from private actors or patients making under-the-table
payments to doctors to expedite medical attention, often for inpatient care (Lewis, 2007; Chattopadhyay, 2013; Berger, 2014; Nagarajan, 2014; Sachan, 2013). I did not encounter or hear of those practices among Pune’s municipal doctors. Health activists in Pune informed me that they had discovered a version of “cut practices” in a large state government hospital in the city, i.e., run by the Maharashtra government. The activists had not looked for and were not aware of such practices in Pune’s municipal health service. In another case, an analyst in a major NGO based in New Delhi, who had helped conduct central government-commissioned studies and draft policy briefs, informed me that petty corruption, while it does exist, afflicts only a small percentage of the public sector workforce in the health sector.

Another graft-related issue is health worker absenteeism, which studies show is a significant problem in public sector health care across India (Muralidharan et al, 2011). Yet research suggests that doctors in more remote, smaller public sector facilities, further away from urban areas, are more likely to be absent than doctors posted in facilities with better infrastructure and access to amenities (Muralidharan et al, 2011, p. 6). Doctors’ absence in Pune’s municipal health service seemed a far lesser problem than indicated by the state-wide average of about 34% reported for Maharashtra (i.e., doctors were absent from their posts 34% of the time during working hours when, according to the health care facility schedule, they would ordinarily be on duty (Muralidharan et al, 2011, p. 3)). Early in my fieldwork, several senior municipal doctors informed me that although a couple of municipal doctors had engaged in wrongful practices in the past, such as running a private medical practice on the side while drawing a municipal salary, such doctors had been routed out. They noted that the municipal health service was small in size; it was relatively easy for administrators to detect such practices. However, a year later, towards the end of my fieldwork, one long-time municipal doctor informed me that over the past year, she came to know of a few doctors who clocked in to work in the morning, left for several hours at a time, and held private consulting hours or worked elsewhere simultaneously. Such practices occurred, she said, among the newer recruits, i.e., some 90 doctors who had joined the municipal health service during 2012-2013. I could not verify the extent of doctor absenteeism or moonlighting. While I observed on a couple of occasions that some doctors were absent during working hours, these were isolated, uncommon observations.

In sum, while I cannot definitively point to small-scale corruption within Pune’s municipal health service, evidence suggests that such practices prevail more commonly and widely in the private sector, in state-level government-run health care services, and in rural areas than in municipal government-run health care.

177 Municipal doctors could prescribe drugs for patients to purchase at any private pharmacy if the drugs were unavailable at the municipal pharmacy. This appeared to be the business the pharma reps pursued. Municipal doctors had limited control over which drugs could be stocked in the health care facility. Formal state-issued criteria and procedures guided the addition of new drugs in the municipal inventory. While municipal doctors could officially recommend drugs to the municipal authorities for inclusion on the list, or ask for higher stocks of certain drugs, doctors informed me that their requests often came to nothing. For pharma reps seeking to increase drug sales, approaching municipal doctors was possibly easier than trying to include a new drug, or expand existing stocks, on the state-approved list.

178 As I elaborate in endnote 176, I did not investigate kickbacks or other forms of corruption within Pune’s municipal health service. I came upon little evidence of it during my fieldwork. While studies suggest corruption exists in both the private and public sector (Lewis, 2007; Chattopadhyay, 2013; Berger, 2014; Nagarajan, 2014; Sachan, 2013), I found that small-scale corruption—doctors accepting informal payments from patients or kickbacks or “cuts” from private actors—did not seem prevalent in Pune’s municipal health service. I cannot rule out such practices among municipal doctors, but
evidence suggests they are more common in the private sector and in rural state-level government health care (e.g., Muralidharan et al, 2011).

179 Collaboration at a higher level, where a private operator contracted to take over the running of an entire municipal hospital (typically on a for-profit basis with concessions for poorer patients) was another matter. The municipal health service had entered into at least four such collaborations according to a local politician I interviewed. At least one of those private-public arrangements had met with protests from local activists, but had gone ahead nonetheless (Shukla, 2007). Newspaper articles reported two further impending privatizations of municipal hospitals (Gadkari, 2013).

180 As reported in the central government-appointed technical resource group report on urban health, tiers of primary-secondary-tertiary care are meant to operate as a pyramid, with ideally the majority (70%) of patient cases handled at the level of primary care and only 5% of cases referred to higher levels of care (MOHFW, 2014b). In practice, there is an “inverse pyramid phenomenon,” whereby “the major proportion of curative primary care provision may be occurring at the medical college and the district hospitals,” with primary-level facilities “catering to a much smaller proportion and almost no care occurring at the outreach of community level for a major part of the population” (MOHFW, 2014b, p. 48-49).

According to the central government-appointed technical resource group on urban health, such overcrowding at higher levels of care and minimal services offered at the level of primary care is a uniquely urban phenomenon—in rural settings, long distances between tiers of health care prevent people from readily accessing higher levels of care (MOHFW, 2014b, p. 49). At tertiary hospitals, patients seeking specialist doctors encounter long queues and waiting times and hurried consultations, without assurance of continuity of care and follow-up at community level (MOHFW, 2014b).

181 Coping mechanisms, according to Lipsky, were general responses street-level bureaucrats developed to deal with inadequate resources, limited control over their work, unclear organizational objectives, and discouraging circumstances of work. As Halliday et al (2009) describe, Lipsky identified three coping mechanisms: “first, street-level bureaucrats develop patterns of practices—routines and stereotyping—to limit demands on their time and resources; second, they modify the concept of their job to narrow the gap between objectives and resources; third, they modify the concept of their clients to render the inevitable gap between objectives and accomplishments more palatable” (p. 406).

182 Batliwala (2011) refers to the “bias and discrimination” of public officials charged with implementing policies and laws. She gives the specific example of “pro-women legislation in the hands of insensitive male judges, for instance, [which] has led to little real change for women seeking legal relief” (p. 23). I contend the charge of bias and discrimination also applies to public sector service providers such as municipal doctors. Although service providers occupy in positions of lesser power than administrators or judges, yet they hold authority in municipal health care facilities and are responsible to realize the state mandate for primary care.

183 Such behavior points to a coping mechanism that Sarangi (1996) specifies as “institutional stereotyping,” wherein frontline workers sort types of clients based on clients’ social or cultural attributes, predict their likely behavior, and adjust the extent and nature of services to provide (p. 373). However, the pervasiveness and harshness of health care workers’ stigmatizing behaviors suggests something other than or in addition to a coping mechanism. I draw here on Sarangi’s (1996) useful distinction between cultural stereotyping and institutional stereotyping. As Sarangi (1996) identifies, “whereas institutional stereotyping refers to the ways in which both clients and gatekeepers
construct fixed notions about each other, cultural stereotyping refers to the tendency of participants from different cultural backgrounds to explain their own and other's discourse behaviour in terms of negative cultural attributes” (p. 373).

In the literature on street-level bureaucrats, stereotyping as a coping mechanism appears to refer largely to institutional stereotyping between frontline workers and their clients. But the stigmatizing and discriminatory attitudes that the poor encounter in seeking health care additionally describe cultural stereotyping between social groups. Put another way, studies of frontline state workers have focused largely on the “state-agent narrative” of street-level bureaucrats, namely on how they apply the “state’s laws, rules and procedures on the cases they handle” (Maynard-Moody & Musheno, 2009, p. 9). They less frequently explore a “citizen-agent” narrative, which “concentrates on the judgments that street-level workers make about the identities and moral character” of people they encounter” (Maynard-Moody & Musheno, 2009, p. 9).

Sarangi (1996) avers that “institutional representatives manage their everyday lives through the rhetoric of stereotypes,” but their clients might perceive in their encounters with such representatives racial or ethnic discrimination, i.e., cultural stereotyping (p. 373). I argue, with Sarangi (1996), that both kinds of stereotyping occur simultaneously and are interlinked, such as where racial, ethnic, or religious discrimination is institutionalized through routine state practices. Sarangi (1996) additionally notes that cultural stereotyping and institutional stereotyping can become reinforced in face-to-face encounters between state agents and the clients they serve.

