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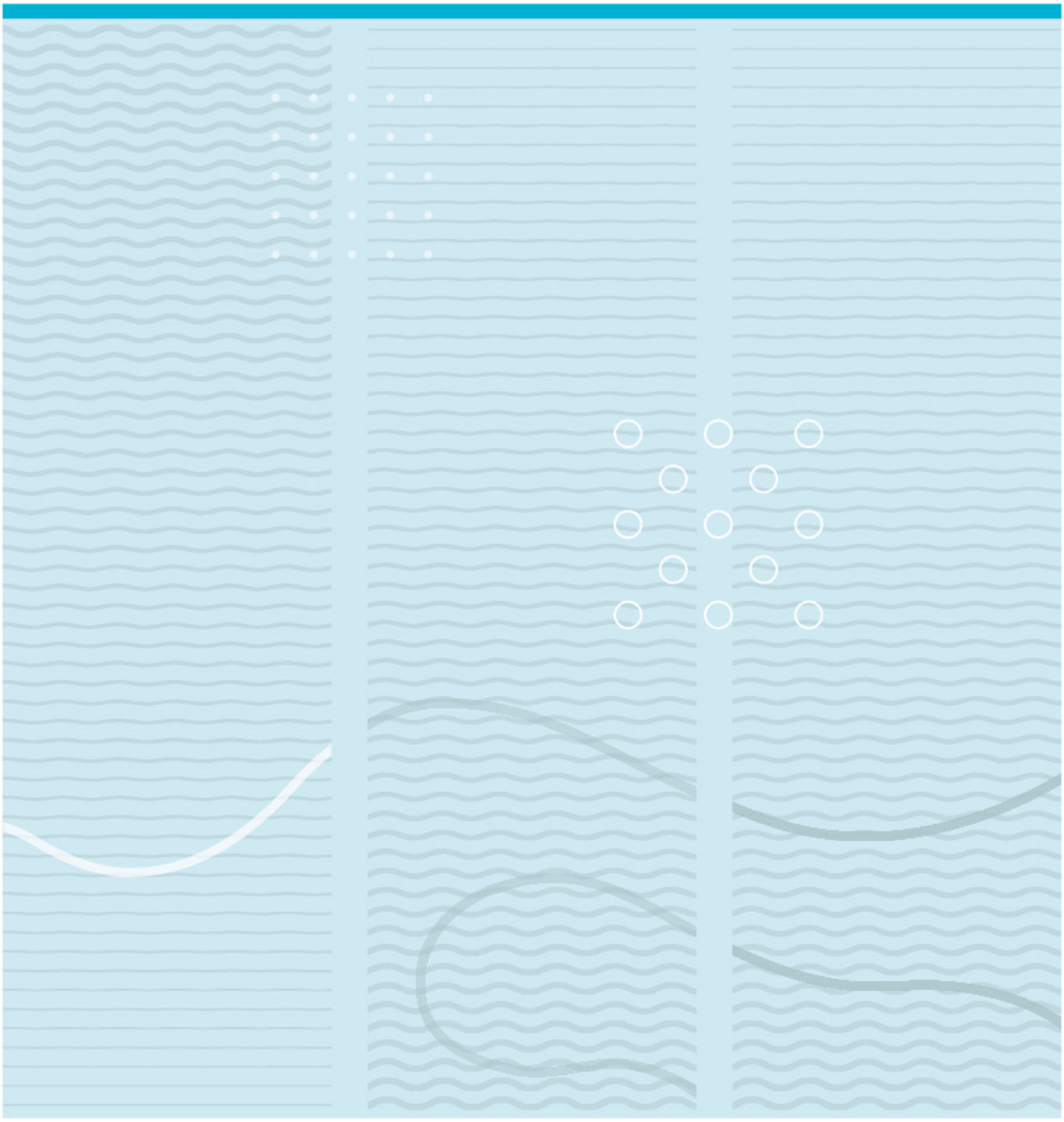
India as a welfare state – Implementation of healthcare policies in Pune, Maharashtra.

Subtitle



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This thesis is worth 30 study points.

Summary

The paper highlights the ongoing corporatization of the healthcare sector in Maharashtra is characterized by the emergence of large private hospital chains and the takeover of smaller hospitals by corporate entities. It discusses the implications of this corporatization on medical practice, employment patterns, and the restructuring of the healthcare workforce. There has been a shift towards private education and employment in corporate hospitals, driven by factors like personal indebtedness and reduced government jobs.' Professionalization' within the private sector involves changes in employment relations, performance targets, and constraints on professional autonomy. Cost inflation, medical malpractice, and challenges in doctor-patient relationships. Destratification within the medical profession, with 'star doctors' gaining prestige while early-career doctors face reduced opportunities. The paper exposes the prevalence of unethical practices in the unregulated and commercialized private healthcare sector, such as unnecessary investigations, overcharging, and violations of patients' rights. It emphasizes the need for accountability measures, regulation, and protection of patients' rights to uphold ethical standards.

A significant focus of the paper is on the work of the non-governmental organization SATHI (Support for Advocacy and Training to Health Initiatives) in Pune. It highlights SATHI's efforts in promoting community-based monitoring and planning processes to improve health indicators and empower marginalized communities to access healthcare services and assert their rights. The paper explores SATHI's research, advocacy, and community engagement initiatives to address socioeconomic disparities, poverty, malnutrition, and lack of access to essential services directly linked to the Sustainable Development Goals (SDGs) 1-6. The paper acknowledges the challenges faced by SATHI, such as gaining trust and credibility among marginalized communities, ensuring equal access to healthcare for those below the poverty line, and the potential shift of accountability away from the government. It also recognizes opportunities to strengthen the public health system by educating and assisting ASHA workers and promoting health awareness in slum areas. Overall, the research paper appears to critically examine the corporatization of the healthcare sector, the prevalence of unethical practices, and the role of community-based organizations like SATHI in promoting social accountability, addressing inequalities, and achieving sustainable development goals related to healthcare and social welfare in Pune, Maharashtra.

Contents

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1 Introduction

“My family only sells mangos” was the answer to why a thirteen-year-old girl was sitting with two small children on her lap, participating in an educational session about health rights one morning in the Karve Nagar slum area when she should have been in school. She stays home, cleans the house, and cares for her younger siblings while her parents are working. She had never attended school and was eager to learn about her rights. She was too shy to ask questions herself, but she was paying close attention to the health-related questions asked by the older women in the meeting. I was devastated to learn that this young girl, eager to learn, was unable to receive an education due to poverty, leaving her future uncertain. Education is expensive and a challenge for most people on par with access to healthcare. I met this girl on the first field visit organized through the exchange program I participated in, Social Justice and Culture. Sustainable Social Welfare in Neoliberal Times (SOJUCU), at Savitribai Phule Pune University (SPPU) in India.

In January, I had the opportunity to travel to India as part of the SOJUCU project. This project was initiated in 2021 to promote international cooperation as a quality measure in higher education and strengthen the partnership between USN and SPP. The project aligns with the 2030 and UN SDGs’ agenda, which emphasizes ensuring inclusive and equitable education, eliminating poverty in all its forms, and reducing inequality within and among countries.

The project results will be joint courses and curricula relevant to our key focus: The relationship between sustainable social justice, culture, and welfare under conditions influenced by neoliberal transformation. How different states like Norway and India struggle with increasing social marginalization will be addressed, but also how both countries have succeeded – in very different ways – in achieving sustainable mechanisms of preserving diversity. The theorizing of justice and welfare state in a new era will be encouraged based on cross-cultural comparison and fine-grained empirical studies. The approach will be student-centered to educate students theoretically sound and methodologically trained (Savitribai Phule Pune University, n.d).

Social welfare and socioeconomic inequalities are pressing issues as the Covid-19 situation has contributed to increasing societal inequalities worldwide, and since state regulations and welfare politics have been met with considerable globalizing challenges,

such as the expansion and naturalization of neo-liberal thought and practice (Universitetet i Sørøst-Norge, 2021, June 24)

On our field visits, we were accompanied by a non-governmental organization (NGO), SATHI, the only organization actively promoting health rights in Maharashtra. After meeting the girl in Karve Nagar, I became curious about why she couldn't get an education in a country considered a welfare state. Social democratic welfare, which provides a social security system that aims for the highest standards of equality, free education, and free healthcare that the Norwegian government provides, is how welfare is defined in Norway, so I wanted to understand how welfare is defined in India, as there are several definitions of the term. The directive principles of state policy in the constitution declare India a welfare state and a secular and democratic state that pledges to support all its citizens with justice, equality, and liberty. (Batra, n.d). The Constitution of India offers a robust and adaptable framework to steer and regulate the nation, tailored to accommodate its rich tapestry of social, cultural, and religious diversity. This is quite contradictory when the social structure in the country is creating an inequality in the society that leads to poverty, which results in uneducated people, malnutrition, and challenges to access to healthcare for people below the poverty line.

The program in India lasted three months, and fieldwork was a significant schedule component. India is the world's most populous country, consisting of 28 states and eight union territories, each with its unique language, cuisine, and clothing. During my stay, I lived in Pune, Maharashtra. Pune's population is estimated to be more than 7,3 million people; the city holds more than 560 slums, and 5,29% of the population lives under the poverty line. Our fieldwork was focused on social justice, and one of the major challenges in this area is that people below the poverty line are unaware of their rights. The concept of social justice is an ideal of equal rights for everyone, which can be achieved if the conditions of the social organization permit the authorities to adopt the necessary measures to secure the ideal (The Concept of Welfare, Chapter 4). As far as I understand, the ideal of social justice is not achieved due to the social hierarchy known as the varna system. The varna system categorizes the population into five hierarchical levels, which divide the population and where the lower castes do not have the same rights as the higher castes. Welfare in India is justified through social justice, but how is social justice implemented in a society with inequalities carved into the social structure?

SATHI is challenging this issue created by this social structure and is working on four angles, focusing on strengthening the public health system and raising awareness about people's rights. Welfare, healthcare, and social justice all fit under one common term: social sustainability. Addressing inequitable access to all aspects of life, including employment, living conditions, services, facilities, and opportunities for participation in social, cultural, and political structures and processes, is essential for social sustainability in a sociological setting. It makes me wonder why that many people are not aware of their healthcare rights, which India has a constitutional obligation to provide.

