

PRIMARY HEALTH CARE IN INDIA: CHALLENGES AND THE WAY FORWARD

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ABSTRACT

Primary health care is the backbone of health care delivery world over. The vision of primary health care is one of comprehensive, integrated, accessible to all, contextually relevant health care rooted in the needs of the community. There are considerable challenges to operationalizing concepts in the delivery of primary health care, especially in low and middle-income countries like India. The epidemiological shift in disease burden characterized by an increase in non-communicable diseases is one such major challenge. A deficit of trust between patients and providers, lack of financial resources and poor governance for primary health care are other challenges in the Indian context. The WHO's primary health care operational framework identifies 'levers' as key elements that need to be addressed to operationalize primary health care in countries. I use this framework to identify opportunities to overcome the challenges identified in this paper relevant to the Indian context. Reorientation of the health care delivery systems to deliver chronic care is required due to the increase in disease burden. This is also an opportunity to empower communities that are central to primary health care as patients need to self-manage their disease conditions more than ever before. Political will, governance structures for multisectoral action, community participation and implementation research will be required for primary health care in India.

I. INTRODUCTION

The first international primary health care conference was held at Alma Ata in 1978, which brought together 134 nations to pledge 'health for all', as was articulated in the Alma Ata Declaration. The Declaration set forth a vision for primary health care as the first level of healthcare, close to people's homes. It defined primary health care as, "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".¹ The visionary concepts of primary health care were rooted in concepts of

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¹ Declaration of Alma Ata: International Conference on Primary Health Care, International Conference on Primary Health Care, USSR, 6-12 September, 1978, UNICEF Document E/ICEF/L.1387, available at https://www.unicef.org/about/history/files/Alma_At_a_conference_1978_report.pdf.

social justice and equity that are echoed in Article 14 of the Universal Declaration of Human Rights.²

While the Alma Ata Declaration was a landmark document in the history of health care, it was criticized for being too broad and unattainable. Operationalizing the broad concept of primary health care became a challenge and led to many different interpretations of primary health care world over.³ One such popular interpretation was ‘selective’ primary health care that identified a package of low-cost interventions, such as oral rehydration, breastfeeding, immunization, and growth monitoring for delivery at primary care facilities close to people’s homes.⁴ This selective approach did lead to improvements in health indices but did not succeed in securing health for all.⁵

Over the years, there has been a realization that to achieve equitable health for all, a comprehensive, and not a selective approach, is needed.⁶ In support of this consensus, world leaders met in Astana, Kazakhstan in 2018, to commemorate 40 years of primary health care that began at Alma Ata in 1978. At Astana, world leaders declared and reaffirmed the holistic vision of primary health care given at Alma Ata.

The Declaration at Astana upholds the primary role and responsibility of governments at all levels to promote and protect everyone’s right to the enjoyment of the highest attainable standard of health. Governments and societies pledged to prioritize, promote and protect people’s health through strong primary health care systems.⁷ Primary health care is an inclusive and societal approach to well-being, centered on the needs and preferences of individuals, families, and communities. Primary health care addresses the broader determinants of health and focuses on the

² UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, Res. 217A, Sess. 3, Document 217 A (III), available at <https://www.refworld.org/docid/3ae6b3712c.html>, last seen on 15/04/2020.

³ L. Magnussen, J. Ehiri, P. Jolly, *Comprehensive versus selective primary health care: Lessons for global health policy - Meeting people’s basic health needs requires addressing the underlying social, economic, and political causes of poor health*, 23 *Health Affairs* 167 (2004), available at <https://doi.org/10.1377/hlthaff.23.3.167>.

⁴ M. Cueto, *The origins of primary health care and selective primary health care*, 94 *American Journal of Public Health* 1864 (2004), available at <https://dx.doi.org/10.2105%2Fajph.94.11.1864>.

⁵ S.B. Rifkin, *Health for All and Primary Health Care, 1978–2018: A Historical Perspective on Policies and Programs Over 40 Years*, Oxford Research Encyclopedia of Global Public Health, available at <https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1093%2Facre/fore%2F9780190632366.013.55>.

