An Exploratory Analysis of Urban Healthcare Stakeholders in India

Report

prepared by

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SUMMARY

The National Urban Health Mission was launched in 2013 to provide universal access to healthcare in urban areas in India. Efforts of stakeholders already present in this field can provide useful lessons that can contribute towards making the mission a success. This report sought to conduct an analytical review of the roles of these stakeholders, the strengths and weaknesses of existing work and examine the scope of possible coordinated action that may help achieve universalization of urban healthcare.

Mapping and analysis was conducted at the national level.

Major Stakeholders in Urban Healthcare in India

The chief stakeholder in urban healthcare is the public sector of which the central Ministry of Health and Family Welfare (MoHFW) lays down policy guidelines, programme frameworks and provides a share of the funding while state governments are the main providers of services geared towards the vulnerable populations. MoHFW also directly provides tertiary care services across the country though access to the same is questionable. Urban Local Bodies (ULBs) are involved predominantly in provision of basic amenities, in some states rudimentary healthcare services and in few selected larger corporation cities, all levels of healthcare. Other ministries/departments play a role via financial allocation, or provision of schemes that address the proximal and distal determinants of health.

The private sector remains the largest provider of curative services to urban populations but these are highly inaccessible to the vulnerable sections. Increasingly, this sector is also being engaged by the government for delivery of services via Public Private Partnerships (PPPs). Another set of key stakeholders that has emerged are donor and aid organisations. Their main role lies in supporting central and state governments for policy and programme implementation but many have a strong impact on policy development as well.

Major public health research institutions also work on urban health specific issues ranging from exploration of broader health system challenges to poverty, migration, gender and health, non-communicable and communicable diseases, financial risks and demographic studies.

The study found that healthcare services in urban India are being delivered without outlaying any broad vision for them. Schemes and facilities have been set up in a random unorganized and haphazard fashion. There are several actors in the field, each playing different roles with varying levels of authority and responsibility. Sectors such as Reproductive and Child Health/Family Planning (RCH/FP) or HIV/AIDS are highly emphasised, as evidenced by the profusion of stakeholders in these fields. This appears to be in line with government or international priorities but does not address community demands which are far greater for general healthcare. Felt needs of communities also include coordinated services with a single window delivery system for both healthcare and associated services.

Despite such drawbacks, the public healthcare system is the main provider of services to the most marginalized sections of urban India. The key to achieving universal healthcare lies in addressing the serious fundamental flaws that exist in the current system. Thus services will have to become more comprehensive, well planned with well thought out long term policies, with strengthened data management, improved co-ordination and engagement of the private sector in a manner that directs its services towards public health goals. NUHM has to address these challenges urgently in order for India to hope for universal urban healthcare.

An Exploratory Analysis of Urban Healthcare Stakeholders in India

The Government of India has committed to providing Universal Health Coverage to all its citizens. The 12th Five Year Plan sought to 'work towards a long term objective of UHC' to provide 'assured access' to drugs and treatment 'entirely free for a large percentage of the population'. It aimed to meet the Millennium Development Goals (MDGs) (UNDP 2016) of reducing India's child mortality by two thirds and bringing to a halt and reversing the trend in its burden of tuberculosis, malaria and HIV/AIDS. The National Rural Health Mission (NRHM), implemented in 2005, sought to shore up the health service delivery in rural India that is based on a pyramidal system of provisioning. Delivery of health services in urban India on the other hand has been far more complex and multifaceted. There is a range of stakeholders, from the central to local city governments, from international donors to private for-profit and not-for-profit organisations, who play varying roles in this scenario. The National Urban Health Mission (NUHM) was launched in 2013 with the aim of universalising health coverage in urban India. The NUHM Framework for Implementation (Framework) and the Report of the Technical Resource Group for NUHM (TRG) offer an architecture for its execution. The work of the existing stakeholders and learnings from current efforts can contribute to the success of this mission. The aim of the present report is to map the roles of these stakeholders and their current work, and thus provide an analytical overview of the present situation. In doing so it hopes to stimulate discussion on the roles of stakeholders, identify the challenges and means of addressing them, and explore possible co-ordinated action for achieving universal access to urban healthcare.

Introduction

India's urban population has been growing at a consistent rate for the last many decades (Bhagat 2011). For the first time in its history, urban population growth rate outpaced the rural counterpart both in relative and absolute terms between 2001 and 2011 (Census 2011). This rising urbanisation brings with it ever increasing pressures on living spaces, infrastructure and services. Lack of provision of these basic needs to in-migrating rural labour force has resulted in the proliferation of slums which have mushroomed extensively. They exist today in abysmal conditions without basic water, sanitation and solid waste disposal services (Census 2011). Needless to say, these conditions are breeding grounds for extremely poor health outcomes resulting in much higher morbidity and mortality among the urban poor than the non-poor (Table 1).