The experiences from the stay in India and the work of SATHI is the starting point of this master thesis in sustainability management, where the following research questions are raised.

1.1.1 Research question 1: How are healthcare policies implemented for social justice in Pune?

On the second field day, we witnessed one woman who came to receive help registering for one scheme implemented for pregnant women to prevent malnutrition and ensure she would birth a healthy baby. The scheme also has mandatory follow-ups for receiving the funds to ensure the women get what they need during their pregnancy. She came to get more information about the scheme she had heard of from other women in the slum area where she was living. The worker from Sathi we accompanied explained how the scheme worked, told her about the mandatory follow-ups at the doctors to be able to receive the funding, and explained the importance of following up for her and her child's health. She wanted to register for the scheme, but to enroll; you must have a social security number and a phone number to receive a one-time password. She explained that she did not have a telephone and that her husband, who has one, was working. The implemented schemes for people below the poverty line depend on access to a phone for enrolling, but in many cases, only the men of the family have a phone.

The government has created several important programs and schemes to fight these societal challenges, but implementation has challenges. Most of the schemes require the recipient to have a phone and mandatory documents to enroll, which is a challenge in slum areas.

1.1.2 Research question 2: What is SATHI's significant role in Pune, particularly in their work for people below the poverty line?

SATHI partners with civil society organizations to work on health rights issues and facilitates advocacy at the local, district, state, and national levels. SATHIs role is to strengthen the public health system by assisting and educating the Asha workers. ASHA workers in India promote health awareness, counsel women on various issues, mobilize communities, provide health services, escort pregnant women and children to health facilities, and provide primary medical care and essential supplies. They also inform the health center about community health issues and promote toilet construction. Graded training can enhance their role as healthcare providers. Asha workers work in the slum areas and are supplemented by the Anganwadi, a government-sponsored initiative that provides courtyard shelters in slum areas to ensure child and maternal care. The program was designed to combat child hunger and malnutrition prevalent in such areas. Anganwadis primarily cater to children aged 0-6. While they form an essential part of the Indian public healthcare system, their contribution goes beyond healthcare, significantly impacting children's early education and overall development.

1.1.3 Research question 3: What are the challenges and opportunities for SATHI in this work?

Observations of challenges Sathi faces in their work include creating relationships and gaining credibility among the people in the slums. They are also facing issues related to the schemes and policies that are implemented in Pune and how accessibility and enrollment are a challenge for people below the poverty line. Another challenge observed during fieldwork is how the NGO has taken responsibility from the government by maintaining and facilitating public measures implemented, which takes away the responsibility from the government. On the other hand, before the NGOs started their work, the people below the poverty line had no security measures and no one to lean on.

1.2 Thesis structure

The introduction has introduced the topic and research questions and explains that it is based on fieldwork in an exchange program in India. In the second chapter, I will introduce some conceptual background for the thesis. Welfare in India is defined and discussed, and health scheme implementation in Pune is introduced, followed by the NGO sathi, to understand their important role related to the schemes, why this NGO is a significant part of this research, and why other NGOs are not considered. The theory and literature chapter explains the welfare state regime theory and the different definitions of welfare. Then, it introduces the research conducted by Sathi, which explains the theories from which they work. Cultural diversity is crucial when studying and conducting research in India, and acknowledging different cultures is important for understanding the challenges in different contexts during fieldwork. The methodology chapter explains how this paper conducts an inductive approach under qualitative methods to keep the study open to capturing data from the field by delving into social complexities (O'Leary, 2021). It utilizes the NGO as a case study to highlight how they work towards social sustainability. The chapter on analysis is divided into three parts: Accessibility to healthcare, SATHIs' work for people below the poverty line, and Challenges and opportunities for SATHIs. The analysis is based on fieldwork and observations of Sathi, which is work combined with the issues related to accessible healthcare for people below the poverty line in Pune, Maharashtra.

2 Conceptual Background

2.1 Welfare

Maharashtra, a state in India, has gained recognition for its remarkable welfare system that advocates for universal social rights. The state has formed a broad political coalition to support the expansion of welfare. An excellent example of this system is the Maharashtra Employment Guarantee Scheme, which legally guarantees employment for rural households. Pune, one of the cities in Maharashtra, has implemented social sustainability initiatives, such as establishing cottage industries and providing tax concessions to support local businesses and livelihoods. This is consistent with the welfare state's focus on promoting economic opportunities. Additionally, Pune has

taken steps to preserve historical monuments and cultural heritage - a responsibility of the welfare state to safeguard national assets.
Despite the progress in implementing social sustainability programs, India's welfare state vision still faces challenges. Poverty, unemployment, poor health, and illiteracy still exist, indicating that more effective implementation of Directive Principles is necessary. Maharashtra and Pune have made significant strides in advancing the welfare state framework in India. However, as stated by the National Institute of Open Schooling in 2012, more work is needed to address persistent socioeconomic disparities and achieve the welfare state's objectives.

The term "welfare state" refers to the state's role in providing essential welfare services and social transfers, encompassing education, health, housing, social insurance, and more within developed capitalist countries post-World War II. (Ivankina, Latygovskaya, 2015). Welfare state capitalism describes the welfare state as a specific form of society and economy emphasizing full employment, universalism, and corporatist partnership. The golden age of welfare pertains to the period post-World War II, marked by significant welfare state development until the crisis in the 1970s. Welfare state retrenchment denotes reforms and cuts to social expenditure following the crisis, involving privatization, entitlement restrictions, means testing, and shifts towards active welfare systems. Welfare state regimes classify countries based on decommodification, social stratification, and welfare provision, which mix into Liberal, Conservative, Democratic, Southern, Confucian, and Eastern European types. Decommodification refers to the extent to which individuals can maintain a standard of living regardless of market performance. Defeminization relates to individuals holding a standard of living independent of family relationships. Social citizenship entails economic and social welfare rights for citizens within society. Universalism means granting social transfers and services based on citizenship rather than income status. Social transfers are income redistribution programs distinct from welfare services like health care or education. (Shukla, n.d.).

The relationship between welfare state regimes and social sustainability is crucial to public health research. Welfare state regimes play a significant role in shaping population health outcomes and addressing health inequalities. Comparative social epidemiology has shown that countries with more generous and universal welfare

provisions, particularly Social Democratic welfare states, tend to have enhanced population health and reduced health inequalities. The classification of welfare states into different types or regimes based on principles like decommodification, social stratification, and the role of the state, market, or family in welfare provision influences international variations in population health. Social citizenship within welfare states ensures citizens' economic and social welfare rights, contributing to social sustainability by providing a safety net for individuals regardless of their market performance. The historical development of welfare states, from the golden age of welfare to the era of welfare state retrenchment, reflects shifts in social policies and the impact on public health outcomes. Understanding key terms related to welfare states, such as decommodification, defamiliarization, social transfers, and universalism, is essential for comprehending how welfare state arrangements influence population health and contribute to social sustainability.

2.2 Healthcare schemes in Pune.

The Public Health Department in Maharashtra is responsible for managing primary and secondary healthcare facilities, which include primary health centers, sub-centers, and first referral units. The Directorate of Medical Education and Research manages most tertiary care facilities, while urban local bodies handle public healthcare in metropolitan cities. Currently, there are 23 district hospitals and 8 general hospitals in the state, with a combined bed capacity of 9,593. In addition to this, there are 13 women's hospitals (1,584 beds), 4 mental health institutions (5,555 beds), and 4 tuberculosis hospitals (290 beds). Of the four leprosy hospitals, only one with 350 beds remains operational.

The sub-district hospitals function as 30-bed community health centers providing comprehensive emergency obstetric care and serving as first referral units. As of 2020, there are 456 such sub-district hospitals with a total of 17,070 beds. As per government regulations, rural and tribal areas with a population of 3,000-5,000 should have one sub-center, one public health department for a population of 20,000-30,000, and one community health center for a population of 80,000-120,000. In urban areas, public health centers should serve 50,000 people in high-slum areas and 75,000 people in areas with sparse slum populations, with each center serving approximately 20,000-30,000 individuals in slums (Mahapatra et.al, 2022).

India has a multi-payer universal health care model funded through a combination of public and government-regulated private health insurance and tax-funded public hospitals. The National Health Policy was endorsed by the Indian Parliament in 1983 and updated in 2002 and 2017. The 2017 updates focus on addressing the growing burden of non-communicable diseases, the robust healthcare industry, unsustainable healthcare costs, and leveraging India's economic growth to enhance fiscal capacity for healthcare. The policy aims to reform the current healthcare system to achieve universal health coverage by increasing access to healthcare services, improving the quality of healthcare, and lowering the cost of healthcare delivery.
The policy emphasizes key principles in the healthcare system, such as professionalism, integrity, equity, affordability, and universality, and recognizes the importance of strengthening health research, including in areas like health systems, medical product innovation, and social determinants of health (Chaudhuri et.al, 2022). Among many of the healthcare schemes provided by state policies and the national health commission, there are three healthcare schemes for people below the poverty line, especially women implemented in Pune.

2.2.1 Urban Poor Health Scheme

Pune Municipal Corporation has implemented the Urban Poor Health Scheme for citizens living within its jurisdiction. Citizens who wish to enroll in the Scheme can submit one of the following documents to gain access to it: They must provide an income certificate up to ₹1 lakh from the Tahsildar's office, a photocopy of a Below Poverty Line (BPL) yellow ration card, or a photocopy of a service tax receipt from the Pune Municipal Corporation's Slum Rehabilitation Department. Additional required documents are a photocopy of the family's ration card, photocopies of children's birth certificates, and two passport-size family photographs.

The annual membership fee for the scheme is ₹200. After submitting the required documents and paying the fees, the Urban Poor Health Scheme card will be issued, and it will also cover family members. Citizens who are eligible for benefits from other government, semi-government, or health insurance schemes cannot enroll in the Urban Poor Health Scheme. Members of the scheme can avail inpatient (IPD) treatment at private hospitals empaneled with the PMC Health Department. For IPD treatment in the

general ward, the PMC will issue a 50% letter to the patient, who must submit it to the hospital during admission.
The hospital will then charge the patient only 50% of the total IPD bill, and the PMC Health Department will pay the remaining 50% directly to the hospital.
The maximum coverage under the scheme for one family per financial year is ₹1,00,000. The patient must pay the hospital any amount exceeding this limit.
The scheme is only applicable for general ward treatment. Patients admitted to semi-private, private, or deluxe rooms are not eligible for benefits. All treatments are provided as per the Central Government Health Scheme rate schedule.
Members of the scheme can avail of free treatment and medicines from the PMC dispensaries, whose names are mentioned on the Urban Poor Health Scheme card.