⁶ J.E. Lawn, J. Rohde, S. Rifkin, M. Were, V.K. Paul, M. Chopra, *Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise*, 372 *Lancet* 917 (2008), available at [https://doi.org/10.1016/S0140-6736\(08\)61402-6](https://doi.org/10.1016/S0140-6736(08)61402-6).

⁷ *Report of the Global Conference on Primary Health Care*, Global Conference on Primary Health Care, Kazakhstan, 25Oct -26Oct 2018, WHO Document WHO/HIS/SDS/2018.61, available at <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>.

comprehensive and interrelated aspects of physical, mental and social health and well-being.⁸

India too upholds and affirms the Astana Declaration 2018 as it did the Declaration at Alma Ata. India's journey with primary health care began even before it was articulated at Alma Ata and Indian experiences of primary health care delivery contributed to the development of concepts that shaped the Alma Ata Declaration.⁹

The basic architecture for primary health care service delivery in India was first described by the Bhore Committee in 1946.¹⁰ In recent years, the National Health Mission has significantly impacted the delivery of health care in India. The National Health Mission undertook the development of infrastructure and developed ASHA (Accredited Social Health Activist) as frontline health workers. The recently launched Ayushman Bharat program of the Government of India is also a move towards strengthening primary care through the proposed health and wellness centers. The program envisages for all citizens, access to comprehensive health care services through financial protection and care closest to people's homes at health and wellness centers.¹¹

In this paper, I discuss why the approach of comprehensive, integrated primary health care is important to achieve health in India, especially with the increase in the burden of chronic diseases such as diabetes. I highlight challenges at various levels of implementation that threaten the realization of primary health care in the Indian context. Finally, I identify opportunities that could impact primary health care in India using the lens of the WHO operational framework for primary health care.¹²

II. PRIMARY CARE AND PRIMARY HEALTH CARE

Primary care and primary health care are very similar terms that are often used interchangeably. However, there is consensus that these are two distinctly different concepts and should not be interchanged. While primary care describes more the provision of medical services by a

⁸ *Primary health care*, World Health Organization, available at https://www.who.int/health-topics/primary-health-care#tab=tab_1, last seen on 2/01/2020.

⁹ Supra 4.

¹⁰ Ministry of Health, Government of India, *JW Bhore Report of the national health survey and development committee (Bhore Committee Report) 1946*, available at https://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report_VOL-1.pdf.

¹¹ *Ayushman Bharat for a new India - 2022 announced*, Press Information Bureau, available at <http://pib.nic.in/newsite/PrintRelease.aspx?relid=176049>, last seen on 19/07/2018.

¹² *Primary health care: transforming vision into action - Operational Framework (Draft for consultation)*, World Health Organization, available at https://www.who.int/docs/default-source/primary-health-care-conference/operational-framework.pdf?sfvrsn=6e73ae2a_2.

primary care physician or family doctor, primary health care is a much broader concept of the health system impacting population health.¹³

The distinctive features of primary health care are that it is comprehensive, promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life of an individual, designed to meet people's health needs close to their homes and at the larger population level, through public health, functions as integrated health services. Primary health care systematically addresses the broader determinants of health such as poor sanitation, poverty and takes actions across all sectors. Primary health care also works to empower individuals, families, and communities to optimize their health.

Primary health care is therefore not merely a selective package of medical services and even though it is relevant at the primary level of health care, it is not merely describing a level at which health care services are delivered. In this paper, it is the holistic concept of primary healthcare and its implementation that I have attempted to analyze in the Indian context.

III. IMPORTANCE OF PRIMARY HEALTH CARE

Primary health care forms the foundation of any health care system. It is the first point of contact of the community with health services and can meet a majority of the community's health needs.¹⁴ The primary level of care is the first tier of service delivery in the three-tiered delivery system prevalent in India. Primary care facilities are positioned close to people with the ability to influence healthy behaviours, promote health impacting the broader social determinants of health, such as clean drinking water, sanitation, and education.¹⁵

There is evidence to support the critical role primary health care has played in preventing illness and death.¹⁶ There is also evidence that it is a good value investment, as primary health care reduces total healthcare

¹³ L.K. Muldoon, W.E. Hogg, M. Levitt, *Primary care (PC) and primary health care (PHC): What is the difference?* 97 *Canadian Journal of Public Health* 409 (2006), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6976192/>.

