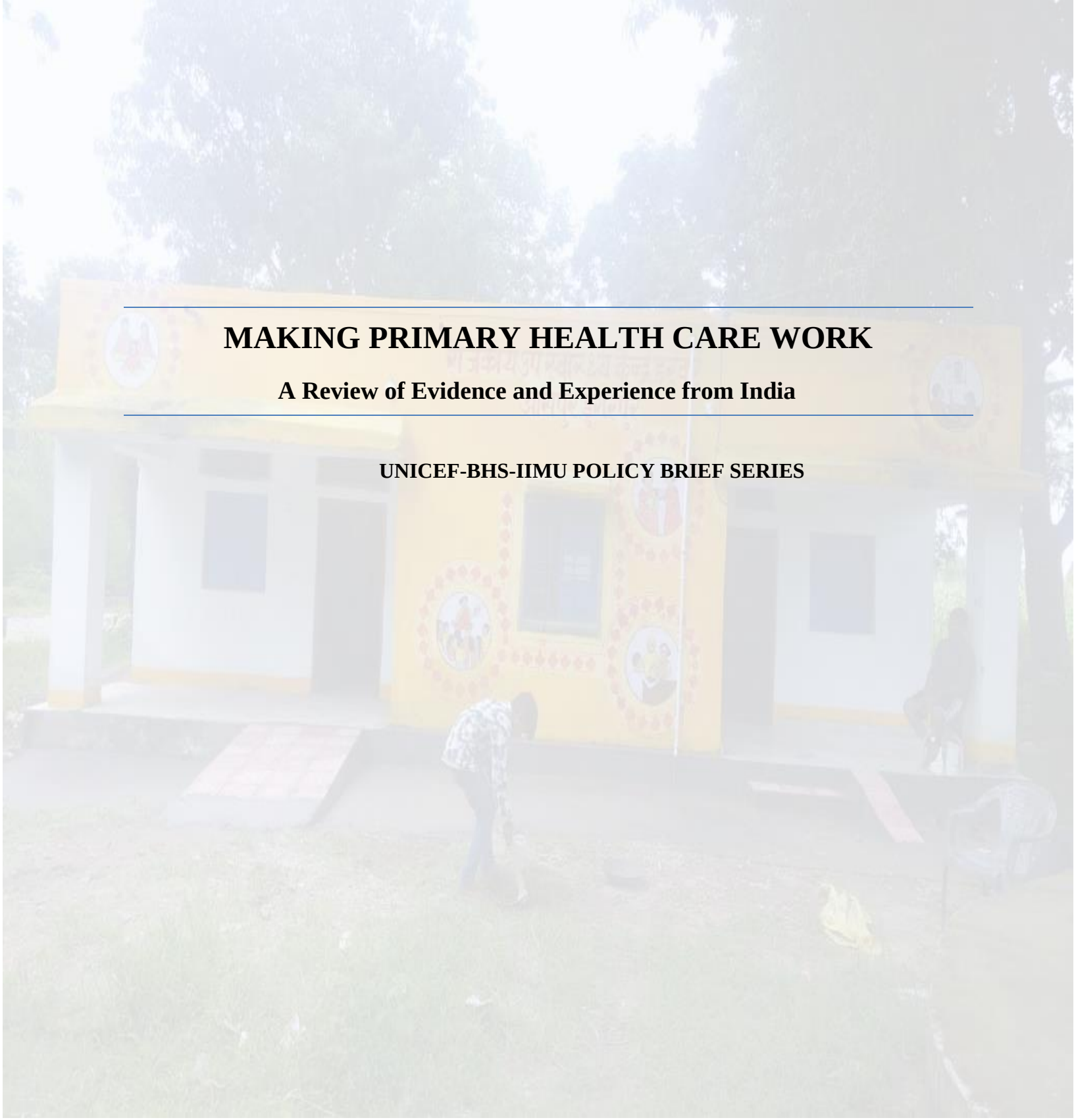

MAKING PRIMARY HEALTH CARE WORK

A Review of Evidence and Experience from India

UNICEF-BHS-IIMU POLICY BRIEF SERIES

unicef for every child

Basic HealthCare Services

Centre for Healthcare
An IIM Udaipur Initiative

INTRODUCTION

There is strong evidence that primary health care (PHC) leads to economic benefits and positive health outcomes.[1] PHC was reaffirmed as central to achieving universal health coverage (UHC) in 2018, which led WHO to define primary health care as "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."[2]

