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Urban Health

Slipping Through the Cracks

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CSEP RESEARCH

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Designed by Umesh Kumar

Urban Health: Slipping Through the Cracks

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List of Abbreviations

AB HWC	Ayushman Bharat Health and Wellness Centre
ANC	Ante Natal Checkup
ANM	Auxiliary Nurse Midwife
CAG	Comptroller and Auditor General
CHC	Community Health Centre
COVID-19	Coronavirus Disease
CT	Census Town
DH	District Hospital
FC	Finance Commission
GIS	Geographic Information System
HMIS	Health Management Information System
HWC	Health and Wellness Centre
IMR	Infant Mortality Rate
IPD	Inpatient Department
IPHS	Indian Public Health Standard
LASI	Longitudinal Ageing Survey in India
MC	Municipal Corporations
MoHFW	Ministry of Health and Family Welfare
MoHUA	Ministry of Housing and Urban Affairs
NCD	Non-Communicable Disease
NFHS	National Family Health Survey
NHP	National Health Policy
NRHM	National Rural Health Mission
NSS	National Sample Survey
NUA	New Urban Agenda
NUHM	National Urban Health Mission
OG	Out Growth
OOPS	Out of Pocket Spending
OPD	Outpatient Department
PHC	Primary Health Centre
PMJAY	Pradhan Mantri Jan Arogya Yojana
RHS	Rural Health Statistics
SDG	Sustainable Development Goals
SDH	Sub Divisional Hospital
SES	Socio Economic Status
ST	Statutory Town
TB	Tuberculosis
UA	Urban Agglomerate
UCHC	Urban Community Health Centre
ULB	Urban Local Body
UNCTAD	United Nations Conference on Trade and Development
UPHC	Urban Primary Health Centre
U5MR	Under Five Mortality Rate
WHO	World Health Organization
XVFC	Fifteenth Finance Commission

Abstract

In the backdrop of rapid urbanisation - globally and in India - health goals of SDGs are unlikely to be met unless both rural and urban areas are included in policy focus. While it is recognised that many of the other SDG goals also have urban contexts, there continues to be a global omission of urban health concerns that makes it harder for countries to push a vigorous agenda on urban health. India currently has a large urban population, living in complexly defined areas with varied structural, administrative, and financial management systems. This paper builds on a parallel analysis done by the same authors (Gupta and Singh, 2024) on inequities in health outcomes and access to services in rural and urban areas, indicating that urban health outcomes remain adverse, especially for the urban poor, and service provision remains woefully inadequate for all, with a much higher burden on the less privileged. The paper attempts to understand the extent to which India has been able to shift from a mainly rural-focus in health policymaking to giving urban health the importance it warrants, especially in the context of the SDGs goals. It reviews current definitions of 'urban,' and analyses whether—and to what extent—the health functions fit into these various structures and definitions administratively, and if clear pathways and policies exist to address urban health concerns. The paper traces the policy changes that have been advocated, formulated, and operationalised over the years for addressing urban health concerns in India including major government initiatives like the National Urban Health Mission, and the success of decentralisation via the 74th Constitutional Amendment. The findings indicate that India currently lacks a coherent and cogent approach towards urban health. Sensibly addressing urban health requires an urgent overhaul of institutional, administrative, and governance structures that currently often work in parallel without converging. Such reforms would have a far-reaching impact on not only the health sector but on other sectors such as education, labour, water, and sanitation as well.

1. Introduction

A large volume of evidence sharply highlights the rural-urban divide in health outcomes in India, along with differences in the availability, accessibility, and affordability of healthcare services between rural and urban areas. Given that most Indians still live in rural areas, the emphasis on rural health is warranted. Meeting the Sustainable Development Goals (SDGs), not only for health but for many of the other thematic areas, would require a concerted effort to improve the social determinants of health in rural areas, translating into better health and well-being outcomes for most of India's population.

However, the share of the urban population has been increasing globally as well as in India over the years. The World Urbanization Prospects (UN, 2018) indicate that by 2050, urban residents will outnumber their rural counterparts, with more than two-thirds of the world's population living in urban areas. With myriad other issues like the environment, water and sanitation, appropriate roads, and transport, health would remain a challenge to meet (United Nations, 2019a). The WHO has developed the Urban Health Research Agenda—a set of global research priorities for 2022–2032 to help member countries refocus on urban health concerns (WHO, 2022). Also, at the United Nations Conference on Housing and Sustainable Urban Development (Habitat III) in Quito, Ecuador, held in 2016, the New Urban Agenda (NUA) was adopted, which was the first internationally agreed document detailing the implementation of the urban dimension of the SDGs (UN HABITAT, 2016).

Recognising the importance of urban concerns, the SDGs had a separate goal, Goal 11, for critical urban and development issues (UN HABITAT, 2016a). While it is recognised that many of the other SDG goals also have urban contexts and challenges, we are yet to see a set of comprehensive health goals for urban and rural areas separately for many of the indicators. This global omission of urban health concerns makes it harder for countries to push a vigorous agenda on urban health.

According to the 2011 Indian Census, the urban population comprises 31.2% of the total population or about 377 million or more individuals (Bhagat, 2018). Of these, 70% live in cities, i.e., towns with more than 100,000 people. Thus, in sheer volume, the urban population is very large in India, and they also live in complexly defined areas with varied structural, administrative, and financial management systems.

The public policy think tank of the Government of India—Niti Aayog—has a dashboard that monitors different health indicators in urban areas, but the list of areas or indicators is not comprehensive enough to guide policy on urban health (NITI Aayog, 2024). It mainly covers maternal and child health indicators along with TB, the latter being part of the health and well-being domain of SDG indicators. The set of indicators pertaining to non-communicable diseases is not a part of the SDG urban index prepared by NITI Aayog, and monitoring is done for only selected 56 cities.

While the available national health data sets—the National Sample Survey (NSS) and the National Family Health Survey (NFHS)—do collect indicators on urban health, the volume of research on comparative rural-urban health outcomes, especially the rural-urban poor, has been much lower compared to health outcomes in rural areas. However, there is a steadily increasing volume of research documenting the state of the Indian urban health sector and services in the recent past, but the overall focus remains mostly on rural health systems and health outcomes.

Successive Five-Year Plans as well as various National Health Policy (NHP) documents have mentioned rural-urban gaps, but mostly to bring out the relative disadvantage of the rural health sector. The NHP 2002 highlighted the disparity in health service delivery in urban areas due to a non-uniform organisational structure, unlike a uniform three-tiered structure in rural areas, and meagre public health infrastructure in slum areas. It, therefore, stressed the importance of strengthening public health infrastructure in urban areas, which were more heterogeneous in terms of habitation compared to rural areas (Agarwal, Kaushik, & Srivasatav, 2006). The Eleventh Five-Year Plan articulated the urban health challenges and the need to address those with some important recommendations like health insurance and public-private partnerships to provide integrated services to the urban poor. Subsequently, the National Urban Health Mission (NUHM) was envisaged along the lines of the National Rural Health Mission (NRHM). Despite this, a holistic approach to urban health has remained an unmet need of health policy in India. One major

reason for this has been the definitional, geographic, and administrative challenges of defining 'urban,' resulting in a fragmented approach towards urban health. This contrasts with rural areas, where greater homogeneity across these dimensions has enabled a smoother policy focus and better implementation.

This paper attempts to bring out these challenges of policymaking in the context of urban health. In Section 2, we attempt to understand the definition of urban and match the administrative and financial structures of these areas. In Section 3, we analyse whether—and to what extent—the health functions fit into these various structures and definitions administratively, and whether there exist clear pathways and policies to address urban health concerns. We trace the policy changes that have been advocated, formulated, and operationalised over the years for addressing urban health concerns in India in Section 4. In the last section, we present our conclusions, prognosis, and recommendations for improving urban health in India.

2. Definition of 'Urban'

The definition of the urban unit in 2011 census was the following:[1]

1. All administrative units that have been defined by statute as urban or statutory towns
2. Statutory towns with a population of 100,000 are categorised as cities
3. Places that satisfy the following criteria (census towns)
    a. A minimum population of 5,000
    b. 75% of male workers in non-agricultural activities
    c. Population density of at least 400 per sq. km

Table 1 presents some basic statistics on different urban units. Some towns are further notified as Urban Agglomerates (UA), Out Growths (OG), or Million Plus Cities. Further, there are 53 Million Plus Cities and 5 mega cities with more than 10 million population.

