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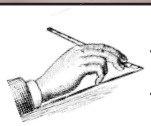

IMPORTANT

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GS 2: POLITY

INDIAN EXPRESS PAGE : 11

Finance commission strengthens local bodies, but at the cost of states

HASEEB A DRABU

THE RECOMMENDATIONS of the Sixteenth Finance Commission (SFC) for the period 2026-31, which have been accepted by the Union government, have raised serious concerns about the future of federal balance.

The changes in the horizontal criteria, discontinuation of statutory grants, and tacit approval to the shrinking of the divisible pool have tilted the scales toward greater central leverage through discretionary transfers. This shift has come at the expense of statutory equity, further compounded by the doubling of transfers to the third tier. In making these unprecedented changes, SFC has taken liberties with the constitutional framework, thereby weakening the statutory backbone of fiscal federalism in India.

Even though the SFC retained the share of states at 41 per cent, it has overseen a reduction in their effective share from around 36 per cent to around 32 per cent. Further, by tweaking the devolution formula, 14 states, mostly the smaller states, have got a lower share in taxes than in the previous commission. The share in tax devolution, for example, of all northeastern states is 15.5 per cent lower than under the Fifteenth FC. This could have a crippling effect on the region.

More damaging is the discontinuation of revenue deficit grants, which had been accruing to the fiscally weaker states. So too the sector-specific grants, and state-specific grants-in-aid. These grants under Article 275(1) have been an important part of all the previous commissions' awards.

Based on the combined states' revenue deficit of 0.3 per cent of GDP, the SFC has reasoned, rather erroneously, that gap-filling has been rendered unnecessary. Not only should needs be assessed individually for states and not by aggregation, the SFC has failed to take cognisance of the post-GST reality. The shift from a producer-oriented to a consumer-oriented tax regime has altered the revenue dynamics of states. The consuming or the destination states may no longer show revenue deficits of the same magnitude as earlier. But this in no way obviates, let alone eliminates, the needs for equalisation: Special area administration and tribal welfare have been explicitly spelt out in Article 275.

Instead of abolishing the revenue deficit grants, the SFC should have redesigned gap-filling as equalising grants by replacing the single deficit criterion with multiple criteria, including SC/ST population or rural consumption patterns. The Commission has also remained largely agnostic to GST Council dynamics, IGST settlement issues, and cost-of-collection variations, missing an opportunity to align horizontal distribution with the current consumption-based indirect tax regime.

In an era of GST interdependence and growing regional disparities, the Commission should have acted boldly — recommending caps or partial inclusion of cesses in the divisible pool, reimagining Article 275 for contemporary needs of consumption-based equalisation, and guiding GST-related adjustments.

Worse still, the SFC has used Article 282 to dramatically double the grants to the third tier — panchayats and urban local bodies. It has recommended nearly Rs 7.91 lakh crore (roughly Rs 4.4 lakh crore for rural and Rs 3.6 lakh crore for urban), with basic (80 per cent) and performance-linked (20 per cent) components, plus urbanisation incentives.

This compositional shift — from tax shares and Article 275 statutory grants towards Article 282 discretionary mechanisms and third-tier focus — has three problematic dimensions. First, the move from criteria-based entitled transfers to more condition-based discretionary ones. Second, from statutory predictable flows charged on the Consolidated Fund to non-statutory flows with hardly any accountability. Third, from equity-driven (based on need, backwardness, social welfare) to efficiency-oriented (based on performance, GDP contribution) criteria.

> The Sixteenth Finance Commission's changes in the horizontal criteria, discontinuation of statutory grants, and tacit approval to the shrinking of the divisible pool have tilted the scales toward greater central leverage through discretionary transfers

The SFC's approach of treating grants under Article 275 and Article 282 as interchangeable ignores the constitutional purpose of the two provisions, which is fundamental and intentional. Article 275(1) offers a safety net for equity and provides a targeted, statutory mechanism for fiscal support to states in need. These grants are charged directly on the Consolidated Fund of India, ensuring accountability, predictability, and parliamentary oversight. The Constitution envisages assistance based on genuine need — including tribal welfare and special area administration, viewed as national responsibilities — rather than narrow post-devolution revenue deficits, a limited criterion introduced by the Third Finance Commission. The Constitution speaks of assistance based on need, not narrow accounting gaps.