While there is a general agreement on the definition of PHC, putting the concept of PHC into practice led to many different interpretations. In the 1980s'selective PHC' was one such interpretation to be implemented worldwide. Selective PHC identified an essential package of low-cost interventions such as oral rehydration, breastfeeding, and immunisation at primary care facilities close to people's homes. [3] Although this approach was successful in achieving health gains in specific intervention areas, it did not lead to the strengthening of health systems that were required to make sustainable gains.

A comprehensive approach to PHC includes three inter-related and synergistic components:

1. Primary Care and Essential Public Health Functions: Meeting people's health needs through comprehensive, promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, and aimed at individuals and families through primary care and the population through public health functions.

2. Multi - Sectoral Action: Systematically addressing the broader determinants of health (including social, economic, and environmental factors, as well as individual characteristics and behaviours) through policies and actions across sectors.

3. Empowered Communities. Empowering individuals, families, and communities to optimise their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

In this policy brief, we use an operational framework (Figure 1) which proposes that the PHC approach is converted into results through a set of strategic and operational levers. [4] The framework bridges the gap between the PHC approach (components) and outcomes (results). Organizations and governments can influence the PHC levers to enhance results such as improved access to care, enhanced community participation, and improved determinants of health.

For the purpose of this Brief, we selected four levers (two strategic and two operational). For each of these levers, we reviewed the evidence of how these levers have been used to enhance PHC results. We also identified examples of community-based programmes or policy interventions from India that have sought to influence these levers. We supplemented these examples with insights from interviews with select PHC practitioners in India and propose some directions for strengthening primary health care in India with these examples and insights.

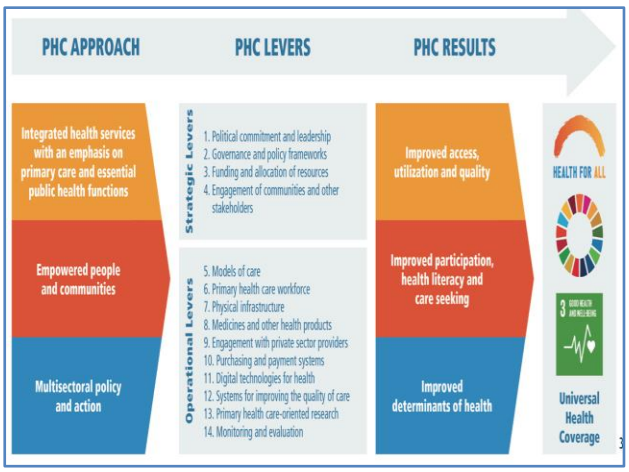

Figure 1. Operational framework for PHC (WHO-UNICEF Vision Document 2018)

I. STRATEGIC LEVERS

1. Political Commitment and Leadership

Political commitment is at the heart of efforts to advance the health of any population. Governments must create policy environments conducive to PHC and advance population health and well-being. They are responsible for 'stewarding' the health systems equitably and efficiently.

Political commitment to equitable and effective health care is demonstrated in health policies that are based on decentralised primary health care, matched by the requisite budgetary allocations. The National Health Policy (NHP) 2017 and Ayushman Bharat do well to articulate PHC as close to people and envisaged to provide continuous care.[5]. However, it lacks in positioning PHC as central to the entire continuum of care, emphasising referral linkages, specifying the community's central role, and articulating a 'whole -of – government' approach for multisectoral action. While the NHP also emphasised increasing the levels of public financing (from existing 1.15 per cent to 2.5 per cent GDP by 2025) and allocating a large proportion of these resources towards primary care services, this intent has not resulted in increased allocations. However, substantial gains in primary health care can be made not only by investing more but also by investing better. [6] For the same public expenditure, some States of India perform significantly better than others, underscoring the value of investing better. Another way political commitment translates into improved primary health care is by adopting a 'whole-of-government approach'. Such an approach helps address major determinants of health such as social protection, education, housing, and livelihood. It requires different government ministries and departments to collaborate, integrate, and articulate health considerations into policymaking across sectors to improve the health of all communities and people. [7] However, this needs a political commitment to health and a culture of collaboration.