The Census of India (2011) defines an OG as a viable unit such as a village or a hamlet that is clearly identifiable in terms of its boundaries and location (United Nations, 2019). These include railway colonies, university campuses, port areas, military camps, etc., which have emerged near a statutory town outside its statutory limits but within the limits of a village or villages contiguous to the town (United Nations, 2019). OGs must possess urban features in terms of infrastructure and amenities such as durable roads, electricity, taps, drainage systems for wastewater disposal, educational institutions, post offices, medical facilities, banks, etc., and be physically contiguous with a statutory town (United Nations, 2019; MHA, 2013).

An urban agglomeration is a continuous urban spread constituting a city/town and its adjoining outgrowths (OGs), or two or more physically contiguous towns together with or without OGs of such towns (United Nations, 2019). A UA must consist of at least a statutory town, and its total population (i.e., all the constituents put together) should not be less than 20,000 (United Nations, 2019). There remain some variations depending on local conditions (United Nations, 2019; MHA, 2013).

Table 1: Urban Units, Definitions, and Numbers

Type of towns	Number of towns
Statutory Towns	4,041
Census Towns	3,894
Urban Agglomerations (UA)	474
Out Growths (OG)	981
Million Plus Cities	53
Total number of towns (Statutory + Census)	7,935

[1] RGI, Census of India 2021, Circular No. 2, 4.9.2018

Type of towns	Number of towns
Megacities	More than 10 million population: Delhi, Kolkata, Mumbai, Chennai, Bengaluru[2]
Number of Slum Blocks by Type of Slums – India: Census 2011	
Notified Slums	37,072
Recognised Slums	30,846
Identified Slums	40,309
Total	1.08 lakh slum blocks
Households by Type of Slums – India: Census 2011	
Notified Slums	49.65 lakh
Recognised Slums	37.96 lakh
Identified Slums	49.88 lakh
Total	137.49 lakh

Source: (Census of India, 2023; Mishra, et al., 2021).

Finally, there are 137.49 lakh slums, classified into notified, recognised, and identified slums. Slums form a major part of the urban landscape and, with the added socioeconomic vulnerabilities, require additional policy focus.

The main difference between statutory towns (ST) and census towns (CT) is that the former has specific political and administrative structures, but the CTs do not. STs are civic towns with a municipality, or a municipal corporation, or specified urban local bodies (ULB). However, CTs mainly fall under the administrative jurisdiction of Panchayats, and thus comprise a somewhat grey area for policy targeting. The number of CTs has increased rapidly over the years (Table 2), especially in states like Kerala, Tamil Nadu, and West Bengal.

In 2016, the Ministry of Urban Development asked 28 states to convert 3,784 census towns to statutory towns on the grounds of planned and coordinated infrastructure development, enhancement of revenues, and efficient delivery of services to citizens, leading to overall growth of economic activities (PIB, 2016). Evidence indicates that there are political economy issues like the desire to avoid taxation, the unwillingness of builders, and the resistance of the real estate lobby to convert rural administration to urban, which are some of the challenges that have slowed down the conversion of census towns to statutory towns (Aijaz, 2019; Tiwana, 2020). States like Maharashtra de-notified many small-sized municipalities and converted them into village panchayats (Pradhan, 2013).

A study looked at the inequality in basic services and amenities between these two types of urban areas in the Nadia district of West Bengal and found that more than 80% of urban institutional, health, financial, and even recreation facilities are concentrated in statutory towns (Ghosh & Khatun, 2022).

A study done on Singur, West Bengal, indicates that the governance of these CTs differ across states, and the “in-between settlements” come under different administrative governance structures, depending on the specific state (Samanta, 2014). Further, the study brings out the tedious and time-consuming process of converting a CT into a ST, which has to go through many layers of the local, state, and central government.

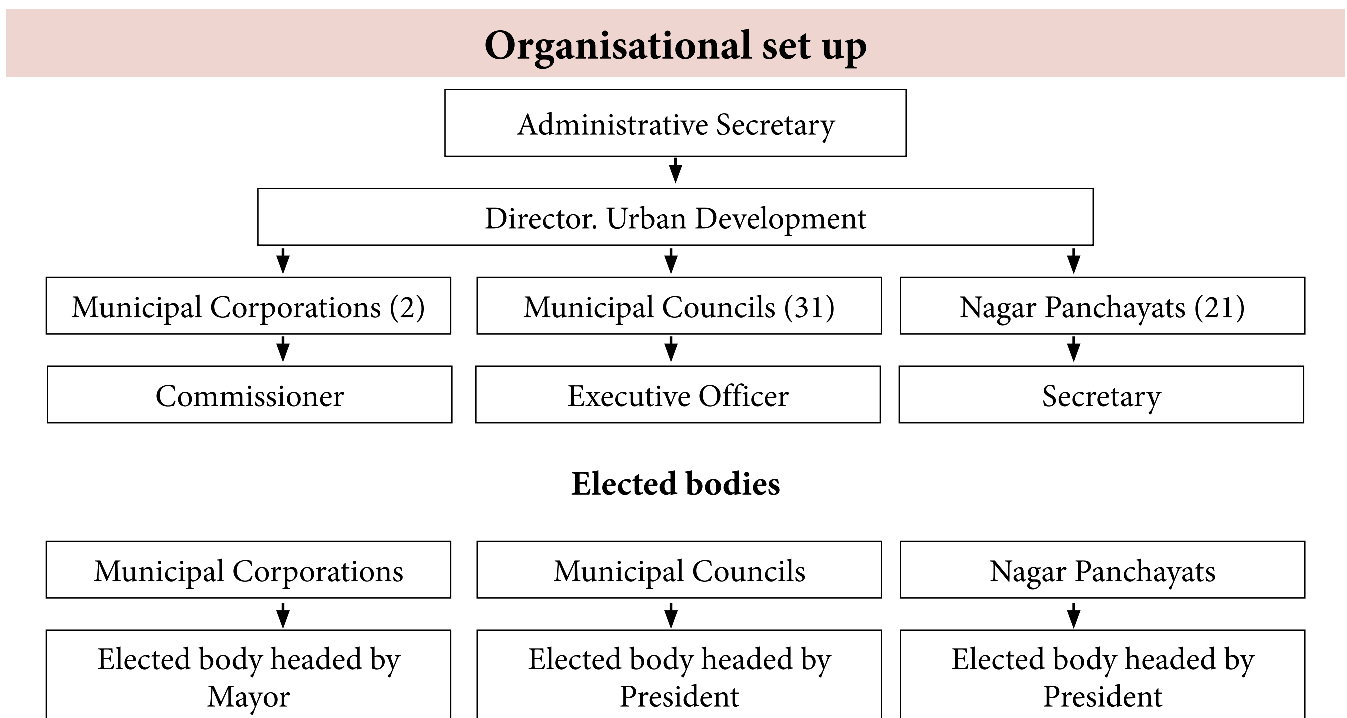
Table 2: Trends in Growth of Statutory and Census Towns, 2001-2011

Census year	Statutory town	Census town	Total urban centres	Decadal growth in statutory town	Decadal growth in census town
2001	3,798	1,363	5,161	6.4%	186%
2011	4,041	3,894	7,935		

Source: (Tiwana, 2020).

[2] The NUHM also mentions two other cities – Ahmedabad and Hyderabad – as megacities.

Figure 1: Urban Local Bodies, Himachal Pradesh



Source: (CAG, 2019).

Thus, the conversions remain very low, and basic amenities like roads, water, sanitation, and health continue to lag behind in CT compared to STs. This has been termed as "unacknowledged urbanization" (Pradhan, 2013) and raises the issue of appropriate governance structures for these areas, which continue to be governed as rural areas.

While there are state-specific variations, Figure 1 gives an idea of the organisational setup of urban local bodies, as given by the report of the Comptroller and Auditor General (CAG) 2019 on Himachal Pradesh. The organogram indicates that there are multiple lines of administrative control over different types of bodies, which include municipal corporations, municipal councils, and nagar panchayats. This leads to fragmented responsibilities and accountability, preventing a cohesive approach to services like health.