2.2.2 Pradhan Mantri Matru Vandana Yojana

Limited access to sufficient nutrition is a prevalent issue among Indian women under the poverty line. To fight this problem, the Indian government has implemented several health initiatives aimed at providing fundamental nutrition to women and children. One of these programs is the Pradhan Mantri Matru Vandana Yojana, which operates under the Women and Child Development Ministry of India. This initiative's primary objective is to offer partial compensation to pregnant women and lactating mothers who had lost income due to their pregnancy and previous employment.

Pregnancy is a crucial period in a woman's life that requires additional nutrition to sustain the pregnancy and ensure the delivery of a healthy child. Proper nourishment during this time is essential for the well-being of both the mother and the unborn child. The PMMVY scheme provides a cash incentive disbursed in three installments, which can be used by pregnant women to meet their daily nutritional requirements. This ensures that they receive adequate nourishment during this critical phase of their lives. The Pradhan Mantri Matru Vandana Yojana (PMMVY) is a significant step taken by the Indian government to address the issue of undernourishment among pregnant women.

Monetary benefits are divided into three payments, each at a specific time. The mother-to-be gets the first payment after pregnancy registration, within 150 days from her last period. The second payment is installed after 180 days, and the last payment is after

childbirth. This scheme ensures that the pregnant woman gets follow-ups and is monitored concerning nutrition so that the mother gives birth to a healthy child. The eligibility criteria for this scheme are that the woman was employed before the pregnancy was conceived and that she is not on a paid maternity scheme.

2.2.3 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is an initiative to promote safe motherhood under the National Health Mission. It encourages women from underprivileged backgrounds to opt for institutional delivery to reduce maternal and neonatal mortality rates. The Prime Minister of India launched the scheme on April 12, 2005.

JSY is a centrally sponsored scheme that combines cash assistance with delivery and post-delivery care. It is being implemented in all states and Union Territories (UTs), focusing on Low-Performing States (LPS).

The Yojana recognizes the Accredited Social Health Activist (ASHA) as an important link between the government and pregnant women. ASHA workers play a crucial role in implementing JSY by identifying pregnant women, helping them register for antenatal care, and encouraging them to opt for institutional delivery.

ASHA workers also assist beneficiaries in receiving cash assistance under the scheme. They provide pregnant women with important information about the significance of institutional delivery, birth preparedness, and postpartum care.

The primary objectives of the Janani Suraksha Yojana are to reduce maternal and neonatal mortality rates by promoting institutional delivery among underprivileged pregnant women. It also aims to provide cash assistance to pregnant women, enabling them to access better healthcare facilities and strengthen the public health system's ability to provide quality maternal and neonatal healthcare services.

By integrating financial aid with delivery and post-delivery care and leveraging the network of ASHA workers, the JSY scheme aims to improve maternal and child health outcomes, particularly among the economically disadvantaged.

2.3 SATHI

SATHI is a non-governmental organization that aims to create a society that is accountable and responsive to the general needs of its people through organized and sustained public action. Rather than searching for substitutes or replacements, SATHI envisions a society where everyone has the right to health and healthcare, health

inequities are eliminated, structural barriers to healthy living conditions are removed, and quality healthcare is provided. In this envisioned society, individuals are not just extensions of the healthcare system but active agents driving it forward, ensuring universal access to healthcare as an inherent human right. SATHI is the only organization working to promote health rights in India. Their work is divided into four areas of focus, and this study aims to investigate what impact SATHI´s work has on healthcare accessibility and how it has affected the issues in their guidelines.

Public Health System Strengthening.

SATHI is dedicated to advancing healthcare accessibility for all, aiming to broaden public access to healthcare services. As a pioneering organization, SATHI advocates the Right to Healthcare through community-driven accountability initiatives. With a notable track record of collaboration with more than 50 civil society organizations in Maharashtra, SATHI has played a crucial role as the State Nodal NGO in spearheading community-based monitoring to fight malnourished children and planning health services.

This approach has not only fostered a more inclusive democracy but has also heightened accountability measures while facilitating comprehensive data collection on crucial health metrics. SATHI's strategic partnerships with national and international entities have developed diverse resource materials to fortify public healthcare services. Renowned for its groundbreaking community-led methodologies, such as decentralized health planning and the Social Audit of Public Services, SATHI has garnered acclaim from policymakers, civil society organizations, and scholars. These initiatives are exemplary models that showcase the organization's commitment to driving positive change in healthcare delivery systems.

Sathi has seven ongoing projects under the public health program funded by external donors. The length of the project varies from one to three years. The projects cover restoring health services post-pandemic, accountability issues in the growing private and corporate health sector, strengthening and improving maternal child health nutritional services, how to increase funds, community action for health, and they have a narrative lab for health communication.

Social Accountability of the Private Healthcare Sector

SATHI promotes social accountability within the private healthcare sector, emphasizing the importance of bolstering public health services, reversing privatization trends, and establishing comprehensive oversight of private medical facilities. India boasts one of the world's largest private medical sectors. However, it operates with minimal regulation, leading to significant challenges such as financial exploitation of patients and substandard care in private hospitals and nursing homes. This lack of oversight results in an alarming number of Indians, approximately four crores annually, being pushed into poverty due to medical expenses. SATHI is a leading advocate for social accountability in private healthcare. In partnership with COPASAH, it hosts the Global Thematic Hub on Accountability of the Private Healthcare Sector. SATHI also works closely with organizations such as Jan Swasthya Abhiyan (People's Health Movement—India) to address critical issues related to private healthcare.

SATHI's efforts include launching a national patients' rights campaign in India, which has garnered significant support from civil society organizations and concerned citizens impacted by the challenges posed by commercialized and unregulated private healthcare providers. The ongoing project sathi has in the private sector is analyzing medicine expenditures where SATHI documented instances of private hospitals overcharging COVID patients in Maharashtra. They assisted patients in negotiating lower bills and audited hospitalization expenses for 480 patients, resulting in over 60 families receiving refunds for excessive charges during the second wave. The analysis focused on medication expenses to identify overcharging patterns.
Concurrently, SATHI monitored pro-people regulatory measures in the private healthcare sector introduced by the Maharashtra government during the COVID crisis. However, these regulations still needed to be fully implemented to benefit patients. This project highlighted the critical need to enforce these provisions to protect patients, prevent overcharging, and uphold patients' rights in the current healthcare environment.

Community Action for Nutrition

SATHI actively engages communities and partners with civil society organizations to address health and nutrition challenges, fostering dialogue and action at various local and national levels. Emphasizing system strengthening and convergence strategy, SATHI advocates for enhancing the functionality and efficiency of public systems rather than replacing them, utilizing community-based interventions to bolster household-level nutritional practices. Through collaborations with over 25 civil society organizations under the Nutrition Rights Coalition in Maharashtra, SATHI works closely with the Tribal Development Department of the Government of Maharashtra to implement Community Action for Nutrition initiatives in 420 villages across ten tribal blocks spanning seven districts in Maharashtra, including Nandurbar, Gadchiroli, Palghar, Nashik, Raigad, Thane, and Pune.

SATHI's ´Building Community Action for Nutrition´ project also operates in 120 villages across one tribal and two rural blocks in Maharashtra's Amravati and Pune districts, with support from Bajaj CSR Pune.[1] By promoting collaboration among key stakeholders such as the Public Distribution System, Employment Guarantee schemes, Rural Development initiatives, Integrated Child Development Scheme (ICDS), and Health programs, SATHI advocates for a comprehensive approach to combat malnutrition, emphasizing community engagement at the grassroots level.

[1] https://www.bajajauto.com/corporate/corporate-social-responsibility

2.4 ASHA

Accredited Social Health Activist (ASHA) workers in India are crucial in creating awareness and educating the community about health determinants such as proper nutrition, sanitation, and healthy living. They also provide counseling to women on various aspects such as birth preparedness, breastfeeding, , contraception, immunization and prevention of infections. ASHA mobilizes the community and facilitates access to health services such as, antenatal care, immunization and ICDS. They work in association with the Village Health & Sanitation Committee to develop a village health plan. ASHA is responsible for accompanying pregnant women and children to the nearest health facility for treatment. In addition, they provide primary medical care for minor ailments like diarrhea and fevers and act as a DOTS provider for tuberculosis. ASHA also acts as a depot holder for essential supplies such as ORS, IFA tablets, contraceptives, etc. They also inform the health center about community births, deaths, and disease outbreaks. ASHA promotes the construction of household toilets under the Total Sanitation Campaign. Graded training, such as for newborn care and managing common childhood illnesses, can enhance Asha's role as a provider.

3 Theory and Literature

This chapter explains the welfare state regime theory and the different definitions of welfare to better understand the term. Then, it introduces the research conducted by Sathi, which explains the theories from which they work and will be a helpful tool when analyzing the data collected. Cultural diversity is another aspect that is crucial when studying and conducting research in a multi-cultural country like India. Acknowledging different cultures is important for understanding the challenges in different contexts during fieldwork.

3.1 Definitions of welfare

According to welfare state regime theory, welfare states can be classified into different types based on their principles, the role of the state, market, and family, as well as social stratification. The main types of welfare states, according to regime theory, are Liberal Welfare States that are found in the UK, USA, Ireland, Canada, and Australia. These states have minimal welfare provisions and modest social transfers, often with strict

entitlement criteria. Social transfers are means-tested and stigmatized, encouraging market dominance by guaranteeing only a minimum level of support and subsidizing private welfare schemes.

Conservative Welfare States are represented by countries like Germany, France, Austria, Belgium, Italy, and the Netherlands. In these states, welfare programs are often earnings-related, administered through employers, and aimed at maintaining existing social patterns. The role of the family is emphasized while the redistributive impact is minimal, with a marginalized role for the market.

Social Democratic Welfare States are typical of Nordic countries like Norway, Sweden, and Denmark. They are characterized by universalism, generous social transfers, a commitment to full employment and income protection, and a strongly interventionist state. They promote social equality through a redistributive social security system and provide highly de-commodifying programs that aim for equality of the highest standards.

