

The Missing Mission in Health

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The National Urban Health Mission was supposed to address the unmet health needs of urban Indians. Yet, it has failed to commence work even 18 months after the announcement of its formation. A rapidly urbanising India has been marked by a series of epidemics of communicable diseases in the last two decades and increasing informalisation of the economy. Urban health systems, therefore, need serious and quick reforms.

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It has been nearly one and a half years since the media reported the proposed launch of the National Urban Health Mission (NUHM) (*The Hindu*, 25 February 2008). The cousin of the high-profile National Rural Health Mission (NRHM), it was also proposed as a five-year mission. The then union minister for health and family welfare was quoted as saying “This is the second largest health programme that will fill the lacunae created after the implementation of the NRHM and take care of the unmet needs in the fast urbanisation process”. Specifically, it sought to address the health of the urban poor and other disadvantaged sections, and facilitate their access to the health service system. Slated to benefit 22 crore people with special emphasis on five crore slum-dwellers, the Rs 9,159 crore mission was to be implemented in 429 cities including 100 cities that would be taken up in the first phase. Optimism was expressed by the minister on two grounds: (i) the NRHM would provide a template for guidelines of “administration and operationalisation”, and (ii) it would have a faster “take-off” on account of “awareness, presence of non-governmental organisations and better accessibility in the cities”.

In hindsight, the optimism about a faster take-off was misplaced given that it is overdue by nearly one and a half years. However, the urgency to focus on matters of urbanisation in general and urban health in particular is not misplaced. The 2001 Census puts the proportion of urban population living in class I cities (population of over 1,00,000) at 68.7%; the concentration of urban population in the larger cities has been a unique feature of urbanisation in India with 35 million-plus cities. The population share of the small towns was less than a tenth of the total urban population. In absolute terms, the 61st round of the National Sample Survey (NSS) recorded an addition of 4.4 million urban poor persons between 1993-94 and 2004-05. This is explained, in part, by the fact that 79% of new jobs (increasingly informalised) totalling 19.3 million between 1991 and 2001 were generated in urban areas. During this decade of casualisation and feminisation of the workforce, the increase in marginal workers was to the extent of about 360% compared to an increase of only 23% of the main workers; simultaneously the proportion of female workers increased from 14.3% to 16%. In short, about half of India’s population is projected to be urban by 2041.

The historical process of urbanisation in developing countries is different from that in advanced industrial societies (Helen Safa 1982). One of the most important factors driving the increase in urban

populations is natural population growth in existing (urban) settings; rural-urban migration is another significant cause. Agricultural sector policies, deforestation, mining and large developmental projects (like dams/hydro electric projects) have increased rural poverty, contributed to landlessness and consequently pushed people from rural areas into cities in search of livelihoods (Global Health Watch 2008).

Current urban economics seeks to explain the existence, size and structures of urban areas as market responses to opportunities for production and incomes (Arup Mitra 1994). Economic globalisation has drawn larger cities into the dominant chain of global economic activity which benefits a small minority, while accelerating informalisation of urban economy, coupled with de-industrialisation leading to increasing underemployment (UN Habitat 2004, International Labour Organisation 2005). Economists have often viewed problems of development in the third world as a division of the economy into dual sectors – a modern, expanding capitalist sector (with large-scale production) with export orientation and a traditional, subsistence sector for the domestic market. The implicit failure to integrate these two sectors is seen as a major deterrent in the trajectory of growth and development. Conversely, it has been argued that, rather than being an impediment in the expansion of a modern capitalist economy, the informal sector is a means of survival to those not in direct employments of formal sectors. The urban poor generally work in small-scale enterprises requiring relatively low levels of skill and capital. Structural adjustment policies (introduced in the third world) have further accentuated these problems owing to rising food prices, declining real wages, and redundancy in the formal labour market and reduced public expenditure on basic services and infrastructure (Moser et al 1993; World Bank 1991). Because of the labour-absorptive capacities of the informal sector, it is capable of sustaining large numbers of urban poor at low standards of living and infrastructure, and ill-health. The NUHM seeks to address the real-life and real-time health

needs of large sections of populations placed in these situations.

Crisis of Urban Health Systems

Urban health systems in India have never been a policy and programme priority. The focus of public health services planning and development in post-independence India has been, and rightly so, the rural populations. In an increasingly urban India, there has been a sense of urgency for some time now. The last two decades were marked by a series of epidemics of emerging and re-emerging communicable diseases – cholera O139, plague, dengue/dengue haemorrhagic fever/dengue shock syndrome, chikungunya fever, SARS (severe acute respiratory syndrome) and H1N1 influenza (swine flu) – most of them clustered in urban locales. The report of the Krishnan Committee in 1982 on reorganisation of urban health services was never seriously implemented; the fate of the Pattanayak Committee set up a decade later by the Delhi Municipal Corporation following the dengue epidemic in 1996 was similar. During this period the World Bank supported India Population Projects (in several phases) that were designed to “extend rapid and targeted assistance to the most vulnerable urban slum population who were not adequately covered by the existing Primary Health Care infrastructure of the cities”. In the name of primary healthcare (for the urban poor), it functioned as a Reproductive and Child Health (RCH) programme to the core. It added to the infrastructure significantly, had assured flow of funds and put in a fairly effective monitoring system. But it failed to implement even the RCH functions adequately; for example, caesarean sections remained a rarity in most 1PP homes. It did significantly draw upon the resources of local (slum) communities by inducting large numbers of Basti Sewikas (BS); indeed, it would be no exaggeration to say that these link workers were the lifeblood of the project. Most BS believed that they would be inducted into the permanent cadre of health workers; the volunteerism of these “female voluntary health workers” was thus a chimera. The urban local bodies (ULB) did not replicate the model beyond the project mode, thus

reinforcing the clichéd issue of sustainability of externally conceptualised and funded health programmes.

