Special Article

Strengthening of Primary Health Care: Key to Deliver Inclusive Health Care

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Summary

Inequity and poverty are the root causes of ill health. Access to quality health services on an affordable and equitable basis in many parts of the country remains an unfulfilled aspiration. Disparity in health care is interpreted as compromise in 'Right to Life.' It is imperative to define 'essential health care,' which should be made available to all citizens to facilitate inclusivity in health care. The suggested methods for this include optimal utilization of public resources and increasing public spending on health care. Capacity building through training, especially training of paramedical personnel, is proposed as an essential ingredient, to reduce cost, especially in tertiary care. Another aspect which is considered very important is improvement in delivery system of health care. Increasing the role of 'family physician' in health care delivery system will improve preventive care and reduce cost of tertiary care. These observations underlie the relevance and role of Primary health care as a key to deliver inclusive health care. The advantages of a primary health care model for health service delivery are greater access to needed services; better quality of care; a greater focus on prevention; early management of health problems; and cumulative improvements in health and lower morbidity as a result of primary health care delivery.

Key words: Affordable health care, Accessible health care, Capacity Building, Health Economics, Inclusive health care, Universal health care

Introduction

During the middle of the 18th century, the British Government in India established medical services, which were primarily meant for the benefit of the British nationals, armed forces, and privileged civil servants. Indigenous systems of medicine were totally neglected. Services which were available in general hospitals located in big cities and commercial centers were largely curative. But, neither health planning nor medical education was related to the health needs of the people. This strong Western bias was largely responsible for blind adoption of sophisticated modern medicine for a few, neglecting the vital interests of the vast majority.[1]

In independent India, keeping in view the constitutional obligations, the Government of India planned several approaches for the health care delivery. The basis for organization of health services in India through the primary health care was laid by the recommendations provided by the 'Health Survey and Development Committee' (Bhore Committee) in 1946.[1]

In the last two decades, there has been a growing concern over the performance of the health care delivery system in India. As per the Government of India's (GOI) National Rural Health Mission (NHRM) Document (2005), only 10% of Indians have some form of health insurance and around 40% of Indians have to borrow money or sell their assets to meet their health care expenses.[2] Nearly 25% of Indians slip below the poverty line because of

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hospitalization due to a single bout of illness.

Inclusive growth is the policy adopted by the Indian government during 11th plan and continued in the 12th plan.[3] Inclusive growth means development of all sections of the population including children, women, and other vulnerable groups. India is aiming for inclusive growth in several fields like education, health, energy and resources, telecom and technology, finance and infrastructure.

This paper suggests measures to increase inclusivity in essential health care in the background of present status of health care services in India.

Status of Health in India

Maternal and Infant Mortality Rates in India's poorest districts are worse than the sub-Saharan Africa. India represents 21% of the global diseases burden with the largest burden of communicable diseases in the world.[4-6] The projected cumulative loss of national income for India due to non-communicable disease mortality for 2006-2015 was USD237 billion.[7]

India is ranked 3rd highest among countries with a high rate of HIV-infected persons.[8] Diarrheal diseases are the primary causes of early childhood mortality.[9] These diseases can be attributed to poor sanitation and inadequate safe drinking water in India.[10] Poor sanitation along with lack of access to basic needs contributes enormously to the health burden of the nation. As more than 122 million households have no toilets, and 33% lack access to latrines, over 50% of the population (638 million) defecate in the open.[11]

Health care delivery system in India

The Indian health care sector, structured in three tiers viz., primary, secondary, and tertiary, is characterized by the presence of several distinct systems of health care delivery such as the government, not-for-profit, charitable organizations, corporate hospitals, and smaller private clinics. There are no well-defined forward or backward linkages between these.[12]

India's public health infrastructure

It is grossly underfunded, under staffed, and poorly equipped. Urban population in India accounts for less than a third of its total population. Allopathic physicians are highly concentrated in urban areas compared to rural areas (13.3 and 3.3 per 10,000 population, respectively). Nurses and midwives are also similarly concentrated in urban areas (15.9 and 4.1 per 10,000 populations).[13]

The density of allopathic physicians is 4.28 per 10,000 populations.[14] There are approximately 0.81 nurses per allopathic physician in India, suggesting that there are more doctors than nurses. From a health systems point of view, the ratio of nurses to doctors is very low. According to the 1993 World Development Report, as a rule of thumb, the ratio of nurses to doctors should exceed 2:1 as a minimum with 4:1 or higher considered more satisfactory for cost-effective and quality care. Nurses can deliver many of the basic clinical care and public health services, particularly at the community level, at a lower cost than trained physicians.

