Primary Healthcare in India: Challenges and Way Forward

Prof. M. Hanumantha Rao
Senior Fellow, ICSSR, Department of Sociology, Sri Venkateswara University, Tirupati

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ABSTRACT: *The scope and emphasis of primary healthcare programs are necessarily influenced by the changing characteristics of the population. The rate of population growth affects the planning of community health and medical facilities. Changes in age composition, internal migration of racial or industrial groups, alterations in population density and increases in urban populations require adaptation of the health program to solve the new problems thus created. Primary healthcare is an essential strategy that remains the backbone of health service delivery in India. To bolster the existing public health services and augmenting a strong referral system, corrective measures are in order. Well-intended efforts for the expansion of physical infrastructure over the decades have not witnessed a commensurate rise in service utilization in the government facilities. Quality of care needs to be improved. A local partnership between public health institutes and the state health services could go a long way toward addressing quality shortfalls*

Key Words*: Primary health care; age composition; community health; Referral system; Infrastructure;*

A strong primary health care system is central to improving the health of any nation. It is also crucial in tackling the inequalities in health. Today we face unprecedented growth and changes in the world populations as well as increase in the vulnerability to disease and disability as inequalities widen.

The scope and emphasis of primary healthcare programs are necessarily influenced by the changing characteristics of the population it serves. The rate of population growth affects long-range planning of community health and medical facilities. Alterations in age composition, internal migration of racial or industrial groups, changes in population density and increase in urban populations require adaptation of the health program to solve the new problems thus created. Among the various characteristics of recent population trends, aging of the population is one of the most fundamental in its bearing on national health.

Six basic principles can be identified in the Primary Healthcare approach:

- It should be accessible to all and cover all people in a society
- It involves community involvement
- It encompasses both curative and preventive dimensions of health
- It should coordinate care across service areas
- Develop effective primary healthcare workforce
- It should be cost effective to address the disadvantaged sections in a society

Primary healthcare is an essential strategy that remains the backbone of health service delivery. India was one of the first countries to recognize the importance of primary healthcare approach. Long before the Declaration of Alma-Ata, India adopted a primary healthcare model based on the principle that inability to pay should not prevent people from accessing health services. Since Independence India focused on providing health services to rural masses. Community Development Programme was launched in 1952. It was envisaged as a multipurpose program covering health and sanitation through establishment of primary health centers (PHCs) and sub-centers.

As per 2011 census, India's population is more than 121 crores of which 83.3 crores (68.84%) live in rural areas (Rural Health Statistics in India, 2011). In 2017 the estimated population of India is 133.92 crores. It means that we have added 12.92 crore persons in the six years since, with an addition of 2.12 crores per annum.

Delivering quality primary care to such large populations is always challenging. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies continue to be important causes of deaths. Noncommunicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are showing the rising trends. The health issues related to elderly population are on the rise due to increase in life expectancy. India has been witnessing rapid urbanization particularly in recent decades. Currently one-fourth of the urban population lives in slums with severely compromised health and sanitary

conditions. While the primary healthcare system is struggling to provide services, there is an emerging need for addressing above mentioned issues. This presents huge challenge to the primary healthcare system in India (Kumar, Kaur and Jha, 2009).

Healthcare Infrastructure

The healthcare infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:

Sub-Centres (SCs)

The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker MPW(M). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Department of Family Welfare provides 100% Central assistance to all the Sub-Centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the State Governments. In India there were 1,56,231 Sub Centres as on 31st March, 2017. The top 5 States/UTs in terms of highest number of Sub Centres in India as on 31st March, 2017 were Uttar Pradesh, Rajasthan, Maharashtra, West Bengal and Bihar. There is significant increase in the number of Sub Centres in the States of Rajasthan (3894), Gujarat (1808), Chhattisgarh (1368), Karnataka (1238), Jammu & Kashmir (1088), Odisha (761), Tripura (448), Madhya Pradesh (318) and Kerala (286).

Primary Health Centres

PHC is the first contact point between village community and the Medical Officer. The PHCs are envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive, curative and promotive aspects of healthcare. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. There were **25,650** Primary Health Centres in India as on 31st March, 2017. At the national level, there is an increase of 2414 PHCs by 2017 as compared to those that existed in 2005. Significant increase is observed in the number of PHCs in the States of Karnataka (678), Assam (404), Rajasthan (366), Jammu & Kashmir (303) and Chhattisgarh (268) and Bihar (251).

Community Health Centres (CHCs)

CHCs are being established and maintained by the State government under MNP/BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, labour room and laboratory facilities.

It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

As on 31st March, 2017, there were 5,624 CHCs functioning in the country. Significant increase is observed in the number of CHCs in the States of Uttar Pradesh (436), Tamil Nadu (350), West Bengal (254), Rajasthan (253), Odisha (139), Jharkhand (141), Kerala (126), Gujarat (91) and Madhya Pradesh (80).

Number of CHCs functioning in government buildings has also increased during the period 2005-2017. The percentage of CHCs in Govt. buildings has increased from 91.6% in 2005 to 96.7% in 2017.