¹⁴ *World Health Report 2008: Primary care now more than ever*, World Health Organization, available at https://www.who.int/whr/2008/whr08_en.pdf.

¹⁵ K. Rasanathan, E.V. Montesinos, D. Matheson, C. Etienne, T. Evans, *Primary health care and the social determinants of health: Essential and complementary approaches for reducing inequities in health*, 65 *Journal of Epidemiology and Community Health* 656 (2011), available at <http://dx.doi.org/10.1136/jech.2009.093914>.

¹⁶ B. Starfield, L. Shi, J. Macinko, *Contribution of Primary Care to Health Systems and Health*, 83 *The Milbank Quarterly*, 457 (2005); J. Macinko, B. Starfield, T. Erinosho, *The impact of primary healthcare on population health in low- and middle-income countries*, 32 *The Journal of Ambulatory Care Management* 150 (2009), available at [10.1097/JAC.0b013e3181994221](https://doi.org/10.1097/JAC.0b013e3181994221).

costs and improves efficiency by reducing hospital admissions.¹⁷ The compelling evidence leads the WHO to conclude that, “the broad focus of primary health care, along with the social determinants of health, should be kept foremost in the policies of all countries.”¹⁸ Primary health care is important now, more than ever, as the world has set itself the Sustainable Development Goals (SDGs). Many goals, such as improving and ensuring child health, curbing communicable diseases, and safeguarding mental health can be directly addressed through primary health care and approximately 16 other SDGs are impacted by primary health care indirectly.¹⁹

1. An Epidemiological Shift in Disease Burden

Primary health care is also the need of the hour, given the shifting trends of disease burdens, globally and specifically in India. The global burden of disease study, a comprehensive worldwide assessment of epidemiological trends, reports a shift in the pattern of diseases from communicable towards non-communicable diseases (“NCDs”) as the leading causes of death.

NCDs include cardiovascular diseases, diabetes, respiratory illness and cancers that together account for 80% of premature mortality globally.²⁰ Cardiovascular diseases were the leading cause of death worldwide in 2016 and the risk factors with the highest burden were obesity and hypertension.²¹ The same trends are seen in India where, in the last decade, NCDs have overtaken communicable diseases to become the leading cause of death.²² In 2016, deaths due to communicable, maternal, neonatal, and nutritional diseases were 27.5% (95% UI 25.4–31.5), due to NCDs were 61.8% (58.2–64.0) and due to injuries was 10.7% (9.6–11.2).²³

Providing care for persons with a chronic condition is a huge challenge for health systems worldwide, including India.²⁴ Chronic disease care

¹⁷ Supra 3.

¹⁸ Supra 14.

¹⁹ L.M. Pettigrew, J. De Maeseneer, M.P. Anderson, A. Essuman, M.R. Kidd, A. Haines, *Primary health care and the Sustainable Development Goals*, 386 *Lancet* 2119 (2015), available at [https://doi.org/10.1016/S0140-6736\(15\)00949-6](https://doi.org/10.1016/S0140-6736(15)00949-6).

²⁰ *Noncommunicable diseases*, World Health Organization, <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>, last seen on 27/04/2020.

²¹ M. Naghavi, A.A. Abajobir, C. Abbafati, K.M. Abbas, F. Abd-Allah, S.F. Abera, et al., *Global, regional, and national age-sex specific mortality for 264 causes of death, 1980–2016: a systematic analysis for the Global Burden of Disease Study 2016*, 390 *Lancet* 1151–1210(2017), available at [https://doi.org/10.1016/S0140-6736\(17\)32152-9](https://doi.org/10.1016/S0140-6736(17)32152-9).

²² L. Dandona, R. Dandona, G.A. Kumar, D.K. Shukla, V.K. Paul, K. Balakrishnan, et al. *Nations within a nation: variations in epidemiological transition across the states of India, 1990–2016 in the Global Burden of Disease Study*, 390 *Lancet* 2437 (2017), available at <https://www.sciencedirect.com/science/article/pii/S0140673617328040>.