Accounts of street-level bureaucrats, in seeking to explain frontline actors’ practices and service quality, may focus more on institutional rather than cultural stereotyping. Evidence from India suggests that encounters between clients (poor patients) and state agents (municipal doctors) are rife with both cultural and institutional stereotyping.

While training and sensitizing health care providers is part of the solution, the problem may lie not only in providers’ competency to respond to social and cultural difference during clinical encounters, but more fundamentally in the design of development policies and programs and in wider social imaginaries and structures (Doshi, 2013). Discerning the sources of providers’ stigmatizing or discriminatory attitudes would entail looking outside of state procedures and health care encounters (where providers are state agents), to providers’ social lives (providers as citizens) and the substantive details of health programs.

In my fieldwork, I could not explore the social context of municipal doctors’ lives (their private lives as citizens) to discern the sources of their social biases. The key relevant guiding mandate here—the municipal mandate for primary care—describes broad municipal responsibilities in health care and not specifics of health care operations. Details of other primary care-related programs, such as for RCH and infectious disease control, are formulated and administered by central and state-level government. I did not analyze intensively the details of these programs for whether and how they perpetuate social exclusion.

Critical analyses of other development programs show how social marginalization might be built in to their design, as Doshi (2013) notes of gender-based exclusion in development programs. Similar analysis is warranted of urban health care-related programs. Nambiar et al (2016), in their report on social exclusion in urban health care, use Naila Kabeer’s framework to analyze “unruly practices,” or the discord between de jure and de facto laws and policies (p. 42). Critical analysis of the de jure laws and policies would help show if and how social exclusion may be manifest in their design, not only in their implementation.

As Hansen and Metzl (2014) explain, the first component of structural competency seeks to introduce “constructive ways of discussing how upstream decisions about resources, and the political economy of healthcare” affects both patients and doctors (p. 129). They clarify that “clinicians often understandably feel that issues such as time or drug pricing are matters over which they have little
control. Yet cognizance of the mechanisms that produce such emotions seems a productive first step in addressing them” (Hansen & Metz1, 2014, p. 129).

Municipal doctors’ narrow depictions of patients’ social circumstances also foreclosed patients’ narratives, where doctors assumed their reading of a patient’s situation was the “definitive interpretation” (DasGupta, 2008, p. 981). This suggests a need to develop the structural competency of “structural humility” (Metz1 & Hansen, 2014, p. 131), so that providers remain reflexive “coauthors of … patient’s illness narratives” and open to the ambiguities, contradictions, and particularities of patients’ stories (DasGupta, 2008, p. 981). For example, in dismissing the majority of patients as not seriously ill, Pune’s municipal doctors neglected the nuances of their patients’ social and health conditions.

I could not explore in my fieldwork whether and how municipal doctors viewed NGOs and community-based efforts as potential and feasible means to address SDH. However, my findings suggest that doctors did not have much contact with such local actors, nor did municipal authorities expect doctors to foster such contact. Only a handful of NGOs collaborated with a few municipal health care facilities in specific locations on specific projects. As far as I discerned, the majority of doctors across Pune’s municipal clinics and hospitals had no regular or tangible relationships with NGOs, which possibly diminished their ability to imagine options to address SDH.

As Pereira et al (2011) report, “some patients requested financial assistance and some refused treatment as they did not feel it would help them” (p. 5). Doctors found that patients’ adherence to treatment was affected by their acceptance of stress as a part of life and their feeling that health care could not do much to ameliorate those life stressors (Pereira et al, 2011). In the words of a lay health counselor:

Some (patients faced) social difficulties like financial problem which is mainly due to seasonal work, daily wages, and alcoholism. Another problem was patients not having proper documentation to apply for social schemes e.g. unregistered marriage, so a woman cannot apply for widow pension. So I found that there is no proper channel to improve their social difficulties and their problem remains same and this worsens their health condition. But I tried to give them information about various available schemes and how to follow the procedure and some even applied for it (Pereira et al, 2011, p. 5).

Welfare services have evolved in areas other than urban health care. Researchers note, for example, dissimilarities and continuities in pre- and post-liberalization policies in food security (Mander, 2013) and women’s empowerment (Gupta, 2012; Doshi, 2013). The state has launched major national health and urban development programs, as I discuss in previous chapters. But these initiatives have done little to change the narrow remit of and resources for municipal health care.

To elaborate the analytical yield of this point: in the two cases, frontline agents’ street-level practices reflect different kinds of tension with formal policy. In the one case (Hungary), changing formal policies compel state agents to alter how they deliver services. In the other case (Pune), unchanged formal policy compels state agents to deliver the same services in the same ways, even as ground-level realities have altered. Both cases show how street-level work is caught in the tangle of ground reality, but they highlight differing sources and emphases of tension, showing how states are manifold and may be out-of-sync in different ways.
Evidence from both LMICs (Mackintosh & Kovalev, 2006) and high-income countries (Fountain, 2001; Henderson & Petersen, 2002) raises concerns about the social and health implications of the idea that state agencies should be client-oriented.

As doctors observed, most doctors sought simply to control patients’ symptoms and prevent mishaps. A patient’s death would lead to questioning from municipal authorities; patients who did not improve would invite little attention. I examine municipal doctors’ perceptions of medical complications and their political consequences in the next chapter.

Mander (2008) writes evocatively of the persistent hunger, chronic malnutrition, and “astounding levels of abysmal impoverishment” among tribal communities in Rajasthan that result from the state’s destruction of forests, curtailing of tribal groups’ rights to forest land, and attempts to “settle” them in agriculture by providing (barren) land but no skills and credit.

When the media focuses on starvation deaths, Sainath (2001) writes,

[It] seems to imply this: if they don’t die, everything’s alright. If they lose their land, cannot feed their families, see their children enter bondage, are forced into debt-driven prostitution — all that is okay. They just shouldn’t starve to death. That's upsetting. It's bad implementation.

Doshi (2013) discusses two specific programs—the Integrated Child Development Scheme and the Mahila Samakhya women’s empowerment program—to note “how contradictions emerge through the feminized enrollment of women in gender-focused development programs where some dimensions of womanhood are privileged over others … Volunteerism in this and other programs naturalizes women’s caregiving roles and represents women’s labor (including wage work) as affective activities that need not be remunerated.”

Doshi (2013) reminds us that the state’s care-giving “biopolitical programs” can effectively operate as “difference producing machines.” That is, “part of the violence of biopolitics is the way it works to reproduce and maintain differentiated exclusions even as the experiences of state practices change and vary across and among groups.” Doshi’s (2013) characterization of biopolitics seems to evoke Reich, Hansen, and Link’s (2016) argument about the structural determinants of health: even if we enhance technologies of welfare (or medicine), we may still continue to obtain inequalities in development (or health) outcomes, unless we address the mechanisms that produce social exclusions.

Gilson (2003) identifies two forms of trust: interpersonal trust, meaning trust between people known to each other, and impersonal trust, meaning “trust in strangers and trust in social systems” (p. 1457). Trust, specifically interpersonal trust, refers how individuals expect others will behave towards themselves in the future – to trust someone is to expect that they will act in your interests (Gilson, 2003). Impersonal trust involves a similar expectation of other-regarding behavior from others in situations of uncertainty, but instead of relations between people known to each other, refers to relations between strangers and to norms embodied in, and fostered by, institutions (Gilson, 2003).

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others in situations of uncertainty, but instead of relations between people known to each other, refers to relations between strangers and to norms embodied in, and fostered by, institutions (Gilson, 2003). In health care settings, interpersonal trust includes relations built through “facework commitments” (Giddens, 1990), meaning regular interactions among people known to each other, such as patients, providers, administrators, that generate and reinforce trust (Gilson, 2003). Impersonal trust in health care settings refers to institution-level trust, or the “faceless commitments” (Giddens, 1990) that health care institutions embody by virtue of the technical expertise and knowledge, ethical codes, and licensing arrangements, among other organizational features, that they maintain (Gilson, 2003).