Table 1: Health Indicator Comparisons

	Urban Poor	**Urban Non Poor**	**Overall Urban**
Children's Health			
Infant Mortality	54.6	35.5	41.7
Under-5 Mortality	72.7	41.8	51.9
Stunting in U-5 Children (%)	54.2	33.2	39.6
Children completely immunized (%)	39.9	65.4	57.6
Women's Health			
Mothers who had at least 3 ANC visits (%)	54.3	83.1	74.7
Births in health facilities (%)	44.0	78.5	67.4
Women age 15-49 with Anaemia	58.8	48.5	50.9
Environmental Conditions			
Households with access to piped water supply at home (%)	18.5	62.2	50.7
Household using a sanitary facility for disposal of excreta (flush/pit toilet) (%)	47.2	95.9	83.2
Infectious Diseases			
Prevalence of medically treated TB (per 100,000 persons)	461	258	307
Prevalence of HIV among adult population (age 15-49)	0.47	0.31	0.35

Source: UHRC n.d (Fact sheet on Urban Poor - NFHS 3)

Along with these challenges come those of addressing the specific health problems of the most vulnerable amongst these marginalized groups – the homeless, the street children, female headed households, sex-workers, single male migrants and those working in hazardous occupations. Their needs can vary considerably from those of the rural and the non-poor populace, both in terms of the types of services required, such as greater healthcare needs for seasonal vector borne diseases, mental

health, substance abuse, as also the means and timing of delivery. The Urban Health Mission is an attempt at addressing these needs. It is being implemented in towns with more than 50,000 population as well as in all district and state headquarters. The mode of its delivery depends on the size and type of city. Thus the seven major metropolises of Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmedabad will implement it through the municipal corporations while in other cities/towns it may be implemented by the Departments of Health of state governments directly or via societies set up in the municipalities and smaller corporations specifically for the purpose.

While the mission seeks to deliver services to urban Indians, with special focus on the vulnerable, a note must be made of the major shortcomings in the public healthcare system that NUHM will have to overcome in order to do that. These include –

***Governance Deficits*:** The TRG notes that a deficiency in data is one of the biggest obstacles to good planning in India today. Wanless (2004) proposed a similar argument, stating that reliable, appropriate and adequate data inputs are a must from the very initial stages of planning. Added to this, the TRG notes that the 'inverse pyramid' of service delivery is a major lacuna in Indian healthcare governance, whereby the primary healthcare facilities are under-utilized while tertiary care facilities are overcrowded and overburdened. Reasons for this have been found to range from a perception of poor quality of services provided at the primary level, to deficiency of the required services, to complete absence of any services due to non-attendance of staff (Griffiths and Stephenson 2001, Ager and Pepper 2005, Chaudhury et al 2006, Banerjee et al 2008). This reversal of the desirable system both compromises the quality of care that the stretched staff at overburdened tertiary care facilities can provide and deskills the personnel at the primary levels due to under-utilization of their services. Poor referral systems and weak convergence are other governance deficits noted by the TRG and the Framework.

***Absence of Comprehensive Primary Level Care*:** Another major governance failure is the stark focus on maternal and immunization needs and family planning, to the detriment of other general healthcare needs of the population. Nayar (2012) has pointed out that India was signatory to the Alma Ata declaration for Comprehensive Primary Health Care but its policy makers soon moved to the 'Selective Primary Health Care' approach that served their ideologies and financial means better. Most general services at the primary level have consequently been seriously compromised in India's public sector.

***Unregulated Private Sector*:** The private health sector in India, from the unqualified informal neighbourhood provider to large corporate super-speciality hospitals, are the largest providers of curative care to its populations. Yet they do so without having been brought under the purview of a regulator (Yip and Mahal 2008, Baru 2013). Baru (2013) opines that despite the many administrative, technical and logistical difficulties in such regulation, it is the profit interest of this sector which poses the greatest challenge to universalisation of healthcare.

***In-accessibilities and Iniquities*:** Though ostensibly free for the poorest and most marginalized, services in the public sector extract a high price in terms of the opportunity cost of time, parallel hidden costs coerced from patients and major corruption that extracts a heavy price from the public exchequer, weakening the entire system (Chattopadhyay 2013). In addition, the most vulnerable sections often have to face hostility when accessing these services (Matthews et al 2005). The private sector on the other hand, even as it provides services at times and distances convenient to the people, has also recently come under the scanner for similar corrupt practices (Nagral 2012, Jain et al 2014).

Making note of many of these shortfalls, the TRG emphasised a detailed mapping of urban slums in order to locate NUHM facilities at sites most convenient to the poor. It also stressed a continuum of care, stronger convergence with municipal services and thereby the determinants of health, strengthened referral systems and careful management of existing facilities under previous projects. Lastly, it called for all these services to be delivered under a single window Urban PHC.