²³ *Ibid.*

²⁴ E. Nolte, M. McKee, *Caring for people with chronic conditions: a health system perspective*, McGraw-Hill Education (2008).

requires the sustained engagement of the health system with the patient over prolonged periods, often extending to the patient's lifetime. Continuity of care, in terms of information regarding medication and investigations as well as relational concerning the service provider,²⁵ is essential to the management of the disease. Coordination of care between multiple providers and health system levels is also required as, in the course of most chronic diseases, specialty care is usually required. Health systems need to support lifestyle behaviours, and self-management skills of the person and the family. Primary health care is positioned well to provide all these essential elements of chronic care.²⁶

IV. PRIMARY HEALTH CARE AND INDIA

Primary health care in India has traditionally been provided mainly by the government. The Primary Health Centre ("PHC") has been the basic unit of service provision and a PHC usually caters to a population of 30,000 persons.²⁷ The staff at a PHC typically includes a doctor, a nurse, a lab technician, and the pharmacist. The rural infrastructure for primary care also includes sub-centres ("SCs") that were created for every 5000 persons in the community.²⁸ As of 31st March 2019, there were 1,57,411 SCs and 24,855 PHCs in India. The sub-centre is staffed by an auxiliary nurse midwife and a male and female multipurpose health worker. The activities envisaged at the sub-centre level, such as awareness and vaccination, are mainly to promote health whereas at the PHC curative services are provided.²⁹

PHCs also function as gatekeepers, referring to higher, secondary and tertiary levels of care only when specialized care is required. The National Health Mission launched in 2005 substantially contributed to the strengthening of health infrastructure, health personnel, equipment and essential medicines.³⁰ There have also been notable contributions from non-governmental, faith-based and not-for-profit health care

²⁵ D. Schwarz, L.R. Hirschhorn, J.H. Kim, H.L. Ratcliffe, A. Bitton, *Continuity in primary care: A critical but neglected component for achieving high-quality universal health coverage*, 4 *BMJ Global Health* 1 (2019), available at <http://dx.doi.org/10.1136/bmjgh-2019-001435>.

²⁶ E.H. Wagner, B.T. Austin, K.M. Von, *Organizing care for patients with chronic illness*, 74 *The Milbank Quarterly* 511 (1996), available at <https://www.ncbi.nlm.nih.gov/pubmed/8941260>.

²⁷ *(IPHS) Guidelines For Primary Health Centres revised 2012*, Ministry of Health and Family Welfare, available at <http://health.bih.nic.in/Docs/Guidelines/Guidelines-PHC-2012.pdf>.

²⁸ *Indian Public Health Standards (IPHS) Guidelines for Sub-Centres Revised 2012*, Ministry of Health and Family Welfare, available at <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154>.

²⁹ M. Chokshi, B. Patil, R. Khanna, S.B. Neogi, J. Sharma, V. K. Paul, S. Zodpey, *Health systems in India*, 36 *Journal of Perinatology* S9 (2016), available at <https://doi.org/10.1038/jp.2016.184>.

³⁰ *Framework for implementation National Health Mission, 2012-2012*, www.nhm.gov.in, available at <https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf>.

organizations that were at the forefront of the health-for-all movement that gained momentum after the Alma Ata Declaration.

V. CHALLENGES TO IMPLEMENTATION OF PRIMARY HEALTH CARE IN INDIA

The primary challenge in implementing primary care in India is the departure from a holistic vision of primary health care that is comprehensive, accessible to all, contextually relevant and rooted in communities.³¹ Most primary health centres merely provide limited, disease-specific curative services. The current emphasis on vertical disease control programs such as tuberculosis and leprosy contribute to the lack of comprehensive, integrated service delivery.³² The vertical disease program structure identifies a clear flow of funds and delineates activities that need to be done at various levels of health care. While vertical programs are an efficient way to manage health care delivery, they are usually driven from the 'top'. People are at the receiving end of such arrangements and not at the centre of planning or delivery as envisaged in primary health care.

The underlying distinction between vertical and horizontal approaches is the contradiction of power; where the horizontal approach responds to patients' needs and the vertical approach is more suited to the requirements of the state.³³ The vertical arrangement of services becomes a challenge because it impedes the integration of services and a person-centered approach that are the hallmarks of primary health care. Further, it also restricts participatory approaches to designing and delivering healthcare in a bottom-up approach that is central to primary health care.

