Sattva Knowledge Institute SKI primer

PRIMARY HEALTH CARE IN INDIA

July 2023

Acknowledgements

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CONTENTS

ABBREVIATIONS

AB-HWC	Ayushman Bharat Health and Wellness Centre
ABHA	Ayushman Bharat Health Account
AI	Artificial Intelligence
AMRIT	Accessible Medical Records via Integrated Technologies
ANM	Auxiliary Nursing Midwifery
ANMOL	Auxiliary Nursing Midwifery Online
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy
CD	Communicable Disease
CHC	Community Health Centre
CPHC	Comprehensive Primary Health Care
DH	District Hospital
DMPA	Depot Medroxyprogesterone Acetate
FLW	Frontline Workers
FP	Family Planning
FPLMIS	Family Planning Logistics Management Information System
FRU	First Referral Unit
HIS	Health Information System
HRH	Human Resource for Health
HSTP	Health Systems Transformations Platform
HW	Health Worker
HWC	Health and Wellness Centre
IEC	Information, Education & Communication
ICT	Information and Communications Technology
IoMT	Internet of Medical Things
IPHS	Indian Public Health Standards
JAS	Jan Arogya Samiti
LMIC	Low and Low Middle Income Countries
LMIS	Logistics Management Information System

M&E	Monitoring and Evaluation
NCD	Non Communicable Diseases
NHM	National Health Mission
NLFEP	National Lymphatic Filariasis Elimination Programme
NHP	National Health Policy
NSS	National Sample Survey
OOP	Out-of-Pocket
OOPE	Out-of-Pocket-Expenditure
PHC	Primary Health Care
PHC-HWC	Primary Health Centres (converted to). Health and Wellness Centre
PMJAY	Pradhan Mantri Jan Arogya Yojna
QA	Quality Assurance
RCH	Reproductive Child Health
RHS	Rural Health Statistics
RKS	Rogi Kalyan Samiti

RPM	Remote Patient Monitoring
SAKSHAM	Stimulating Advanced Knowledge for Sustainable Health Management
SHC	Sub Health Centre
SDH	Sub-District Hospital
SHC-HWC	Sub Health Centres (converted to). Health and Wellness Centre
SHGs	Self Help Groups
TB-DOTS	Tuberculosis Directly Observed Treatment, Short-Course
UHC	Universal Health Coverage
UHWC	Urban Health and Wellness Centre
UNICEF	United Nations International Children's Emergency Fund
UPHC-HWC	Urban Primary Health Centres (converted to). Health and Wellness Centre
VHSNC	Village Health, Sanitation and Nutrition Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

Primary health care (PHC) is defined as a whole-of-society approach to health that ensures high quality, equitable distribution and timely access to health and well-being by focusing on people's needs. This is intended across the care continuum, from health promotion and disease prevention, to treatment, rehabilitation, and palliative care, and should be easily accessible. Health systems built on the principles of PHC are essential to achieve universal health coverage. India's commitment to PHC has evolved to align with global priorities, recognising the right of all people to achieve the highest attainable levels of health. PHC should serve as a gatekeeper to improve efficiency, reduce inappropriate care and minimise the burden on facilities providing higher levels of care. This primer presents a comprehensive framework which draws on building blocks of health systems, while recognising cross cutting levers and community at the centre, by adapting frameworks by WHO and USAID India Alliance.

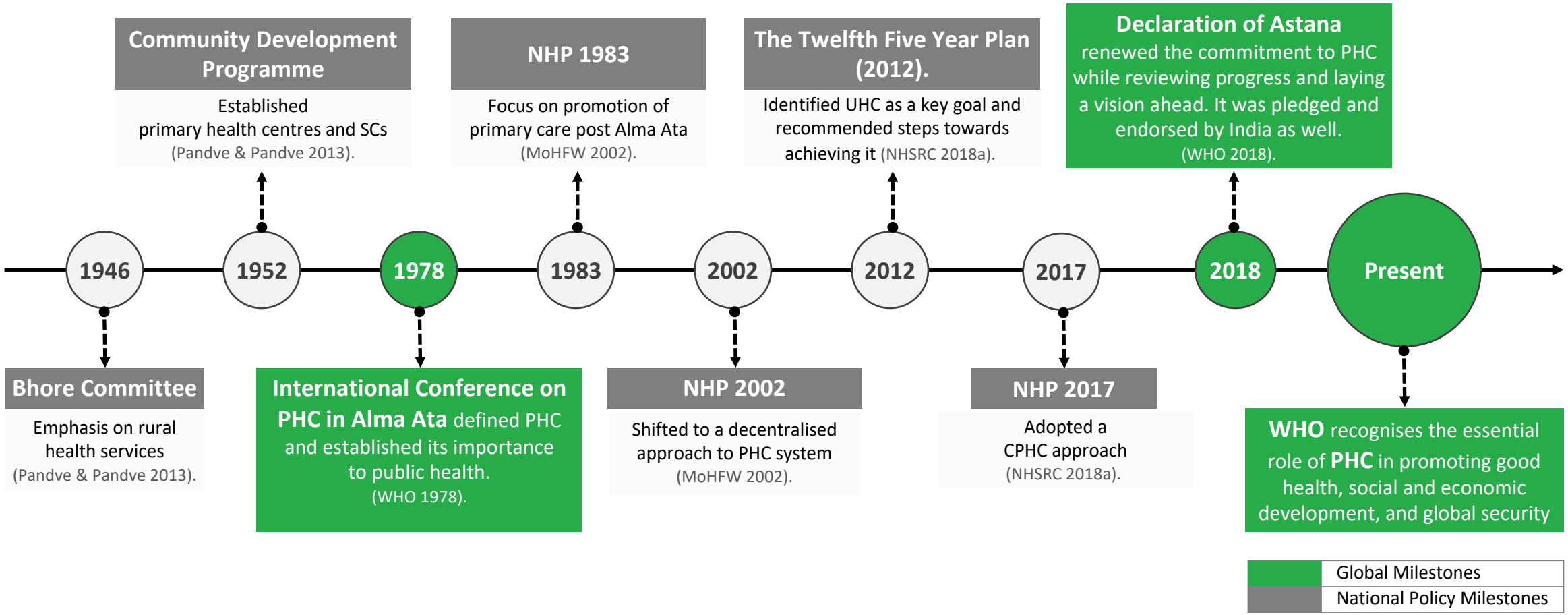
PHC challenges in India persist across all aspects of the health system, including aspects such as the lack of outcome orientation, ineffective policy implementation, skewed infrastructure-driven focus, inadequate human resources, to name a few. Overcoming these challenges requires a comprehensive approach addressing multiple systemic aspects of primary healthcare.