In contrast, Article 282 grants are purely discretionary. Both the Union and states "may" make grants for any public purpose. They are drawn from revenues of India and lack the same statutory obligation, transparency, and charging mechanism.

By abolishing statutory grants under Article 275 and replacing them with discretionary funding — including for centrally sponsored schemes — the Commission has diverted resources that should strengthen the divisible pool or statutory grants towards Centre-led initiatives. This mirrors past practices that weakened the Gadgil formula and proliferated conditional schemes, long regarded as detrimental to fiscal federalism.

Also, the SFC has, contrary to the Constitution, made local bodies effectively another stakeholder, besides the states, in the scheme of vertical distribution. Consequently, the horizontal distribution has been bifurcated: Formula-driven tax devolution primarily for the second tier (states), with grants increasingly tailored for the third tier (local bodies). This move of treating the two levels at par doesn't sit well with the basic structure of the Constitution.

States are fundamental constituent units of the Union of India with a direct constitutional status under Part VI of the Constitution. In contrast, local bodies (panchayats and municipalities) which gained constitutional recognition only through the 73rd and 74th amendments (1992), remain subordinate to the states. Their powers, functions, and finances are devolved by state legislatures, not directly granted by the Constitution. Local bodies as institutions of self-government promote decentralisation but operate but under state oversight with limited and derived autonomy. While strengthening local governance is welcome, equating or subordinating state-level needs with that of the third tier dilutes the federal compact. Promoting decentralisation should not be used as a pretext to harm federalism.

The writer is former finance minister of Jammu and Kashmir

GS 2: INTERNATIONAL RELATIONS

INDIAN EXPRESS PAGE : 12

An Indo-Pacific strategy minus West Asia is incomplete

VANSHIKA SARAF

FOR MUCH of the last decade, the "Indo-Pacific" has been discussed as though its defining pressures lie almost entirely to its east: The Taiwan Strait, the South China Sea, the Korean Peninsula, and the uncertain future of American power in East Asia. But the ongoing war in West Asia is a reminder that the Indo-Pacific is not insulated from instability to its west.

The most immediate shock is energy. A large share of oil and LNG moving through the Strait of Hormuz, roughly 80 per cent, is for Asia-Pacific markets. For more than two decades, these nations got used to oil arriving predictably, affordably, and in quantities that kept the wider economy functioning. Even if countries can adapt and switch to alternative suppliers, the current crisis has pushed them out of their comfort zone. The second is maritime shipping. It has pushed up insurance premiums, affected tanker availability, delayed delivery schedules, and forced refiners to adjust to substitute crude grades. That has had a ripple effect on aviation, fertilisers, petrochemicals, and food supply chains. The third effect is geopolitical. The redeployment of the THAAD system components from the Korean Peninsula and the repositioning of carriers and munitions from Japan towards the Gulf have Indo-Pacific allies concerned about their deterrence capabilities.

Japan has already started tapping its strategic oil reserves. South Korea has increased nuclear plant utilisation above 80 per cent and scrapped seasonal caps on coal power. Unlike the Ukraine war, grave as its consequences have been, the war in West Asia cuts far closer to the region's core strategic and economic interests. Yet crises of this sort also clarify priorities and should prompt governments to rethink existing policy responses. First, the acceleration of energy diversification efforts and investments in renewables must be viewed through a hard security lens, not just a climate or economic rationale. Second, the crisis should deepen maritime coordination among Indo-Pacific states. India, Japan, Australia, and ASEAN countries share a common interest in securing critical sea lanes. Third, the disruption may create selective commercial opportunities for countries with refining flexibility or alternative export capacity to supply deficit markets with surplus petroleum products as trade flows adjust to the crisis.

> Unlike the Ukraine war, the war in West Asia cuts far closer to the region's core strategic and economic interests

Robert D Kaplan argued that the Indian Ocean would become central to global power politics, precisely because it links West Asia, East Africa and East Asia through the movement of energy and trade. An Indo-Pacific strategy that ignores West Asia is incomplete, as the region's prosperity and stability still depend on developments there. The true lesson of this war is not only that the region is vulnerable in myriad ways, but that its map is wider than many policymakers have been willing to admit.

