Episode 8: Health Governance in India's National Capital – Delhi

TRANSCRIPTION

Speakers:

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Vivek Divan:

This is Status of States where we explore health and healthcare across India's diverse regions with a particular focus on policy, programs and ground realities. The Indian Constitution lists public health as the responsibility of states. Join us as we speak with health experts from different states, understanding the unique contexts, challenges and innovations shaping public health.

I'm Vivek Divan, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy at the Indian Law Society in Pune. Let's dive right in.

Today we're going to journey to a unique state in India, a city state, being the national capital territory of Delhi. Do note that this episode was recorded before the recent state elections. Joining us is Dr. Rajib Dasgupta, an eminent epidemiologist and public health expert. He is currently Professor and Chairperson at JNU's Center of Social Medicine & Community Health and previously served as an epidemiologist with the Municipal Corporation of Delhi.

Dr. Dasgupta has been a Fulbright Senior Research Fellow at Johns Hopkins Bloomberg School of Public Health and an Erasmus+ Fellow at WHO's Collaborating Centre for Health in All Policies. His current research focuses on One Health and Climate Change, and he serves in advisory capacity in national health policy and programme bodies including the Indian Council of Medical Research, and the National Health Mission. He is also Editor of the Indian Journal of Public Health, and handled key responsibilities related to COVID-19 media and communications and is a regular commentator on public health matters.

Glad to have you on our podcast Rajib. So before we get into the issues of health it would be great if you could tell us a little bit about the governance structure of Delhi given its unique nature, because I think its governance structures would have a significant impact on how health is delivered to the people.

Dr. Rajib Dasgupta:

Thank you very much. As you said, Delhi is a city state. At the same time, it's pretty large in terms of its population. Officially, this is the National Capital Territory of Delhi, NCTD, in view of its Act, under which the Delhi Assembly functions. Historically, the Delhi Assembly had been there at some point in time in history, but it wasn't really functional for a long time. And then it resumes in 1993 with the state elections and subsequently has had state governments of multiple parties. This is to be understood in distinction with the National Capital Region, which is an agglomeration of Delhi and certain districts of the adjoining states, Uttar Pradesh, and Haryana, and Rajasthan.

The relevance for NCR (National Capital Region) is that a lot of people work and travel between and across these districts and states. And as far as health goes, Delhi certainly attracts quite a bit of population from the national capital region. But the adjoining areas such as Noida, Gurgaon as cities in their own rights have their own health institutions as well, particularly of the more private corporate sort. I hope that gives an overview of the things.

Vivek Divan:

Okay, I think that's a very informative overview. However, there is another aspect to this which is the fact that the union government is also located within Delhi and responsibilities are divided between what the union government actually is in charge of in the NCTD and what the state government's responsibilities are.

For instance, the police come under the union government's ambit. But are there any other aspects, given this kind of complexity, which impact health governance?

Dr. Rajib Dasgupta:

So, what I explained was the distinction between NCT and NCR. Now to understand the governance structure of Delhi or the city state, it's got the union government, which is relevant not just because it's the seat of the union government, but also because certain domains such as law and order, land use, etc. are still under the jurisdiction of the union government. And then we have the state government with an elected assembly. Plus, there are three local bodies: the Municipal Corporation of Delhi, which is the largest, the New Delhi Municipal Committee, which roughly corresponds to what we would understand as New Delhi, which is the seat of the Union Government of India, and the Delhi Cantonment Board, which administers the military areas, as the name suggests. So, as far as health services go, these are the three or four major players. Plus, you have other very specific providers such as the railways, such as the ESI (Employees' State Insurance) Corporation and so on, which would also understandably be reflected in health governance structures of other states, but because there is a relatively larger proportion of central government or central agencies, and their staff including dependents in the NCT or in the NCR, these are also significant players but within their own specific domains. So to restate, major public providers are the union government, the state government, as well as the three local bodies.

Another basic distinction to remember, and this is a bit in contrast with the other states, is what we understand by public health functions, as distinct from clinical facilities, by the very nature of the municipal acts, are generally vested with the municipal bodies. However, increasingly the government of Delhi has also taken its share of public health functions, and to that extent there are some overlaps, there can be some conflicts and there can be some strengthening too. As can be guessed, it would be a mix of all things, but essentially in terms of the municipal Acts the public health functions, and particularly some of the sections of these Acts, are very specifically in connection to the respective local bodies and their jurisdiction.