Solutions in the ecosystem in the form of established models, research, collaborative initiatives and innovation in PHC provide an opportunity to revolutionise and strengthen PHC in India. Complementing existing solutions, PHC in India and globally is experiencing a wave of prioritisation and shift towards areas such as self-care, gender-responsive care, linkages of climate change and PHC, alternate financing models, and remote monitoring, along with others shared in this primer.

UNDERSTANDING PHC: ROLE, LEVERS AND STAKEHOLDERS

India's commitment to primary health care has evolved to align with global priorities.

Primary health care is based on the fundamental premise that all people, everywhere, have the right to achieve the highest attainable level of health (WHO n.d.a).



What is primary health care?

PHC

PHC is a "whole-of-society approach to health **that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health** promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (WHO 2021a).

India's Approach to PHC

India now aims to provide an expanded range of **twelve services through HWCs,** moving beyond maternal and child health services to also include **NCDs, CDs, oral care, eye care, mental health and others.**

(Refer to the Annexure for more details).

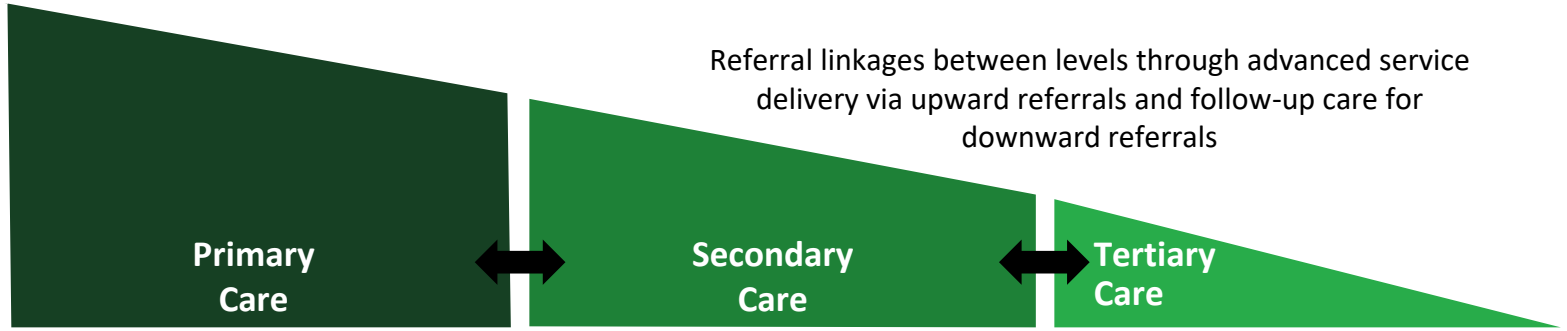
NHP 2017
calls for a shift from a **selective to comprehensive** provision of primary care, with linkages to referral hospitals, **towards outcomes** of:

- **Reduced OOPE and catastrophic health expenditure**
- **Decongestion of secondary and tertiary health facilities**
- **Risk factor mitigation** through health promotion and timely diagnosis
- **Improved population coverage** and equity
- **Increased cost-efficiency** (through prevention and promotion).
- **Improved health security**

(MoHFW 2018, 2022a, 2022b)

PHC forms the first level of healthcare with 'time to care' envisioned to be not more than thirty minutes from the farthest village.

(MoHFW 2022b).



	Primary Care	Secondary Care	Tertiary Care
Levels of health care	Initial contact with the community	Advanced level of care delivered by a specialist upon referral	Complete delivery of care and training from medical professionals
Complexity and specialisation	Low	Medium	High
Facilities	SC Primary Health Centres HWC	CHC SDH DH	Medical colleges
Nature of services	While health promotion, prevention, treatment, palliation and rehabilitation are supposed to be provided at all levels of care, health promotion and prevention are expected to form the greatest weightage of care provided at the primary care level.		

(MoHFW 2022a; USAID n.d.b)

What are the components of primary health care?

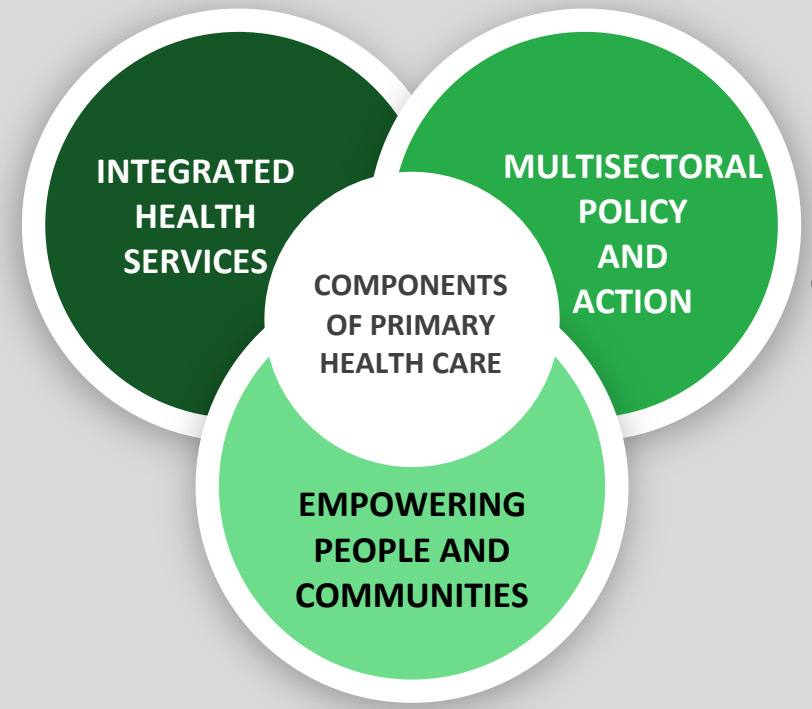
Comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout an individual's life with essential public health functions as the central elements of integrated health services

Systematic addressing of socio-economic, behavioural and environmental determinants of health through knowledge-based action across sectors

Accentuating their role as advocates of policies and as co-developers of services, both pertaining to their health and well-being, and as self-carers and caregivers

(WHO & UNICEF 2020)

Health systems built on the principles of PHC are essential to achieve UHC.



