Urban Health Issues

ROLE OF GOVERNMENT

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Trend of Urbanization..
In 1950, two thirds of the world’s population lived in rural areas. 100 years later, this ratio will be reversed: By 2050, two thirds of the world’s population will be city-dwellers.

Currently, 48 percent of Asia’s population live in cities, while it is 40 percent in the case of Africa.

By 2050, cities in Asia will have grown by 1.25 billion inhabitants, equaling 60 percent, whereas in Africa an increase of 900 million or 190 percent is estimated (UN DESA 2014).
2,458 mil. more people in cities worldwide

- India: 404 mil.
- China: 292 mil.
- Nigeria: 212 mil.
- Indonesia: 94 mil.
- USA: 88 mil.
- Pakistan: 85 mil.
- DR Congo: 65 mil.

% of the country urbanized:
- Red: 0-25%
- Yellow: 25-50%
- Green: 50-75%
- Light green: 75-100%

Figure 4: Urban population growth between 2014 and 2050 (UN DESA 2014)
Figure 5: Total number of inhabitants in millions in cities worldwide of different size classes (UN DESA 2014 and own calculations by Alliance Development Works)
Problem with Urbanization
Why is it a problem?

1. Overcrowding
2. Housing
3. Unemployment
4. Slums and Squatter Settlements
5. Transport
6. Water
7. Sewerage Problems
8. Trash Disposal
9. Urban Crimes
10. Problem of Urban Pollution!
11. Time constraints.
Light and dark – citizens and invisible city-dwellers

Cities divided into light and dark – a phenomenon that is a characteristic of many metropolises in developing countries.

These individuals live in the cities and contribute to them but at the same time, they have only limited access to decision-making and power structures.

They are living in the twilight zone as unregistered inhabitants that are not represented in the city’s statistics.

They and their children are denied access to public services such as a steady power supply and sanitation as well as healthcare and educational institutions.

Throughout the world, around one billion people are currently living in informal settlements, almost all of them without citizens’ rights.

By 2030, this figure will have doubled and is set to rise threefold by 2050 (UNFPA 2007)

In developing countries, four out of ten city-dwellers live in huts, WorldRiskReport 2014
In Mumbai, India, these people account for at least 55 percent of the inhabitants. 30 to 50 percent of all newborn children in the rapidly growing cities and metropolises of the developing countries and emerging economies are not registered due to their parents’ informal status. (UNICEF 2012)
Health cannot be addressed in isolation.
In summary..

• Urbanization is one of the megatrends of our times – and as such it bears a vast complexity.

• While the pull of the cities often creates problems for rural regions in the industrialized countries, massive urban population growth is posing great challenges for the metropolises in many developing countries.

• For often enough, the growth of cities exceeds the capacity of authorities to develop and maintain adequate social and physical infrastructure.

• One of the most pressing results is the formation of marginal settlements in which urban dwellers lack basic civil rights and frequently face high levels of vulnerability towards natural hazards.
Health Perspective..
Universal health coverage (UHC)

- Described by the Director-General of the World Health Organization (WHO), Margaret Chan, as ‘the most powerful concept that public health has to offer’, Universal health coverage (UHC) has risen to the top of the global health agenda. At its core, UHC is about the right to health.

- UHC means that all people get the treatment they need without fear of falling into poverty.

- Universal health coverage (UHC) has the potential to transform the lives of millions of people by bringing life-saving health care to those who need it most.