Southern European Welfare States Include countries like Italy, Greece, Portugal, and Spain. These states are described as "rudimentary" due to their fragmented welfare system, which includes diverse income maintenance schemes ranging from meager to generous. They heavily rely on the family and voluntary sector for support and offer limited coverage in welfare services like healthcare.

Radical/Targeted Welfare States are represented by countries like the UK, Australia, and New Zealand, where poverty alleviation and income equality goals are pursued through redistributive instruments rather than high expenditure levels.
Confucian Welfare States: These include Japan, South Korea, Taiwan, Hong Kong, and Singapore. Low levels of poverty characterize these states.
These classifications help understand how different welfare state regimes influence population health outcomes and inequalities based on their specific approaches to welfare provision and social policies.

Welfare in India is justified through social justice, which aims to achieve ideal conditions if the social organization allows authorities to adopt necessary measures. The

legal and constitutional character of the state plays a significant role in attaining social justice ideals. A welfare state, founded on the idea of people's welfare, obligates authorities to implement welfare measures to achieve social justice. The state's duty in a welfare state is to provide the means for attaining social justice by promoting welfare and justice, thus fulfilling the ideal of social justice. The concept of a Welfare State in India is crucial for fostering social security, equality of opportunity, and basic living standards within a democratic framework, aligning with social welfare and justice principles. (Eikemo, Bambra 2008).

3.2 SATHIs research.

SATHI's work on strengthening the public health system discusses the corporatization processes in the healthcare sector in Maharashtra, which are characterized by the emergence of large private hospitals and corporate entities' takeover of medium-sized and charitable hospitals. (Marathe, 2020, April-June).

They highlight the implications of these changes on medical practice and professionals, focusing on the shift in employment from practitioner-owned small and medium hospitals to more extensive corporate settings (Marathe, 2020, April-June). The research points to a restructuring of medical practice in Maharashtra, emphasizing the trend towards private education and employment in corporate hospitals, driven by personal indebtedness, reduced government employment opportunities, and the perceived benefits of working in larger providers.

Marathe et al.'s (2020) article, "The Impacts of the Corporatization of Healthcare on Medical Practice and Professionals in Maharashtra, India," describes a 'professionalization' of medicine within the private healthcare sector involving changes in employment relations, performance targets, and constraints on professional autonomy. This leads to issues like cost inflation, medical malpractice, and challenges in doctor-patient relationships.

Additionally, it discusses the destratification within the medical profession, where 'star doctors' gain prestige and influence while young and early-career doctors face reduced status and opportunities. The research raises important questions about the role of government and medical professionals in overseeing private healthcare transformation and the broader implications of these trends for health systems.

Another article by Marathe (April-June 2020) "Ensuring Accountability and Responsiveness of the Private Health Sector in India: National Workshop Report," addresses the increasing prevalence of unethical practices in the private healthcare sector in India, such as unnecessary investigations, overcharging, and violation of patients' rights. It emphasizes the unregulated and commercialized nature of the private healthcare sector, drawing attention to the need for accountability and responsiveness. It also discusses the challenges of these unethical practices and the importance of regulating the private health sector to protect patients' rights and uphold ethical standards. The workshop report may provide insights into strategies or recommendations to enhance accountability, responsiveness, and ethical practices within the private healthcare sector in India. The private healthcare sector in India is rapidly growing, with around 75% of outpatient care provided by for-profit private healthcare facilities (Marathe, 2020)

The sector has undergone corporatization processes, leading to a shift from simple commercialization to deep corporatization of healthcare, which impacts medical practice and professionals in Maharashtra, India.

There is a lack of effective regulation in the private healthcare sector, and issues like malpractices, patient exploitation, and unregulated private healthcare expenditures lead to severe consequences. Civil society networks, health activists, and public health professionals have raised calls for better regulation and a patients' rights charter, highlighting the urgent need for improved governance in the private healthcare sector.

The National Institution for Transforming India (NITI Aayog) has emphasized the importance of a regulatory framework for commercial insurance. Still, it has yet to specifically address the profit-centered private sector's implications and the necessity for its regulation before engagement. (Marathe et al.,2020).

Health Policy & Systems Research

SATHI engages in health policy and systems research within its core focus areas: strengthening the public health system, promoting community action for enhancing child nutrition, and advocating for social accountability in the private healthcare sector.

The organization's dedicated research team collaborates closely with the action team to ensure that research aligns with issues identified through community activities and advocacy efforts, fostering seamless integration across teams. This approach ensures that research is driven by practical needs, with findings informing further advocacy and action.

SATHI's research delves into evaluating the performance of health systems in program implementation and assessing the real-world impact of health policies. By providing insights to enhance community initiatives, bolster policy advocacy, and refine the design and execution of health programs and policies, SATHI's research plays a crucial role in shaping healthcare practices. The organization employs innovative research methods, including less common approaches like witness seminars, which have been underutilized in Low- and Middle-Income Countries (LMICs) until now.
Recent studies conducted by SATHI cover a range of topics, such as documenting patient experiences during the COVID-19 pandemic across public and private healthcare systems, examining practices, regulation, and accountability in Maharashtra's evolving private healthcare sector, understanding challenges faced by nurses during the pandemic, and evaluating the impact of Community-Based Monitoring and Planning (CBMP) initiatives in Maharashtra.

The knowledge products derived from SATHI's research efforts are disseminated widely through various channels, including popular media articles, vernacular language booklets, research briefs, policy briefs, reports, journal articles, and papers. These reach a diverse audience and contribute to informed discussions on critical healthcare issues. SATHI´s work on strengthening the public health system discusses the corporatization processes in the healthcare sector in Maharashtra, characterized by the emergence of large private hospitals and corporate entities' takeover of medium-sized and charitable hospitals. (Marathe, 2020, April-June).

They highlight the implications of these changes on medical practice and professionals, focusing on the shift in employment from practitioner-owned small and medium hospitals to more extensive corporate settings (Marathe, 2020, April-June). The research points to a restructuring of medical practice in Maharashtra, emphasizing the trend towards private education and employment in corporate hospitals, driven by personal

indebtedness, reduced government employment opportunities, and the perceived benefits of working in larger providers.

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3.3 Cultural differences

Indian society is characterized by a hierarchical structure where individuals, social groups, and families are ranked based on various qualities, leading to differences in status and power. Indian culture reflects deeply ingrained values around social relations and gender dynamics, as highlighted in the provided sources. The SOJUCU project in India gave me insights on India’s rich culture diversity, how pop culture is considered the leftovers of “higher classes of culture”, and how it is important to understand different cultures in a social context.

The Varna system in ancient India was a social structure that divided society into four main categories or varnas based on factors like occupation, birth, and societal roles. The four principal categories of the Varna system were Brahmins, Kshatriyas, Vaishyas, and Shudras. Brahmins were priests and intellectuals, Kshatriyas were protectors and rulers, Vaishyas were traders and farmers, and Shudras were laborers serving the upper three varnas. The untouchables are the lowest cast and cannot touch the upper casts (FSCJ, 2024, March 30). Each varna had specific duties and responsibilities to maintain societal harmony and prevent conflicts. The Varna system was not rigid and allowed for some social mobility. Women in this society were often considered part of the Shudra varna and restricted from studying or working outside their homes.

Patriarchal Values: Indian society, like many others, is still patriarchal, with values regulating sexuality, reproduction, and social roles expressed through cultural metaphors and symbolism. Women are often portrayed as self-sacrificing and subordinate, with societal norms restricting them from aspiring beyond marriage. Men, on the other hand, are expected to embody masculinity, with their sense of self often

tied to controlling women. Women's protection and virtue are linked to their fathers' honor and masculinity until marriage.

Gender Inequality emphasizes the paradoxical nature of gender dynamics in India, where the oppression of women coexists with a significant level of respect for them. The existence of organizations like Aarti Home and the Vijay Foundation Trust illustrates the disadvantages faced by women, with female infanticide, discrimination, and societal expectations contributing to gender disparities. Men are often valued more than women, leading to behaviors and attitudes that perpetuate gender inequality. Efforts towards gender equality in India require mobilizing various sectors of society to change perceptions and values. UNICEF emphasizes the importance of involving men, women, and boys in transforming societal views to achieve gender equality and enable every child to reach their full potential. In conclusion, Indian culture exhibits a complex interplay of traditional patriarchal values, evolving gender relations, and ongoing efforts to promote gender equality and social change. (UNICEF, 2024, March 29).

In his article published in the Journal of the History of Ideas in 1975, T. R. Bates explores Gramsci's theory of hegemony. The article discusses how hegemony operates through cultural influence and consent rather than coercion. Gramsci's differentiation between "political society" based on force and "civil society" based on consent is emphasized, highlighting how hegemony is maintained through the reproduction of dominant ideas and values in cultural institutions such as universities, media, and religious organizations. The article also underlines Gramsci's idea of a "war of position" as a prerequisite to a "war of attack," underscoring the significance of ideological struggle in creating a new hegemony. Bates' work provides a comprehensive overview of Gramsci's theory of hegemony and its implications in understanding societal power dynamics, including its influence on popular education practices, liberation theology, participatory action research, and approaches to media and cultural action.
Culture is often associated with developing higher faculties that involve mental, intellectual, artistic, and spiritual aspects. This distinguishes culture from everyday activities and emphasizes refined human expression. However, introducing the term "popular" complicates the definition of culture, leading to a distinction between popular culture and high culture.

Based on social structure, pop culture is defined as the leftovers of high culture. Popular culture involves practices widely distributed among many people and contrasts with high culture, often associated with exclusive or refined activities (Williams, 2018, p.904). Popular culture has emerged to represent activities that involve many individuals, actively or passively. In contrast, high culture is linked to a more refined and rarefied cultural expression. The differentiation between popular culture and high culture reflects historical assumptions and theoretical tendencies, highlighting the challenge of defining culture in a way that encompasses both the widespread practices of the masses and the more exclusive, refined activities associated with intellectual, artistic, and spiritual development.