The writer is research analyst, Indo-Pacific Studies programme, Takshashila Institution

GS 2: HEALTH

THE HINDU PAGE : 8

Climate change as a public health emergency

Dr. Naresh Trehan

Chairman and Managing Director, Medanta

India faces growing health crises from climate change impacts

When we talk about climate change, the conversation almost always veers toward rising sea levels or extreme weather events. Some may even talk about the economic disruption that these natural disasters can and do cause. However, few, if any, touch upon another dimension of climate change: the broad-spectrum medical crisis that changing planetary patterns can trigger, as climate change intensifies every disease we already know and opens the door to those we have yet to face.

Nowhere is this more visible than in India. Increasingly frequent and severe waterlogging due to excess rain in cities such as Mumbai is creating ideal conditions for waterborne infections including cholera, typhoid, hepatitis A and leptospirosis. Recurrent waterlogging overwhelms sanitation infrastructure, contaminates clean water supplies, and leaves urban populations exposed to serious illnesses.

Conversely, drought-prone regions are facing worsening water scarcity, forcing communities to rely on unsafe water sources, thereby increasing the burden of diarrhoeal diseases as well as chronic dehydration.

Expanding disease risk

Meanwhile, shifting seasonal patterns are driving a rise in infections, allergies and vector-borne diseases, as changing temperatures and rainfall cycles disrupt established trends and prolong pollen seasons. Disease windows are expanding, and their geographic reach is steadily widening, quietly accelerating climate-driven spread. Communities with no prior exposure lack immunity, while health-care systems in these regions remain underprepared to respond at scale. One major example of this is the exponential growth of mosquito-borne diseases, as rising temperatures have made previously inhospitable regions suitable for this insect. The impact on dengue patterns is already measurable in Delhi-NCR. The number of cases traditionally peaked in September but now peaks in November, as warmer and rainier conditions sustain mosquito populations for longer periods.

Malaria, once largely confined to endemic pockets of the Gangetic Plains and the warm, humid regions of central India, is now being reported in cooler areas such as Himachal Pradesh, where it historically had minimal presence.

Climate change threats

Climate change also triggers rising air pollution. As summers become increasingly hotter, greater reliance on air conditioning drives higher energy use and greenhouse gas emissions. These emissions contain elevated levels of $PM_{2.5}$ – microscopic pollutants that penetrate deep into the lungs and bloodstream – exerting widespread effects across multiple organs in the body, particularly the lungs, heart and kidneys.

Fine particulate matter penetrates deep into the lungs, causing inflammation, reduced lung function, and exacerbating respiratory conditions such as asthma and chronic obstructive pulmonary disease.

These particulates can also damage blood vessels, accelerate atherosclerosis, and increase the risk of hypertension, heart attack and stroke. The kidneys are equally vulnerable, and chronic exposure can impair kidney function, reduce filtration efficiency, and contribute to the progression of chronic kidney disease.

Greenhouse gases also trap more heat in the atmosphere, creating a feedback loop that amplifies the very crisis we are trying to manage through air conditioners and other cooling appliances. This heat stress forces the heart to work harder to regulate the body's temperature, increasing strain on the cardiovascular system. This can trigger complications such as hypertension, heart attack, and stroke. These conditions disproportionately affect people without adequate shelter, such as manual labourers who spend long hours working outdoors in extreme conditions.

Parts of the country, such as Odisha, Telangana, and Vidarbha, are reporting a rising number of heat-stroke-related deaths. In addition, rising night-time temperatures in urban pockets such as Delhi-NCR and Mumbai are eliminating the critical recovery window that the human body relies on to cool down after prolonged daytime heat exposure.

Infant health outcomes are also increasingly at risk – exposure to extreme heat and air pollution has been linked to preterm births and low birth weight among newborns.

