

## SUMMARY SECTOR ASSESSMENT: URBAN HEALTH

### A. Sector Performance, Problems, and Opportunities

1. India's health outcomes have improved over the last decade, with reductions in the infant mortality rate from 58 per 1,000 live births in 2005 to 40 per 1,000 live births in 2013, and the maternal mortality ratio from 254 per 100,000 live births during 2004–2006 to 178 per 100,000 live births during 2010–2012.<sup>1</sup> Much of this progress may be attributed to efforts under the National Rural Health Mission (NRHM), launched in 2005, to address systemic deficiencies in the rural health system, including lack of infrastructure, human resources, community participation, and integration of vertical health programs. Despite the success of the NRHM—which includes significantly increased rural health delivery infrastructure, and a dramatic rise in institutional deliveries through community mobilization and accredited social health activists—challenges remain for the overall health sector, including a shortage of health workers, gaps in service quality (including as a result of worker absenteeism), and high out-of-pocket health expenditures.

2. Comparisons of rural and urban health status have generally indicated that conditions are worse among the rural population. However, such broad comparisons have tended to mask the stark health disparities within urban areas, and the low health status of the urban poor. For example, the under-five mortality rate among the urban poor was 72.7 per 1,000 live births, compared to the urban average of 51.9.<sup>2</sup> Almost 60% of urban poor children aged less than 1 year missed total immunization, compared to the urban average of 42.4% (footnote 2). Only 52.6% of urban poor children were immunized for measles, compared to 54.2% of rural children, and 80.1% of urban non-poor children (footnote 2). The majority of urban poor women delivered their babies at home (footnote 2). More than 46% of urban poor children are underweight (footnote 2). Poor environmental conditions and crowded living spaces also make the urban poor vulnerable to infectious diseases, such as tuberculosis, acute respiratory infections, and diarrhea.

3. **Urban health systems.** In contrast to rural health, there has generally not been a holistic approach to the development of urban health delivery systems. Past interventions have tended to involve vertical programs—focusing on particular diseases or reproductive health—with limited investment to more broadly strengthen urban health systems; as a result, these systems have not evolved in an organized manner, and the delivery of urban health care services remains largely sub-optimal and fragmented, with inadequate public system infrastructure and weak referral linkages. The urban primary health care system needs to be significantly strengthened. Most curative primary care occurs at secondary and tertiary levels, leading to overcrowding of these centers. Existing primary health facilities are limited in number, underutilized, vary in norms and quality, and have limited scope of services, including community outreach and health promotion. Despite their proximity to private health facilities, many urban residents cannot afford such services. Financial protection for the poor and near-

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<sup>1</sup> Infant mortality rate: Government of India, Registrar General of India. 2006 and 2014. *Sample Registration System Bulletins*. New Delhi. Maternal mortality ratio: Government of India, Registrar General of India. 2009 and 2013. *Special Bulletins on Maternal Mortality in India*. New Delhi.

<sup>2</sup> Government of India, Ministry of Health and Family Welfare. 2007. *National Family Health Survey (NFHS-3), 2005–2006*. New Delhi. Additional data analysis on the urban poor was done based on NFHS-3 by the Urban Health Resource Center. The next survey, NFHS-4, 2014–2015 is due in 2016.

poor is a key concern, given that a major part of total health expenditures is paid out-of-pocket, which can lead to their further impoverishment.<sup>3</sup>

4. **Coordination and convergence.** Health in the urban context is affected by multiple physical and social environmental factors, and access to health care services. For example, the prevalence of some diseases (e.g., diarrhea) is clearly correlated with water quality, sanitation and hygiene. Improving the health of the urban population and reducing rising urban health disparities requires that related determinants, within and beyond the immediate health sector, be addressed simultaneously and effectively. However, coordination mechanisms and organizational capacity are weak, resulting in a lack of convergence between health services and essential public health functions outside the health sector.

5. There are marked diversities in the organization of urban health delivery systems. The 74th Constitutional Amendment calls for complete integration of urban primary health care and other urban public health functions under a municipal health officer. In many states, however, health care services are handled by the state health department, and municipal health officers do not assume leadership of public health activities. Funding, functions, and functionaries are fragmented in existing institutional structures, undermining convergence around public health goals and effective disease outbreak response. The multiplicity of service providers in urban areas, with urban local bodies (ULBs) and state governments jointly providing primary health care, has resulted in a weak referral system, with consequent overloading of tertiary hospitals and underutilized primary health facilities. There is a need to clarify functional roles and responsibilities at various levels to improve urban health coordination and governance, and to revive, support, and strengthen the public health capacity of ULBs, with a particular focus on critical aspects of public health and disease control.