In the context of weakening of national and local public institutions, urban services and infrastructure have failed to keep pace with urban population growth. The Eleventh Five-Year Plan recognised that despite a high density of public and private healthcare providers and institutions in urban areas, “the homeless and those living in slums or temporary settlements are left out”, and, that urban health “initiatives in the country to date have been limited and fragmented”. Disaggregated data reveal urban unauthorised settlements as areas of concentrated disadvantages. The 60th round of the NSS reported that nearly a quarter of episodes of ailments remained untreated among the urban poor with a fifth of them citing lack of finance as the reason. The cost per hospitalisation in government hospitals ranged from Rs 1,666 in urban Tamil Nadu to Rs 30,822 in urban Bihar. Not unexpectedly, the National Family Health Survey 3 (NFHS-3) found that the health indicators for the poor were startlingly worse than the non-poor in urban areas; in keeping with the expectations of social gradients, indicators (for both slum and non-slum populations) were worse in lower categories of towns within the same state (Mumbai and Nagpur).

NUHM: Basic Elements

The Eleventh Five-Year Plan proposed to introduce the NUHM as a “thrust area”, which in conjunction with the NRHM would form the Sarva Swasthya Abhiyan. In keeping with the regime of health sector reforms (HSR), the three key elements that were included were:

- Provision of “essential primary health-care services”; *essential*, not, *comprehensive*
- Appropriate technology through public-private partnership, and
- Health insurance for the urban poor.

It proposed to create urban health centres (UHCS) by upgrading the existing urban health posts (UHPs) and urban family welfare centres (UFWCS). Existing human resources would be rationalised and reorganised to strengthen these UHC catering to defined geographic areas, particularly slums. In continuing with the doctrine of

Accredited Social Health Activist (ASHA), the Urban Social Health Activist (USHA) would be the incentivised link community health worker. She would provide leadership for the Mahila Arogya Samiti (MAS). In order to operationalise all these, city health plans would be drawn up through a process similar to that of the NRHM. In a similar vein there would be urban health management units, urban health societies and urban health missions at city, district and state levels. Within these institutional structures the NUHM would seek to “provide integrated health service delivery to the urban poor” through a strategy “based on health insurance and public-private partnership”.

The Road Ahead

Despite its promise of urban health as a thrust area, the Eleventh Plan did not provide for the NUHM in terms of budgetary support. The outcome of the series of hearings conducted by the National Human Rights Commission (NHRC) in 2004-05, in collaboration with the Jan Swasthya Abhiyan (JSA), in the context of denial of healthcare are nearly forgotten. The recommendations on urban health (as other recommendations) were not formalised. Some of the principal areas of concern included:

- Currently, public health programmes operate in a vertical manner in urban areas; thus, the need to move away from the regime of vertical, and, essential and selective services to comprehensive services in tune with local needs.
- Need to strengthen the entire complement of support services including blood banks, ambulance and hearse van.
- Social security schemes like Central Government Health Services (CGHS) and Employees' State Insurance Corporation (ESIC) should integrate and network with secondary and tertiary level public institutions allowing public funds to be used for strengthening of public services (rather than be siphoned off to private and corporate providers) and build pressure for the strengthening of public institutions.

Both the NRHM and the proposed NUHM are conceptualised and designed within the framework of HSR. The NRHM has created an elaborate set of standard operating procedures (SOPs) without adequately

integrating with local self-government institutions such as panchayats and zilla parishads; the NUHM is likely to go the same way. It is pertinent to remind ourselves that the World Health Assembly Resolution 44.27 in 1991 called for development, reorientation and strengthening of urban health services and decentralisation of responsibilities. It also argued for urban health districts that would be the most peripheral fully organised unit of local government and administration, with its own political mandate and identity. The Healthy Cities and Municipalities Movement approach of the WHO thus called for putting health high on the political and social agenda, underpinned by the principles of the Health for All strategy and Local Agenda 21 emphasising equity, participatory governance and inter-sectoral collaboration to address the social determinants of health.

Urban health systems are highly complex entities involving “sub-actions” across many institutions with numerous goals. Despite recognising the urgency for revitalising urban health services, the NUHM is yet to be rolled out. The efforts at

approaching urban health have suffered from truncated visions. The range of participatory processes that marked the formulation of the NRHM has been lacking for NUHM. Urban health needs serious debate and academic introspection. That ought to be the starting point for renewal of urban health systems which undoubtedly need to be “reformed”, much beyond the conventional wisdom that has come to be associated with this loved-and-hated term.

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