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Primary Health Care Strengthening in India: Imperative to Providing Inclusive Health Care

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Abstarct:
The primary contributors to poor health are inequality and poverty. Access to adequate health care on a reasonable and fair basis in many sections of the country remains an unfulfilled desire. Healthcare disparity is seen as a compromise. "Right to Life" To promote inclusion in health care, it is vital to define "essential health care," which should be made available to all residents. The best use of public resources and more public investment in healthcare are recommended solutions. Strengthening capacity through training, particularly training paramedical staff, is a crucial component of cost reduction, particularly in tertiary care. Another significant component is the improvement in the health care delivery system.The progress of preventive care and decrease in tertiary care costs will result from expanding the role of "family physicians" in the health care delivery system. These findings support the importance of primary healthcare and its function in providing inclusive healthcare. More access to necessary treatments, higher care quality, an emphasis on prevention, early management of health issues, and overall health gains and decreased morbidity as a consequence of primary health care delivery are all benefits of the primary health care paradigm for the delivery of health services.

Keywords: Health Economics, Inclusive Health Care, Capacity Development, and Accessible Health Care.

Introduction

The British Government in India created medical services in the middle of the 18th century, principally for the benefit of British nationals, armed personnel, and wealthy government officials. Indigenous medical systems have been completely ignored. The services provided by general hospitals in major cities and commercial hubs were mainly curative.Yet, medical education and health planning were based on something other than the requirements of the general public. Due in significant part to this pervasive Western bias, a

small number of people have blindly adopted advanced modern medicine while disregarding the vital interests of the vast majority. [(1)]

The Government of India planned numerous options for health care delivery in independent India, bearing in mind constitutional requirements. The suggestions made by the 'Health Survey and Development Committee' (Bhore Committee) in 1946 laid the groundwork for the organization of health services in India through primary health care. [(1)] Throughout the last two decades, there has been rising concern about the performance of India's healthcare delivery system. According to the Government of India's (GOI) National Rural Health Mission (NHRM) Document (2005), just 10% of Indians have some health insurance, and over 40% of Indians must borrow money or sell assets to fulfill their health care needs. [(2)]A single episode of sickness causes over 25% of Indians to fall below the poverty level. The Indian government implemented an inclusive growth policy during the 11th plan, which was continued in the 12th plan.3 Inclusive growth entails the development of all population segments, including children, women, and other disadvantaged groups. India aims for inclusive growth in various areas, including education, health, energy and resources, telecom and technology, finance, and infrastructure.

In light of the current state of health care services in India, this article proposes strategies to promote inclusion in vital health care.

Indian Healthcare System Status

In India's poorest areas, maternal and infant mortality rates are higher than in Sub-Saharan Africa. India has the highest burden of infectious illnesses globally, accounting for 21% of the global disease burden. [(4-6)]From 2006-2015, India's predicted total loss of national income owing to non-communicable disease mortality was USD237 billion. **[(7)]**

India is rated third among nations having a high prevalence of HIV infection. [(8)]Diarrheal illnesses are the leading causes of death in children under five. [(9)]In India, many illnesses are caused by poor sanitation and a lack of clean drinking water. [(10)] Inadequate sanitation and a lack of access to basic necessities significantly add to the nation's health burden. About 50% of the population (638 million) defecates in the open because more than 122 million households lack toilets and 33% lack access to restrooms. [(11)]

India's system of providing healthcare

The Indian healthcare industry, divided into three tiers: primary, secondary, and tertiary, is distinguished by numerous diverse healthcare delivery systems, including the government, not-for-profit, charity organizations, corporate hospitals, and smaller private clinics. There are no clearly defined forward or backward connections between these. [(12)]

Infrastructure for public health in India

It needs to be more funded, understaffed, and underequipped. In India, the urban population accounts for less than one-third of the overall population. Compared to rural regions, allopathic physicians are more concentrated in cities (13.3 and 3.3 per 10,000 population, respectively). Nurses and midwives are equally clustered in cities (15.9 and 4.1 per 10,000 populations). [(13)]

The population density of allopathic physicians is 4.28 per 10,000 people. [14] In India, there are around 0.81 nurses for every allopathic physician, implying that there are more physicians than nurses. The nurse-to-doctor ratio is relatively low in healthcare systems. According to the 1993 World Development Report, the percentage of nurses to doctors should be more than 2:1 as a rule of thumb, with 4:1 or higher regarded as more desirable for cost-effective and quality treatment. Nurses may provide many primary clinical care and public health services at a lesser cost than qualified physicians, particularly at the community level.

