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A REVIEW OF URBAN POOR HEALTH AND HEALTH INEQUALITIES

Sheetal Sharma*

Abstract

Health of the nation is increasingly seen as a robust predictor of economic growth and assuring a minimal level of health care to the population is a critical constituent of the development process. While rising incomes could lead to better health, the relationship also works in the opposite direction. Urbanization is a symbol of development and also of demographic shifts representing a substantial change from how most of the world's population has lived for the past several thousand year . (In India with the rapidly growing urbanization is also increasing the urban poverty at a high pace and posing challenges to the delivery of the health care services to the urban poor.) Despite focused health reforms and several growth orientated policies of the government health inequalities prevails creating not only "rural and urban divide" but also "rich and urban poor divide".

This research paper attempts to statistically review and assess urban poor health issues, reasons of health inequalities &, inhibiting factors to access of health care infrastructure and based on the findings attempts to provide suggestions for improving the efficiency of the health delivery system of the urban poor for improving the health and well-being of individuals and communities.

INTRODUCTION

India has shared the growth pattern and rapid urbanization with some of the fastest growing regions in Asia. Urbanization is a rapid phenomenon, and along with the increase in urban population, there has been an upsurge in the absolute numbers of the urban poor, as is the trend, engaged in informal services. This has also led to the formation of squatter settlements and there is a steady emergence of urban slums where people have little or no access to basic amenities such as water and sanitation facilities. The Country has witnessed around 8% growth in GDP in the last couple of years and has planned to achieve a target of over 9% growth by the end of 11th plan period. India's urban population is also increasing at a faster rate than its total population. With over 575 million people, India will have 41% percent of its population living in cities and towns by 2030 AD from the present level of 286 million and 28%. It is now widely recognized that the rapid growth of urban population has led to a worsening in absolute and relative poverty in urban areas.

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Urban poverty has, until recently, been low on the agenda of development policy because of dominant perceptions of urban bias and the need to counter this with a focus on rural development policy. ***(Source: India Urban poverty report 2009)***.

An overview of the demographic situation indicates that virtually all growth will be urban in the future. Growth is fastest in concentrations of urban poor – e.g. slums. Most growth and population will be in small and medium size cities. Mega-cities will continue to grow – and have importance beyond their proportion of the urban population. The urban population is expected to increase up to 43.2crores by 2021.This urban growth has led to growth of the urban poor especially the slum population which is posing a bigger challenge to the urban health scenario .It was emphasized that urban averages mask sharp disparities between the rich and poor in urban settings thereby creating health inequities. Health inequities are "systematic, socially produced (and therefore modifiable) and unfair."***(Source: UN-HABITAT, 2010).*** Inequities result from circumstances stemming from socioeconomic status, living conditions and other social, geographical, and environmental determinants that can be improved upon by human actions. In other words, they are neither naturally predetermined nor inevitable. By many health indicators, urban poor populations are comparable to nearby rural populations – or worse in many cases. The determinants of health in urban areas are complex, but social and cultural factors, including composition of the family and cultural restrictions are important ***(Fustukian 1996).***

The urban health facts are presented in the **Table I**

Table: I Urban Health facts: India

Demographic Indicators	
Total Population (in million)	1027
Urban Population (in million)	285.4
% Population in Urban Areas	27.81
Population Growth Rate (1991-2001)	21.34
Urban Population Growth Rate (1991-2001)	31.39
No. of Million Plus Cities	35
No. of Towns with Over 1 Lakh Population	423
Population Below poverty line in Urban Areas (in million)	67.4
% Population Below poverty line in Urban Areas	23.62

Health Indicators among Urban Poor	
Neonatal Mortality Rate	39.1
Infant Mortality Rate	66
Child Mortality Rate	101.3
% Children Receiving All Immunization	42.9
% Children Receiving ORS or Recommended Home fluid during Diarrhea	31.2
% Children Underweight	56.8
% Pregnant Women Receiving the Recommended 3 ANC Visits	47.7
% Deliveries Attended by Health Personnel	50.7
% Using any Modern Method of family Planning	42.3
% Women Anemic	57.5
Environmental Health Indicators	
% Having Access to Piped Water Supply	61.7
% Having Access to Toilets	34