Vivek Divan:

And when you refer to local bodies, you mean?

Dr. Rajib Dasgupta:

So the three local bodies are the Municipal Corporation of Delhi, which is the largest body, which governs about 90% of the population and approximately 85% of the land area, and the two other municipal bodies are the New Delhi Municipal Committee, which is 'New Delhi' the seat of the union capital, which is a small area which is highly planned and well endowed in

terms of budgets. That's approximately 5% of the population. And the Delhi Cantonment Board, which governs the military cantonment areas, that's approximately another 5% of the population, but given that it's a cantonment board, it has certain other mandates and privileges.

Vivek Divan:

Sure, this is extremely useful Rajib. It makes me wonder, considering that we were just at that time of the year where air quality in Delhi is particularly problematic, and both for the residents and people who watch from the outside it is bewildering that why we are not able to find solutions and we constantly see the passing of the buck on responsibilities etc.

So could you tell us in light of what you've just said, for issues around air quality, issues around sanitation, and generally issues related to social determinants of health, who is responsible for delivering on those?

Dr. Rajib Dasgupta:

Since you raise the social determinants issues, again the reality is that the social determinants scenario is very fragmented. So for example, the solid waste collection and disposal is with the municipal bodies. Water supply, which used to be with the municipal bodies, became in the 1990s first an autonomous undertaking and then a full department of the Delhi government. In fact, if you go back to the Municipal Corporation of Delhi Act in the 1950s, services such as fire and the Delhi Transport Corporation were also under the ambit of the municipal services. Similarly, liquid waste and its disposal is also with the Delhi Jal Board, which manages both water supply as well as liquid waste collection and disposal. There are other entities also such as the UP Irrigation Department who has canals within the administrative jurisdiction of Delhi. Similarly, the water supply is drawn both from canals of the Haryana Irrigation Department, which in turn draws upon the Yamuna River system. As well as Uttar Pradesh and the Ganga river system. So, water itself again is a pretty, if I may say, a national contribution as far as water consumption in Delhi goes. All of this also falls short of the actual demand. And therefore there is rampant drawing of groundwater, which is partly regulated and partly unregulated.

As far as air pollution goes, the fact is that, I mean, as we all know, It's a challenge for the entire northern India, even extending to Pakistan and to the east often as far as Guwahati. However, on a lighter note, it's air pollution in Delhi that makes news. The air pollution management plan, as one knows, probably from the media discourse, actually involves multiple agencies which are graded into 1,2,3 and 4 stages and across these different stages as maybe operational from time to time. Currently, it's level 2, but it could change to 3 or 4 even if the current quality worsens. It again is a multi agency responsibility and a multi agency effort.

So most of these services when it comes to impact, it's one thing that who provides water, but when it comes to impact, such as the waterborne diseases or vector borne diseases, it's actually a multi agency response and collaboration that's both essential as well as functional. I hope that answers the question.

Vivek Divan:

Well it certainly clarifies a lot of things, but obviously the solutions then are complex to find, given that there's a multilateralism that's going to be involved in attempting to resolve some of this stuff.

In this context, I'm also wondering if solutions have been offered to a more streamlined, governance model around some of what you've raised, especially the social determinants of health issues? Or are we still in a place where the complexity persists and really no effort at trying to find more practical ways in which to govern?

Dr. Rajib Dasgupta:

As we all know, and hopefully can agree quickly, that air pollution or managing air pollution or mitigating is a far more complex issue than some of the other public health challenges. But to give you certain positive examples, let's take, for example, the water and vector borne diseases.

In 1988, as some may recollect, there was a major cholera epidemic in Delhi, without going into its reasons at this point, we may discuss that later. This led to a fair amount of sensitization of local governments on the issue of waterborne diseases. And in fact, it wouldn't be incorrect to say that it did acquire a political connotation, and I say this in a positive way, in a positive sense, because it brought waterborne diseases into the reckoning of the political systems, not just the health administration.

