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Do the urban poor delay urban universal health coverage in India?

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ABSTRACT

Many health planners, local bodies and general literate people see urban population as one unit of literate, financially sound and well informed population, seeking health care when needed; Health infrastructure is more than required. Cumulative data is the reason for this misconception while the actual situation among urban poor may be worse than their rural counterparts. Urban health would make the biggest impact in global health and is also the most challenging particularly taking care of the population at highest risk.

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Government influences the health of urban populations by providing municipal services, regulating activities that affect health, and setting the parameters for urban development. Government policies can exacerbate or reduce social inequality and support living conditions that promote or damage health. Government activities in many sectors affect health, including those in public education, public transportation, public safety, criminal justice, welfare, housing, and employment.

City governments and urban populations have limited resources to face multiple problems (e.g., in education, employment, crime prevention, environmental protection, and sanitation). Investment in these areas will be key to improving the health of populations. The priority for municipal governments to demonstrate inter--sectoral approaches within their agencies and to assemble the coalitions and political support needed to sustain their interventions becomes essential. Urban public health planners need to define disparity reduction as an explicit goal.

Today we as a country have agreed on a roadmap to progressively ensure that all people have access to the health services they need, when they need them, without fear of financial hardship. This will be a gradual process. Countrywide two important recent initiatives namely *Pradhan Mantri Bhartiya Janaushadhi Pariyojana 2015*[2] *and National Health Protection Scheme (NHPS)*[3] *have promised better sickness care more Accessible, Acceptable and Affordable.*

The National Health Mission (2013)[1] for the first time has committed to urban health infrastructure on the line of rural infrastructure. To address these it has committed to: a) Advance toward providing universal access to comprehensive health services that address people's health needs, including the needs of vulnerable groups, b) Progress toward the elimination of out-of-pocket payments that are a barrier to access to care, replacing them with pooled contributions based on taxes and other sources of financing, c) Establish national targets and goals and a roadmap for advancing toward universal access to health and universal health coverage, setting national priorities for the period 2018 to 2020, 2025 and 2030,d) Improve the organization, management and efficiency of health services using healthcare models that focus on the needs of people and communities e) Improve care at the primary level by strengthening multidisciplinary health teams and

integrated health service networks for Urban poor, Rural remote and Tribal Population, e) Increase employment options, especially at the first level of care, with attractive labor conditions and incentives, particularly in underserved areas, and provide healthcare workers with access to health information and digital health services (including telemedicine) Improve health authorities' capacity to provide leadership in the health sector and to influence policies and legislation in other sectors that have an impact on health or on social conditions that impact health.

This article reviews the determinants of the urban health, urban health infrastructure present and planned, the present status of Urban Health particularly for the vulnerable population and course of action need to achieve the universal health care and wonders if urban poor will delay the achievement of UHC by 2030.

INTRODUCTION

Many health planners, local bodies and general literate people see urban population as one unit of literate, financially sound and well informed population, seeking health care when needed; Health infrastructure is more than required. Though mostly dominated by Private sector with all specialist services all levels of health care is available & accessible, affordability decides choice where individual family seeks care. Cities private super-specialty facilities are keen and seen as Health tourism & business opportunity sites. They often exploit the clients in the garb of better quality and multi-media canvassing. One assumes that due to media exposure people are well informed of health, life style /behavior and remedies through digital information sources. It is also believed that people are generally healthy & therefore preventive & promotive activities through the National health programs were given low priority in the past. Then situation is changing since the launch Urban Health mission 2013.

Cumulative data is the reason for this misconception; actual situation can be summarized as: Desegregated data shows the disparity in Health Status of certain urban population especially poor and peri-urban population sometimes even worse than rural and tribal population. Primary health care facilities are few and far off, and most of the private health facilities are inaccessible financially. Public Sector facilities (e.g. State Govt. CGHS, ESIS, Railways, and Defense etc.) cater to sickness care of sizeable urban poor and middle class population and Public sector workers. Poor outreach of National Health Programs services is the hallmark of Govt. /Municipal dispensary apart from timings that are inconvenient to majority families as almost all adults and healthy people go for work.

INDIAN URBAN HEALTH CONTEXT

Global health allows us to realize human rights, particularly the right to health of every human being. Human rights legislation is the backbone of effective global health. Human rights are not simply a nice thing to do--there is international legislation that defines what they are, who is responsible for what and what must be done. Urban health would make the biggest impact in global health and is also the most challenging particularly taking care of the population at highest risk.

Today we as a country have agreed on a roadmap to progressively ensure that all people have access to the health services they need, when they need them, without fear of financial hardship. This will be a gradual process. Achieving universal access and universal health coverage will not only promote the well-being of people throughout our country but also contribute in an important way to the overall development of our states and districts, especially those are generally deemed inaccessible. The new strategy addresses inequities in access to health systems and services that prevent people from enjoying optimal health. Today some 30% of people in India cannot access health care for financial reasons, and 21% lack access to care because of geographical barriers. Groups living in vulnerable conditions, children, women, older adults and ethnic minorities are those most affected by these problems. Urban Poor & slums population fall under this category of vulnerable population. A shortage of public funds for health is a challenge for most of the cities/states. Spending on health as of 2013 averaged

only <3 of GDP. Out-of-pocket payments for health services remain high in many States of India often pushing people into poverty. The strategy also calls for increased public financing of health, citing as a benchmark public spending of 6% of GDP. Health infrastructures of all Public (Govt.) sector facilities need to adhere to SOPs , coordinate and participate in disease surveillance .Private sector facilities getting some sort of Govt. support to establish, need to keep up the commitment of treating poor patients free and enforce SOPs and participate in surveillance. Public Private Partnership has a big role in Urban Health.

WHAT IS UNIQUE ABOUT URBAN POPULATION IN THE CONTEXT OF HEALTH?

Unlike rural population that has defined health infrastructure across the length and breadth of the country, the urban population is unique in many determinants of Health.[9]

1) Economic conditions: We see heterogeneous population in terms of economic conditions. On one side we have some filthily rich or influential people having access to both private and Government facilities, on another side we urban poor that include homeless, Jhuggi-Jhopri (JJ), relocated from JJ, Dalit Basti's, Nomadics, construction site camps, unauthorised slums, regularized slums and registered slums, approved colonies, transient population who need health services most and are generally have difficulty in accessing either geographical or financial. Health outcomes depend upon irregular employment, poor access to credit when needed.
2) Social Conditions: Heterogeneous again as they migrate and settle together from different rural background (villages in towns, Talukas in district capital and different districts in state capital and from different states in national capital and other metropolitan cities). The hallmark of this migration are gender inequity, poor educational and skill background, socio-cultural practices, Alcoholism and drug abuse
3) Living Environment: The inhabitations are generally having poor access to water supply, sanitation and sewerage system. Overcrowding, insecure land tenure and poor housing standards add to the health problem
4) Unlisted slums with Rapid mobility: The temporary migrants are denied access to health and other development services. They need to commute long distances to go for work to earn their living and are exposed to additional risk of road accidents, sound and smoke pollution and addition to commuting pain.
5) Multiple Disease burden: Since people come from different background may bring various infections, chronic diseases and mental health conditions and expose other for the risk of transmission
6) Collective Capacity: Since people come from different background, lack collective efforts or organizing the community for fighting against civil authorities.
7) Environmental Pollution: Air pollution, water pollution and Noise pollution and waste disposal are issues that many of them would not have faced in their rural life adding to health outcome risks
8) Access to use of Public Health Facilities: Lack of access to health and ICDS facilities and poor quality of services in these facilities withhold them seeking early care or go to private sector and get exploited leading to push into poverty.