Out of the 660,856 doctors registered in India, only 12% are in the public sector.[13] According to the approach paper for the 12th five year plan, in 2010, 10% of posts of doctors at the primary health centers, 63% of the specialist posts at the community health centers, 25% of the nursing posts at PHCs and CHCs combined, 27% posts of pharmacist, and 50% of laboratory technician posts are vacant.[3]

India, ranked among world leaders in manufacturing of generic medicines, has the largest number of its citizens living without access to basic medicines.[8]

Unregulated private health sector

Both urban and rural Indian households tend to use the private medical sector more frequently than the public sector.[15] Various studies show that private health sector accounts for over 70% of all primary care and over 50% of all hospital care.[15] However, the private health sector's focus is on curative care. Several reasons are cited for relying on private rather than public sector; the main reason at the national level is poor quality of care in the public sector. Other major reasons are distance of the public sector facility, long wait times, and inconvenient hours of operation.[13]

At one end of the spectrum are private hospitals with world class facilities and personnel offering services, which are competitively priced, compared to similar services abroad, but remain beyond the capacity of most Indians. At the other end, there is an unregulated private

sector which is more affordable, but offer services of varying quality, often by under-qualified practitioners.

Health Care Costs

It has been observed that the private health sector expenditure is increasing, while the public health expenditure is shrinking. Public spending on health care in India is as low as 0.9% of the Gross Domestic Product (GDP) in contrast to a total health expenditure of 5% of GDP making public health expenditure a mere 17%.[16] Decreasing public health expenditure has adversely affected the health outcomes. The average rural sub center caters to four villages with a service delivery radius of 2.61 km.[17] A comparison of the influences of access and economic status shows the latter emerging as a more crucial determinant in access to institutional delivery in rural India.[18]

Urban-rural disparities

According to the 2011 Census, 377 million Indians live in urban areas.[19] The number of people not receiving treatment because of 'financial problem' and 'lack of medical facility' is higher in rural areas than in urban areas.[20] Piped water is available to only 25% of the rural population and 75% of urban population.[13] Although rural areas house 68% of the Indian population, only 20% of the total hospital beds are located in rural area.[13] An imbalance in the urban-rural distribution of specialists and perceived poor quality health care services in the rural areas result in almost two thirds of the patients in urban hospitals coming from rural areas.[20] Half of the rural population continues to live below the poverty line, struggling for better and easy access to health care and services.[20]

According to the National Family Health Survey III (2005-06), the under-5 mortality rate among the urban poor, at 72.7, is significantly higher than the urban average of 51.9.[13] More than 50% of urban poor children are underweight, and almost 60% of poor children do not receive complete immunization before completing their first year.[21] Poor environmental conditions in slums, along with a high population density, make population especially vulnerable to lung diseases like asthma and TB.[22] The effect of disparity in availability of health care has shown that the Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population.[13] These facts underline the importance of the need to deliver health care to urban poor.

Social Disparity

Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.[23]

In the background of the status of health care services in India discussed above, suggested methods to foster inclusivity are discussed as follows:

Inclusive is a term often used in the context of growth to mean 'broad-based' or 'all encompassing.' In the context of health care, 'inclusive' means availability of health care to all sections of society. In India, this means offering health care services to the entire population of nearly 1.2 billion. Since 'total health care' for all is a dream for any country to realize, we need to consider providing primary and, if possible, secondary health care to all.

Defining essential health care and health education on quality of health care

While it is very tempting to include all aspects of health care as essential, the hard realities of economics have to be kept in mind. So, the difference between desirability and essentiality needs to be made known to common man. Basic health care services can be outlined and categorized under the essential services that every citizen may have a right to. Primary and preventive health care are undoubtedly essential. Health education dealing with health promotion, prevention of diseases through awareness, and information of availability of treatment must also be considered as essential health care.

Capacity Building

Issues concerning the health workforce such as its capability to cover different socio-economic groups and geographic regions, the technical competence and skills of individual health workers, and motivation with which they perform their jobs – all contribute in important ways to improving health system performance and population health.

There is an acute shortage of health workers. Having an adequate health workforce in terms of numbers and skill mix is critical for countries like India, which hope to make significant progress towards achieving the Millennium Development Goals for health. Recent studies show that greater availability of health workers is associated with better service utilization and health

outcomes such as immunization coverage, outreach of primary care and infant, child and maternal survival.[24] In addition to numerical strength, the effectiveness of the health workforce is influenced by the skill mix, quality, and geographical distribution of health workers, a work environment and infrastructure which enables them to effectively use their skills, adequate remuneration, and opportunities for upgrading and refreshing skills.

New broad-based training programs need to be designed to create the second rung of health care workers like Physician Assistants, Medical Technologists, and Nurse Practitioners so that the doctors can devote their skills to more complex tasks. This is not to be considered as dilution of quality. Multi-skilling that enables paramedical workers to perform tasks within their capacity but beyond their traditional professional roles may be considered as a way forward towards improving efficiency of the system.[25] Consultants regularly end up looking at routine health problems that could have been easily be managed by a well-trained second rung paramedic or a capable nurse, thereby reducing the cost of treatment while improving the outcome.