People’s trust in health care institutions facilitates their expectation that a health care worker will act in their best interests even when people do not personally know the specific worker who attends to them. Institution-level trust is created and reinforced on the basis of numerous interactions between social groups over time and across space (Gilson, 2003). In the case of state-run health care institutions, this would imply interactions between citizens and “faceless” state agents across multiple levels and agencies of the state, as well as interactions among state agents. Relations of trust are particularly important in health systems given the information asymmetries that characterize the provision of medical care.

199 In many LMICs, urbanization is associated with a dual burden of disease, i.e., rising prevalence of chronic or noncommunicable diseases alongside continued challenges of infectious diseases (Stenberg & Chisholm, 2012). A dual disease burden is evident in urban India, and chronic illness is of increasing importance on the health policy agenda (Engelgau, El-Saharty, Kudesia, et al, 2011; Gupta & Ahuja, 2010). While the burden of communicable diseases in India has decreased slightly, non-communicable diseases, such as cardiovascular disease and diabetes, have emerged as a major cause of death, especially among urban populations (Yadav & Arokiasamy, 2014).

200 Studies show that health care providers in India overprescribe injections in part because of their perceived efficacy, e.g., patients might “overvalue them compared to oral medication” (Kermode & Muani, 2006). Where biomedical science coexists with cultural contexts in which other explanations for health and illness prevail, the efficacy of injections, a biomedical practice, may be judged in alternate, unintended ways (Reeler, 2000). For instance, “the act of filling a syringe and penetrating the body with a needle may be perceived as an elaborate ritual and a sign of powerful medicine” (Reeler, 2000, p. 136). The injection may contain only a placebo.

201 Drugs for diabetes and hypertension were already available for municipal employees under the municipal government health insurance plan. The memo expanded the drug schedule for the general patient population.

202 I was unable to obtain a copy of the memo or a list of drugs for the general patient population in order to check to see which drugs had been added over the years. Municipal authorities responded to my repeated requests about the question of drug lists, including a formal query I filed under India’s 2005 Right to Information Act, with broad answers and few details. My conversations with pharmacists and doctors yielded conflicting answers. One pharmacist told me that they did not have records of years past. Another pharmacist said the expanded list, i.e., the list that specifically included certain drugs for chronic illness, had been in place for several years, but I could not ascertain how many years. Another pharmacist flatly said general patients do not receive drugs for chronic illness. Yet another pharmacist’s remarks struck middle ground: he said that while these drugs were available for government employees, “our doctors don’t prescribe them” for general patients. Therefore, I could not date the year when the drug list was expanded or confirm on paper whether it was in fact expanded. I was unable to confirm whether doctors could provide them to general patients but chose
not to, or whether doctors were unable to stock them for general patients. Pharmacists’ remarks generally described what doctors did (de facto practices), rather than specify what doctors were authorized to do (de jure mandate).

Mechanisms for redress under the COPRA encompass state and district level forums as well as state and central level commissions (Bhat, 1996). States can either adopt and implement the CEA, or enact their own legislation on the subject. The purpose of the CEA is to provide for the registration of all health care establishments belonging to all lines of medicine (allopathic and alternative medicine), and to prescribe and regulate minimum standards for their facilities and services.

Comparing Pune’s municipal hospitals to Mumbai’s with respect to surgical procedures performed in each, Dr Mangesh pronounced Pune’s municipal hospitals as “’dead’ institutes.” In Mumbai, he said, “They can do cardiac surgeries. … here, we have beds lying empty,” which led to doctors losing interest in their work.

I could not locate laws categorically prohibiting MBBS doctors from performing the procedures Dr Mangesh mentioned, and unfortunately I was unable to return to Dr Mangesh to clarify which law or court order he meant in his remarks. India’s national guidelines on abortion care stipulate that a registered medical practitioner (which includes MBBS degree holders), appropriately trained in abortion care, can perform medical and surgical abortion (Stillman, Frost, Singh, et al, 2014). National health program guidelines on obstetric care include training for MBBS doctors and general surgeons to perform c-sections in rural health care facilities (MOHFW, 2014a, 2015b).

Several court cases have ruled that MBBS doctors do possess the credentials to perform c-sections; medical negligence in these cases lies not in fact of an MBBS doctor performing the procedure, but in that doctor’s actions or failure to take certain actions (Gupta & Gupta, 2006). I was unable to find more recent, reliable information on court rulings in this regard. Blog posts by lawyers and hospital administrators caution doctors against performing procedures when there are specialists in the vicinity: “One view is that medical professionals should strictly practice within the scope of his/her qualification only i.e., the MBBS doctor should generally not perform cataract surgeries and caesarean sections. … This view is based on a purely legal angle, in the era of COPRA 1996. After all every patient is a potential litigant and when he cries foul and alleges medical negligence, the public, the politicians and the authorities tend to sympathise and favour the patient.. … There can be situations when a person who is not a gynaecologist may justifiably conduct obstetric surgery [such as in an emergency]. … Rules have to be such that they are appropriate to the context where they apply. In remote areas, the specialist doctors are very few and specialist healthcare facilities are, more often than not, unavailable. An MBBS doctor in PHCs/district hospitals is authorised to perform tubal ligations, obstetric emergency surgeries, conduct postmortems and even to administer general anaesthesia, but this is not permitted in private practice, especially in urban areas.” (Sood, 2012). See also MC Gupta (2012).

Other commentators have agreed that some legal stipulations are “rational [but] impractical to implement at present” (Phadke, 2010, p. 230). But they have also strongly made the case for the need for laws such as the Clinical Establishment Act, for standards and regulation of medical care and medical establishments, and have held that the laws would not pose undue financial burden on
medical establishments (Srinivasan, 2013; Phadke, 2010). Studies conducted in the 1990s to survey conditions of private health care facilities found “medical establishments … housed in dilapidated buildings – sometimes just tin roof sheds – cramped and overcrowded, with dirty toilets and no running water. Operation theatres had leaking ceilings and peeling paint and lacked essential equipment. The resident doctors were often from other systems of medicine and worked with the support of visiting consultants. Most of the nurses were unqualified. Many of these establishments were not even registered under the BNHRA [Bombay Nursing Home Registration Act]. A study in Satara district of 53 practitioners and 49 nursing homes/hospitals resulted in similar findings” (Srinivasan, 2013, p. 15).

Municipal authorities recognized the high incidence of referrals for obstetrics care, but cast material inadequacies as the root of the problem, specifically the lack of specialist expertise in the municipal health service—when questioned by the media, administrators stated that specialist positions remained unfilled despite the municipal government’s repeated recruitment attempts. The municipal doctor informed me of a surprise visit the municipal commissioner (chief administrator in municipal government) had paid to a municipal hospital. The commissioner had asked to see the register of the maternal ward, and noted with consternation a long list of referrals of obstetric cases from the hospital.

The course is designed to develop doctors’ knowledge and competencies in diabetes care and establish networks between primary care doctors and physicians specialized in diabetes (CCEDM, 2014). The course is delivered by the Public Health Foundation of India and recognized by the International Diabetes Foundation (CCEDM, 2014).

The study involved doctors from four private clinics and hospitals, each matched with a “control” private clinic or hospital of equivalent profile, for a total of eight facilities. Doctors from the latter set of facilities were interviewed but given no intervention. The intervention included providing doctors a list of generic medications for diabetes that were available for free at local public hospitals, and an hour-long training session on standard treatment guidelines for diabetes management.

The evaluation showed no change in doctors’ treatment practices for diabetes care. Doctors who participated in the study noted, firstly, that their role was not to diagnose patients, that diagnosing diabetes and that deciding a patient’s treatment plan was usually the role of a specialist. Doctors reported that most patients who came to them had already seen a specialist for diabetes. Thus one explanation for doctors’ “limited use of the standard treatment guidelines was that these doctors mainly provided follow-up care to patients who were previously put on a given treatment plan by specialists” (Bhojani, Kolsteren, Criel, et al, 2015). Secondly, doctors in the study believed generic medications were not as strong or effective as branded drugs, and hence did not prescribe them to patients. These factors, among others, e.g., related to patients’ care-seeking behavior, contributed to doctors’ practices and help explain why their practices did not change following the intervention.