Culture refers to a group's shared beliefs, values, customs, and practices, encompassing aspects like religion, art, dance, literature, and philosophy. It manifests how people think, behave, and act, reflecting their identity and traditions. On the other hand, civilization denotes a more advanced stage of human social development characterized by urbanization, complex social structures, and technological progress. It involves the establishment of complex social and political structures, the development of urban centers, and the organization of economic systems. Written language, monumental architecture, legal systems, and other indicators of a sophisticated society mark civilizations. While culture focuses on intangible aspects of society, civilization encompasses tangible, like infrastructure, and immaterial, like laws and elements. Culture can exist in simpler societies and smaller groups, passed down through generations via oral tradition and rituals. At the same time, civilization emerges in more complex societies with organized systems involving technological advancements and governance structures. Culture is more personal and emotional, shaping individual and group identities, while civilization is more impersonal and functional, relating to organized systems and societal functionality. In essence, culture and civilization are interrelated yet distinct concepts that define human societies, each contributing uniquely to the multifaceted nature of human existence.

4 Methodology

4.1 Qualitative methods.

This study uses qualitative, inductive methods to explore a phenomenon while maintaining ethical standards. I have used an inductive approach under qualitative methods to keep the study open to capturing data from the field by delving into social complexities (O'Leary, 2021). The data is collected through fieldwork directed by SPPU, accompanied by employees of the non-governmental organization sathi. The fieldwork organized by the sociology department at SPPU was spread out over three months between courses at the department.

I will utilize a qualitative case study approach to explore the phenomenon in its real-world context. This methodology is well-suited to developing a rich, contextual understanding of the subjective meanings and experiences of the participants and the subject manner. Epistemologically, the study will adopt an interpretative stance to understand the subjective meanings and experiences of the participants.

I will collect observational data, including participant observation and field notes, to capture the phenomenon naturally occurring in the real world. This observational component will allow me to develop a deeper, more holistic understanding of the context and behaviors surrounding the case. “Observation invites you to take it all in – to see, hear, smell, feel, and even taste your environment. It allows you to get a sense of reality and work through the complexities of social interactions.” (O'Leary, 2021) Initially, I set out to do interviews, but language and time were challenging. We were accompanied by sathi workers who could translate the interviews for them and me. Still, with the fear of getting a biased result on my research, I chose to combine the observatory and participatory fieldwork.

4.2 Fieldwork

Fieldwork is a qualitative research technique that enables researchers to study human interactions and behavior without interfering with or influencing the participants. This is particularly important because conducting interviews or creating unfamiliar environments for participants can lead to biased responses, which can negatively impact

the quality of the study. Therefore, fieldwork is a valuable tool for researchers who want to study human behavior in a natural setting without disrupting the participants.

Scholars like Bronisław Malinowski pioneered British social anthropology. This approach involved conducting long-term ethnographic fieldwork and participant observation to understand societies comprehensively. It also employed a comparative approach to distinguish between societies, identify universal patterns, and develop general theories. The approach rejected the evolutionary and diffusionist perspectives prevalent in 19th-century anthropology. British social anthropology differed from American cultural anthropology's more humanistic and interpretive tradition. This method became prevalent in the early-to-mid 20th century, particularly in studying non-Western societies within the British Empire and Commonwealth. Although it has faced criticisms and undergone changes over time, it remains an influential perspective within anthropology in Britain and parts of Europe (Fangen, 2010).

Observing and interacting with a specific group of individuals for an extended period is common when conducting fieldwork. This firsthand experience of being present in their environment enables me to gather data with greater understanding, empathy, and knowledge, which I can then use to write about my experiences in the field. When I did fieldwork in India, I participated in the meetings held by sathi in slum areas in Pune, which allowed me to observe the local participants. Interacting, asking questions, and opening for conversations allowed me to get to know the people living in the slums and their struggles and despairs. Getting to know and interacting with them in their own safe environment makes it easier for them to talk about their issues related to my research. The purpose of doing fieldwork is to be able to describe what people are saying and doing in contexts that the researcher does not structure. Instead of initiating activities or scenarios, I observed what activities they initiated, which allowed me to observe their behaviors and positions without necessarily asking questions. In this research, I used a combination of observing and participating. This approach gave me an advantage by participating and getting to know the participants in the study. My fieldwork for this paper was arranged by the sociology department in Pune, where we would join SATHI and see how they work for people below the poverty line. The disadvantage of joining only one organization in the field that I am researching is that I may only see what the organization wants to show. Another disadvantage is the attention I got when visiting

the slum areas, standing out. We, as humans, have the habit of showing ourselves from the best side possible, and we do not want to show our weaknesses to people we don't know. Here, I had the advantage of being accompanied by an organization that the people knew and trusted, which made it safer to talk to me as a visitor.

4.3 SOJUCU project in India.

The courses at SPPU introduced the Indian welfare system and the public and private health system and gave a thorough introduction to the social structure in India. These lectures enabled me to structure my research questions and create the foundation of this paper. I decided to conduct interviews based on the scheduled field visits in slum areas where we would attend meetings with the women living there and then put together an interview guide based on this. The questions refer to accessibility to sustainable development goals 1-6, no poverty, zero hunger, good health and well-being, quality education, gender equality, and clean water and sanitation as the focus areas.

The project at SPPU was structured to include fieldwork and lectures from different NGOs and department professors. However, some issues related to the scheduled fieldwork led to delays, and the first field day we had with the NGO SATHI was on February 9th. We had four field days with sathi, where we visited two slum areas, SATHI's office, and a tribal village on the outskirts of Pune. We attended educational meetings with women and children, where the learning topics were sanitation, health, health rights, and nutrition. Sathi invited us to a state-level health rights assembly in Pune, where dialogues with political parties and a public manifesto about health rights were discussed and published.

This project in India gave me the idea and opportunity to research the injustice practiced in Pune, Maharashtra. We had lectures on how India is a welfare state, yet there is so much injustice in society. As a sustainability management student with a special focus on social sustainability, I wanted to understand how healthcare policies, as a central part of both welfare and social sustainability, are in Pune.

4.3.1 Ethical considerations

Researchers must seek informed consent from all participants, communities, and relevant authorities before fieldwork. This involves providing a clear explanation of the purpose, methods, risks, and benefits of the research and ensuring that participants understand and voluntarily agree to participate. During fieldwork, researchers should respect all individuals' dignity, privacy, and autonomy. They must keep cultural norms, values, and practices in mind, and avoid causing any harm or offense. Research should aim to benefit the participants and communities involved or at least minimize potential harm. Researchers should consider their work's short- and long-term impacts and strive to create positive outcomes. Fieldwork should be conducted in a fair and equitable manner, without any discrimination or exploitation. Researchers must ensure that the benefits and burdens of the research are distributed fairly among all participants and communities involved. Confidentiality and Anonymity: Researchers must protect the privacy and confidentiality of participants and ensure that data is collected, stored, and disseminated securely and anonymously unless explicit consent is given otherwise. Conducting fieldwork in a manner that is safe, ethical, and responsible while adhering to relevant laws, regulations, and institutional policies is of utmost importance. As researchers, it is crucial to minimize any negative impacts on the environment and the local communities. It is highly recommended that researchers collaborate with local communities, stakeholders, and partners throughout the research process, starting from designing the research to disseminating the results. This collaboration fosters mutual understanding, trust, and shared benefits for all involved. Many institutions require fieldwork proposals to undergo ethical review and approval before research can commence. Therefore, researchers must familiarize themselves with these processes and ensure compliance with all requirements related to ethical review (Picot, 2022). Adherence to ethical guidelines outlined by the relevant research ethics committee will be maintained. Sikt has been a pertinent tool for maintaining ethical guidelines in this research. Sikt provides guidelines for education and research, and the project was registered and approved in Sikt when the data collection started.

The interview guide had to be approved by ethical guidelines outlined by SPPU to conduct interviews in Pune, along with a consent form provided by the university in the local language, Marathi, which, unfortunately, I was informed far too late to collect data through interviews. Another ethical consideration is the language barrier. Having an interpreter translate the interviews also has ethical issues when doing sociological

research. This research explores personal experiences and opinions on healthcare access. However, working with an interpreter can be challenging because the main points of the answers may not be conveyed accurately, leading to misinterpretation.

4.3.2 Data collection.

The data is collected through observations, conversations, and information given by employees of the NGO and participants in the meetings. While observing, I wrote thorough and detailed notes in the form of keywords and phrases mentioned. The keywords contain what I could see, feel, smell, and hear. I was allowed to take pictures to document expressions, tensions, and atmosphere to help me remember the experiences of participating in these meetings and visits.

During my stay in India, I kept a personal journal where I wrote down my experiences and thoughts. This journal gave me an overview of these visits' impact on me and has been helpful when analyzing the field notes. After writing my personal impressions and observations in the journal, I wrote detailed field notes from when we entered and left the field. Then, I added the pictures to preserve the emotions behind the visits.

United Nations sustainable development goals 1-6 have been the focus of investigation in the field, with a special focus on goal 3- good health and well-being. This was to investigate the connection and consequences of one of the goals not being valued and properly implemented. Another observation of interest in this research is the change in participants' behavior when they saw us participating and observing the close connection among the people in the different communities and how they supported each other compared to interactions and behavior in the bigger cities. Challenges regarding equal access to healthcare in Pune relate to Sustainable development goals 1-6 due to the high percentage of people below the poverty line.

4.4 Case study SATHI

SATHI is an action center of the Anusandhan Trust and has been based in Pune since 1998. They are working alongside the government to strengthen the public health system. The methods sathi uses in their work for a better public system are community-level interventions, like education for the women in slum areas and helping to organize the Anganwadi. Sathi is constantly working to provide women with knowledge of their

rights, and no other organizations in the country are working toward the same goals. One of the other significant areas sathi is working on is a community action in nutrition, collaborating with over 400 villages. They assist Asha workers who help and monitor families with malnourished children. These Asha workers are women from the town who know the people they support and monitor. They started a community action for the nutrition process in 2007. As a part of that, the community-based monitoring and planning of health services in Maharashtra has been part of the National Health Mission since 2007. We were taken through the six critical components of the CAN process. The first key is to strengthen the community's awareness of nutrition services, and the second one is to facilitate community-based consultations so they can review the nutrition services provided in the communities. The fourth and fifth components are promoting improved household nutrition practices and individual counseling for mothers or caregivers of malnourished children. This is the work the Asha is doing in the villages.

The Asha educates and helps the mothers prepare nutritious food from the available ingredients and helps them grow vegetables, etc., so they have what they need to provide healthy food. These components have been implemented in several villages in Maharashtra, and the number of malnourished children by enhanced access to health and nutrition services combined with an improved household nutritious practice. Sathi showed us the positive impact achieved through the CAN process from June 2019 to March 2020, where the proportion of SAM (severe acute malnutrition) children reduced from 5.2% to 2.5%, and the reduction was from 14.3% - to 8.8% for MAM (moderate acute malnutrition) children. Sathi is also doing extensive research on nutrition, medicine, and available health services on a local level.