Source: UHRC visited on 11.10.11

The health indicators clearly explain the urban poor health challenges, where there is a mismatch between the growing urban poor population and access & affordability of the health facilities. Further lack of adequate water and sanitation, poor housing, lack of hygiene and access to basic services, the urban poor suffer from an extremely low health status and restricted access to healthcare services. Despite natural proximity to healthcare, the utilization and reach is very low among the urban poor due to various factors such as sub-optimal facilities, unsuitable timings, high costs, and low awareness of services / programmes and weak community-provider linkages. This heightens the need for addressing the access constraints faced by them. This study based on secondary data is relevant as it attempts to review the urban poor Health infrastructural issues and health inequalities.

REVIEW OF LITERATURE

It is estimated that of the nearly 30 % of India's population or about 300 million people live in towns and cities. It is estimated that nearly one-third of India's urban population or nearly 100 million live in slums characterized by poverty, illiteracy, overcrowding, poor hygiene and sanitation and the absence of civic services. Urban poverty has been a low priority on research and development agenda dominated by focus on rural development and rural poverty. The income dimension of poverty defines poverty as a situation of low income or low consumption. This has been used for constructing poverty lines. Accordingly people are counted poor when their measured standard of living in terms of income or consumption is below the poverty line.

Thus, the poverty line is a measure that separates the poor from the non-poor. However, poverty has both income and non-income dimension usually intertwined. The poor are those who are unable to obtain an adequate income, find a stable job, own property or maintain healthy conditions. They also lack an adequate level of education and cannot satisfy their basic health needs **(Sancho 1996)**. Thus, the poor are often illiterate, in poor health, and have a short life span **(World Bank, 1995)**. They have no (or limited) access to basic necessities of life such as food, clothing, decent shelter, are unable to meet social and economic obligations, they lack skills and gainful employment, have few, if any economic assets, and sometimes lack of self-esteem **(Olayemi, 1995)**. An extensive review of literature available provides evidences that the large and continuous increase in India's urban population, and the concomitant growth of the population residing in slums and shanty towns, has resulted in over-straining of infrastructure and deterioration in public health. Urban malaria, tuberculosis and pneumonia, leprosy, meningitis, preventable infections in children such as measles, whooping cough and polio, diarrhea diseases and intestinal worm infections are some of the most common health problems apart from higher morbidity and mortality due to accidents.

Lack of stronger information base about who has access to those forms of infrastructure and services that are critical determinants of health (e.g. provision for water, sanitation, health care, emergency services) and a stronger information base related to health outcomes (for instance, infant and child mortality rates, life expectancies, nutritional status), we would find that the urban populations in small and intermediate urban centers would generally be worse off than the urban average" **(Satterthwaite and Tacoli (2003)**. Here it was also pointed out that public sector programs are often not well developed and function mostly in isolation from other departments directly or indirectly linked. **Source: United States Agency for International Development (USAID).**

Much of the demographic and health literature has concentrated on the largest cities of developing countries, leaving the impression that most urban residents are found in these huge agglomerations. In fact, small cities and towns house the vast majority of developing-country urban dwellers. : **UN, World Urbanization Prospects: The 2007 Revision; and Mark R. Montgomery, 2008)**

A number of studies suggest that rates of poverty in these smaller settlements often exceed the rates in large cities, and in many countries small-city residents go without adequate supplies of drinking water and minimally acceptable sanitation **(Mark R. Montgomery et al., 2003)** Rural shortages of health personnel and services are receiving attention in the recent literature, but similar shortages also plague smaller cities and towns and especially the slums.