DEFINING URBAN POPULATION IN INDIA

Defining urban population[10] in India is still ambiguous and evolving. Starting with typical description of monocentric settlement pattern of 200,000 or more people, moving on to polycentric semi-practical pattern of combination of city centre, inner urban and suburban and peri-urban areas consisting of urban fringe, urban periphery and rural hinterland and latest realistic situation of Greater metropolitans cosseting of multiple combinations of urban, peri-urban areas and villages getting submerged in commonly termed Urban Conglomerations.

For administrative purpose Municipality is a city or town, possessing corporate existence and usually its own local government with members elected for 5

years and seats reserved for Scheduled Castes, Scheduled Tribes, backward classes and women. After 74th amendment act of 1992 municipal areas shall be declared having regard to the population of the area, the density of population therein, the revenue generated for local administration, the percentage of employment in non-agricultural activities, the economic importance or such other factors as specified by the state government by public notification for this purpose.

The urban areas are classified as:

1) Mahanagar Nigam (*Municipal Corporation*): Has a population of more than 1 Million.
2) Nagar Palika (*Municipality,* Nagar Nigam): Is an urban local body that administers a city of population 100,000+ and
3) Nagar Panchayat (*Notified Area Council*, *City Council*): An urban centre with more than 11,000 and less than 25,000 inhabitants is classified as a "Nagar Panchayat".

The municipal bodies of India are vested with a long list of functions delegated by the state governments under the municipal legislation. These functions broadly relate to public health, public safety, public infrastructure, welfare, regulatory functions, works, and development activities. Public health includes Water supply, Sewerage and Sanitation, eradication of communicable diseases etc.; Public safety includes Fire protection, Street lighting, etc.; Public works measures (Infrastructure) such as construction and maintenance of inner city roads, etc.; Welfare includes public facilities such as Education, recreation, etc.; Regulatory functions related to prescribing and enforcing Building regulations, encroachments on public land, Birth registration and Death certificate, etc.; Development functions related to Town planning and development of commercial markets.

In addition to the legally assigned functions, the Sectoral departments of the state government often assign unilaterally, and on an agency basis, various functions such as Family planning, Nutrition and slum improvement, disease and Epidemic control, etc.

DETERMINANTS OF URBAN HEALTH [7]

There are four key determinants of urban Health.

Population Composition

Characteristics of populations that influence health are: age and gender distribution, genetic characteristics, health beliefs, and cultural attitudes. The diversity of urban populations ensures that there is no urban genotype; genetic characteristics interact with environmental conditions to produce urban phenotypes with particular health resiliencies and vulnerabilities. Changes in urban population composition over time as a consequence of urbanization, immigration, aging, and fertility decline have a profound impact on health.

Urban areas are characterized by population density and diversity: Density is considered as crowding, enhances transmission of infectious diseases. It also enables public health programs to reach large sectors of the population efficiently. Diversity increases a cultural richness but can also lead to cultural clashes; It necessitates tailoring interventions to meet the needs of different subpopulations. Finding the right balance between these competing pressures of density and diversity is a constant challenge for planners of urban health interventions. Characterized by high levels of inequality, interventions – even beneficial ones helping everyone run the risk of reinforcing or even widening disparities in health.

Characteristics that are more pronounced for the poor in urban areas are commoditization (reliance on the cash economy); overcrowded living conditions (slums); environmental hazard (stemming from density and hazardous location of settlements, and exposure to multiple pollutants); social fragmentation (lack of community and inter-household mechanisms for social security, relative to those in rural areas); crime and violence; traffic accidents; and natural disasters.

Measuring urban poverty can be carried out using a number of approaches summarized below. Regardless of the methodology chosen, the data should ideally be comparable across cities, and allow for disaggregation at the intra-city level. This will capture vast differences between the poor in small

towns and mega cities, or between urban slum areas within a given city.

1) Income or Consumption Measures: based on data that assess whether an individual or HH can afford a basic basket of goods (typically food, housing water, clothing, transport, etc.).
2) Unsatisfied Basic Needs Index: Poverty classifying based on households who do not have access minimum threshold for several dimensions of basic needs
3) Asset Indicators: a car, refrigerator, television, dwelling, access to clean water and electricity
4) Vulnerability: The risk that a HH or individual will experience an episode of income or health poverty over time, and the probability of being exposed to violence, crime, natural disasters, being pulled out of school.

Physical Environment and Health Issues Related to Environment

Air Pollution, Inappropriate drinking water supply, poor waste water management/waste disposal/sanitation, Lack of toilet facilities, Housing, Roads/Traffic/Industries, Commuting Pain Index, Garbage collection remains sporadic in urban slums. Poor spatial planning and changes in urban morphology and Prostitution & Alcohol and Drug Abuse.

Providing access to safe water, garbage removal, and sanitation are the key challenges cities in developing nations face these days. The issue of "illegality" in most of the "slums" in low- and middle-income nations inhibits public service provision and accentuates the influence of "bad governance." This lack of legal recognition of slums means not only the absence of basic services, such as water, sanitation, garbage removal, health care services, but also the absence of health surveys and even a census on which to document the extent of the need. Effective and representative government, including the institutional means to ensure provision of an infrastructure and services and the control of pollution, are necessary to address urban health problems effectively.

Especially important from a health perspective are the pathogens and vectors associated with high levels of infectious and parasitic diseases, including diarrheal diseases, intestinal parasites, and "water-washed" diseases.

The ranking exercise 2018, part of the Swachh Bharat Mission, was conducted between January 4 and March 10 and results announced on 16th May 2018. It aimed at inculcating a spirit of healthy competition among cities to becoming clean cities. The parameters included segregation and processing of waste at source, sanitation, open defecation free status, financial sustainability of local bodies and adoption of innovations and best practices. The survey was done by direct observation and citizen feedback, apart from monitoring progress in terms of service levels.

