Chapter III

PUBLIC HEALTH: THE CASE OF BOMBAY
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With rows of high-rise buildings along Cuffe Parade and Colaba, the business towers at Back Bay, the vehicular streams whirling around Flora Fountain, the lights of Marine Drive, the fantasies of the film world, and numerous other ostensible symbols of modernization, Bombay, though not the nation's capital, is India's premier metropolis often described as the most 'city like city' in India. It is the financial capital of the country, as the headquarters of many national and foreign banks, the National Stock Exchange and Reserve Bank of India are all located in Bombay. It is now called Mumbai.

The city of Bombay was the capital of Bombay Presidency once upon a time and the principle seaport of western India. The city is situated in an island in 18° 55' N. and 72° 54' E. This island is one of a group of seven small islands lying off the coast of northern Konkan. This peninsula covers an area of 22.48 sq. miles, and is connected at its northern extremity to the larger island of Thane district, which is further connected to the main land by means of two causeways, one at Sion and the other at Mahim, and two railway embankments. These islands consist of low-lying plains about 11 miles long and 3 to 4 miles broad, flanked by two parallel ridges of low hills. The population according to the census of 1901 was 776,006, and a special enumeration in 1906 placed it at 977,822.

Today, Bombay is a business city and a cosmopolitan centre with its multicultural, multiethnic population, and the economic backbone of India. India is known for its tremendous growth of the population in the world. With a decadal growth of 21.34 % for year 1991 – 2001, the population of the country is 1027million. As a developing country a large chunk of its economic activities are taking place in urban areas, forcing the rest of the population to migrate to the cities. Bombay, being the economic capital of India, and the hub of industrial and commercial activities, it is apparent that people are flocking to this city, as migrants, for job opportunities. Apart from its picturesque location on the Arabian shore, the avenues available in the city for jobs, and other openings have always been a centre of attraction for people from the neighbouring regions as well as from all over the country. As per the 2001 census,
the total population of Greater Mumbai was 11.9 million, of which 3.3 million is that of Mumbai city alone. The decadal growth rate of Mumbai city for year 1981 – 91 was -3.35 and for year 1991 – 2001 was 4.79. Whereas, in case of Mumbai suburban area this growth for year 1981 – 91 was 36.15 and for year 1991 – 2001 was 27.20. Such an extreme rate of population growth on a small and definite area places restrictions, and being as one of the most crowded and congested city makes the life of people miserable, especially for the poorer class, given the inadequate basic amenities, sanitation and housing facilities. The population density of Mumbai city for the year 1991 and 2001 was 20,222 and 21,190, respectively, and for Mumbai suburban areas was 15,137 and 19,255 respectively, as against 257 and 314 for Maharashtra state. The increasing immigrants are an area of great concern for the municipal corporation. The fast and expensive life of Bombay city hardly provide any place for people coming with hopes of survival, but pushes them into congested accommodations in the slums. The 1991 housing census figures showed that in Greater Bombay 73 percent of the population was living in one room tenements as against 68.9 percent in 1981, and average number of persons per room was much higher, i.e. 4.7 persons for one room tenements. According to 2001 census as much as 50 percent i.e. 5.8 million of the total population of Greater Mumbai was living in slums or slum like places. And, at one end many live on pavements at amidst all the abundant affluence on the other end.

**Brief History of Bombay Presidency and City**

Prior to the coming of the British in Bombay Presidency, the region was ruled by various Muslim and Maratha kings from 1600 onwards. In 1698, Kanhoji Angria, an Admiral of the Maratha fleet, reigned supreme on the Western coast from Malabar to Bombay. He had his headquarters at Colaba, then an island-fort within 20 miles of the present city of Bombay, from where he and his fleet fought all enemy ships, including there of the British and Portuguese. His supremacy was broken after his Death, and in 1748 the region was taken by the combined forces of the Peshwa and the British. The latter handed it over to the Peshwas. Some descendants of the Angrias ruled the region as feudatories of the Peshwas. The powers of the Angrias were transferred to the British after the fall of the Peshwas in 1818.
However, the group of islands that we know now as Bombay was a part of the kingdom of Gujarat until 1534, when it was surrendered to the Portuguese. These islands were gifted in dowry to the English king Charles II in 1661, when he married a Portuguese prince. It was leased to the East India Company seven years later at an annual rent of £10 only. The second Governor of the island Gerald Aungier, filled the beaches between the island and Bombay became a compact mass of land, except for Colaba, which was brought in much later. The opening of the Suez Canal established Bombay as the principal 'Gateway of India'. Originally, the island comprised of the villages of Mahim, Parel, Varella (Vadala), Syva (Sion), Mahim and Mazzagon, Bambain and Varal (Worli) (Dossal, 1991).

THE COLONIAL PERIOD: Population and Immigration

Bombay experienced tremendous growth in terms of immigrants during the colonial period because of its trade prospects. The original inhabitants of the Bombay were Kolis, whose main occupation was fishing in the sea. They lived in hamlets in parts of the islands now known as Upper Colaba, Lower Colaba, Dongri, Mazgaon, Naigaon, Sion, Mahim, and Worli. They earned a precarious livelihood by agriculture, fishing and perhaps boat-building. Due to paucity of records about the growth in population and trade, it is difficult to say anything definite about the trade that took place in ancient Bombay Island. The records available for year 1294 mention that the Kolis of Bombay met many strangers during the rule of Silaharas of Puri (810 – 1260), and that the large trade connections, which the chiefs maintained between their ports in North Konkan and the outside world, introduced into the island from time to time, a considerable floating population of traders and merchants, both Hindu and Muslim, Arab and Persians, and even Jews and Chinese (Gazetteer of Bombay City, vol.1, 1977 p. 143). Thus these records point to the phenomenon of immigration to Bombay city from the year 1294. Although some Muslim population was present in this period on the island, their actual immigration started after the complete establishment of Muslim rule in the region. Those who immigrated probably were the Newaties (shipmen), who have merged into the Konkani Muhammadan community of Bombay. It was considered that these people originally came from Arab countries and were driven to India in the 8th to 9th centuries and had intermarried with local Hindu women of the coast. By the year 1530 they settled in Bassein as traders, having
journeyed thither, as also to Bombay, from Surat, Gogha and other towns in Gujarat. Their original settlement was on the island of Mahim. During the period of Portuguese a large number of Konkani Musalman migrated from the main land and founded a colony, which was later included in the fort. The occupation of these migrants was primarily that of sailors and shipmasters but soon they took-up trade and rapidly became the most influential Muhammadan sect in Bombay (Ibid, 1977, pp. 147-148).

The earliest recorded estimate of the population belongs to the year 1661, when the population of the city was about 10,000 and by 1675 the population swelled up to 60,000 due to the gradual immigration of Banias from Surat, and Armenians and Brahmans from Salsette. A new period began with the transfer of the British Government’s headquarter from Surat to Bombay. The fall of Bassein in 1738, the end of the struggle between the old and new companies, a careful foreign policy and great progress in internal administration, all together helped in the growth of Bombay as a trading city. The dockyards were extended under the superintendence of a Parsi ‘Wadia’, or ship builder, from Surat, Lowaji Nasarwanji, who arrived in the city in 1736. A criminal court was developed in 1727 and a mayor’s court in 1728 for the settlement of civil disputes. A bank was established for encouragement of trade and agriculture in 1720. Monetary loans were granted and other conveniences offered to various classes, such as weavers and small traders, whose settlement was held desirable to stimulate trade. Thus people were encouraged in various ways to emigrate from the mainland. Among them were several Bhandaries from Chaol, many weavers from Gujarat, goldsmiths, ironsmiths, several Bhattias and Banias, Shenvi Brahmans and Parsis. The most well-known member of the Parsi community was Rostom Dorabji, who was appointed as Patel of Bombay. Thus the population of the city rose to 70000 during the year 1744 (Ibid, 1977, pp. 153-154).

Mrs Graham in her work on Bombay states that a great influx of Parsis commenced with decline of Surat and the transfer of its trade to Bombay, that the Persians, Arab and Kandahari settlements marked the epoch of the trade in horses, while the Brahman population commenced to increase as a consequence of decline of Peshwas and received a great impetus and has since then been on the increase. In 1812, Bombay was a perfectly secure place and attracted many native inhabitants,
together with much of the wealth of the neighbouring countries. Each year brought
fresh and more wealth and settlers as every sea breeze wafted into the crowded
harbour of Bombay. The third census report, which was brought out in 1881,
mentioned an increase in the population of Bombay to 773,196. The increase recorded
was due to the general progress in trade, particularly in the cotton spinning industry,
the extension of railway communication and the advance of urban administration. The
fourth official census, again, showed an increase in population. This growth was due
to the mill industry and trading. Of the 820,000 population nearly 5.5 lakh were
Hindus, 1.5 lakh were Muslims and about 77,000 were Jain, Parsis and Jews (among
whom Parsis were in twice in number).

After a quarter of century, in 1906 the population of the city increased by
about 2 lakhs, to 977,822 and the religion – wise composition was 706,154 Hindus
and Jains; 168,677 native Muslims; 78,731 Christians of which native Christians were
30,223; Europeans and Eurasian 18,285; Parsis 48,824 and others 5,659. In post
independent India the population of Bombay rose to 2.8 million on an area of 90.8 sq.
miles (ibid, 1977, pp. 159-166).

Thus we see that, right since pre-colonial times, Bombay has had a steady
stream of migrants, who came not just from different parts of the country, but also
from outside the country. The burgeoning economic activities of the city attracted
migrants from nearby rural districts and eventually from the whole country.
Nineteenth century new comers hailed principally from the areas today included in
Maharashtra and Gujarat. Workers from the coastal Konkan strip and the Western
Ghats manned the docks and cotton textile mills. Most of business and trading groups
came from Gujarat. In the twentieth century, and particularly after independence, new
waves of migrants arrived both north and south India (Patel and Thorner, 1996, p. xv).

Settlement Pattern of the City

Bombay town is located in the southern part of the island and had originally
been divided into two quarters. There were separate residential areas for Indians and
for Europeans. The Fort or European quarter was separated from the Indian quarters
(comprised of the old and new Native town) by an open maidan or esplanade. The
central and northern parts of the island were used to grow coconut, date and brab
(palmyra or *tadgola*), palms on oarts (farms), rice and to lay out salt pans. The important Indian communities living in this part of the island were the *kolis* (fisherman), *agris* (farmers), and bhandaries (toddy tappers). The old and new Indian town was settled by merchants and financiers from Gujarat, artisans groups and people in the informal trades from the Deccan, Konkan and Gujarat (Dossal, 1996, p. 91).

