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Editorial

'More, better, faster & sustained': Strengthen primary health care to advance universal health coverage

The World Health Day 2019 (WHD2019) theme is 'Universal Health Coverage (UHC)' with focus on primary health care (PHC) and slogan of 'UHC: Everyone, everywhere'[1]. Alma Ata Conference in 1978 brought global attention on PHC, while UHC became the centre of global health discourse, mostly in last two decades[2-5]. The WHD2019 theme builds on these two health developments of last four decades[2-6]. The momentum is likely to be followed through the United Nations High-Level Meeting (UN-HLM) on UHC in September 2019 and hoped to be sustained in the years ahead[7].

Why primary health care more than ever?

Evidence points that estimated 80-90 per cent of health needs of any population can be dealt with and tackled through a well-functioning PHC system[8,9]. Alma Ata had focused on PHC system based on principles of social inclusion, equity and comprehensiveness[2]. PHC has been foundation on which countries have embarked on journey towards UHC. Thailand started strengthening PHC in 1972, nearly three decades before the launch of Universal Coverage Scheme in 2001[10]. Brazilian healthcare system under Unified Health System is based on strong foundation of PHC[11]. The economic case for PHC itself, and as a tool to advance UHC, is based on sound evidence[12,13]. The cost of outpatient services delivered through PHC is 5 to 8 times lower than when the same services are availed at higher levels of facilities[14,15].

Although PHC has never been out of agenda in the last 40 yr, it lost some attention in-between. Astana 2018[6] has become a new rallying point behind PHC. UHC has laudable and widely understood objective of 'Universal Health' with 'Coverage' in all three dimensions[1,3], namely: *(i)* a wide range of quality services delivered through health systems having strong foundation of comprehensive primary healthcare; *(ii)* all populations, with focus on leaving no one behind, keeping equity and social justice as principles; and *(iii)* appropriate mechanisms are in place to ensure financial protection while people access health services they need. However, UHC is sometimes 'incorrectly interpreted' in a narrow sense of 'universal coverage' with either 'limited package of services' and/or with 'insurance coverage' only. The confluence of PHC and UHC is a promising opportunity. The global community is increasingly realizing that UHC could be superior in quality, efficiency and equity, when based on the pillars of comprehensive primary health care; financing and service provision that is predominantly public; supported by effective state regulation to assure/guide the universal access and a vision of health care as a public good[11]. The goals of UHC and PHC are interlinked and WHD2019 provides an opportunity to revitalize PHC in a synergistic and mutually beneficial approach for UHC.

Why India needs stronger primary health care system?

India though has an elaborate network of nearly 200,000 Government PHC Facilities (GPHCFs), these facilities delivers only a fraction of total outpatient services. In 2013-2014, excluding services for mothers and children, only 11.5 per cent of rural and 3.9 per cent of urban people in need of health services accessed these facilities[15,16]. Poor in India either chose for higher level of facilities for PHC needs (an issue of subsidiarity) or attend a private provider [resulting in the out-of-pocket expenditure (OOPE)], both situations not good for health system. The situation has changed very little in spite of launch of a few national-level and State-specific initiatives[17-19].

The government spending on health has also been another recognized challenge. Government in India

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spend nearly 1.18 per cent of Gross Domestic Product (GDP) on health[20]. Majority of State government in India spends nearly 4-5 per cent of their annual budget on health. The spending on primary care in India in 2015-2016 was around 51 per cent of total government spending[20]. Recognizing these challenges, India's new National Health Policy 2017 (NHP-2017) has proposed strengthening of PHC; increased government funding for health to 2.5 per cent of GDP by 2025 and that two-third or more government budget be allocated for PHC services[21]. NHP-2017 also proposes that, at State level, eight per cent or more of State government budget allocation for health, by yr 2020.

In February 2018, the Government of India announced *Ayushman Bharat* Programme (ABP)[15] with one of the components being the Health and Wellness Centres (HWCs), aiming to revamp existing Health Sub-Centres (HSCs) and rural and urban PHCs. The plan is to make 150,000 HWCs functional by December 2022. One of the key features of this discourse in India is explicit attention on 'comprehensive' primary health care, so to ensure that it is not left to interpretation. The HWCs seem to have been designed with learnings and available evidence, both globally and in India. A pilot study in Tamil Nadu, India, reported that strengthening of HSC and PHC in three districts resulted in increased attendance for outpatient consultations and reduced OOPE for target beneficiaries[22]. Another study of best performing PHCs in four States of India (Kerala, Tamil Nadu, Maharashtra and Meghalaya) identified (*i*) an assured package health services with 'limited intention to availability gap'; (*ii*) appropriate mix and sufficient availability of providers; (*iii*) continuum of care with functional referral linkages; (*iv*) initiatives to achieve quality standard; (*v*) stronger local-level leadership; and (*vi*) community engagement as some of the common characteristics in these facilities[23]. Similar models, interventions and approaches in countries such as Brazil, Ghana and South Africa, with components under HWCs, being planned and implemented in India, have shown good or promising outcomes[24-26].