In the national rankings, Indore, the commercial hub of Madhya Pradesh, was adjudged the cleanest city in the survey for the second year in succession. While Madhya Pradesh (Indore & Bhopal) shared top 2 positions, followed by Chandigarh and New Delhi Municipal Corporation share third and fourth position, Andhra Pradesh (Vijaywada-5, Tirupathi-6 and Vishkha Pattanam-7) shared next 3 positions, Mysuru (Karnataka) stood at 8th position followed by Navi Mumbai and Pune in Maharashtra. The tag of India's best city in citizens' feedback was given to Kota in Rajasthan, best city in innovation and best practices to Nagpur in Maharashtra, best city in solid waste management to Navi Mumbai in Maharashtra, cleanest medium city to Mysuru in Karnataka and cleanest small city to the New Delhi Municipal Council area.[19]

Social Environment

The social environment influences health through a variety of pathways, including the support of individual or group behaviors that affect health, buffering or enhancing the impact of stressors, and providing access to goods and services that influence health (e.g., housing, food, informal health care). Problematic characteristics of the urban social environment may include social support for health damaging behavior (e.g., drugs, gangs) and high levels of social stressors such as social isolation

violence, and extreme poverty. The concentration of poverty leads to social exclusion, which can reduce the availability of social support and access to health and social services. Illegal immigration has lead to exploitation of household labor, children and women.

Upstream Influences on Living Conditions
Living conditions shape health but are also influenced by municipal, national, and international trends. Municipal factors include government, markets, and civic society.

Government
It influences the health of urban populations by providing municipal services, regulating activities that affect health, and setting the parameters for urban development. Government policies can exacerbate or reduce social inequality and support living conditions that promote or damage health. Government activities in many sectors affect health, including those in public education, public transportation, public safety, criminal justice, welfare, housing, and employment

Public transportation and the municipal regulation of private transportation offer one example of how municipal services in non-health arenas can affect health. Public transportation can facilitate population mobility in densely populated urban areas, increasing access to education, employment, and stores that sell fresh foods and vegetables. Effective traffic management speeds the delivery of emergency medical services.

City governments and urban populations have limited resources to face multiple problems (e.g., in education, employment, crime prevention, environmental protection, and sanitation). Investment in these areas will be key to improving the health of populations. The priority for municipal governments to demonstrate intersectoral approaches within their agencies and to assemble the coalitions and political support needed to sustain their interventions becomes essential. Urban public health planners need to define disparity reduction as an explicit goal.

Markets
Today local and global markets play a central role in shaping the conditions that determine the health of urban populations. Markets allocate housing, food, medical care, and transportation and increasingly play a role in education, public safety, and other sectors previously confined to the public realm. Markets play a role in undermining health by making tobacco, illicit drugs, alcohol, obesogenic food, firearms, unsafe and polluting cars, and other products available to the urban rich and poor. They have also played a key role in promoting the lifestyles associated with the growth of chronic diseases

A key component of commercialization is reductionism of medical services, health products and nutritional components into small, marketable units. This reductive force makes both medical services and nutritional components more costly and is corrosive to more holistic concepts of Public health.

Civic Society
Community-based organizations, like neighborhood associations and RWA & Tenants groups provide services, mobilize populations and advocate for resources. Churches, religious organizations and leaders and faith-based organizations offer social support, safe space, and political leadership. The state of civil society in a community at a given time can influence its ability to protect the health of residents; promote social cohesion; and counter isolation, stigma

The human resources and the social capital constitute key assets for intersectoral urban health promotion and make it easier to operate in multiple sectors, with limited resources. Finding the right assets, mobilizing them, and ensuring their sustainability are important tasks for urban health interventionists. Providing adequate external support to capitalize on these strengths presents a continuing challenge for developed nations and international organizations.

Health and Social Services (Urban Health Care System in India)
Cities are characterized by a rich array of health and social services agencies, each with a distinct mission and service package. The situation in slums because

of the illegal status and, therefore, absence of emergency or other formal services is most common. They may have a variety of informal (Quacks) and self-help groups.

The complexity of health care in urban areas increases as the size of the town/city increases. Generally there are dispensaries, maternity homes, infectious diseases hospitals and urban ICDS centres run by either State Government (Health & Family Welfare, & Municipal Administration and Women and Child Welfare Departments. Host of Private health providers including Private Medical colleges, pro-profit corporate hospitals and nursing homes and dispensaries are the hallmark of the urban health services. Bigger cities will also have some Trust & Charitable Hospitals. Primary Health Care is provided generally by dispensaries run by Govt. the Corporations, the Cantonment Board, CGHS, ESIC, Railways, Defense etc.

Supplementary health services available like the School Health Clinics, ICDS centers, Balwadi's, NGOs, Mobile Dispensaries etc.

After the launch of National Health Mission I 2013, primary health care set up for universal Health Coverage. (UHC) have started coming up recently, though there is very little on the ground as of end 2017. Take off of urban health initiatives have been slow across the country.

Multiple systems interact; pluralistic political structures create competing stakeholders; and cities are inextricably linked to other sociopolitical levels, such as neighborhoods, metropolitan regions, and nation-states, each of which make demands and offers resources to the other levels, and local political and social forces create wide variations in the contexts in which programs are delivered. This contextual complexity requires a similar level of intervention complexity—A defining characteristic of intersectoral approaches, Industrial Corporate Social Responsibility (CRS) and Public Private Partnerships (PPP).

BURDEN OF ILLNESS IN URBAN INDIA[14] {Source: NSSO 71st Round- (January – June 2014)}

1) About 12% of urban population reported ailment during a 15 day reference period. It has increased from 54 to 118 in urban areas between 1995-96 and Jan-June 2014 as compared to from 55 to 89 in rural area. While for urban females it has gone up from 51 to 101 for rural females it has gone up from 58 to 135 during the same period.
2) Proportion of ailing person (PAP- no. per 1000) was highest for the age group of 60 & above (276 in rural, 362 in urban) followed by that among children (103 in rural, 114 in urban). The lowest being the youth (age bracket 15-29 years) for male & age bracket 10-14 years for female, in both sectors
3) Clearly a higher inclination towards allopathic treatment was prevalent as around 90% in both the sectors sought allopathic care. More than 70% (72% in rural and 79% in urban) spells of ailment were treated in the private. Public sector facilities catered only 21.2 % in urban areas.
4) The highest expenditure was recorded for Cancer (INR 56712), followed by Cardio-vascular diseases (31647). For cancer treatment an average amount of INR 24526 was spent in public hospital whereas INR 78050 was spent for the treatment in private hospital.
5) About 4.4% of the urban population was hospitalized (excluding childbirth) any time during a reference period of 365 days.
6) As high as 82% of urban population were still not covered under any scheme of health expenditure support. While 82% of urban population was not covered by any scheme, 12% were covered by Govt. funded insurance scheme, 3.5% by household insurance with companies, 2.4% by employer funded schemes and remaining 0.2% by others.