3. Urban Health Services: Administration and Governance

3.1 Recognising Urban Health in Government Mandates

There have been genuine attempts made by the government to recognise urban health as distinct from the health issues of rural areas. The four major recognitions given in policies to urban health are the 74th Amendment to the Constitution, the 2002 National Health Policy, National Urban Health Mission (NUHM), and the findings and recommendations of the XV Finance Commission (XVFC), discussed briefly in this section.

74th Constitutional Amendment

The 12th schedule of 74th Constitutional Amendment Act (1992) contains the power, authority, and responsibilities of urban local bodies. There are 18 items covered under 12th schedule listed below. While numbers 5 and 12 are directly related to health, many others like water supply, provision of urban amenities, slum upgradation, etc., can be related to health as well (CAG, 2019; Mishra, et al., 2021). Thus, even though the 74th Amendment recognises public health (water, sanitation, hygiene, and record of vital statistics) as one of the main responsibilities of urban local bodies, it fails to explicitly include healthcare delivery as one of the responsibilities.

1. Urban planning including town planning
2. Planning for economic and social development
3. Urban poverty alleviation
4. Water supply for domestic, industrial, and commercial purposes

5. Public health sanitation, conservancy, and solid waste management
6. Slum improvement and upgradation
7. Provision of urban amenities and facilities such as parks, gardens, and playgrounds
8. Promotion of cultural, educational, and aesthetic aspects
9. Burials and burial grounds, cremation, and cremation grounds, and electric crematoriums
10. Cattle ponds, prevention of cruelty to animals
11. Public amenities including street lighting, parking spaces, bus stops, and public conveniences
12. Vital statistics including registration of births and deaths
13. Regulation of slaughterhouses and tanneries
14. Regulation of land use and construction of land buildings
15. Fire services
16. Urban forestry, protection of the environment, and promotion of ecological aspects
17. Construction of roads and bridges
18. Safeguarding the interests of the weaker sections of society, including the physically handicapped and mentally unsound

For panchayats, there are additional details given for health: health and sanitation—including hospitals, primary health centres, and dispensaries—and family welfare are listed at serial numbers 23 and 24 of the Eleventh Schedule for panchayats (XV Finance Commission, 2020). On the other hand, for municipalities, only public health is listed, along with sanitation conservancy and solid waste management at serial number 6 of the Twelfth Schedule (XV Finance Commission, 2020). However, even for the areas listed—water, sanitation, hygiene—there has been very modest progress in urban areas (Gupta, Sengar, Manar, Bansal, & Singh, 2023); significant improvements in these would certainly have resulted in improved health outcomes, especially in slum areas.

Urban Health in Health Policy 2002 and After

The omission of the urban healthcare delivery system in the 74th Amendment was addressed to some extent by the National Health Policy (NHP 2002), which highlighted the basic challenge in urban areas: non-uniform organisational structure, unlike the uniform three-tiered structure in rural areas, resulting in a disparity in health service delivery in urban areas. It also mentioned sparse public health infrastructure in slum areas. The resultant dependence on private providers and financing treatment via out-of-pocket expenditure of households was mentioned as an important feature of Indian urban health systems. The NHP 2002 envisaged the establishment of a two-tiered urban health infrastructure: primary health centres covering one lakh population delivering OPD services and essential drugs (at the first tier), and at the second tier, general government hospitals serving the referred patients from PHCs (Govt of India, 2002). The focus on the referral system aimed to reduce the burden on hospitals.

However, despite recognising the urban health challenges, no discernible changes were made to policies that could have fundamentally altered the urban health landscape in the country until 2008. The reason for the lesser focus on urban health in health policy could be attributed to the intractability of analysing urban spaces: geographically, economically, socially, and politically, urban spaces are harder to define, and urban systems are difficult to comprehensively understand compared to rural spaces. The ease of analysing the rural, in general, has meant that much of the health sector analyses have centred around rural regions globally, and in countries with explosions in urban population like in India. Furthermore, the heterogeneity in political and administrative structures of urban habitats makes interventions, programs, and policies harder to implement and evaluate, leading to a somewhat non-coherent body of such activities and actions that pertain to urban sectors. Even the terminologies used in government documents differed across documents, at times between states and over time. For example, metropolitan areas defined by the constitution, urban agglomeration with population above 1 million defined by the Census, and metropolitan cities defined by Urban and Regional Development Plan Formulation and Implementation are not uniform. The rapidly growing urban areas lack any semblance of planned governance, and it has been contended that the various terms have no operational significance. “There is no governance structure at the metropolitan region level. Nor are there any funds earmarked collectively for planned development of these large urban settlements” (ICRIER 2019).

The emergence of a distinct group—the 'urban poor'—has made the task of health policy much harder. Existing evidence confirms that the health status of the urban poor is relatively worse, and the accessibility to the health system is largely determined by the socioeconomic status of the population (Butsch, Sakdapolrak, & Saravanan, 2012; Gupta & Singh 2024). This is supported by evidence from the National Family Health Survey (NFHS) data for 2005-06 that indicates that the utilisation of reproductive and child health (RCH) services was mainly concentrated among the urban non-poor across most of the states, and there were significant gaps in the utilisation of ANC and delivery services between urban poor and non-poor populations (Kumar & Mohanty, 2011).

Urban governance is closely knit with political factors, especially in the presence of a large informal sector and migrant workers, who offer a ready vote bank during elections (Jha, 2023; Parchure, Phadke, & Talule, 2017; Auerbach and Ziegfeld 2020). Policy implementation in urban health has possibly also been impacted by political economy factors of local governance; since the state governments are empowered to decide the structure and functioning of the urban local bodies, municipal corporations have little room to make any significant changes in the local policies. This leads to a lack of accountability in local governance, creating in turn a lack of interest in participating in the local elections, especially among the middle and upper-middle-income groups. This also opens the window for manoeuvring the municipal elections by the large political parties.

National Urban Health Mission

Early evidence of the inadequate reach of government health services to the urban poor, inequity in the distribution of resources within the urban setting (higher allocation for metro cities), and an increase in the slum population (or urban poor) due to urbanisation have been documented as potentially worrying features of urban areas, especially in the vulnerable Empowered Action Group (EAG) states, with a significant share of the urban population (Agarwal & Sangar, 2005). The authors recommended that the functioning of municipal government be strengthened so that they can participate in urban health planning and implementation. They also recommended improving outreach services in slum areas through greater community participation as a key policy suggestion.

With evidence mounting on the state of the urban poor, the Eleventh Five-Year Plan flagged the uneven progress in health outcomes between urban and rural areas, and specifically the encouraging improvements in rural areas because of the National Rural Health Mission (NRHM) (Planning Commission, 2008). It suggested the need for a similar Urban Health Mission to improve the disease burden in urban areas, especially on the urban poor (Planning Commission, 2008).

