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HEALTH CARE CHALLENGES IN URBANIZING INDIA

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Rapid urbanization in India, driven by a globalized economy and its accelerated growth, will increasingly demand attention of policy makers. Indian cities and towns–the so-called 'engines of economic growth'–will attract public investments in infrastructure as well as in service delivery (health care and education). In tandem, public investment in human development is also expected to increase as not only will such investments influence the well-being of a burgeoning urban population, but also for the vital role they will play in the overall growth of the country, and the fuller realization of the 'demographic dividend'.

The central government is proposing to launch the National Urban Health Mission (NUHM) to complement the on-going National Rural Health Mission (NRHM). As the thinking on the content of the urban mission develops, this set of policy briefs that deals with the issues in urban health is expected to guide the evolving thought process. This thematic series consists of eight additional policy briefs, each attempting to answer one of the following questions.

- What are the general constraints in urban settings within which the proposed urban health mission would be implemented?
- Considering the importance of institutional structures in public service delivery, what guidance is available on institutional arrangements for delivering health care, particularly to the urban poor?
- Given that achieving environmental health standards requires a state-wide (as opposed to municipal-level) approach, has any Indian state been successful in meeting these defined standards and can show the way forward to other states?
- Are there any replicable lessons that can be learnt from any urban model in India that has successfully dealt with urban health challenges, especially in the area of public health?
- What important social challenges will be faced and must be addressed in implementing the current NUHM framework?
- What insights can be gained from the health seeking behavior of urban slums' residents?
- Why have an exclusive policy focus on urban areas?
- How might the health care needs of the urban dwellers differ from those of their rural counterparts to warrant a special focus?

The objective of this policy note is to introduce readers to the selected themes covered in this volume as well as positioning these within a broader perspective. We take each of the themes in sequence below:

What are the general constraints in urban settings within which the proposed National Urban Health Mission (NUHM) would be implemented and how might those constraints limit its scope?

It is necessary to understand the current urban context within which the proposed national urban health mission will be rolled out. This will help gain insight in what to expect from the proposed NUHM as also to appreciate how the urban context differs from rural setting.

Urban context is marked by (i) a great number of different actors; (ii) hierarchy (voters, bureaucrats, elected councilors, neighborhood associations, service users, etc.) which plays an important role in interactions among the actors; and (iii) both formal and informal elements which influence governance. Therefore, the urban context has a number of power equations at play. An important implication is that policy mediation in urban space is diverse, contested and increasingly structured along class lines (Tawa Lama-Rewal 2009).[1] Therefore, from a policy perspective, enacting change in an urban context is far more complex, resulting in longer than anticipated delays, as is evident from the slow progress of Jawaharlal Nehru National Urban Renewal Mission (JNNURM).

The 74th Constitutional Amendment Act grants a new constitutional status to Urban Local Bodies (ULBs) and to the elected representatives. However, part devolvement to ULBs is proving to be a major hindrance in them fulfilling their roles. Perhaps, the best example of this incomplete decentralization is the fact that ULBs continue to be financially dependent on the state and the centre. Moreover, non-state actors have become more prevalent in public

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health service delivery as is seen by the trends in utilization rate of outpatient and inpatient care in urban areas; this fact holds true to not just the health sector but other sectors as well. Except in primary and preventive health care (mainly immunization and family planning services), the private sector is already dominant and growing further in significance, in urban areas.

At present, institutional arrangements, functions, and governance structures for public health are weak and fragmented in all major cities of India. Unless, these arrangements, functions and structures improve, the ULBs will not taste real empowerment. **Policy Note #2** by Meera Chatterjee explores the issues in strengthening urban governance.

Considering the importance of institutional structures in public service delivery, what guidance is available on institutional arrangements for delivering health care, particularly to the urban poor?

The role of institutional arrangements in public service delivery cannot be overemphasized. While multiple institutional platforms exist in urban areas, these need nurturing and strengthening before they can be used for other purposes. Many developed countries have followed an 'executive agency' approach which separates the policy-making role of government from its implementation responsibilities. This separation helps in adopting a more professional approach to management of public service delivery.

Indeed, Indian health policy makers need to look no further than a few excellent examples that exist within the country and are discussed in **Policy Note #3** by Shomikho Raha. Besides, this policy note throws some light on how to go about achieving ward-level planning and coordination as well as building accountability through community engagement. There is a need for serious discussion and debate on this important dimension of public service delivery, which is currently lacking in the context of the National Urban Health Mission.