RESEARCH QUESTION

Behind the glamorous façade of glittering high rises and the picture of prosperity in Indian cities, lies the grim face of poverty and squalor, epitomized by slums, which are home to 15 percent of India's urban population. It is estimated that about 335 million people inhabit India's cities, of which about a fourth (80.8 million) are poor. By 2020 the number of urban poor is expected to reach 202 million persons. ***Source: Ministry of Housing and Urban Poverty Alleviation (MoHUPA), 2008.*** This present paper attempts to review critically India's current urban poor health status, issues and challenges of urban poor health infrastructure and to probe- **Are we investing well for ensuring accessibility, affordability and utilization of health to urban poor?**

DISCUSSION

Review of urban poor health-*A Statistical Overview*

The answer to above question comes from reviewing the Urban health infrastructure .There are evidences of discrimination between the urban rich and the poor /disadvantaged in their access to quality education. The access problem is further compounded along the gender, caste, and physical and mental disability lines. The poverty of health is exacerbated not only by wealth but also by other socio-economic measures, such as sex, race, ethnic group, language, educational level, occupation and residence. Lack of access to formal land market forcing poor people to inhabit unhealthy environment which creates serious implications on their health and they have to spend higher percentage of their income on health care. Besides the physical and social factors, lack of access to money ,poor are unable to use health services and have less access to the facilities in the public or private sector. They hardly seek heath care when they are ill. The poor have to depend on loans and sale of assets to pay for hospitalization. Cost is a greater barrier than the physical access to health providers.

DEMOGRAPHIC PROFILE OF URBAN POPULATION

For better understanding of the health status, it is important to understand the demographic profile of the urban population which includes both population statistics and vital statistics. These indicators for the country as well as states will help in identifying areas that need policy and programmed interventions, setting short and long term goals, and deciding priorities, besides understanding them in an integrated structure.

Table II Population in (Crore)

	2001	2011	Difference
India	102.9	121.0	18.1
Rural	74.3	83.3	9.0
Urban	28.6	37.7	9.1

Source: Census of India, 2011

According to the Census of India 2011 for the first time since Independence, the absolute increase in population is more in urban areas that in rural areas. The level of urbanization has increased from 27.81% in 2001 census to 31.16% in 2011 Census.

Table III Proportion of population below Poverty line in India 1999-2000

State Specific Poverty line (Rs Per capita/Month)		No. of Persons (Lakhs)			Percentage of Persons		
Rural	**Urban**	**Rural**	**Urban**	**Combined**	**Rural**	**Urban**	**Combined**
327.56	454.11	1932.43	670.07	2602.50	27.09	23.62	26.10

Note:

- The poverty line (implicit) at all India level is worked out from the expenditure class-wise distribution of persons & poverty ratio at all India level.
- The poverty ratio at all India level is obtained as the weighted average of the state-wise poverty ratio.
- Data for 1999-2000 Relates to NSSO 55th round

Source: Planning Commission

Table IV Total Urban and Slum Population in India 2001

Number of cities/towns reporting slums	Total urban population	Population of cities/towns reporting slums	Total slum population	Percentage of slum population to total	
				Urban population	**Population of cities/towns reporting slums**
640	283,741,818	184,352,421	42,578,150	15.0	23.1

Note: Arunachal Pradesh, Dadra & Nagar Haveli, Daman & Diu, Himachal Pradesh, Lakshadweep, Manipur, Mizoram, Nagaland and Sikkim have not reported any slums in 2001.

Source: National Health profile 2005

NFHS-3 data, reanalyzed on the basis of wealth index, reflects low health status of urban poor and their restricted access to healthcare services. Urban Health Resource centre (UHRC) has analyzed the National family Health Services (NFHS)-3 datasets by wealth index (an asset based indicator which reflects the economic status of the household) to arrive at disaggregated health indicators among different groups within urban areas.

Table V

Key Indicators for Urban Pooin in India from NHFS-3 and NHFS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All India	Urban poor NFHS-2(1998-99)
Marriage & Fertility						
Women age 20-24 married by age 18(%)	51.5	21.2	28.1	52.5	44.5	63.9
Women age 20-24 who became mothers before age 18(%)	25.9	8.3	12.3	26.3	21.7	39
Total fertility rate(children per women)	2.8	1.84	2.06	2.98	2.68	3.78
Higher order births (3+ births) (%)	28.6	11.4	16.3	28.1	25.1	29.5
Birth Interval(median number of months between current and previous birth)	29	33	32	30.8	31.1	31
Maternal Health						
Maternity care						
Mothers who had at least 3 antenatal care visits (%)	54.3	83.1	74.7	43.7	52	49.6
Mothers who consumed IFA for 90 days or more (%)	41.8		34.8	18.8	23.1	47
Mothers who received tetanus toxoid vaccines (minimum of 2) (%)	75.8	90.7	86.4	72.6	76.3	70
Mothers who received complete ANC (%)	11	29.5	23.7	10.2	15	19.7
Births in Health facilities (%)	44	78.5	67.4	28.9	38.6	43.5
Births assisted by a doctor/nurse/LHV/ANM/Mother health personnel (%)	50.7	84.2	73.4	37.4	46.6	53.3
Anemia among women						
Women age 15-49 with anemia (%)	58.8	45.3	50.9	57.4	55.3	54.7