DIET & NUTRITIONAL STATUS OF URBAN POPULATION IN INDIA AND PREVALENCE OF OBESITY, HYPERTENSION, DIABETES AND DYSLIPIDEMIA IN URBAN MEN & WOMEN

A total of 171,928 individuals in 52,557 HH in 1097 wards of 16 cities were studied. The Sample for Diet Survey included 12903 households, 44883 Individuals and for IYCF – 6542 mothers of <3 yrs. For Nutritional Assessment- <5=12097, School age & Adolescents=36656. Monthly Per capita income pooled = INR 4941, ranged from 2884 in WB to 8027 in A&N. Key findings were:

1) In urban India, 31% men and 26% women suffer from hypertension Prevalence of hypertension among urban men and women was maximum in Kerala (31% to 39%), it was lowest in Bihar (16% to 22%).
2) The prevalence of diabetes among men and women was 22% and 19%, respectively, it was significantly associated with overweight and obesity, physical inactivity, hyper-lipidaemia.
3) The prevalence of tobacco smoking & alcohol consumption among men was 16%, & 30%
4) While 82% (pooled- range WB 51.6- Kerala= 99.6) households used sanitary toilets and 84.9% (range- Bihar 22.2- A&NI 99.6) used safe drinking water
5) A majority (85%) HH used Tap water, 11.4% sued Bore well water and 3.6% open well water
6) Most HH -93% had TV & Mobile phones, refrigerators 60.9% and Two Wheelers 55.2%

Food Choices of Urban Population in India

The findings are based on 4 million users of Healthifyme from 200 towns and cities. The app works by asking what people eat and calculating calories. The findings are based on what people reported eating. Chapati (wheat bread) emerged as more popular than rice among people trying to lose weight, even in regions where rice is the traditional staple. Healthiest Meal: Lunch is the healthiest, with higher protein and vegetable consumption.

Day: Monday is the healthiest day, when people have the most fruit and vegetables.

Unhealthiest Meal: Breakfast has the lowest intake of protein, fruits & vegetables, and is high in fat.

Day: Sunday is the day of the week when people have the most sugar and fibre.

As far the specific food items the study indicates that Boiled eggs, Cucumber, Tomato, Papya, Water Melon emerge as common health foods and Mutton Curry, Jilebi, freid items like Samosa, Kachori, Chips etc as unhealthy items. There is a marginal difference among men and women in their choice of these foods.

The choices of foods naturally lead to nutritional status of urban population as following:

1) The Pooled underweight among <5's was 25% (range Pondicherry 14.2% to UP 43.6%)
2) The pooled stunting among <5's was 28.7% (range Pondicherry 11.6 % to UP 44.8%)
3) The pooled wasting among <5's was 16.9% (range Orissa 8.4% to UP 28.9%)
4) No significant gender difference in under nutrition and more among boys in stunting
5) Over all 25% boys and 20% girls were thin among school age and adolescents
6) Among adult men Chronic energy deficiency (CED) (BMI<18.5)was 13% & overweight / Obesity (BMI-25 or more) (UP- 21.3 to Pondi 44.5%) and among women CED was 11% and Obesity/ Overweight= 44% (UP=29.7% to Pondi 59.8%)
7) All most all had received 4 ANCs and Majority had consumed IFA based AWW records
8) Prevalence of LBW was 16% (Pondicherry=9.9% to UP=28.2 & New Delhi 30.2%)
9) Only 42% initiated BF within 1 hour (Gujarat 14% to A&N 55%) & another 31% in 1-3 hrs.
10) 36% were solely BF and 34% complimentary feeding after 6 months
11) More than 96% of 12-13 months children were fully immunized and 71% of 12-36 months had received Vit. A
12) 95% Mothers (12-36 ch) hand washed with soap after toilet use and 62 % before feeding
13) Over all prevalence of underweight, stunting and wasting of <5 years children was

significantly higher among children belonging to the families of SC & ST lower per capita income with illiterate fathers and having no access to latrines.

14) Chronic disease among men and women prevailed HT-13% & 14%, Diabetes 11% & 8% and heart attack 2% &1%
15) Over all prevalence of Hypertension among men and women was 38.5 and 29% (age adjusted for men & women was 31 & 26%). The range for men was (high Kerala 46.6% and low in MP 28% and among women High of 36% in Kerala and low of 21% in A&N Islands)
16) Over all prevalence of Diabetes among men and women was 28.1 and 23.3% The range for men was (high Pondicherry- 42% and low in MP 27% and among women High of 30% in Pondicherry and low of 13% each in MP & Orissa) (age adjusted diabetes for men & women was 22% & 19%). The prevalence of diabetes was highest among 60-70 year olds in both sexes.
17) In general more than 20% of men and women had higher levels of high levels of cholesterol with highest among 50-70 yrs. (>200mg/dl).
18) Similarly 21% of men and 23% women had high levels of LDL Cholesterol level (<130 mg/dl) and 74% of men and 82% women had low levels of LDLs (<40-50 mg/dl).
19) About 40% of men and 51% of women had high levels (>150mg/dl) of triglycerides

Prevalence of Lifestyle Diseases[14]

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How Poor Households are Affected by Health Care Cost? [14]

1) Young students with Myopia cannot buy spectacles because a parent fall sick, this inability to see what is written on black board that determines individual's performance in the exams and the college or career they can pursue
2) In the decade between 2004-2014 health care expenses pushed an estimated 7% of India's population (80 million individuals) below poverty line (*NSSO)
3) Around 80% of the families pushed below poverty line by health care expenses were most severely affected by the steady drip-drip of OPD care.(Rajeev Ahuja et al. Economic & Political weekly)
4) Heath costs accounted for 10% of annual expenditure for one in four Indian homes (25%)
5) Chronic underfunding has crippled public health system from PHC to AIIMs like institutions & Govt. spending amounts to only one third of total expenses on health and the rest comes from OOPs.
6) Poor households delay seeking medical care, which in turn aggravates the sickness ad pushes up medical cost.
7) Illnesses force families to burn through money intended for school fees, tuitions, festivals, marriages, clothing, travels etc. This might affect the child's performance in schools, colleges, and India's fearsomely competitive exams and entire future.

8) Poor HH delay seeking care for want of near free facilities near their homes , inconvenient timings or mobilizing requisite resources, lack of people friendly services in the facilities

UNIVERSAL HEALTH COVERAGE [4]

Universal health coverage (UHC) is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. It has three Objectives:

1) Equity in access to health services - those who need the services should get them, not only those who can pay for them;
2) That the quality of health services is good enough to improve the health of those receiving services; and
3) Financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship.

Achieving the health Millennium Development Goals and the next wave of targets looking beyond 2015 will depend largely on how countries succeed in moving towards universal health coverage.

Universal health care has six components namely health financing, national health policies, health statistics and information system, skilled health work force, essential drugs and supplies and service delivery, quality of services and safety.

Health Targets[13] for Achieving Sustainable Development Growth (SDG) include:

1) Mortality Reduction Targets: i) Reduction of MMR (<70), ii) CMR (<25),iii) NMR (<12) iv) reduce by one third premature mortality from NCDs v) halve the number of global deaths from road traffic accidents vi) substantially reduce the number of deaths from hazardous chemicals and air, water and soil pollution and contamination. Deaths from CDs (VBDs etc.?)
2) End the epidemics of AIDS, tuberculosis, malaria (VBDs) and neglected tropical diseases & and combat hepatitis, water-borne diseases and other communicable diseases.
3) NCD: Promote mental health & Halve injuries from road traffic accidents and substantially reduce illnesses from hazardous chemicals, air, water and soil pollution and contamination.
4) Substance abuse: Strengthen the prevention and treatment of narcotic drug abuse and alcohol.
5) Sexual and reproductive health-care services: ensure universal access S&RCH Services
6) UHC: Achieve universal health coverage
7) Research and development: Support the research and development of vaccines & medicine
8) Increase Health Resources: Substantially increase health financing & Health workforce
9) Strengthen the capacity: Of all Countries for Tobacco control, early warning, risk reduction and management of national and global health risks.