In order to make PHC **comprehensive and universal in India,** these areas of action are essential

- Strengthen institutional structures and organisation
- Improve access to technologies, drugs and diagnostics
- Increase utilisation of ICT
- Promote continuity of care for patient-centric services
- Enhance quality of care
- Focus on social determinants of health
- Emphasise community participation and address equity
- Develop a human resource policy
- Strengthen governance, financing, partnerships, and accountability

(MoHFW n.d.)

Desired Outcomes

- Improved **access, utilisation and quality**
- Improved **participation, health literacy and care seeking**
- Improved **determinants of health**

UNIVERSAL HEALTH COVERAGE

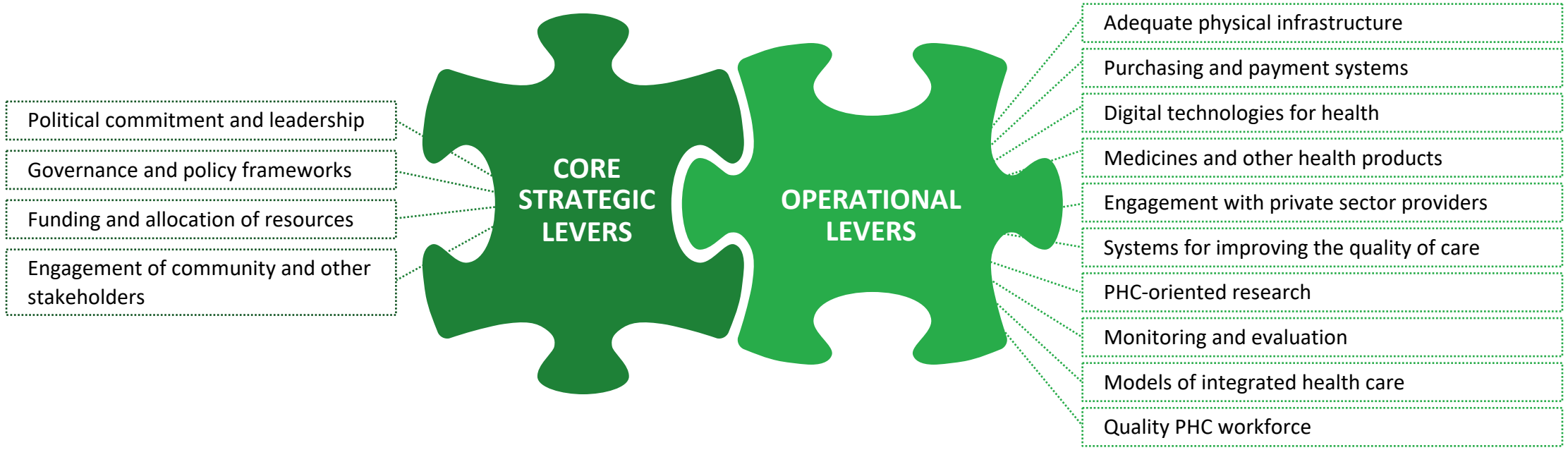
(Adapted from WHO & UNICEF 2020)

Core strategic and operational levers identify key elements of the health system that can be used to accelerate progress in PHC.

WHO's operational framework proposes fourteen levers that translate the commitments from the Declaration of Astana into actions and interventions. **There are two types of levers – Core Strategic Levers and Operational Levers.**

Core strategic levers are overarching for all operational levers **to provide effective PHC** (Lall 2020).

These levers are intimately **interrelated**, and **impact** and **enable** each other. They provide **practical, evidence-based actions** (Lall 2020).



Refer to the *Annexure* for details of each lever.

(WHO & UNICEF 2020)

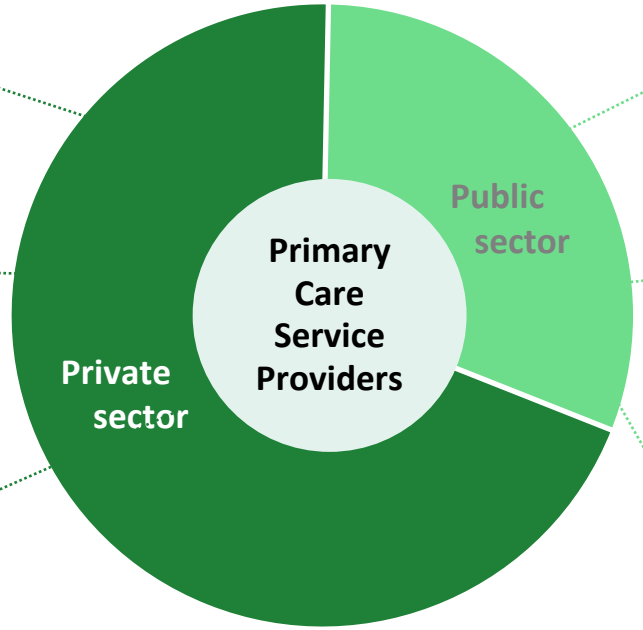
Despite a more comprehensive package of services by the public sector, the private sector provides over 70% of first-point care in India

(Chandani et al. 2017).

The private sector focuses on specialised care with secondary and tertiary care, without a tiered gatekeeping system for upward referrals based on need.

Private PHC predominantly caters to **urban populations,** and is highly **fragmented and unorganised,** with minimal regulations (USAID n.d.).

The private sector does not reflect the PHC approach, has no stated community-oriented responsibility, no focus on preventive health, no functional referral systems and often offers direct access to specialist care that can be inappropriate and expensive (Ugargol et al. 2023).



The **comprehensive package of services** offered by public PHC has no equivalent offering in the private sector.

Public PHC has a predominantly rural focus, and the design and delivery of primary care in the public sector are guided by the **Indian Public Health Standards (IPHS).**

Public dissatisfaction with primary care health services is also attributed to households opting to access private healthcare with the corresponding increase in OOPE, even among the poorer rural populations (Ugargol et al. 2023).