Pune´s population is estimated to be 7,3 million in 2024, with a population density of 5,600 individuals per square kilometer (World Population Review, 2024). Access to healthcare is essential to fulfilling fundamental needs, and it provides a foundation for better health and mental well-being and facilitates a healthier lifestyle. Pune has a wide choice of hospitals and healthcare facilities. Pune Municipal Corporation has listed an overview of hospitals. Pune has 41 public hospitals, but with increasing growth in the private sector, Pune has 126 private hospitals. During fieldwork and conversing with employees of the public health system, we were informed that patients often choose to

go to private hospitals since there are fewer patients and shorter waiting times. However, when discussing the topic with NGOs or health system users, they say the quality of care in private hospitals is better. Still, private healthcare is more expensive and only available to some people.

Pune holds more than 560 slums, whereas the government notifies 353 slum areas, and 211 are not notified (Pune Municipal Corporation, 2023). 5,29% of the Pune population lives below the poverty line. The hierarchy in Indian society, such as the caste system, categorizes the people below the poverty line as the shudras or the untouchables, who are left out of the educational system and do not have the same access to healthcare as the casts above. Due to this system, people below the poverty are not aware of their rights or the importance of healthcare. As stated in the Constitution, the government is responsible for providing health care for everyone. Still, more information on health rights needs to be given to the people, especially those who do not have the resources to seek the knowledge by themselves.
The government has many good policies that must be implemented appropriately to reach the people.

In slum areas, there is a significant gap in women's knowledge about the importance of their health, and they face difficulties in how and if they can access healthcare. They are often unaware of their rights, and government-funded schemes are often unknown in these areas. The government has implemented other schemes to address issues related to poverty and health. Malnutrition is one of the biggest concerns in slum areas, and to address this issue, the government has implemented the Anganwadi program. The Anganwadi works as a kindergarten where children between one- and six years old stay for some hours through the day, and the anganwadi workers provide them with primary education, basic healthcare, and nutrition. The children in the Anganwadi receive a hot meal during the day or supplies that their mothers can take home to prepare nutritious food.

The government introduced the Accredited Social Health Activist (Asha) scheme in 1975, and the Asha workers were implemented in 2005. Asha workers are trained midwives who work in slum areas and villages to educate women about healthcare, prepare them for birth, and provide information on immunization and breastfeeding. She

does weekly home visits of pregnant women and follows up on nutrition in the households and the anganwadi in the villages. These women have spent much time building relationships with the women in the villages and have struggled to gain their trust (Rahul et al., 2021). However, despite their excellent jobs, the Asha workers require training, guidance, and assistance, which the government does not have the funding to do properly.

SATHI addresses this issue. They work alongside the government and educate women in slum areas about their rights, including their right to health. SATHI trains the Asha workers and helps them follow up with their patients. SATHI also holds meetings and seminars in the different villages/slum areas in Pune, where it educates people about their rights and assists them in dealing with health service issues. The health promotion meetings are held monthly in each area sathi has a collaborative relationship with, and the Asha workers are there as a safeguard for the women and a supplement to sathi workers that arrange the meetings.
Malnutrition is, as mentioned, one of the significant issues in the villages, and sathi is focusing on fighting the issue. Together with the Asha workers, the Anganwadi workers, and a nurse from the nearest health facility, they monitor the children monthly; in the meantime, the Anganwadi provides the families with supplements to make nutritious food for the children.

5 Analysis

5.1 Introduction

This chapter is divided into three sub-chapters: Accessibility to healthcare, SATHIs' work for people below the poverty line, and Challenges and opportunities for SATHI. The analysis is based on fieldwork and observations conducted in collaboration with Sathi, who is working to address the issues related to accessible healthcare for people below the poverty line in Pune. The analysis also incorporates my experiences and observations based on my understanding of welfare, social sustainability, and healthcare accessibility in Pune, Maharashtra. The first part of the analysis focuses on three areas: healthcare accessibility and sustainable development.

5.2 Accessibility to Healthcare.

In my notes from one of the first field visits to the Karve Nagar slum area in Pune, I portrayed a grown woman approaching the Asha worker and sathi after the discussions had ended. “We worked very hard for about eight months to gain the trust of the women in this area,” said Rupali, the project assistant at sathi, who brought us along that day. When sathi started their work in the Karve Nagar slum, the women were restrained and did not participate in the discussions during the meetings, and there were not many people at the beginning. The slums have a close community, and there had been a challenge to enter and start these meetings where the NGO came to educate them, disrupting their ways of doing things. Due to expensive healthcare, these people have not visited a doctor for any health-related issues. They have had their ways of handling illness, and chronic diseases like diabetes have never been detected or treated. People in these areas could have had a better and more functioning life if they had been followed up by medical care as they are entitled to.

People had already started gathering when we entered the venue in Karve Nagar. Several of the women brought documents from their doctors and had questions. The question was regarding prices, if bloodwork was necessary, and how they would afford insulin for their diabetic husband. The doctors would have better answered these questions, but the mistrust in the health care system appears clearly when they direct the questions to the sathi workers.

Despite India's pledge to provide universal access to healthcare, the Maharashtra government allocates less than 4% of its budget to health and health services. As a result, several social groups in Maharashtra still do not have access to quality healthcare, and underprivileged individuals are often compelled to choose expensive private options. Maharashtra falls short of the recommended norms regarding primary health centers, sub-centers, and community health centers. Additionally, there are over 1,800 unfilled positions of medical officers in public hospitals, leading to a shortage of capacity in the public healthcare system. The uneven distribution of healthcare infrastructure is negatively impacting the country's education, economic prosperity, and overall human development.

Maharashtra is the third costliest state for hospitalization in rural India, with 80.8% of the rural population still choosing private healthcare providers, not the public sector. This points to a high out-of-pocket expenditure on healthcare, which affects the poor and marginalized sections of society. Although India is stated as a welfare state with an obligation to provide healthcare for the population, these health disparities between different social groups indicate a lack of equitable access to quality healthcare. Maharashtra has high rates of malnutrition, especially in tribal areas where 40% of children are malnourished. The government initiated the Anganwadi to defeat these issues (Ghosh, 2024, January 21).

The combination of insufficient public health infrastructure, inadequate public spending, high out-of-pocket costs, malnutrition, and a fragmented healthcare landscape have resulted in limited accessibility to quality and affordable healthcare for many residents of Pune, particularly the poor and marginalized communities.

There are several tribal communities and slums located on the outskirts of the city. Due to the geographical location, access to healthcare is more difficult due to distance in rural areas and villages. During another field visit to a tribal village in Junnar, we learned that malnutrition is the major challenges faced by the locals. Access to clean water is also a significant issue, and the nearest well was a couple of kilometers away from the village. The day we accompanied sathi to the village, many children and mothers gathered to measure their children. They used the height and weight charts to follow the development of the children. The mothers would get up and tell us all about the progress of their children, one after the other, told us about the positive news of their child had gone from moderate acute malnutrition into the severely underweight category. As everyone applauded their accomplishments, I noticed a woman sitting beside me with two young children. One of her children was sleeping in her lap while the other was climbing around her. While other mothers were receiving applause, she seemed anxious as her turn approached. She could not stand up due to her sleeping child and appeared ashamed as she began to speak. She informed us that her eldest child had gone from being severely underweight to having moderate acute malnutrition - the opposite of what she had hoped for. Before she could finish her sentence, the other mothers in the room began applauding and offered words of support. They reminded her that her achievement was still significant and that they all stood together. Witnessing

how these women uplifted and encouraged each other despite facing similar challenges was heartwarming. Being part of this heartwarming but heartbreaking event gives room for reflection. The fact that these women have to work so hard to provide food so their children can grow up healthy, choose to celebrate their achievements, and not lose hope or give up is admirable.

SATHIs research on complementary feeding practices among children in tribal areas has revealed that most mothers lack knowledge about the appropriate feeding practices necessary to meet their child's nutritional requirements. The commonly used feeding practices are often inadequate and do not provide a nutritionally balanced diet, which can negatively affect a child's growth. The study found that mothers' beliefs, misconceptions, child sickness, child unwillingness to eat, and lack of knowledge contributed to these inadequate feeding practices.

The combination of the anganwadi and the complementary work sathi is doing in this area is significant. Sathi is educating the women about nutrition, breastfeeding, and the importance of a nutritious diet, which has helped them provide the proper food to their children to some extent. The anganwadi provides some nutrient ingredients to the families to allow them to make more nutritious food at home. They now have more knowledge about nutrition and what to feed their children. Still, this village's other challenges, like no water access, prohibit them from growing vegetables outside of the rainy season, another challenge these women face in providing nutritious food.

A nurse from the closest public health facility accompanied us to the meeting. We had an open discussion during which we could ask each other questions. When I was informed that the closest hospital was far away and that getting an ambulance to the village was challenging since not everyone had a phone, the nurse explained that this was a challenge in the other villages in the same area.

Access to healthcare in urban slums is not obstructed by distances but by knowledge.

5.2.1 Sustainable Development Goals 2,3 and 6

At a state-level public hearing in February, people from multiple organizations were gathered to talk with the political parties also attending, where a manifesto about the

demands the people of Pune have regarding their health rights was published. The different organizations had put up ten posters demanding the government to answer and make changes. “Does the government spend enough funds on health?” “Are there adequate health facilities for the population of Pune?” and “Severe malnourished children are the highest in the country!” were the headings on some posters. They demand better healthcare. The meeting was in the local language, Marathi, but we had translators with us, and the people sitting next to us in the auditorium were helpful and explained the main themes throughout the meeting.

The targets of Sustainable Development Goal number three- good health and well-being, have become more visible with the collection and analysis of data. Unfortunately, those who live below the poverty line often don't have access to necessary healthcare due to the associated costs and lack of information. The government of India has implemented policies and schemes to achieve universal access to quality, affordable healthcare, essential medicines, and financial risk protection. However, implementing these schemes is not working effectively or accessible to all. Moreover, there is a shortage of information provided to the public about these schemes. Sathi constantly strives to provide the people of Pune and Maharashtra with information about their health rights.