Key Indicators for Urban Pooin in India from NHFS-3 and NHFS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All India	Urban poor NFHS-2(1998-99)
Child Health & Survival						
Child immunization and Vitamin A supplementation						
Children completely immunized (%)	39.9	65.4	57.6	38.6	43.5	40.3
Children receiving measles immunization (%)	52.6	80.1	71.8	54.2	58.8	35.3
Children left out from UIP (Children not receiving DPT 1(5)	29.5	9.8	15.6	27	24	35
Children dropping from UIP (DPT1 to DPT 3) (%)	19.1	13.2	15.3	22.6	20.7	21.2
Child feeding practices						
Children under3 years breastfed within one hour of birth (%)	27.3	31.5	30.3	22.4	24.5	17.7
Children age 0-5 months exclusively breastfed (%)	44.7	38.6	40.7	48.6	46.4	44.3
Children age 6-9 months receiving solid or semisolid food and breast milk(%)	56.2	66.1	63.1	54.7	56.7	52.7
Nutritional status of children(6-59 months)						
Children under 3 years who are stunted (%)	54.2	33.2	39.6	50.7	48	52.5
Children under 3 years who are underweight (%)	47.1	26.2	32.7	45.6	42.5	48
Anaemia among children (6-59 months)						
Children with anaemia(%)	71.4	59	63	71.5	69.5	79
Childhood diseases and treatment						
Children who had diarrhoea in the last two weeks (%)	8.9	8.9	8.9	9	9	22
Children with diarrhoea in the last 2 weeks who received ORS (%)	24.9	36.3	32.6	23.8	26	25.6
Children with diarrhoea in the last 2 weeks taken to a health facility (%)	55.1	69	64.5	58.2	59.8	66.3
Children with fever in the last 2 weeks (%)	15.1	13.5	14	15.1	14.9	29.1

Key Indicators for Urban Pooin in India from NHFS-3 and NHFS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All India	Urban poor NFHS-2(1998-
Children with the acute respiratory infection in the last 2 weeks (%)	6.1	4.4	5.1	6	5.8	20.8
Children with the acute respiratory infection in the last 2 weeks taken to a health facility (%)	76.1	79.4	78.1	66.3	69	65.3
Mortality						
Neonatal Mortality	34.9	25.5	28.7	42.5	39	45.5
Infant Mortality	54.6	35.5	41.7	62.1	57	69.8
Under-5 Mortality	72.7	41.8	51.9	81.9	74.3	102
Family Planning(Currently Married Women, age 15-49)						
Current use						
Any modern method (%)	48.7	58	55.8	45.3	48.5	43
Spacing method (%)	7.6	19.8	16.9	7.2	10.1	4.6
Perinanent sterilization method rate(%)	41.1	38.2	38.9	38.1	38.3	38.4
Unmet need for family planning						
Total unmet need (%)	14.1	8.3	10	14.6	13.2	16.7
a. For spacing(%)	5.7	4.1	4.5	6.9	6.2	8.5
b. For limiting	8.4	4.2	5.2	7.2	6.6	8.3
Environmental Conditions						
Households with access to piped water supply at home (%)	18.5	62.2	50.7	11.8	24.5	13.2
Households accessing public tap/hand pump for drinking water(%)	72.4	30.7	41.6	69.3	42.0	72.4
Households using a sanitary facility for the disposal of excreta (flush/pit toilet) (%)	47.2	95.9	83.2	26.0	44.7	40.5
Median number of household members per sleeping room	4.0	3.0	3.3	4.0	3.5	3.5
Infectious Diseases						
Prevalence of medically treated TB (per 100,000 persons)	461	258	307	469	418	535
Women(age 15-49)who have heard of AIDS	59.2	83.0	76.1	62.9	66.4	61.4