Impact on food security

The health consequences of climate change also extend into food systems and nutrition. Extreme weather events and unseasonal rain disrupt crop cycles and reduce agricultural productivity, contributing to food shortages. The declining nutritional quality of food crops, combined with rising prices, further compounds the crisis, creating a hidden burden of micronutrient deficiencies and chronic malnutrition, especially among children.

Rising temperatures can also cause a decline in milk production, as cattle affected by heat stress compromise infant and child nutrition. These cascading effects on food security translate directly into weakened immunity and greater vulnerability to disease particularly among children and the elderly.

The warnings have existed for decades, but were largely overlooked. Climate change is no longer a distant threat – for public health in India, it is already a present reality. It is a multifaceted challenge. Treating it as purely environmental overlooks its profound human cost. Recognising it as a medical emergency is the first step toward responding with urgency.

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GS 2: HEALTH

THE HINDU PAGE : 9

Reinforcing the case for a One Health approach

Global health risks demand a One Health approach grounded in coordination and scientific collaboration to strengthen pandemic preparedness and response

When the 1995 film *Outbreak*, starring the inimitable Dustin Hoffman, was released to audiences worldwide, it seemed like surreal science fiction, pitched at the very edge of the realm of possibility. The pacy film profiled the desperate race to contain an imaginary zoonotic virus, *Motaba*, that jumped to humans as a result of anthropogenic activity – deforestation and trade in wild animals – spreading across nations like a forest fire.

The movie, though dramatic, served as a prescient illustration of a crisis that was to visit the world, nearly a quarter of a century later: the COVID-19 pandemic.

Interestingly, the film also stood out for its early portrayal of the core principles of One Health – long before the term was even coined. Since then, though, One Health, which draws on the interconnectedness between humans, animals and the environment, has emerged as a key concept gaining traction among nations, though practical implementation has progressed at a nearly glacial pace.

From fiction to reality

This year's World Health Day message – "Together for health. Stand with science" – underlines the essentiality of adopting a One Health approach to protect animals, the environment, and humans. It also highlights the critical role of scientific collaboration and the use of evidence in crafting policy. As *Outbreak* outlines cinematically, there is a permanent state of conflict between different departments, arms of the government, and even nations, that come in the way of working synchronously to better tackle health crises.

As John S. Mackenzie and Martyn Jeggo indicated in their 2019 editorial in *Tropical Medicine and Infectious Diseases*, the term 'One Health' was first officially used in 2003-2004, associated with the emergence of severe acute respiratory syndrome. With the spread of avian influenza H5N1, it gained ground. A significant contributor was the 'Manhattan Principles,' derived at a 2004 Wildlife Conservation Society meeting, which recognised the link between human and animal health and the threats diseases pose to food supplies and economies.

The authors explained: "It has become increasingly clear over the past three decades that the majority of novel, emergent zoonotic infectious diseases originate in animals and that the principal drivers of their emergence are associated with human activities, including changes in ecosystems and land use, intensification of agriculture, urbanisation, and international travel and trade."

Swift action: Post-COVID, the Indian government fast-tracked collaborative positions to address future crises. K. MURALI KUMAR

Today, international wisdom acknowledges that a pathogen unknown to mankind can suddenly emerge, wreak havoc on populations, and threaten the stability of the world faster than one can say 'One Health'.

According to the One Health Commission: "One Health is an integrated, unifying approach that aims to sustainably balance and optimise the health of people, animals and ecosystems." The approach it advocates involves mobilising multiple sectors, disciplines and communities to foster well-being and tackle threats to health and ecosystems.

The COVID-19 pandemic, in some senses, was the fulcrum that convinced even reluctant nations of the world to invest in One Health, demonstrating visibly what the lack of coordination; and on the other hand, seamless coordination can do. It was the collective sharing of SARS-CoV-2 genetic data and the study of human genetic factors in COVID-19 susceptibility that drove the international vaccine development effort. The WHO Pandemic Agreement, adopted on May 20, 2025, is a legally binding international treaty aimed at enhancing global prevention, preparedness, and response to future pandemics. It focuses on equity, establishing a Pathogen Access and Benefit-Sharing system to ensure rapid pathogen data sharing and equitable access to vaccines and treatments.