Since health is a state subject, political commitment and leadership at the State level are critical for improving health outcomes. Examples of such commitment that result in improved health outcomes are evident via improvements in maternal health indicators, especially in States in south India. Some of these States have further decentralised the stewardship of primary health care to local bodies. For example, the Basthi Dawakhanas, the first urban local body (ULB)-led community clinics launched by the Greater Hyderabad Municipal Corporation (GHMC) in Telangana (inspired by the Mohalla clinics of Delhi). [8]

Basti dawakhana: a model of decentralised primary health care

Aligning with the 73rd and 74th amendments in the Constitution of India, the Basti Dawakhana Initiative in Hyderabad city, Telangana, transferred primary care and public health responsibilities to the ULBs. These dawakhanas are community halls modified into clinics owned by local administrative bodies and administered through the City Health Society, including officials from the Department of Health and Family Welfare, the Government of Telangana, and the GHMC. They receive funds through both the State government and the GHMC. At the same time, the GHMC takes responsibility for necessary infrastructure such as buildings, and the Health and Family Welfare department is responsible for supplies, medicines, and the posting of human resources. Because these community clinics are based in urban slums with a population of 5000-10,000, they have the potential to offer better geographical and financial reach for the marginalised groups.

Another example of decentralised local leadership comes from Karnataka, where improved coordination and capacity building of local political and programme functionaries resulted in significant improvements in PHC services. (9) Under the 'Ardram mission program', PHC reforms in the State of Kerala demonstrate yet another example of decentralised leadership and political will to create 'people friendly' Family Health Centres (FHCs). Since local self-governments and autonomy are needed for the functioning of the FHCs, they are able to address of the social determinants of health. Community participation is promoted through ASHAs, VHNSCs, *Kudumbashree* health volunteers, and *Arogyasena*.

2. Engagement of Communities and Other Stakeholders

The need to engage communities to define problems, find solutions, and prioritise actions for primary health care cannot be emphasised enough. (10)

Engagement with the community is envisaged as more than mere health education. It demands a more collaborative approach where people are involved in decision making, especially the meaningful representation of the marginalised. True community engagement requires a reversal of traditional hierarchies--giving power to the people instead of the traditionally more powerful health care providers.

Communities can potentially assume three broad roles--as advocates for multi-sectoral action for health, co-developers of health and social services, and as self-carers and caregivers.

Based on the above roles of the community, an operational framework proposed by WHO conceptualises community engagement at three interlinked levels: health systems' governance; planning and priority setting; and delivery of health services.

Commuinitisation of health care in Nagaland

In 2002, the Nagaland Communitisation of Public Institutions and Services Act was established to legalise 'communitisation'. The intent was to empower the community and delegate powers to local authorities for all local public utilities, including institutions and services for health. The value base of this Act is: "Trust the community, train community members, and transfer government assets and powers to them".

The communisation of health was ensured by the formation of two rural and two urban committees with representatives from respective villages and towns. The villages in Nagaland are administered by Village Councils, which have members chosen by villagers every five years, and the hereditary Village *Gaon Buras* is part of the council. The committees formed for the implementation of communitisation of health in every village includes not just members from this village council but also sub-centre health workers, members from *mahila sanghas* (women's collectives), pastors from the village church, and other members of the community.

These local health committees take the ownership of and manage the health centres, including their funds and planning. A case study that assessed their impact reported better reach and utilisation of services and schemes. The infrastructure has also improved significantly in places

where community involvement and support is strong; they were able to generate funds and resources through local NGOs, local church, women's groups, students' groups, and so on. Another example of the impact of communitisation is that with the 'no work, no salary' policy by the village health committee (in Mokokchung district) the attendance and efficiency of health workers showed improvement and people developed trust and faith in the system.

As one of the interviewees said, "There is an inherent information asymmetry in health care, but PHC is an opportunity to set it right. PHC is about giving power to people. People should have choices; we should explain all the options, and they should [be able to] choose from them".

