

Strengthening Primary Care in India

Opportunities and Challenges

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India has made significant strides in enhancing primary healthcare delivery in the past two decades post the introduction of the National Rural Health Mission (NRHM) in 2005. The National Health Mission (NHM) launched in 2013, as a successor to NRHM, aimed to revitalise primary healthcare by implementing 'architectural corrections' for the basic healthcare system through horizontal integration and increased scope of primary health services. Its core strategies included integrating vertical programs and structures, aligning health with its broader determinants, incorporating traditional medicine systems, decentralising health planning, promoting community participation and ownership, and improving public health management.

While these reforms led to an increase in the utilisation of public facilities, for both in-patient and out-patient care, only 30% of the population used public facilities for out-patient care in 2018. The preference for private facilities in both rural and urban areas highlights the need for further strengthening of primary healthcare facilities.

While the strengthening of primary healthcare services through NHM increased the utilisation of public facilities, its focus remained limited to reproductive and child health and select non-communicable diseases (NCDs). Inadequate public health expenditure and lower fund absorption capacity in some states hindered the program's effectiveness. While the need was recognised, the transition from selective to comprehensive primary healthcare was not fully achieved for multiple reasons, staff shortages and unavailability of medicines and equipment being key amongst them.

The Ayushman Bharat-Health and Wellness Centres (AB-HWC) program was launched in 2018 (subsequently renamed Ayushman Arogya Mandir) in recognition of the gaps in the primary care system. This initiative aimed to transition from selective to comprehensive primary care in a phased manner by upgrading existing sub-centres (SCs) and primary health centres (PHCs) into Health and Wellness Centres (HWCs).

This paper examines the structural features of primary healthcare in India, identifying areas for incremental changes and fundamental corrections in the design, administration, and governance of the health system. It draws on the experiences of other emerging economies (e.g. Brazil, China,



Turkey, Indonesia) that have successfully expanded primary healthcare coverage. The paper makes a case for a stronger system-initiated model as opposed to a patient initiated one in case of illness; integrated healthcare provisioning with public-private coordination; multidisciplinary workforce with increased density of frontline workers, greater budgetary allocation and leveraging technology to optimise resources and train the health workforce for Comprehensive Primary Health Care (CPHC) objectives.

The HWC program seeks to address gaps by upgrading existing primary care facilities, offering comprehensive services, ensuring the availability of medicines and diagnostics, introducing a new cadre at the SC level, enhancing community awareness, and using technology to address the shortage of doctors. Simultaneously, the Indian government has invested in digital infrastructure to improve integration across care levels, launching the Ayushman Bharat Digital Mission (ABDM) in September 2021. This mission focuses on creating a health registry with unique Health IDs for individuals to track their health history, along with initiatives like the Health Facility Registry (HFR), the Health Professional Registry (HPR), and a telemedicine platform (e-Sanjeevani).

The HWC program has shown early success, with a 68% increase in patient visits per quarter at SCs with Community Health Officers (CHOs) and state-specific evidence indicating increased utilisation of HWCs and reduced burden on higher-level public and private facilities. This has led to reduced travel and wait times, and lower out-of-pocket expenditure (OOPE) on health. However, challenges remain in financing, infrastructure, service quality and accountability, and structural design elements.

Primary healthcare financing in India requires attention in terms of funding adequacy, fund flows, and expenditure distribution. While India's primary healthcare expenditure is about 56% of Government Health Expenditure (GHE), comparable to the global norm, a large proportion is spent on hospitals rather than primary care centres. Actual allocations for programs like HWCs have been significantly lower than the estimated needs. Delays in fund flows and complex administrative procedures also hinder the effective use of available resources. Additionally, a significant portion of primary healthcare spending is allocated to salaries, with a smaller proportion spent on drugs and consumables, which is concerning given the share of out-of-pocket expenditure on these items.

The focus on primary healthcare through NRHM/NHM has reduced the shortage of physical and human resources at the national level, but significant inter-state differences in infrastructure availability persist. Shortfalls in workforce, role clarity, duplication, and workload are also significant concerns.

Quality of care and accountability in India's primary healthcare system are affected by input gaps (workforce and supply shortages), motivation gaps (know-do gaps, lapses in examination, minimal time spent per patient, absenteeism), regulatory gaps (limited adherence to protocols, over-prescription, lack of periodic accreditation), and ineffective grievance redressal and accountability systems. A comprehensive framework for quality evaluation is needed, along with a robust data system to monitor infrastructure performance.

The current health system structure in India, with funds flowing from the District Health Society (DHS) to various levels, may disadvantage primary care due to the varying capacities of PHCs and SCs. The District Medical Officer's (DMO) responsibility for all levels can dilute accountability at the primary level. Additionally, the system is primarily reactive, focusing on curative care rather than proactive, community-based healthcare.

Several countries offer valuable lessons for strengthening primary healthcare. Brazil's decentralised approach, with municipalities managing primary healthcare, demonstrates the importance of fiscal devolution and local autonomy. Its Family Health Strategy (FHS) programme significantly expanded primary care coverage and reduced inequality. Brazil also ensured access to essential medicines through institutionalised pharmaceutical services at PHCs.

Costa Rica's experience highlights the benefits of a system-initiated model with universal registration of the population with a primary healthcare team. This approach, combined with capitation payments, has led to greater accountability and increased primary care utilisation. The integration of a multidisciplinary team, including nutritionists, psychiatrists, and pharmacists, has further improved health outcomes.

Turkey's health reforms, initiated in 2003, also provide insights. The transition to a referral system, where family physicians serve as the first point of contact, improved service delivery and reduced the burden on hospitals. Linking physician salaries to performance, including enrollment numbers, service coverage, and work in less-developed areas, enhanced accountability. Additionally, leveraging technology, as demonstrated by Tamil Nadu's collaboration with Google for a population-wide registry and direct drug delivery, can optimise resource utilisation and improve follow-up care.

Key Policy Recommendations

To strengthen primary healthcare in India, a shift towards a system-initiated model with population empanelment is crucial. This approach can build trust, increase utilisation of public facilities, and enhance non-curative aspects of care. Integrated care systems, with clearly defined referral

pathways and formalised coordination between public and private sectors, are also essential. India can draw lessons from countries like Brazil, Costa Rica, and Turkey in implementing these models.

Addressing the shortage and skill gaps among healthcare workers is vital. This includes task-sharing, increasing the density of frontline workers, and leveraging technology for training and support. Mechanisms to ensure quality and accountability, such as comprehensive quality frameworks, robust data systems, and community-driven accountability measures, are necessary.

Successful implementation of these reforms will hinge on strengthening state-level regulatory capacity and deploying robust IT systems for monitoring. Capacity building for facilities and the health workforce, alongside initiatives to improve digital literacy, are equally important. Greater devolution to local governance institutions and enhanced community participation for awareness, grievance redressal, and monitoring will also facilitate the transition.

About the authors



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