Methodology

The present study adopted a qualitative research design based on the methodologies delineated by Schmeer (1999), and Varvasovzsky and Brugha (2000). Such methodologies for stakeholder analysis have often been used as a tool for strategic planning in management sciences and organisational behaviour. Its best use in policy analysis for healthcare according to Brugha and Varvasovzsky (2000) is to study the roles, interests, practices and partnerships of actors in the field. Walt and Gilson (1994) also opine that mapping stakeholders provides a useful, though simplified, view of their inter-linkages and their means of engagement with the policy development process.

In the present work, a preliminary list of stakeholders in urban health in India based on literature review and existing knowledge was edited after detailed discussions with health sector experts such as former senior health bureaucrats and academicians. A further detailed literature review on the priority stakeholders was then conducted. Key informants identified through existing knowledge, the literature reviews conducted and snowballing were interviewed. Sources of secondary data included reports, surveys, policy documents, annual reports and websites from government and stakeholder sources. Academic and grey literature on the SHs was also reviewed.

Specific data was sought on domain of work of the SHs in urban healthcare, their partnerships and nature of these, resources invested or available and the extent of their influence on urban healthcare issues and policies. Attempt was made to analyse the strengths, weaknesses and challenges faced in the efforts of most major SHs so as to gather a comprehensive overview.

Mapping and analysis has been attempted at the national level. Major actors with a presence at the pan-India or multi-state level have been studied.

Limitations of the study

This study offers a snapshot of a dynamic situation that is constantly evolving, subject to pressures, influences and interests of the various SHs. The situation reflected in the findings may therefore change rapidly. In addition, the findings are to some extent dependent on information provided by SHs themselves; thus even as all attempts have been made to validate the data, it is possible that they reflect some of their predispositions.

Findings

Unlike the well-structured pyramidal system of rural health services, urban health services in India have evolved in an organic and random manner. The foundations of urban healthcare were provided by Urban Local Bodies (ULBs) under the British regime and supplemented by various schemes in the post-independence period. The result today is non-uniform and haphazard delivery of services across the country by the public sector along with a large unregulated private sector that ranges from the solo unqualified practitioner to large super-speciality corporate hospitals.

Major Stakeholders in Urban Healthcare

The key SHs in urban healthcare in India are –

- Public Sector
- Autonomous Organisations
- Donor and Aid Organisations
- Non-Government Organisations
- Private Sector and Professional Organisations
- Research Institutions, Universities, Think tanks
- Communities and Civil Society Organisations

I. Public Sector in Health

Public sector is *the* key stakeholder in urban healthcare. Within this sector, actors present at all levels of administration – from central to state to local government – play different roles. The central Ministry of Health and Family Welfare (MoHFW) plays the chief guiding role by laying down policy guidelines and programme frameworks that largely determine the services all states provide to their citizens. This includes all previous schemes for urban healthcare such as the India Population Projects (IPP) and Urban Revamping Scheme, or the urban specific components of national health programmes such as the Urban Malaria Scheme (UMS) or the 'Pradhan Mantri Swasthya Suraksha Yojana' (PMSSY). The UMS specifically addresses the high API cities in the country while PMSSY is geared towards development of urban healthcare institutes. NUHM is the latest, broadest and most ambitious of these programmes; once fully implemented, it will subsume all previous national urban healthcare programmes.

The planning and implementation of these policies is administered by the Secretary, MoHFW and bureaucrats under him. Technical guidance to states on all matters related to the execution of the same programmes is overseen by the Director General of Health Services (DGHS) and the technical wing of the ministry under him. The MoHFW also has a research wing – the Department of Health Research –

which coordinates medical and health research supported by the ministry at its Centres of Excellence (CoEs) across major medical and research institutions.

Apart from laying down the frameworks for provision of services, the MoHFW is also a provider of tertiary care services in major cities, predominantly metropolises and state capitals. It also provides limited primary care to federal government employees under the Central Government Health Scheme (CGHS). Beyond this provisioning, it is the single most important source of funding for urban components of national health programmes, and now NUHM. The amount and proportion of funding provided varies with the programme, and the economic and health status of the state, but ranges from 100% of NUHM funds for Union Territories to 60% for larger better off states. The other key role of the MoHFW is that of regulator – for provision of medical care, ethics, research, and pharmaceutical standards in both public and private sectors. It is this role where the government has been most severely criticized for its under-performance and failures (Baru 2013).