This was reinforced by another interviewee who also saw community engagement as central to PHC, "Systemically, we need to respect the community. We need to acknowledge that they are equally aware of their health. It is an emotional connection between providers and people. But when we operationalise this, we end up becoming transactional. The basic principle is that we should realise that the person in front of us is not at our mercy. They are a partner in our journey to providing health. Not only consumers". The interviewed experts also reiterated that "primary care practices have to adapt and respond to the hyper-local needs of the community in which they are based".

Community engagement proves to be challenging and requires time and patience. A study reported that most organizations providing CPHC (community primary health care) in rural areas invested time in understanding local needs and spent many months in dialogue with local groups, before establishing a health facility. Examples of such primary health care delivery models include Tribal Health Initiative and Jan Swasthya Sahyog, among several others. continuously engage with communities such as with patient groups, village committees, self-help groups, voluntary health The dialogue is not a one-time event but a continuous process. Many exemplar organizations have built mechanisms to workers from the community, and so on. [11]

Other strategies used in various organizations are setting up community advisory groups that participate in planning, affirmative action in staff recruitments to represent vulnerable communities, use of panchayat-owned buildings such as clinics, and facilitating peer groups. Such relationships with the community work when they are patiently built on trust and truly seek the empowerment of people, not mere token involvement in committees.

Peer support groups improve adherence to treatment in rural Chhattisgarh

Jan Swasthya Sahyog (JSS), a non-governmental organization that provides primary and secondary health care in rural, tribal Chhattisgarh, established peer groups of people suffering from chronic diseases (such as sickle cell disease, epilepsy, diabetes, and so on). The interface of health care providers with peer groups helps in 'co-producing' health outcomes. Even as these groups were formed to impart information, they became a space for community members to support each other and share learnings. Some groups have also lobbied for better access to medication with the government. The peer groups significantly improved drug adherence from 20-44 per cent to 76-94 per cent. [12]

II. THE OPERATIONAL LEVERS OF PHC

1. Models of Care

A 'model of care' is defined as the conceptualisation of how services are organized and delivered, including the processes of care, organization of providers, and management of services. [13] Any model of primary health care model would aim to promote continuous, comprehensive, coordinated, person-and people-centered care rather than providing episodic, fragmented, or disease-specific care.

A model of care includes specifying *what* services are to be delivered (such as mental

health or maternal and child health) and *who* will deliver them (nurses, midwives, or doctors). The model would further specify *how* these services will be delivered (outreach, community-based clinics, home-based care) and who owns them (government entities, private entities, or partnerships).

People-centered approach to primary health care

A person/people-centered approach consciously adopts the perspectives of individuals, carers, families, and communities as participants and beneficiaries of trusted health systems. It responds to the needs and preferences of the people. In people-centered models, there is an emphasis on 'shared decision-making' and 'co-production of health care'. People are actively encouraged and invited to participate in decisions regarding their health and the community's health. This principle is usually translated as having peoples' representatives in committees for decision-making regarding service delivery. However, more than token community involvement, true empowerment of people to participate and co-produce health is envisioned.

People-centered models of care are holistic in approach, not fragmented by the disease approach but support a whole-person view. A bio-social approach to health and disease is consistent with a person-centered approach. The implication of this is in the organization and structure of service delivery. A vertical program structure specific to diseases limits integration and a holistic approach to the care of people. PHC needs to be responsive to and use information about the population and geographical location to make health planning and management-related decisions.

1.1 Organization of models of primary care

The hub-and-spoke model: Primary care centres are the hub from where coordination of services and continuous care is possible. [14] The base centre is the hub and the outreach arms are the spokes that remain connected to the hub. The base hospital can be either a primary care centre or a secondary-level centre, depending on the needs of the community. The hub and spokes need to work closely together to provide integrated care to individuals and families. For example, a woman who receives antenatal care at the spokes delivers the child at the hub, and then receives continued postnatal care at the spokes. If the hub and spokes work together, continued care can be provided seamlessly. In practice, however, the hub and the spoke team may work in silos, thereby fragmenting the care.