This requires a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; and a sufficient capacity of well-trained, motivated health workers.
Three Dimensions to consider - UHC

Source: WHO World Health Report 2010
Figure 1: Out-of-pocket Health Expenditure as proportion of Total Health Expenditure

Figure 2: Government Health Expenditure as proportion of GDP

Source: World Health Statistics 2013, 190 countries; India’s 12th Five-Year Plan document
Trends in Out of Pocket Spending on Health in India, 1987-2004
Source: Mahal A et al.; 2011

<table>
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<th>Expenditure Category/Year</th>
<th>Urban Population</th>
<th>Rural Population</th>
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<tr>
<td>Poorest (20%) 1987</td>
<td>58</td>
<td>60</td>
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<tr>
<td>Richest (20%) 1987</td>
<td>110</td>
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<td>Poorest (20%) 1996</td>
<td>126</td>
<td>121</td>
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<td>Richest (20%) 1996</td>
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<td>Poorest (20%) 2004</td>
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<td>Richest (20%) 2004</td>
<td>482</td>
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<td>Outpatient Expenditure/visit (INR) 1987</td>
<td>801</td>
<td>1781</td>
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<td>1996</td>
<td>864</td>
<td>8182</td>
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<td>2004</td>
<td>4705</td>
<td>16910</td>
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<td>Inpatient Expenditure/visit (INR) 1987</td>
<td>1000</td>
<td>4532</td>
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<tr>
<td>1996</td>
<td>4532</td>
<td>760</td>
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<td>2004</td>
<td>2927</td>
<td>10926</td>
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<td>4532</td>
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<tr>
<td>1996</td>
<td>2848</td>
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<tr>
<td>2004</td>
<td>4967</td>
<td>6744</td>
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Further analysis in 2015 updated these estimates to $86 per capita, stressing more clearly than previous estimates that this is the amount which governments need to spend.

The analysis also noted that countries would find it difficult to get close to universal health coverage, if public spending on health is less than 4-5% of GDP.
How much do countries rely on public revenue sources?
### Percentage of Rural Households Falling BPL due to Health Care Expenditure

<table>
<thead>
<tr>
<th>Insurance Scheme</th>
<th>Chronic Diseases</th>
<th>Maternity</th>
<th>Preventive &amp; Wellness care</th>
<th>Ayush</th>
<th>Out-Patient</th>
<th>Inpatient</th>
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<tr>
<td>CGHS</td>
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<td>Rajiv Aarogyaasi Scheme (AP)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Kalaignar (TN)</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vajapyeer Arogyasi Scheme (KN)</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Commercial Health Insurance</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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1. The preventive and wellness care under the two schemes is also very limited.
2. RAS scheme provides partial Out-patient care in the form of free consultations.

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**Wealthiest segments of the population**

Covered through social or private health insurance schemes, giving them access to high quality services.

**Uncovered middle mostly in the informal sector**

Not covered by health insurance, tend to pay for healthcare out-of-pocket, putting them at constant risk of financial hardship.

**Poorest or most vulnerable segments of the population**

Targeted entitlement to relatively low-quality publicly financed services.
Catastrophic and Impoverishing payments

Catastrophic payments are greater than a given proportion of total household expenditure (or income); Impoverishing payments are when a household is pushed below, or further below, the poverty line.
What has been India’s response?

The National Rural Health Mission (NRHM) launched by the Government of India in 2005 seeks to provide accessible, affordable and quality health care to the rural population, especially the most vulnerable.

Despite significant progress especially since the launch of NRHM, challenges remain:

- The availability of health care services provided by the public and private sectors taken together is inadequate;
- The quality of healthcare services varies considerably in both the public and private sector as regulatory standards for public and private hospitals are not adequately defined and, are ineffectively enforced; and
- The affordability of health care is a serious problem for the vast majority of the population, especially at the tertiary level.

According to NSSO (2005-06) estimates most people accessed private providers for outpatient care—78% in rural areas and 81% in urban areas. For inpatient care, 58% of Indian people in rural areas and 62% in urban areas accessed private health facilities.
Despite the supposed proximity of the urban poor to urban health facilities, their access to them is severely restricted. This is on account of their being “crowded out” because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits/restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system when contrasted with the rural network makes the urban poor more vulnerable and worse off than their rural counterpart. Many components of the
Urban Health Care Facilities

For every 2.5 lakh population (5 lakhs for metros)

U-CHC
Inpatient facility, 30-50 bedded
(100 bedded in metros)
*Only for cities with a population of above 5 lakhs

