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Review Article

Primary health care strengthening in India: Imperative to providing inclusive health care

Soumen Jana[1,*], **Debarati Chakraborty**[2]

[1] *Vidyasagar University, Midnapore, West Bengal, India*
[2] *All India Institute of Medical Sciences, Bhubaneswar, Odisha, India*

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ABSTRACT

The primary contributors to poor health are inequality and poverty. Access to adequate health care on an affordable and fair basis in many sections of the country remains an unfulfilled desire. Health care disparity is seen as a compromise. "Right to Life" To promote inclusion in health care, it is vital to define "essential health care," which should be made available to all residents. The best use of public resources and more public investment on healthcare are recommended solutions. It is suggested that strengthening capacity through training, particularly training paramedical staff, is a crucial component of cost reduction, particularly in tertiary care. Another component which is deemed highly significant is improvement in delivery system of health care. The improvement of preventive care and decrease in tertiary care costs will result from expanding the role of "family physicians" in the health care delivery system. These findings support the importance of primary healthcare and its function in providing inclusive healthcare. More access to necessary treatments, higher care quality, an emphasis on prevention, early management of health issues, and overall health gains and decreased morbidity as a consequence of primary health care delivery are all benefits of the primary health care paradigm for the delivery of health services.

1. Introduction

The British Government in India created medical services in the middle of the 18th century, principally for the benefit of British nationals, armed personnel, and wealthy government officials. Indigenous medical systems have been completely ignored. The services provided by general hospitals in major cities and commercial hubs were mostly curative. Yet, neither medical education nor health planning were based on the requirements of the general public. Due in great part to this pervasive Western bias, a small number of people have blindly adopted advanced modern medicine while disregarding the essential interests of the vast majority.[1]

The Government of India planned numerous options for health care delivery in independent India, bearing in mind constitutional requirements. The suggestions made by the 'Health Survey and Development Committee' (Bhore Committee) in 1946 lay the groundwork for the organisation of health services in India through primary health care.[1]

Throughout the last two decades, there has been rising concern about the performance of India's health-care delivery system. According to the Government of India's (GOI) National Rural Health Mission (NHRM) Document (2005), just 10% of Indians have some type of health insurance, and over 40% of Indians must borrow money or sell assets to fulfil their health care needs.[2] A single episode of sickness causes over 25% of Indians to fall below the poverty level. The Indian government implemented an inclusive growth policy during the 11th Plan, which was

* *Corresponding author*.
E-mail address: janasoumen45@gmail.com (S. Jana).

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continued in the 12th Plan.3 Inclusive growth entails the development of all segments of the population, including children, women, and other disadvantaged groups. India aims for inclusive growth in various areas, including education, health, energy and resources, telecom and technology, finance, and infrastructure.

In light of the current state of health care services in India, this article proposes strategies to promote inclusion in vital health care.

2. Indian Healthcare System Status

In India's poorest areas, maternal and infant mortality rates are higher than in Sub-Saharan Africa. With the highest burden of communicable illnesses in the world, India accounts for 21% of the global disease burden.[3–5] Over the period 2006-2015, India's predicted total loss of national income owing to noncommunicable disease mortality was USD237 billion.[6]

India is rated third among nations having a high prevalence of HIV infection.[7] Diarrheal illnesses are the leading causes of death in children under the age of five.[8] In India, many illnesses are caused by poor sanitation and a lack of clean drinking water.[9] Inadequate sanitation, along with a lack of access to basic necessities, significantly adds to the nation's health burden. About 50% of the population (638 million) defecates in the open because more than 122 million households lack toilets and 33% lack access to latrines.[10]

2.1. India's system of providing healthcare

The Indian health care industry, which is divided into three tiers: primary, secondary, and tertiary, is distinguished by the existence of numerous diverse health care delivery systems, including the government, not-for-profit, charity organisations, corporate hospitals, and smaller private clinics. There are no clearly defined forward or backward connections between these.[11]

2.2. Infrastructure for public health in India

It is severely underfunded, understaffed, and under equipped. In India, the urban population accounts for less than one-third of the overall population. In comparison to rural regions, allopathic physicians are more concentrated in cities (13.3 and 3.3 per 10,000 population, respectively). Nurses and midwives are equally clustered in cities (15.9 and 4.1 per 10,000 populations).[12]

The population density of allopathic physicians is 4.28 per 10,000 people.[13] In India, there are around 0.81 nurses for every allopathic physician, implying that there are more physicians than nurses. The nurse-to-doctor ratio is quite low in health-care systems. According to the 1993 World Development Report, the ratio of nurses to doctors should be more than 2:1 as a rule of thumb, with 4:1 or higher regarded more desirable for cost-effective and quality treatment. Nurses may provide many basic clinical care and public health services at a lesser cost than qualified physicians, particularly at the community level.