1. Reorientation to Team-Based Care for Chronic Disease

Another major challenge in delivering primary health care today is the increasing burden of chronic non-communicable diseases. The burden of communicable diseases such as diarrhoea, pneumonia, and tuberculosis in India continues to be high and NCDs are an additional burden on the health care delivery system. The epidemiological shift, described earlier in this paper, has resulted in a dual burden for health care. Our health care system is traditionally designed to deal with acute disease conditions and

³¹ Y. Balarajan, S. Selvaraj, S.V. Subramanian, *Health care and equity in India*, 377 Lancet 505 (2011), available at [https://dx.doi.org/10.1016%2FS0140-6736\(10\)61894-6](https://dx.doi.org/10.1016%2FS0140-6736(10)61894-6).

³² S. Ramani, M. Sivakami, L. Gilson, *How context affects implementation of the Primary Health Care approach: an analysis of what happened to primary health centres in India*, 3 BMJ Global Health (2019), available at <http://dx.doi.org/10.1136/bmjgh-2018-001381>.

³³ S. Cairncross, H. Periès, F. Cutts, *Vertical health programmes*, 349 Lancet S20 (1997), available at [https://doi.org/10.1016/S0140-6736\(97\)90079-9](https://doi.org/10.1016/S0140-6736(97)90079-9).

now needs to be reoriented to care for persons with a chronic condition.³⁴

The organization, at the level of primary care, must ensure that services are continuous, coordinated and ensure consistent access to medicines.³⁵ This will involve putting in place health information systems, training and skill-building of health care professionals, referral mechanisms to allow patients to move between levels of health care as well as counselling that empowers patients.

Ensuring care for chronic diseases requires that different tasks such as recording information, counselling, examining are shared and distributed between the team members at PHCs. Each member of the team needs to be empowered to deliver aspects of care such as the nurse counsels' patients, the pharmacist ensures patient information is captured, etc. Chronic disease care needs to be team-based and studies show that improved outcomes of care result from meaningful interactions between a proactive team and empowered patients.³⁶ However, there are challenges inherent to the Indian health system, in implementing team-based care, that are often overlooked.

The organizational culture at primary care facilities characterized by strong hierarchies³⁷ is known to inhibit equal participation of all team members in the enactment of team-based care. The doctor is usually at the apex of the hierarchy and team members perform tasks directed by the doctor. Typically, primary care team members, in the Indian context, do not participate equally and do not take individual responsibilities. Reorienting primary care in India will need to include these additional aspects relevant to the context.

2. Trust Between Providers and People

Trust is understood to be a fundamental underlying principle in all social interactions. In health care, trust is the basis of the relationship between providers and patients. Trust has been conceptualized as a patient's

³⁴ D. Lall, N. Engel, N. Devadasan, K. Horstman, B. Criel, *Challenges in primary care for diabetes and hypertension: an observational study of the Kolar district in rural India*, 19 BMC Health Services Research 44 (2019), available at <https://doi.org/10.1186/s12913-019-3876-9>.

³⁵ D. Lall, N. Engel, N. Devadasan, K. Horstman, B. Criel, *Models of care for chronic conditions in low/middle-income countries: A "best fit" framework synthesis*, 3 BMJ Global Health (2018), available at <https://doi.org/10.1136/bmjgh-2018-001077>.

³⁶ E.H. Wagner, B.T. Austin, C. Davis, M. Hindmarsh, J. Schaefer, *A Bonomi Improving chronic illness care: translating evidence into action*, 20 Health Affairs 64(2001), available at <https://doi.org/10.1377/hlthaff.20.6.64>.

³⁷ M.A. Hall, E. Dugan, B. Zheng, A.K. Mishra, *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?*, 79 The Milbank Quarterly 613 (2001), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2751209/pdf/milq_223.pdf.

voluntary acceptance of vulnerability in the expectation that the healthcare provider will do the best for him.³⁸ Trusting the health care provider is determined by a patient's assessments of physician rapport, compassion, understanding, and honesty.³⁹ Studies indicate that trust between healthcare providers and patients impacts compliance, regular follow up and better outcomes of disease conditions.⁴⁰ Trusting relationships also enable providers to identify and address the social determinants of health at the primary level of care.