So with the first elected government or rather the Delhi Assembly, and the elected health minister in 1993, we talk of political will, and here is an example of political will. So a multi agency coordination mechanism was set up and chaired weekly during the vulnerable months, which is roughly six months in a year, to monitor weekly both waterborne and vector borne diseases. This actually meant nearly 20 agencies, not just from Delhi, as I said, it includes the irrigation departments of the adjacent states, landowning agencies such as the Delhi Development Authority, the railways, because, for example, the lands along the railway lines are also breeding ground for mosquitoes. So this is a multi agency body which straddles across states, across levels, and so on. But being led by the health minister himself it accorded a different kind of importance. And gradually though this was not felt initially, gradually, some of these bodies, and very specifically, say, the health and the sanitation and the water, which are more directly linked, actually started developing more horizontal linkages. And I'll just digress a bit, but that's relevant here because the Delhi government has its own political administrative divisions, which are called districts and then subdivisions. And this is like the nomenclature is like any other state. And similarly, the Municipal Corporation of Delhi has its own zones which are subdivided into wards as with any municipal body.

Often and understandably so, these political and administrative boundaries often do not coincide. So there's a lot of inter agency collaboration and conversation required at the sub district levels or sub zone levels also. So more organic, horizontal connections developed, and that was simply because the mandate at the highest level was set up by the health minister.

The other thing to remember is that, when the first government changed, I mean, when the second government came in, the ruling party changed, but the practice didn't. And that to me is a very, very significant lesson that interagency collaborations can be put together, and I give the credit to the manner in which the two health ministers, with whom I've worked very closely during those tenures, the way they have handled it, it wasn't really handled in a very top down or in a very authoritarian manner. But the fact that the ministers and the top administrators made it very clear that we are sitting around the table and we need each other and we need to collaborate with each other. So, these things take time to develop and a lot of effort to sustain also.

So the model exists, now whether it can be applied in all cases or not, whether everything should require the health minister to coordinate or not, these are questions that we may debate, but this interagency collaboration is certainly possible and demonstrated.

Vivek Divan:

Right, so it is clearly demonstrated, but it's not emulated since that time. Is that correct understanding?

Dr. Rajib Dasgupta:

Well, the honest answer is I'm a little out of the state activities now, so it wouldn't be fair to comment. But I do understand that for water and vector borne diseases, these interagency linkages exist and they have been institutionalized for a fair bit.

The important thing is how well can those be institutionalized rather than be led simply by political will, which has a demonstration effect. I think the journey to be made is from the demonstration effect to actually institutionalizing it.

Vivek Divan:

Absolutely. I think you're absolutely right in that institutionalizing it is critical. I'm wondering, did that sort of an experience, was that leaned on in any way during the COVID challenge?

Dr. Rajib Dasgupta:

COVID is an outlier, in many ways. COVID can't be compared to cholera, not because of the, I mean, the nature of the disease, but simply because COVID as a pandemic meant people rallying around the flag. Now whether that flag was a union flag or a state flag, everyone rallied around the flag. So it's not directly comparable. But the fact is, COVID was a very different situation because we were dealing with a new disease. We were putting in new infrastructure. So much was unknown so much got known almost overnight and then what got known that also changed and given that this was a pandemic, the union government's role or the central role was far stronger. The fact that the National Disaster Management Act was invoked also meant a certain framework put in one may debate about the positives and negatives of it. But given as things were, there was a lot of rallying around the flag and, and a lot better coordination and that sort of coordination in a crisis management setting is not the same in terms of dynamics as endemic conditions such as air pollution or waterborne diseases or vector borne diseases go

Vivek Divan:

Quite so. I think quite a different situation, but I think there's something to be said about inter agency, inter ministerial kind of efforts which have benefits despite the nature of the challenge being somewhat different.

Could I just pivot a little bit now to your reflections on how you think the state of health in the National Capital Territory is and by that I mean, generally speaking, you've spoken, of course, a little bit about, the social determinants of health, but I'm wondering, do you think that this model of governance has lent itself to better handling of healthcare, generally speaking also, apart from the social determinants of health and what would you say are the positives that we can see in the governance of health in Delhi?

Dr. Rajib Dasgupta:

If I interpret your question correctly, the state of governance of health, whether it's medical/ clinical services or public health programs, including social determinants, given the very structure that we have depends on a very robust measure of federalism and federal spirit.