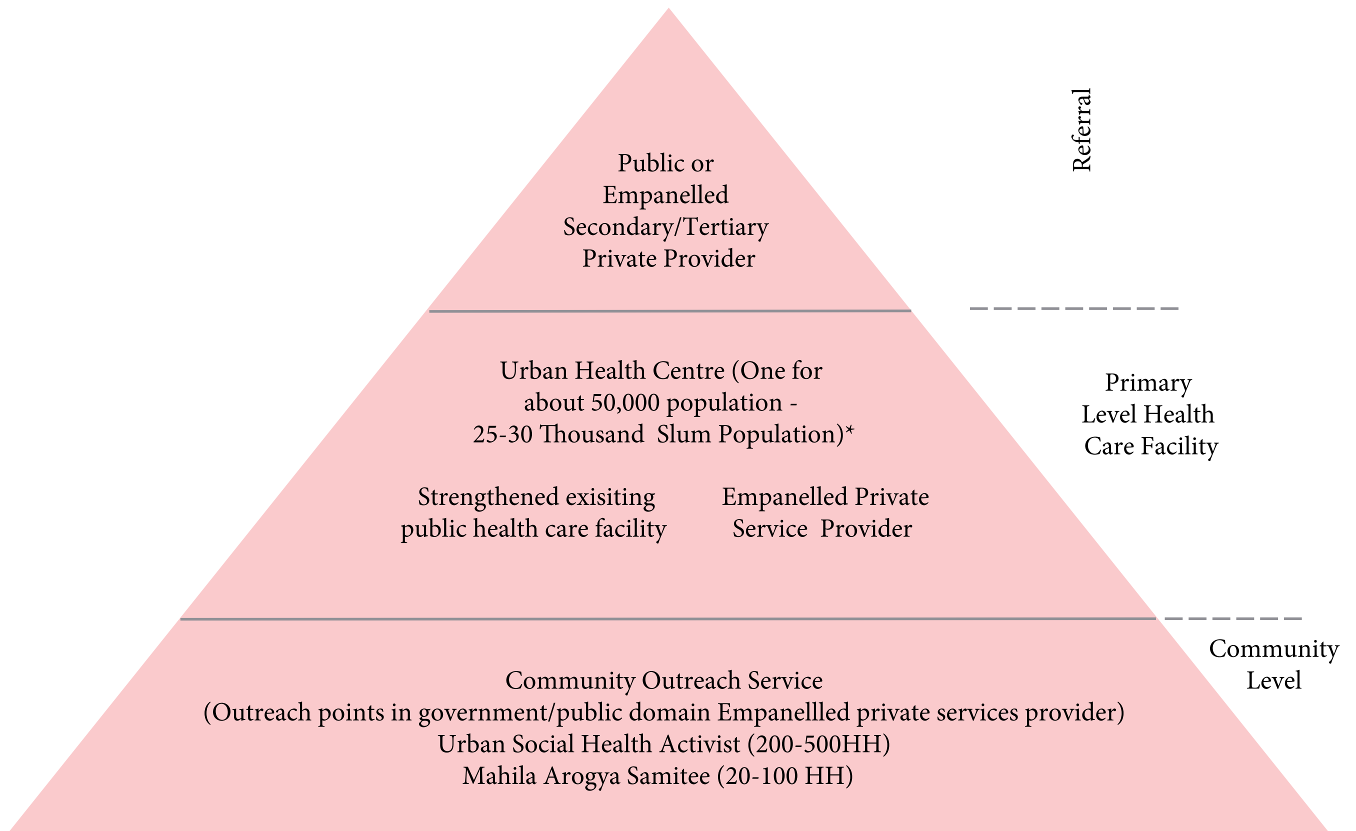
The Ministry of Health and Family Welfare (MoHFW) proposed the National Urban Health Mission (NUHM) to meet the challenges of the urban population, especially the urban poor, in 2008. The duration of the mission was 2008-12, covering all the cities. The proposed model was expected to rationalise and strengthen urban healthcare and promote engagement of the private sector (profit/not profit) to enhance reach to the urban poor (based on the identification of target group i.e., slum dwellers and other vulnerable groups) through the distribution of health *Suraksha* cards (individual/family) (MoHFW, 2008).

As Figure 2 shows, the proposed pyramid structure was similar to the rural health system; in terms of strengthening and integration of the urban health system, it largely followed the NRHM model. One Mahila Arogya Samiti/ Rogi Kalyan Samiti per 500 people, one urban ASHA for 2,500 people, one ANM per 10,000 people, one PHC per 50,000 people, and one CHC per 250,000 people (MoHFW, 2008). However, there was a novel feature in the proposed NUHM: it was designed as a health insurance model.

The proposed NUHM was expected to establish an urban health insurance model covering inpatient costs for the urban population, with a subsidised insurance premium for slum and vulnerable populations. In addition to this, a risk pooling system with partnerships from the centre, state, local bodies, and the community was proposed to be set up, enabling resource sharing, facility empanelment, and establishing standard treatment protocols and costs. Initially, the model was supposed to be piloted in five metro cities (MoHFW, 2008).

However, some key features of the draft NUHM 2008-12 were missing from the implementation framework of 2013. The core objective of the draft NUHM 2008-12 was: "to improve the health status of slum and vulnerable populations by providing equitable access

Figure 2: Pyramid Structure of National Urban Health Mission



Source: (MoHFW, 2008).

**This may be adapted flexibly based on spatial situation of the city.*

to healthcare through revamping the public health system, community risk pooling, insurance mechanism, and partnerships with active involvement of local bodies." (MoHFW, 2008; John, Chander, & Devadasan, 2008). However, in the NUHM implementation framework 2013, this was not mentioned, indicating that it was no longer seen as a key strategy. The 2013 policy strategy suggests that financial protection could be achieved through the universal provision of health services from UPHC/UCHC (NHM, 2013a).

The main objective of NUHM 2013 was the provisioning of urban healthcare services through equitable access by rationalising and strengthening existing capacity (of health delivery) to improve the health status of the slum and vulnerable population. It is clear that the focus of NUHM 2013 was primarily on strengthening the healthcare delivery system rather than insurance (NHM, 2013).

Table 3 presents a brief comparison of the draft NUHM of 2008-12 and the NUHM implementation framework 2013.

Currently, a number of activities listed under the NUHM are, in turn, listed under the NHM. These include guidelines for organising UPHC services, capacity development framework, inter-sectoral convergence, tools for vulnerability mapping, etc. (NHSRC, 2023). A series of activities and interventions for almost all the main programs of the MoHFW seem to have been planned under the NUHM, including immunisation.

There was a five-year delay in the launch of NUHM—the vision document was drawn up in 2008, but the implementation document was written in 2013. Also, three major recommendations of the vision document were modified in the implementation document. The first one pertained to community insurance, which was conspicuous by its absence in the implementation document. The other was about facility norms: the implementation document mentioned UCHC norm of one UCHC per 2.5 lakh population. A third one was about the identification of beneficiaries through the *Suraksha* card, which was absent from the implementation document.

Table 4 presents the NUHM classification of urban areas.

While there are different ways of classifying urban areas, there exists a huge variation in the way healthcare delivery by ULBs is organised. While ULBs in the Million Plus Cities were engaged with delivering primary care, in many other municipal corporations, the services were mostly confined to water and sanitation. The last column presents some highlights from the various case studies of cities, Million Plus Cities, and megacities that confirm this finding.

Table 3: Comparing Draft NUHM 2008-12 and NUHM Implementation Framework 2013

S no.	Components	Draft NUHM (2008-12)	NUHM Implementation Framework 2013
1	Urban health insurance model	Provision of an urban health insurance model (voluntary scheme) to cover inpatient costs for slum and vulnerable populations at a subsidised insurance premium. Non-poor urban residents to pay the full premium without subsidy.	Not mentioned
2	Community risk pooling	Mahila Arogya Samiti or MAS (20-100HH) to set up a community insurance fund with a minimum contribution of Rs 10 per household. To initiate community risk pooling, urban health mission to provide a seed money of Rs 25 per household.	Detailed guideline regarding the functioning of community risk pooling is absent. No mention of seed money for the insurance fund or of community risk pooling under the objective and goals of MAS in guidelines provided by MoHFW.
3	Health system strengthening	Strengthening urban primary healthcare delivery system with referral linkage. Use GIS maps for referral mechanisms.	No change
4	Facility norms	Mahila Arogya Samiti (100HH), ASHA (2,500 urban poor population), UPHC (50,000 population). UCHC population norm was not explicitly mentioned.	Norms did not change (Urban community health centre or UCHC norm is explicitly mentioned—one UCHC per 250,000 population)
5	Institutional mechanism	NUHM would leverage the institutional structure of the NRHM at the national, state, and district level for the implementation of the mission. Nevertheless, for a dedicated focus on urban health, NRHM institutional mechanisms would be strengthened at various levels. In megacities like Delhi, urban local bodies will implement NUHM.	No change
6	Identification of beneficiaries	Mapping of households through baseline surveys and distribution of individual/ family health *Suraksha* card (smart card).	Household surveys with validation from community to identify slums & vulnerable population
7	PPP and intersectoral coordination	Public-Private Partnership (PPP) (profit and not-for-profit) at the community level to address gaps in healthcare delivery; intersectoral coordination for enhanced community participation and empowerment.	No change

S no.	Components	Draft NUHM (2008-12)	NUHM Implementation Framework 2013
8	Convergence of CD & NCD	Convergence of communicable and non-communicable diseases through integrated planning at the city level. UPHC will be the centre for all primary care service provisioning with referrals to secondary and tertiary care.	No change
9	Monitoring & surveillance	IT-enabled services and e-governance to improve monitoring and surveillance.	No change

Source: (MoHFW, 2008; NHM, 2013; John, Chander, & Devadasan, 2008).