In India, there is an acknowledgement of the erosion of trust between providers and people.⁴¹ This is reflected in the poor utilization of public health services and the preference for private providers.⁴² People do not feel confident to seek care at primary health facilities and instead seek private care. Care at public facilities is associated with long waiting times among hordes of other patients.⁴³ Further, many medicines and tests are not available in the public sector, so patients have to go to private shops and laboratories.

The lack of attention to primary health care has contributed to the unregulated rise of the private sector, unethical practices and lack of transparency that has further eroded trust between provider and patients. A health system founded in trusting relationships contributes to generating wider social value and better health outcomes.⁴⁴ The increasing deficit of trust between healthcare providers and the community in the Indian context is, therefore, a big challenge, especially in the provision of primary health care.⁴⁵

3. Financial Resources

³⁸ V Gopichandran, *Trust in healthcare: an evolving concept*, 10 Indian Journal of Medical Ethics 79 (2013), available at <https://doi.org/10.1136/bmjgh-2018-001077>.

³⁹ S.D. Pearson, L.H. Raeke, *Patients' trust in physicians: Many theories, few measures, and little data*, 15 Journal of General Internal Medicine 509 (2000), available at <https://dx.doi.org/10.1046%2Fj.1525-1497.2000.11002.x>.

⁴⁰ S. Chandra, M. Mohammad Nezhad, P. Ward, *Trust and Communication in a Doctor-Patient Relationship: A Literature Review*, 3 Journal of Healthcare Communications 36 (2018), available at DOI: 10.4172/2472-1654.100146.

⁴¹ S. Kane, M. Calnan, *Erosion of trust in the medical profession in India: Time for doctors to act*, 6 International Journal of Health Policy and Management 5 (2017), available at <https://dx.doi.org/10.15171/ijhpm.2016.143>.

⁴² Supra 29.

⁴³ A. Sengupta, S. Nundy, *The private health sector in India*, 331 The BMJ 1157 (2005), available at <https://doi.org/10.1136/bmj.331.7526.1157>.

⁴⁴ M. Calnan, R. Rowe, L. Gilson, *Trust in health care: theoretical perspectives and research needs*, 20 Journal of Health Organization and Management 359 (2006), available at <https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1108%2F1477726061070168>.

⁴⁵ S. Kane, M. Calnan, A. Radkar, *Trust and trust relations from the providers' perspective: the case of the healthcare system in India*, 12 Indian Journal of Medical Ethics 157 (2015), available at <https://doi.org/10.20529/IJME.2015.045>.

The other major challenge to realizing primary health care is chronic under-funding for health in India. Competing interests and poor political will may be reasons for the poor allocation of resources to health. India is among the countries with the lowest spending on health according to the World Bank.⁴⁶ Primary care for chronic conditions requires financial resources to ensure health professionals, access to medicines and robust information systems. The Ayushman Bharat Yojana proposes to develop 1.5 lakh health and wellness centres to deliver comprehensive services, both promotive and curative.⁴⁷ However, there is no substantial increase in budgetary allocations for the same.⁴⁸

4. Governance and Leadership for Primary Health Care

Governance and leadership in health systems involve ensuring that policy frameworks are combined with effective oversight, regulation, and accountability. Leadership and governance structures that commit to implementation of primary health care are lacking in India. For example, there is no governance structure in the ministries of health, at the state or central level, which monitors the implementation of primary health care. Another example is the disease-focused indicators currently used to measure primary health care.

There is no standard definition of leadership in health, however, it is known to be centered on the ability to identify priorities, provide strategic direction to multiple actors within the health system, and create commitment across the health sector to address those priorities for improved health services.⁴⁹ It can be argued that the challenges of financial resources, trust between providers and people and comprehensive models of care are all related to governance and leadership issues within the Indian health system. Developing leaders that have the vision and commitment to realize primary healthcare is a challenge that is not unique to the Indian setting.⁵⁰

Leadership for primary health care providers is not taught in medical curricula nor included in the orientation of PHC doctors. Leadership

⁴⁶ *Country Profiles*, The World Bank, available at <http://data.worldbank.org/data-catalog/country-profiles>, last seen on 19/01/2016.