Key Indicators for Urban Pooin in India from NHFS-3 and NHFS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All India	Urban poor NFHS-2(1998-99)
Prevalence of HIV among adult population (age 15-49)	0.47	0.31	0.35	0.25	0.28	NA
Educational Attainment and Schooling						
School attendance 6-17 years (male) (%)	61.3	83.7	77.1	74.7	75.4	67.3
School attendance 6-17 years (female)(%)	59.2	83	76.1	62.9	66.4	61.4
Women age 15-49 with no education (%)	46.8	12.7	22.0	49.7	40.6	60.9
Access to Health Service						
Children under age six living in enumeration areas covered by an AWC (%)	53.3	49.1	50.4	91.6	81.1	N.A
Women who had at least one contact with a health worker in the last three months (%)	10.1	5.8	6.8	14.2	11.8	16.7

Source: NHFS III: Reanalyzed Data by Urban Health Resource centre (UHRC, 2005)

The data depicts that health of the urban poor is considerably worse off than the urban middle and high income groups and is as worse as the rural population. Malnutrition among urban poor children is worse off than in rural areas. Only 42 % of slum children receive all the recommended vaccinations. Over half (56 %) of child births take place at home in slums putting the life of both the mother and new born to serious risk. Poor sanitation conditions in slums contribute to the high burden of disease in slums. Two-thirds of urban poor households do not have access to toilets and nearly 40 % do not have piped water supply at home.

Living in such appalling conditions has severe bearing on health of the urban poor population. This analysis has been undertaken for different states of India and for the country as a whole. This analysis reveals the poor status of health among slum dwellers and the sharp disparities which exist.

REVIEWING URBAN POOR HEALTH INFRASTRUCTURE

Unlike rural areas which have a dedicated government health care structure, urban areas do not have such a structure. The rapid growth of urban population in recent decades has rendered the already inadequate primary health care facilities further deficient. The policy scenario in India has also been rural centric as India was predominantly rural till recently. This has resulted in a relative neglect of urban areas especially the urban poor. This is reflected in the shortage of resources, facilities and implementation mechanisms for health in urban areas. Health Infrastructure

basically includes the service and education infrastructure. **Educational infrastructure** provides details of medical colleges, students admitted to M.B.B.S. course, post graduate degree/diploma in medical and dental colleges, admissions to BDS & MDS courses, AYUSH institutes, nursing courses and Para-medical courses.

Service infrastructure in health include details of allopathic hospitals, hospital beds, Indian System of Medicine & Homeopathy hospitals, sub centers, PHC, CHC, blood banks, mental hospitals and cancer hospitals. Urban Health Infrastructural statistics overview is presented below:

EDUCATION INFRASTRUCTURE

- Medical education infrastructures in the country have shown rapid growth during the last 20 years.
- The country has 314 medical colleges, 289 Colleges for BDS courses and 140 colleges conduct MDS courses with total admission of 29,263 (in 256 Medical Colleges), 21547 and 2,783 respectively during 2010-11.
- There are 2028 Institution for General Nurse Midwives with admission capacity of 80332 and 608 colleges for Pharmacy (diploma) with an intake capacity of 36115 as on 31st March, 2010.

SERVICE INFRASTRUCTURE

Urban Health Service Delivery Machinery

One important concern of poor urban health is that there is no well-organized public healthcare system in the urban areas. The government's efforts have till now been directed towards rural health and thus there is not much attention given to urban areas. In urban areas, public hospitals, dispensaries and clinics that are generally more focused on curative aspects of medicine, rather than primary health care and dissemination of information. As a result private health care plays a critical role in bridging a need gap for the urban population.

The Directorate General of health services as the technical wing to the ministry of health and family welfare and its activities cover the whole spectrum of medical care and public health apart from general administration in the urban areas.

At the state level we have the Directorate of Health Services to administer public health, medical services and medical education. Due to increasing responsibilities and abundant health problems some states have established more than one Directorate and separated medical care facilities and medical education from the public health.