The first two state governments that I speak of were not necessarily ‘double engine times’ but it didn't really matter, or at least, I haven't seen it to matter for the simple reason that the state health minister took the onus and put his best foot forward again across parties. This has got nothing to do with parties. And similarly, the municipal body, just like the municipal bodies of Bombay or Chennai, are pretty large bodies, pretty complex bodies in terms of its political organization, in terms of its administrative responsibilities, mandates, budgets. So the political arm of the municipal body is also a force to reckon with.

Now, if these three levels, or primarily these three levels, the union and the state and the local, after all, everybody is jostling within this 1,500 odd square kilometers of space. If these three levels do not have a healthy approach and a healthy practice of federalism, it would take a toll whether on health or urban planning or transport or law and order, just name it. That's an added responsibility. It's not that federalism is unimportant for any state, but because it's so directly linked to almost every service, and therefore, it touches almost every life. I don't think perhaps, federalism, or the nature of federalism, affects every life in a manner in which it in Delhi it does or certainly has the potential to.

Vivek Divan:

That's very interesting. As you just said, the way federalism and its discontents play out in Delhi is probably more acutely felt there, than elsewhere. I’m also drawing links with a case that I have been peripherally involved with recently, a Delhi High Court suo moto case on emergency care services in government hospitals. In 2017 a perturbed court took this up on the basis of newspaper reports and the case is ongoing, being monitored by the court. I'm wondering if the issue of federalism has a role to play in actually how healthcare through tertiary government hospitals in Delhi is impacted or not.

While following the case we have realized that there are certainly challenges with resources being allocated, infrastructural or human, to ensure good governance of these hospitals. Do

you see federalism playing a role there or is this just a question of prioritizing healthcare in a certain way or not?

Dr. Rajib Dasgupta:

Let me take upon your example of hospital or clinical care, if I may put it in a generic manner. Consider any person, you or me, falling ill, the obvious response possibly in most cases, particularly if it starts with a relatively mild illness, let's say, and assuming one is accessing public care systems, would probably go to our nearest health outpost, which could be, and watch how these categories change and shift, which could either be a Delhi government dispensary, it could either be a municipal corporation dispensary, or it could be a Delhi government Mohalla clinic, the much wanted model. So, it could be any of these three. You would need, let's say, more diagnostics, a higher level of care. You would be referred to a higher level institution, which again, can be a municipal hospital, a smaller one or a higher level. It could be a Delhi government one. It could also be a union government facility, and certainly if you require higher levels of surgery or any other clinical intervention, you would probably end up with a medical college setting, which again could belong to any of these three agencies. Municipal Corporation Delhi now has one medical college.

So you are constantly straddling across agencies, across levels. And therefore, what we in our jargon call continuum of care meets its toughest challenge here. and, and there are many dimensions of continuum of care. It's what's called relational continuity, informational continuity. Anyway, without getting into the jargon. The point is that if an individual were to straddle across systems, therefore, there has to be a healthy coordination. There may be coordination mechanisms like the one I spoke of, put in response to the politicization of the cholera epidemic, and therefore, it called for a political response.

Those health ministers were products of grassroots Delhi politics, both of them were doctors, they were also products of grassroots Delhi medical politics. But those could more be exceptions rather than rules. There aren't any mechanisms that make care seamless, if I may or at the very least, less burdensome, forget seamless, across these levels of care and agencies.

This could be anything such as a fever, which gets complicated, or if you talk of a specific disease such as tuberculosis, which has a national health program, again, there are multiple levels and all of these agencies do touch an individual illness episode for any man, woman, or child, potentially. I hope that exemplifies some of what we are discussing.

Vivek Divan:

It certainly does, but it makes me wonder if there are these challenges, what possibly could be two or three solutions, measures taken to actually resolve some of this, because clearly, this is a very complex kind of context in which we're speaking. Just to add to that question, is it something to do with allocation of resources?

Dr. Rajib Dasgupta:

Allocation of resources, in fact, it's often the starting point of some of these conflicts. If I go bottom up, the municipal corporation of Delhi's wage bill for health is certainly larger than its entire tax collection.