PHC as a gatekeeper ensuring efficiency and quality of care in a tiered system with well-established two-way referrals

In resource-limited settings, PHC can play the role of gatekeepers to ensure equity and reduce self-referrals, thereby improving the efficiency of doctors in secondary care and saving patients from overtreatment (Faizi et al. 2016).

However, PHC in India needs a well-functioning public health system that is sensitive to patient needs, avoids the over-burdening of higher referral centres and is structured to avoid 'direct access' to specialist care, thereby reducing inappropriate care, over-medicalisation, unnecessary diagnostics and catastrophic OOPE for PHC (Ugargol et al. 2023).

The Government is undertaking targeted initiatives for PHC in India.

Name	PHC Focus
Ayushman Bharat Health and Wellness Centre	• Moving from a selective approach to a comprehensive range of services, also leveraging telemedicine • 1,50,000 HWCs will be created to deliver CPHC
The National Commission for Allied and Healthcare Professions Act, 2021	• Regulates and standardises the education and practice of allied and healthcare professionals • Defines categories of allied and healthcare professions
IPHS Guidelines 2022	• Lays down essential and desirable standards for service provision, as well as a framework for implementation of IPHS, including CPHC provision at CHCs, primary health centres and SCs
Operational Guidelines FOR CPHC	• Serves as a framework for operationalising the multiple components required for CPHC delivery via HWCs
Ayushman Bharat Digital Mission	• Creates a national digital health ecosystem that supports UHC in an efficient, accessible, inclusive, affordable, timely and safe manner, including at the PHC level
National Health Policy 2017	• Calls for a move from selective to comprehensive PHC to achieve UHC • Advocates for allocation of upto two-thirds or more of the health budget to PHC
Pradhan Mantri Janaushadhi Pariyojana	• Provides generic medicines at affordable prices via Janaushadi Kendras with prices 50-90% lower than those in the open market
Aspirational Districts Programme	• A proportion of centres converted to HWCs and compliance of primary health centres with IPHS included in M&E of district performance, pushing for improved PHC delivery

Guidelines Programme Act Policy

However, outcome orientation is lacking and translation to action is ineffective.

Insufficient resourcing and lack of implementation

Despite the presence of policies and guidelines, translation of policy to action and ineffective implementation are critical challenges. There are state-level variations in the effectiveness of implementation and prioritisation of PHC. In India, conditional grant allocation from the centre to states for PHC results in states not receiving adequate funds and does not result in increase in effective use of funds (Hanson et al. 2022)

Lack of outcome-focused policies

Policies are largely input-focused and driven with a limited focus on outcomes and outcome metrics. While there is a target-based approach and mission mode for specific diseases, health planning in India is fundamentally input driven. While there is a recognition of the need to focus on outcomes, reflected in initiatives by the Niti Aayog to develop outcome frameworks for the health sector, this is yet to be reflected in policy and implementation (Mathur 2022).

Need for active customisation to reflect local needs

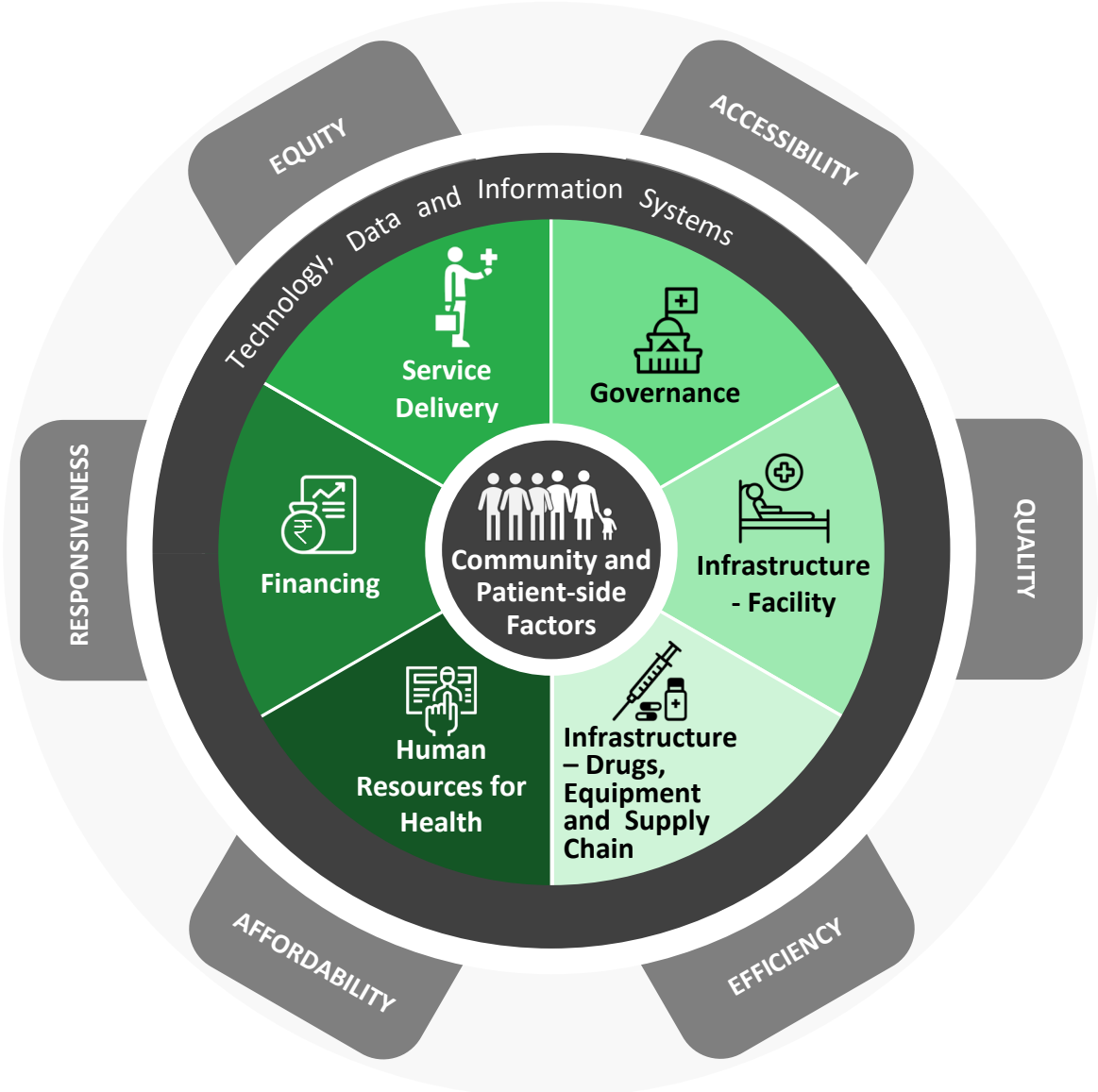
Effective PHC needs to adapt to the local and evolving needs of the population towards enabling user-centric care. Eg. Odisha not only effectively adhered to guidelines for implementation of the NLFEP but also adapted and tweaked the guidelines to address context-specific challenges, including targeted prioritisation and efforts as part of CPHC. This is not a uniform practice across states and facilities, and there is a need for a more proactive adaptation of PHC to reflect the needs, preferences, behaviours and practices of populations (Exemplars in Global Health n.d.).