At the District level we have the District health office that is in charge of all activities concerning medical, public health and family welfare and district health administration.

In urban areas we have local self governing bodies having three tier administrations.

1. Medical officer in charge
2. Zonal-office in charge
3. The chief executive in charge

To further strengthen delivery of family welfare services in urban areas, Government of India in first five year planning established 126 urban clinics called Urban family welfare center (UFWC) of different types, the number of which has fairly increased by now. **Refer Table VI**

Table VI Types of Urban Family welfare Center

Category	Number	Pop.Cov. (in`000)	UFCW Staffing Pattern
Type I	326	10-25	ANM (1)/FP Field Worker male (1)
Type II	125	25-50	FP Ext. Edu./LHV (1) in addition to the above
Type III	632	Above 50	MO- Preferable female (1),ANM and storekeeper cum Clerk (1)
TOTAL	**1083**		

Source: MOHFW, GOI: Annual Report on Special schemes, 2000

Note: **ANM - Auxiliary Nurse & midwife, LHV - Lady Health Visitor, MO-Medical officer, FP-Family planning**

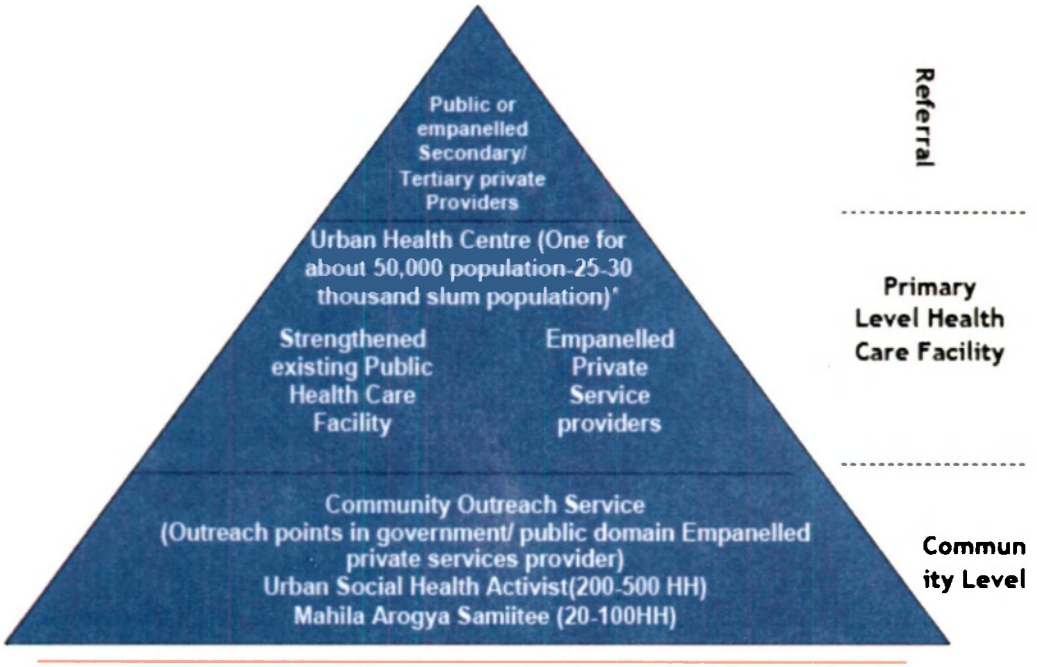
Further on the recommendation of Krishnan Committee, in 1983 government established four types of Urban Health posts (UHP) with a precondition of locating them in slums or in the vicinity of the slums.

Table VII Types of Urban Health Posts (UHP)

Category	Number	Population Covered	Staffing Pattern
Type A	65	Less than 5000	ANM (1)
Type B	76	5,000-10,000	ANM(1), Multiple Worker-Male (1)
Type C	165	10,000-20,000	ANM(2), Multiple Worker-Male (2)
Type D	565	25,000-50,000	Lady MO(1),PHN (1),ANM(3-4) Multiple Worker-Male(3-4), Class-IV Women (1)
TOTAL	**871**		