The study provides additional evidence that the role of primary care providers in diabetes care is subsidiary to that of specialists. But it also suggests alternate reasons that primary care doctors may not treat diabetes, namely doctors’ perceptions about generic medications. In particular, the study highlights corrupt practices where private doctors and pharmacies share profits when they prescribe specific drugs, which might explain private doctors’ reluctance to prescribe generic drugs that are available for free from public hospitals (Bhojani, Kolsteren, Criel, et al, 2015; Bhojani, Thriveni, Devadasan, et al, 2012).

As the study’s investigators found in previous research, “Pharmacies and laboratories interviewed reported the practice of kickbacks (10 to 25% of investigation or medication costs) given
by them (and other laboratories/pharmacies) to most GPs [private sector general practitioners] in the area” (Bhojani, Thriveni, Devadasan, et al, 2012).

One such report observed that in confronting the problem of tuberculosis, the Indian state and the WHO had tended to blame the failure of public health programs on patient “noncompliance” (Amrith, 2007, p. 119). But the problem lay in the state’s failure to recognize and respond to local conditions, illustrated by the “decline in the scope and extent of public discussion of health” (Amrith, 2007, p. 119).

The private supply of professional education in other sectors, such as engineering, has increased even more significantly than in medicine.

According to the NBE (2016) website, “The National Board of Examinations was established in 1975 with the prime objective of improving the quality of the Medical Education by elevating the level and establishing standards of post graduate examinations in modern medicine on an all India basis. … The Medical Council of India has laid down standards for post graduate examinations conducted by various medical colleges and affiliated to concerned universities and other institutions, yet the levels of proficiency and standards of evaluation vary considerably in these institutions. The setting up of a National Body to conduct post graduate medical examination was intended to provide a common standard and mechanism of evaluation of minimum level of attainment of the objective for which post graduate courses were started in medical institutions. Moreover, intra country and international comparison is facilitated with the availability of commonly accepted evaluation mechanism.”

Analyzing the reasons for the existence of two boards administering different standards in higher medical education is beyond the scope of this study. It is imperative to mention, however, that the Medical Council of India has been charged with corruption (Ghosh, 2014), and its functioning was recently investigated by a parliamentary committee (Pandya, 2016). The committee found that “The Medical Council of India … has repeatedly been found short of fulfilling its mandated responsibilities … the MCI, as presently elected, neither represents professional excellence nor its ethos” (Pandya, 2016, p. 68).

The Indian Medical Association, the main medical professional association, has been charged with obstructing the passage of laws regulating medical care and medical establishments such as the CEA (Phadke, 2010).

While an MD degree is gained through admission to MCI-accredited medical colleges attached to teaching hospitals, a DNB diploma is gained through admission to training programs managed by NBE-accredited hospitals (NBE, 2009). The MOHFW (2006) has, since 2006, considered the DNB and MD degrees as equivalent credentials for teaching and employment eligibility. The MOHFW expressly issued a letter to this effect, overturning a previous statement dating from 1994, under which DNB diploma holders were required to undergo an additional one or two years of teaching experience prior to their promotion to higher posts. The letter states:

The Government has reviewed in detail the issue of the [previously issued MOHFW] requirement of additional one/two years teaching experience for DNB degree holders for appointment as Lecturer in Broad Specialities/Super-specialities [as per earlier MOHFW letter No. V.11025/6/94-ME(UG), dated Oct 3, 1994.] After taking into consideration all facts of the matter, the Government has come to the conclusion that for the purpose of appointment of DNB degree holders to the teaching posts, the requirement of additional one/two years teaching experience as
stipulated in the above instructions dated 3.10.1994 needs to be discontinued. Accordingly, these instructions stand amended to this extent. …

As clarified in the above instructions dated 3.10.94, it is reiterated that the medical qualifications awarded by NBE are recognized qualifications included in the First Schedule to IMC Act, 1956 and are considered at par with MD/MS,DM/M.Ch qualifications of other universities.

214 Evidence shows the challenge of violence against doctors is global (WHO, 2014). Such violence is occurring “with growing frequency in all regions of the world, and in all contexts, during peacetime as well as armed conflict and other humanitarian crises … In recent years, the outcry has softened. The sense of outrage has been muted. The fact that these attacks have become so widespread must not be tolerated as the new normal,” stated Margaret Chan, head of the WHO (2014).

215 In these cases, the views of doctors, hospital and/or state authorities, and patients’ relatives were often mixed and conflicting. I recognize that by summarizing the cases I leave aside the contested views and the “truth” of the matter, but my aim is to illustrate the kinds of medical events that gained medical attention and the incidents of violence they provoked.

216 Several other municipal doctors made this point. Their attitudes reflected research that shows “barriers of mistrust” among public and private sector providers (de Costa, Johansson, & Diwan, 2008; see also Ergler et al, 2011; Kane, Calnan, & Radkar, 2015).

217 And yet if the press circulates information expressly for popular consumption, it can become a medium to “intensify a message” rather than investigate and objectively present all facets of a story, notes Rao (2010, p. 76).

218 Gupta (1995) found that vernacular newspapers in rural districts were more active than metropolitan papers in following local cases of corruption. By depicting the workings of the state at the local level, the vernacular press provided citizens a way to see the state, constructing and reinforcing narratives of corruption, corruption being a key construct through which citizens imagined the state (Gupta, 2012). I did not systematically compare Pune’s urban press to newspapers published for areas outside Pune. Yet the greater vigor of the vernacular news held here too: municipal doctors would at times bring to my attention stories in Marathi newspapers that I had missed because I largely read the English versions of the same newspapers.

219 Job positions in municipal government ranked Class 4 at the lowest level (e.g., sweepers), Class 3 (e.g., nurses), Class 2 (e.g., doctors), and Class 1 (e.g., administrators) at the highest level.

220 Doctors experienced in community-based health care as opposed to hospital-based tertiary care have been “effectively disenfranchised” from leadership positions in medicine, policy, and education (Kumar, 2014).

221 Gupta (2012) explores three such mechanisms through ethnographic fieldwork in rural India: corruption, inscription, and governmentality. In Gupta’s (2012) work, corruption refers to everyday forms of corruption, which shape poor people’s understanding of the state; inscription refers to the writing practices of bureaucracy and literacy as a tool of domination; and governmentality implies the “expansion of processes of government in nongovernmental organizations and realms of social life” (Gupta, 2012, p. 38).
Bureaucratic procedures do certainly lead people to avoid state-provided health care facilities. The long waits to see a doctor, uncertainty that the doctor will be able to treat the specific condition, uncertainty of whether medical supplies and medications will be available in the facility, and the opportunity cost that the waiting and uncertainty entail, can drive the poor to pay out-of-pocket to seek care at private providers of uncertain credentials. But, I propose, difficult bureaucratic procedures are not the only reason that the poor experience denials of care from the state.

For instance, in the state of Andhra Pradesh, less than 35% of rural households opted for private pre-school across all socioeconomic classes, while over 45% chose government pre-schools (the rest did not send their children to pre-school) (Woodhead, 2012, p. 252). Among urban households in Andhra Pradesh, a greater proportion chose private pre-school, but among the poorest urban families, roughly 45% still opted for government pre-schools.

Indeed, researchers have critiqued Gupta’s (2012) argument for its premise of inclusionary policies. Doshi (2013), for example, notes that both “pre- and post-neoliberal” development programs for women’s empowerment and child welfare are marked by “long-standing modalities of violence and dispossession” (Doshi, 2013). If bureaucratic procedures to implement such development programs appear to sustain structural violence against women, it is not because of routine procedures of the state, but because of the “illiberal exploitation” of women that mark the design of development programs.