Infrastructure-driven approach to PHC

While strengthening PHC is a focus of the government, with over fifteen thousand crore rupees for conversion of rural primary health centres and SCs into HWCs, over twenty four thousand crore rupees for UHWCs, and more than eighteen thousand crore rupees for diagnostics infrastructure for PHC in rural and urban areas announced in 2021, the focus is skewed towards infrastructure. With a disproportionately high focus and spending on infrastructure, challenges across other systemic levers in PHC persist (Ministry of Finance 2021).

CPHC FRAMEWORK: HEALTH SYSTEM LEVERS AND GUIDING PRINCIPLES

Health System Levers in the context of PHC



Note: WHO's framework recognises six building blocks of health systems, and the Alliance's approach to CPHC recognises six levers with the community at the centre. This framework combines and adapts both and additionally recognises patient-side factors at the core, and technology, data and information systems as factors applicable to all levers.

(Adapted from WHO 2010; USAID n.d.b)

Health System Levers
Cross-cutting Levers
Principles

Attributes of Health System Levers

Community and Patient-side Factors

Health-seeking behaviour, perceptions, consumption and uptake of services, self-care, and community engagement cut across all other systemic levers

Governance

Structures and accountability systems that finance, monitor, deliver and ensure the quality of PHC while also maintaining relationships across stakeholders at various levels in the ecosystem

Infrastructure - Facility

Facility-level infrastructure with amenities like water, electricity, adequate rooms, spaces and beds to enable outpatient and in-patient care, health messaging and IEC, diagnostics and dispensing of medicines and services

Infrastructure - Drugs, Equipment and Supply Chain

Infrastructure enabling availability, delivery and management of drugs and essential equipment, and logistics and supply chain management

Human Resources for Health

Availability, knowledge, skills, motivation, performance and deployment of the health human workforce responsible for organising and delivering health services

Financing

Mobilisation, accumulation, allocation and utilisation of money in the form of government expenditure, patient expenditure and monetary transactions in pursuit of health

Service delivery

Includes availability, readiness and provision of health services including the curation of a range of services, and the mode and quality of their delivery

Technology, Data and Systems

Use of technology for service delivery, digital solutions, databases, information systems and digitisation of any aspect of PHC cutting across all other systemic levers

(Adapted from WHO 2010)

INDIA'S PHC LANDSCAPE: THE STATE OF SYSTEMIC LEVERS

Current Status of PHC in India

Community and Patient-side Factors

Patient preferences skewed towards private sector facilities with inequities in access across regions

As per NSS 2018, 95% of healthcare users in both rural and urban areas seek allopathic care and only 5% of survey respondents (both rural and urban). have been found to seek care from other systems of medicine (Srinadh n.d.).

NSS data has also revealed a preference towards private facilities, with more than 2/3rds of outpatient care sought through them (Srinadh n.d.).

Governance

Strong focus on community-based monitoring and governance systems in addition to review mechanisms at other levels

VHSNC at the village level, JAS with representation from Panchayats and SHGs, and RKS are the institutional platforms envisaged to enable community ownership and accountability of PHC in facilities and also enable community participation (MoHFW 2022d).

Review mechanisms at village, block, district and state levels review data on PHC performance in the public sector. States also partner with NGOs to form and facilitate operations of community governance structures. (NHM n.d.; SNEHA n.d.).

Infrastructure - Facility

Significant commitment and resourcing to improve facility-level infrastructure

- India has 1,59,838 functional HWCs (as of 09.05.2023). including over 1.2 lakh SHC-HWCs, more than 23,000 PHC-HWCs, over 4,700 UPHC-HWCs and 7700+ AYUSH-HWCs (MoHFW n.d.c.).

- As of March 2020, only 3.4% of the 1.55 lakh SCs were functioning as per IPHS. Merely 13% of the 24,918 primary health centres and around 8% of CHCs adhered to basic standards (MoHFW 2022g).

Current Status of PHC in India

Infrastructure - Drugs, Equipment and Supply Chain

Strong focus on technology platforms to manage the supply chain for drugs and equipment

e-Aushadhi is a Drug and Vaccine Distribution Management System that facilitates procurement, logistics, finance, QA and other aspects (CMMS n.d.). with 9,038 approved manufacturers and 55 drug testing facilities (Ministry of AYUSH n.d.).

FPLMIS is an application enabling inventory management and monitoring of FP commodities from a national to the ASHA level, with an e-learning portal for it launched at the National Family Summit, 2022 (USAID n.d.c; MoHFW 2022f).

Financing

Inadequate financial resources and insurance coverage for PHC and high OOPE

High OOPE on health is impoverishing some 5.5 crore Indians annually with over 17% of households incurring catastrophic levels of health expenditure every year (Selvaraj et al. 2022).

Most insurance programmes only cover hospitalisation expenses for secondary and tertiary care. PHC coverage and ambulatory care etc. are largely absent (HTSP 2022).

Human Resources for Health

Significant shortages in HRH, with low prioritisation and aspiration to deliver in PHC

Over 80% of service providers in villages are in the private sector and over 60% are informal providers (Das et al. 2022).

Digital learning platform SAKSHAM hosts more than 200 public health and 100 clinical courses for training PHC cadres (MoHFW 2023a).

Assuming 80% availability of over 13 lakh registered allopathic doctors and 5.65 lakh AYUSH doctors, the doctor-population ratio in the country is 1:834 (MoHFW 2022c).