Continuity of care between hub and spoke in south Rajasthan

Basic HealthCare Services (BHS) run a PHC in south Rajasthan as a public-private partnership. The 'spoke' teams of the sub-centers also perform duties at the 'hub' PHC. Similarly, PHC team members are also entrusted with supporting the teams at the spokes. Processes are designed to ensure continuity of care between the hub and the spokes. For example, information on any high-risk pregnancy detected at a sub-center is referred to the PHC, with information shared with the PHC team over WhatsApp. Or, a low-weight baby born at the PHC is handed over to the respective Auxiliary Nurse Midwife (ANM) who then ensures continued care at home, including via Kangaroo Mother Care.

The social franchisee model: The hub-and-spoke model assumes that the hub and spokes are managed by the same organization, and that there is a hierarchy of services and management functions. That is increasingly not the case. With multiple services such as optometry, physiotherapy, laboratory, social services, and so on that are required to provide primary care, there is a need to coordinate care across multiple care agencies at multiple levels. This is especially true for cities where these services are available but managed by different agencies in different locations. An example is a social franchisee model that organizes services through several different providers located in different parts of the city but coordinated by a franchise. [11] The franchise defines the fee and ensures a minimal set of standards in the delivery of services.

Integrated care: To build trust and ensure effectiveness and continuity of care, primary health care needs to be organized as a continuum with secondary and tertiary care. One of the interviewees articulated this well:

"PHC/ primary care needs to be envisioned as a system, as a complex, adaptive, dynamic health care approach that involves people with agency." again, "Primary care has a responsibility, but it is critical that primary care is not in competition with secondary care or tertiary care. It is part of a continuum".

In operational terms, PHC teams need to help the patients navigate secondary and tertiary care when required. The range of activities includes organizing referral transport, escorting on the way, assisting in navigating the hospital systems, and providing follow-up care. Many not-for-profit models of care perform these integrative functions

Service delivery platforms: Traditionally, the models of care used brick-and-mortar service delivery platforms such as health posts, pharmacies, clinics, and hospitals. In the last decade or so, realizing the limitation of these static platforms, newer forms of service delivery such as home-based palliative care and digital platforms are evolving, thereby extending care provision to households. While digital platforms are being used to provide information regarding the availability of health care, create appointments, offer tele-consultations, and provide health record storage spaces, future models would require a combination of traditional and newer platforms and synergies between the two.

Ownership: Service delivery platforms may differ by ownership--public or government-owned, private, not-for-profit, or public-private-. In times to come, newer ways of public-private ownership will emerge. There have been many examples of engaging private players in the provision of PHC through public-private partnerships. Scoping reviews of these partnerships have revealed that despite several challenges, they can facilitate access to quality health care services, especially in remote areas. [15] However, to make such partnerships effective, governments need to play a stronger stewardship role and formulate robust regulatory frameworks.

Designing primary care systems to provide care for chronic illnesses

An important consideration for developing models of care relevant to PHC is the need to move from predominantly acute episodic care models to those designed for chronic care. Primary health care is best positioned to care for people with chronic diseases because they require sustained engagement with the health system, often over a lifetime, and across levels of health care. Medical records with clinical information may not have been necessary to care for acute illnesses like fever or diarrhoea. However, it is a must for quality chronic-disease care to inform clinical decision-making. A recent review adapts the chronic care model of Wagner and others to an LMIC context using the best-fit methodology based on available literature from LMICs. [16] The Innovative Chronic Care framework of the WHO is also an example of a contextualized modification of the chronic care model. [17]

Package of services: As mentioned above, primary health care models of the future would need to be equipped for managing chronic illnesses. Increasing life expectancy also means that increasingly palliative care and care for the elderly will be included in the package of services that primary care models offer. Many experts we interviewed identified mental health, emergency services, and rehabilitation as necessary inclusions for strong PHC.

Identifying local epidemiology is crucial to respond to local needs. To be responsive, primary care models use information about the population and geographical location. An interviewee suggested a practical idea on how a primary care practice can incorporate the local needs in the package of services: "A transformative idea I have seen in primary care practice is to create a registry of all the patients in the community. I need to know about my community; this will also give me an indication of the main needs, the hyper-local needs."

Besides clinical services, the package should include interventions that address the social

determinants of health. As one of our interviewees pointed out, "A note of caution is to resist equating PHC with only medical care through OPD. Also, care models for primary health care should focus on prevention because PHC is not for illness but wellness".