A case study of Nagpur Municipal Corporation indicates that Nagpur has been proposed as a smart city, and the Nagpur Municipal Corporation (NMC) has established a three-tier public health system with three tertiary care hospitals, three indoor hospitals, and two diagnostics centres (Maheshwari, et al., 2022). "It also has 26 UPHCs and 25 dispensaries. However, the authors contend that the city's 26 UPHCs are less than the required 50 UPHCs as per NUHM norms, resulting from underutilisation of healthcare services in existing UPHCs, inadequate capacity building among health personnel, and negligible investment in health by the urban local body" (Maheshwari, et al., 2022).

Table 4: Classification of Urban Areas Under NUHM

Category	Criteria	No	Governance
Mega Cities	More than 1 crore population	7	The case studies of Bruhat Bengaluru Mahanagar Palike, Greater Hyderabad Municipal Corporation, Thiruvananthapuram Municipal Corporation, Brihan Mumbai Municipal Corporation, and Delhi Municipal Corporation suggest that urban local bodies in Million Plus Cities and Mega Cities are engaged in delivering comprehensive primary healthcare. However, it should be noted that the services are not entirely delivered by municipal corporations. In the case of Hyderabad, medicine supplies and human resources are provided by health and family welfare department.
Million-plus Cities	10 lakh and above	40	
Class 1 Urban Agglomeration/Towns	Cities with 1 lakh – 10 lakhs population	552	–
Cities with 50 thousand - 1 lakh	Population	604	–
Municipal Corporations	74th Const. Amendment	101	The case study of Davanagere and Raipur municipal corporation suggests that the role of healthcare delivery by urban local bodies is non-existent and is mainly confined to water sanitation and hygiene management, as mentioned in the 12th schedule of the 74th amendment.
Municipalities (Municipal Councils)	74th Const. Amendment	1,430	
Notified Area Committees	74th Const. Amendment	56	
Town (Nagar Panchayat)	74th Const. Amendment	2,000	

Source: (Mishra, et al., 2021; Lahariya, 2019).

The primary objective of the Surat Municipal Corporation appears to be the provision of WASH facilities and facilitation of healthcare services. However, it does have a separate health department that provides preventive, promotive, and curative healthcare services. The municipal corporation has a tertiary hospital, which includes a medical college and hospital. It serves a population of 46 lakh (Surat Municipal Corporation, 2023).

The objective of the Patna Municipal Corporation aligns with the 12th schedule of the 74th amendment, which mainly focuses on water, sanitation, and hygiene practices. The municipal corporation employs health officers mainly to supervise sanitation works. It has two public health-related departments: sanitation, and death and birth. It seems that the municipal corporation is not involved in health services delivery, not even primary healthcare. The municipal corporation serves a population of more than 20 lakh (Patna Municipal Corporation, 2023).

Clearly, each ULB has interpreted and implemented urban health objectives differently. It is possible that despite the many additions to the NUHM document 2008-12, the implementation framework had much fewer details, indicating that many of the planned reforms were not operationalised or could not be implemented, and no clear-cut administrative guidance was provided to ULBs, resulting in uneven and varied interpretation of their mandates.

In 2023, a revised NUHM implementation framework was released (MoHFW, 2023), and some of the key features are mentioned below:

- Identification of beneficiaries is not seen as a major issue: Since all the urban poor households do not have BPL cards, there was a need to develop mechanisms to identify actual beneficiaries (other than conducting baseline surveys because of migration). The current framework seems to indicate that mapping of health facilities and their catchment areas (vulnerability assessment) would be a sufficient step forward.

- Coverage of cities: Currently, NUHM covers 1,213 cities/towns out of total 7,935 towns. Besides this, no concrete strategy has been stated to convert census towns to statutory towns. The onus seems to be on the states to initiate and implement this.

- City planning and mapping: 1,012 cities had completed health facility mapping, 999 cities had completed slum mapping, while only 779 cities had completed vulnerability mapping by March 2023.

- Capacity of municipalities: The current framework acknowledges that relatively smaller ULBs lack the capacity to provide healthcare services. However, there is no mechanism suggested to increase the administrative and financial autonomy of ULBs so that this can be addressed.

- Strategic purchasing: Low utilisation of public health facilities, the mushrooming of private providers, and their utilisation in urban areas have led to high out-of-pocket expenses incurred by individuals, exacerbating the disparity between the urban poor and non-poor. To leverage the existing private providers, it suggests strategic purchasing. However, it does not use the word "insurance" as an implementation strategy. Since strategic purchasing is emphasised, it becomes even more essential to set up a mechanism like a *Suraksha* card or a similar identification system or link existing cards (the original plan in 2008 draft) to identify beneficiaries. However, the current framework does not provide any concrete mechanism to address this issue.

An important limitation of the NUHM is the low coverage of city/towns under the programme. Only 1,213 cities/towns are covered, which is much below the Census 2011 numbers of 474 Urban Agglomerations and 5,697 Towns. The NUHM Framework document recognises this as an important limitation of the program and attributes it to the lack of alignment in definitions between the NUHM framework and the definition adopted by the Registrar General & Census Commissioner. Thus, the NUHM leaves out the smaller cities and towns from its ambit.

Additionally, the capacity of smaller corporations and municipalities is inadequate to monitor the full gamut of health services required for their urban population, especially in the face of the changing epidemiological profile of diseases in urban areas. While in the large cities and metro cities, the ULBs can provide a system that offers more comprehensive healthcare, the smaller towns and cities are unable to do so, and their focus remains on sanitation, sewerage, waste management, and vector control. These are also critical factors that impact health outcomes, but health services are equally essential to address the disease burden in the areas under their jurisdiction.

Fifteenth Finance Commission

The XV Finance Commission (XV FC) for the year 2021-26 recognised the need to strengthen urban healthcare and recommended providing comprehensive primary healthcare through urban Ayushman Bharat-Health and Wellness Centres (AB-HWCs) and polyclinics (XV Finance Commission, 2020). "Such urban HWCs would enable decentralised delivery of primary healthcare to smaller populations, thereby increasing the reach to cover the vulnerable and marginalised. It is envisaged that the urban HWCs would create a mechanism for representatives of the Medical Administrative Staff and Resident Welfare Associations to disseminate information on public health issues at least once a month." (XV Finance Commission, 2020). The Commission proposed to provide support for setting up urban HWCs in close collaboration with ULBs.

In a departure from the recommendations of the previous FCs, the XVFC (2021-26) recommended a sizeable grant to local bodies of INR 4,36,361 crore for the period 2021-26. Of these total grants, INR 8,000 crore was to be performance-based grants for the incubation of new cities and INR 450 crore for shared municipal services (XV Finance Commission, 2020). INR 2,36,805 crore were earmarked for rural local bodies, INR 1,21,055 crore for urban local bodies, and INR 70,051 crore for health grants through local governments (XV Finance Commission, 2020).

The Finance Commission (2021-26) categorised ULBs into two groups based on population, with different norms used for the flow of grants to each, depending on needs and aspirations (XV Finance Commission, 2020). For the Million-Plus cities, 100% of the grants are performance-linked through the Million-Plus Cities Challenge Fund (MCF) (XV Finance Commission, 2020). Basic grants are proposed only for cities/towns with a population of less than a million (XV Finance Commission, 2020).

The FC indicated that Category I cities (urban agglomerations with a population of more than one million) will be treated as a single unit for monitoring performance indicators of ambient air quality and service level benchmarks (XV Finance Commission, 2020). It also indicated that one-third of the total MCF of each city will be earmarked for achieving ambient air quality, while the balance two-thirds of the city-wise MCF was to be earmarked for achieving service level benchmarks for drinking water (including rainwater harvesting and recycling) and solid waste management (XV Finance Commission, 2020). Additionally, 60% of the basic grants for urban local bodies in non-Million-Plus cities should be tied to supporting and strengthening the delivery of: (a) sanitation and solid waste management and attainment of star ratings as developed by the MoHUA; and (b) drinking water, rainwater harvesting, and water recycling (XV Finance Commission, 2020).