Current Status of PHC in India

Service Delivery

Expanded package of services are enabling community engagement through promotion, prevention and screening

14.40 crore people screened for NCDs via the CPHC NCD software and their records maintained in the NCD application (MoHFW n.d.b).

15.08 crore hypertension screening for 30+ year old individuals, as of 31st March 2022 (MoHFW 2022d).

Over 1.02 crore wellness sessions conducted at HWCs, as of 31st March 2022 (MoHFW 2022d).

Technology, Data and Systems

High prioritisation of use of technology and data systems for delivery and monitoring of PHC

CoWIN has over 100 crore registered users as of June 2023. It facilitated user registration, appointment booking, certificate issuance, as well as vaccine inventory tracking, and reporting for the government (MoHFW n.d.d.).

As of 31st March 2022, 2.43 crore teleconsultations were conducted via eSanjeevani at HWCs (MoHFW 2022d).

AMRIT, a platform for primary health interventions in resource-poor districts, currently serving 70+ lakh people (with an archived record base of 7+ crore data points). has enabled the vertical integration between FLWs, HWCs, and FRUs which creates a longitudinal view of health information (Nadhamuni et al. 2021).

Over 23 crore ABHA numbers have been issued and 1.14 Lakh health facilities registered in the Health Facility Registry (MoHFW 2022e).

BARRIERS IN PHC: CHALLENGES IN IMPLEMENTATION

Community and Patient-side Factors

Treatment-focused health seeking behaviour

- Consumers across income categories may undervalue and under-consume primary care, and may value expenditures on medicines more than they value advice that is offered to them (Mor 2020).

High provider switching behaviour

- Consumers have a higher willingness to delay accessing even the curative components of primary care, preferring to pay a larger amount for higher levels of care at the point when they experience a higher intensity of sickness (Mor 2020).
- Patients tend to switch between multiple service providers and across public and private sectors. The inability to identify quality providers or their lack thereof could be a reason for the behaviour (Mor 2020).

Complex determinants of health seeking behaviours

- Public health facilities are preferred for free-of-cost services whereas private practitioners are preferred due to their availability and perceived quality of care, resulting in a complex interplay of factors influencing user decision-making (Chauhan et al. 2015).

Gendered experiences in health seeking

- Women face challenges of access to PHC. 63% of married women cannot take decisions related to their health, and only half of the urban-dwelling women can freely visit a health facility alone (Asian Development Bank 2020).

Low acceptability among tribals due to discrimination

- There is often low acceptability of formal health services among tribal populations due to language barriers, exploitation and discrimination, thereby resulting in a preference to visit traditional healers (Pinto S.C 2011).

Governance

Uncoordinated governing bodies

- There are multiple agencies, parallel authorities, and uncoordinated action in the urban health context. Jurisdictions of stakeholders are overlapping, leading to administrative challenges and resulting in dysfunctional referral linkages established for UPHCs (Mishra et al. 2021).

Challenges in evaluating performance

- Disease-focused indicators currently used to measure PHC lead to skewed, incomprehensive evaluation and the commitment of PHC leadership to improve health outcomes is not measured (Lall 2020).

Unsatisfactory data-driven governance

- Lack of focus on integrated, adequate or quality data for planning, budgeting and management (Dandona 2022)

Large unregulated private sector

- Estimates suggest that over half of the providers in rural India are informal providers with challenges in quality, cost and measurement of care provided (Das et al. 2022).

Ineffective community governance structures

- Systems for implementing decentralised participatory governance like RKSs, JAS, VHSNCs, and more continue to function sub-optimally. There is inadequate delegation of administrative and financial powers, lack of transparency, weak organisational capacity and cohesion, poor awareness of roles and responsibilities and non-prioritisation of health agendas (Selvaraj et al. 2022).

Infrastructure - Facility

Shortfall of facilities

- There is a shortfall of 40% in the number of primary health centres in the country as per RHS as of March 2022 (MoHFW 2022g).
- There was a shortfall of 9,357 SCs and 1,559 primary health centres in tribal areas as of March 2022 (MoHFW 2022g).

Overburdened infrastructure

- SCs and primary health centres are stretched and overburdened, catering to 5,691 and 36,049 people respectively as per the RHS, well above the recommended population limits (MoHFW 2022g).

Overdependence on infrastructure

- Exclusive efforts to strengthen infrastructure will not result in an increase in the utilisation of services, in the absence of demand generation, outreach and health education efforts in communities, especially in areas where access is limited (Lahariya 2020).

Inadequate infrastructure

- In SCs in rural areas, more than 9% did not have a regular water supply, and over 11% did not have any electricity supply as of March 2022 (MoHFW 2022g).
- Only 74% of the primary health centres had at least four beds, and only 45% of them operated 24X7 as of March 2022 (MoHFW 2022g).

Infratructure - Drugs, Equipment and Supply Chain

Absence of equipment supply chain platforms

- Supply chain management systems such as e-Upkaran in Rajasthan have been shown to improve the upkeep of equipment in primary health centres in the state but such platforms do not exist for other states, and neither is there a nationwide implementation of the same (Bhardwaj et al. 2022).

Dated drug regulations

- The pharmaceutical regulation in India stems from an outdated Drugs and Cosmetics Act of 1940, with inconsistent and varied implementation across states. Inadequate resources and dual licensing authorities add to the difficulty of ensuring quality control for imported drugs (HSTP 2022).

High operational costs

- Supply chain costs are 15% higher in India compared to the best-in-class global pharmaceutical companies, which impacts the affordability of services key to delivering PHC (GS1 India 2022).

Inefficient inventory upkeep

- Primary health centres in many parts of the country fail to comply with IPHS guidelines in terms of the required inventory of their drugs and laboratory reagents (Sriram 2018). Lack of diagnostics and appropriate drugs at primary care facilities drives people to seek care at higher levels, leading to inefficiencies in the system.

Fragmentation across geographies

- Most drug suppliers operate in the core metropolitan areas and tier 1 and tier 2 cities, clustered across only a few economic zones with a limited pan-India coverage, creating challenges for last-mile healthcare providers across the country (GS1 India 2022).