So it depends upon the budgetary allocation from the state level and this gap has actually increased over years and with budgetary allocation from the state level comes other forms of governance requirements and challenges. The union government is almost as a rule limited to clinical care and that too tertiary care. It funds and runs the very large medical, teaching institutions, which also provides care not just to the citizens of Delhi, but from the adjoining states or even maybe from the far flung states. But even Delhi government and municipal clinical facilities, particularly the bigger hospitals or specialized institutions such as pediatric care, the rule of the thumb is that anything between 10, 20, or even on the occasion up to 30% of the beneficiaries could be from outside the state, from the national capital region. So budgetary constraints remain, conflicts around budgetary allocation and its administration remain. But to go back to your original question, and budget is just one facet of that, in general, health services is a very, very complex entity. There is a reasonably streamlined machinery in an ‘average state’ where the centrally sponsored programs are few and specific. And those are very structured in a sense, both in terms of governance, reporting, data, logistics, supply logistics, etc. And you can essentially walk into any of the institutions.

An individual is constantly straddling across these institutions and there is no coordinated mechanism to make this referral and continuum streamlined or smooth. Of course, one can argue and expect that with the new models of health insurance such as Ayushman Bharat, etc. this could get streamlined to a certain extent. But these insurance schemes bring their own operational challenges, and therefore, who you access, where you access, and how you access, those issues crop up and they're a slightly different breed of problems from what we are discussing so far.

Vivek Divan:

It sounds to me like there are several challenges and require really, you know, multiple levels of solution and multiple aspects to be addressed. In that context, you mentioned insurance just now and I've been looking at the issue of universal health coverage or universal health care as something which is aspirational and frankly a commitment that governments have signed up to. India attempts to address it through Ayushman at the union level and then state governments have their respective health schemes.

Do you see insurance being a mechanism through which universality can be achieved? Have you seen it play out in any particular ways? You mentioned that it comes with a unique set of challenges, the insurance packages that are offered. Have they alleviated some of the problems people have, for instance, around out of pocket expenditure especially, people who are accessing healthcare, obviously, in this context in Delhi?

Dr. Rajib Dasgupta:

Well, without delving into the merits or demerits of publicly funded insurance as a whole, that would be a different area of conversation. But what it's meant for Delhi is that Delhi had set

up this Delhi Aarogya Khosh, which was also a pretty similar insurance scheme and then comes Ayushman Bharat scheme. Two states, in fact, Delhi and West Bengal, have steadfastly argued that their own schemes are better. Now, there have been a diversity of experiences as far as very similar packages promoted by the state government. By state government, I mean, different states of India at different points in time, as well as the central schemes have and each has its own evaluation reports and records and perceptions and so on.

But to come back to the Delhi issue, the Delhi Aarogya kosh, what the Delhi state government claims to be much more comprehensive. Now it's essentially my comprehensiveness versus your comprehensiveness. So the Delhi Aarogya Kosha is argued by the Delhi state government to be more comprehensive, to have less exclusions than the Ayushman Bharat and that's the reason or claim, on which the Delhi government has steadfastly so far refused to take up the national scheme and carry on with its own scheme. However, the matter then enters the arena of the courts and the High Court really questions the wisdom of it, and this is an issue still in flux. It is still an unresolved issue. But one way of arguing could be that if any state has access to central resources, vis a vis a certain scheme, why not take it up etc.

But there are states, as I said in this case Delhi and West Bengal which have sort of put its foot down to argue that ours is better, more comprehensive, more sensitive, more inclusive. On one hand it could be a matter of program evaluation and so on. The other is that the state governments have chosen to take a certain stance and obviously that the matter, the acrimony that's been witnessed in the arguments of both sides in the court, also some of the observations of the court, the Delhi High Court actually expressed shock under inverted commas. It shows that very clearly, one doesn't need only this to demonstrate that federalism or the federal spirit is certainly under strain. This is something that shouldn't really have to be a matter for the courts to deliberate or adjudicate. So clearly federalism or the federal spirit is certainly at a strain here. And to me, in my experience of both working and living here, working with the state governance structures, if the federal spirit comes under strain, it's going to make things difficult in many sectors and certainly health.