For example, organizations such as Basic Healthcare Services and Tribal Health Initiative have, directly or through partnerships, addressed livelihood issues for economic development and reduced migration in remote tribal areas.[18] Another example is how the Basic Needs Model in Nepal (29) integrated mental health services with livelihood and other human rights issues.

2. Primary Health Care Workforce

The health care workforce for primary health care in India has traditionally included doctors, nurses, laboratory technicians, pharmacists, and community health care workers. This workforce is riddled with two major constraints: (a) availability and effective deployment of skilled human resources, and (b) the motivation of the available workforce.

Even though a recent Rural Health Statistics (RHS) publication [19] reports that many States have surplus doctors at PHCs, the persistent shortfall nationally, high prevalence of absenteeism, and their short duration of stay at PHCs affects their availability on the ground, especially in remote and rural areas. A large proportion of primary health care is delivered by non-physicians such as nurses, ANMs, and community health workers. This cadre is also more available to live and work in rural areas.

'Task shifting' and 'task sharing' are well-known mechanisms for the efficient delivery of services through nurses, paramedical staff, and community health workers. Where 'task shifting' is defined as "the rational redistribution of tasks to individuals (within the health care team) with fewer qualifications that conventionally were not within their scope of work", 'task-sharing' involves health professionals working together in teams to deliver a task or service that they may not have carried out before.[20]

Task shifting and task sharing are useful strategies to ensure access to quality health care. As part of Ayushman Bharat, a new workforce cadre is being rolled out - a Mid-level Health Provider (MLHP) to manage the Health and Wellness Centres. A summary of available evidence (through systematic reviews) on MLHPs in low- and middle-income countries reveals that they are acceptable and effective for delivering primary health care, especially for pregnancy, childbirth, and communicable diseases. [21] However, the effectiveness of Mid-Level Health Providers (such as Primary Care Nurses) depends on the following factors:

Integrating MLHPs within primary care teams: Mid-level providers should be seen as part of a primary care team and not as a standalone solution to absent physicians. While the role of mid-level providers is important to enhance access, many experiences (such as that from South Africa and India's Rajasthan and Chhattisgarh) emphasize a team-based approach. The team in well-performing primary care systems often includes a family physician or a generalist and non-physicians such as nurses, other health care providers, and community health workers. Such a team appears to be critical to providing comprehensive primary health care through improved access, quality and culturally sensitive care, and equity. [22]

At the moment, HWCs are considered to be manned by the MLHP, and the role and relations with PHC physicians and other team

members (including ANMs and ASHAs) are not well defined. Efforts to forge teams consisting of all these members are inadequate.

Empowering primary care teams: Primary health care staff requires multiple skills that include clinical, managerial, leadership, and social. They further need to understand and internalize values such as equity. As an interviewee shared, "Staff should be trained in a positive environment and non-threatening way to be non-judgemental and unlearn biases such as those towards unwanted pregnancy of unmarried women".

Organizations such as Tribal Health Initiative (in rural Tamil Nadu) and Jan Swasthya Sahyog in rural Chhattisgarh) conduct in-house trainings to build these capacities while taking into consideration specific interests and preferences of the staff. Training PHC team members together helps build team cohesion. Ongoing mentoring is as important as initial or periodic training. The above-mentioned organizations also provide ongoing mentoring support to team members, as stated by an interviewee - "Treasuring people, and giving them time and training in terms of mentorship capacity is important for strengthening PHC (teams)".

Standardised protocols and Standard Operating Procedures (SOPs): Standardised protocols and SOPs help mid-level providers offer standardised care. At the K.C. Patty Primary Health Center (Kodaikanal), tools such as protocols and SOPs have enabled teams to deliver effective care. The PHC team comprising doctors, nurses, and health volunteers, share tasks to deliver comprehensive care.