McLaughlin (2007) specifies authority as a type of social power to clarify that it concerns human relations and the power of human persons over other persons, as opposed to power of or power over objects or non-human animals (p. 44). He further clarifies that social power implies not only an intentional power, i.e., the power of party A (holder of authority) to intentionally produce specific effects in party B (subject to authority), but also power that is “unintentional,” in the sense that it may not be explicitly oriented to the interests of a party. In other words, social power remains operative as an effective capacity of human relations even in case of “mutual disinterest” (McLaughlin, 2007, p. 47). For instance, legal authority (such as that of judicial officials) is a form of social power that operates through laws; holders of such authority have a right, provided under the law, to issue certain commands. But the exercise of legal authority, or the laws and rules upon which it is founded, is not oriented to the interests of a particular subject.

Theorists make a distinction between authority and raw coercive capacity. Authority implies that the holder of power enacts a normative claim (a right to rule) over subjects and that they accept and submit to the claim, while coercive capacity implies the holder of power might enact dominative force over subjects but claims no right to do so, and subjects do not recognize any duty to obey.

Scholarship on authority encompasses fields of law, philosophy, sociology, and political science. Political theory particularly investigates three questions: what does authority mean (a conceptual problem), what are the different kinds of authority (a classificatory problem), and how can we justify or legitimate authority (an evaluative problem) (McLaughlin, 2013).

These two entities hold “practical authority” over municipal doctors, which refers to authority in matters of action or conduct. The other kind of authority scholars commonly define is “theoretical authority,” which refers to authority in matters of belief (McLaughlin, 2013). As Chistiano (2012) observes, “A theoretical authority in some area of intellectual inquiry is one that is an expert in that area. … Theoretical authorities do not normally impose duties on others, although they might give advice on what a person’s duty is.”
My focus is primarily on practical authority, i.e., authority over municipal doctors’ conduct or actions, not on authority in the realm of belief. Medical specialists, for example, are a theoretical authority with respect to municipal doctors. The previous chapter on “risk” preliminarily indicates how the authority of medical specialists might bear upon municipal doctors, who may consider the skills and knowledge of medical specialists as more appropriate than their own to handle illnesses such as hypertension and diabetes. However, I don’t explore the authority of medical specialists in this project.

In a legal and political order, the authority of a bureaucratic office or political position extends to the person or persons—here, municipal administrators and local politicians—who hold that office and exercise that authority (Anleu & Mack, 2015). As McLaughlin (2007) puts it, their authority is not personalistic but “determined officially, by office occupied (p. 57).

The pressure of popular opinion invokes citizens’ social power over state functioning. In the health systems literature, this power has largely been studied in terms of mechanisms and evidence of health providers’ responsiveness or accountability to communities, not as a normative relationship between citizens and the state or as citizens’ effective capacity to direct state functioning (Shiffman & Berlan, 2012; Molyneux et al., 2012). The health systems literature recognizes the “value in considering citizens and political systems more broadly” (Shiffman & Berlan, 2012, p. 272) and that “community accountability is … inevitably embedded in social relations and power struggles (Molyneux et al., 2012, p. 549). Yet health systems research on that front has largely involved documenting evidence about and mapping mechanisms to enhance accountability of health care providers towards communities, not theorizing citizens’ claims-making over service providers as a species of social power.

As I will show, in their role as state agents, municipal doctors’ interactions with communities conveyed to them a sense of the legitimacy of the state and popular regard for their work. These meanings reflected popular opinion about state-provided services in general and municipal health care in particular. Popular opinion thus informed municipal doctors’ understanding of their mandate and consequently their practices, even if it did not have formal practical authority over municipal doctors’ everyday work.

Designations for city government employees ran from Class 4 (lowest) to Class 1 (highest). Class 4 positions included ancillary and unskilled positions, including sweepers, general ward assistants (untrained in medicine), security guards, and drivers. Class 3 included nurses.

When party B “recognizes” the authority of party A, we mean that party B believes party A has the right to impose duties upon party B or accepts party A’s claim to do so, and also accepts that party B has the duty to obey party A’s directives, even if party B does not agree with the correctness of what party A says (McLaughlin, 2007, p. 54). Party B recognizes that party A bears some “mark” of authority, such as of public office, religious claim, or social station.

Theorists further distinguish de facto authority, de jure authority, and legitimate authority. Since these terms can mean somewhat different things to different theorists, I clarify what I mean by them here by following McLaughlin (2007). I define de facto authority as authority that is “claimed, recognized, and effective,” (p. 59), i.e., where the authority makes a claim to power, its subjects recognize or acknowledge that claim and submit to it or act accordingly towards it, and the authority has the capacity to effect power over subjects (Lancaster, 2002). I define de jure authority as authority claimed, recognized, effective, and also justified on account of a set of principles, frequently legal principles (McLaughlin, 2007, p. 59).
However, neither de facto nor de jure authority may be legitimate from a moral perspective. Some theorists question, for instance, the moral legitimacy of de facto authorities, i.e., whether authorities who claim and exercise authority and whom subjects recognize as authorities should yet be counted as “legitimate” in the moral sense (McLaughlin, 2007, p. 59). Can de jure authorities be counted as morally legitimate if the laws upon which they are founded are morally suspect?

While I recognize these critical questions, for present purposes I do not analyze the moral legitimacy of the authorities I identify in my project. I take the authorities I identify—municipal administrators, local politicians, and popular opinion—to be legitimate to the extent that each claims a right to power (or draws justification for) its authority from laws and rules of democracy in India, and Indian society recognizes these claims as rightful, as evident in actual political participation and democratic practices. I understand the ideal and empirical functioning of authority can diverge, and such divergence raises questions about how authority features in the practical reasoning of subjects.

These questions indicate, among other things, the myriad ways authority and power operate in the social world. If the ideal and empirical functioning of authority can diverge, when or how do we say an authority is legitimate? For instance, Christiano (2012) observes that “most contemporary theorists” describe a state as having authority over subjects if “the state maintains public order and … issues commands and makes rules that are generally obeyed by subjects because many of them … think of it as having authority in the normative sense,” meaning in the sense of a rightful claim to power. For some theorists, it is enough that authority functions in an ideal way “often enough” to justify its claim to power; for others, this does not clarify when is “enough” or who decides when or what is enough (McLaughlin, 2007).

In practice, in some cases, an authority may not be able to exercise its effective capacity, such as a government in exile that is recognized as an authority by its population but is unable to exercise its powers in practice (Raz, 2006, p. 1005-1006). Or an entity that does not claim to be an authority may yet exercise a rightful claim to power in specific situations, such as an adult passerby who stops a child—not his/her own—from recklessly crossing a busy street (McLaughlin, 2013, p. 53-54). The former is an authority that is not effective in practice; the latter is a non-authority that nonetheless exercises rightful effective capacity. They are distinct not only in their real practice and effect in the world, but also in how subjects recognize them. The examples suggest that to explain authority, we need to understand not only how authorities claim and justify authority in practice, but also how subjects recognize authority, how it features in their reasoning (McLaughlin, 2013, p. 54).

Thus, moral and practical concerns both suggest we need to understand how authority operates from the perspective of those subject to it—the perspective of party B—and this vantage motivates my approach in this chapter. I do not inquire into the moral legitimacy of authority. Rather, my approach is to understand the workings of authority (administrators, politicians, popular opinion) from the perspective of its subjects (municipal doctors) in order to explain deficiencies in health care quality, specifically by analyzing municipal doctors’ actions as responses to authoritative directives (and not only instances of doctors’ discretionary power), thus offering insight into the interplay of structural and agential forces in the making of health care quality.

According to McLaughlin (2007), sociological approaches to authority, following Max Weber, have tended to study authority from the perspective of the actor holding or exercising authority, and, from that perspective, to present socio-historical analyses of relations of power (p. 41).

Weber’s conceptualization of legal-rational, traditional, and charismatic authority is an emblematic sociological account of authority (Furedi, 2015; McLaughlin, 2013). Weber’s account of authority “explicitly tied authority to legitimacy,” and following that tie, some researchers have focused on how actors holding authority enact or perform authority, i.e., how they “cultivate” people’s belief in their legitimacy (Anleu & Mack, 2015, p. 1054), and have traced the historical foundations of such legitimacy (Furedi, 2015). McLaughlin (2007) draws on Stephen Lukes’
arguments to make the point that Weber studies claims to power and obedience made by those in command, but does not investigate relations of authority from below.