Clearly, it is now up to the local bodies how they want to prioritise health since there is no direct reference to health services except for the HWCs. As of yet, there is no body of evidence regarding how the local bodies utilise the grants they receive, and this is an area of research that needs to be addressed in the near future.

3.2 Urban Health and Health Coverage in Government Programs

Despite the attempts made by the government to recognise the need to address urban health issues separately from rural health concerns, progress has been very slow. Apart from public and private health facilities, there are entitlement-based health coverage programs that cater to select urban residents by operating through occupational channels. Table 5 presents an overview of most of these health coverage programs.

There are programs for nutrition, food distribution, children's nutrition, and health support, and these clearly impact the health of the recipients of these programs. However, the most striking are the various separate programs for employees of different ministries, as Table 5 indicates. While there are rural residents who are covered by these schemes as well, most of these programs cover primarily urban residents since service employment is mainly in urban areas. While this may seem like a positive feature in terms of urban health, these programs are insufficient to cover most of the informal sector workers comprehensively and may end up deepening existing inequalities.

Part of the problem is the lack of a coherent health coverage program in the country that covers all residents for basic healthcare services. The ESIC, CGHS, Railways, Defence, and other coverage by ministries are the most comprehensive coverage that any good health coverage system can offer; however, these schemes are unavailable for those not employed by these ministries. ESIC covers formal sector workers, but the large population of the informal

sector workers is not covered by any program. The Prime Minister's Ayushman Bharat hospitalisation insurance scheme—the PMJAY—was designed to cover vulnerable populations for tertiary care, but there is insufficient evidence currently to show that PMJAY has worked to reduce out-of-pocket expenditures. In any case, PM-JAY does not cover outpatient services, which have been a major part of OOPS in the country.

Table 5: Urban Health Programmes and Health Coverage of Selected Ministries

Name	Programs	Remarks
Ministry of Health and Family Welfare	National Health Mission (NHM), PM-AYUSHMAN BHARAT comprising Health and Wellness Centres and PM Jan Arogya Yojana or PM-JAY, PM Swasthya Suraksha Yojana, Central Government Health Schemes (CGHS)	Nodal ministry for health infrastructure and insurance programs
Ministry of AYUSH	National Ayush Mission (NAM)	Establishing AYUSH facilities, Provision of Quality Ayush Services (HR and physical infrastructure)
Ministry of Housing and Urban Affairs	Smart City, Atal Mission for Rejuvenation and Urban Transformation (AMRUT), Swachh Bharat Mission – Urban (SBM-U), Pradhan Mantri Awas Yojana, Deendayal Antyodaya Yojana-National Urban Livelihoods Mission (DAY- NULM)	Deendayal Antyodaya Yojana National Urban Livelihoods Mission NULM (housing, livelihood, and social security to urban homeless) Smart City (essential infrastructure, including health)
Ministry of Women & Child Development	ICDS, PM Cares for Children	Nutrition and health support for women and children, Health insurance up to 5 lakh for children
Ministry of Consumer Affairs, Food and Public Distribution	National Food Security Act 2013, Public Distribution System	Rules governing food and nutrition
Ministry of Labour and Employment	Aam Admi Beema Yojana (Health Insurance for informal Workers), The Employees State Insurance Act 1948 (ESIS)	The ESI Act 1948 (Social Security Benefit – Sickness, Maternity, Disablement), Medical benefits to employees and family members through ESIS-owned medical facilities and empanelled hospitals
Ministry of Minority Affairs	Pradhan Mantri Jan Vikas Karyakram (PMJVK)	PMJVK has been implemented with the aim of reducing any gaps in the socio-economic parameters in 1,300 identified areas of the country. It builds health infrastructure apart from education, skill development, and women-oriented projects.

Name	Programs	Remarks
Ministry of Railways	The Ministry of Railways provides health services to its employees via own facilities.	Health coverage and services for employees
Ministry of Defence	The Ministry of Defence provides health services to its employees via own facilities.	
All other ministries	All ministries cover their employees through medical reimbursement.	

Source: Compilation of data from the respective ministry website by the authors.

Also, the other part of the Ayushman Bharat—the Health and Wellness Centres (HWC)—is mostly being strengthened in rural areas, while primary care in urban areas continues to be sparse, leading to overcrowding in tertiary care facilities. The HWC initiative primarily aimed at revitalising the sub-centres and PHCs, predominantly located in rural areas, to transform them into integrated primary care facilities. Thus, the focus remained on rural areas by design.

4. Finances for Urban Health

The administrative complexities mirror the financial ones in the case of urban health. In this section, we briefly discuss the source and trends in revenues for local bodies, the finances of NUHM, and the adequacy of health finances overall for urban health.

4.1. Finances of Local Bodies

Do the ULBs have adequate finances, and are they able to spend on sectors like the health sector?

The funds of ULBs come from four sources:

(i) **Own revenue**: property tax, fire-brigade tax, taxes on vehicles, taxes on boats, education cess, development fees, and rent on municipal property (CAG, 2022)

(ii) **Central Finance Commission grants** devolved to the ULBs on the recommendation of Finance Commission (CAG, 2022)

(iii) **Assigned Revenue**, which accrues to the ULBs as a certain percentage of a tax levied and collected by the state government (CAG, 2022)

(iv) **Grant-in-aid** from the government, which may be tied to a specific purpose or may be untied (CAG, 2022)

A study done for the XV Finance Commission on 37 Municipal Corporations (MCs) from the 53 urban agglomerations/cities with a population above one million indicates that the finances of MCs have remained stagnant or have declined across states. The study indicates that the total municipal revenue in GDP has declined from 0.49% in 2012-13 to 0.45% in 2017-18 (ICRIER, 2019). Own revenues in GDP have declined from 0.33% in 2012-13 to 0.23% in 2017-18 (ICRIER, 2019). The major setback came with the introduction of the Goods and Services Tax (GST) in 2017 (ICRIER, 2019). Most of the consumption taxes like octroi, local body tax, entry tax, and advertisement tax that could be levied by the local governments have now been subsumed under GST (ICRIER, 2019).

Currently, property taxes are the main sources of finance for local bodies, but property tax revenue as a percent of GDP went down from 0.086% in 2012-13 to 0.084% in 2017-18, as reported in the same study (ICRIER, 2019). There are variations across MCs, and MCs of large metropolitan cities like Mumbai, Pune, and Kolkata have larger property tax bases, because of higher density and value of properties (ICRIER, 2019). On the other hand, smaller MCs in cities like Faridabad and Patna have much smaller revenues from property tax (ICRIER, 2019).

Another important point to note is that several local public goods functions are now taken over as national priorities with the implicit assumption that these will be financed by central/state finances (Mathur, 2022). This has shrunk the space for local bodies to act on the immediate needs of their target populations like health, water, and sanitation. However, within these constraints, there are instances of ULBs that have innovated to extend services locally, but this is not true of all such ULBs.

The main source of revenue for Municipal Corporations/Councils/Nagar Panchayats was property tax (CAG, 2022). As per the provisions of all three Acts, property tax could be levied on the basis of the rateable value of the property (land and building) (CAG, 2022). State Governments amended (2010) all three Acts to levy property tax on rateable value or capital value (CAG, 2022). Property tax revenue depends upon the enumeration of property, tax rate, assessment and valuation system, extent of exemption, and collection efficiency (CAG, 2022). Furthermore, despite property tax constituting approximately 50% of the own-source revenue, the actual collection of property tax has been quite low, ranging from 5% to 20% (Awasthi & Nagarajan, 2020). There are many determining factors behind low property tax collection, such as incomplete property tax register, undervaluation, policy inadequacy, and ineffective administration. The incomplete and inaccurate property tax register is considered to be a big challenge for municipal corporations (Awasthi & Nagarajan, 2020).

The local bodies are now critically dependent on state and central transfers for funds, both due to insufficient funds and because some of the critical functions that they could have undertaken are now being managed by the state and the central government.

It has been argued that Indian cities lack the empowerment "to take on the enormous challenges of delivering public services and planning and managing the process of urbanisation, which is inevitably associated with rapid economic growth" (Ahluwalia, 2019). Additionally, the potential provided by the GST system to transfer funds to the local bodies has not been fully utilised. This could have strengthened the urban bodies if accompanied by some degree of financial autonomy, strengthening their capacity for urban planning and management (Ahluwalia, 2019).