Note: **PHN-Personal Health Nursing**

Further in order to effectively address the health concerns of the urban poor population, the ministry has launched National Urban Health mission (NUHM), which aims at improving health of the urban poor through a revamped public health system, partnerships, community risk pooling and insurance mechanism. The Mission would include all cities with population above one lakh and state capitals during phase 1 (430 such cities have been identified with a population of 22 crores with focus on 6.25 crores slum population). The NUHM envisages a 3-tier "Urban Health Delivery Model' i.e. (i) community level which includes outreach services including school health services, (ii) primary level health care facilities through Urban Health Centers (one for about 50,000 population-25-30 thousand slum population) and (iii) referral through public or empanelled Secondary/ Tertiary private providers. This mission has high focus on the vulnerable populations such as homeless rag pickers, rickshaw pullers, street children, sex workers and any other temporary migrant.



Even though over the plan periods the number of community health centers, primary health centers and sub-centers has increased substantially, infrastructure facilities remain inadequate. Of the total dispensaries and hospitals in the country, 46 per cent and 67 per cent are found in the urban areas respectively. The larger outpatient care is the monopoly of the private health sector.

Table VIII

Dispensaries /Hospitals and Beds in urban areas 2002(All India)

	Dispensary	Hospitals
Total (urban+rural)	22291.00	15393.00
Urban total	10278.00	10288.00
Percent urban areas beds	46.1	66.83
Total (urban+rural)	29662.00	683545.00
Total beds(urban)	13670.00	498287.00
Percent beds (urban)	46.08	72.9

Source: Central Bureau of Health Intelligence (respective years), Health Information of India

As per NSSO data about 24 per cent of the urban population is living below the poverty line and the lack of adequate public health facility is bound to adversely affect their chances of accessing proper health care. A succinct indicator of health infrastructure is the number of hospital, beds and dispensaries per 100,000 population.

Between 1961 and 1998 in urban areas the number of hospitals has increased, but there hasn't been a corresponding increase in the number of beds and dispensaries per 100,000 populations.

Table IX

Number of Urban Hospital,Beds and Dispensaries per 100,00 Population

Year	Hospitals per 100,000 population	Hospital beds per 100,000 population	Dispensaries per 100,000 population
1961	2.50	NA	6.35
1981	3.12	261.56	7.26
1991	3.51	241.96	5.38
1996	4.30	207.64	6.70
1998	3.70	188.55	5.50

Source: Central Bureau of Health Intelligence (2004)

On the contrary, these ratios show a declining trend across time .According to the Health Information of India in 2003 there were about 58 medical practitioners per 100,000 population while there were about 80 nurses per 100,000 persons (Table X)

Table X

Number of allopathic Medical Practitioners Registered with Medical Council of India along with Ratio

Year	Medical practitioners	Population (in crore)	Medical practitioners per 100,000 population	Nurses per 100,000 population
1991b	3936	84.63	46.51	40
2000a	5556	100.86	55.09	77
2001a	5771	102.86	56.11	78
2002a	6070	104.48	58.10	
2003a	6254	106.24	58.87	80
2004a	6397	107.99	59.24	

Notes:

(a) Data is provisional (b) Includes projected population of J&K, where 1991 census could not be held.

1. Registered Medical Practitioners data are given by Medical Council of India and relate to Allopathic System of Medicine.

2. Population figures for the years 1951, 1961, 1971, 1981, 1991and 2001 are the actual census figures for Registrar General of India (RGI).

3. Population figures for the years 1982 to 1990 and 1992 to 1995 (as on 1 March) are taken from the report of the Standing Committee of Experts on Population Projections, CSO.

4. Population figures for the years 1996 to 2000 and 2002 to 2004 (as on 1 March) are taken from Provisional Population Tables,Paper-1 of Census of India, 2001(RGI).

Source: Central Bureau of Health Intelligence (2004)

Table XI

Total Number of Govt. Hospitals & beds in rural & Urban Areas (including CHCs) in India (Provisional) Reference period 01.01.2011

Rural Hospital		Urban Hospitals		Total Hospitals		Population Served Per Govt. Hospital	Population Served Per Govt. Hospital Bed
No.	Beds	No.	Beds	No.	Beds		
6795	149690	3748	399195	12760	576793	90972	2012

Notes:

- Government hospitals includes central government, state government and local govt. Bodies
- Rural & Urban bifurcation is not available in Bihar & Jharkhand.