Enabling technology: While training, mentoring, and tools support MLHPs and PHC teams to deliver effective care, technology enables them further. The case study of the mPower project shows how a mobile-based, clinical decision-support system (CDSS) enabled nurse coordinators to deliver effective care for non-communicable diseases. [23] Besides CDSS, technology for diagnostics, tele-consultations, and information management enables MLHPs and primary care teams. For example, provider-provider tele-medicine interventions enable the primary care providers/teams to access specialist care in remote areas, such as with the Aravind Eye Care network of vision centers.[24]

Nurse-led primary care is effective and sustainable

There has been growing evidence, mostly from middle-income and high-income countries, that nurse-led care can be sustainable, efficient, and lead to similar outcomes as that of doctor-led care. Some of the evidence is from models where registered nurses provide care independently, as well as from settings where they are supervised by doctors.[25] Some studies have also shown that care provided by nurses is compassionate and patients have better experience and satisfaction than that provided by doctors.[26] Basic HealthCare Services in Rajasthan, India, has been running comprehensive PHC through nurse-led clinics (Amrit Clinics) that are well-supported by doctors and community health workers. Continuous training, standardised protocols, and enabling technology have been crucial in maintaining quality in such models.

While task shifting is important, it should not be seen as a solution to physicians' absence, lack of skills, or lack of motivation. Most medical officers report that their basic MBBS training does not equip them to deliver primary health care in rural areas. Delivering primary health care requires a 'generalist' workforce with a wide range of skills. Over the last decade, there has been an expansion of training sites for post-graduation in Family Medicine, the discipline that imparts 'generalist' skills required to manage primary health care servicing.

However, the seats for post-graduate courses are still highly inadequate to manage primary

health care in rural areas. Besides, States do not have specific positions or cadre of family physicians within the public health care system.

An interviewee suggested that our opinion about specialisation needs to be challenged: "It is born out of our own intrinsic philosophy that being a general practitioner and a family physician is lower in status than being a specialist'.

While the availability of an adequate workforce and competency is important, retention of doctors and other workforce has been a constant challenge in rural India. This largely depends on the work culture, good communication, clarity of role, mutual respect, and pathways for career progression for all cadres in of the workforce. [27] Leaders from various non-governmental initiatives that deliver CPHC successfully also mentioned a positive work culture that is respectful and non-hierarchical, where each health worker is acknowledged for their contribution. This has been key in instilling motivation and improving the quality of care. [18]

Besides the structured post-graduate programs in Family Medicine, some unstructured fellowship programs are emerging to orient, sensitize, and skill young doctors to deliver, manage, and lead primary health care services (such as the Fellowships by the Academy of Family Physicians of India and Karuna Trust, and a travel fellowship for young doctors by an informal network of rural health care organizations in India).

LEVERAGING PRIMARY HEALTH CARE IN INDIA: SOME DIRECTIONS

1. **Develop, support, and evaluate innovative and decentralised models of primary care:** As mentioned above, there are new platforms (technology and home-based), new organization structures (social franchisees), and new ways of management (public-private). Different models integrating these elements may be appropriate for different settings, such as urban, rural, deep rural, and so on. UNICEF could help in the development and piloting of these models. Such an initiative would help provide the evidence and tools for scale-up.

2. **Build and support PHC teams:** While MLHPs are introduced in the system, they are not integrated into the primary health care teams. Integration would require clearer roles and responsibilities, and relationship building. Team training and mentoring are some techniques to build strong PHC teams with requisite task sharing.

3. **Implement and evaluate initiatives to improve work culture in government primary health care systems:** As discussed earlier, poor work culture affects the performance of PHC staff and teams in government-run primary health centers. There has been limited evidence on what works for sustainably improving work culture in government systems. There is a need to design, implement, and evaluate initiatives that build work cultures that promote mutual respect, team spirit, and responsibility.

4. **Support training and deployment of family physicians in primary care:** Managing and leading primary health care requires skilled and socially conscious physicians. At the moment, primary health centers are led by medical graduates who are trained in tertiary hospitals in cities. They have limited skills and sensitization to primary health care in rural areas. We urgently need a larger number of medical graduates trained in Family Medicine, who are exposed and trained in primary care

settings and appropriately entrusted and deployed there.

5. **Promote a cadre of Primary Care Nurses:** As mentioned above, there is reasonable evidence and experience to suggest that nurse-led models of primary health care are effective, sustainable, and efficient. However, there is no cadre or specialized training for nurses to deliver and lead primary care. There is a need to define the skills required for nurses to lead primary health care services, design appropriate training and certification, and chart out clear roles and career pathways for them in primary care.

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