6. **Private sector engagement.** Private health facilities provide about 80% of patient care in urban areas. They have immense potential to contribute to achievement of public health goals. However, primary reliance on the private health sector for delivery of health services would face numerous challenges. For example, private investments largely neglect primary health care and preventive health services because of the lower profit margins. Organizing diverse private providers around public health goals (e.g., implementing vaccination and communicable disease control programs, which need to be systematically applied at very large scale) may be costly and difficult. Additionally, in the absence of a strong regulatory environment, relying on the private sector raises issues of quality, accountability, and reliability. There are thus good arguments to support strengthening of urban public health care facilities, with a requisite focus on quality and accountability.

7. The dominance of the private sector in provision of urban healthcare provides challenges as well as unique opportunities to leverage private sector capacity in strengthening public provisioning of health services. However, partnerships between public and for-profit private providers in India's health sector have resulted in problems with respect to poor quality, high costs, and rent-seeking behavior. Some states (e.g., Tamil Nadu, Gujarat, Karnataka, and Andhra Pradesh) have demonstrated that public-private partnerships (PPPs) with non-profit providers can expand health access. The overall enabling environment for health sector PPPs—in both the for-profit and non-profit sectors—needs to be further assessed and facilitated. This includes studying mechanisms, regulations, and appropriate incentives to increase the quality and accountability of for-profit health providers, and enhance the capacity of non-profit

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<sup>3</sup> A study by the National Sample Survey Organization indicates that 5% of urban households fell below poverty line as a result of healthcare expenditure in 2004, mostly due to expenditures on outpatient care (3.8%).

providers. Given the diverse contexts, several PPP options and models for various scenarios will be needed, along with mechanisms to ensure appropriate checks and balances.

8. **Urban health data.** The urban population, unlike the rural population, is highly heterogeneous. Most published data are not disaggregated within urban areas, obscuring marked health disparities among the urban population. The informal or often illegal status of low-income urban clusters results in public authorities lacking a mandate to collect data on the urban poor. Strategies to identify and reach the most marginalized poor are inadequate, resulting in limited evidence- or community needs-based health planning. Most cities lack epidemiological data and adequate information on the urban poor and illegal settlement clusters. Marshalling health technologies—especially in the context of India’s increasing investments towards *Digital India*—could help improve monitoring, service delivery, and disease surveillance.<sup>4</sup>

9. **Trends in sector expenditure.** India’s total health expenditure is 4% of gross domestic product (GDP); per capita spending on health is \$61.4, compared to an average of \$86 spent by lower-middle-income countries. The portion of private expenditure on health is high (2.7% of GDP), of which out-of-pocket spending is about 86%.<sup>5</sup> The high level of out-of-pocket health spending suggests a high level of inequity. The current public expenditure on health is relatively low, but India’s Twelfth Five-Year Plan (2012–2017) envisages increasing the total public funding on “core health” to 1.87% GDP by 2017.<sup>6</sup> This indicates a three-fold increase at the central level from the Eleventh Five-Year Plan. The central government accounts for 33% of total public sector health funding, and state governments for 67%.

## B. Sector Strategy

10. The Government of India launched the National Urban Health Mission (NUHM), as part of the National Health Mission, in May 2013 to strengthen urban public health systems. The launch of the NUHM shows the government’s recognition of the need for focused attention on urban health. The NUHM was also intended to contribute to economic growth through human development and by creating a healthy workforce for sustainable urbanization. Given the explicit focus on improving the health of the poor and disadvantaged urban groups, NUHM will reinforce government efforts to alleviate poverty and make growth more inclusive.

11. NUHM seeks to facilitate equitable access to quality health care through strengthened public health systems, partnerships, and community participation, with active involvement of the ULBs.<sup>7</sup> The urban poor, numbering about 77.5 million, will be the primary beneficiaries.<sup>8</sup> NUHM will strengthen urban primary health care by establishing urban primary health centers (UPHCs) in all cities with a population of above fifty thousand (footnote 7). UPHCs would be linked with

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<sup>4</sup> *Digital India* is the government large-scale, umbrella e-governance initiative, coordinated by the Department of Electronics and Information Technology (DeitY) and implemented across the entire government, with Health as a key ministry. The program focuses on 3 key areas: (i) digital infrastructure, (ii) governance and services on demand (including leveraging geographic information systems for decision making), and (iii) digital empowerment of citizens.

<sup>5</sup> World Health Organization National Health Accounts Database. 2012.

<sup>6</sup> Government of India, Planning Commission. 2013. *Twelfth Five-Year Plan, 2012–2017*. New Delhi. Considering the health sector more broadly (e.g., including schemes to improve health through drinking water and sanitation), total government expenditure as a percentage of GDP in the Twelfth Five-Year Plan will increase from 1.94% in 2011 to 3.04% in 2017.

<sup>7</sup> Government of India. 2013. *National Urban Health Mission, Framework for Implementation*. New Delhi.

<sup>8</sup> The number of urban poor as estimated in the NUHM Implementation Framework. The 2011 Census of India estimates the urban poor population to be 65.6 million.

community outreach and referral services. NUHM outcome indicators include achieving 100% coverage in immunization, ante-natal care, and institutional delivery; and national disease control program targets (footnote 7).