Source: Directorate General of State Health Services

There are 12,760 hospitals having 576793 beds in the country. 6795 hospitals are in rural area with 149690 beds and 3748 hospital are in urban area with 399195 beds.

- Medical care facilities under AYUSH by management status i.e. dispensaries & hospitals are 24,465 & 3,408 respectively as on 1.4.2010.
- Total No. of licensed Blood Banks in the Country as on January 2011 are 2445.

FINDINGS

Major findings from the review are:

1. There is limited information available regarding the health conditions of urban poor in India. Most of the available information sources, including National Family and Health Survey (NFHS)* provide only rural - urban comparisons. Thus there exist data inadequacy and also flaws in health planning as most of the data related to urban health fails to capture the heterogeneity as it is often not disaggregated by the standard of living index.

2. The inadequate infrastructure and poor health delivery has exacerbated the consequences of poor infrastructure pinpointing deficiencies in the institutional set-up in delivering health services.

3. Limited state level initiatives is another area of concern as the public health centers available to the urban poor essentially included Aanganwadi Centers, Urban Family Welfare Centers and the first tier hospitals, but the former were few compared to the population and provided limited services like immunization and vaccination, nutrition related services and prevention of malnutrition etc. While these activities have been given impetus in the urban health plan, additional efforts in terms of infrastructure and personnel are crucial.

4. The lack of awareness in the community and especially vulnerable groups about services available at health facility level. This often results in under utilization of services and there is a large communication and information gap between service providers and the community.

5. There remains inequitable spatial distribution of facilities with multiple service providers and also overload on tertiary institutions and underutilized primary institutions due to weak referral system.

6. Inadequate health manpower in public health system facilities and skew ness towards private health service providers is prominent feature, there are also instances that first interface is with non qualified practitioner.

7. Cost, timings, distance and other factors put the secondary care and private sector facilities out of reach of most urban poor residents. Other factors like slums inhabiting land belonging to other agencies and therefore illegal and vulnerable to eviction, rapid migration and mobility among slum population also affect health delivery in urban poor communities.

RECOMMENDATIONS

Despite the efforts of Government to improve health conditions in urban areas work needs to be urgently done on the development of health infrastructure and services. The two main challenges that emerge from the current policy and programme scenario are - firstly the need for partnership and convergence, and secondly the need for participation of local representatives and the community in programme implementation. These challenges can be met by:

1. Greater public–private partnerships (PPP) as the urban health system is dauntingly complex, a strategy of "joined-up governance," whereby public health agencies join with concerned actors in other sectors of municipal, regional, and national government would ensure better management.

2. The urban district plans should have NGOs involved so that they could help in the identification of link workers from within the community or the slum that they are working with. The need is to link volunteers preferably women from same community and preferably married, identified through a participative and transparent process through community meetings and community recommendation considering their attitude, capabilities, sincerity and willingness to serve the community they represent and they can further help in the capacity building and training of these link workers.

3. Shortage of field staffs needs to be addressed and their sensitization towards people oriented/friendly service delivery needs to undertaken. Management issues like lack of organized infrastructure in towns, quantitative and qualitative improvement in supply of medicines and equipment and proper and complete identification of target population needs to be addressed.

4. Need is for encouraging greater involvement of consumers and local governments and associations either through e-Governance or sample surveys in the decision making process.

5. Since slum communities have extremely low access to sanitation facilities need is to have a comprehensive time bound strategy to collaborate with the Nagar Nigam to increase the number of community toilets and to improve all reproductive and child health services and provide timely and regular maternal services.

6. For strengthening the functioning of the public health delivery system a system of rewards and incentives needs to be introduced at all levels of the delivery hierarchy Incentives could be in the form of matching the observed improvements with a system of rewards. The current time-bound promotion system works against the institution of such incentives; however it is possible to institute many different types of monetary and non monetary rewards.

7. Clear demarcation of catchments area and monthly planning of outreach makes it more effective and proper allocation of funds to match services needs to be ensured and fund needs to come from the centre or the state government with clearly defined roles and responsibility and monitoring indicators helps in better management of the services.

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