Just 12% of the 660,856 physicians registered in India work in the public sector. [13] According to the approach paper for the 12th five-year plan, 10% of doctor positions at primary health centers, 63% of specialist positions at community health centers, 25% of nursing positions at PHCs and CHCs combined, 27% of pharmacist positions, and 50% of laboratory technician positions are vacant in 2010. [3]

India, which ranks among the world leaders in the production of generic medications, has the most significant number of individuals who lack access to essential medicines. [8]

Unrestricted private health industry

Both urban and rural Indian households prefer to use the private medical sector over the governmental sector. [15] According to several surveys, the private health sector accounts for more than 70% of all primary care and more than 50% of all inpatient care. [15] The private health industry, conversely, is focused on curative care. Many reasons are given for depending on the private sector rather than the public sector; at the national level, the primary cause is the low quality of care in the public sector. Other factors include the public sector facility's location, excessive wait periods, and inconvenient operating hours. [13]

At one end of the range are private hospitals with world-class facilities and people providing treatments that are reasonably priced compared to equivalent services elsewhere but remain out of reach for most Indians. On the opposite end of the spectrum, an unregulated private sector is less expensive but provides services of uneven quality, typically by unqualified practitioners.

Expenses of Health Care

It has been noted that private health sector spending is growing while public health spending is decreasing. In India, public spending on health care is as low as 0.9% of GDP, compared to a total health expenditure of 5%, making public health expenditure 17%. [16] Reduced public health spending has hurt health outcomes.

The typical rural subcenter serves four settlements with a service delivery radius of 2.61 kilometers. [17] Comparing the influences of access and economic status reveals that the latter is a more important factor in access to institutional delivery in rural India. [18]

Discrepancies between urban and rural areas

The 2011 Census shows that 377 million Indians reside in urban areas. [19] Rural regions see a greater rate of non-treatment due to "financial problems" and "lack of medical facilities" than metropolitan ones. [20] About 25% of the rural and 75% of the urban populations have access to piped water. [13] Just 20% of all hospital beds are in rural regions,

even though 68% of Indians live there. [13]Due to an imbalance in the distribution of specialists between urban and rural regions and the perceived poor quality of health care services, nearly two-thirds of patients in urban hospitals come from rural areas. [20] Half of the rural population remains impoverished, battling for improved access to health care and services. [20]

According to the National Family Health Survey III (2005-06), the under-5 mortality rate among urban poor children is 72.7 percent higher than the urban average of 51.9 percent.[13] More than half of urban poor children are underweight, and over 60% do not obtain complete vaccination before the end of their first year. [21]Slums' poor environmental conditions and high population density make residents particularly prone to respiratory ailments such as asthma and tuberculosis. [22] The effect of disparities in access to health care has demonstrated that the infant mortality rate in the poorest 20% of the population is 2.5 times greater than that in the wealthiest 20%. [13]These statistics highlight the critical need to provide health care to the urban poor.

Disparities in Social Status

Children under three in scheduled tribes and castes are twice as likely as children in other groups to be malnourished. [23]

In light of the discussion above of the state of healthcare services in India, the following measures for fostering inclusion are proposed:

Inclusive is a phrase that is frequently used in the context of expansion to denote 'wide-ranging' or 'all-encompassing.' In health care, 'inclusive' indicates that health care is available to all segments of society. In India, this entails providing health care to the whole population of almost 1.2 billion people. While achieving "complete health care" for everyone is a pipe dream for any society, we must consider giving primary and, if possible, secondary health care to all.

- **Defining necessary medical treatment and health education regarding the standard of care**

Although it is very tempting to consider every component of health care crucial, one must consider the harsh realities of economics. Thus, educating the general public on the difference between desirability and essentiality is necessary. The necessary services to which every person may be entitled include primary health care services, which may be described and classed under that heading. There is no doubt that primary and preventive healthcare is crucial. Health education focusing on illness prevention via awareness and knowledge about treatment options must also be regarded as necessary health care.

- **Improving Capacity**

The technical proficiency and abilities of individual health professionals, their motivation to execute their professions, and their capacity to cover a variety of socio-economic groups and geographic locations are all significant factors that affect the operation of the health system and population health.There is a severe scarcity of healthcare workers. An appropriate health workforce regarding numbers and skill mix is crucial for nations such as India that want to make significant progress toward meeting the Millennium Development Goals for health.

Current research indicates that increased availability of health professionals is connected with improved service usage and health outcomes such as vaccine coverage, primary care outreach, and newborn, child, and mother survival. [(24)] In addition to numerical strength, the effectiveness of the health workforce is influenced by the skill mix, quality, and geographical distribution of health workers, a work environment and infrastructure that allows them to use their skills effectively, adequate remuneration, and opportunities for skill upgrading and refreshing.

More broad-based training programs are needed to develop the second tier of healthcare workers, such as Physician Assistants, Medical Technologists, and Nurse Practitioners, so that doctors may devote their abilities to more challenging jobs. This is not to be interpreted as a loss of quality. Multi-skilling, which allows paramedics to conduct duties within their ability but outside of their typical professional roles, is a way to enhance system efficiency. [(25)] Consultants frequently look at common health problems that might have been readily addressed by a well-trained second-rung paramedic or a good nurse, lowering treatment costs while improving outcomes.