SDGs and Beyond

Crucially, the global health community needs to move beyond assessing to investigating the links between different goals. There can be little doubt that factors such as Poverty (SDG-1), Hunger/Nutrition (SDG-2) education (SDG-4), gender equality (SDG-5), access to clean water and sanitation (SDG-6) peace, justice, & strong civil institutions all have a profound impact on health.

Sanitation has already been made national priority with Swachh Bharat Mission and a 2018 assessment and rankings have just been announced in May 2018. Education is important for increasing the number of trained health workers, particularly at the community level, and it also helps build the kind of behaviours and habits that have a positive impact on an individual's health.

Children who complete basic education eventually become parents who are more capable of providing quality care for their own children and who make better use of health and other social services available to them. Evidence indicates that when girls with a basic education reach adulthood, they are

more likely than those without an education to manage the size of their families according to their capacities, and are more likely to provide better care for their children and send them to school.

Ending hunger & ensuring balanced Nutrition (macro & micro nutrients: under & over) have direct influence on the health status and resistance to many infections. End poverty in all its forms everywhere especially during natural Calamities (Floods, Fire, Famine, Earth quakes & Accidents) & disease disasters (outbreaks) and finally Gender equality especially in seeking health care is the most neglected and needing social revolution and better behaviour from service providers

The urban health system in most of the cities and towns in India face many challenges to addres the complex issues listed above. Socio-demographic issues like large segment of urban population is poor. Constant migration and floating populations, and greater vulnerability of such population pose a major challenge to any service provider/program. Diverse social and cultural back grounds also pose a challenge even for awareness creation.

From the health point of view triple burden of diseases including a) communicable diseases like Dengue, Malaria, Chickengunia, and Tuberculosis that are associated with overcrowding, poor sanitation and personal hygiene, diseases associated with water like diarrhoeas, cholera, food poisoning and air pollution like Asthma, Influenza, Pneumonia etc b) Life style, commuting pain and stress related diseases like Diabetes, hypertension, substance abuse, road accidents, violence, psychological disturbances c) Silent killers of nutrition deficiencies like protein energy mal-nutrition, obesity, Vit D, B12 deficiencies are affecting the quality of life and production capacity of the general population .

The operation issues of importance are inequitable distribution of facilities, multiple agencies providing health care and other health impacting services with poor coordination, lack of standardization of and use of standard protocols to manage diseases and lack of integrated health management and information system and data base across the cities.

Last but not the least administrative issues like coordination among different administrative units of the Municipality, state government and central government, demarcation of wards /zones etc and lack of grass root level functionaries to deliver outreach services and referral system management even during emergencies.

Continuing to look at the urban health challenges one has to look at environment, sanitation, safe water supply, air pollution, Noise pollution, roads & transport, commuting pain index, structural or functional aspect of health system and service delivery particularly in private sector in that order to minimize the health risks to the population and challenges of mitigating them to the benefit of the population.

Environment Related Problems

These include Inappropriate drinking water supply, poor wastewater management/waste disposal/sanitation, Lack of toilet facilities, Garbage collection remains sporadic in urban slums and Poor spatial planning and changes in urban morphology has resulted in a changing disease spectrum that demand coordinated management by the local bodies, Central & State Govt. facilities, Railways, Defense, Cantonment Board and Professional bodies, Industries and other private sector establishments.

Air pollution is becoming the most damaging environment for urbanites in the recent years due to vehicular traffic, cutting of trees to make way for roads and buildings, construction activities and Industrial pollution. The data clearly reflects stark regional divide between north and south India. While Bengaluru with its traffic snarls continues to be the cleanest city, Gurugram runs out to be most polluted Indian city.

According to the Ministry of Drinking water and sanitation 's the SBM (U) MIS system overseen by the MoHUA, 4,322,776 IHHL toilets and 280,347 community and public toilets have been constructed. In addition 57,475 urban wards now have a hundred percent door-to-door solid waste management collection systems in place. Approximately 24% of

the wards not only received from door-to-door waste collection but also have their waste processed after. Overall, SBM (U) has verified 118 districts and 292 ULBs to be ODF.

The situation of sanitation in India is still pathetic particularly for the urban poor. There are three years left for the government target of ensuring all Indians use toilets, but in urban India alone, no more than 30% of sewage generated by 377 million people flows through treatment plants.

About 85 million in urban India lack adequate sanitation–more than Germany's population India's towns & cities contaminate their own water, with no improvement over the years.

An estimated 62,000 million litres per day (MLD) sewage is generated in urban areas, while the treatment capacity is only 23,277 MLD, or 37% of sewage generated, that means 70% of sewage generated in urban India is not treated. Sewage generation in India from class-I cities (with a population more than 100,000) and class-II towns (population 50,000–100,000) is estimated at 38,255 MLD, of which only 11,787 MLD (30%) is treated, according to a CPCB report.

The untreated sewage is dumped directly into water bodies, polluting three-fourth of India's surface water. An estimated 75% to 80% of water pollution is from domestic sewage, discharged untreated into local water bodies. About 17 million urban households lack adequate sanitation facilities in India, with 14.7 million households having no toilets, the FSM report said

Structural Problems

Structural Problems include a) Catchment areas for the specific health facilities are not well defined b) Inadequate focus on Primary health care facilities c) Governance-Fragmentation of health care services under different government departments and local bodies and Low use of technology for data collection and integration of services. Naturally solutions should include i) coordination at the district / zonal level comprising members of Health Department, Municipalities, IPP-VIII, Social Welfare department, Slum and JJ wing etc will help ensure collaboration among different agencies ii) Partnerships with the formal private sector and informal providers to rapidly expand reach of services to the unreached and IT enabled services (ITES) and governance for improved urban health surveillance and monitoring.

Service Delivery Challenges

Health service delivery challenges include i) Skewed distribution of public health facilities leading to lack of coverage ii) Lack of urban health promotion towards better access iii) Multiplicity of Service Provides and lack of Coordination & Convergence (among Govt. of India/State Government/ Municipal Corporation / Municipalities and NGO sector) iv) Inadequate policy & infrastructural capacity to deal with swelling migrant populations.