⁴⁷ *Home*, National Health Portal of India, available at <https://www.nhp.gov.in/>.

⁴⁸ V. Paul, A. Shukla, T. Sundararaman, *Can Ayushman Bharat make for a healthier India?*, *The Hindu* (13/04/2018), available at <https://www.thehindu.com/opinion/op-ed/can-ayushman-bharat-make-for-a-healthier-india/article23516837.ece>, last seen on 19/07/2018.

⁴⁹ S. Chunharas, D.S.C. Davies, *Leadership in health systems: A new agenda for interactive leadership*, 2 *Health Systems and Reform* 176 (2016), available at <https://doi.org/10.1080/23288604.2016.1222794>.

⁵⁰ S. Cleary, A. Du Toit, V. Scott, L. Gilson, *Enabling relational leadership in primary healthcare settings: Lessons from the DIALHS collaboration*, 33 *Health Policy Plan* 65 (2018), available at <https://doi.org/10.1093/heapol/czx135>.

development through structured training programs is used in several countries to overcome this challenge and could be included at the time of inducting medical officers at PHCs.⁵¹ Mentorship and positive role modeling are other ways in which leadership can be built.

VI. THE WAY FORWARD - WHO OPERATIONAL FRAMEWORK

The World Health Organization (WHO) provides a comprehensive operational framework for implementing primary health care across countries.⁵² This framework is useful for planning as it identifies key elements within the health system that are crucial to advancing primary health care in countries.

Key elements in the WHO operational framework are referred to as 'levers' and are broadly categorized as those that enhance governance and those that deal with operational issues. The two are interdependent and most levers have both a policy and an operational component. Table 1 summarizes the levers and relates them to the components of primary health care over which each lever has the most influence. Both governance and operational issues directly impact the enactment of the core concepts of primary care, namely comprehensive essential care, multisectoral action to address social determinants of health and the empowerment of people and communities (Table 1).

While the framework provides a list of actions, these are not to be interpreted as meaning that each country should undertake every action in every lever. Instead, the suggestions are intended to provide practical, evidence-based actions that countries that are committed to improving primary health care can use to accelerate efforts.⁵³ Each country would need to prioritize as well as choose actions based on contextual issues relevant to their setting for action. I suggest below a few of these priorities for India.

Table 1: WHO Operational Framework for Primary Healthcare¹²

Levers	Primary health care elements		
		Comprehensive essential services	Multisectoral action to address social

⁵¹ T. Wanwick, R. Varnam *Leadership development and primary care*, 3 BMJ Leader 59 (2019), available at <http://dx.doi.org/10.1136/leader-2019-000145>.

⁵² Supra 7.

⁵³ Supra 12.

		determinants	es
Governance Levers			
Political commitment and leadership	✓	✓	
Governance and policy frameworks	✓	✓	✓
Adequate funding and equitable allocation of resources	✓	✓	
Operational Levers			
Engagement of community and other stakeholders to jointly define problems and solutions to prioritize actions	✓	✓	✓
Models of care that prioritize primary care and public health functions	✓		✓
Ensuring the delivery of high-quality and safe health care services	✓		✓
Engagement with private sector providers	✓	✓	
The workforce	✓		✓

Physical infrastructure and appropriate medicines, products and technologies	✓		
Digital technologies	✓	✓	✓
Purchasing and payment systems	✓		
Primary healthcare-oriented research	✓	✓	✓
Monitoring and evaluation			

VII. OPERATIONALIZING THE ELEMENTS OF PRIMARY HEALTH CARE- OPPORTUNITIES AND ACTIONS FOR INDIA

1. Comprehensive Essential Services

Universal health coverage and the provision of essential services at health and wellness centres proposed in the recently launched Ayushman Bharat scheme is a huge opportunity in India that should be maximally leveraged to deliver primary health care. I recommend attention to funding for health as a priority action of the governance lever in the WHO operational framework for India. There is a need for health care providers and civil society to continue to push for greater budgetary allocations by the government.

The private sector takes care of a large proportion of the primary health care needs in India and is a reality that is here to stay. The large private sector presents opportunities to increase population coverage through partnerships and strategic purchasing arrangements. These are operational actions that are recommended in the WHO operational framework and could be prioritized. Private health care providers, communities and civil society organizations should engage and participate in delivering primary health care. However, robust regulatory mechanisms to ensure quality and transparency will need to be established before entering into partnerships. Regulation regarding pricing, availability, and adherence to standards of quality of care will be required.