- **Enhancing the healthcare delivery system**

There are several advantages to receiving health care from designated primary care physicians or family physicians. This will lower the expense of long-term care and assist patients in deciding the necessity for needless expensive therapy. [(26)] Areas with superior primary care will have better health outcomes, including lower total death rates, lower heart disease mortality rates, and lower newborn mortality rates, as well as early identification of malignancies such as colorectal cancer, breast cancer, and uterine/cervical cancer. We must guarantee that NUHM subcenters, ICDS centers, and PHCs serve all urban slums and settlements. The continued efforts to integrate AYUSH and increase the competence of other traditional healthcare practitioners, such as Registered Medical Practitioners (RMPs), must be strengthened.

Because the density of health professionals in India is fewer than the WHO requirement of 2.5 employees per 1000 people, policy actions are needed to enhance the density of health workers, particularly in rural regions and economically deprived states. Just 193 of the 640 districts have medical colleges; the remaining 447 districts do not have any medical institutions. Furthermore, the present instructional capacity for training paramedics needs to be more adequate. We need to enhance the number of medical colleges in each district.New medical and nursing colleges should ideally be linked to district hospitals in underserved states and communities, with districts with populations of 25 lakhs or more preferred for constructing such colleges if they do not already have them. The actions done by India's Medical Council in this respect are applaudable.

- **Increasing the effectiveness of the public sector**

Instead of the commercial sector, the public sector must lead the health sector. Only until the impoverished and oppressed classes receive better treatment will inclusive health care be secured. If adequate illness treatments are not accessible in the government sector, we must find ways to treat impoverished patients at discounted prices in private institutions. For this to

happen, the public and private sectors must work together to provide inclusive health care to the people. One such element is care quality, and local collaboration between public health institutes and state health services might go a long way toward eliminating quality gaps.

Public funding for health care only sometimes implies that public providers provide the service. It is feasible to have public financing while private sector participants, subject to adequate regulation and control, supply the service. Several trials are presently in existence that allow for private-sector engagement. At the national level, the RashtriyaSwasthya Bima Yojana (RSBY) is a health insurance plan offered to the poor and other identified target groups. Partnerships are the keyword in public health, and our tactics must keep up.

- **Raising government expenditure on healthcare**

India's public spending is far lower than that of wealthy countries, not just in absolute numbers but also as a proportion of GDP. [27,28] The recent decision by the Government of India to boost health expenditure to 2.5% of GDP by the conclusion of the Eleventh Five-Year Plan (2012-17) from the present 1.4% is excellent news for the industry. [3]The government must invest more in healthcare infrastructure development. Yet, we must prioritize our goals for government expenditure.Something as simple as providing good sanitation and clean drinking water to its residents, tiny children, should be prioritized. Primary prevention and enhanced health education have been shown to reduce death and morbidity. [29] The next priority for government spending should be universal primary health care. These are diseases for which competent outpatient treatment may be able to avoid hospitalization or for which early management may be able to prevent complications or more severe illness. [30] Unnecessary hospitalizations are avoided with high-quality primary care. [31] As a result, healthcare expenses would be reduced. The primary care setting must be strengthened to provide inclusive health care. [32]

- **lowering the price of excessive tertiary healthcare**

Hospitals must prioritize the distribution of available capital as a group. It is critical to close the gap in access to high-quality health care between the affluent and the poor to avoid societal unrest.

- **Monitoring national health programs efficiently**

National Rural Health Mission, RashtriyaSwastya Bima Yojana, Rajiv Gandhi Creche Scheme for Children of Working Mothers (0-6 years old), Janani Suraksha Yojana, Janani Suraksha Karyakram, Integrated Child Protection Scheme, Support for Training and Employment of Women, RashtriyaMahilaKosh, etc. are just a few of the government's programs that have been implemented to promote inclusive health care. Within health delivery systems, we need creative management changes.

Reorganizing health initiatives like the Integrated Child Development Program (ICDS) is necessary. While the age group 0-3 years has the highest need for nutritional support, it mainly focuses on kids in the 3 to 6-year-old range who attend Anganwadis.

- **Community engagement**

The ability of a community to engage in the design and implementation of services impacts the success of a healthcare system. The capacity to design and manage such delivery

empowers the community while improving access, accountability, and transparency. Healthcare delivery has to become more collaborative and inclusive.

This can be accomplished in three ways: (1) strengthening Panchayat Raj Institutes through improved devolution and capacity building for better design and management, (2) increasing user participation through institutionalized audits of health care service delivery for better accountability, and (3) biannual evaluation of this process by empowered civil society organizations for greater transparency.Methods based on community-based monitoring, which have proven effective in some regions of the nation, will need to be implemented in others.

The organized private sector provides almost little health care at the primary level, highlighting the necessity for substantial public resources to develop a public sector health system.

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