The first suburbs date back to the 18th century and were developed by reclamation in Mahim and Sion. Large-scale reclamation of the marshes helped to wield the seven islands together into one mass and a large area was made available for development in response to the burgeoning population. The beginning of the 19th century saw the urban expansion of Bombay outside the Town, and of the Fort to the native Town beyond the esplanade. The original Native town was an Indian commercial residential area like North fort, but more densely populated. The extension of the Native town housed the non-commercial Indian population. The European residential growth outside the fort was confined largely to the suburb of Colaba in the South, and to Parel and its vicinity in the North. The latter suburb was to be abandoned in favour of Malabar Hill in the mid-nineteenth century. The European settlements were located in wooded, sparsely populated areas, offering a scenic view.

Giving details about the early residential patterns, Dossal points out that, around the mid eighteenth century, wealthy Indian merchants and financiers, such as the Wadias, Camas and Jeejeebhoys, who acted as intermediaries in the European-dominated overseas trade, had their own houses in the northern fort as well as the outlying suburbs of Parel, Lalbaug, Byculla and Malabar Hill. This was because they felt the need for more residential space and healthy surroundings. These localities were primarily for the British, though some Indian families, emulating British lifestyle, also lived there.

In the Indian town, residential patterns based on occupations and castes were common. For instance, the *sulphas* or weavers lived mainly on Duncan Road, at Byculla and near Babula Tank. Carpenters were found mainly in Khetwadi; the southern portion of the Mandis was the business quarter of the richest cloth merchants, while the northern portion contained the *Sona-Chandi* or bullion bazaar.
The granaries and major warehouses were grouped along the eastern foreshore. Wholesale trade in copper was concentrated at Paidhuni, in drugs at Ganeshwadi and Sugar and Ghee at Mandvi. Bazaar Gate Street was the headquarters of the Hindu shroffs, indigenous financiers, crucial to the coastal and local needs of Bombay. Mandvi and Chakala were the most important commercial areas in the Indian quarter, fronted by docks. With warehouses and wholesale shops in the close proximity, they constituted the heart of the Indian town (Dossal, 1991, pp.19-20).

The pattern of generalised functional land use observed in Bombay in 1900 was obviously affected by the restrictions imposed by its shape. It is highly probable that in the absence of site restrictions, the city would have grown in a large semicircle around the harbour, and a somewhat different spatial pattern would have emerged. This hypothetical pattern still shows concentric development, but within two ethnically segregated halves, European and Indian, separated by an open green space, a continuation of the green belt surrounding the original town. These two halves are largely the mirror images of each other, composed essentially of the same functional areas: the commercial residential section closest to the harbour and the docks, encircled by an open space also accommodating army troops; which in turn is surrounded by the extension of the commerce-residential section, followed by residential areas near the periphery, bordering on agricultural land. The only variation is the industrial area, which is located in the Indian part of the city, surrounded by working class residential areas. This spatial pattern hypothesised for Bombay also characterised Calcutta and Madras and therefore it is described as the 'colonial port city pattern' in India (Dossal, 1991).

Bombay’s first textile mill was set up in 1857 at Tardeo (in D ward bordering on E ward). Subsequent growth of the industry covered the area from Byculla to Parel (E to F/ S ward) with 82 mills employing 73,000 men by 1900, with 40 percent of the city’s work force. The implications for residential location were important. Prior to this, middle class Indians had been settling in the Girgaum area, while the Europeans and Parsis were colonising Byculla. Further, movement in this direction was now foreclosed and indeed, the Parsis began to shift to Malabar Hill. For the time being the mills constituted the northern border of the city, and they remained confined to the outskirts of the city.
In the second half of the nineteenth century, industries surrounded the native town in a semi-circular belt. Their spread was accompanied by the growth of new working class residential areas, extensive development of the docks, and continuation of the European commercial residential area into lower Colaba (former old women's island). The fort ramparts were demolished at this time and the area was occupied by a row of public buildings; but the Esplanade was left largely untouched. On the whole, the physical expansion did not affect the character of the older urban areas (Kosambi, 1991, p.160).

In 1920, the Bombay suburban District was formed. This included the towns of Bandra, Santacruz, Kurla, Ghatkopar-Kiral as well as the surrounding rural areas and it constituted a separate administrative unit. However, sub-urbanisation on a large scale is characteristic of the post-Independence period. The Greater Bombay Municipal Corporation was constituted in 1950 and the six municipalities of Bandra (including Santacruz), Parel, Andheri, Juhu, Kurla and Ghatkopar along with the village Panchayat of Chembur and 34 revenue villages from Bombay suburbs and Thane district were incorporated in it.

Trade

The growth of Bombay as a modern city began only in the seventeenth century, when the Portuguese offered it as dowry to the English King, Charles II. Writing about the development of Bombay, Haris writes that, 'trade was the basis for the growth of Bombay from a small fortified settlement to a city of some significance within the British Empire' (Harris, 1978, p.7). Since then, it continued to serve as a colonial city fashioned to a large degree by external inputs and demands. Foreign conquests set the stage for the establishment of the city and imperial rule defined the parameters within which it grew. It served as an open gateway for the exploitation of its hinterland and the people of its country. It is through the city of Bombay that resources were transferred from the colony to the Empire. One of the most important reasons for the development of Bombay as a modern trading city has been its link to the world market due to the opening of the Suez Canal. In their initial years, the British identified Bombay as the principal point of growth for their commerce and industry. With this limited intention of trade development, they selectively recruited merchants, artisans and labourers, as well as educated clerks and petty officers.
The people who migrated to the city with the intention of pursuing trade were Hindus, Muslims, Parsis, and Jews, who largely came from the hinterland of Gujarat and Rajasthan. The principal commodities of internal trade were grains, metals, cotton goods, coconuts, salt, timber and piece goods.

The initial growth of Bombay into a major trading centre, and, subsequently into an industrial and commercial centre has been studied by (Harris, 1978, 1996) and (Markovits, 1996). Until the mid-eighteenth century, Bombay was nowhere in the picture on the western coast of India as compared to Surat, which was the main centre for trade. Moreover, it was absolutely incomparable to Calcutta, which was at its peak as a trading and financial centre. Calcutta was well connected with China since the 1770s and its rich and easily accessible agrarian hinterland proved a major asset for its trade (Markovits, 1996, p. 27). The mid-eighteenth century saw a marked increase in the internal and external trade of India, due to the beginning of commercial agriculture and recognition of its large scale mechanised industry. As compared to some of the other European colonies in Asia and Africa, Indian businessmen were capable of exploiting some of the new opportunities offered by the development of trade and industry. While foreign trade itself was largely monopolised by the European firms, financing and forwarding of commercial crops, such as cotton and jute, to the ports, as well as redistributing imported goods to trading areas offered vast business opportunities to the Indian traders. Some trading communities of Western and Northern India seized these opportunities. Among them were the Parsis, who developed special relationships with the British, first in Surat and later in Bombay where they played the role of junior partners in Chinese trade. Bombay’s urban environment was significantly restructured and it emerged as the leading port city within the British Empire. The end of the East India Company’s monopoly of trade with India in 1813 led to the growth of private European firms and agency houses. Bombay served as their headquarters in Western India. In 1819, after the defeat of the Marathas in the third Anglo-Maratha war, Bombay was made the capital of the newly created Bombay Presidency. The expansion of Bombay demanded the destruction of Maratha power in 1819 so that trading links could be developed in the Deccan and could help support the development of communications abroad. The Bombay business class pushed for extended and improved land transport and regular shipping services. Until this was accomplished, Bombay could never rival Calcutta’s control of the great
Ganges waterways. And unless the second was developed, Bombay’s primary advantage – proximity to Europe [Bombay was half the distance from Aden as compared to Calcutta] could never be fully exploited. As it were, there was already an increasing demand for a regular Red Sea steamship service to Europe in the 1820s. The first regular road through the ghats to the Deccan was opened in 1830 and in 1838, a monthly mail carrier service to London was started, creating the Bombay Post Office, in those times the most important one in India. The political conquest of the Deccan led to the formation of Kolaba district in 1841, the Kolhapur district in 1842 and the Satara district in 1848. This further opened up the cotton growing tracts for export. The Bombay merchants took this very opportunity to expand into cotton. The conquest of the cotton growing areas, the opening of communications and the increasing price of American cotton were factors which coincided with each other and proved advantageous to Bombay businessmen. Until the 1830s, Bombay’s trade was fairly insignificant as compared to Calcutta’s. However, from 1830 onwards, Bombay’s trade market witnessed rapid growth. Broadly speaking, two main reasons can be identified for the growth of business and trade in Bombay. One was mainly a rise in Chinese demand for opium, as well as a growing tendency to ship the opium of Malwa through Bombay rather than through the ports under Portuguese control. The abolition of company monopoly of Chinese trade in 1833 stimulated the trade further. With the ‘opening’ up of China by British guns in 1842, a huge market was securely offered to the enterprising Bombay merchants. Bombay also benefited from a renewed interest of the mills in Manchester in Indian cotton, as the textile industry of Lancashire went through a period of quick expansion and found American cotton prices too high. This raised trading in Bombay, which was 40 percent higher than that in Calcutta in 1860.

According to Harris, 'The industrialisation of Bombay followed an import substitution pattern, still a powerful motive in the city. This was the main factor in the development of cotton manufacturing. In 1860, about ten mills employed some 7000 workers. And during the 1880s, 30 to 40 mills provided some 30,000 jobs. By the end of the century, there were 82 mills and nearly 73,000 jobs were provided. In the early 1920s, some 11 percent of the population was said to be employed in the cotton industry. India had become one of the world’s largest cotton manufacturing countries in the number of spindles, fifth in the quantity of raw cotton consumed, fourth in the
size of its labour force, third in the size of raw cotton production. The industry locked Bombay much more securely into the Indian economy and made more difficult the city’s earlier role as an intermediary broker between the Indian farmer and the London market (Harris, 1978, p.8).

