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Editorial

Designing primary healthcare systems for future in India

Abstract

Changing epidemiology, rapid urbanization, and rising expectations of populations are creating new challenges and opportunities for India's primary healthcare system. A group of primary care experts, practitioners, and researchers got together to design key elements of primary healthcare models for the future that would address these challenges and make use of emergent opportunities in rural and urban India. Based on experiences and evidence from India and across the globe shared in the consultation, the article lays out a vision and components of India's primary healthcare for future. It provides answers to questions such as how will healthcare be financed and organized, what mechanisms will assure quality of services, who will provide primary healthcare, and what role will technology have. Finally, it provides an agenda for primary healthcare practitioners and researchers to translate this vision into action.

Keywords: India, primary healthcare

Evidence from across the world shows that countries that have a strong primary healthcare system have better health outcomes, lower inequalities, and lower costs of care. Increased investments in primary healthcare in India between the years 2005 and 2015 led to equitable improvements in health-related behavior and coverage of preventive interventions. However, access to curative care and out-of-pocket expenses on healthcare remain more or less static.

Indian primary healthcare system in rural areas, consisting of a network of primary health centers (PHCs) and community health centers, was designed almost seven decades ago, based on Bhore Committee recommendations. National Rural Health Mission infused newer flexible resources and redesigned some elements – creating the cadre of community volunteers (ASHAs), setting up an assured referral transport (108) and enhanced community engagement through Village Health and Sanitation Committees and Rogi Kalyan Samitis. National Health Policy 2017, and subsequently launched Ayushman Bharat aim to expand the scope and reach of primary healthcare through a network of 150,000 Health and Wellness Centers.

Changing epidemiology, rapid urbanization, and rising people's expectations are creating new challenges for India's primary healthcare system. Fragmentation of healthcare system in multiple programs and schemes limits its impact on promoting health and wellness of the populations it serves. On the other hand, innovative ways of delivering and financing healthcare and a greater understanding of need for integrated systems are creating new opportunities. It is now imperative to develop new designs for delivering integrated and comprehensive healthcare that address the arising challenges and make use of the emergent opportunities.

Health System Transformation Platform (HSTP), in partnership with Basic Health Care Services (BHS), Post-Graduate Medical Education and Research (PGIMER), Chandigarh and Access Health International, convened a consultation to arrive at a common understanding of primary healthcare and its principles, and to identify key issues and elements of primary healthcare models for the future. The workshop also hoped to connect a group of like-minded professionals who work collectively to design, implement, and evaluate such models. Over 40 practitioners, academicians, trainers, financing experts, and health technology experts from various institutions participated and shared their expertise and insights.

The following section draws from the presentations and discussions in the consultation and articulates a vision and components of primary healthcare of the future. It presents the paradigm and critical design elements of primary healthcare models of the future. It ends with an agenda for primary healthcare organizations and researchers to enable the vision of robust and equitable primary healthcare systems of the future.

Key attributes of Primary Healthcare

The participants identified the following attributes of primary healthcare that will stay relevant for future models [Box 1]:

Paradigm Shift

The primary healthcare models will move from the current paradigm of reactive care to proactive care, and from fragmented to integrated and accountable care. This will require a cultural shift from hospital- and physician-centric to person- and population-centric care. Such shift will strongly integrate public health functions with primary care. Primary healthcare models of the future will empanel a defined catchment, stratify the population by risk, and will be responsible for providing comprehensive care to that population.

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Box 1: Key attributes of primary healthcare

1. Delivers care closer to the community, within 30 min of walking from home
2. Is the most accessible arm of the system
3. Provides cost-effective and comprehensive care (preventive, promotive, and curative) but with a focus on screening and primary and secondary prevention
4. Ensures person- and population-focused rather than disease-oriented care
5. Is universal in reach and meets the needs of the most marginalized people
6. Is integrated with advanced levels of care
7. Empanels the catchment population, assesses risk of individuals, and delivers care according to need
8. Integrates information systems that enable continuity of care and timely public health action
9. Most importantly, impacts health and wellness of the catchment population

In urban areas, migrant populations will constitute a much larger proportion, and primary healthcare models will become migrant-friendly: flexible timings, outreach to work locations, portability of insurance and other entitlements, and active linking with the tertiary care will be some features of such models.