Internationally, One Health is led by the Quadripartite collaboration – including WHO, FAO, the United Nations Environment Programme, and the World Organisation for Animal Health. In October 2022, they launched the One Health Joint Plan of Action.

Post-COVID, the Indian government fast-tracked collaborative positions to address future crises. It mobilised the National One Health Mission as a collaborative initiative designed to integrate human, animal, and environmental health sectors. It avowedly aims to enhance pandemic preparedness, disease surveillance, and zoonotic disease control.

With increasing evidence emerging of stressors from climate change and how these affect the natural ways of the world, it has become clear that addressing the effects of extreme climate events is essential. While several national initiatives exist to drive India ahead on this path, continuous monitoring, evaluation, and interim mitigation programmes are urgently needed.

In this context, some State-led initiatives present inspired examples for replication. These include Odisha's pioneering Climate Budget to track climate-resilient development expenditures, Kerala's participatory carbon-neutral plan in Meenangadi, and Tamil Nadu's Green Climate Company and Cool Roof Project in Chennai.

Coordinated solutions

The One Health Summit in Lyon, France, currently under way, in time for World Health Day, will focus on the main factors contributing to infectious and non-communicable diseases, such as zoonotic reservoirs, vectors, antimicrobial resistance (AMR), sustainable food systems, and exposure to pollution. It hopes to foster international and interdisciplinary dialogues about global challenges, particularly with reference to co-operation, propose solutions to strengthen health systems, and rethink global institutional frameworks that will align with One Health goals.

Welcoming increasing political consensus on One Health, WHO Director-General Tedros Adhanom Ghebreyesus said in 2023: "A One Health approach makes public health sense, economic sense and common sense." Indeed, the only thing that makes sense in an increasingly interconnected world is an approach that recognises and acts on these connections.

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GS 2: HEALTH

THE HINDU PAGE : 8

To mark World Health Day on April 7, a set of articles on the Editorial and Opinion pages that highlights key health issues

A disturbing step for rights, dignity and mental health

Dr. Kavita Arora

Senior psychiatrist with over 25 years of clinical practice and lived-experience expertise, Founding Cohort member of India Mental Health Alliance (IMHA), Co-Founder of Children First, and adviser and trainer in gender-affirming mental health practices across several Indian institutions

The Transgender Persons (Protection of Rights) Amendment Bill, 2026 has caused deep confusion, perplexity, and, over the past two weeks since its introduction, apprehension and fear. In trying to make sense of both the intent and the possible implications of the amendment, these days have raised more questions than they have provided satisfactory answers. At the core is the question, "Who owns my gender and therefore my gender identity?"

For the majority of men and women who happen to be cisgender, life hardly ever brings us to a point where we are faced with this as a question. There is no 'evaluation' that we need to undergo. Whether it is a form at a hospital, clinic, bank, or workplace, we claim our gender ourselves by ticking a box. We simply state our gender, not expecting anyone to question the obvious. However, for gender diverse and transgender individuals, this is what is proposed henceforth. This violates the foundational principles of dignity, autonomy and mental well-being.

From progression to regression

In 2014, the Supreme Court of India delivered a historic judgment in *NALSA vs Union of India*, recognising transgender persons as a legitimate gender identity. It was a watershed moment for jurisprudence, public policy and governance because it rested on a simple and powerful principle: gender identity is self-identified. Just as any individual declares themselves a man or a woman without external verification, transgender persons, too, were reaffirmed as the final and only authority on their gender identity. This principle is rooted not only in human dignity and autonomy but also in constitutional morality under Articles 14 (Equality before Law), 15 (non-discrimination), 19 (Freedom of Expression) and 21 (Right to Life and Personal Liberty).

In 2019, Parliament passed the Transgender Persons (Protection of Rights) Act. While parts of it were criticised by the community, it remained aligned with *NALSA* on the cornerstone issue of self-identification. Indeed, it acknowledged the community's long history of discrimination and exclusion, and sought to prohibit discrimination, ensure access to education and health care, extend welfare measures such as housing, skill development and employment support. These welfare schemes, in our minds, as allies and health-care practitioners, represented an attempt to build an enabling framework rather than a restrictive one.