Other major developments in this era which added substantially to Bombay’s trade included, among others, the establishment of a rail link between Bombay and the ports in 1871 and the first rail link established to Thane in 1853 and then extended through the Bhor Ghats to the Deccan. It was now possible to channel raw cotton from its major growing areas, particularly from Nagpur, to foreign markets through Bombay. Later the old established weaving centres of Gujarat-Ahmedabad were connected by the railways. Transportation to the North had always been bad, and the sea route was inoperative during the monsoon. But by this time Bombay had a direct and an all-weather connection to the Northern trade routes viz., to the Punjab and the heartlands of India in the Gangetic Plains. Thus, Calcutta’s monopoly in trade was reduced. Bombay also competed with Calcutta to secure the lion’s share of the external services. Its traders lobbied with the government for the profitability of steamship communication. In 1865, a weekly mail service to Aden prepared the ground for securing regular service through the Suez Canal, which was opened in 1866. Henceforth, Bombay’s advantage was enhanced because the closest port to Europe was now secured in terms of man-made communication need. These were the factors that largely proved Bombay’s capacity to maintain global parity in the period after 1865, though the city faced a setback in 1830-1865, due to some international and locally determined conditions. Even when trade was the main activity generating Bombay’s income, there were elements of manufacturing, such as ship-building and repair activities. However, proper manufacturing awaited the development of railways, which in turn was related to the expansion of the British political power.

Indian traders and financiers played a major role in the birth of modern Indian cotton-textile industry in Bombay and Ahmedabad, while the jute industry was owned by the British. In 1931, Bombay had eighty one cotton textile industries, with 3,427,000 spindles (37.2 % of the Indian total), 76,975 looms (42.7% of the Indian total), a paid up capital of Rs. 15 crore (37.1 % of the Indian total), and employing a daily average of 129,057 hands (33.1 % of the Indian total). European and Jewish
controlled mills accounted for 30.9% of the spindles, 29.5% of the looms, 43.1% of the paid up capital and 30.2% of the workforce. The rest was controlled by Indian entrepreneurs belonging to the Parsi, the Khoja, the Vani, the Bhatia, and the Marwari communities, who also owned mills outside Bombay (Markovits, 1985, p.31).

As the demands of the growing population employed in the various mills and manufacturing industries increased, so also Bombay expanded into its hinterland. Since the year 1830 onwards, Bombay never looked back in terms of its trade and economic growth. It retained its position as the financial capital of the country even after Independence. The achievements of the business class of Bombay over more than a century appears more impressive than its counterparts, such as Calcutta or other prominent trading cities. This was possible for the Bombay business class due to its characteristic work style and business behaviour, which helped it to reach that stage. The ability of Bombay to maximize its available advantages and minimize its many hindrances was a special advantage, which helped the business community respond to these challenges and opportunities. The business class of Bombay was more flexible and innovative in response to these business trends. They showed a better capacity to adapt to the challenging conditions of business and at times also moulded or diverted these conditions to their own benefit. The response of the Bombay businessmen to the decline of the opium trade in 1860-1960 shows that this decline did not affect Bombay’s business as much as it did Calcutta’s. Many firms, which had been prominent in the opium trade, managed a successful conversion to cotton trade or to textile industry, in order to avoid the ill-effects of the opium trade. The competing trading cities like Calcutta fell pray to the opium depression.

The Bombay businessmen showed similar flexibility in case of the cotton textile industry. Initially, they tried to gain a share of the domestic market in yarn and cloth but, faced with stiff competition from Lancashire, and, increasingly, from other business centres in India, from 1873 onwards, they turned to the Chinese market in a big way. In the 1880s about 80 percent of Bombay yarn production went to China. Soon, when faced growing competition from Japanese and Chinese mills, they turned gradually again to the domestic market, taking advantage of the Swadeshi movement of 1904-07. They reoriented their mills towards the production of cloth for the Indian customer. Thus, the Bombay industry constantly introduced changes in layout and
organization to adapt itself to changes in market conditions. Apart from this greater flexibility, Bombay businessmen also showed greater capacity to adapt to innovations. Bombay pioneered many developments in the history of Indian finance and the large-scale industry originated in Bombay. The first successful modern factory was Cowasji Davar’s *Oriental Spinning* started in 1854. Modern methods of financial promotion were introduced by the extraordinary financial genius, Premchand Roychand, who towered over the Bombay financial scene for 15 years. The first stock exchange, however rudimentary, was started in Bombay in 1875. Bombay industrialists were responsible for most of the technological innovations in Indian industry, such as the ring spindle, which was first introduced and adapted to Indian conditions at Tata’s *Empress Mills* in Nagpur, a company financed and controlled from Bombay. Production of *Porland Cement* was started by the Bombay-based firm Khatau, automobile and aeronautics industries were started by the Bombay-based pioneer, Walchand Hirachand, etc (Markovits, 1996, p.40). Thus Bombay’s businessmen showed more dynamism than the businessmen of any other city of India during pre-independence period. It is considered that their relations with British businessmen was less discriminatory and hostile than that between Indian and foreign businessmen based in other cities. The Parsi community played an exceptional role in establishing a special relationship with the British.

**Social Role of Businessmen in the City**

One of the significant characteristics of Bombay’s businessmen was that they belonged to diverse ethnic and religious communities. It included traders belonging to many communities of Gujarat, including the Parsis, the Hindu Vanis and Bhatias, the Muslim Bohras, Khojas and Memons, businessmen from other provinces of India such as Sindh and Marwar, the Baghdadi Jews (like Sassoon Family), the non-British Europeans like the Swiss firm Volkarts, the Japanese (Toya Menka Kaisha) and the British. Some of the leading businessmen of Bombay were the Parsi Tatas, who established India’s electric power, steel and vegetable oil industries, the Wadias, another Parsi family, that managed the Bombay Dyeing complex and the Thakerseys, a Bhatiya from Cutch who owned four mills, Raja Govindlal Pitty, a leading Marwari merchant and banker of Hyderabad and Bombay, who owned two cotton mills. The Seksarias were prominent in Bombay textiles. Bombay was the centre of the Indian
shipping and steam navigation Companies, whose driving force was the Gujarati Jain contractor, Walchand Hirachand. The financial expert H P Mody, the financier and mill owner Cowasji Jahangir, the cotton textiles’ mill owner Morarjis, the cotton and grain trade businessman Kilachands, the Parsi industrialist Godrej and many others were icons of Bombay’s business. It is these industrialists who successfully developed their businesses even under unfavourable conditions, thus making Bombay into one of the top-most industrial centres (Markovits, 1996, p.42; 1985, pp. 38-39; Timberg, 1978, pp. 63-64).

These industrialists not only raised the financial status of Bombay as India’s economic capital city but they also helped in its social development. They helped Bombay economically as well as socially. They contributed in many ways to improving the social conditions of the city as they expanded their business. This is one of the significant roles that Bombay businessmen played, and through it, paved the way for a different work culture and ethos for the city. They established many social institutions for the benefit of the poor and marginalized communities of Bombay. Many of them, like Phirozshah Mehta who belonged to the Parsi family, also were active in introducing economic and social reforms for the city. One of the most important values that these traders (latter industrialists) exhibited traditionally and specifically, prior to the period of Independence, was a sense of social responsibility towards the society within which they developed their business. This motivation was not sudden but was more continuous among these businessmen. There is plenty of evidence in the history of Bombay to show that the earlier traders contributed to build the city, with either religious or other motives. In the initial period the motive seemed to have been more religious. Majority of these businessmen of Bombay belonged to Gujarati, Parsi and Marwari communities and carried influence of Hinduism, Zoroastrianism and Jainism, and the contributions they made for the city is a reflection of their religious motives. Numerous social contributions were made by these businessmen, through the establishment of various social institutions such as schools, colleges, hospitals, dharmashalas etc. for the benefit of the people of Bombay and in order to bring about changes in the city. A later section on history of hospitals in Bombay gives an idea that many of the hospitals were established by these traders in the city, like educational and other institutions. Talking about the social motives of these traders, an industrialist Dorabji Tata, mentions in his
speech delivered on 8th February 1911 at Lonavala Dam, “To my father (Jamsedji Tata), the acquisition of wealth was only the secondary object in life; it was always subordinate to the constant desire in his heart to improve the industrial and intellectual conditions of the people of his country; and the various enterprises which he, from time to time undertook in his lifetime, had for their principle object the advancement of India in these important aspects” (from Leaflet on Dorabji Tata, undated). The Tata family has established institutions like, Tata Memorial Hospital, Tata Institute of Social Sciences, Tata Institute of Fundamental Research, all in Bombay and the Indian Institute of Science, Bangalore. There were other such business communities who showed social responsibility and established many educational and social institutions.

Broadly speaking, prior to the nineteenth century the role of these businessmen was restricted to the establishment of such social institutions, to bring about some reforms in society and even in the structure and functioning of Bombay city as part of its development. Such action was more in congruence with that of the social reforms, which were then taking place in Maharashtra, of which Bombay and Poona were the centres. It is important to understand here that the notions of the businessmen to work for the people, which later shaped the work culture of the city, were largely influenced by the reform and social movements that took place in Maharashtra from fifteenth century onwards, initiated by the Bhakti Movement. In this period many saints in Maharashtra, like Chokamela, Gorakumbhar, Dhyaneswar, Tukaram, Ekanath and many others revolted against the religious and social inequality. They advocated social equality and fraternity, and put them into practice in their personal lives.

Subsequently, Maharashtra, and more specifically Bombay, experienced a reform movement, which was the result of the education and exposure to western culture, introduced by British to Indian people. The spread of western education in India after the establishment of British rule over the country created a new awakening in the minds of the people, especially among the educated class. The humanistic ideals of social equality and the equal worth of all individuals, which inspired the newly educated middle class, played a major role in the social reform. They were discontented with the social ills and inhuman social practices then prevalent in Indian
society. Initially the social reform movements formed an integral part of religious reforms, primarily because nearly all the social ills, such as untouchability and gender based inequalities, derived legitimacy from religion in one way or the other. Later they adopted a secular approach by disassociating from religion. Many from the educated classes of Maharashtra were active in introducing correctional changes through various activities among the people of Maharashtra. To name some of them, Bal Shashtri Jambhekar, Jyotiba Phule (Satya Shodhak Samaj -1873), Gopal Ganesh Agarkar, Gopal Krishna Gokhale (The Servants of India Society -1905), Narayan Manohar Joshi (Social Service League), Dayanand Saraswati (Arya Samaj- 1875), Mahadev Govind Ranade (Prathana Samaj- 1842), Keshab Chandra Sen (1849) and Behramji M Malabari, a Parsi reformer (Seva Sadan - 1885). These reform movements mainly intended to bring social equality among the people by eradicating the social ills prevalent in society. Directly or indirectly, the values upheld by these movements influenced the business community of Bombay. It inspired them to take up some responsibilities for the society during this period. Their social concern and actual participation in social reform and developmental activities was one of the main factors that led to their participation in the national freedom movement. The involvement in the national freedom movement, however, was not completely dedicated and committed to the social and national cause, but was due to mixed reasons. One reason was that they supported some of the national business motives; secondly, some credit goes to the traditional values, which nurtured their sense of responsibility and third was the motive of philanthropy.