2. Multisectoral Action to Address Social Determinants

Political commitment to the vision of primary health care is a basic prerequisite to the delivery of primary health care and a priority action of the governance lever (WHO operational framework) for India. Ministries of health need to ensure that service delivery at primary care is not only comprehensive in providing essential medical services but also addresses social determinants of health through multisectoral action. To strengthen the governance of primary health care, a division within the Ministry of Health for primary care could coordinate multisectoral action (between sectors such as education, water, sanitation, public works). Strong leadership that can mobilize and bring together all stakeholders will be required to drive the agenda of primary health care in our context and settings. Some lessons can be learned from other countries, even though the local context is different, that have reported positive experiences in developing leadership for health systems.⁵⁴

3. Empowered People and Communities

Reorienting service delivery to a model for chronic care that is person-centred is an opportunity to empower communities. Encouraging and equipping families and communities to self-manage chronic conditions is the need of the hour that will only increase with the rising incidence of chronic conditions. Community participation to achieve health is a key concept of primary health care articulated in the Alma Ata Declaration. The Declaration states that primary health care ‘requires and promotes maximum community and individual self-reliance and participation in the planning, organization, cooperation and control of primary health care, making the fullest use of local, national and other available resources and to this end develops through appropriate education the ability of communities to participate’. I consider this a priority action, mentioned in the WHO operational framework as an operational lever to implement primary health care.

This has been achieved to varying degrees in India but needs to be applied widely. The National Rural Health Mission, in 2005, introduced the term ‘Communitisation’ to describe the institutionalizing and scaling up of community led action for health. The formation of village health and sanitation committees, the selection and training of social health activists, the involvement of panchayats (local self-government) to

⁵⁴ L. Gilson, I.A. Agyepong, *Strengthening health system leadership for better governance: What does it take?*, 33 Health Policy Plan 1 (2018), available at <https://doi.org/10.1093/heapol/czy052>; J. Daire, L. Gilson, S. Cleary, *Developing leadership and management competencies in low and middle-income country health systems: a review of the literature*, Resyst, available at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1024.7623&rep=rep1&type=pdf>, last seen on 19/07/2018.

monitor funds at the community level at community discretion, a formalized method to give people an opportunity at periodic hearings (Jan Sunwai or Jan Samvad) are initiatives that were begun and need to be continually strengthened. Nagaland's experience in communitisation is worth mentioning as they demonstrated significant improvement in health delivery, education, water management through community participation.⁵⁵

Primary health care-oriented research is also an activity that should be prioritized to strengthen primary health care delivery. There is a great role for research in determining the way forward. I bring to attention the need for funding this type of research as well as the need to build the capacity of researchers to employ methods suitable for this type of research. Implementation research and quality improvement research using mixed-method designs informed by the social sciences needs to be conducted to determine locally relevant solutions. Quality improvement initiatives, governance models, multi-sectoral actions, increased community participation, as I suggest, need to be backed by evidence of what works for whom in the Indian context.

VIII. CONCLUSION

Primary health care is the backbone of health systems world over. There is compelling evidence to support that investments in primary health care save lives and are cost-effective. However, the implementation of primary health care is challenging in the Indian context. Selective primary health care instead of comprehensive, acute episodic care models, an erosion of trust between providers and people and the chronic underfunding of health in India are major challenges to the implementation of primary health care in India.

The broad, system-level vision of primary health care that empowers communities and delivers health care close to people's homes in culturally relevant and appropriate ways, needs to be continually reinforced. Operationalizing the core concepts of primary health care will require political will, governance structures, strong leadership and engagement of all stakeholders including the community listed in the WHO operational framework. Lastly, implementation and quality improvement research to test local solutions and produce evidence for scale-up are opportunities to catalyse the move towards primary health care in India.

⁵⁵ K. Singh, K.K. Jha, *The communitisation of public institutions and services in Nagaland, India*, 40 *IDS Bulletin* 31 (2009), available at <https://doi.org/10.1111/j.1759-5436.2009.00082.x>.