Where do we go from here? Slums in Versova, Mumbai.

Given that achieving environmental health standards requires a state-wide (as opposed to municipal-level) approach, has any Indian state been successful in meeting these defined standards and can show the way forward to other states?

Environmental health services such as sanitation, drainage, waste removal, water, and food safety have an important role in preventive health. In developed countries one of the core functions of public health authorities is to assure or guarantee environmental health by monitoring other agencies' services. In India, this function is mostly neglected. Achieving this not only calls for state leadership but also a legal mandate through a Public Health Act that would specify institutional structures, set out power for action, and define public health laws and standards. **Policy Note #4** by Monica Das Gupta highlights the importance of environmental health services and summarizes Tamil Nadu's experience – a viable and effective model that other Indian states can eminently replicate.

What replicable lessons can be learned from any urban model in India that has successfully dealt with health challenges, especially in the area of public health services?

There are not many models in India where the city administration has been successful in making health care services available to its inhabitants, as well as in tackling public health challenges that play an important role in defining health status of a population. In many respects Surat's success story in transforming the status of its public health service delivery stands out. A crisis (the plague-epidemic of 1994) heightened the civic consciousness of the public, which demanded action/results from the city administration and made it imperative for the state leadership and city administrators to consider Surat's development with a long-term vision. Surat's transformation occurred under the aegis of the 'commissioner model', which has its own weaknesses. Since this model is quite prevalent in India, Surat's case validates that reforms can be supported within the limits of a municipal model.

In Surat's case, the state leadership appointed an able administrator with a free hand to transform the city. Consequently, the administrator/commissioner introduced a slew of measures: strengthening of internal (within

municipalities) accountability and control mechanisms; sensitizing and motivating staff/officers for better performance; enforcing city rules and regulations; mandating public compliance with these rules; and improving resource base of municipality to finance many of its new initiatives. He also encouraged Public Private Partnerships (PPPs) to aid the reformation process. However, with the recent widening of municipal limits, the municipality is facing the next round of challenges of having to expand civic amenities to people who now fall within the extended municipal boundaries. Municipalities now need to plan and build capacities keeping this situation in mind. **Policy Note #5** by Rajib Dasgupta enumerates the Surat success story.

Surat's transformation is a special case in that the epidemic played an important role in increasing awareness of all important stakeholders, which helped sustain the momentum of reforms. This momentum arose from an enlightened leadership which was able to respond effectively to the crisis situation. To what extent this is replicable is an open question.

What important social challenges will be faced and must be addressed in implementing the current NUHM framework?

Given their living and sanitary conditions, it is not surprising that the urban poor have worse health outcomes in comparison to their non-poor counterparts. But what may not be well known is the fact that even within urban slums and amongst the urban poor, vulnerabilities differ, which calls for appropriate targeting of health care interventions to ensure uptake by those in greatest need. Reaching the truly vulnerable is not easy, since not all poor reside in slums. Moreover, the city administration is not mandated to extend services to the poor residing in the non-notified slums. Identifying these groups and extending the reach of public services to them is a challenge.

In order to identify and reach the urban poor, micro-level planning is a must. To genuinely address the health care needs of the poor, micro-level planning ought to be performed with peoples' participation to allow them to articulate their real health care needs. Furthermore, for effective health interventions, the poor ought to have access to other public services such as water supply, sanitation, and environmental hygiene which implies that micro-planning ought to be a multi-sectoral, integrated effort. Thus, integrated micro-level planning with peoples' participation is an ideal situation which must begin in some form and then can evolve over time.

Likewise, enhancing health awareness of slum communities and building their capacities for forging community-provider linkages, to improve service utilization, is an important ingredient of any urban health intervention. The NUHM framework envisages an important role for women health associations. Better understanding of social dynamics, especially in urban slums as well as within slum households is essential for giving concrete shape to the framework. Undoubtedly, the NUHM framework needs to be informed by a better understanding of the sociology of urban settings, especially where the poor live. The complexity in planning for the urban poor and what it takes to ensure their use of public services is detailed by Meera Chatterjee in **Policy Note #6.**

What insights can be gained from the health seeking behavior of urban slums' residents?

Slums form an integral part of India's urban landscape. While slum populations rank among the poorest, most under-served and vulnerable groups, they exhibit tremendous diversity. It is essential to better understand this diversity and vulnerabilities to devise strategies for reaching the most vulnerable within the slum population. Improving availability and access to public services in slum areas is necessary, but not sufficient. Improved utilization by the poorest and most disadvantaged, also calls for their mobilization, as is clearly demonstrated by the Mumbai case study (**Policy Note #7** by More et al.), which analyzed customs and traditions to be the commonest reason for home births in Mumbai slums. Hence, it is imperative that policy makers take cognizance of the realities within urban slums while devising urban health strategies.