Equally challenging are the solutions such as revamp the existing facilities with ensuring one "primary urban health centre with outreach and referral facilities', rationalizing urban primary health structure, introduction of a public health management cadre and health systems management cadre, strong regulation, accreditation, and supervision framework and partnership with non-governmental providers for closing gaps in health delivery gaps in the urban sector

Current Status of Private Health Care in Urban India[14]

India's annual per capita spends on healthcare is pegged at about USD 75. Compare this with the per capital expenditure of China (USD 420), that of South Africa (USD). Urban Indians spend four times more on private hospitals (507 US$ vs. 120 US$) and twice as much on transporting patients compared to costs in government hospitals, according to the National Health Accounts (NHA- MOSPI) While 79% of care takes place in private in Urban area compared to 72% in Rural India. Estimates for the financial year 2013-14 (NHA reports 20 Sept 2016). Considering all revenue sources, including government funding, expenditure on private hospitals — Rs. 88,552 crore — was double that on government hospitals — Rs. 41,797 crore. In August 2017, the NITI Aayog had further decided to privatize medical facilities and hospitals in Tier I and Tier II cities. This will allow the

hospitals to charge the patients for all treatments not covered by government health schemes. The private healthcare sector in India has always been known for its easier access to quality and reliable services. The growth is however owing to a number of factors like perceived high quality of care, rising income and spending on health care by families, public awareness of health care and its economic gain. A shift from communicable diseases to lifestyle diseases in view of Today's urbanization and problems associated with modern living that has further increased the demand for specialized healthcare services. Indian Government had subsidized private sector organizations by providing low rates for hospital establishments and giving exemptions from taxes and duties for imported medical equipment and drugs. Medical Tourism in India is becoming a billion dollar business. Everything from cosmetic and regenerative treatments to cardiac treatment and other serious ailments is being handled successfully by the Indian private healthcare sector. High-end technology, advanced medical facilities, professionally qualified healthcare providers and relatively low-cost treatments are the reasons for the international recognition and growth of medical tourism in India. It has also encouraged international accreditation and private health insurance, bringing further changes in the financing and regulations of private hospitals.

The private sector consists largely of sole practitioners or small nursing homes having 1-20 beds, serving an urban and semi-urban clientele and focused on curative care. Health Insurance is picking up but still limited to Inpatient care. Diagnostic services (Labs/Radiology etc) are mushrooming without proper HR.

REALITIES OF DATA FOR URBAN HEALTH IN INDIA

Municipal Administration attaches low priority of health data. Most cities rely upon Registration of births & deaths and Census data. Registration is good but rarely complete. Town/City Specific Desegregated data for many health determinants in India is lacking. Some Data (CBR, CDR, IMR) are generated yearly by RGI under SRS for all urban areas of a state. Even the data available is integrated for the entire city. Most cities lack capacity for collecting, collating and analyzing data due mainly to priority given and poor HR

Key Data Desired for Urban Health Planning

1) Population data including Vital Statistics by wards/ urban poor/Slum-Registered & unregistered/Peri-urban but what we have is Trend of Urban Population: 1951- NA 1991-26.1, 2001-27.8, and 2011-31.2.
2) Nutrition Status (Under nutrition, Over nutrition, Obesity, Anemia, etc especially among Children, mothers and elderly)
3) Diseases Data (Communicable, Non-Communicable Diseases, Mental and Dental health)
4) Program Implementation and outcome data: (Family Planning , TB Immunization, Leprosy, HIV/AIDS, Dengue, Malaria , Chikungunia, JE and other VBDs and Diabetes, CVDs)
5) Roads, Transport, Commuter Pain Index & Road Accidents
6) Urban Poverty /Slums / HH with Toilets/ Sewerage/ Industrial data
7) Environmental Pollution Data (Ambient air quality, Noise Pollution, water pollution, Industrial waste water, Vehicular pollution, Solid waste, Bio-medical waste, Hazardous waste, Electronic waste, plastic waste, E-waste,).

Components of Urban Health Services

The components of health care services mainly include Individual sickness care either at primary, secondary or tertiary care facilities. They also include regulatory functions like licensing medical practice, food industries, slaughter houses, sewage disposal, waste disposal, managing traffic accidents and environment pollution monitoring and management for the better health. They also include implementing national health programs following the guidelines and cremation / burial grounds.

Why Large Hospitals in Public Sector are Managed Poorly?

Reviewing the public health system in urban areas one can infer that large hospitals in public sector are managed poorly because:

1) Govt. Doctors are not compensated adequately & are permitted for Private Practice
2) Most senior doctors share administrative and clinical work in Govt. & Private
3) Centralized bureaucracy does not provide required autonomy to the hospital
4) Comprehensive Primary Health Care facilities fail to provide essential basic services, putting burden on district, Medical College and specialty hospitals
5) Public Health Professionals with program and hospital management skills for better design & delivery of services leaving clinicians to focus on patient care are scarce commodities. Hardly two states in the country have a mandatory creation and promotional opportunities.
6) Transparent procurement systems for drugs & other supplies lacking
7) Technological up gradation and Human resource capacity updating take long time and need to follow cumbersome processes

NATIONAL COMMITMENT FOR BETTER HEALTH

A National Perspective Pradhan Mantri Bhartiya Janaushadhi Pariyojana 2015

It ensures Accessibility, Acceptability, and Affordability. "Jan Aushadhi" is the novel project launched by Government of India in the year 2008 for the noble cause – Quality Medicines at Affordable Prices for All. The campaign was undertaken through sale of generic medicines through exclusive outlets namely "Jan Aushadhi Medical Store"in various districts of the country. The first "Jan Aushadhi Medical Store" was opened on 25 November 2008 at Amritsar in Punjab. In September 2015, the 'Jan Aushadhi Scheme' was revamped as 'Pradhan Mantri Jan Aushadhi Yojana' (PMJAY) and in November 2016, to give further impetus to the scheme; it was again renamed as "Pradhan Mantri Bhartiya Janaushadhi Pariyojana" (PMBJP). It is a campaign launched by the Department of Pharmaceuticals, Govt. Of India, to provide quality medicines at affordable prices to the masses through special kendras known as Pradhan Mantri Bhartiya Jan Aushadhi Kendra. Pradhan Mantri Bhartiya Jan Aushadhi Pariyojana Kendras (PMBJPK) have been set up to provide generic drugs, which are available at lesser prices but are equivalent in quality and efficacy as expensive branded drugs. BPPI (Bureau of Pharma Public Sector Undertakings of India) has been established under the Department of Pharmaceuticals, Govt. of India, with the support of all the CPSUs for co-coordinating procurement, supply and marketing of generic drugs through Pradhan Mantri Bhartiya Jan Aushadhi Kendra. NGOs/agencies/individuals establishing Jan Aushadhi stores in Government hospital premises where space is provided free of cost by Government to operating agency. BPPI will provide one time financial assistance up to Rs. 2.50 lakh as per details given below:

1) Rs. 1 lakh reimbursement of furniture and fixtures.
2) Rs. 1 lakh by way of free medicines in the beginning.
3) Rs. 0.50 lakh as reimbursement for computer, internet, printer, scanner, etc.
4) 20% trade margin shall be included in MRP for retailers and 10% for distributors.
5) Jan Aushadhi stores and Distributors will be allowed 2% of total sales or actual loss, whichever is lower, as compensation against expiry of medicines. Expired goods need not be returned to BPPI. Stocks expiring at the C&F level will entirely be the loss of BPPI.
6) Credit facility will be given to all Jan Aushadhi stores for 30 days against postdated cheques. Distributors will also get credit of 60 days against post dated cheques. C&F agencies will have to deposit a security amount depending upon the business.