Much of the work being done at both the health-care training and education levels, as a result of the 2019 Act, requires sensitisation drives to ensure that curricula and training for health care and allied professions are sensitive to gender-affirming practices, and to make welfare schemes more widely known and implementable. In these six years, all stakeholders had just about started to align themselves with the global standards that the 2014 judgement and the 2019 Act both validated.

The amendment to the 2019 Act – which was notified in the Gazette on March 30, 2026 – fundamentally reverses the NALSA judgment. It replaces self-identification with medical and bureaucratic gatekeeping, redefining who is 'allowed' to call themselves transgender. Under this amendment, a transgender person must appear before a medical board; undergo an assessment to 'prove' their gender identity; wait while the board forwards its recommendation to the District Magistrate, and obtain a certificate declaring them transgender.

There is no medical or evaluative biomarker for gender identity. No external knowledge or proof of any sort can determine the deeply held and personally felt experience of one's gender identity. There would have been no need for trans individuals to "come out "at all if that had been the case.

This is the accepted truth in medicine and health care across the globe. Therefore, it is perplexing that the Amendment talks about determining and validating someone's gender through a process in which the answer to the question "what is my gender?" has to be given by complete strangers.

This raises many issues that seem to present challenges at many levels.

Medical boards – many of which do not exist at the district level – are already overburdened even for urgent health-care needs. In the absence of criteria, as well as time and process, it is likely that boards may fall back on arbitrary, invasive or abusive examinations, including the possibility of genital inspection. This stems arguably from the traditional way of "assigning "gender at birth by looking at the genitals of a newborn child by a doctor or another adult. This is far from what we know to be the understanding of gender identity for gender diverse and trans individuals. Extrapolating this method to an adult and making it mandatory is in direct and complete violation of dignity, privacy and bodily autonomy. I cannot imagine any circumstance that would make me wish to approach this premise for myself as an adult cisgender woman. The very thought of such a scrutiny by a board of strangers, would probably create anticipatory mental distress and make me actively avoid approaching such a premise.

Instead of improving welfare access, the amendment will likely shrink it, deter individuals from approaching the state, and reintroduce fear and humiliation into an already vulnerable population.

The Transgender Amendment Bill threatens welfare access and instils fear and humiliation for an already vulnerable population

Mental health fallout, crisis in the making

The transgender community already faces extreme vulnerability. Data show that 99% of transgender persons have faced social rejection; 52% have faced harassment or violence in educational spaces; 57% of trans women report experiencing physical or sexual violence at least once, and transgender adolescents have suicide attempt rates estimated between 13% and 50%, far above the national average.

Against this backdrop, introducing additional layers of suspicion, verification and scrutiny is not just insensitive. It is unsafe. As a mental-health practitioner and an ally for the trans community, I am deeply concerned.

Not just prospective; what is concerning is the uncertainty for thousands of transgender individuals currently enrolled in health-care services, whose access may now be questioned or invalidated in the face of the ambiguity about supporting the gender exploration and gender journey of an individual. This is not merely a procedural shift; it has the potential of developing rapidly into a public mental-health emergency.

The amendment introduces a clause that criminalises 'undue influence' in helping someone identify as transgender, with penalties up to 15 years of imprisonment. For mental-health practitioners, psychologists, lawyers and educators, this creates an unprecedented ethical and legal risk. In many families, gender-identity journeys create tension or disagreement. Community-based organisations, trans-affirmative mental health practitioners and services are frequently accused of 'encouraging' adolescents simply for acknowledging their lived reality. Under this amendment, such allegations could become criminal charges.

This will discourage health-care practitioners from providing essential, evidence-based care; challenge community-based organisations to remain as allies, and push transgender persons away from formal health care and heighten mental distress that will likely remain unsupported.

Additionally, the amendment collapses distinctions between transgender, intersex and hijra identities, erasing cultural, social and biological differences. Trans men remain nearly invisible in the framework, further marginalising them.

An appeal for reflection and action

The current amendment risks undoing a decade of progress across law, governance, health systems and institutional practice. If misuse has occurred – even if limited to the 0.01% that the government suggests – the solution lies in audits, verification protocols and administrative strengthening – not in policing gender identity or forcing medicalisation.