For every 50,000 population

U-PHC
MO ÍJC – 1
2nd MO (part time) – 1
Nurse – 3
LHV – 1
Pharmacist – 1
ANMs – 3-5
Public Health Manager/Mobilization Officer – 1
Support Staff – 3
M & E Unit – 1

For every 10,000 population

1 ANM
Outreach sessions in area of every ANM on weekly basis

200-500 HUs
(1000-2500 population)

Community Health Volunteer (ASHA/AV)

50-180 HUs
(250-900 population)

Mobil Asmya Samiti
The current ‘brick & mortar’ approach is a two pronged strategy,

1) To maintain / construct the minimum number of health facilities as per the governing population norms.

2) To construct new facilities which are located in difficult areas or to have additional facilities for special reasons (E.g.: Birth waiting room) so as to ensure equitable distribution of health services.

There have been too many efforts to build the ‘brick & mortar’ buildings to ensure equitable distribution of health services. The challenges associated with this approach are tremendous. While this is an ideal way to build the health system, it may be argued that this very conventional approach and may not have much relevance in the days to advancement and technology more so at the PHC level.

Hence as per the discussion it may be concluded that the current approach to ensure equitable distribution of health services using the conventional brick and mortar (especially for the PHC level) approach is not only tedious, prolonged, financially expensive, off the habitation but also fares poorly in addressing the health needs on an immediate basis.
1) Accessible health services are those that are physically available, affordable (economic accessibility), appropriate and acceptable.

Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical barriers and economic barriers, or if the community is not aware of available services.

2) The vast health infrastructure and resources in the district are significantly underutilized mainly due to the problems relating to,

   a. Access
   b. Lack of an ‘appropriate’ place for conduct of services such as ANC, FP etc.
   c. Poor supervision and stewardship of the Sub-district health office.
   d. Lack of electricity, running water and clean toilets at the SC and PHC levels.
   e. Absence or poorly coordinated efforts with other related government wings.

**WHAT WORKS**

Addressing physical and economic barriers through strategies such as:

- providing services **locally**
- providing **transport** to health services
- using **home visitation** as part of a multi-faceted engagement strategy
- **Improving access to private health insurance and private health services.**
- employing Indigenous health professionals and health workers to promote culturally safe service delivery.
- Providing services in non-traditional settings.
Electronic Recording and Reporting
FOR PUBLIC HEALTH IN INDIA
Traditional System.

Service Delivery

Recording & Reporting

Monitoring & Supervision

Planning, decision & policy

- Inherent Transcription and duplication errors
- Prone for systematic erroneous entries
- Data incomplete and not real-time
- M&E affected by quality of data, not data-driven
- Consumes up to 80% of the work time
- Ineffective

Huge differences in Actual Vs Reported

Quality of services, difficult geographic area

The George Institute for Global Health
With E-health

Service Delivery

Recording & Reporting

Monitoring & Supervision

Planning, decision & policy

Quality of services, difficult geographic area
Huge differences Actual Vs Reported
Prone for systematic erroneous entries
Data incomplete and not real time.

In effective

1. Door step diagnostics
2. One time entry
3. No duplication errors, no systematic errors
4. Reduces time taken by >60%
5. M&E will be data driven, real time data
6. Effective planning.
The diagnosis in 1880

Ultimate medical tools in 1880

The stethoscope was invented 130 years ago

Stetoscopio originale in legno nato da René Théophile Laennec (1820)
E health is the way Forward..

- Commitment at all levels.
- Conscious effort initially to get the new system in place.
In 2015, the international community agreed on a new set of comprehensive and universal sustainable development goals (SDGs) that bring together economic, social and environmental priorities.

These goals are ambitious, and they demand equal ambition in using the “billions” in ODA and in available development resources to attract, leverage, and mobilize “trillions” in investments of all kinds: public and private, national and global, in both capital and capacity.