Vivek Divan:

Great points, Rajib. I think that's, eye opener also, again, in the Delhi context specifically, of course, but could I ask you, well a related question certainly, which is the issue of privatization. What role does privatization play in people seeking healthcare services in Delhi? By that I mean, do most people go to private hospitals? Are some of them empanelled, for instance, in the Delhi Aarogya Khosh scheme, or are they not? Is then out of pocket expenditure the norm that people have to endure? And also, you mentioned the courts just now and the contestation going on in the courts, but I'm also as a lawyer wondering, do you see the law playing a certain role in ensuring the right to health is delivered?

One of the questions that has been, you know, in the conversation over the last few years has been how the private sector is or is not governed through the law, especially in relation to health. You have the Clinical Establishments Act in a few states, but not in many others.

Does that require some sort of a framework for accountability, transparency, and other issues to be fully addressed? I've raised a few issues here, but any thoughts on that?

Dr. Rajib Dasgupta:

That's a lot of questions. Let me try and address these as far as I can.

One, of course, Delhi has a very large and a very heterogeneous private sector, as can be imagined, a pretty significant proportion of Delhi's population are in low income settlements. What must be also put on record is that once the Delhi state government came into being in its current phase, 1993-94 onwards, the state government has certainly, all state governments, successive state governments, have made very specific and distinct measures to reach out to low income populations, to reach out to more peripheral geographies of the city. The city state also has 170 - 180 odd villages, many of them 'rural', but of course they're all peri-urban. Many would gradually be or already are connected by the metro network and so on. But they still retain rural structures, rural social norms and so on. The successive Delhi governments have certainly made efforts and, in terms of institutions, in terms of outreach to reach out to margins of various kinds. What it also means is that these relatively low income settlements also have a plethora of private providers, formal, informal, etc. There are also many small unregulated institutions, as well as very large, high end corporate institutions.

The Clinical Establishment Act is under the jurisdiction of the state government. And, it has its own apparatus to implement and monitor that. Many of these licensed institutions, private institutions from the regulated part, are certainly part of the central government health service scheme, which is also a pretty large scheme given the very large body of central government employees here. They are also empanelled with the Delhi Arogya kosh, which is also increasingly roping in private providers. Also, there's a provision of transferring patients from those who are admitted in Delhi government hospitals to private institutions, should you require a certain component of care, which is not available there.

So in principle, it could be a pretty sensitive and inclusive system. Of course, all empanelment, all insurance which ropes in the private provider does come with its own pitfalls, its own challenges, and therefore periodic evaluations, feedback mechanisms, grievance redressal mechanisms, all the usual measures that we know really need to be robust for the inclusion of private institutions to be more meaningful and to help address the needs, the problems and the backlogs.

Vivek Divan:

The way you have described the complexity within which Delhi is placed, really brings to the fore the challenges that there would be with governance and accountability issues and the many ways in which health is delivered.

I want to move now towards something which has been lauded in the past, the Mohalla Clinics, which you mentioned earlier in the conversation, if you could throw some more light on. Now, this is focused on primary healthcare, which is something that often doesn't get enough attention. Especially in conversations we've had on the status of health in other states on this podcast, we have seen that primary health care doesn't get the sort of

attention that it should. The Mohalla clinic was attempted as a method to localize healthcare at a primary level. It was praised at one time. It would be great to know what your assessment of that effort has been and if that is a positive model for emulation.

Dr. Rajib Dasgupta:

The Mohalla Clinic like any other initiatives comes with its pluses and minuses. So, on the plus side, as you very rightly said, it did attempt to, in some senses, hyper localize primary care in terms of its outreach, in terms of selecting where to set up the Mohalla Clinic. Many a times government institutions can only be set up where you find land or a building and so on. To that extent, the Mohalla Clinic prioritized the area first, and then it would seek out rented premises, it could run out of a porter cabin, and so on and so forth. So it demonstrates a great measure of flexibility in many of the conventional wisdoms of government and governance. Wherever it was set up, it certainly delivered meaningful services in terms of routine and daily medical needs. It did bring in, in most cases, an assured supply of medicines, a fair range of diagnostics.

What unfortunately has happened is that it's really suffered from governance deficits, which is a little strange in the sense that a political commitment was not really backed up by the requisite governance measures. I mean, it's for the law enforcement agencies and courts to examine and establish, but there are allegations and there are cases filed vis a vis malpractices regarding diagnostics because it was also buying private services in terms of diagnostics and so on. And I'll come to the larger problem in a minute. There have been issues of salaries not being paid, again, another paradox, while this was a top priority of the Delhi government, yet all staff here are contractual. It therefore did not put the weight of the government, machinery and budgets and governance systems into this.