To uphold constitutional values, protect mental health, and ensure administrative feasibility, this amendment must be reconsidered. We owe each individual in India the assurance that governance frameworks do not deepen fear, stigma, or exclusion for any community.

GS 2: HEALTH

THE HINDU PAGE : 9

What TB reveals about India's urban health system

Tuberculosis shows how gaps in India's urban health systems, combined with socio-economic disenfranchisement and migration, continue to exclude the vulnerable from timely care

Tuberculosis rarely appears overnight. It develops slowly at the intersection of impoverishment, precarious livelihoods, and fragile health systems. Each case tells a larger story – not just about infection, but about the conditions in which people live and the systems meant to protect them. On World Health Day, TB serves as a stark reminder that if "Health for All" is to mean anything, it must include those whose health risks are produced by the way our cities' systems are built and governed.

Nearly 35% of the population now lives in urban areas, and cities continue to expand as people arrive in search of work, education, and opportunity.

Urban risks

Urban India is often assumed to have better healthcare infrastructure than rural areas. Yet cities also concentrate risk. Overcrowded housing, poorly ventilated workplaces, long working hours, pollution, informal employment and weak social support systems create conditions that drive poor health outcomes. For infectious diseases such as tuberculosis, these are not peripheral concerns – they are central.

India continues to bear the largest burden of tuberculosis globally, accounting for nearly one-fourth of the world's TB cases. In India, where exposure is common, infection alone does not necessarily lead to disease. For most people, the immune system contains it. Disease develops when vulnerabilities converge: malnutrition, overcrowding, physically demanding work, untreated co-morbidities and delayed access to care.

TB can therefore be read as a proxy indicator of how well health and social systems function.

Missed opportunities

TB unfolds through a series of missed opportunities. Early symptoms often go unrecognised or untreated. Delays in diagnosis and interruptions in treatment increase the risk of transmission, severe illness, and drug resistance. Each stage represents a point where effective public health systems could intervene. Where nutrition support, social protection, adequate housing, and accessible primary healthcare are in place, TB is more likely to be detected early and treated successfully. Conversely, rising TB incidence, treatment interruptions and multi-drug-resistant TB often point to deeper failures in surveillance, follow-up, pharmaceutical regulation, and the broader systems that sustain health.

Health crisis: India continues to bear the largest burden of tuberculosis globally, accounting for nearly one-fourth of the world's TB cases. FILE PHOTO

TB can no longer be framed only as a disease of the poor; it is increasingly an urban public health challenge. In a pathways study of multi-drug-resistant TB patients in Mumbai (Bhattacharya et al., 2019), people often navigated complex and prolonged care-seeking journeys, moving between multiple providers before receiving the correct diagnosis and treatment. Delays, fragmented care and financial burdens not only worsened outcomes but also prolonged transmission within households and communities.

These are not isolated stories.

Urban primary healthcare remains fragmented and unevenly distributed. While the National TB Elimination Programme provides diagnosis and treatment through designated centres, a large proportion of urban residents seek care from private providers. Data integration between public and private sectors remains incomplete, making continuity of care difficult.

Migration adds another layer of exclusion. Migrants frequently change residences, move between worksites, or travel back to their home. Many lack documentation linked to their current residence or stable access to social protection. This can disrupt treatment, delay care, and make follow-up difficult.

The geography of services also matters. Informal settlements, peri-urban industrial zones, and construction clusters often remain underserved by accessible primary healthcare, reliable transport, and essential public services.

This is where the language of health as a right becomes critical. If health is indeed a right, access to care cannot depend on whether a person has address proof, speaks the dominant language, or is settled enough to fit neatly into administrative categories. The promise of "Health for All" cannot be realised through systems designed primarily for stable, documented, and visible populations.

TB, then, is more than a disease to be controlled. It is a diagnostic tool for the health of our systems. If India is serious about building healthier cities, healthcare must be portable, primary care strengthened, and disease control programmes integrated with neighbourhood-level services.

Ending TB will require building urban systems that make health possible – when 'health for all' starts not only when people fall sick, but for those not visible to policy and for those whose labour sustains the city while their health remains marginal to its planning.