12. The NUHM will address the urban health challenges through the following core strategies: (i) improving the efficiency of government health system in cities by strengthening and rationalizing existing government primary urban health structures and designated referral facilities; (ii) promotion of access to improved health care at the household level through community linkages and participation (e.g., accredited social health activists, *Mahila Arogya Samitis*); (iii) strengthening public health through innovative disease prevention and health promotion actions; (iv) financial protection for the urban poor through community risk-pooling mechanisms; (v) information technology-enabled services and e-governance to improve disease surveillance and monitoring; (vi) capacity building of stakeholders (building managerial, technical, and public health competencies among ULBs, medical providers, community workers); (vii) prioritizing the most vulnerable among the poor; and (viii) ensuring quality health care services. The NUHM and its strategies were developed through a highly consultative process, and based on an extensive knowledge base and lessons drawn from the implementation of the NRHM. The NUHM provides broad national parameters and priorities, within which states have the flexibility to plan and implement state-specific actions to deliver overall NUHM results. Given that urban health is a developing field and a new priority area for the Government of India, NUHM requires strong support at all levels to gain critical momentum and to effectively tackle evolving challenges unique to the urban context.

13. To provide universal access to sanitation facilities in urban areas, in October 2014, the Government of India introduced Swachh Bharat Mission (Clean India Initiative). Ensuring coherence and convergence of the NUHM and SBM will be crucial to attaining the desired health outcomes. Building upon the NRHM and the NUHM, the government also plans to progressively move towards universal health coverage under the Twelfth Five-Year Plan. Success of the NUHM will be critical to the universal health coverage agenda, as UPHCs are expected to play a gatekeeping role in referrals and insurance coverage for the urban poor.

### **C. ADB Sector Experience and Assistance**

14. Asian Development Bank (ADB) has designed and implemented urban health-related projects in countries such as Bangladesh, Philippines, and Mongolia.<sup>9</sup> In Bangladesh, which has a similar governance structure as India, ADB has been involved since 1998 with the Local Government Division and ULBs to deliver a large scale, pro-poor urban primary health care program. The program builds on a model of service delivery through PPPs between local governments and non-profit private providers (primarily nongovernment organizations) to fill gaps in government primary health service delivery capacity in urban areas. ADB's experience in Bangladesh will be useful to inform the enabling environment for engaging with the non-profit sector on a larger scale to improve health outcomes. In addition, ADB has been engaged in the long-term Initiative for Mainstreaming PPPs in India through the Department of Economic Affairs, which can offer valuable insight, knowledge, and tools for developing PPPs in the health sector.

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<sup>9</sup> ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific*. Manila. emphasized an increased focus on health sector operations.

15. ADB has nearly 2 decades of experience in the urban sector in India. ADB's operation in the urban sector in India began with an integrated urban project in Karnataka in 1995.<sup>10</sup> Since then, ADB has provided loan and grant assistance of about \$3.5 billion to support 25 urban projects (completed and ongoing). These projects span 14 states covering more than 80 towns and cities.<sup>11</sup> The main focus of ADB's urban sector operation is to support the Government of India in its endeavour to provide affordable and sustainable urban services to its cities and towns through infrastructure development (primarily focusing on water, sanitation, and waste management); and strengthening of urban governance through reforms, capacity building, and improvement of service delivery.

16. Many urban sector operations also focus on slum rehabilitation, with targeted components to improve livelihoods through the formation of self-help groups and extensive awareness campaign on various sanitation and hygiene-related issues. ADB will continue focusing on improving basic municipal service delivery (water supply and waste management). Support is also envisaged for the government's new flagship program on total sanitation (Swachh Bharat Mission). ADB's long experience in the urban sector has forged strong relationships with cities and municipal structures. ADB can build on past and ongoing work in the urban sector—including governance reforms, capacity building of ULBs and municipal institutions, and integrated urban planning—to support successful implementation of the NUHM.

17. ADB support to NUHM, through the results-based lending instrument, will add value by (i) strengthening NUHM's management capacity and implementation processes through significant capacity building, thus accelerating the pace of implementation and ensuring timely delivery of the desired outcomes; (ii) facilitating convergence between health and urban sector interventions, emphasizing integrated city-level planning with active involvement of ULBs; (iii) fostering partnerships with the private health sector, including not-for-profit entities, to contribute to NUHM objectives; (iv) mobilizing community participation to enhance governance, effective delivery of health services, and improved health and hygiene behaviors; (v) strengthening program monitoring and evaluation systems for evidence-based planning and implementation; and (vi) facilitating learning and knowledge sharing, good practices, and innovations to improve urban health.

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<sup>10</sup> ADB. 1995. *Report and Recommendation of the President (RRP) to the Board of Directors on a Proposed Loan to India for the Karnataka Urban Infrastructure Development Project*. Manila.

<sup>11</sup> The 14 states comprise West Bengal, Assam, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Bihar, Madhya Pradesh, Uttarakhand, Karnataka, Rajasthan, Jammu and Kashmir, and Kerala.

### PROBLEM TREE