4.2. Financing NUHM

Since there are no clear-cut directions regarding spending on urban health apart from NUHM, it is important to examine the allocations and expenditures under NUHM. However, it's important to note that there are other government expenditures allocated to urban health services besides NUHM. Therefore, the total expenditure on urban health exceeds what the NUHM alone reflects. Nevertheless, since the primary purpose of NUHM was to provide focused attention to urban health due to shortcomings in conventional approaches, it is important to assess whether the spending under NUHM is adequate and increasing over the years.

Table 6 presents the central release and total expenditure under NRHM and NUHM for the years 2019-20, 2020-21, and 2021-22, respectively. It also displays the total government expenditure for health at both the central and state levels. The last two rows depict the share of each mission in the total expenditure.

The central release remained unchanged for the first two years but saw a drastic decrease in the last year, 2021-22, for NUHM. The total expenditure was also significantly less than half of what it was in 2019-20. However, the situation was similar for both NRHM and NUHM, with a notable decline in spending in the last year.

In terms of the share of NRHM and NUHM in total government health expenditure, it was 17% and about 1% in 2019-20 respectively, but both went down drastically to 4% and 0.2% respectively in 2021-22. While the last two years were COVID years, in a normal year like 2019-20, the share of NUHM was very low compared to NRHM.

Figure 3 displays actual NUHM expenditure per capita across states to illustrate the inter-state disparities in spending. While the all-India figure shows spending of a mere INR 39 per capita in 2020-21, Bihar and Jharkhand spent much less than, for example, Andhra Pradesh and Telangana. We do not present the 2021-22 figures because all spending was majorly hit due to the pandemic.

Table 6: Central Release and Expenditure Under NRHM and NUHM, 2019-21 (INR)

Health Mission	Release & expenditure	2019-20	2020-21	2021-22
NRHM	Central Release	27,990	28,506	10,548
	Expenditure	41,808	41,904	14,087
NUHM	Central Release	950	950	202
	Expenditure	1,602	1,793	618

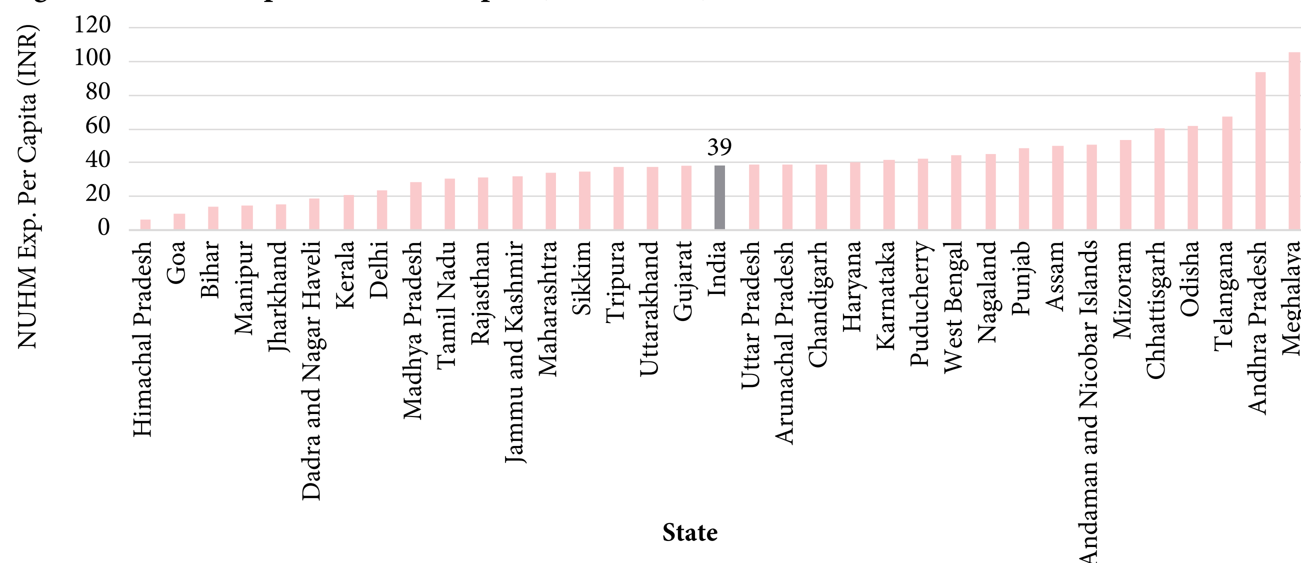
Health Mission	Release & expenditure	2019-20	2020-21	2021-22
Total Government Health Expenditure (Rs crore)		2,42,048	2,86,373	3,64,972*
NRHM (% of Total Government Health Expenditure)		17	15	4
NUHM (% of Total Government Health Expenditure)		0.7	0.6	0.2

**Revised estimate.*

Sources: (Reserve Bank of India, 2023; PIB, 2021).

Note: Total Government Health Expenditure is referred from RBI's "State Finances: A Study of Budgets" and Demand for Grants for MoHFW. The figures are representative of the volume of total government health expenditure for the respective year. The values may vary based on the sources referred.

Figure 3: NUHM Expenditure Per Capita (Actual, INR), 2020-21



Source: (Census of India, 2023; PIB, 2021).

Note: Population Projections for India and States 2011-2036: Report of the Technical Group on Population Projections has been referred for the urban population in 2020-21.

NUHM expenditure per capita has been calculated using NUHM expenditure divided by the respective urban population of the state.

5. Conclusions and Recommendations

This paper builds on a parallel analysis done by the same authors on inequities in health outcomes and access to services in rural and urban areas (Gupta and Singh, 2024), indicating that urban health outcomes remain adverse, especially for the urban poor, and service provision remains woefully inadequate for all, with a much higher burden on the less privileged. Lack of equitable and available primary care services and overburdened secondary and tertiary care services with inadequate availability of human resources and infrastructure have meant that healthcare is either unavailable or available with dubious quality in urban areas. It has also resulted in high out-of-pocket expenditures for many households without financial protection. The rural-urban divide in health outcomes like IMR, U5MR, and MMR has narrowed, indicating that rural areas have made relatively better progress than urban areas. However, the inequalities in urban areas in health outcomes and health coverage between the urban poor and non-poor are likely to have increased due to occupation-based entitlements, and also due to the lack of adequate health facilities prompting overuse of private facilities (Gupta & Singh, 2024).

The 74th Constitutional Amendment of 1992 gave a directive that all municipalities would be empowered to function as effective institutions of self-government. Among the various areas mentioned, health, including public health, was seen as an important responsibility of the local bodies. India is far from reaching the goal of effective self-governance of local

bodies in urban areas, and one casualty of this gap has been the lack of a comprehensive and cogent approach towards urban health.

The urban administration is incoherent in India and comprises a set of diverse rules and policies about an equally diverse set of geographic and jurisdictional urban entities. To address urban health comprehensively and sensibly, policymakers will have to navigate the parallel administrative and governance structures that have been set up for—and added to—urban areas since independence. Unless the multiple and fragmented administrative and governance structures are either aligned or harmonised, it seems difficult to predict whether a program-based approach will sustainably improve urban health, especially for the urban poor. While fragmented patterns of local governance are not peculiar only to India, there may be context-specific solutions that vary across countries. The Institutional Collective Action problems have been studied by many and solutions offered have varied (Ostrom, 2005; Feiock, 2009).

To realistically address urban health, there is a need to work on two fronts simultaneously.

To overhaul the institutional, administrative, and governance structures that often work in parallel without converging will require major reforms with far-reaching impacts not only on the health sector but also on other important areas. This recommendation will require medium to long-term planning and implementation, but it can be broken down into tractable parts, many of which can be planned for and implemented in the near future.

One immediate step could be to bring all urban health facilities under one umbrella, whether in an existing ministry or creating a separate body for urban health. The administration can be unified and would be responsible for planning, research, coordination, and implementation. The finances can be from a diverse set of sources, but the planning for the finances for urban health needs to be done in an integrated manner.

In a parallel fashion, a multisectoral team can start an exercise of mapping the various sources of service provision and their finances, to assess the gaps therein and draw out a plan for human resources, infrastructure, and financing for urban health with roles and responsibilities of the major actors and players. All this can happen if a separate administrative body is set up for urban health and a time-bound plan is drawn out and implemented in a pre-planned manner. This might go a long way to address the yawning gaps in urban health services and provision that currently exist in the country.