Besides this central role of the MoHFW, several other Government of India (GoI) ministries play indirect but critical roles in determining urban health. These include the Finance Ministry which decides the annual financial allocation for healthcare, Ministries of Urban Development (MoUD), Housing and Urban Poverty Alleviation (MoHUPA), and Women and Child Development (MoWCD), all of which implement schemes that impact the proximal determinants of health. These include programmes to provide housing, livelihoods, basic amenities and supplementary nutrition to the most needy of the urban populations.

The state governments are the other key public sector player in urban healthcare. Departments of Health (DoH) are the main providers of primary, secondary and, in most cases, tertiary care services to the citizens. Primary care centres often focus specifically only on maternal services and immunisation while the secondary level facilities provide general services (TRG report). Tertiary care services are delivered at district and state headquarter cities. The TRG found that these, instead of serving as referral centres as they ideally should, serve often as the first providers of primary care, due to the absence of general service provisioning at the primary care facilities.

The role of the ULBs varies with the state but most often these are associated with little or no provisioning of healthcare. Only in states such as Gujarat, Maharashtra, Andhra Pradesh and Tamil Nadu, where they have customarily enjoyed greater autonomy and authority, they are involved in provision of basic primary healthcare while the bulk of services are provided by the state departments. In the seven large metropolises and in few cities with larger corporations such as Surat, Thane, Pune, Pimpri-Chinchwad, Vishakhapatnam and Madurai, they provide all levels of care – from the primary to the tertiary (TRG report). This speaks to the traditional autonomy they have enjoyed here or the powers granted them under the 74th Constitutional Amendment Act (which provided for greater financial and administrative urban decentralization), as well as the rich resources at their command. There are

however glaring examples of a mismatch in the priorities and internal policies of the local governments. Mumbai Corporation for instance finds it challenging to provide healthcare to all its vulnerable sections given that more than 50% of its population lives in slums. Yet, the Mumbai Municipal Corporation Act does not allow provision of basic public services to non-notified slum dwellers, thus creating conditions deeply detrimental to the health of populations here. This, in effect, increases the burden on the corporation's own division of health services.

II. Autonomous Organisations

The National Health Systems Resource Centre (NHSRC) is an autonomous organisation which serves as a technical support unit to the central health ministry. It helps in collecting evidence for development of policies and building capacities of the state public health systems. It has played a strong role in developing the institution of community workers called ASHAs for the rural health mission and can be expected to play a similar role for NUHM.

III. Donor and Aid Organisations

These organisations are either currently supporting MoHFW and state governments in policy development and programme implementation for urban health, or have played a major role in laying the foundations of urban healthcare in the country.

ADB, as an institution, has a defined and specific thrust towards the urban sector in its aid programme. In healthcare, it is providing direct support to MoHFW for implementation of NUHM. The support is in the form of technical assistance (TA) for planning and management of the mission.

USAID is another agency with an active engagement policy specifically for the urban health sector. Its largest health investment has been the 'Health of Urban Poor' (HUP) programme which was implemented in eight of the poorest states of India and five demonstration cities of Delhi, Agra, Jaipur, Bhubaneshwar and Pune, starting in the late 2000s. The programme aimed at institutional strengthening including convergence between departments, increasing private sector participation and capacity building in the public sector for planning, monitoring and evaluation. It also provided services for maternal and child health through both public and private agencies along with outreach activities via self-help groups amongst slum women (Mahila Arogya Samitis or MAS). The programme has been successful with regard to development of MAS and inclusion of the WASH agenda in the DoH policies, but it has not been as effective in its attempts at engagement of the private sector in delivery of services to the poor (USAID 2015). Nevertheless it has provided substantive groundwork for the framing of NUHM.

Another major nationwide programme that has formed the base of urban health services to a large extent is the India Population Project, a series of World Bank aided projects implemented between 1972 and 1998 at both the central and state government levels. The IPP projects were implemented in urban centres of several states across India. They focused on delivery of family planning and reproductive health services, and infrastructure development, project management and monitoring for the same. The infrastructure and services built under these projects continue till date in various avatars, even as they are now financially supported by local or state governments. The World Bank's current involvement in urban healthcare is limited to its support for the Targeted Intervention (TI) activities under the National AIDS Control Programme, which are geared towards the high risk groups centred principally in urban locales.

WHO India, in line with its global policies, provides technical guidance to the MoHFW. The key domain where its role has been particularly significant for urban healthcare is the Polio eradication programme. The programme faced special challenges in this space in terms of immunization of the homeless, mobile and undocumented populations. This required substantial strengthening of the surveillance systems in the country, a mechanism to which WHO contributed significantly.