Whatever may be the reasons for their support of the national movement by the businessmen, it is important to note their contribution around which the movement grew in Bombay. Their support was largely of two kinds: one they were personally involved in the freedom struggle and the other was their monetary contribution to the Indian National Congress and other social causes. During this period the Marwari community was strongly affected by the social reforms, the abolition of untouchability and the nationalist movement. This was true especially after the World War I. Many Marwaris were prominent Gandhian workers in their own right; but the primary contribution of the community was naturally financial. In the years before independence, the amount of money they gave to the nationalist movement has been estimated in excess of Rs. 10 crore. In 1921 the Tilak Memorial Fund collection was
the first large scale fund raised by the Indian National Congress which had just emerged as the mass national movement of India. The leading Marwari industrialists were among the leading donors. G D Birla and Jamnalal Bajaj were active supporters of the Congress. Jamnalal Bajaj was able to use his influence, mediate with people like Anandilal Poddar of Bombay to get other Marwaris to contribute to the fund (Timberg, 1978, p. 68). Many of the industrialists supported the nationalist movement secretly, and some were also fired by value of pride and self-respect and rose against the subjugation of the British Raj. G.D. Birla, a leader of this progressive group and one of independent India's largest industrialists, wrote about the genesis of his nationalism. He said, "when I was 16 (1908) I started an independent business of my own as a broker, and thus began my contact with Englishmen who were my patrons and clients. During my association with them I began to see their superiority in the business methods, their organizing capacity and many other virtues. But their racial arrogance could not be concealed. I was not allowed to use the lift to their offices, nor their benches while waiting to see them, I smarted under these insults, and this created within me a political interest which from 1912 until today I have fully maintained. The other family members of Birla also were involved in social cause. His father Raja Baldevdas and older brother Jugal Kishore were leading a life of retirement dedicated to religion and also supported indirectly Gandhi's program against untouchability and other reforms. In Bombay some of the western educated Parsis also gave their financial support to the nascent Indian National Congress (Ibid, 1978, pp. 69-70).

The support of the educated class, some of whom were also from economically sound conditions, was one of the important factors for the overall success of the first phase of Civil Disobedience. This support was in two forms; one was financial and second was active participation in the boycott of foreign goods. The government's estimation as well as personal testimonies point to a constant flow of funds from business group during most of the campaign for national struggle. The Congress leader S K Patil in Bombay city and Kasturbhai Lalbhai, the Ahmedabad mill owner and friend of Gandhi, have testified to the large amount of financial help which the Congress received from businessmen in Bombay and Ahmedabad (Markovits, 1985, p. 72). Mass participation by merchants, in civil disobedience activities including hartals and processions, contributed notably to the movement in the city. The prosperous suburb of Vile Parle in North Bombay close to the opulent
residences of the Gujarati and Marwari communities became one of the major centers of opposition to the Raj under the leadership of Jamnalal Bajaj, who set up a Satyagraha camp. (Markovits, 1985, p. 74).

This shows that these rich philanthropists played a very prominent role in the growth of national movement were very prominent, and ideas of nation building and pride were prevalent among these individuals. With these ideological motives and inspirations they built many social institutions to promote social welfare and fulfill their responsibilities. We see that prior to independence, although business or related profit was one of the main motives of these philanthropists, they also had a sense of responsibility to share some of the profits of their business with people.

POST INDEPENDENCE PERIOD

Bombay’s growth in the post-Independence era has been phenomenal. Greater Bombay was created in 1951 by combining the old island city of Bombay and the Bombay suburban district on Salsette Island to its immediate north. The limits of Greater Bombay were further extended in the north in 1961. In continuation with the earlier trends, industrial expansion in Bombay continued in post-colonial period also. Bombay’s industry, modernised on a larger scale than elsewhere in India, supported many ancillary enterprises. In response to it the population of Bombay also increased. In order to accommodate the growing population the city had to expand its geographic area, and when it was not possible to grow physically it had to look for a satellite city as an alternative to population growth. The city continues to grow with a multi-ethnic, multilingual identity, accommodating people from diverse communities, who come for employment and other opportunities. The city has developed from a trading city to a metropolitan to a cosmopolitan one, keeping pace with cities in the West, like New York and London.

After acquiring independence from British the goal before the nation was to establish itself as a sovereign and self-reliant country. Therefore the focus was on developmental activities in order to meet challenges like poverty and social inequality, rampant in India society. The country focused on industrial and agricultural development to achieve its target. Bombay, once again got tuned to the
industrial development of the country and the city experienced high industrial growth till the 1970s.

Maharashtra had the largest share of small-scale industrial units namely 14.4 percent of the total number of registered units in 1968-69. About a third of the state's total industries were located in Bombay, around 59 percent, if we include Greater Bombay and the neighbouring district of Thane, and 67 percent if we consider Bombay division as a whole. The share of capital invested in small-scale units, registered and unregistered, probably favoured Bombay area even more. Some 43 percent of Maharashtra's employment in the small scale was said to be in Greater Bombay. It had roughly 31 percent of India's looms, 29 percent of loom production and 23 percent of the spindles. Bombay's 59 mills (out of India's 680) were among the most modern and productive. There were some 2000 diamond firms in Bombay, dealing in gems, organising, polishing, (mostly by cottage polishers in neighbouring Gujarat state), setting and export (Harris, 1978, p.15). In 1961, about 73.9 percent of the factory employment was located in Greater Bombay, Pune and Thane, with Greater Bombay claiming the lion's share of 65.9 percent. (Kosambi, 2000, p.280).

The per capita income in Greater Bombay was substantially higher than any other major city in India. It was also nearly four times the average level for Maharashtra state (excluding Bombay) in 1964-65. Greater Bombay's income per head was estimated at Rs.1500, and the rest of Maharashtra at Rs.400. The Bombay Metropolitan Region had an overwhelming preponderance of large scale factories, for example, 87 percent of basic metals, machine and transport, and 85 percent of rubber chemicals and petroleum (Harris, 1978, p.15).

The city expanded from an initial area of less than 27 sq. miles and the limits of the corporation was expanded thrice, successively, in 1950, 1957 and again in 1965, which brought about 160 sq. miles within the municipal ambit. With tax revenue exceeding Rs.40 crore per year and a per capita tax incidence of Rs.89.13 (probably the country's highest), the Bombay Municipal Corporation provided a wide variety of services to its citizens.

In 1951, Greater Bombay had an area of 235.2 sq. km. and a population of 2.8 million. Of this Bombay city accounted for an area of 65.5 sq. km, and a population of
2.3 million, while Bombay suburban district located in Salsette comprised 169.7 sq. km area and 0.5 million population. Hence in 1951, the northern municipal boundary of Greater Bombay was Versowa, Oshivara and Majas villages in the West and Paspoli, Kanjur and Bhandup in the east. In 1957, the administrative and jurisdictional limits of the Corporation were extended in the West up to Dahisar and in the East up to Mulund (M.C.G.B. 1964, cited in Kakade, 1998).

However, since the 1980s there seems to be some measure of de-industrialisation. The city saw some stagnation in 1970s and 1980s, when total employment in the registered sector also fell; however, employment in the unregistered sector is estimated to have increased by 159 percent between 1973 and 1987. Formal sector employment in industry declined absolutely in 1980s. The share of manufacturing in the city’s output had already declined in the 1970s, from 41 to 37 percent. This decline was largely due to poor performance of the cotton textiles and garments (employment here seemed to have declined over 200,000 to a remarkable 60-70,000 in the two decades to 1990). It also affected food, machinery and chemicals. Simultaneously, there was expansion in rubber plastics and oil products. It seems that like cities elsewhere Bombay has declined as manufacturing centre or has changed the scale of operation from registered to unregistered units (Harris, 1996, pp.49-50).

For years together Bombay has been receiving a daily stream of several thousand immigrants. It is pointed out that the number of job seekers arriving in Bombay is no more than those who have gone to other parts of states. It was generally estimated that the population of the metropolitan area (as a whole) would increase from 7.2 million in 1971 to 9.9 million in 1981, 11.6 million in 1988 and 13.5 million in 1991, and that in the absence of some conscious and forceful policies to deflect growth from the BMC limits, Greater Bombay itself would account for 7.8 million in 1981, and 10.6 million in 1991 as against 5.97 million in 1971. Time and again the idea of setting a ceiling on the population of Bombay city has been mooted (Sivaramakrishnan, 1993, p.17). As per the census 2001, Greater Bombay’s population is one crore and 19 lakhs.

The problems of the city stem from excessive concentration of population and activities and the limited space. Efforts of planning of the city began in the late forties
of the last century. A development committee headed by Mayer and Modak was
appointed in 1948. They suggested, among other things, the inclusion of the suburbs,
setting up heavy industries beyond the Thane creek, and establishment of satellite
towns in Panvel, Kalyan, and Bassein. In 1965 the Gadgil committee suggested the
setting up of Bombay Metropolitan Regional Planning Board, which was constituted
in 1967. It recommended a multi pronged approach, of which one was the
development of a metro centre on the mainland, which would open up an east-west
axis movement. In order to decongest Mumbai, the then Bombay Metropolitan
Regional Planning Board (BMRDA), in 1970, prepared a regional plan in which the
development of a twin city, to be known as New Bombay (now Navi Mumbai) was
mooted (Sharma, 2001, p.17). The prime purpose of building New Bombay was to
contain the congestion on Bombay Island and its suburbs.

In year 1991 the population of Greater Bombay district was 9.9 millions, and
that of Greater Bombay urban agglomeration was 12.6 millions, which made the latter
the sixth largest metropolis in the world like Mexico (20.2 million), Tokyo (18.1), Sao
Paulo (17.4) New York (16.2) and Shanghai (13.4). In Maharashtra, Greater Bombay
was the single largest destination of migration in 1991. It claimed 46 percent of the
inter-districts rural urban migration, and 64 percent of the inter-state rural urban
migration. For urban-urban migration the corresponding figures were 20 percent and
54 percent (Kosambi, 2000, p. 280).