In addition to 4,156 Specialists, 14,350 General Duty Medical Officers (GDMOs) are also available at CHCs as on 31st March, 2017. There is huge shortfall of surgeons (86.5%), obstetricians and gynaecologists (74.1%), physicians (84.6%) and paediatricians (81%). Overall, there is a shortfall of 81.6% specialists at the CHCs vis-a-vis the requirement for existing CHCs.

First Referral Units (FRUs)

An existing facility (District Hospital, Sub-divisional Hospital, Community Health Centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU:

- Emergency Obstetric Care including surgical interventions like caesarean sections;

- new-born care; and
- blood storage facility on a 24-hour basis.

At present there are 3, 076 FRUs functioning in the country. Out of these total 94.2% of the FRUs are having Operation Theatre facilities, 96.3% of the FRUs are having functional Labour Room while 68.9% of the FRUs are having Blood Storage/ linkage facility.

Health Infrastructure in PHCs

1) ***Availability and Adequacy of facilities***

Almost all the PHCs do not have essential facilities like well-equipped operation theatre, labour room, observation ward, two quarters, generator, drinking water, ambulance and lady doctor that were required to be created in each PHC. The facilities in PHCs are very poorly maintained. Almost no PHC is equipped to perform institutional deliveries. Among the requisite facilities, the post of lady doctor for attending on delivery cases is envisaged to be most essential, but most PHCs do not have a lady doctor. Though, a few facilities like labour rooms, operation theatres and observation wards are available in many PHCs, such facilities are not utilised for attending delivery cases without the availability of lady doctors. This mis-match between the manpower and essential facilities is a matter of serious concern. Ambulances seem to be a little more commonly available than other facilities (Programme Evaluation Organisation, Planning Commission, 2001).

2) Availability of Man-power

Though doctors in PHCs may be available, absenteeism among the doctors from their work-places is very high. This is a constraint in the utilisation of health care services in PHCs (Programme Evaluation Organisation, Planning Commission, 2001).

3) Population Coverage

Adequate number of PHCs have not been established against their requirement. This not only affects the quality and delivery of health care services adversely, but also accentuates the problem of overcrowding in CHCs and district hospitals (Programme Evaluation Organisation, Planning Commission, 2001).

4. Utilisation of Medical Services

In the absence of doctors, the cases coming to PHCs are attended by para-medical and auxiliary para-medical staff. Many PHCs are not equipped with diagnostic facilities because of which the patients prefer to visit tertiary/district hospitals for treatment of their ailments (Programme Evaluation Organisation, Planning Commission, 2001).

While the service utilization of PHCs takes a nosedive, there is a considerable increase in the utilization of private facilities for outpatient care in rural (78.0%) and urban (81.0%) areas (Bahuleyan Nair and Durairaj, 2007). The utilization of government facilities for inpatient care also declined from 60% in 1986-1987 to 40% in 2004 (Bahuleyan Nair and Durairaj, 2007).

We need to explore and understand the reasons that prompt people to visit private health facilities and the reasons driving them away from free government care. Ubiquitous absenteeism, low client-provider interaction, poor referral systems, and a low perceived quality of care might be the possible reasons for this situation.

Patient satisfaction represents a key indicator of the quality of healthcare delivery and this internationally accepted factor needs to be studied repeatedly for smooth functioning of the healthcare systems (Prasanna, Bashith and Sucharita, 2009). A better appreciation of the factors pertaining to client satisfaction would result in implementation of custom made programs according to the requirements of the patients, as perceived by patients and service providers (Iftikar and Sirajud, 2010).

It has been observed that there is poor level of client satisfaction in rural as well as urban areas of India regarding primary healthcare services. Client satisfaction is an important measure of the quality of healthcare and needs to be addressed in order to improve the utilization of primary healthcare services. Patients often complain of rude and abrupt health workers that discriminate against women and minorities from scheduled castes or tribes (Patel, 2014)

The current primary healthcare infrastructure and manpower not keeping pace with the growing population and are largely deficient. According to Rural Health Survey (RHS) 2011, as on March 2011 there are 148,124 sub-centers; 23,887 PHCs; and 4,809 community health centers (CHCs) functioning in India. The norms set for the population coverage for subcenter, PHC, and CHC for plane areas are 5,000; 30,000; and 120,000; respectively.

As per Rural Health Survey, 2011 the average population covered by a subcenter, PHC, and CHC was 5,624; 34,876; and 173,235; respectively. As on March, 2011 the overall shortfall in the posts of health

worker(female (F))/auxiliary nurse midwife was 3.8% of the total requirement. For allopathic doctors at PHCs, there was a shortfall of 12% of the total requirement for existing infrastructure as compared to manpower in position. Similarly, in case of health worker (male (M)), there was a shortfall of 64.7% of the requirement. In case of health assistant (female)/lady health visitor, the shortfall was 38% and that of health assistant (male) was 43.3%. For allopathic doctors at PHC, there was a shortfall of 12% of the total requirement. As compared to requirement for existing CHC infrastructure, there was a shortfall of 75% of surgeons, 65.9% of obstetricians and gynecologists, 80.1% of physicians, and 74.4% of pediatricians. Overall, there was a shortfall of 63.9% specialists at the CHCs as compared to the requirement for existing CHCs (Rural Health Statistics in India, 2011).