The health schemes implemented in Maharashtra, especially in Pune, have varyingly impacted efficiency and effectiveness. On the one hand, these schemes have helped significantly improve health indicators like maternal and infant mortality rates and institutional deliveries. However, despite these improvements, the out-of-pocket expenditure (OOPE) on healthcare remains high. This indicates the presence of inefficiencies in the existing health schemes and insurance coverage. A recent study highlighted that despite the availability of social security schemes, many households in Pune still incur substantial OOPE due to inconvenience, unsatisfactory quality of services in government facilities, and cumbersome procedures for claiming insurance benefits. (Palal et al., 2023)

Despite implementing schemes like the Mahatma Jyotiba Phule Jan Arogya Yojana and the National Health Mission, the government health expenditure in Maharashtra has remained low. This lack of public spending could impact the efficiency and reach of

health schemes, as it may not adequately protect households from financial hardship due to healthcare costs. The incidence of catastrophic health expenditure in Maharashtra has increased from 17% in 2004 to 23.3% in 2014, which is higher than the national average increase during the same period. This suggests that the existing health schemes need to be reevaluated to better address households' financial challenges.
The SDG is a goal to ensure healthy lives for all. SATHI is working towards that goal, and the government is doing the same to an extent. There are still a lot of challenges in this work, but with the combination of the anganwadi, the health schemes provided by the government, and the education and follow-ups by sathi, they are heading in the right direction. There has been a great improvement among malnourished children in the slum areas after sathi started their educational meetings with the Asha workers.

5.3 SATHIs work for people below the poverty line.

Improved healthcare access through education, enrollment in government schemes, and advocating for better public facilities and services.
Sathi is working towards strengthening the public health system by collaborating with ASHA workers to enhance health awareness and primary care delivery in slum areas. They are also conducting community-based monitoring and planning of health services across more than 400 villages. The aim is to provide training and resources to strengthen the public health workforce.

Their objective is to promote social accountability through various means. We advocate for regulation and accountability in the private healthcare sector to protect patients' rights. Additionally, we conduct research to document issues such as overcharging and rights violations by private hospitals. We strive to empower communities to voice their concerns and demand better healthcare services.

SATHI aims to enhance community engagement by facilitating various healthcare initiatives. This includes organizing health promotion meetings to raise awareness on different health issues and conducting community-based consultations to review nutrition services and health plans. SATHI aims to address critical gaps in healthcare access, service delivery, and accountability by fostering a sense of ownership and active participation in healthcare initiatives. SATHI hopes to drive significant improvements

in the health and well-being of vulnerable communities through its multifaceted approach.

SATHI's work is divided into four main areas of focus. SATHI aims to achieve the sustainable development goal of good health and well-being through its work. Its focus areas include strengthening the public health system, promoting social accountability within the private healthcare sector, and mobilizing community action for nutrition. Additionally, SATHI conducts extensive research on health policies and systems. During my fieldwork, I have seen some of the outcomes of SATHI work in these areas.

We arrived in Laxmi Nagar in the Kothrud area at 11.30 in the morning. We received much attention, and children came curious, asking our names. Rupali from SATHI accompanied us and told us about the anganwadi we would visit. The trees in the streets were used as drying racks for laundry, and women were sitting outside their homes washing dishes as we walked through. The streets are narrow, and the roads are not maintained. In a small pond made of water from dishwashing stood a small child in only a t-shirt. We walked further up the streets and arrived at the anganwadi. They were doing some construction work at the center, and to enter the anganwadi, we had to step over ceiling tiles and a pile of old bricks and other construction waste. We entered the playground and were met by children playing around on their bare feet, and mothers and older siblings was coming out from one of the rooms in the anganwadi. Rupali explained that the anganwadi was just closed for the day, and they were handing out food for the families as they picked up their children. The government provides food to the families, and sathi helps the anganwadi workers distribute it so all the families are given some food. In the tiny room, more than twenty people were waiting in line to get their share of food while children were walking around tipping over bags of lentils and stepping on the food. Prior to Sathi's involvement in the distribution of food at the anganwadi, there was no proper structure in place. The food would run out before all families could receive their share and some donated food didn't even make it to the center. However, Sathi took the initiative to organize the food distribution system and ensured that everyone received an adequate amount of food.

The Indian government is responsible for ensuring that healthcare is a fundamental right for all citizens. However, it is still a challenge for vulnerable populations, especially

those living in slum areas, to access healthcare facilities. This is where SATHI comes in, playing an indispensable role in educating women about their health rights, training healthcare workers, and conducting community outreach programs to address health service issues. SATHI proactively engages with communities and collaborates with civil society organizations to tackle health and nutrition challenges, advocating for community-based interventions to improve health outcomes.

SATHI´s work on strengthening the public health system discusses the corporatization processes in the healthcare sector in Maharashtra, which are characterized by the emergence of large private hospitals and corporate entities' takeover of medium-sized and charitable hospitals. (Marathe, 2020, April-June).

The research sathi is doing highlights the importance of community-based monitoring and planning processes in improving health indicators in Maharashtra. The research discusses how involving local communities in monitoring health indicators can empower them to use data effectively, hold service providers accountable, and ultimately enhance health service delivery. It may provide insights into the challenges faced in the existing health information systems, the need for socio-cultural data in health planning, and the role of community engagement in strengthening the health system. Sathi aims to share lessons and learnings to inspire health activists, community practitioners, and public health systems to leverage performance health indicators data to mobilize communities toward better health outcomes.

They highlight the implications of these changes on medical practice and professionals, focusing on the shift in employment from practitioner-owned small and medium hospitals to more extensive corporate settings (Marathe, 2020, April-June). The research points to a restructuring of medical practice in Maharashtra, emphasizing the trend towards private education and employment in corporate hospitals, driven by personal indebtedness, reduced government employment opportunities, and the perceived benefits of working in larger providers.

Marathe et al.'s (2020) article, "The Impacts of the Corporatization of Healthcare on Medical Practice and Professionals in Maharashtra, India," describes a 'professionalization' of medicine within the private healthcare sector involving changes in employment relations, performance targets, and constraints on professional

autonomy. This leads to issues like cost inflation, medical malpractice, and challenges in doctor-patient relationships.

Additionally, it discusses the destratification within the medical profession, where 'star doctors' gain prestige and influence while young and early-career doctors face reduced status and opportunities. The research raises important questions about the role of government and medical professionals in overseeing private healthcare transformation and the broader implications of these trends for health systems.

Another article by Marathe (April-June 2020) "Ensuring Accountability and Responsiveness of the Private Health Sector in India: National Workshop Report," addresses the increasing prevalence of unethical practices in the private healthcare sector in India, such as unnecessary investigations, overcharging, and violation of patients' rights. It emphasizes the unregulated and commercialized nature of the private healthcare sector, drawing attention to the need for accountability and responsiveness. It also discusses the challenges of these unethical practices and the importance of regulating the private health sector to protect patients' rights and uphold ethical standards. The workshop report may provide insights into strategies or recommendations to enhance accountability, responsiveness, and ethical practices within the private healthcare sector in India. The private healthcare sector in India is rapidly growing, with around 75% of outpatient care provided by for-profit private healthcare facilities (Marathe, 2020)

The sector has undergone corporatization processes, leading to a shift from simple commercialization to deep corporatization of healthcare, which impacts medical practice and professionals in Maharashtra, India.
There is a lack of effective regulation in the private healthcare sector, and issues like malpractices, patient exploitation, and unregulated private healthcare expenditures lead to severe consequences. Civil society networks, health activists, and public health professionals have raised calls for better regulation and a patients' rights charter, highlighting the urgent need for improved governance in the private healthcare sector.

The National Institution for Transforming India (NITI Aayog) has emphasized the importance of a regulatory framework for commercial insurance. Still, it has yet to

specifically address the profit-centered private sector's implications and the necessity for its regulation before engagement. (Marathe et al.,2020).
SATHI is currently undertaking a project in the habitations of Junnar and Ambegaon-block of Pune district. The aim of the project is to strengthen community action towards nutrition services and to improve the health of malnourished children by reviving food diversity. During a visit to the villages in Junnar, we were shown around the local anganwadi and a vegetable garden, established to provide more nourishing food for the children. The local women explained that the main challenge they face is the water supply since they must travel over two kilometers to collect water from a well. The soil in the area is too dry to grow vegetables outside of the monsoon season, and with no access to water, they rely on forest vegetables. The SATHI worker informed us about the Forest Vegetables Festival, where they promoted food diversity by having three rings on the ground. Everyone was encouraged to bring food from home and place them in the right circle, representing protein, minerals, and carbohydrates.

SATHI is an organization that conducts research to improve public health in India. They focus on promoting community action for child nutrition, strengthening the public health system, and advocating for social accountability in the private healthcare sector. SATHI believes that equitable healthcare access, community empowerment, and regulatory measures are critical to ensuring social justice and better health outcomes in the country. SATHI emphasizes the need for accountability, regulation, and protection of patients' rights in India's corporate and private healthcare sectors. Implementing policies is essential for enhancing healthcare delivery systems, regulating the private healthcare sector, and improving governance for better patient outcomes.

During the COVID-19 pandemic, SATHI researched patient rights violations and overcharges by private hospitals. They collected stories and analyses of people's struggles during the pandemic, highlighting their treatment in public hospitals and how much families had to borrow to pay for private hospitals to treat their loved ones. Many testimonies also mentioned the exorbitant billing amounts private hospitals charge before releasing the dead body of a loved one (Marathe et al., 2024). These testimonies show how private hospitals took advantage of people in vulnerable situations.

SATHI's multifaceted approach to addressing healthcare challenges through research, advocacy, and community engagement is a model for driving positive change in public health systems and promoting social justice.

5.4 Challenges and opportunities for SATHI.

Challenges

It is crucial to create relationships and gain credibility among people living in slums. Issues related to accessibility and enrollment in government schemes for those below the poverty line exist. However, taking on responsibilities from the government by facilitating public measures shifts accountability away from the government. It is important to ensure equal access to healthcare in Pune, especially for those below the poverty line, related to Sustainable Development Goals 1-6.

It took SATHI around eight months to earn women's trust in the Karve Nagar slum area. Gaining credibility within closely-knit slum communities can be a significant challenge, requiring much hard work. Despite India's pledge to provide universal healthcare access, the Maharashtra government allocates less than 4% of its budget to health services. This leaves several social groups, particularly those living in poverty, without access to quality healthcare, posing a challenge to SATHI's efforts.