The other international agencies with important roles in urban healthcare are UNICEF, the Bill and Melinda Gates Foundation (BMGF) and United Kingdom's Department for International Development (DFID). UNICEF provides technical assistance to the MoHFW for strengthening child health programmes such as the Integrated Management of Neonatal and Childhood Illness (IMNCI) programme, Facility Based Newborn Care (FBNC) and for piloting Special Newborn Care Units (SNCUs). Since these units are located at secondary or tertiary level urban facilities, the TA has fed into improved urban healthcare systems. BMGF has partnered with WHO in its Polio eradication programme. Its other main urban health projects are an Urban Health Initiative (UHI) in Uttar Pradesh which functioned in multiple cities to provide basic maternal and child health clinical and outreach services in poor communities. The foundation has also recently started work on a TB project that links patients with selected private providers and pharmacies through a digitised notification system in an attempt to improve monitoring of patients. It has however invested most heavily in programmes geared towards some of the proximal determinants of health. It is thus assisting the Ministry of Urban Development (MoUD), in partnership with USAID, in implementation of the urban component of the national sanitation programme – the Swachh Bharat Mission.

DFID's engagement thus far was with programmes geared towards the rural underserved and marginalised communities but it is now realigning its strategies to work more closely in urban healthcare.

IV. Non-Governmental Organisations

There are several national and international NGOs active in the urban healthcare space. Most work in a rural-urban continuum and in the RCH/ FP or HIV/ TB sectors. The main ones include Population Foundation of India (PFI), CARE India, Family Health International 360 (FHI), Urban Health Resource Centre (UHRC) and PATH.

PFI was the implementing NGO for the USAID funded Health of Urban Poor project that provided a base map for framing NUHM. The urban programmes of CARE India are spread across several northern Indian states and sectors such as MCH, HIV/AIDS and TB. They include an integrated health, nutrition, sanitation and hygiene programme in Bihar, a project aimed at improving access to HIV services for migrants in multiple states, an MCH project in Odisha and Madhya Pradesh, and a community mobilization and technical support project for TB control in the states of Madhya Pradesh, Chhattisgarh and Jharkhand. CARE was also one of the core partners in the UHI project funded by BMGF. Another partner in UHI was FHI 360 which was associated with the knowledge generation activities of the project. Currently FHI's urban programme in India is centred upon the 'BRIDGE' project – a scheme aimed at generating awareness on HIV/AIDS.

UHRC is an NGO working in the cities of Delhi, Agra, Meerut and Indore, and with several state governments. It works with slum communities directly and through other ground NGOs, provides technical support to state governments, and does research on urban health.

PATH works with the MoHFW on technical issues of vaccine development, maternal health and tuberculosis control. Although not directly associated with urban healthcare, its work on newer medical interventions in these three areas has impact on policies and strategies cutting across rural and urban sectors. The vaccines the organization works on that are of particular significance to India are those on malaria, pneumonia, meningitis and rotavirus.

V. Private Sector/ Professional Associations

The private sector is the largest provider of curative services to urban populations in India. Healthcare to 79% of OPD and 68% of IPD cases in urban India are provided by private practitioners (MoSPI 2015). The largest national organisation of allopathic doctors in India - the Indian Medical Association (IMA) - started as a representative organisation of both public and private doctors, has today come to represent the interests of only the private sector. As such it is viewed as a body comprising only private sector elements (Nagral 2012). Despite not having a formal major role in urban health policy, its interaction with the government on regulatory matters pertaining to the private sector have the greatest impact on healthcare provisioning, as does its singularly strong voice in the Medical Council of India, the regulatory authority for medical education in the country.

The formal role of the private sector, apart from direct provisioning, is via the PPP mode where the government has increasingly engaged private players in provisioning of services at public sector facilities since the advent of NRHM.

VI. Research Institutions, Universities, Think Tanks

The main public health research institutes in India working on urban health issues include the All India Institute of Hygiene and Public Health (AIIHPH), All India Institute of Medical Sciences - Delhi (AIIMS), Tata Institute of Social Sciences - Mumbai (TISS), Jawaharlal Nehru University (JNU), Post Graduate Institute of Medical Education and Research – Chandigarh (PGI), Institute of Economic Growth (IEG) and Public Health Foundation of India (PHFI). The research done encompasses a wide range of domains including exploration of health service delivery to the poor and migrant populations, health of urban children, women's health in urban spaces, injuries, financial risks and willingness to pay for care, and demographic studies.

AIIHPH, AIIMS and PGI also run community based clinical services in slum areas that serve as learning centres and research areas for their students.

VII. Communities and Civil Society Organisations

The Indian chapter of the global People's Health Movement, the Jan Swasthya Abhiyan (JSA), brings together several CBOs, NGOs, CSOs, activists, academics and health professionals for conducting research and advocacy on broader health system issues such as health financing, accessibility and equity. The organisation is a key civil society voice in the UHC discussions.