How HWCs can accelerate strengthening PHC system in India?

The recent community clinics in Indian States (*Mohalla* Clinics of Delhi and *Basthi Dawakhana* of Telangana) are proofs that people prefer PHC over hospitals, if service provision is assured[18,19,27]. There is attention on setting up HWCs in India, and in the first year of implementation, by March 31, 2019, a total of 17,149 HWCs (that includes 8,801 PHC; 6,795 HSC and 1,553 Urban PHC) were made functional across India[28]. Although assessing success of this initiative through monitoring the change in availability of services and utilization by beneficiaries is a bit early at present, it needs to be initiated soon uptill facility level. In first year of implementation, majority of HWCs have been set up in high performing States; and in the years ahead, States with weak or sub-optimally functioning PHC systems should be prioritized for rapid scale-up, proportionate to the need. The additional six service packages are included in HWCs; however, only one package for non-communicable diseases is currently being added. In efforts to achieve the numerical targets, focus should not be lost from adding remaining services at already functional and at yet to be started facilities.

Alongside, there must be active efforts to establish a functioning referral linkage between two components of ABP: the HWCs and *Pradhan Mantri Jan Arogya Yojana* (PMJAY) services (from secondary and tertiary care services). In addition, getting the HWCs functional (supply side strengthening) is not enough and bringing the trust of the community in services at GPHCF/HWCs (demand side) would be key to success. This can be attempted, through active community participation and involving local representatives and civil society organizations, in health services planning and implementation, from the very early stage.

The complementary steps and measures are needed. Health is a State subject in India, and in urban settings, elected local bodies are responsible for primary care and public health services. Therefore, the singular reliance on union government initiative would not be enough. The Indian States and urban local bodies have to take leadership in designing their own PHC initiatives and the innovations with experience sharing for cross-learning. This collaboration is also needed to achieve target of increased government spending on health to 2.5 per cent of GDP, which is possible if there is annual and sustained increase of 20-25 per cent in government budget for the next 6-7 years. The government in Thailand could increase spending from 1.5 to 3.0 per cent of GDP on health in nearly 13 years[29].

Strengthening PHC is essential to advance UHC

India has made a commitment to UHC through NHP-2017[21]. PHC is an important component in path to UHC; and many complementary steps have to be taken. Evidence suggests that a strengthened PHC system performs better when supported by an equally

well-functioning hospital services/system, with two-way referral. This demands to end an 'outmoded dichotomy' and underscores the transformative role of hospitals in the future of PHC[30]. Second, 'PHC for all' starts with better measurements, and strengthening monitoring systems for PHC and UHC will guide the corrective actions and accelerate progress. Digital technology can be leveraged to address health challenges in remote areas, generate awareness about health entitlement, deliver preventive and promotive health services, empower people and support communities to look after their own health[31]. Mobile and web-based applications and increasing availability of telecom network are opportunities. Third, progress on PHC and UHC would be dependent on additional evidence generated, and it would need institutionalized mechanisms, at both national and sub-national level, for implementation research and capacity building of relevant stakeholders, supported by sufficient government funding for both[32]. Fourth, Astana 2018[6,11] and the follow up discussions have emphasized that PHC and UHC need to be supported by legislative or right-based approaches to make these sustainable. There is emerging global consensus on strengthening universal public health systems, governments accepting responsibility to guaranteeing right to health, bringing social justice in the discourse on health, higher attention on equity and 'leaving no one behind' with inclusion of vulnerable groups such as lesbian, gay, bisexual, transgender and queer (LGBTQ), people with disabilities and tribal populations[33,34]. The dialogue is also on preventing commodification of health and re-emphasizing the need for interventions to address economic, social, political and environmental determinants of health. Fifth, another step to make PHC and UHC policy sustainable would be re-enforcing and highlighting the linkage between health and development (human capital formation; poverty alleviation; employment and educational achievement) to all stakeholders. The early global conversation on government provision of universal basic services which includes health, education, water, sanitation and physical infrastructure, is an opportunity. Health in general and PHC and UHC in specific should be integrated with the overall development dialogue and agenda.

Conclusion

UHC has become centre of global health discourse for nearly a decade and half. There is a renewed global policy dialogue to strengthen PHC, which is comprehensive, equitable and predominantly government funded. There is a need to prioritize PHC as the foundation of UHC. WHD2019 is opportunity that gears are shifted, and the policy decisions are urgently implemented and scaled up at ground level, in rapid succession and sustained, to achieve UHC.

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