Organizing Healthcare

Populations will be serviced by a network of family health units (with different names), each of them being responsible for an empanelled catchment population. Moving ahead, there are likely to be two parallel running paths: these family health units would be funded and managed by government, or a group of professionals will be engaged by the government to provide services to a defined population. In urban areas, where there is limited government infrastructure, and greater availability of private providers, there would be a tilt toward the latter.

Scope of Services

The scope of primary care services will continue to include preventive, promotive, and primary curative services. However, they would need to enhance their focus on screening and prevention of diseases, thereby decreasing costs and improving health outcomes.

Changing epidemiology of disease burden in India necessitates expansion of scope of services to include prevention, screening, and management of noncommunicable diseases, mental health, and palliative care. However, in view of continuing high and unacceptable levels of disease and death burden due to communicable diseases such as tuberculosis and maternal-newborn conditions, primary healthcare systems will need to be equipped to deal with this double burden. Availability of diagnostics for screening and early detection will be important to play this role.

To become proactive, and to provide continued care, clinic-based services will be well-supplemented with home-based and outreach services, which will also be opportunities for health promotion. In urban areas, in view of high levels of workforce engaged in potentially hazardous occupations, urban primary services will need to have a capacity to detect and manage occupational health conditions.

Finally, it will be critical for these primary healthcare systems to play an active role in linking those who need it, with advanced levels of care.

Human Resources for Primary Healthcare

Human resources are the most critical resources for delivering primary healthcare and though increasingly enabled with technology, will remain so. Nurses and community health workers will play an increasing role in service delivery and would need to be empowered and skilled to do so.

The reliance on a standalone provider, such as a physician, will move to a multidisciplinary team that will, at the least, consists of a family physician, nurses, and community health workers. Nonphysicians such as primary care nurses will play an increasingly critical role. A care coordinator will be crucial to provide comprehensive care and integrate various primary care functions and to plan continued care. Depending on the need, for services such as dentistry and palliative care, there will be a requirement of other professionals in the ecosystem, such as physiotherapists and dentists. There will be need for a much larger cadre of suitably trained primary care physicians and primary care nurses to lead the primary healthcare teams. Family physicians and nurse practitioners are likely to fill that role.

Innovative ways of motivating, training, and mentoring primary healthcare teams will be crucial to optimize performance. Large numbers of training sites will be required to train large numbers of primary care professionals. The PHC teams will be skilled in management and coordination functions, as much as in clinical skills. Continued training and mentoring will be instituted to ensure maintenance and upgrading of skills. Technology will enable large-scale continued training.

Quality of Care

Reducing the norms of a physician to population (from the current 1:25,000 in public systems) will mean more time and attention per person and would lead to improved quality. Besides this, an

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integrated health management information system, which may be as simple as well-designed Excel sheets, will enable quality and continued care. Quality improvement of primary healthcare will also be contingent on improving quality of secondary and tertiary care to provide referral care. One of the ways to do so, as in the case of National Capital Territory of New Delhi, is to take primary care out of hospitals into community-based outpatient clinics, thus unburdening the hospitals to provide quality secondary and tertiary care.

Delivering primary healthcare with quality will require standardization of care protocols (including for referral), incentives based on high-quality care, external audits to measure performance, and continued medical and nursing education. Expanding the assured availability of drugs and supplies will be crucial to maintain quality. Primary care services will need to adopt the continuous quality improvement cycle of constant measurement, reporting, and improvement.

Patients' rights will need to be defined and redressal mechanisms set up wherever they are violated. To enforce quality, healthcare organizations will have to move from standardized reimbursement to performance incentives based on coordinated and quality care. Government will have to ensure good governance, and enforce regulation, for pubic-run and private services.

Community Participation and Decentralized Governance

Close engagement with families and communities will remain a fundamental element of primary healthcare models of the future. They would be located in communities and neighborhoods, and health workers from within the communities would provide the interface between the community and health facility. In remote and impoverished areas, primary healthcare services will also address other sociocultural barriers to improved health. For ensuring that healthcare providers are sensitive to the social and economic realities of the populations they serve, primary healthcare professionals of future will need to be immersed and trained in these communities. Primary healthcare staff will maintain long-term relationships and forge trust with the empanelled families. Mechanisms to ensure that communities can hold the service providers accountable for delivery and quality of care, and for service providers to engage communities in planning healthcare, will be instituted.