This will require making the best possible use of each dollar from every source, drawing in and increasing available public resources as well as private sector finance and investment.

In every country, regionally and at the global level, we must work together to generate the resources needed to realize the transformative vision of the proposed SDGs.
Figure 1.1: Annual Infrastructure Investment Needs in Developing Countries Will Be Substantial for the Next Two Decades, with the Greatest Needs in East and South Asia (US$ billions)

a. Total Infrastructure Needs, 2010–30

b. Regional Infrastructure Needs, 2030

Action areas of the Addis Agenda

A. Domestic public resources
B. Domestic and international private business and finance
C. International development cooperation
D. International trade as an engine for development
E. Debt and debt sustainability
F. Addressing systemic issues
G. Science, technology, innovation and capacity building

The continuum of public and private financing and the non-financial means for achieving sustainable development

- Private finance
  - Employment (e.g. SMEs)
- Public finance
  - Social services
  - Structural transformation (e.g. infrastructure)
  - Protecting ecosystems
- Non-financial means and enabling environment
  - Trade, Technology, Capacity Building, Systemic Issues

* The figure is for illustrative purposes only and size of boxes is not representative of magnitudes of flows
MDBS LEVERAGE AND MULTIPLY DEVELOPMENT RESOURCES AND IMPACT

Increase Domestic Resources
MDBS help countries improve tax systems and spending, increasing available resources and development impact.

Increase Private Finance
MDBS increase available flows by mobilizing private sector investment.

Development Investments
- Roads
- Energy
- Education
- Agriculture
- Health etc.

Development "Returns"

Financing for Development
- Concessional Loans
- Loans
- Equity investment
- Guarantees

Capital
Equity
Bonds and Investments

Financial Leverage

PAID-IN CAPITAL, SUBSCRIPTIONS, ODA CONTRIBUTIONS AND GRANTS FROM SHAREHOLDERS

INCREASE RESOURCES AVAILABLE FOR DEVELOPMENT FINANCING

RETAINED EARNINGS INCREASE EQUITY
Mobilizing Domestic Resources

- Developing countries need to take the lead in mobilizing the financing necessary for their development.

- Nevertheless, increasing domestic revenue mobilization (DRM) remains a challenge for many governments, particularly in low-income countries.

- Broadening the tax base, improving tax administration, and closing loopholes could make a significant difference in lower-income countries.

Source: World Bank classification and World Development Indicators.
Private Finance for Development

Achieving Post-2015 development goals will require the mobilization of resources from private sources including FDI, bank loans, bond issuance, institutional investors and private transfers (notably remittances, estimated to be approximately US$400 billion in 2012).

The good news is that globally, there are ample savings, amounting to US$17 trillion, and liquidity is at historical highs.

The challenge will be to direct savings to support the achievement of global development objectives.

Figure 4.1: International Capital Flows to Developing Countries, 2012
(in US$ billions and as a % of total flows)

Note: FDI inflows are net of disinvestments by non-residents. Debt Inflows are debt disbursements net of repayments. Official flows include bilateral and multilateral lending and are not equivalent to ODA. Data on official capital inflows are “debt enhancing official assistance”, and thus not the same as ODA, which is concessional in character with a grant element.
Strategy for achieving SDG’s

- Consider over all development (Economic, social, environment)
- Enhance overall spending on development
- Health not to be addressed in isolation
- The myth of rich, poor and everything in between (middle-class)
- Conducive environment for FDI and investment
- Mobilize domestic resources
- Invest in technology and new ways of doing things
- Insurance for all irrespective of economic status.
- More thrust on developing cities.
- Encourage and engage in partnerships with private players.
The challenge for individual developing countries is to make themselves more attractive destinations for resource from the private-sector and donors.

This can be accomplished by improving the effectiveness with which existing resources are used, enhancing domestic resource mobilization and by making strides to develop and access new sources of financing.

“All that is valuable in human society depends upon the opportunity for development accorded the individual.”

Albert Einstein

Thank you.
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