So there are issues vis a vis the contractual staff. There are occasions when staff have gone on strike, even as we speak (December 2024), some other clinics are shut for a couple of weeks now because of the nature of these protests and conflicts. So, the paradox is that a model which really had seemingly the heart of the state government in it, a model which was hailed globally, was seen as a very important step towards achieving universal coverage, more so as we get closer and closer to the SDG (Sustainable Development Goals) datelines. Why the government failed or did not adequately back it up with the health system fundamentals, it's a bit mystifying.

And finally, which had always been my critique from the beginning is that it never really integrated into the healthcare system, even of the state government. Here was a situation where you could actually establish a continuum of care for those who needed it most, but somehow the currency of political expediency of simply being there rather than seeing an individual patient’s continuum needs through the chain. To me, it's always been a conundrum. And therefore, Mohalla Clinics, despite their popularity in systems terms, could gradually be losing their sheen. And there hasn't been, to the best of my knowledge, a very formal evaluation of Mohalla Clinics in a very systematic manner. And somehow one gets the sense that it's lost a bit of its original steam and enthusiasm. But if that happens, blame that on the intensely contractual nature of the engagements of buying diagnostic services. It is in no manner organically, as common systems logic would suggest, that there should have been a hub and spoke model with other Delhi government health institutions. There are no

horizontal linkages with the municipal institutions. Of course, what Mohalla Clinics has achieved, and it's a very positive thing, is that, I mean, it certainly brought basic healthcare closer to a much larger proportion of population.

The municipal corporation simply didn't grow or didn't have the means to grow at the rate at which Delhi grew. So let's take that into account also, yet somehow it fails in organically linking even to the Delhi government, forget other agencies. I hope that gives some picture of what you asked for.

Vivek Divan:

It certainly does. It also raises many other questions in my mind, but unfortunately, time is limited. For instance, the whole issue of this idea of public private partnership in delivering on everything from primary health to upwards. Unfortunately, we can't get into that for reasons of time. And I wanted to actually conclude Rajib by asking, you've laid out in very clear terms, what the challenges are. And one of the things at the heart of, I think what you've articulated is the issue of federalism. And when that works well, what is possible, and when that does’nt, what the challenges are, which fester.

I would want to, though, ask you if given your deep knowledge on this and the long association you've had with health in and healthcare in Delhi, what would you say are top of the hat, two or three ideas which need focus if things are to improve and to actually ensure delivery of health.

Dr. Rajib Dasgupta:

Well what really needs to be demonstrated across, and it's all about agencies. It's not so much of what is happening within, but what is happening across. As far as the within elements go, the Delhi government is doing its best, or is trying to do its best. The municipal body is trying to do its best. The union government is putting resources into its own institutions, etc. So it's not so much the within problems, but really the across problems, or across challenges.

Now, the level of acrimony across the political leadership of the three levels do need to go down. I mean, tempers need to cool if I may. There is simply too much acrimony now. It's understandable that politics will always be contested. It could be contested even if you belong to the same party, but if you're in a state government or local. government, but there's a measure of healthy dose of competing priorities and so on.

Unfortunately, the level of acrimony has just worsened with every passing year or month and so on, or with every passing issue or agenda such as the Ayushman Bharat. It's a different issue, whether this scheme is more inclusive than the others, or if it gives more benefits than the others. But in terms of functioning, in terms of day to day affairs, matters, affairs of running the state, the level of acrimony, the tempers need to cool down.

Politics is necessary, competitive politics will stay. But at the stake, in any state or in any context is the citizenry and that to me does become a casualty on some of these.

Vivek Divan:

Thanks a lot, Rajib. I think that's a great initial overview with so much more to be said, I'm sure. I think you've given us a very good glimpse into what is peculiar to the National Capital Territory and the issues of health governance, delivery and social determinants that unfold in this unique arrangement and its impact. Thanks again for your insights.

Dr. Rajib Dasgupta:

Thank you very much. A pleasure to have this conversation.

Vivek Divan:

Thanks for joining us for this episode of Status of States. Stay tuned for more such conversations. This is your host, Vivek Divan, signing off.