Thus, to have an over all view of the development of Bombay in terms of
population and administrative growth we can say that, at the time of Independence
'Bombay as an island had about 23.28 lakh populations on an area of 68.71 sq. km.
This inadequacy of land made it obvious to the citizens of the island that they needed
to look for alternative place for settlement in the suburban areas of Bombay. In 1950
the suburban area, consisting of Bandra-Kurla to Jogeswari-Bhandup, an area of
210.34 sq. km. with 5 lakhs population, was incorporated into the municipal
corporation as a town planning development. In 1956 the remaining 158.66 sq. km
area that extended till the suburbs of Dahisar-Mulund, was then added on the same
pretext. Now according to the 2001 census the population of Mumbai island is
33,47,802, where the population of the suburban area is 48,80,075 and of the extended
suburbs is 36,86,521, making total population of one crore 20 lakhs over a total area
of 437.71 sq. km of Greater Bombay. Interestingly these figures indicate that the population of the island city has not even increased to one half of its size in the last fifty years. On the contrary, the population of suburban area increased by more than 9 times, and in the case of extended area it increased by 25 times for the same period. Importantly, of the 35.5 lakh population, of the island city about 10 lakh people are residing in the slums, pavements of the roads and old houses. In case of the suburb and extended suburb out of 85.5 lakhs population more than 55 lakhs people are living in the slums or slums like area without any basic amenities. When the suburb and extended suburb of Mumbai were absorbed in Mumbai Corporation a provision was made to have independent allocation for suburb and extended suburb. While doing that the probable intention was that such provision would create more space for better service delivery in these areas. But it did not happen, in reality it remained as a sub-part of the main budget allocated to Municipal Corporation. And it ultimately resulted in making the officers and people’s representatives reliant on the Municipal Corporation. According to the 1981 census when the population of the suburbs increased by more than 20 lakhs than the population of Mumbai city, it was decided to increase the number of councillors from 140 to 170, of which 68 councillors were for Mumbai city and 102 for suburbs. Today there are 226 councillors for in all Greater Bombay Corporation.

To carry out the work of people at one place in the local areas 17 wards were created in 1963 and a ward officer appointed for each of these wards. To have better coordination in there functioning, to have control over them and increase the efficiency in the work and communication, three zones were created – one for Mumbai city, another for the western zone and the third for the eastern zone. For each of these zones Deputy Commissioners were appointed. Today they all have been ranked as Assistant Commissioners. These officers were expected to discuss the needs of the people with the councillors of the respective wards, evaluate and prepare a report to present to the senior officers for planning and implementation. During 1983, to reduce the heavy workload of the corporation two IAS officers was inducted as Additional Commissioners and later it was increased to four. In 1972, the 74th amendment by the Parliament made it mandatory for the giant municipal corporation to be divided into sections and to appoint co-operative committee in each of these sections for better administration. Accordingly, with the sanction of the legislative
assembly the Maharashtra Government brought concurrent amendments in the Mumbai Municipal Corporation to adopt new changes. But in reality these committees have to wait till the 21st century to function. At present the Municipal Corporation is handling Annual budget of crore of rupees, with a meagre staff of 1.5 lakhs for as much as 1.25 crore population’ (Mahajan, J B, Loksatta, 6 September, 2002, translated from Marathi).

Public Health

The residential pattern and the attendant spatial distribution of disease and mortality were shaped by the rapid expansion of the textile industry. With some variation this holds true even today. In the latter part of the nineteenth century the municipal health officer, T.S. Weir, had heated debates regarding water supply and sanitation, with other members of the municipal corporation (Health Officer’s Report for Bombay Municipality, abstract in Report on Sanitary Measures in India, House of Commons, Accounts & Papers, 1889 & 1892).

Apart from the industrial expansion, which influenced the health of Bombay, years of famine added to the steady drift into the city of destitute from the countryside. In 1877 there was a major movement of people into the city to escape the famines that spread over much of Western India. The localities to which these people came were Khara Talao and Kumbharwada (today’s C ward). The Chief Medical Officer drew attention to caste differentiation in mortality in this locality at a time of crisis, when different classes found themselves living next to each other by the force of events (Health Officer’s Report 1877, Abstract in House of Commons, Accounts & Papers). The crude death rate among Hindus was 58.8 per thousand, but among lower caste Hindus it reached 94.0. Weir also commented on the high mortality among destitute migrants in the city (Ibid. 1877). This issue is debated even today: Do migrants arriving in the city for treatment or for subsistence ‘bring their own mortality with them’. Or is it the case that migrants are forced to live in overcrowded or marginalized localities where environmental conditions are at their worst? We can see the early signs of the creation of the modern C ward as a kind of ghetto (Ramasubban and Crook, 1996, p.146).
In the 1880s, Weir commented in some detail on Bombay’s spatial mortality differentials. The highest mortality in the city then was (the modern Island city) to be found in certain localities within the modern C and E wards. Tubercular mortality was also highest in these two wards, and is till today the highest in E ward. Weir comments on the fact that cholera was widespread among lodging house dwellers in Kurla and even in parts of D ward. Ward A had lower mortality from cholera. Mortality has much to do with one’s ability to withstand the worst onslaught on the body from adverse environmental conditions: Nutrition and access to health care are crucial in determining the mortality outcome. The social composition of the Fort area (which included the cantonment) was on the whole more likely to represent a better nourished population than in the neighbouring C and E Wards, whatever the environment (Ibid., 1996, pp.146-147). It may have been the case that the mill workers living in the Parel area also enjoyed lesser mortality as a result of fairly stable employment conditions at the time of economic boom. But by the 1890s Parel was also referred to as one of the high mortality localities, and Weir concluded that the very rapid residential expansion here during the previous decade was responsible for this. There were 30,000 mill workers in the 1880s, and 73,000 by the end of the century. He noted that the new residential areas had no sewerage connections (Health Officer’s Report, 1889-90).

By the end of the century the mills were no longer located on the fringes of the city. Areas such as Sion, Mahim and Worli had lower mortality rates than those further South (until one reached South Fort at Malabar Hill). The elite were still resident in some of the new frontier regions (to the North of the mills) and were able to colonize the western seaboard, a location that ‘filled up’ much more rapidly before the advent of luxury high rise apartments. The middle classes could no longer move gradually northwards to less crowded areas as such a move by that time required leap frogging the polluted area of the mills. Hence there was a considerable degree of juxtaposition of poor and middle-income groups to the South of the mill area. In 1892, the South Fort locality returned a mortality rate of 8.6 per thousand, compared to 46.2 in Kamatipura. In nearby Mahalaxmi, the rate was only 15.3 (Ramasubban and Crook, 1996, p. 147).
The noted technical debate on the advisability of flooding the city with water from additional sources while the drainage system remained inadequate to take it away seemed to miss the important class and economic dimensions influencing the level of Bombay’s mortality not only during the late nineteenth century, but for the whole of the twentieth Century as well. However, at the same time, the debate did reflect the formation of class positions on public health, with property owners opposing the raising of taxes and the disruption that public works expenditure would entail, an opposition that culminated in hostility towards the establishment of the City Improvement Trust in 1898 (Ramasubban and Crook, 1996, p.148).

Bombay was prey to catastrophes whether it was a famine in the countryside, which drove cultivators to the city, or epidemics in the city itself, which drove out its inhabitants to the rural areas. For example, the droughts of 1802-3 and 1899-1900 prompted major flights from the land to the city. It is said that the bubonic plague of 1897 forced out, some 10,000 in the first week; at the peak of the epidemic, over half the inhabitants had fled the city. No sooner was the plague curbed than rural famine generated a reverse flow until the epidemic returned in 1900. Economic fluctuation stimulated similar – if less large and panic stricken-reactions. The authors of the 1931 census estimated that, because of the flight from the slump, their enumeration of the city’s population was possibly 2 lakhs below what it might have been. (Condon, 1900, p.130, cited in Kakade, 1998)

The city was always ill prepared either for disaster or even for simple growth. Its settlement and extension was haphazard even when, as in 1803, a catastrophe laid waste a major part of the inner city, making possible systematic re-planning. Once the danger of attack from sea and land disappeared, the richer inhabitants moved away from congested and extremely unhealthy conditions within the front area – covering part of what is today the central business district and southern area of the docks. Continuous efforts throughout the eighteenth century to consolidate the landmass by drainage and to exclude the tide with dykes made more land steadily available. The Sion causeway was completed between 1798 and 1803, and the last gap – the southern extremity at Colaba was spanned in 1838. New settlements were created at the beginning of the nineteenth century at Dongri Hill and Backbay. In the 1830s, country houses were established on Malabar Hill near the Governor’s summer-time...
residence on Malabar Point (1835). With slow improvement in transport and growth in population, the 'native town' also moved outwards from the walls – to Byculla, Mazagaon, and Kamatipura, and then to Dhobi Talao, Girgaum, Choupatty and Khetwadi. Beyond what was becoming the island (i.e., the consolidated land area of the original seven islands) Salsette peninsula, there were market gardens and the country estates of wealthy Paris and British.

In the middle of the century, the danger of epidemic and the growing wealth of the city promoted the final destruction of the fortification and the filling in of ditches, yet there was little sanitation or safe water supply. Improvements depended upon a tangible danger; otherwise the restless pursuit of self-interest that had created the city continued undisturbed. Even the monumental status symbols of a rich business class – the town hall, the university, the railway station, the post and telegraph office – waited for their creation upon the great prosperity of the 1860s. Bombay's pride was in achieving the first elected Municipal Corporation (in 1873), India's first stock exchange (1875), private telephones (1881), and tramways (1877), rather than in the use of its wealth to improve the welfare of the majority. (Report on the Development Plan for Greater Bombay, Bombay, 1964, pp.24-31, Town Planning in Maharashtra 1914-64, Poona 1964, cited in Kakade, 1998).