Financing

Inefficient financing and expenditure

- While the NHP 2017 calls for two-thirds of the allocation to go to the primary care sector, there is a skewed focus of health expenditure towards secondary and tertiary sectors, resulting in insufficient financing for PHC. There is a lack of strong financial policy that leverages existing resources better (eg. private sector resources can be leveraged for PHC more efficiently through focused policy) (Lall 2020).

Over-reliance on out-of-pocket expenditure

- Household's OOPE on health is over ₹3 lakh crore accounting for 47.07% of total health expenditure, 1.54% of GDP, an ₹2,289 per capita (MoHFW 2020).
- India's high OOP spending — health spending through payments at the point of care — at almost 60% is one of the highest in the world. Over two-thirds of OOP spending is on account of outpatient consultations, medicines and diagnostic tests accompanying it (Sarwal & Kumar 2020).

Inadequate role of insurance

- There is a lack of schemes with outpatient coverage and an overall skew towards coverage of only non-primary healthcare services. The PMJAY, launched under the Ayushman Bharat programme is the largest health assurance scheme in the world, but it excludes primary care coverage from its purview (Ambade et al. 2022; National Health Authority n.d.).
- Financing primary care is as expensive to provide as are higher levels of care, however, families and individuals are willing to purchase insurance against high-cost-low-volume in-patient expenditures, they are less willing to pre-pay for the relatively lower-cost-high-volume primary care (Mor2020).

Human Resource for Health

Shortage of workforce

- There is a vacancy of more than 14% and 35% of HW (female)/ANM at SCs and primary health centres in rural and urban areas respectively, compared with the sanctioned posts as of March 2022. At primary health centres in rural areas, there was more than a 74% shortfall of health assistants (male and female) in 2022 (MoHFW 2022g).

Not aspirational for doctors

- Doctors often find little professional fulfilment in providing primary-level care services, even more so in public facilities where the services they can offer are extremely restricted, resulting in mismatched aspirations for doctors wanting to specialise and not focus on PHC (Ramani et al. 2019).

Rural-urban inequity

- Quality of skilled health workforce and locational distribution is skewed towards the urban healthcare facilities, leaving a dearth of providers in the rural last mile primary care (Selvaraj et al. 2022).

Overdependence on doctors

- Doctors are seen as central to the performance of the primary health centre to the extent that it often forms the basis for the entire facility's performance. Doctors are required to perform administrative tasks in low-resource settings accentuating the challenge of retaining them. Insufficient task sharing further exacerbates this problem resulting in ineffective population coverage (Sathyananda 2019).

Risk with qualification of rural clinicians

- National surveys indicate that up to 63% of clinicians practising in rural India have inadequate medical training (Rao et al. 2013).

Service Delivery

Specific curation of services

- Emphasis on vertical disease control programmes across PHC contributes to the lack of CPHC delivery. A top-down programme-driven mandate by states often restricts participatory approaches to care delivery, which is critical for primary care (Lall 2020).

Lack of respect and trust

- Poor client satisfaction with PHC in rural and urban areas stems from a lack of respectful care, including experiences with rude health workers who discriminate against women and minorities from scheduled castes or tribes (Pandve & Pandve 2013).
- Lack of trust between public sector providers and patients due to poor, low-quality care experience is an important factor in the poor uptake of services in public sector facilities (Lall 2020).

Limited customisation of service packages

- Localisation of care packages to meet the needs of the local population is lacking. Adoption and expansion of service packages by AB-HWCs are at risk of depriorisation in light of number-based targets for service delivery (Lahariya 2020).

Lack of focus on gatekeeping role

- PHC in India performs a very limited gatekeeping role, with high self-referrals, especially in urban areas and unavailability of quality service and absence of effective two-way referral systems (Faizi et al. 2016).
- Nearly 122 Indians per lakh population due to poor quality of care each year. Amenable deaths due to the use of poor-quality service in India are worse than in other LMICs like Sri Lanka, Nepal, Brazil, etc (Kruk et al. 2018).

Lack of poor quality care

- The research methods described above are often inadequate for quality measurement in hospitals, where the process of health care delivery is even more difficult to observe than it is in primary care settings (Mohanan et al. 2016).

Technology, Data and Information Systems

Structural weaknesses impeding expansion

- Multiple applications have been developed under national health programmes but currently, there is a limited role of HIS in enhancing the effectiveness of CPHC. Systems are proprietary-based, and the long-term sustainability and integration of these systems remain a challenge (Faujdar et al. 2019).
- Lack of interoperability, standardisation, fragmentation and scalability issues, limited configurability and weak security and privacy frameworks limit the potential of technology in advancing comprehensive PHC in India (Nadhamuni et al. 2021).

Limited convergence across applications

- ANMOL application is being used in 22 states for RCH. There is limited convergence and low interoperability leading to fragmented data. Efforts are being made to address this as part of ABDM (NIPI n.d.).
- HISs in the PHC space are technology-centric and do not centre around the needs of the user (Faujdar et al. 2019). and lack the configuration to support the heterogeneity of health systems across states (Nadhamuni et al. 2021).

Incongruence of solutions with user demands

- 193 million people in India do not have access to ICT devices and digital solutions today continue to face the challenge of inequitable access marginalising rural populations (Chatterjee 2022).

HARNESSING TAILWINDS: OPPORTUNITIES FOR ACTION

India is witnessing a growing body of solutions in PHC.

MODELS

Successful models have been established with evidence on impact in addressing challenges across one or many health system levers to enable effective primary care delivery across diseases.

Examples:

- Task shifting models in mental health (Centre for Mental Health Law and Policy n.d.)
- Tribal health initiatives using telemedicine models for last-mile delivery (Swasti Health Catalyst 2020)
- Kilkari mobile health education service for RMNCH (ARMMAN n.d.)

RESEARCH

Concerted efforts towards building rigorous research and evidence on PHC in India including evaluation of the effectiveness of existing models and generation of data on the existing landscape.

Examples:

- Research and analysis on the role of decentralisation in the country's health system in rural and urban contexts, evaluation of insurance scheme (HSTP 2023).

COLLABORATIVE INITIATIVES

Ecosystem collaboratives and initiatives to foster partnerships, cross-learning, sharing of good practices and enabling ecosystem dialogue on key issues.

Examples:

- Dynamic database of India's PHC landscape by USAID and Swasti (Swasti Health Catalyst 2020).
- Collaboratives leveraging technology towards UHC (Swasth Alliance n.d.)