Discussion

The policy direction for health services provision in the public sector in India and the framework for their implementation is provided by the central ministry of health. It charts the course and content of services within the broader structure of its commitment to, earlier the MDGs, and now the SDGs and Universal Health Care for all Indian citizens. This requires that there be clearly defined and well laid out policies and roadmaps that help deliver the needed services in a contextual and timely manner. However, this study reveals that unlike rural services, healthcare in urban India is being delivered in a largely random and unplanned manner. There is an array of stakeholders in the arena, providing services ranging from direct healthcare to those targeting determinants of health, but most of these services have not taken into account the specific needs of urban populations. Urban healthcare needs differ significantly from those of non-urban populations. While the burden of communicable diseases continues to be high in urban settings, especially amongst the poorest sections, that of NCDs is rising significantly (Das et al 2005, Ramachandran et al 2008). Reports indicate a marked increase in incidences of mental illness and substance abuse, apart from cardiovascular diseases and diabetes, but this need remains unaddressed (Trivedi et al 2008). The rising prevalence of HIV in Delhi and that of MDR-TB in Mumbai are indicative of the need for evidence based and specifically directed schemes that address both the immediate healthcare needs as well as their proximal determinants, which in crowded living and working urban conditions assume even greater significance. Urban services also have to urgently address the many social, spatial and economic, both formal and informal, barriers to access that impact the neediest populations disproportionately, if UHC is to be achieved. Instead, as this study found, healthcare provisioning in urban India is at present a combination of default public sector provisioning via the spill-over from the upper tiers of the rural pyramidal healthcare delivery structure and a vast unregulated private sector. Neither of these speak to the specific problems of the vulnerable urbanite, either in terms of services rendered, mode of delivery or the cost the population has to pay.

The role of the central ministry extends beyond policy formulation to providing a major share of the finances to the states for provision of services and defining the fields of utilization for the same. The budget allocated, and that assigned to specific sub-areas, restricts to a large extent the types of services finally delivered. This is because most states follow the central guidelines in their entirety with little if any change to the allocation or the kinds of services decided at the centre. Thus in 2014-15 when only 5% of total National Health Mission (NHM) funds were allocated to urban health and of these too only 48% were approved (AI n.d.), urban services in all states saw little new provisioning. Importantly, the largest proportion of funds continue to go towards RCH and infrastructure components, to the detriment of other elements, including human resources. This despite the fact that healthcare is well-recognised as an HR intensive service sector that requires a well-trained and motivated workforce. The handicaps of a systemic thrust on infrastructure as opposed to people and processes are evidenced in Delhi which

despite its high density of hospitals and the highest bed capacity in the country (2.14 beds/ 1000 population against a national average of 0.7) has relatively poor health outcomes (DHS 2005).

As noted earlier, Departments of Health in the states are the major providers of services under all public sector programmes, within the guidelines and financial allocation set by the central ministry. They are also the major collaborators for both international and national donors and aid agencies as well as NGOs. While co-ordination with these agencies is generally harmonious, that between different departments of the government itself needs improvement. The main departments associated with service provisioning for urban healthcare and basic public health amenities viz. the health and urban development departments, demonstrate a lack of ownership towards those services they consider the responsibility of the other (Chikersal 2016). The absence of effective reporting mechanisms between the two departments due to such poor co-ordination and a singular lack of accountability are major reasons for the neglected condition of basic civic amenities, poor delivery of services and poor health indicators. Such poor convergence appears to have become the norm in Indian government departments but Parkes et al (2003) and Breton et al (2009) offer models for convergence of environmental health services with clinical services that are practical and would serve Indian conditions well. Another major cause of the poor health indicators is the mis-match in policies themselves. Rules of the different divisions within the Mumbai Corporation working at cross purposes is a case in point. There is an urgent need for resolute efforts to put comprehensive policies in place so that such contradictions do not continue to override the needs of the vulnerable populations in future.

It is to be noted at this point though that even as the public healthcare system suffers from these serious gaps, it is the only system delivering qualified and at least partially affordable services to the poor, and often to the middle-class as well. Selvaraj and Karan (2012) point out that the private sector is an unviable option for universalisation of healthcare due to its extreme economic unaffordability, its questionable quality, and the ineffectiveness of insurance mechanisms to protect from financial risk or address the most common out-patient needs. In such circumstances what is therefore required is to strengthen the public healthcare system in such a way that it is able to deliver those services that are needed by the population, in an effective and accessible manner.