Even without periodic disasters, conditions were appalling, although possibly not worse than those existing in London or other major European cities in the first half of the nineteenth century. The 1814-15 Census recorded that some 27 percent of the enumerated population was 'floating' and that there were some 20,000 'houses' for the rest, or 7.8 persons per house. The rich might flee the inner city, but in their wake came the shanty towns, which soon reached Malabar Hill, Breach Candy, and Mahalaxmi, still high-income residential districts. In most areas, the city was as foul as some medieval slum (For a detailed account, see S.M. Edwards, 1902, p.170, cited in Kakade, 1998). At the beginning of the twentieth century housing statistics came to be seen as one of the indices of squalor. The 1911 Census recorded that 69 percent of the population lived in one-room dwellings. A 1921-1923 survey noted that 97 percent of working class families lived in single rooms, which housed between 2 and 8 families. The 1931 Census calculated that on an average 4.4 people lived in each of the quarter of a million tenements (and over 80 percent of the tenements consisted of
one room). By 1951, the average had risen to 6 people per room (Harris, 1978, pp.10-11)

A series of hospitals was opened in Bombay city as per the demand of the local people to provide health services, although it is a different matter whether it reached the needy people of the locality or not. On the other hand, the public health department also developed its infrastructure to serve its citizens. Under Act XI of 1845 the Board of Conservancy was authorized to make appointments of officers without any limitation, subject to the sanction of the justices in session. Another important landmark in Bombay history is the establishment of the Bombay Municipality under the Municipal Act 1861, which was further converted into Bombay Municipal Corporation (BMC) under an Act, to govern the city. The Board of Conservancy was superseded by Act XXV of 1858 and was supplanted by a triumvirate of commissioners. As this experiment was unsuccessful, the same was superseded by the Municipal Act of 1865, which forms a very important milestone in the history of local self-government in Bombay. This Act changed completely the executive machinery of the municipality and introduced a consulting officer of health as one of the principal functionaries. A part time officer was created for services of conservancy in the BMC. Hence the Commissioner cancelled the contract and organized the Public Health Department under which the following establishments were incorporated:

1. Scavenging establishment
2. Drain cleaning establishment
3. Road sweeping establishment
4. Town sweeping Bunder establishment
5. Market and slaughter houses establishment
6. The night soil and halalkhore establishment
7. Foreman, carpenter and store-keeper’s establishment.

For the convenience of sanitary administration, ten wards were created which were further divided into number of sections and subsections. In charge of each ward was a European Inspector whose duty was to conduct daily rounds to ensure cleanliness. Towards the end of 1863 Dr. Leith was commissioned by the government
to report on the sanitary conditions of the city. He came up with some striking findings in his report. The municipal reforms as embodied in the Act II of 1865 were largely based on his report. The Act came to be implemented on 1st of July 1865 and the health department was formed by the end of that year (Manual BMC, 1977, pp. 2-3).

The constitution of the Municipality was subsequently altered and finally settled under the Municipal Act of 1888, which also provided for a full time health officer for the city at the end of the nineteenth century, in 1896. The occurrence of plague in Bombay forced the Municipal Commissioner as well as the Public Health Department to take special measures. The Patients were admitted to hospitals but they did not get proper services. To overcome the drawbacks the authorities came up with some strong steps. Firstly, the government appointed a Committee for the abolition of plague. Secondly it allotted seven Deputy Health Officers for the seven wards of the city in 1896. The appointment of these officers caused some resentment and heart burning on the part of the old staff. These Deputy Health Officers had to chiefly work for the removal of plague cases to hospitals and ensure disinfection of the houses. With regard to medical relief for the poor, although efforts were made to streamline the work of registration of births and deaths, the system was still unsatisfactory. Barring the statutory obligation of the corporation for making a contribution towards the maintenance of the three Government hospitals, the JJ, GT and Cama Hospital, practically no provision for medical relief to the poor existed in the city. Thus until the beginning of the nineteenth century no medical aid was provided by the state to the poor (Manual BMC, 1977, pp. 4-6). After independence, due to the rapid growth of population and urban-rural migration, the city started expanding greatly towards the immediate hinterlands. The expansion of Bombay Municipal Corporation in the 1950s was mainly to provide adequate facilities and services to the expanding population. The problem of medical relief was also entrusted to the medical relief and public health committee of the Bombay Municipal Corporation and it was made responsible for the maintenance of public hospitals and health care centres.
Functions of the Public Health Department

The following functions are performed by the staff in the wards under the supervision and guidance of the Executive Health Officer, the Deputy Executive Health Officer, 4 Zonal Assistant Health Officers, and an Epidemologist.

1. Prevention and control of communicable diseases
2. Maintenance of vital statistics regarding births, deaths and occurrence of diseases
3. Maternity and child welfare services
4. Medical relief through dispensaries, including mobile dispensaries
5. Regulation of places for the disposal of the food
6. Prevention of adulteration and misbranding of articles of food.
7. Licensing and controlling trades dealing in food and those coming under the purview of sections 394 and 412 A of BMC Act and Maharashtra Prevention of Food Adulteration Rules 1962.
8. Licensing and controlling trades (other than food establishments) involving nuisance or danger to public health
9. Controlling places of public amusement from public health point of view, namely cinema houses, drama theatres etc.
10. Registration and inspection of nursing homes
11. Licensing of nursing establishments
12. Expansion program of public health and medical relief services
13. Other miscellaneous functions, such as inquiries about proper lunatic cases, control over Dhobiwada at Mahalaxmi, control of VD clinic and laboratories, lifeguard services at Juhu beach, seizure and impounding of stray cattle, etc.

Organization of Public Health Activities

The medical and public health activities in Greater Bombay are entirely carried out by the Municipal Corporation of Greater Bombay. The subject of public health is completely dealt with by the Corporation and, hence, the department of
public health of the state government has little voice in this matter. The controlling authority of public health services is the Executive Health Officer, who in turn is responsible to the Municipal Commissioner. The deputy Executive Health Officer and Assistant Executive Health, along Officer with other staff, help the Executive Health Officer in his/her day to day work. The public health committee, one of the special committees of the Corporation, gives guidelines to the public health department in order to carry out effectively the public health activities in Greater Bombay.

**History of Hospitals in Bombay**

The unhealthy climatic conditions of Bombay created a need for the East India Company to establish a hospital in Bombay, as early as in 1668. The Bombay Office of the Company wrote to the headquarters at Surat in October of that year stating that many soldiers were ill and that medicines were urgently required ‘especially marmalade of Bussora for the flux; the epidemical disease of their place (Kala, 1985-86, p.17). As a result of this, during the Governorship of General Aungier, a representation to the Court of Directors ultimately got the erection of a hospital sanctioned in 1675. But the proposed building was never erected. The old court building in Esplanade to the south-east of the present Cooperage was transformed into a hospital in 1677. It was Bombay’s first established hospital and continued to be used up to 1773. Later a new hospital was built on Hornby Road, which was used until 1860 when the medical authorities closed it and the Government decided to sell it. But the medical services were available only for the military and the European civilian population. No state medical aid was provided to the local people till the beginning of the nineteenth century. But the activities of the public department of the BMC had started much earlier; it can be traced to the conservancy service. The office of the scavenger appears to be one of the most ancient civic offices and the office-in-charge at times, took charge of the primary functions of the conservancy – the duty of collecting the ground rents. In those years the conservancy of the city was the only problem that the scavengers had to deal with. But since 1757, public health appears to have received the constant attention of the government. During those days, the public had nothing between them and the ‘Angel of Death’, except one medical man. Going back to the eighteenth Century serious efforts were made by the public health department in order to stop the ravages of small pox. During the later part of
eighteenth century, action seems to have been taken by demolishing the houses from point of nuisance. The town was gradually cleaned and a new town began to rise (Manual BMC, 1977, pp. 1-2).

Soon after, some changes were brought about by the order issued by the Board of Directors in September 1785, under which the entire administration of the city was carried on by different Boards, because there were no special departments to look after the problems of public health and conservancy. These Boards were authorized by the Institution of Justices of Peace for the Municipal Administration of the City. The statute instituting this change forms an important landmark in the municipal government of Bombay, for it replaced the autocratic regime of the scavenger and other officers by corporate control. The most interesting functions attached to the Justice of Peace were those of looking after the cleaning, repairing and watching of the streets and levying assessments (Ibid, 1977, p.1).

In 1809, a kind of native general hospital, provisioned by the government, came into existence that treated about twenty patients daily. These were mainly destitute. The citizens of Bombay held a public meeting for the establishment of a dispensary and one was started in the Fort area in 1854, followed by several other private dispensaries on the persistent demand of the local people. To cater to the requirements of the city, J J hospital was constructed by Dr. James Burn in 1843. The construction cost of the hospital was met by the East India Company and Sir Jamshedjee Jeejeebhoy, the first Baronet. There were many dispensaries set up during the period 1850 – 1862, mostly financed by Indians and run by Indian doctors and medical assistants. Bhau Daji started Nagdevi Dispensary in 1850. Burjorji Dorabji started the Fort Gratuitous Dispensary in 1852. The Meethabhayi Hormusji Charitable Dispensary was established at Kurla in 1856 and the Jagannath Sankar Sheth Charitable dispensary at Girgaum in 1858. Other dispensaries were set-up by Cawasji Jehangir at Bandra, Jehangir Nasserwanji at Mahim, Khoja Sajanbhai at Meerally, Nasserwanji Manekji Petit at Khetwadi and one by Ardesir Hormasji Wadia, etc. (Ramanna, 2000, p.52).

Other large hospitals were constructed in 1882, including Cama hospital and three hospitals providing medical facilities for women. This move was initiated by Sir Sorabjee Shaporjee Bengali. The third group of hospitals centred around the Gokuldas
Tejpal General Hospital on Carnac Road, which was established in 1865. This hospital became the second main centre for Indians, as the existing hospital facilities were inadequate. The initial task of establishing hospitals in the city was taken up by the Europeans for their own welfare. However, increasing interest among the aristocrats as well as elite Indians in providing health services to the local people led to the establishment of a number of other hospitals. The year 1890 saw the establishment of a new hospital named Bomanji Edalji Albless Obstetric hospital. In the same year the Acworth Leper Asylum at Matunga was started. In 1892 the obstetric ward of the Jamsethi Jeejeebhoy Hospital was replaced by the Bai Motlibai Wadia Hospital and the Sir Dinsha Maneckji Patit Hospital, and an outdoor department for both these hospitals was provided by the Dwarkadas Lallubhai Dispensary for women and children.