Just 12% of the 660,856 physicians registered in India work in the public sector.[14] According to the approach paper for the 12th five-year plan, 10% of doctor positions at primary health centres, 63% of specialist positions at community health centres, 25% of nursing positions at PHCs and CHCs combined, 27% of pharmacist positions, and 50% of laboratory technician positions are vacant in 2010.[14]

India, which ranks among the world leaders in the production of generic medications, has the greatest number of individuals who lack access to essential medicines.[8]

2.3. Unrestricted private health industry

Both urban and rural Indian households prefer to use the private medical sector over the governmental sector.[15] According to several surveys, the private health sector accounts for more than 70% of all primary care and more than 50% of all inpatient care.[15] The private health industry, on the other hand, is focused on curative care. Many reasons are given for depending on the private sector rather than the public sector; at the national level, the major cause is low quality of care in the public sector. Other main factors include the public sector facility's location, excessive wait periods, and inconvenient operating hours.[12]

At one end of the range are private hospitals with world-class facilities and people providing treatments that are reasonably priced when compared to equivalent services elsewhere but remain out of reach for the majority of Indians. On the opposite end of the spectrum, there is an unregulated private sector that is less expensive but provides services of uneven quality, typically by unqualified practitioners.

2.4. Expenses of health care

It has been noted that private health sector spending is growing while public health spending is decreasing. In India, public spending on health care is as low as 0.9% of GDP, compared to a total health expenditure of 5% of GDP, making public health expenditure 17% of GDP.[16] Reduced public health spending has had a negative impact on health outcomes.

The typical rural subcenter serves four settlements and has a service delivery radius of 2.61 kilometres. A comparison of the influences of access and economic status reveals that the latter is a more important factor of access to institutional delivery in rural India.[17]

2.5. Discrepancies between urban and rural areas

The 2011 Census shows that 377 million Indians reside in urban areas.[18] Rural regions see a greater rate of non-treatment due to "financial problems" and "lack of medical facilities" than metropolitan ones.[19] About 25% of the rural population and 75% of the urban population have access to piped water.[12] Just 20% of all hospital beds are situated in rural regions, despite the fact that 68% of Indians live in these areas.[12]Due to an imbalance in the distribution of specialists between urban and rural regions, as well as perceived poor quality health care services in rural areas, nearly two-thirds of patients in urban hospitals come from rural areas.[19] Half of the rural population remains impoverished, battling for improved and easier access to health care and services.[19]

According to the National Family Health Survey III (2005-06), the under-5 mortality rate among urban poor children is 72.7 percent higher than the urban average of 51.9 percent.[13] More than half of urban poor children are underweight, and over 60% do not obtain full vaccination before the end of their first year.[20]Slums' poor environmental conditions, along with high population density, make residents particularly prone to respiratory ailments such as asthma and tuberculosis.[21] The effect of disparities in access to health care has demonstrated that the infant mortality rate in the poorest 20% of the population is 2.5 times greater than that in the richest 20% of the population.[12]These statistics highlight the critical need of providing health care to the urban poor.

3. Disparities in Social Status

Children under the age of three in scheduled tribes and castes are twice as likely as children in other groups to be malnourished.[22]

In light of the aforementioned discussion of the state of health care services in India, the following measures for fostering inclusion are proposed:

Inclusive is a phrase that is frequently used in the context of expansion to denote 'wide-ranging' or 'all-encompassing.' In the context of health care, 'inclusive' indicates that health care is available to all segments of society. In India, this entails providing health care to the whole population of almost 1.2 billion people. While achieving "complete health care" for everyone is a pipe dream for any society, we must consider giving primary and, if feasible, secondary health care to all.

3.1. Defining necessary medical treatment and health education regarding the standard of care

Although it is very tempting to consider every component of health care to be crucial, one must keep in mind the harsh realities of economics. Thus, it is necessary to educate the general public on the difference between desirability and essentiality. The necessary services to which every person may be entitled include basic health care services, which may be described and classed under that heading. There is no doubt that primary and preventive healthcare is crucial. Health education that focuses on illness prevention via awareness and knowledge about treatment options must also be regarded as necessary health care.

4. Improving Capacity

The technical proficiency and abilities of individual health professionals, their motivation to execute their professions, and their capacity to cover a variety of socioeconomic groups and geographic locations are all significant factors that affect the operation of the health system and population health. There is a severe scarcity of health care workers. Having an appropriate health workforce in terms of both numbers and skill mix is crucial for nations such as India that want to make significant progress towards meeting the Millennium Development Goals for health. Current research indicates that increased availability of health professionals is connected with improved service usage and health outcomes such as vaccine coverage, primary care outreach, and newborn, child, and mother survival.[23] 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 that allows them to use their skills effectively, adequate remuneration, and opportunities for skill upgrading and refreshing.

More broad-based training programmes are needed to develop the second tier of health care workers, such as Physician Assistants, Medical Technologists, and Nurse Practitioners, so that doctors may devote their abilities to more difficult jobs. This is not to be interpreted as a loss of quality. Multi-skilling, which allows paramedics to conduct duties within their ability but outside of their typical professional roles, may be seen as a way forward in enhancing system efficiency.[24] Consultants frequently find up looking at ordinary health problems that might have been readily addressed by a well-trained second-rung paramedic or a good nurse, lowering treatment costs while improving outcomes.