National Health Protection Scheme (NHPS) (Ayushman Bharat Scheme)

It seeks to provide health insurance of Rs 5 Lakh to 10 crore poor and vulnerable households. The government has proposed rates for over 1,350 treatment packages, ranging from Rs 1, 000 to over Rs 1.50 lakh, for the Pradhan Mantri Rashtriya Swasthya Suraksha Mission. This National Health Protection Scheme will have major impact on reduction of Out of Pocket (OOP) expenditure on

ground of. The salient features of NHPS: Ayushman Bharat - National Health Protection Mission will have a defined benefit cover of Rs. 5 lakh per family per year.

Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country.

1) Ayushman Bharat - National Health Protection Mission will be an entitlement based scheme with entitlement decided on the basis of deprivation criteria in the SECC database.
2) The beneficiaries can avail benefits in both public and empanelled private facilities.
3) To control costs, the payments for treatment will be done on package rate (to be defined by the Government in advance) basis.
4) One of the core principles of Ayushman Bharat - National Health Protection Mission is to co-operative federalism and flexibility to states.
5) For giving policy directions and fostering coordination between Centre and States, it is proposed to set up Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) at apex level Chaired by Union Health and Family Welfare Minister.
6) States would need to have State Health Agency (SHA) to implement the scheme.
7) To ensure that the funds reach SHA on time, the transfer of funds from Central Government through Ayushman Bharat - National Health Protection Mission to State Health Agencies may be done through an escrow account directly.
8) In partnership with NITI Aayog, a robust, modular, scalable and interoperable IT platform will be made operational which will entail a paperless, cashless transaction.
9) Increased benefit cover to nearly 40% of the population, (the poorest & the vulnerable)
10) Covering almost all secondary and many tertiary hospitalizations. (except a negative list)
11) Coverage of 5 lakh for each family, (no restriction of family size)

This will lead to increased access to quality health and medication. In addition, the unmet needs of the population which remained hidden due to lack of financial resources will be catered to. This will lead to timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency, job creation thus leading to improvement in quality of life. While these initiatives will benefit urban poor mostly, ensuring better living and working conditions and reducing commuting pain Index will have to be planned by local self government organizations and Public and private sectors.

What each city need to ensure to achieve Universal Health Coverage? [17]

A recent studies by BMGF studies 4000 HH in UP, MP, Rajasthan, WB & Karnataka for DW&S Ministry & UNICEF studied 10,068 rural HH across 12 states on Financial & economic impact have highlighted the fact that

BMGF Study:

1) Becoming ODF had a positive impact on Child Health, Nutrition as the indicators belonging to ODF area were comparatively better
2) Cases of Diarrhea among children living in non-ODF was 46% higher
3) Cases of worms were higher by 78% in non-ODF areas
4) Stunting cases were higher by 17% in non-ODF areas and
5) Women with lower BMI than normal were 48% higher in non-ODF areas.

UNICEF STUDY:

1) Building & using toilets can help families avoid INR 50,000 of burden per year
2) INR 18,991 increase in value of house with toilet
3) INR 8,024 less medical cost due to reduction in illnesses
4) INR 24,000 saved because of time saved
5) INR 17,622 saved due to lower mortality rates

A recent release on 2 October 2017 by

1) Total seven states and a Union territory have been announced open defecation free and in all, 1,472 cities and towns of the total 4,041 have so far become ODF.
2) Urban areas of five States namely Madhya Pradesh, Maharashtra, Chhattisgarh, Jharkhand and Haryana have been declared 'Open Defecation Free' (ODF) on the completion of third anniversary of Swacch Bharat Mission on Monday. Gujarat, Andhra Pradesh and Chandigarh have become ODF last year.
3) As against the target of building about 66 lakh individual household toilets in urban areas, 38 lakh toilets have already been built and construction of another 14 lakh toilets is in progress. Over two lakh community and public toilet seats have been built as against the mission target of five lakh toilet seats.
4) As far as ODF (rural) is concerned, out of 204,245 (39% of 6.3L) villages that self-declared to be open-defecation free (ODF), only or 51.6 %t have been verified.
5) Working with The poorest quintile of the population in Urban slums, Dalits, Floods and Draught hit areas yields greatest achievement
6) It also directly improves dignity and safety of women that is imperative of Socio-economic development of any country

Solid Waste Management

1) Solid waste management is equally important in the context of urban health. Urban India generates on an average 151,831 tonnes of solid waste every day
2) Only 53% of wards are covered with door-door collection of waste, an average 22% of waste is processed, 78% contaminates land or makes way into river & lakes
3) Many of these dumping areas, are used for OD, exposing to unsafe environment
4) Hotel & Hospitals lack technology to dispose of waste CPCP/NGT-HT 4/9/17
5) In most cities everyone from the five star hotels to the biggest Govt. hospitals and railway stations, bus depots are found disposing solid waste in violation of Govt. norms in the absence of proper infrastructure and trained personnel.
6) For every hospital bead 1-2 kg of biomedical waste is generated daily in India
7) Only 15% of the solid waste is hazardous or infectious, but mixing this with the rest leads to contamination of entire solid waste
8) Nearly 10% of hospitalized patients acquire at least 1health care associated infection
9) Most 3 + star hotels have STPs but majority of them are non-functional at any given time and if functional there is no proper sludge management practice.
10) Underground sewage man-holes pose additional risk of life in urban areas. Many cities have reported deaths in recent months
11) Railway stations /Bus depots /stands generate/ big markets generate solid waste
12) Waste segregation is essential for its treatment but is not a common practice in all most all cities and towns. Sewage treatment Plants (STPs) and Effluent Treatment (ETPs) in case of hospitals establishment are mostly non-existent or non-functional

Indoor Air pollution

1) Air inside many of the HH in Urban areas may be much worse than outdoor air as Co2 and PM 2.5 levels peak at night and early morning due to lack of ventilation may reach up to 2000 ppm more than double the indoor limits.
2) Most indoor pollutants include CO_2, PM2, VOCs and biological pollutants
3) Air purifier work for only stale air but not Co2 levels
4) Lowest pollution between 3-6 pm & peak pollution 9 PM-12AM and 6AM-9AM
5) Volatile organic compounds (VOCs) and Co_2 due to combustion & fumes are found in kitchen
6) VOCs are also generated from furnishings, furniture's, paints and perfumes.

Remedies like ensuring proper ventilation, use indoor green plants that purify air and also provide Oxygen

at night and Ensuring that items like carpets and sofa sets are dry-cleaned regularly need to be promoted.