While facilitating public health measures and taking on responsibilities that the government should handle, there is a risk of shifting accountability away from the government, which could be a challenge for SATHI. Additionally, SATHI advocates for social accountability within India's largely unregulated private healthcare sector. The lack of effective regulation enables unethical practices like overcharging and rights violations, making it challenging for SATHI to address these issues.

Although not explicitly mentioned, civil society organizations like SATHI may face resource constraints, such as limited funding, personnel, and logistical challenges, which could hinder the scale and reach of their initiatives. Furthermore, working in diverse communities with varying socio-cultural norms and beliefs may pose challenges in effectively communicating and implementing healthcare initiatives.

However, SATHI's community-based approach, collaborative efforts with other organizations, and commitment to research and advocacy provide opportunities to address critical healthcare issues and promote social accountability in the healthcare sector.

Opportunities

Strengthening the public health system by educating and assisting ASHA workers is crucial in promoting health awareness and providing primary care in slum areas. It is essential to facilitate community-based monitoring and planning of health services in collaboration with over 400 villages. Organizing health promotion meetings and educating people about their rights are other essential steps to improve the health system. Focusing on fighting malnutrition by monitoring children's health with ASHA workers and providing nutritious food supplements can also help to improve overall health. Promoting food diversity through initiatives like the Forest Vegetables Festival is another approach. Advocating for social accountability within the private healthcare sector is also necessary since it operates with minimal regulation. Conducting research to evaluate health policies and programs and their real-world impact can inform advocacy efforts. SATHI's work presents opportunities to address critical healthcare challenges faced by vulnerable populations, particularly those living under the poverty line. By leveraging its expertise, community-based approach, and collaborative efforts, SATHI can continue to drive positive change and promote equitable access to healthcare services.

6 Discussion

The research conducted by SATHI has brought to light various important aspects of healthcare accessibility, challenges encountered by marginalized communities, and the crucial role of civil society organizations in promoting social accountability and strengthening public health systems. One of the major concerns that were identified is the absence of efficient regulation and accountability mechanisms in the rapidly expanding private healthcare sector in India.

The trend toward corporatization of healthcare has resulted in a shift towards large corporate hospitals, which has had an impact on medical practices, employment dynamics, and doctor-patient relationships. This has led to concerns about cost inflation,

medical malpractice, and constraints on professional autonomy, and their implications for the overall health system. SATHI, through its research and advocacy efforts, has played a crucial role in documenting and addressing the unethical practices that have emerged in the private healthcare sector, such as unnecessary investigations, overcharging, and violations of patients' rights. The organization's work emphasizes the urgent need for improved governance, regulation, and a patient's rights charter to protect the interests of vulnerable populations and uphold ethical standards.

SATHI's community-based approach has played a crucial role in enabling marginalized communities, especially those residing in slum areas and below the poverty line, to access healthcare services and become aware of their health rights and entitlements. By working together with ASHA workers and organizing community-based monitoring and planning initiatives, SATHI has enhanced the public health system's ability to provide primary care and tackle pressing issues like malnutrition. The findings of their research also highlight the significance of addressing socioeconomic disparities and persistent challenges related to poverty, hunger, and access to fundamental services, which are directly linked to the Sustainable Development Goals (SDGs) 1-6.

SATHI strives to promote food diversity in the tribal areas, revive local vegetable gardens, and advocate for social accountability together with the Asha workers. These efforts are in line with the broader objectives of achieving sustainable development and ensuring equitable access to healthcare and essential services. The major issues in many of the tribal areas are no access to clean water, which is preventing them from growing their own food. The village in Junnar is located a couple of kilometers from a lake. The government has made pipelines to other inhabited areas around the lake and the water issues in this villages are known to the local government, but they are not prioritizing this area due to location and costs. At a meeting we had with the local government of Junnar, I raised these questions, and wanted to know if they acknowledge the connection with malnutrition and no access to water in this village. We were talking to the health department in the local government, and they responded my question by telling me that this issue was not related to his department. When I asked again about water access, it was one of the reasons the people in this village do not have the opportunity to grow vegetables due to lack of water. I did not get an answer to this question. I asked if the government provides the villages with water since they do not

have access, as in other villages, by providing water with a truck a few times a month. Still, the tribal village in Junnar is not receiving any water.

SATHI's approach involves research, advocacy, and community engagement. This multifaceted approach has shown that civil society organizations can drive positive change and address systemic issues in healthcare delivery and social welfare. By fostering collaborations, empowering communities, and informing policy discussions, SATHI's work contributes to the ongoing efforts to achieve universal health coverage and promote social sustainability in India.

The corporatization of healthcare in Maharashtra has raised significant concerns about the quality of care, ethical practices, and the overall well-being of patients, particularly those from disadvantaged backgrounds. Addressing these issues through effective regulation, community engagement, and focusing on social determinants of health is crucial for building a more equitable and accountable healthcare system in India. The healthcare sector in Maharashtra is currently being corporatized, characterized by the emergence of large private hospital chains and corporate entities' takeover of smaller hospitals.

This corporatization has led to restructuring medical practice, shifting towards private education and employment in corporate hospital setups, driven by personal indebtedness, reduced government jobs, and perceived benefits of working with larger providers. Within the corporatized private healthcare sector, there is a 'professionalization' involving changes in employment relations, performance targets, and constraints on the professional autonomy of medical practitioners. Issues like cost inflation, medical malpractice, and challenges in doctor-patient relationships have emerged because of this corporatization.

There is a destratification within the medical profession, where 'star doctors' gain prestige and influence, while young and early-career doctors face reduced status and opportunities. The private healthcare sector in India, including Maharashtra, lacks effective regulation, enabling unethical practices such as unnecessary investigations, overcharging, and violations of patients' rights.

These unethical practices are increasingly prevalent in the unregulated and commercialized private healthcare sector, highlighting the need for accountability and responsiveness measures.

The research by SATHI highlights the importance of community-based monitoring and planning processes in improving health indicators and empowering marginalized communities to access healthcare services and assert their rights.
SATHI's work emphasizes the need to address socioeconomic disparities, poverty, malnutrition, and lack of access to essential services, which are directly linked to the Sustainable Development Goals (SDGs) 1-6.
The key findings underscore the significant implications of the corporatization of healthcare in Maharashtra, the lack of regulation enabling unethical practices in the private sector, and the crucial role of community engagement and addressing social determinants of health in improving health outcomes and achieving sustainable development goals.

The paper sheds light on the ongoing corporatization of the healthcare sector in Maharashtra, characterized by the emergence of large private hospital chains and corporate entities' takeover of smaller hospitals. This corporatization has led to a restructuring of medical practice, with a shift towards private education and employment in corporate settings. The findings underscore the implications of this trend, including cost inflation, medical malpractice, challenges in doctor-patient relationships, and the destratification of the medical profession, where 'star doctors' gain prestige while early-career doctors face reduced opportunities. The research exposes the prevalence of unethical practices in India's unregulated and commercialized private healthcare sector, such as unnecessary investigations, overcharging, and violations of patients' rights.

By highlighting these issues, the paper emphasizes the urgent need for accountability measures, a patient's rights charter, and improved governance to protect vulnerable populations and uphold ethical standards in the private healthcare sector.
Emphasizing Community Engagement and Social Determinants
The findings underscore the importance of community-based monitoring and planning processes, as demonstrated by SATHI's work, in improving health indicators and

empowering marginalized communities to access healthcare services and assert their rights. The paper highlights the crucial role of addressing socioeconomic disparities, poverty, malnutrition, and lack of access to essential services in achieving the Sustainable Development Goals (SDGs) related to poverty, hunger, health, and well-being. The research findings can potentially inform policymakers, healthcare professionals, and stakeholders about the challenges and opportunities in the healthcare sector in Maharashtra. By shedding light on the implications of corporatization, unethical practices, and the need for community engagement, the paper can contribute to shaping policies, regulations, and practices that promote equitable access, ethical standards, and improved health outcomes for all sections of society.
Overall, the paper's findings are significant because they can raise awareness, stimulate discussions, and provide a foundation for addressing critical issues related to healthcare access, equity, ethical practices, and the achievement of sustainable development goals in Maharashtra and potentially other regions of India.

7 Conclusion

The paper brings attention to the ongoing corporatization of the healthcare sector in Maharashtra. This is characterized by the emergence of large private hospital chains and the takeover of smaller hospitals. This trend has led to the restructuring of medical practice, with a shift towards private education and employment in corporate setups. It would be valuable for future research to investigate the long-term impacts of corporatization on healthcare quality, accessibility, and affordability for different socioeconomic groups. Additionally, there should be studies on the effects of corporatization on medical education, training, and the professional development of healthcare workers. Comparative studies across different states or regions would also clarify the variations in corporatization processes and their implications.

The research reveals that unethical practices such as overcharging, unnecessary investigations, and violations of patients' rights are prevalent in the unregulated private healthcare sector. This finding highlights the need for future research to focus on developing frameworks and mechanisms for effective regulation and accountability in the private healthcare sector. Additionally, strategies should be explored to protect patients' rights and promote ethical practices within corporate healthcare settings. The

role of professional bodies, civil society organizations, and government agencies in monitoring and addressing unethical practices should also be investigated. Community-based monitoring and planning processes have been shown to be effective in improving health indicators and empowering marginalized communities, as demonstrated by SATHI's work. Future research should evaluate community-based initiatives' long-term impacts and sustainability on healthcare access and health outcomes. Also, replicable models and best practices for community engagement in healthcare planning and decision-making processes should be explored. Holistic interventions should be developed by investigating the intersections between healthcare, poverty, malnutrition, and other social determinants of health.

The research findings demonstrate the complex interplay between healthcare, social welfare, cultural factors, and sustainable development goals. Future research could benefit from interdisciplinary approaches integrating public health, sociology, anthropology, economics, and policy studies perspectives. This could lead to a more comprehensive understanding of the challenges and potential solutions.

Overall, the paper's findings provide a foundation for future research to delve deeper into the implications of corporatization, unethical practices, community engagement, and the interconnections between healthcare and social determinants. Such research could inform evidence-based policies, regulations, and interventions to promote equitable access, ethical practices, and achieving sustainable development goals in the healthcare sector.

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