Why have an exclusive policy focus on urban areas?

With 70 percent of its population in 2009 residing in rural areas, India is still a largely rural country. Nevertheless, the sheer size of its urban population (360 million in 2009), and the fact that 35 of its cities had a population of one million plus in 2001, implies that policy makers can no longer ignore the emerging urban challenges confounding the country. Large cities are already facing acute shortage of basic infrastructure, resulting in major environmental problems for all city-dwellers, and extremely poor living conditions for slum dwellers accounting for one-fourth to half the population of megacities. Receptive to the escalating urban problems, the central government, in 2005, launched the Jawaharlal Nehru National Urban Renewal Mission (JNNURM)–a national urban flagship program with the aim of ushering in municipal level reforms and supporting urban infrastructure.

India is well on the track of rapid urbanization. Its urban population is projected to increase to 535 million, and its cities with one million plus population to 61 by 2026. While natural increase in population is the major source of urban population growth, migration as well as expansion of city boundaries/reclassification of villages has also contributed significantly. All three sources will continue to play an important role in the growth of India's urban population. It is interesting to note that this urbanization is not uniform across regions/states/cities. For example, southern states are urbanizing faster than northern states; likewise, smaller cities are growing faster than larger cities. While urban India

will increasingly occupy centerstage in the policy arena, it will be useful to see how the political economy will play out prioritizing regions and cities.

With a growing urban population and continued migration into urban areas, poverty will increasingly be concentrated in urban areas. The share of urban poverty in total poverty is a rising trend which is likely to continue. One of the important implications of this trend is that social policies and programs will increasingly focus on the urban areas. **Policy Note #8** by Swati Gupta explains in some detail the broad trends in urbanization, with respect to demography, poverty and migration. Although this policy note is based on the projections of 2001 census survey data, these are unlikely to deviate from the findings of the ongoing 2011 census survey.

How might the health care needs of the urban dwellers differ from their rural counterparts to warrant a special focus?

India is undergoing an epidemiological transition with the share of Non-Communicable Diseases (NCDs) in the total disease burden growing substantially and that of communicable diseases gradually reducing. With an increasing proportion of its total population residing in urban areas, the disease burden is also expected to shift there. However, there are reasons to believe that this shift will be more than proportionate. First, since NCDs are positively correlated with urbanization, their burden is bound to increase with urbanization. Second, overcrowding and unhygienic living conditions, so characteristic of urban slums, will pose high risks for spread of communicable diseases, if urbanization continues to proceed in a haphazard manner. Since the disease burden is not uniformly distributed even within urban areas, urban health planning has to be city/town specific. **Policy Note #9** by Ankur Gupta and myself deal with the emerging disease burden in the country with a special focus on NCDs in urban areas.

The urban health system will increasingly be called to deal with non-communicable diseases. Municipalities are better placed to deal with the shifting burden of disease due to the widespread presence of non-state providers in major towns and cities. However, partnering with the private providers will be a challenge, especially when coordination even among all public health care providers (associated with different public agencies within municipal areas) has proven difficult.

Treatment for many NCDs is costly and beyond the capacity of many middle-class households, not to mention the poor. The Government will increasingly be expected to play an important role in the management of NCDs, not only for equity reasons but also to correct 'market failures' such as information gaps in the NCD risks associated with smoking, diet, nutrition, etc. This implies that policy response to dealing with NCDs and its risk factors must spring forth not only from within the health sector but also from outside, and ought to happen at multiple levels.

To conclude, this volume of policy briefs covers limited but important sets of issues concerning urban health in India. In the limited space these policy briefs occupy, it is impossible to do full justice to the issues covered. Nevertheless, these briefs do give a flavor of the complexities involved in defining policy, establishing frameworks and suitable planning for urban health. The issues selected in this volume are not exhaustive; in fact, there are many more important issues that remain to be covered or even explored (perhaps in another volume of India Health Beat).

[i] Tawa Lama-Rewal, S. 2009. Chapter 1 "**Engaging with the Concept of Governance in the Study of Indian Metropolises**" **in Governing India's Metropolises** edited by Joel Ruet and Stephanie Tawa Lama-Rewal, Routledge Press.

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