237 A reason for action “is a consideration that renders its choice intelligible, and counts in its favor” (Raz, 2006, p. 1006). Authoritative directives thus “constitute appeals to the reasoning of its subjects about how to act or which beliefs to accept” (McLaughlin, 2013, p. 54).

238 This describes how authority functions in the ideal. Further theoretical questions concern, for example, the limits of authority: which reasons cannot be trumped or excluded by the content-independent reason for action that authority offers? How can authority be justified? Can we say that authority is legitimate when it actually functions in the ideal way “often enough”?

As discussed previously, I do not debate here the theoretical limits of or justification for authority. That is, I do not critique the legitimacy of the authority of municipal administrators and local politicians over municipal doctors—I take their authority as deriving from their holding public offices, offices established by law in the independent, democratic Indian state. In exercising authority, administrators and politicians do at times abuse power, such as where politicians might support relations of patronage with the urban poor by keeping incompetent employees secure in their jobs. While abuses of power raise questions about the divergence between ideal and empirical functioning of authority, they do not give me cause to question the legitimacy of the authority of the relevant public office. Theorizing and delineating the limits of authority of these public offices is outside the scope of the present chapter.

239 Put another way, whereas “conformity with a directive … means simply doing what the directive requires, … compliance … means that the directive must actually figure in the practical reasoning which leads an individual to do as the directive requires” (Perry, 2013, p. 14).

240 Public providers role as state agents in this regard distinguishes their work from that of private providers. Unlike consumer satisfaction about a private service, to which a private provider may or may not respond, popular opinion about state-provided services carries the force of authority of citizens over the state. For a private provider, ignoring consumer preferences may cost market share. For a state agent, ignoring popular opinion would violate the social contract between citizens and the state. I return to this point later in the chapter.

241 The “long route” lies in institutional channels for citizen participation and “involves broader social and political change” (Molyneux et al, 2012, p. 542; Standing 2004). In contrast, the “short route” comprises specific, immediate strategies such as community monitoring of health care providers (Molyneux et al, 2012, p. 542; Standing 2004). Direct encounters between service providers and communities are another way citizens may potentially voice opinion, and may or may not demand responsiveness from service providers (Gilson, 2003; Berlan & Shiffman, 2012).

Formal mechanisms or strategies for accountability with regard to state-provided health care services are mostly absent in Indian cities, apart from the efforts of a few community-based NGOs who have addressed the cause of health care services for the urban poor. These NGOs have attempted to mobilize communities in low-income urban neighborhoods to collectively discuss local health care needs and engage with local state health care providers to improve services. During my fieldwork, I talked with staff from several such NGOs.

242 To elaborate conclusions of the cited literature: Sheikh and Porter (2011) examine how public and private medical practitioners charged with implementing HIV testing guidelines in selected Indian cities conduct this task. Their findings suggest that despite doctors’ evident flouting guidelines and asserting autonomy in their everyday practice, doctors did not exercise autonomy in the intellectual
dimension of their interactions in the health system and did not articulate, “beyond their circle of immediate peers,” their own perspectives and ‘alternative’ ideas about HIV policy guidelines (Sheikh & Porter, 2011, p. 89).

Mishra (2014) also illustrates the expectations and constraints that confront health system actors in the course of policy implementation. Mishra (2014) examines how community health workers in rural India face both a top-down hierarchical bureaucracy and the imperative, under national health reforms, to meet statistical targets for health system performance. The target-oriented goals undermine community health workers’ qualitative, field-based knowledge as well as their role as liaison between communities and the health system (Mishra, 2014).

Exploring a different kind of balance, Kielmann et al (2014) examine how frontline health workers find their way as they help implement a public-private partnership model for tuberculosis control in an Indian city. The frontline health workers (“tuberculosis health visitors”), who mediate between public health officers, private providers, and patients, are compelled to balance physicians’ relatively greater power and their own personal ethics and commitment to patients. Kielmann et al (2014) show that in a context where health care providers are many, diverse, and largely unregulated, public-private partnerships not only represent an institutional arrangement but also highlight “interactions among a broad range of actors who have different sources of legitimacy, power and willingness to contribute towards a shared goal” (p. 987). In Kielmann et al’s (2014) study, frontline health workers’ experiences illustrate they are “unequal partners” in the public-private tuberculosis control program—their role within a pluralistic health system brings into view differentials in power and levels of trust among actors.

George (2009) similarly illustrates how informal relationships can override formal arrangements for accountability and disciplinary action. In the rural Karnataka district where George (2009) conducts research, administrators and health workers enact formal accountability measures (signing attendance ledgers, recording minutes of disciplinary action taken). But they also negotiate informally amongst each other based on their social relations (pardoning 10 days absence of a junior employee, paying a bribe to obtain a job transfer) in ways that can empower some actors and marginalize others (George, 2009).


244 National policy reforms such as NRHM have affected municipal resources for selected areas of reproductive and child health (MOHFW, 2013a), but these funds are expressly allocated for nurses and doctors designated to implement the RCH program.

245 Soss and colleagues are writing about agents of the U.S. welfare state; their observations concern the narrow discretionary space that frontline agents enjoy in the course of delivering welfare under the rubric of “poverty management.” These are neoliberal formulations of welfare programs instituted through policy devolution, decentralized governance, and “strategies of social control.
applied to lower-level governing authorities as much as to the poor themselves” (Soss, Fording, & Schram, 2011, p. 8).

246 In other words, forms of power are not only held and wielded by individuals or institutional actors (Lukes, 2005; Scott, 1992), but may be “de-faced,” i.e., power can inhere in social identities, exclusions, and systems of laws, norms, and practices that are imbued with meaning (Hayward, 1998). In the latter “de-faced” conception of power, mechanisms of power operate by shaping the field of what is considered possible, legitimate, or normal for all actors, including those considered “powerful” (Hayward, 1998).

247 As Lukes (2005) discusses, power can take multiple forms or dimensions. The first dimension of power concerns observable conflicts and observable decisions—overt ways in which actors exercise power over other actors. The second dimension refers to potential conflicts, to decisions that are not made—overt or covert ways in which some actors may exclude potentially controversial issues from the policy agenda altogether or may restrict the choices that are available to other actors. The third dimension refers to power that inheres in social identities, exclusions, and systems of laws, norms, and practices that are imbued with meaning (Hayward, 1998). Such forms of power can shape people’s perceptions, cognitions, and preferences, effectively disposing people against certain choices.

248 “Popular opinion” is not an agent or actor, of course. The specifiable entity here is more accurately the local community, whose opinion has power over state agents. But public opinion derives its power from the citizen-state relationship, and scholars have focused on the “will of the citizenry” or the opinion of the public in analyzing the workings of state decisions, actions, and legitimacy (Powers & Faden, 2008, p. 182).

249 Authoritative directives are a regular part of the work of municipal primary care, and as such, can constrain or enable the “project” of providing primary care as a state benefit. “Project” is Archer’s (2003) term for human enterprise or purpose, the intentions and plans of action that guide what people do. The causal effects of such constraints and enablements are not determinate, argues Archer (2003, p. 7), but are contingent upon agents’ reflexivity, acuity, and creativity: “Human reflexive deliberations play a crucial role” in mediating between structure and agency (Archer, 2003, p. 14).

These reflexive deliberations are, in other words, a feature of municipal doctors’ subjectivity (Ortner, 2005). Consistent with the tenet that being “subject” to authority does not imply a full surrender of private judgment, Ortner (2005) suggests people have at least partial knowledge of the ways in which they are formed by their circumstances, and can reflect upon (and react against) the structures that make them. My focus in this chapter is on how municipal doctors reflect upon structures of authority.

250 I am not suggesting that all municipal doctors were entirely blameless in this regard. Some doctors themselves contributed to creating and sustaining a low equilibrium of work performance. Not all lower level employees were delinquent in their duties, and most patients did not use political connections. However, what I highlight is that expressions of authority often hindered rather than helped a particular situation.