In comparison to urban areas in other states, much better medical facilities were available in Bombay because of the effective network of medical institutions controlled by the Government, Bombay Municipal Corporation and charitable trusts in the city. These hospitals are well equipped and known in the country for their effective services. Table 3.1 below provides details of the steady growth of government and government aided hospitals and dispensaries in Mumbai till 1960.

Table 3.1

<table>
<thead>
<tr>
<th>Hospitals and Dispensaries in Mumbai in 1960</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1920</td>
</tr>
<tr>
<td>General hospitals and dispensaries</td>
<td>21</td>
</tr>
<tr>
<td>Hospitals and dispensaries for females</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
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</tbody>
</table>


These 74 hospitals contained 4528 beds, including 1630 beds meant exclusively for women patients during 1960. Moreover there were thirteen hospitals and dispensaries with 500-bed capacity catering to womenfolk. By 1975 the number of hospitals rose to much as 191 hospitals and 284 dispensaries with bed strengths of
19,526 and 27 respectively, the details of which are provided in the following Table 3.2.

**Table 3.2**

Hospitals and Dispensaries in Mumbai during 1975

<table>
<thead>
<tr>
<th>Management</th>
<th>Hospitals</th>
<th>Dispensaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Beds</td>
</tr>
<tr>
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<tr>
<td>Central government</td>
<td>8</td>
<td>1477</td>
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<tr>
<td>Municipal corporation</td>
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<td>7187</td>
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<tr>
<td>Others</td>
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<td>6171</td>
</tr>
<tr>
<td>Total</td>
<td>191</td>
<td>19526</td>
</tr>
</tbody>
</table>


To meet the need for teaching and training of medical students Bombay City had a number of medical colleges. Some of them are known for their excellence in the field of medicine in the country. These hospitals are BYL Nair Hospital located in Bombay Central.

KEM at Parel, Sir JJ Memorial Group of Hospitals at Byculla, and Lokmanya Tilak Municipal Hospital at Sion etc. To provide education in traditional medicine the city has hospitals like Podar Hospital at Worli, Smt. Kamaladevi Gauridatta Mittal Punarvasu Ayurvedic Mahavidyalaya at Charni road, Ayurvedic Hospital at Sion, and instructions in homeopathy are provided at the Government Homeopathy Hospital at Irla, etc. The city also developed a number of specialized hospitals for its population like the Tata Memorial Cancer Hospital, Acworth Leprosy Hospital, Kasturbhai Hospital for TB, hospitals for Eye and ENT of Municipal Corporation, BJ Wadia Hospital for Women and Children, an orthopaedic hospital at Haji Ali for physically handicapped people, and Cama and Albless Hospital at Fort etc. Apart from hospitals managed by the government, Municipal Corporation and private bodies, the city also has hospitals specifically serving the government employees, such as staff of railways, the police, the navy, port etc. These hospitals are run under the Employee State Insurance Scheme (Greater Bombay Gazetteer, vol III, 1986, p.189).
Hospitals Managed by State Government

St. George’s Hospital at Fort, the JJ Group of Hospitals at Byculla, GT Hospital, Cama and Albless Hospital at Worli, Government Homeopathic Hospital at Irla, and the Police Hospital at Nagapada and Naigaum are some of the hospitals controlled and run by the state government. The following paragraphs carry some interesting information about the establishment of these hospitals and their founders, and the services provided by them (The details have been culled from the Greater Bombay Gazetteer, vol. III, 1986).

St. George’s Hospital

The hospital was formally known as European General Hospital and was later taken over by the state government. Its construction was completed in 1892 and had 130 beds. Over a period of time the hospital extended its work and now it is considered to be one of the largest hospitals in Mumbai with 467 beds. During 1977, the hospital had 34 doctors and 838 nurses.

Sir JJ Hospital

This is one of the premier government hospitals in the state and renders a wide range of medical aid in almost all type of specialized care. The foundation stone of the Sir JJ group of Hospitals was laid in 1843 and the hospital was formally opened in 1845. The cost of the hospital was jointly shared by the East India Company and Sir Jamshedji Jeejeebhoy Batliwala. A new building was added to the hospital in 1961. Initially the hospital had 18 wards with 237 beds. By 1977, it increased to 1292 beds. There are two other hospitals as a part of the JJ Group of Hospitals known as B J Hospital for children and Sir C J Ophthalmic Hospital. All these hospitals are situated in one compound and are also attached to a full-fledged medical college called the Grant Medical College. The hospital has received encouragement and guidance from Indians such as Jagannath Sankarseth and Bhau Daji Lad, the latter being one of its first medical graduates.
**G T Hospital**

The Gokuldas Tejpal Hospital was established in 1868 for Indian nationals. An endowment of Rs. 1.5 lakhs was offered by Gokuldas Tejpal. In the initial stage the hospital started with 120 beds in year 1874, of which 20 were for women, later it increased to 521 in 1980. There were 13 doctors and 167 nurses, working in the hospital in the year 1977. In the year 1920 the total indoor patient and outdoor patients were 4,388 and 12,274 which increased to 1,75,200 and 2,42,300 respectively in the year 1980.

**Cama and Albless Hospital**

The Pestanj H Cama Hospital for Women and Children, with which are connected the BE Albless Obstetric Hospital and JS Dispensary, originated in a movement commenced in 1882 to offer medical assistance to Indian women. The following year the government sanctioned land and P H Cama offered a donation to construct a hospital on Esplanade, well-known as Cama hospital. The hospital started functioning in 1886. In the year 1890 a dispensary was attached. All these three institutions are maintained and financed by the government. In 1930, about 5087 indoor patients were treated in the hospital. It had 150 beds for females. By 1980 the number increased to 96,000 indoor patients and 78,000 outdoor patients, with 367 beds for females.

**Employees’ State Insurance Scheme**

The Employees’ State Insurance Scheme was passed by Parliament in 1948. It covers industrial workers from all non-seasonal factories using power and employing more than 20 workers. Under the scheme, workers having a salary of up to Rs. 1000 per month are entitled to avail medical facilities in a hospital. The state government provides benefits such as OPD treatment, specialist examination, hospitalization, maternity benefits and ambulance services. Hospitalization benefits are provided to the workers in the five ESIS hospitals located in various parts of the city such as Parel, Worli, Andheri, Kandivli, and Mulund, where the working class population is dense. All these hospitals consist of 2150 beds.
Municipal Hospitals

The Mumbai Municipal Corporation runs six major hospitals for its population. Among these, three are tertiary level super speciality teaching hospitals, providing a wide range of services to the patients of the city and the country as a whole. These hospitals are KEM Hospital – Parel, BYL Nair Hospital – Bombay Central, LTMG General Hospital – Sion, Kasturba Hospital – Jacob Circle, Group of TB hospitals – Sewri and Sheth AJB Municipal ENT hospital – Fort. Of these the first three provide facilities for medical education.

**KEM Hospital**

The King Edward Memorial Hospital, Parel, was started in 1926, with a donation by Seth Gordhandas Sunderdas of Rs. 43,86,000. In the initial years the bed strength of the hospital was 353, including 145 beds for women, which increased to 1595 in the year 1980. At present the strength is 1800 beds, and there is a separate ward for women and children. The hospital is well equipped with sophisticated technology to cater to the needs of patients. The services offered in various prominent departments are pathology, bacteriology, pharmacology, surgery, medicine, preventive and social medicine, radiology, orthopaedics, neurology, cardiology, gynaecology, and obstetrics. The Seth Gordhandas Sunderdas Medical College is attached to the hospital. It admits 160 students every year.

**BYL Nair Hospital**

The management of this hospital was taken over by the Bombay Municipal Corporation in 1946. The hospital provides facilities like central clinical laboratory, blood bank, full fledged x-ray department, eye bank, school health clinic, and medical check up centre functions in the hospital. The Topiwala National Medical College and Nair Hospital Dental College is attached to this hospital.

**LTMG Hospital**

The Lokmanya Tilak Municipal General hospital was taken over by the corporation of Mumbai in 1946 and renamed in 1958. It was previously known as Indian Military Hospital. At the time of its opening, the hospital had only 50 beds; in
1980 it had 984 beds and is now a full-fledged hospital. Almost two decades later in 1964, the Lokmanya Tilak Municipal Medical College was incorporated to the hospital. In 1977 the College had a capacity of 315 seats.

Kasturba Hospital

This hospital was started in year 1892, when it was formally known as City Fever Hospital. The hospital is meant for treatment of all infectious diseases. It also imparts instructions for the undergraduates and post graduates students of medicine and student nurses as well. There were 680 beds available to patients for treatment in the year 1977. It has services like paediatric ward, pathology lab, and X ray department, clinical lab, and a welfare centre.

Group of TB Hospital

The group of TB hospitals at Sewri was started with 338 beds in 1948 by amalgamating the Maratha Hospital, the Turner Sanatorium and RPYB Hospital. It had facilities such as OPD, X-ray department, Operation Theatre and laboratory. The bed strength of the hospital during 1980 was about 1330 beds. The students of GS medical college, LTMG Medical College and DPH students of Bombay University are taken here for clinical teaching in tuberculosis. Apart from its present bed strength, about 350 beds are hired from private hospitals by the corporation for tuberculosis patients. In addition to this, there are four TB clinics located at Princess Street, Foras Road, Dadar and Khar for primary diagnosis and treatment of TB.

Over a period time the Mumbai Municipal Corporation has developed an extensive infrastructure to cater to the needs of the people in the city. The Table 3.3 illustrates the number of institutions that have been added by the Corporation to provide health services in the city. Moreover, the Corporation has reserved beds in hospitals managed by charitable trust hospitals. During the year 1977 the Corporation had reserved 20 beds in SBCJ general hospital - Santacruz, 16 beds in Holy Spirit Hospital - Andheri, 600 beds in Sarvodaya Hospital - Ghatkoper, and 50 beds in S K Patil Arogyadham – Malad, thus making a total of 7209 beds in all municipal hospitals (Greater Bombay District Gazetteer, vol. III, 1986, p. 196). Thus, today the Municipal Corporation of Greater Bombay and the State Government runs 23 general hospitals and 20 maternity homes in different parts of the city. This number is quite
small when compared to the area and population of Bombay City. The corporation runs 20 general hospitals with 3 specialized hospitals, for Eye, ENT and TB and the bed strength of the municipal hospitals is 4436.