INNOVATIONS

Innovations in the design and delivery of health systems for PHC in India, adapting to the evolving landscape needs and enabling greater impact.

Examples:

- Reimagining the cadres of community health workers (Chandani et al. 2017)
- Reimagining the role of AI and IoMT in India's healthcare system (PwC & Bengal Chamber of Commerce and Industry 2018)

(Swasti Health Catalyst 2020)

Tailwinds in the Global and Indian PHC Ecosystem

Moving beyond treatment to health prevention and promotion

- The Government of India has launched population-based screening of common NCDs at the community and PHC level for early detection and management recognising its importance (WHO 2021b).
- Social enterprises and innovations in the sector are providing preventive primary health services at affordable costs, leveraging technology for screening and testing, and addressing overtreatment (USAID n.d.a).

Ensuring gender-responsive PHC systems

- Global call towards formulating gender-transformative PHC policies and health professional regulations for women of all ages and at all stages of life that provide comprehensive care and deliver sex-specific, sex-aware, and gender-sensitive care (WHO n.d.b, Zephyrin et al. 2020).
- A growing body of evidence on women's autonomy and freedom of movement (or lack thereof). significantly influences health-seeking behaviour, with a growing adoption of a gendered lens to PHC in solutions across the globe (Nayak & Varambally 2017, UNIFEM 2009).

Digitisation of health at all levels, including PHC

- WHO member states including India have called for prioritising national investment in digital health in support of PHC and UHC in the short term (WHO 2021c).
- With India's G20 presidency, there is an emphasis on emerging technologies like AI, blockchain, 3D printing in medical device manufacturing, etc., to create a more holistic health ecosystem that improves health outcomes (MoHFW 2023b).

Recognition of linkages between climate change and PHC

- India's approach to health adaptation on green and climate-resilient healthcare facilities includes both retrofitting existing facilities and incorporating principles of resilience and "greening" new establishments across sub-centres and primary health centres across the country (MoHFW n.d.d).

Tailwinds in the Global and Indian PHC Ecosystem

Recognising the value of self-care

- Global recognition of self-care approaches plays a critical role in PHC, taking the form of self-testing kits for common conditions eg. monitoring blood pressure, testing blood glucose levels, and conducting urine analysis (WHO 2022).
- India has included self-care components in certain programmes indicating a recognition of its role in PHC. For example, the TB DOTS programme utilises ICT-based tools to ensure patients' continued compliance with their treatment (NTEP 2021). Or the use of tele-counselling to enable self-injectable contraceptive administration by DMPA users (Abt Associates 2021).

PHC's role in One Health and resilient systems

- PHC is envisioned to play an integral role in pandemic preparedness and integrated disease control against priority diseases of both human and animal sectors, with early warning systems built on integrated surveillance systems and response readiness, under the National One Health Mission (Principle Scientific Advisor n.d.).
- Outlined by NITI Aayog, India, the 2035 vision for public health surveillance envisions PHC playing a critical role in a predictive, responsive, integrated, and tiered system of disease and health surveillance (Blanchard et al. 2020).

Alternate forms of financing to build sustainable models

- Growing focus on the use of blended finance models to incentivise investments in PHC in underserved areas with an outcome focus, with a need to tailor approaches based on investment attractiveness and healthcare priorities of various regions (SAMRIDH Healthcare Blended Finance Facility 2022).

Remote monitoring as an efficient and effective mode of service

- RPM solutions have been gaining traction in India's private healthcare sector for treating chronic diseases, especially during and since the COVID-19 pandemic. As the cost of RPM systems decreases and awareness of RPM increases, it is likely to become an important part of PHC in India (CII 2017; Jain et al. 2022).

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ANNEXURE

CPHC Service package in AB-HWCs

Package of services (Expanded 12 range of services incorporated to achieve CPHC in HWCs).

1. Care in pregnancy and childbirth
2. Neonatal and infant health care services
3. Childhood and adolescent health care services
4. Family planning, contraceptive services and other reproductive health care services
5. Management of communicable diseases: national health programmes
6. Management of common communicable diseases and general out-patient care for acute simple illnesses and minor ailments
7. Screening, prevention, control and management of non-communicable diseases and chronic communicable disease like TB and leprosy
8. Basic oral health care
9. Care for common ophthalmic and ENT problems
10. Elderly and palliative health care services
11. Emergency medical services
12. Screening and basic management of mental health ailment

These services would be delivered at both SHCs and in the PHCs, which are transformed as HWCs.
The level of complexity of care of services delivered at the PHC would be higher than at the sub health centre level.

(MoHFW n.d.c).

Annexure B: Core Strategic Levers of PHC

Political Commitment and Leadership that recognises the importance of primary healthcare as a way to achieve Universal Health Coverage (UHC).

Governance and policy frameworks that partner within and across sectors, promote leadership and accountability within communities

Funding and allocation of resources to promote equity in access, provide a platform and incentive environment to enable high-quality care and services and to minimise financial hardship

Engagement of community and other stakeholders from all sectors to define problems and solutions and prioritise actions through policy dialogue

(WHO & UNICEF 2020).

Annexure C: Operational Levers of PHC

Models of care that prioritise high-quality, people-centred primary care and essential public health functions as the core of the integrated health services throughout the course of life.

Primary health care workforce of a requisite quality, quantity and includes distribution of a multidisciplinary primary healthcare workforce with facility, outreach, and community based workers that are effectively managed and sufficiently compensated

Physical infrastructure including safe health facilities with adequate and reliable water supply, sanitation, waste management, network connectivity and power supply and adequate transport systems

Medicines and other health products that are safe, effective, affordable, available and managed and administered transparently

Engagement with private sector providers for partnership between public and private sectors

Purchasing and payment systems that foster the reorientation in the models of care for the delivery of integrated services with primary healthcare at the core

Digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability

Systems for improving the quality of care at the local, subnational and national level to assess and improve the quality of health services

Primary health care-oriented research and knowledge management which includes dissemination of actionable insights, as well as the use of those insights to accelerate the scale-up of successful strategies to strengthen primary healthcare-based approaches

Monitoring and evaluation through information systems that generate reliable data and support actors at different tiers of administration

(WHO & UNICEF 2020).