To date however a top down, central government driven approach has been the basis for the services delivered. Important on this path, both as collaborators in the implementation and helping shape the policies, have been international donors and aid agencies. Maternal and child healthcare has been the focus of health provisioning of these policies. It continues to be so in the current state of NUHM implementation. The highest participation of most donors and aid agencies is accordingly in the FP/ RCH field. The other most common area of involvement is the HIV/AIDS sector, in line with the philosophy of international donor agencies. Other than such service provisioning, development banks are currently strategically focused more on providing ‘technical assistance’ or lending for infrastructure

projects, be it in general health services infrastructure strengthening, infrastructure for specific disease control programmes or general urban development. Additional fields of specific service provisioning include the proximal determinants of health such as nutrition or WASH. In all these settings their involvement is most often not specifically urban-centric but a combination of rural and urban work. Because they are not local organisations, their work often does not reflect contextual perspectives that are critical to a nuanced understanding of health challenges and means of addressing them. At the same time however they have provided much needed global expertise, perspectives, and management modalities that have strengthened the institutional processes in Indian public healthcare systems.

The work of a large majority of NGOs, as with donors and aid agencies, is focused on the FP/ RCH sectors, where they work in a rural-urban continuum. The strength of NGOs lies in the proximity of their work to the communities which helps them develop a relationship with a certain level of compatibility. This helps them achieve success in advocacy and communication campaigns or in developing and strengthening community processes. Many NGOs have also been effective at building capacities in community level workers and providing support to state governments for monitoring and evaluation of projects or programmes for this very reason (USAID 2015). The limitation of these organisations to mostly RCH/ FP and few selected disease related activities reflects the predisposition of the policy makers and the aid agencies and the resulting skewed use of their services in these fields alone. At the same time, while NGOs are expected to work on government or donor projects, they usually receive little or no feedback from the ground level government staff on the activities undertaken; nor are there any formal mechanisms to engage all partners in consultative processes to do so. This leads to a lacuna in communication and understanding of the desired outcomes or ground level participation that can lower the achievements (USAID 2015).

The private sector is the largest provider of curative services in urban India, yet the parameters of its role have not been quantified in any definite way. The reasons for this are manifold but two stand out – lack of regulation with subsequent functioning of the sector without any oversight; and a vast informal private sector that is virtually unreachable. Lack of data sharing by this sector on any issue that is not mandatory, and often even on mandated issues, adds to its non-transparency. 79% of OPD care and 68% of hospitalisations in urban India take place in this sector (MoSPI 2015). Given these figures, participation of this sector in government programmes remains one of the biggest challenges for achieving UHC. A major mechanism adopted since the advent of NRHM to include this sector in public provisioning as well as an attempt to address weaknesses in the public sector has been the PPP mode. PPPs have been working well in niche high skilled areas of healthcare delivery such as super-specialisations of cancer treatment or low-skill areas of dietary services and security. However most PPP models have so far been experimented with in the rural healthcare system under NRHM. The need of the hour is to develop models specifically moulded to urban contexts and to build expertise in the government to plan for and monitor these. It would also be important to develop context appropriate

models rather than remain within few successful frameworks adopted elsewhere previously. Most importantly, these cannot be viewed as a uniform means of involving the private sector in universalization of healthcare, for while they may deliver niche services in specific circumstances, PPPs inherently lack the accountability towards public health goals that is required of a healthcare system.