251 My fieldwork did not reveal explicit instances of municipal doctors’ leveraging political connections, which seemed more common among lower-level employees than among municipal doctors. Municipal doctors could respond in kind, with their own political connections, and some allegedly did. But in general, doctors seemed less connected to local politicians and less willing to cultivate and use such connections than lower-level employees. My objective, however, is not to
document forms of patronage across levels of the municipal bureaucracy, but to illustrate the pressure of political authority upon municipal providers’ performance.

According to news reports, another reason the ICU could not be started was because the municipal health service had not received permission from the controller of explosives in the central ministry of commerce and industries for operation of the ICU’s medical oxygen facility (Isalkar, 2015a). Without the medical oxygen facility, the ICU could not function. Although the system had been installed in 2012, permission from the petroleum and explosive safety agency to operate it arrived only in 2014 (Isalkar, 2015a).

From 1991 to 2011, the number of doctors in the municipal health service increased by about 40%. Over that period, the city’s population grew by 85% (see Graph 3-3). The municipal health service had attempted to circumvent this problem by trying to recruit specialized doctors as consultants rather than payroll employees (Isalkar, 2012). News reports had quoted the chief of the municipal health service as saying that specialists did not find the compensation and prospective experience it offered to be as attractive as in the private sector (TGS News Service, 2015). There were few takers for the jobs, insufficient to begin ICU operations (Isalkar, 2012).

Municipal doctors contrasted politicians’ interventions in the municipal health service with the independence of national public health programs. National health programs utilized the infrastructure of the municipal health service but ran autonomously from it. Municipal doctors in charge of locally implementing such standardized national programs faced little political interference. Since financial resources, technical guidance, and reporting for the programs followed well-developed nation-wide processes, local politicians could not freely influence the local running of the program in the city.

By governance I mean “patterns of rule” or “the activity of ruling,” which include a role for state and non-state actors in the delivery of public services (Bevir, 2009, p. 4). By municipal governance I mean the “activity of ruling” that municipal governments undertake, including their role and capacity to make and enforce rules and to plan and deliver services.

In Mumbai, for instance, the Municipal Corporation of Greater Mumbai is the central governing body, but its jurisdiction and responsibilities overlap with the Mumbai Metropolitan Regional Development Authority (MMRDA), the Maharashtra Housing and Land Development Authority (MHADA), and the Maharashtra State Road Development Corporation (MSRDC) (Ruet & Tawa Lama-Rewal, 2009).

Murthy and Mahin (2016) explain that although India is a federation of states, it remains highly centralized. State governments therefore resist taking actions that would result in their losing power to central or municipal governments. State governments have enjoyed some increase in their powers since the 1990s and are reluctant to cede these powers (see Murthy & Mahin, 2016, p. 110).

Municipal governments depend on state governments for grants-in-aid and loans, and on central governments for funds for national development programs, among other sources of municipal finance (Ruet & Tawa Lama-Rewal, 2009).

One example of strong state-level oversight lies in the structure of municipal government and its decision-making positions. The executive head of municipal government is a nominal, technical post held by the city mayor. The most powerful official in most cities is the municipal commissioner, who
is a state government-appointed civil servant from the Indian Administrative Service—a bureaucrat, not a locally elected official (Weinstein, Sami, & Shatkin, 2014).

Ward committees may comprise several administrative wards grouped together (Baud & Nainan, 2008).

In defining “informality,” Roy (2009c) observes that urban planning in India is marked not by legal bounds and formal regulations, but by a flexible, unstable “relationship between the published plan and unmapped territory” (p. 81). Informality refers to a flexible stance of the state, which the state “actively utilize(s) … as an instrument of both accumulation and authority” (Roy, 2009c, p. 81). Yet this flexibility poses a challenge for the state: it can make governance impossible and “paralyze the developmentalism of the state in myriad Lilliputian negotiations” (p. 81), meaning the state’s many negotiations with actors across the income spectrum. Roy (2009c) argues that “The Indian city is made possible through an idiom of planning whose key feature is informality, and yet this idiom creates a certain territorial impossibility of governance, justice, and development” (p. 81). For example, the state might allocate monopoly land rights to private developers and also allow squatters to establish territorial claims on public land. The expansion of Bangalore’s airport road was in similar ways mired in conflicting land claims (Roy, 2009c).

Weinstein (2009) refers specifically to the politically important large, high profile slum Dharavi in Mumbai, but the point applies broadly to urban politics in India. She additionally notes that the state’s engagement with political society is intertwined with its efforts to “court international investment and undertake the type of developments believed to bolster the desirability of Mumbai as a world-class city” (p. 419). In the 1970s and 1980s, development schemes in Dharavi were financed by either state funds or World Bank loans and were implemented by state agents; project delays were anticipated and not “actively avoided” (Weinstein, 2009, p. 419). The Dharavi development project that she examines was formulated in the mid-2000s and includes domestic and foreign developers. In recent years, the forces of global capital, which are fickle, speculative, volatile, and opportunistic, have made it urgent for the project developers and supporting state actors to avoid delays and negative publicity to reduce the risks of capital flight. To do so, they have “engaged with Dharavi’s political society to subdue opposition before or immediately once it arose. Amid the bourgeois revolution that Chatterjee and others have shown has diminished the state’s interest to work with these groups, pressures for private and globally oriented development have also created the conditions for deeper engagement” (Weinstein, 2009, p. 419).

Weinstein (2009) explains that, in India’s cities, the state has had to engage with the urban poor not only to respond to the “moral assertions of popular demands” (Chatterjee, 2004), but also to “co-opt” disadvantaged groups who would resist mega urban projects (Weinstein, 2009, p. 403). The state has tried, that is, to by create space for various affected groups in the development process, and the role of local politicians remains important in those negotiations (Weinstein, 2009). Such evidence suggests that outside of or absent such mega projects, local politicians’ engagements with the poor would entail enacting piecemeal improvements and dispensing individual services.

Unless elected officials deemed an issue a priority and marshaled agreement within these meetings to bring it to light, municipal government would apparently neglect the issue. The NGO manager informed me that in Pune, many local politicians invested a great deal of energy in “handing over the reins of municipal health care services to the private sector.” Some politicians did try to resist this. For instance, one politician had tabled the matter of the impending privatization of a municipal hospital at a general body meeting. But the privatization discussion was scheduled on the same day as discussion about a major new city road worth Rs 50 million (roughly US$ 830,000). Assembled
members of the general body postponed the debate about health care privatization, as they had several times before. One elected official who wanted to advocate against privatization “got fed up” with the issue being pushed over and went to court to contest the case, said the NGO manager.

That particular hospital was eventually not privatized, but according to one local politician I met, the municipal government had contracted four municipal hospitals to private entities, with terms specifying that poor patients would receive discounts at these for-profit facilities. Ensuring the poor enjoy equitable access to such public-private ventures involving private hospitals remains a challenge in Pune and across India (Dror & Vellakkal, 2012).

He explained that, “Health care has gone from being in the public sector to being in the private sector.” There were people who could afford to pay, they had the income or insurance, and they used the private sector. And there were those who belonged to low- and middle-income groups, who also went to the private sector, but they usually had no insurance cover and “they get milked,” he said.

The politician’s remarks were not unfounded. The journalist P. Sainath has written scathingly of food policy in India. According to Sainath (2001), “The Public Distribution System (PDS) was not just buried by inefficient officers. It has wilted under policies clearly aimed at dismantling it.”

Institutions for community participation in municipal governance, specifically to discuss state-provided health care services, are limited in Indian cities. Community-based NGOs in some cities provide a few opportunities for communities in specific neighborhoods within a city to gather together to deliberate local health care needs (e.g., Subbaraman et al, 2014; More et al, 2013; Prost et al, 2013; Agarwal et al, 2008). In my fieldwork, I spoke with staff from several such NGOs with experience in Pune, Mumbai, New Delhi, and Indore. Where such NGOs operate, public health care workers may encounter popular opinion about their work through NGO-coordinated meetings with community members. Absent these channels, the only way public sector health care workers would encounter voices of “the people” in most cases would be through medical interactions in clinics and hospitals.