More and more states will adopt a decentralized form of governance of primary health services, as in Kerala, to ensure community participation and ownership in its true spirit. Such a form of governance will, however, need to be supplemented with strong technical oversight by the health systems.

Financing Primary Healthcare

Primary healthcare services will require much greater financial resources, innovative funding mechanisms, and leaner and more efficient operations. The aim will be to reduce out-of-pocket expenditure and prevent impoverishment, on one hand, and increase equitable access to high-quality care, on the other.

While the central and state governments will need to, and have committed to, enhance their allocations to healthcare in general and primary healthcare in particular, limited fiscal space in future may prohibit some states to do so. Alternative financing mechanisms such as cooperative-based financing (as in Canada), Sin taxes (as in Philippines), Employee State Insurance (for informal sector workers), and CSR funding would play a larger role. Alternative ways to engage and incentivize providers (especially to a group of providers) to provide ethical and quality services to a population will evolve, as will the mechanisms of greater community contribution. When a group of private providers are engaged by the government to provide primary healthcare to a defined population, especially in the urban areas, they will be reimbursed through mix of payments: incentives for performance and capitation. Alternately, cross-subsidization-higher fees from those who can afford, to subsidize those who cannot, will also play a larger role. Government will have to substantially enhance its capacity to manage contracts, and to regulate.

Agenda for Future

To enable the above vision of a robust and equitable primary healthcare in India, primary healthcare practitioners and researchers will need to pursue some of the following agenda:

1. **Design, implement, and evaluate futuristic models of primary healthcare:** These models will take into account the design elements of future primary healthcare as specified above. Primary healthcare organizations and researchers can help design, implement, and evaluate such innovative models in different contexts: in rural and urban, in close partnership with state governments.
   A special effort should be to design models for remote and tribal areas, as well as for urban areas. Radically new thinking will be required to design urban models, especially for the marginalized populations such as migrants, as there is a limited experience and no clear structures.
2. **Identify and advocate for removal of barriers to provide primary healthcare:** There are several barriers to production and deployment of primary healthcare providers. For example, there are legal barriers to nurses practicing independently in primary care settings, and there are administrative barriers to increased production of family physicians. Organizations should identify these barriers and work toward their removal through sustained advocacy.
3. **Help set up training sites for primary healthcare professionals:** Primary healthcare professionals need to be immersed and trained in community settings. Nonavailability of good quality community-based training sites will inhibit production of competent and committed professionals.
4. **Generate data on costs and effectiveness of different interventions:** It was pointed out that such a data would

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specially be critical to help states decide on optimal primary care package.

5. **Evaluate and introduce relevant technology:** A large gamut of technology for instituting information systems, affordable and reliable screening, and diagnostic services and training of human resources is available. There is a need to catalog, promote, and adopt those that would be most suitable and appropriate for primary healthcare systems of the future.
6. **Forum on primary healthcare:** Many participants articulated the need for creating a network of primary healthcare practitioners and academics to continue to exchange ideas, share resources, and advocate for suitable policies.

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Pavitra Mohan[1], Himani Sethi[2], Kadarpeta Rahul Reddy[3], Maharaj K. Bhan[4]

[1]Secretary, Basic Health Care Services, [2]Program Officer, Access Health International, [3]Senior Fellow, Health Systems Transformation Platform, [4]Professor Emeritus, Indian Institute of Technology, New Delhi, India

Address for correspondence: Dr. Pavitra Mohan, Basic Health Care Services, 39 Krishna Colony, Bedla Road, Udaipur - 313 001, Rajasthan, India. E-mail: pavitra@bhs.org.in

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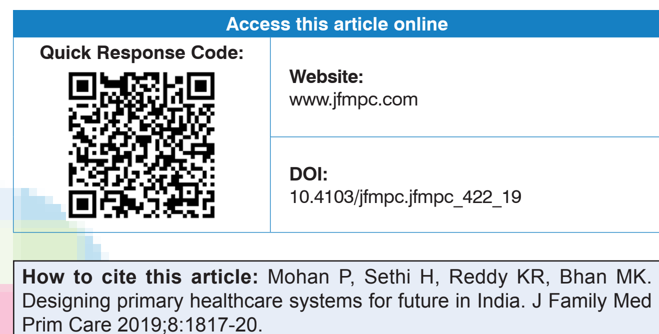

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