Improving health care delivery system

There are many advantages of delivery of health care through designated primary care physicians or family physicians. This will reduce the cost of long term care and patient will get help in determining the need for avoidable expensive treatment.[26] Areas with better primary care will have better health outcomes, including total mortality rates, heart disease mortality rates, and infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer. We need to ensure that all urban slums and settlements are covered with sub-centers, ICDS centers, and PHCs, through NUHM. The ongoing initiatives for integrating AYUSH and capacity development of other traditional health care providers such as Registered Medical Practitioners (RMPs) must be strengthened.

As the density of health workers is less than the WHO norm of 2.5 workers/ 1000 population, India needs policy measures to increase density of health workers, especially in rural areas and certain economically poor states. Only 193 districts of a total of 640 districts have medical colleges – the remaining 447 districts do not have any medical colleges. Further, the existing teaching capacity for creating paramedical professionals is grossly inadequate. We need to increase the coverage of each district with a medical college. New medical and nursing colleges should preferably be linked to district hospitals in under-served states and districts, ensuring that districts with a population of 25 lakhs and above are prioritized for establishment of such colleges if they presently lack them. The steps taken by the medical council of India in this regard are a welcome one.

Strengthening public sector

Public sector must become the dominant player to lead the health sector rather than the private sector. It is only then that inclusive health care can be ensured if poor and downtrodden class gets better care. We need to find ways to treat poor patients at subsidized rates in private hospitals if proper treatments for diseases are not available in government sector. For this to happen, the public and private sector must join hands in ensuring inclusive health services for the population. Quality of care is one such factor, and a local partnership between public health institutes and the state health services could go a long way toward addressing quality shortfalls.

Public financing of health care does not necessarily mean provision of the service by public providers. It is possible to have public financing while the service itself is provided by private sector players, subject to appropriate regulation and oversight. There are a number of experiments now in operation, which allow for private sector participation. At the Central level, the Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance scheme available to the poor and other identified target groups. Partnerships are the buzzword in public health, and our strategies must also be in tune with the times.

Increasing public spending on health care

India's public spending is much less than those of the developed countries not only in absolute terms but even as a percentage of GDP.[27,28] The Government of India's recent decision to increase health expenditure to 2.5% of the gross domestic product (GDP) by the end of the Twelfth Five-Year Plan (2012-17) from the current 1.4% is good news for the sector.[3] Government has to spend more on infrastructure development of the health sector. However, we need to prioritize our objectives for public spending. Something as basic as providing proper sanitation and safe drinking water to all its citizens, especially young children should figure high up on agenda. The reduction in mortality and morbidity due to primary prevention and improved health education is well-documented.[29] The next priority for public

expenditure should be given to universal primary health care. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.[30] Good quality primary care prevents unnecessary hospitalizations.[31] This in effect would reduce health care costs. Strengthening of the primary care setting would be the key to deliver inclusive health care.[32]

Reducing the cost of expensive tertiary health care

Hospitals collectively need to prioritize the allocation of the available capital. It is essential to reduce the gap in availability of good quality health care between the rich and the poor, so that the disparity does not induce social unrest.

Effective monitoring of national health programs

There have been a number of programs of the government towards achieving inclusive health care such as National Rural Health Mission, Rashtriya Swastya Bima Yojana, Rajiv Gandhi Creche Scheme for Children of Working Mothers (0-6 years old), Janani Suraksha Yojana, Janani Suraksha Karyakram, Integrated Child Protection Scheme, Support for Training and Employment of Women, Rashtriya Mahila Kosh, etc. We require innovative management reforms within health delivery systems. There is a need to restructure the health programs such as Integrated Child Development Scheme (ICDS). It focuses mainly on children in the age group of 3 to 6 years who actually attend Anganwadis, whereas the greatest need for nutritional support is in the age group of 0-3 years.

Community participation

The effectiveness of a health care system is also affected by the ability of the community itself to participate in designing and implementing delivery of services. The opportunity to design and manage such delivery provides empowerment to the community as well as better access, accountability, and transparency. In essence, the health care delivery must be made more consultative and inclusive. This can be achieved through a three-dimensional approach of (1) strengthening Panchayat Raj Institutes through improved devolution and capacity building for better designing and management, (2) increasing users' participation through institutionalized audits of health care service delivery for better accountability, and (3) bi-annual evaluation of this process by empowered agencies of civil society organizations for greater transparency. Methodologies based on community-based monitoring, which have proved successful in some parts of the country, will need to be introduced in other parts.

Health care provision by the organized private sector is virtually absent at the primary level, which highlights the need for providing adequate public resources to build a public sector health system.

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