Security guards in the municipal health service were not muscled or trained men or women. The position required minimal educational qualifications and no previous skills. The municipal government provided no skills training. The position was largely to ‘mind’ the crowds.

People behaved badly in private facilities too, Dr Biren added. Yet the examples Dr Biren provided of such behavior in private facilities—refusing to pay doctors in full and vandalizing premises if doctors insisted on getting paid—suggested that patients were responding to alternate sources of frustration. In private facilities, patients were reacting to unexpected or high cost of health care. In state-run facilities, while patients’ frustration was certainly related to the inadequacies and inconveniences of public sector facilities, people were also “venting,” as Dr Manisha put it, their grievances against “everything that has gone wrong in their lives.” Municipal doctors were easy targets for this anger—they were more accessible than private doctors, since people had to pay to visit the latter.

I do not wish to suggest that municipal doctors’ behavior was impeccable. Some doctors, even when well-intentioned as Dr Nina, could at times be short and paternalistic with patients. Studies already document the unsavory behavior of public sector doctors (and other state workers) towards the poor in India (Tharu, 2010; Kutty, 2010; Mishra & Chatterjee, 2013), attitudes that are steeped in inequities of class, caste, religion, and gender. Notwithstanding their attempts to serve communities, municipal doctors did at times commit those same transgressions against the poor. What I wish to highlight here is the experience of medical encounters from the perspective of municipal doctors.
Leonard et al (2013) conclude that creating and maintaining such signals of commitment to quality is costly for organizations. Empirically, finding examples of such organizations is likely only in settings where “pre-existing ‘other-regarding’/altruistic values” towards communities prevail (Leonard et al, 2013, p. 78). In LMICs, given the “pervasiveness of patronage” and weak management capacity, such organizations are difficult to find (Leonard et al, 2013, p. 78).

Doctors’ “responsiveness” reflects the extent to which health care provision is “organized around the person, not the disease or the financing” of health care services (WHO, 2010, p. 3). As I discuss in Chapter 5 on service, doctors’ responsiveness reflects how they understand of their mandate and their ability and capacity to address the social circumstances of patients’ lives. Responding to patients’ needs and expectations should ideally include considering and addressing how social factors—such as age, gender, occupation, income, social support, and housing situation—affect a person’s health and might impede his or her recovery. Responsiveness can potentially, if not driven and overseen by other standard measures of performance, collapse to simply mean giving people what they want without regard to the rationality, efficacy, ethics, and safety of treatment.

India’s PDS is one of the largest distribution networks of its kind globally, possibly the largest, say Balani (2013) and Jenkins and Goetz (2002). The term “ration” derives from its historical beginnings: the PDS began in colonial India on the eve of World War II as a measure to distribute a fixed or rationed quantity of food grain to entitled families, who were and still are designated “ration card holders” (Mooij, 1998). Ration card-holders (eligible households) can purchase specified quantities of food grains (mainly rice and wheat) and other essential commodities (such as edible oils and cooking fuel) at subsidized prices from ration shops. While the PDS was initially a nominally universal scheme, the central government reformed it in the 1990s, and, in 1997, launched the Targeted Public Distribution System (TPDS). Central and state-level governments “share the responsibilities of identifying the poor, procuring grains and delivering food grains to beneficiaries” (Balani, 2013, p. 2). The National Food Security Act of 2013 relies largely on the TPDS to deliver food grains as legal entitlements to poor households, which the poor claim at ration shops (Balani, 2013).

Recent reviews find continuing problems, including leakage of food grains “during transportation to and from ration shops into the open market” (Balani, 2013, p. 12).

The 16 participants in De Costa, Johansson, and Diwan’s (2008) study included “senior bureaucrats of the Indian Administrative Service (IAS; India’s premier civil service) who were associated with the public health sector, directors/joint directors in the public health sector, and representatives of private practitioner associations/institutions” (p. 757).

In that study, public providers in Chennai considered their services to be an equivalent but cheaper alternative to expensive private services (Ergler et al, 2011).

As noted above, while expressions of popular opinion do not oblige municipal doctors to act, they do nonetheless enter into municipal doctors’ reasoning and indirectly shape their actions.

It also shows how providers are constrained to voice their concerns in administrative processes or have their opinions and knowledge counted in policy decisions, leaving them unable to exercise “positive” power (Sheikh & Porter, 2011; Baru, 2005, 2009; George, 2009; Mishra, 2014).

Bureaucratic “discretion” implies the independence or space provided (by authorities) to frontline agents to make decisions or follow courses of action to implement a specific mandate. If agents flout...
that mandate altogether, this is not an exercise of discretion but a subversion of authority or the failure of authoritative entities to enforce that mandate.

280 That is, whereas most studies of power in health systems have explored power relations as they play out under a particular health policy or program, my approach examines authority without novel sources of power “that a new policy might bring” (Gilson, Schneider, & Orgill, 2014, p. iii62).

281 As Harriss (2007) explains, a key theme that animates “governance in the context of liberalization” is that of citizen empowerment (p. 2716). Empowerment refers to expanding the “capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives,” notes Harriss (2007), quoting from a World Bank (2002) report. Those who are thus empowered are “the desirable subjects of a liberal market economy.”

282 See http://www.smartcitieschallenge.in/

283 Apart from the obvious fact of my ease with English and affiliation with a US university, other factors created the impression of high socioeconomic status. For instance, my last name indicated I did not belong to a disadvantaged caste. People asked if I was married and had children, and the conversation sometimes revealed that my husband was not Indian but white and American.

284 This was an entirely anticipated challenge of fieldwork. Of course, doctors had no reason to be nervous. I never disclosed what I had learned through conversations with other people.

285 Weber wrote: “In principle a system of rationally debatable ‘reasons’ stands behind every act of bureaucratic administration, namely, either subsumption under norms, or a weighing of ends and means … If, however, an ‘ethos’ – not to speak of other impulses – takes hold of the masses on some individual question, its postulates of substantive justice, oriented toward some concrete instance and person, will unavoidably collide with the formalism and the rule-bound and cool ‘matter-of-factness’ of bureaucratic administration. Emotions must in that case reject what reason demands” (Weber, Roth, & Wittich, 1978, p. 979-980).
References


Bennett, S., Akua Agyepong, I., Sheikh, K., Hanson, K., Ssengooba, F., & Gilson, L. (2011). Building the field of health policy and systems research: an agenda for action. PLoS Medicine, 8(8), 1023.


Duggal, R. (2011). The retreat of the state in healthcare policy and the right to the city. In M.-H. Zérah, V. Dupont, & S. Tawa Lama-Rewal (Eds.), *Urban policies and the right to the city in India* (pp. 133–142). New Delhi: UNESCO.


Gilson, L., Hanson, K., Sheikh, K., Akua Agyepong, I., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: social science matters. *PLoS Medicine, 8*(8),


institutions and culture affect health (pp. 1–22). Cambridge University Press.


Herrera, C., Rada, G., Kuhn-Barrientos, L., & Barrios, X. (2014). Does ownership matter? An overview of systematic reviews of the performance of private for-profit, private not-for-
https://doi.org/10.1371/journal.pone.0093456


Isalkar, U. (2012). 17 civic hospitals, but not one has permanent gynaecologist. *Times of India*.


MOHFW. (2006). No. V.11025/13/2004-ME(P-I): DNB qualification awarded by the National Board of Examinations - Equivalence of Board’s qualification for appointment as teachers.


OSMECON. (2014). *OSMECON-2014 Undergraduate Medical Conference - DNB and MD/MS Differences*


473


Sivaramakrishnan, K. C. (2013c, May 1). The devolution deficit: Why we need to revisit the 74th amendment. *The Indian Express.*


and patients’ views of Delhi’s public health services. New Delhi: Collaboration of Hospital Employees Union, Jobs with Justice, and Society for Labour and Development.


UNFPA, & HelpAge International. (2012). Ageing in the Twenty-First Century: A Celebration and A