Road Accidents

1) A total of 480,652 road accidents took place in India last year (2016) resulting in the loss of 150,785 lives and inflicting serious injuries on 494,624 persons.
2) On an average 413 deaths per day (2016) are attributable to road accidents and most of them occur in urban areas. Road deaths up 15% in 2016 during 'very bad year' for road safety according to Road Safety Authority of India
3) The Accidents India 2016 report, revealed that 46.3 % killed in road accidents were young, between the age group of 18-35 years.
4) While overall road accidents declined by 4.1% the fatalities were up by 3.2 %.
5) As many as 1,591 people lost their lives in road accidents in Delhi, in Chennai, the death toll was 1,183 last year. Jaipur at 890 and Bengaluru at 835 followed the two Indian mega metros in road deaths. Mumbai was comparatively safer in terms of road deaths, with 562 deaths, lower than even Kanpur and Lucknow.
6) As per the data released by the transport ministry, Chennai witnessed the maximum road accidents during the year - 7,486. It was followed by Delhi with 7,375, Bengaluru 5,323, Indore 5,143 and Kolkata 4,104.

Sewer Deaths & Health Risks

Tackling health risks for sanitation workers is becoming a challenging task for many municipal authorities in these days. Delhi, Mumbai and Bangalore have reported deaths also in the recent past. No bunny suites, no masks, no oxygen cylinders are common sight one sees and, worse, nobody even thinking of mechanising the periodic cleaning of gutters. The only way to survive these inhuman working conditions is to drink liquor to numb the senses therefore one sees about 90% of the workers are hooked to liquor.

Flooding in Urban Areas

Come rainy season flooding is a normal feature in many cities. Main reasons for the flooding include: Blockage of natural water ways, channels and courses due to excessive use of plastic/ polythene bags, Dumping of Waste from colonies & encroachment of drains, Untreated Industrial waste, Mushrooming of unauthorized colonies, Mixed flow of Municipal waste collection and disposal system, Poor Sweeping mechanism and Excessive concretization of road berms. Planning to end the health damages of flooding and manual scavenging need to be addressed by Super sucker Machines, Suction Machine and Suction cum Jetting machines, Mobile all Terrain Excavator and Multi-Functional Dredger

IBM Commuter Pain Index February 2017[18]

Commuter Pain Index ranks the emotional and economic toll of commuting in Cities. A recent survey used Commuting time, Time stuck in traffic, Prices of fuel, worsening traffic, start-stop traffic, stressful driving, driving stimulated anger, Traffic effected work, Traffic bad to the extent of stopping driving & Cancel the trip fearing traffic. An average Indian spends about 91 minutes in commuting per weekdays compared to highest of 97 minutes in Israel and lowest of 39 minutes in Japan.

What Urban Municipal Authorities need to do for Improving Health?

As clearly enunciated in the previous paragraphs non-health services issues like water, air and noise pollution, roads, traffic, working conditions influence and affect health of the population in general particularly more so the urban poor. Therefore urban health departments should aim to ensure

1) Household toilets and community toilets to achieve Open air defecation free status
2) Fix all the open drainage system and flooding during rains
3) Make and maintain all the streets and roads clean
4) Bring in best solid waste management practices
5) Water and waste water pipeline system, so that they don't mix and cause outbreaks
6) Make the last mile connections so that work force have minimum commuting pain

7) Minimize potholes in roads and thereby accidents are minimized
8) Ensure periodical inspection of all vehicle for pollution and fuel efficiency

Summary:

1) As per NSSO 2008, the private sector accounted for 60 percent of all in-patient admissions and 78 percent of out-patient consultations especially in urban areas.
2) "Call to action (C2A)" February 2013 advocated universal health care coverage as an imperative if India should progress socially and economically
3) NRHM , NUHM & RMNCH+A the main Govt. program investment in Public Health and are now under one umbrella " National Health Mission"
4) National Health Protection Scheme (NHPS) – launched recently aims to cover in-patient treatment, possibly making quality healthcare and private sector facilities accessible to the poor.
5) Many Private Health Insurance are competing for big share in market justice but mostly covering Inpatient care paving way for malpractices
6) Tax exemption on expenditure on HI premiums for preventive health will go a long way in boosting focus on prevention, rather than curative care, as well as towards creating a facilitative environment
7) Private sector Hospitals are exuberant and competing for Tertiary care and attracting foreign Medical tourists and are also investing in preventive and promotive care
8) Pradhan Mantri Bhartiya Janaushadhi Pariyojana 2015 is paving way for making essential generic drugs accessible, affordable and acceptable.
9) Mandatory spending as CSR has opened up a new opportunity for Public Health Good and employment opportunities for public health professionals
10) Key lever for Uran Health is access, efficiency and quality in healthcare especially for urban poor.
11) COLLABORATION Need d for stakeholders to use each other's strengths to leverage the existing infrastructure & resources
12) INNOVATIONS Needed for product and process innovations to provide affordable and cost-effective solutions
13) Stakeholders need to synergize to bring about Innovative models in service delivery and technology
14) Sustainable Ecosystem for Public Health is the key driving factor
15) PH Professionals who can fit into corporate/Govt./NGO & Development Partners world from first day through action learning and shoulder huge responsibility are in Demand

To achieve universal health coverage in urban areas it is equally important to monitor non-health service components and jack of all public utility services and environmental challenges. These will affect the health of urban poor especially and any slackness on this front will definitely impede the urban poor in achieving health goals and thus delay the entire country reaching the goals.

Urban Poor need not delay the achievement of UHC-

Urban health interventions differ from interventions in rural or other settings both because:

1) urban populations present a different health profile and
2) the urban environment is markedly different from suburban or rural ones.

To be successful, public health interventionists must address both types of differences. Effective public health programs must use:

1) Available scientific evidence to meet the unique needs of urban populations and
2) A thorough understanding of the relevant social and political contexts to manage the process of program implementation and institutionalization.
3) Intersectoral approaches will help to overcome these daunting challenges.

If policy makers show the will- India has the skills & resources to provide it. Yet low public outlay so far has made it impossible for the public sector to respond to the growing health needs of the population. We cannot achieve UHC as long as we have dumbed governance. A robust public health system acts as first defence by preventing outbreaks, if occur controlling the spread soon and also limit the damage of endemic diseases.

The health system should prioritize interventions for preventions of untimely deaths, diseases, disability limitation & rehabilitation. Approach to health care needs to take comprehensive view, pay attention to broader determinants of health such as sanitation, safe drinking water, water & noise pollution, roads and transport.

Accountability can be enforced only when there is clear chain of command. There is simply no where in India where the buck stops!!!

India attracts medical tourism for its high quality, low cost advanced care & has emerged as the global pharmacy for inexpensive drugs and vaccines.

Financial resources cannot be cited as a constraint nor fragmented as we are seeing stand alone Swachh Bharat cess to raise resources for sanitation. What is needed is transformational initiative in health financing, public private mix in service delivery & strengthening PHC to take to peoples' doorsteps. Involve people in deciding health priorities, own interventions through iec, social mobilization and community system strengthening to lower inequities.

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