**Table 3.3**

<table>
<thead>
<tr>
<th>Hospitals Run by BMC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
</tr>
<tr>
<td>General dispensaries</td>
</tr>
<tr>
<td>General hospital</td>
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<tr>
<td>Teaching hospitals</td>
</tr>
<tr>
<td>Maternity homes</td>
</tr>
<tr>
<td>Hospital for infectious disease</td>
</tr>
<tr>
<td>ENT hospital</td>
</tr>
<tr>
<td>TB hospital</td>
</tr>
<tr>
<td>Eye hospital</td>
</tr>
<tr>
<td>Leprosy clinic</td>
</tr>
<tr>
<td>STD clinic</td>
</tr>
<tr>
<td>Dental college</td>
</tr>
<tr>
<td>Ambulances</td>
</tr>
</tbody>
</table>

Source: Compiled from Ex. Health Officer Reports - 1969, 1979, 1989
*Excluding 12 wards

**The Trust Hospitals**

The health needs of the people of Mumbai are also dealt with by the big private hospitals. These hospitals are run by charitable trusts. Some of the details of these hospitals are follows.

**Acworth Leprosy Hospital**

This hospital was stared in 1890 to meet the needs of leprosy patients for treatment and shelter. The hospital started as Homeless Leper Asylum – Matunga, by the efforts of H A Acworth, the then active Municipal Commissioner of Mumbai. The total cost of the hospital was shared by the government and Municipal Corporation in proportion to the number of Bombay domiciled and non Bombay domiciled patients. In the year 1976 the hospital had 342 beds, of which 158 were meant for female
patients. The hospital also provides various types of occupational opportunities like supervisory, skilled and unskilled jobs for the patients, for which they are paid on a monthly basis.

**B J Wadia Hospital for Children**

This hospital was established in 1929 at Parel, a central part of Bombay. The cost required for construction of the hospital was Rs. 16, 67,150, of which the Bombay Municipal Corporation contributed Rs. 7, 00,000. At the time of its establishment the hospital had 126 beds, which was increased to 250 by year 1975. The hospital is known for its services such as medical, surgical, orthopaedics, plastic surgery, orthopaedic appliances, and physiotherapy and occupational therapy departments in the hospital. Moreover this hospital also runs a child welfare center, a well baby clinic, and a skin bank as well as burns research unit. The hospital has a child guidance clinic, which was started in 1948 and is controlled by the Tata Institute of Social Sciences.

**Bhatia General Hospital**

This hospital is located at Tardeo in D ward of the corporation, where the dominant population is from the rich class. Although there is a middle class population, it is in low concentration. The hospital was started by some industrialists of the city in 1932, and was originally meant for the Bhatia community only. But over a time it started accommodating patients from other backgrounds, rather it opened up to all people. The hospital began with strength of only 25 beds, which increased to 125 by 1973.

**Bombay Hospital**

The Bombay Hospital is located in Fort area. It was founded by RD Birla, the industrialist. The hospital got a new look by incorporating the P A Singhania Hindu Hospital Trust and the Marvadi Medical Relief Society, to convert a trust into hospital. This new hospital took complete shape in 1950, and had a capacity of 280 beds in the initial stage, which increased to 625 in 1976. Of the total beds about 293 were paying beds. The hospital has as many as 26 departments, like medicine, cardiology, surgery, ENT, obstetrics and gynaecology, intensive care unit, etc. In
1972, the hospital opened a Medical Research Center. The hospital carries out highly specialized medical care and surgical treatment. The University of Bombay has recognized nine units of this hospital for postgraduate studies.

**Holy Spirit Hospital**

This hospital is situated in Andheri, a sub-urban area of Mumbai, and was started by Christian Missionaries in 1966. To begin with the hospital had 100 beds serving the population spread over Andheri and Jogeswari. The hospital offers services like medical, surgical, gynaecologic, paediatric, ophthalmic, orthopaedics, ENT, etc.

**Sir Harkisondas Narittumdas Hospital**

This hospital, popularly known Harkisondas Hospital, is located at Girgaum. It opened in 1925 with 40 beds. Donations for the hospital were made by Sir Harkisondas Narottumdas. It was the one of the biggest hospital in 1976, with 351 beds, and has departments such as pathology, medicine, surgery, orthopaedics, neurology, ophthalmology, dental, gynaecology, intensive care unit, blood bank, etc.

**Jaslok Hospital**

The Jaslok Hospital was established in 1973 at Cumballa Hills, and is managed by the Jasoti Lokumal and Mulchand Charity Trust. It has various departments, such as medicine, surgery, ENT, orthopaedics, cardiology, ophthalmology, dental, gynaecology and obstetrics, intensive care unit, blood bank etc. The OPD has a referral system similar to that followed by the Mayo Clinic in the USA. It provides the latest form of radiotherapy and chemotherapy for treatment of cancer. It has one multi-patient artificial kidney unit in addition to an intensive care unit, the largest such unit in India. It is one of the best-equipped hospitals in India. In 1976 the hospital had 625 beds, of which for 332 beds no charges were levied.

**Nanavati Hospital**

Nanavati hospital was started in 1950 at Vile Parle with a capacity of 50 beds. The hospital has departments like medicine, surgery, ENT, orthopaedics, cardiology, ophthalmology, gynaecology, and obstetrics, ayurvedic medicine, pathology, casualty, and intensive care unit, blood bank, etc. The hospital is recognised by Bombay
University for post-graduate teaching of general medicine, gynaecology and obstetrics
and by the college of Physicians and Surgeons for FCPS in medicine and general
surgery, diploma in family planning etc. it is also recognized by the Maharashtra
Nursing Council for training of nurses. Between 1952 and 1960 and 34,319 in-door
patients and 4, 11,286 out door patient were treated in the hospital.

Tata Memorial Hospital

Located in Parel area, Tata Memorial Hospital was established in 1941 by Sir
Dorabji Tata Trust, with the objective of providing treatment and undertaking
research on cancer and allied diseases. At the time of its establishment the hospital
had a capacity of 100 beds, which increased to 210 in 1976. In 1957 the hospital was
given by the trust as a ‘national gift’, to the Government of India, which placed it
under the control of the Ministry of Health. Subsequently it was transferred to the
Department of Atomic Energy. A Radiation Medicine Centre was housed in the Tata
Memorial Centre to facilitate treatment of cancer patient. The Indian Cancer Research
Centre was established in 1952 and, later in 1967, this unit was amalgamated with the
hospital. These two institutions are doing pioneering work in the field of diagnosis
and treatment of cancer patients. The activities of the hospital can be classified as
service (patient care), education and research. The hospital is recognized by Bombay
University as a post-graduate centre for teaching and research. Thus, Tata Memorial
Hospital not only provides patient care, but also undertakes teaching and research.

Hospitals Under Government Organizations

There are several hospitals run by some of the government organizations, such
as the Railways, the Navy and Bombay Port Trust for the benefit of their employees.
The Central Railway started a hospital in Byculla in 1926. In 1977, its bed strength
was 315. Jagajivan Ram Hospital managed by the Western Railway, is located at
Bombay Central. A hospital was started by the Indian Navy at Powai in 1964.
Amongst semi-government organizations providing medical facilities for their
employees mention may be made of the Bombay Port Trust that started a hospital in
1968. This 160 bedded hospital is located at Wadala (East).
### Table 3.4

**Number, Characteristics and Distribution of Health-Care Services**

<table>
<thead>
<tr>
<th>Municipal Wards</th>
<th>General Hospitals</th>
<th>Shushrushalaya</th>
<th>Maternity Homes</th>
<th>Polyclinics</th>
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<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>G south</td>
<td>5</td>
<td>1</td>
<td>7</td>
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Table 3.4 gives an overview of the private and public health care institutions that are available in the 23 wards of Mumbai city. It needs to be stated here that: one is not possible to say anything definite about the year for which the data hold. The publication, itself was published in 1994. However, it is not clear when exactly the data was collected by the municipal corporation. We can assume that the number of health services is for the early 1990s. While enumerating from the document the number of each kind of institution, it was found that certain private hospitals and nursing homes occurred in both these categories. Hence the number of private hospitals and nursing homes could be a slight overestimate.

We find that services ranging from tertiary care to general hospital to immunization are provided through a total 2757 institutions. There are as many as 231 general hospitals, of these 24 is Municipal Corporation hospitals, including 3 teaching hospitals 189 are private hospitals and about 18 hospitals belong to the state government. We can see that of private health providers is very high, as compared to the government and municipal hospitals, compelling large sections of the population to resort to private services. Amount the Shushrushalaya (Nursing homes) nearly 500 are privately owned, with only 5 nursing homes run by the Corporation. Moreover,
there are about five thousand private practitioners across the city. The table indicates that the private sector is the largest provider of services under the heads of hospitals, polyclinics, nursing homes, maternity homes and even immunization centres.

**Distribution of the Institutions**

We find that the distribution of state government and private hospitals is extremely uneven across the wards. Of the 23 wards listed, all, except 6, have between 1-3 municipal hospitals. On the other hand, only 9 wards have one or more state government hospitals. In fact these are concentrated, rather clustered in the wards A and E (seven in all out of 18), while the rest are unevenly distributed in the remaining wards. In fact, ward E has 7 public hospitals in all 3 - municipal and 4 - state government. Where as, some wards do not have either. Almost all wards (except 2) have one or more municipal family welfare centres.

As observed in earlier studies (K.Kala, 1985; Banerjee-Guha and Thomas, 1994) 45 percent of the public hospitals are located in the old city, in the southern tip that fall in wards A to G. Even within this area the city centre, which was the centre for the growth of hospitals, has continued to receive more hospitals, even though it started losing population since the sixties. In fact, available data indicate that few public hospitals have come up outside this area since the process of suburbanization began. This uneven-ness is applicable to private facilities too; almost 60 percent are located in this same old city areas mentioned earlier. In fact, ward D, covering the affluent Mahalaxmi area on the western side of the old city area, has 64 private hospitals and the largest number of private practitioners too. Further, the private facilities are concentrated in the western suburbs rather than in the eastern suburbs.

As per the study of Banerjee-Guha, in terms of the population concentration, the old city areas have lower population density as compared to the suburban areas that come under wards H onwards. In the suburbs areas, large parts of the eastern suburbs have the highest population density interestingly, nearly 50 percent of the population density. Interestingly, nearly 50 percent of the private practitioners too
seem to be located in the wards A-G. What emerges then is that the eastern suburbs of Bombay, which have in general and inadequate public hospitals in specific. What they have are a large number of private maternity homes (75 percent of the total) and municipal health centres.