Secondly, evidence exists to indicate that strong local administration, with clearly defined roles and functions, is essential for improved outcomes at the lowest levels of governance. Resource dependency and harmonisation of interests has been mentioned as two key factors that can facilitate superior local governance (Guha & Chakrabarti, 2019), and it has been contended that SDG goals cannot be fully achieved without empowered local governance and efficient decentralisation. This is true of all development goals, including health goals. However, any reform needs to be accompanied by adequate finances to empower the local bodies to carry out some of the key functions envisaged in the 74th Amendment. There needs to be a policy initiative aimed at reducing the dependence of ULBs on the state and central governments for finances, as well as directives on how to utilise the funds. This recommendation has been advocated by numerous experts in the past as well.

Apart from the specific goal of empowering ULBs to raise and retain revenues, there is also an urgent need to increase overall public health spending in India. Low levels of spending have prevented India from building a resilient health sector, more so in urban areas. The central and state governments need to prioritise the health sector and raise adequate resources for it, which will have an impact on both rural as well as urban areas. Thus, a third recommendation—oft repeated by experts—is to raise total health spending in the country to at least the level recommended by the latest NHP, which is 2.5% of GDP. The distribution of these resources across even the current heads of spending would ensure some additional flow to the urban health sector.

However, it is also true that while rural health outcomes are quite responsive to adequate health finances, finances alone would be necessary but not a sufficient condition for urban health to improve, in the absence of institutional and administrative reforms. Thus, the first recommendation—of overhauling the institutional and administrative structures for urban health—still stands as a key recommendation of this paper.

For all these recommendations to work, an equally urgent step will be to harmonise definitions of "urban" across all levels of the government. Disparate definitions do a disservice to the cause and results

in a fragmented approach in urban planning. Future research on this can include the opinions of experts and specialists as well as the relevant stakeholders that can inform and strengthen policymaking.

Lastly, proper analysis of urban health is hampered by a lack of data; a robust health information system for urban areas that also provides the size of the target population in each category would be greatly helpful. Also, there is no easy way to analyse expenditures undertaken by ULBs, which disallows a proper analysis of the success and priorities of ULBs. NUHM requires proper monitoring, and a system needs to be set up to allow data collection and compilation of key indicators in the urban health sector.

While planning is critical, implementation failures can hamper progress, and a mere framework on paper gives a false sense of achievement. With continuous increases in the urban population, slums, and peri-urban areas, and megacities reaching unmanageable proportions, the time to act is now, and not later, if India wants to address the challenges of urban health.

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Appendix

Table 1A: The Classification of Cities and Towns (As per New NUHM Implementation Framework 2023)

S No.	Classification	Sub-category	Population range	Governing local authority	Number of cities as per census, 2011
1	Small town	Small Town I	5,000 - 20,000	Nagar Panchayat	7,467
		Small Town II	20,000 - 50,000	Nagar Panchayat/ Municipal Council	
2	Medium town	Medium Town I	50,000 to 1,00,000	Municipal Council	
		Medium Town II	1 lakh to 5 lakh	Municipal Council	372
3	Large city		5 lakh to 10 lakh	Municipal Corporation	43
4	Metropolitan city	Metropolitan City I	10 lakh to 50 lakh	Municipal Corpo-ration/Metropolitan Planning Committee	45
		Metropolitan City II	50 lakh to 1 crore	Municipal Corpo-ration/Metropolitan Planning Committee	5
5	Megapolis	–	More than 1crore	Municipal Corpo-ration/Metropolitan Planning Committee	3

Source: (MoHFW, 2023).

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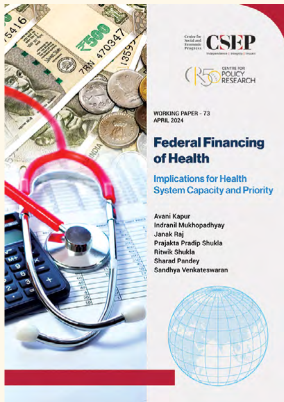

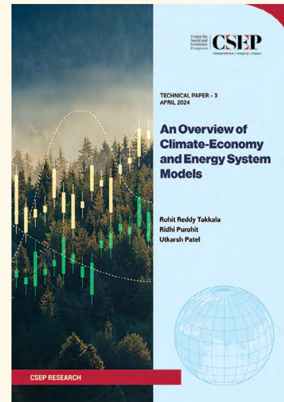

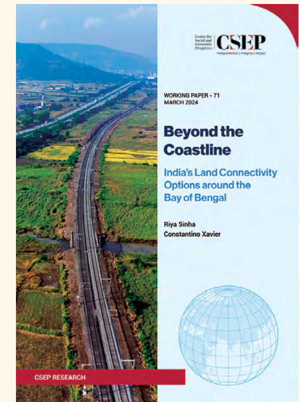

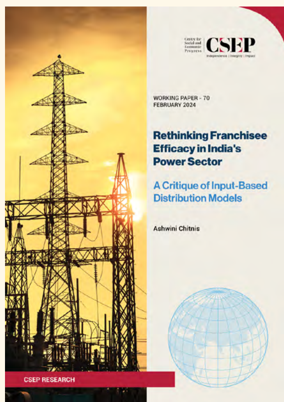

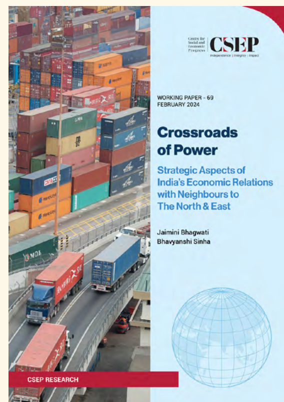

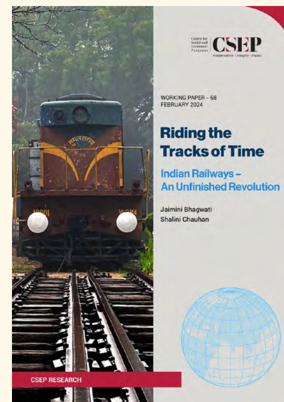

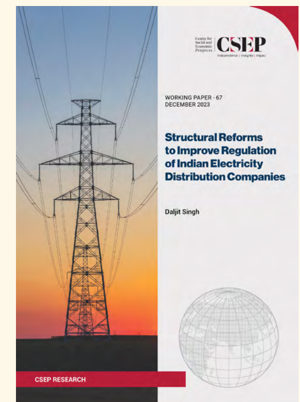

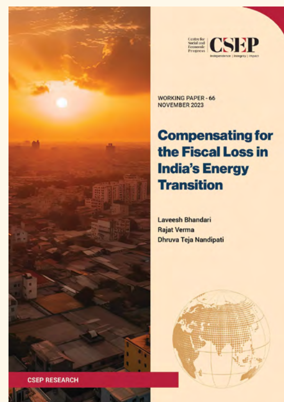

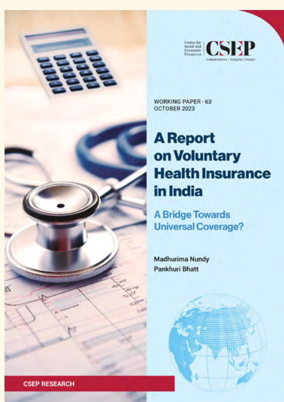

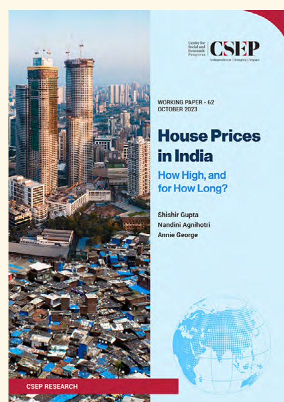

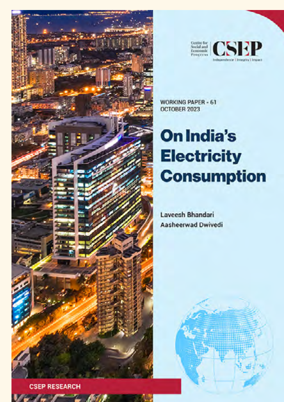

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