4.1. Enhancing the health-care delivery system

There are several advantages to receiving health care from designated primary care physicians or family physicians. This will lower the expense of long-term care and assist patients in deciding the necessity for needless expensive therapy.[25] Areas with superior primary care will have better health outcomes, including lower total death rates, lower heart disease mortality rates, and lower newborn mortality rates, as well as early identification of malignancies such as colorectal cancer, breast cancer, and uterine/cervical cancer.

We must guarantee that all urban slums and settlements are served by NUHM subcenters, ICDS centres, and PHCs. The continued efforts to integrate AYUSH and increase the competence of other traditional health care practitioners, such as Registered Medical Practitioners (RMPs), must be strengthened.

Because the density of health professionals in India is fewer than the WHO requirement of 2.5 employees per 1000 people, policy actions are needed to enhance the density of health workers, particularly in rural regions and economically deprived states. Just 193 of the 640 districts have medical colleges; the remaining 447 districts do not have any medical institutions. Furthermore, the present instructional capacity for training paramedics is woefully inadequate. We need to enhance the number of medical colleges in each district. New medical and nursing colleges should ideally be linked to district hospitals in underserved states and districts, with districts with populations of 25 lakhs or more preferred for the construction of such colleges if they do not already have them. The actions done by India's Medical Council in this respect are applaudable.

4.2. Increasing the effectiveness of the public sector

Instead of the commercial sector, the public sector must take the lead in the health sector. Only until the impoverished and oppressed classes receive better treatment will inclusive health care be secured. If adequate illness treatments are not accessible in the government sector, we must find ways to treat impoverished patients at discounted prices in private institutions. In order for this to happen, the public and private sectors must work together to provide inclusive health care to the people. One such element is care quality, and a local collaboration between public health institutes and state health services might go a long way towards eliminating quality gaps.

Public funding for health care does not always imply that the service is provided by public providers. It is feasible to have public financing while the service is supplied by private sector participants, subject to adequate regulation and control. A number of trials are presently in existence that allow for private sector engagement. At the national level, the Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance plan offered to the poor and other identified target groups. Partnerships are the keyword in public health, and our tactics must keep up.

4.3. Raising government expenditure on health care

India's public spending is far lower than that of wealthy countries, not just in absolute numbers, but also as a proportion of GDP.[26,27] The recent decision by the Government of India to boost health expenditure to 2.5% of GDP by the conclusion of the Eleventh Five-Year Plan (2012-17) from the present 1.4% is excellent news for the industry.[14] The government must invest more in health-care infrastructure development. Yet, we must prioritise our goals for government expenditure. Something as simple as providing good sanitation and clean drinking water to all of its residents, particularly small children, should be prioritised. Primary prevention and enhanced health education have been shown to reduce death and morbidity.[28] The next priority for government spending should be universal primary health care. These are diseases for which competent outpatient treatment may be able to avoid the need for hospitalisation, or for which early management may be able to prevent complications or more severe illness.[29] Unnecessary hospitalisations are avoided with high-quality primary care.[30] As a result, health-care expenses would be reduced. The primary care setting must be strengthened in order to provide inclusive health care.[31]

4.4. lowering the price of extortionate tertiary healthcare

Hospitals must prioritise the distribution of available capital as a group. It is critical to close the gap in access to high-quality health care between the affluent and the poor in order to avoid societal unrest.

4.5. Monitoring national health programmes efficiently

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. are just a few of the government's programmes that have been implemented to promote inclusive health care. Within health delivery systems, we need creative management changes.

It is necessary to reorganise health initiatives like the Integrated Child Development Program (ICDS). While the age group 0-3 years has the highest need for nutritional support, it mostly focuses on kids in the 3 to 6-year-old range who actually attend Anganwadis.

4.6. Community engagement

The ability of a community to engage in the design and implementation of services has an impact on the success of a health care system. The capacity to design and manage such delivery empowers the community while also improving access, accountability, and transparency. Essentially, health care delivery has to become more collaborative and inclusive.

This can be accomplished in three ways: (1) strengthening Panchayat Raj Institutes through improved devolution and capacity building for better design and management, (2) increasing user participation through institutionalised audits of health care service delivery

for better accountability, and (3) biannual evaluation of this process by empowered civil society organisations for greater transparency. Methods based on community-based monitoring, which have proven effective in some regions of the nation, will need to be implemented in others.

The organised private sector provides almost little health care at the primary level, highlighting the necessity for substantial public resources to develop a public sector health system.

5. Source of Funding

None.

6. Conflict of Interest

None.

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Author biography

Soumen Jana, Research Article https://orcid.org/0000-0003-2380-9884

Debarati Chakraborty, Medical Social Work

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