Challenges for Primary healthcare and the way forward

Considering the population norms for PHC of 30,000 in plane areas (here the population norms for PHC of 20,000 for tribal and hilly areas is not considered), India requires more than 27,700 PHCs. So there is a deficiency of more than 3,800 PHCs. There is urgent need to address inadequate infrastructure as well as manpower for better service and delivery of primary healthcare. Only after addressing these issues we can think of applying Indian Public Health Standards to all healthcare infrastructures. The current primary healthcare structure is extremely rigid, making it unable to respond effectively to local realities and needs. The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary healthcare system (Patel, 2014). There is a need to explore and understand the reasons that prompt people to visit private health facilities and the reasons driving them away from free government care. Ubiquitous absenteeism, low client-provider interaction, poor referral systems, and a low perceived quality of care could emerge as possible reasons for this situation (Zopey, 2010). Large diversity in India calls for local adaptation of the basic healthcare package and its delivery mechanism. The question confronting health systems in India is how best to reform, revitalize, and resource primary health systems to deliver different levels of service aligned to local realities, ensuring universal coverage, equitable access, efficiency and effectiveness, through an empowered cadre of health personnel. To encourage accountability, access should be monitored at district level by an independent agency (Kumar, Kaur and Jha, 2009).

There is growing need of research in improving the service delivery of primary healthcare. Qualitative research into this area could yield lessons for the delivery of future services. Research into factors influencing service utilization could lead us to developing a public health marketing strategy for care access.

A conjoint effort by the state and the institutes can thus be used to reinvent primary healthcare and bring it to the forefront. Several opportunities can be explored within the facilitating atmosphere of National Rural Health Mission (Carter, Shaw and Macfarlane, 2002).

The success of health systems lies in tapping the existing potential and making appropriate structural changes. The role of primary care should not be defined in isolation but in relation to the constituents of the health system. The Millennium Development Goals (MDGs) which include eight goals were framed to address the world's major development challenges with health and its related areas as the prime focus. In India, considerable progress has been made in the field of basic universal education, gender equality in education, and global economic growth. However, there is slow progress in the improvement of health indicators related to mortality, morbidity, and various environmental factors contributing to poor health conditions. As rightly mentioned by Nath, even though the government has implemented a wide array of programs, policies, and various schemes to combat these health challenges, further intensification of efforts and redesigning of outreach strategies is needed to give momentum to the progress toward achievement of the MDGs (Nath, 2011)

India's progress towards achieving MDGs is slow and it is evident that role of primary healthcare is essential in the progress towards achieving them. It is essential that the challenges for primary healthcare system in India need to be addressed effectively to achieve the MDGs.

The public health benefit of preventive medicine cannot be over emphasized. The rising morbidities clearly showed that a regular, complete health checkup should be embedded in the essential elements of the primary healthcare (Agarwal, Verma and Kotwal, 2011).

To bolster the existing public health services and augmenting a strong referral system, corrective measures are in order. Public health practitioners need to adopt a wider role in this regard. An increased synergy between the public health institutions engaged in teaching and training with the state health services would be mutually beneficial to both groups. The absence of a formal health area under the direct responsibility of a medical college should not be a barrier to this partnership. The first steps can be the provision of technical support from the public health institutes to the state services. This partnership can have three positive implications for the states: provision of technical support, temporary availability of staff

with high visibility in the community, and establishment of a strong referral linkage between the public health institute and the neighboring districts. The Indian Public Health Standards (IPHS) provide the benchmark for the quality of service provision in health centers. Public health institutions can participate by supporting the districts in adhering to these standards. The public health institutes and medical colleges will have an opportunity to step out of the proverbial ivory towers of disease and recognize and address true community concerns. A conjoint effort by the state and the institutes can thus be used to strengthen primary healthcare and bring it to the forefront. Several opportunities can be explored within the facilitating atmosphere of NRHM.

Efforts for the expansion of physical infrastructure over the decades have not resulted in a commensurate rise in service utilization in the government facilities. Research into factors influencing service utilization could lead us to developing a public health marketing strategy for access to primary healthcare institutions. 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 (Zodpey, 2010).

Conclusion

The spirit of primary health care has been reduced to just primary level care. The concentration on building the health services lacks a sense of integration. The importance of a strong referral system is not recognized. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The multi-sectoral approach that is much needed and the inter-sectoral linkages that are essential for a vibrant health system have been neglected. A holistic approach to primary healthcare is missing. Low budgetary allocations for health sector are not the only reason for the poor performance of the primary healthcare institutions. The framework, design and approach to primary healthcare have to be revamped.

Raising awareness about health and enhancing popular participation should be emphasized. Close monitoring of the inequities in the delivery of health care at the local level should be addressed. A massive human resource development in the health sector is the need of the hour.

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