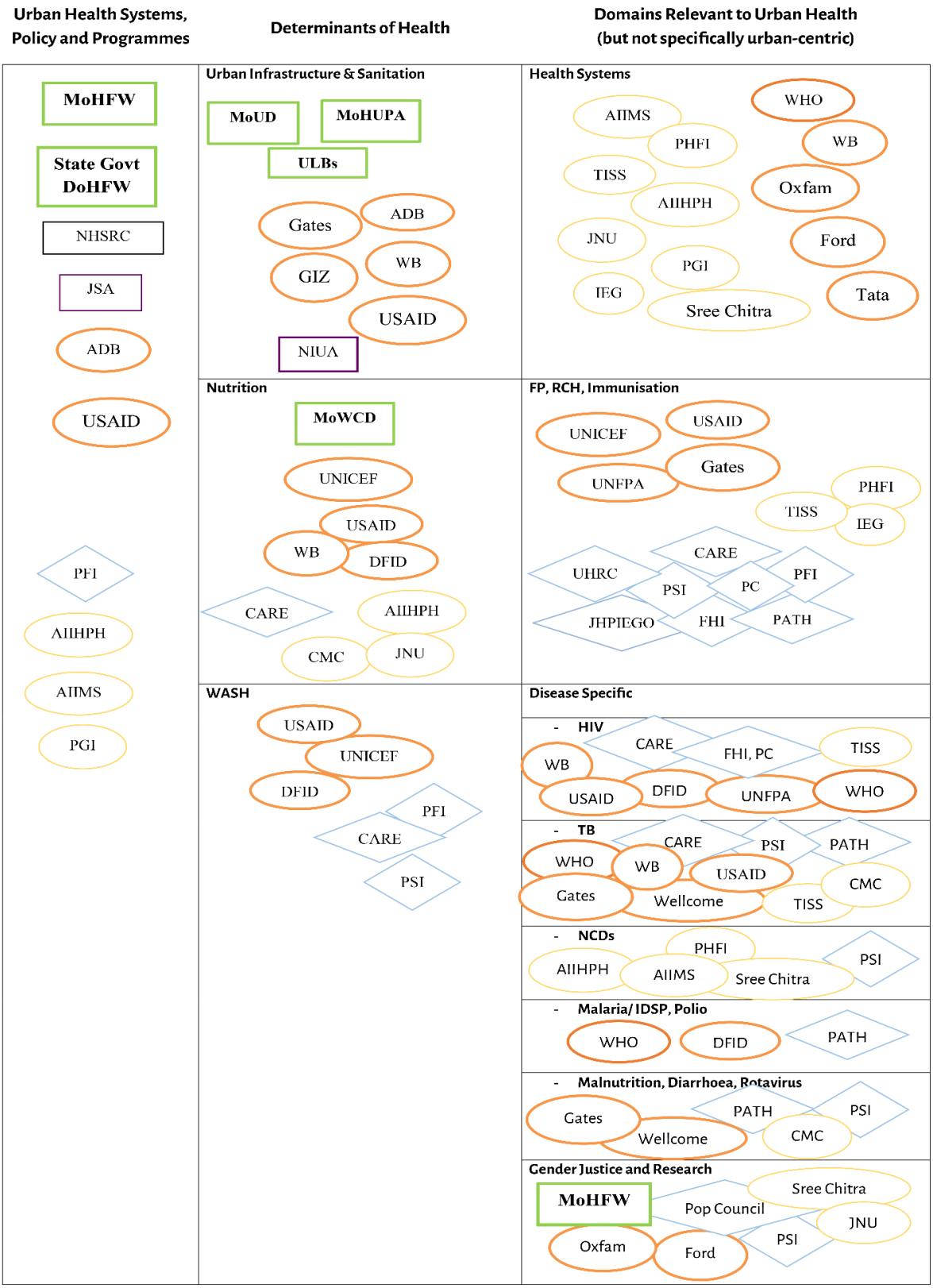
Many of the challenges discussed above have been explored by research organisations as part of work done on general health systems. However issues with regard to urban health specifically have only recently become the focus of investigations. Major ongoing research on urban health focuses on maternal health, financial aspects, injuries, non-communicable diseases (NCDs) and cancer. Some of the key under-researched topics include gender issues beyond FP/RCH, urban HRH needs and capacities, and the possible role of the private sector or PPPs while maintaining public health goals. Also, though NCDs have been researched, this work includes little on the increasingly reported mental illnesses and substance abuse among urban residents. The key role of research organisations in establishing the status of health and healthcare, and pointing to the future directional needs of the system, have been seriously affected due to government ennui towards research. Other financial sources have also seen a decline with diversion towards implementation projects creating a lacuna in effective evidence generation on urban health issues.

Collaborations

One of the objectives of this study was to identify possible fields of collaboration between the stakeholders in their future endeavours. The figure below provides a graphic mapping of the domain distribution of the activities of these stakeholders. This provides a useful guide that can suggest future collaborations in the common areas of work. Each of the domains lists organisations from different arenas which can work together on different aspects of that sector– policy makers, donors, implementers, researchers. However it is useful to bear in mind that while the course of work of the government, both at central and state levels, is likely to continue on its defined course, many amongst the other stakeholders, especially donors and aid agencies are in the process of shifting and re-aligning their strategies. The World Bank and ADB intend to continue their policies of extending loans for projects with focus on infrastructure rather than on softer elements of healthcare such as HR or service provisioning. Most UN or bilateral agencies on the other hand are in the process of changing strategies in light of India's altered economic status as compared to a decade or two ago. Some of these proposed changes have greater potential for collaborative work in urban health. For instance, USAID proposes to shift away from project driven approach to system strengthening based on local partnerships. This appears similar to WHO's strategy which also speaks of broad policy support as opposed to sectoral interventions. DFID is also departing from its earlier rural-centric efforts to more urban inclusive policies. Most research organisations already work on broader health system issues though there is a

dearth of urban specific studies. All these changes will clearly impact the scope and domain of collaborative approaches.

Figure: Domains of Work of Major Stakeholders



Conclusion

Healthcare service provisioning to urban India has unfolded in a largely random, unplanned and organic manner, and hence presents challenges unique to itself. The work of, and relationships between, the current stakeholders reflect complex interplays that reveal underlying institutional weaknesses that will have to be addressed in order to effectively implement NUHM. It is crucial that governance failings in the public sector, ineffective coordination and skewed delivery of services be addressed urgently. Equally, means to engage the vast private sector while effectively regulating it must also be found if universal healthcare is to become a reality.

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