HSTP
Health Systems Transformation Platform

Basic Healthcare Services

ACCESS health international

FUTURE DESIGNS OF PRIMARY HEALTHCARE IN INDIA: REPORT OF A WORKSHOP

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"He aha te mea nui o te ao
He tangata, he tangata, he tangata"

"What is the most important thing in the world?
It is the people, it is the people, it is the people"

Maori proverb

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EXECUTIVE SUMMARY

Background

Evidence from across the world shows that countries that have a strong primary healthcare system have better health outcomes, lower inequalities, and lower costs of care. Increased investments in Primary Health Care in India between the years 2005-2015 led to equitable improvements in health related behavior and coverage of preventive interventions. However, access to curative care and out-of-pocket expenses on healthcare remained more or less static.

Indian primary healthcare systems in rural areas, based on a network of primary health centers and community health centers, were designed almost seven decades ago, based on Bhore Committee recommendations. National Rural Health Mission (NRHM) infused newer resources, and redesigned some elements, especially creating the cadre of community volunteers (ASHAs) and setting up an assured referral transport (108). National Health Policy 2016 and subsequently launched Ayushman Bharat aims to expand the scope and reach of primary healthcare through a network of 150,000 Health & Wellness Centers.

Changing epidemiology, shrinking fiscal space and rapid urbanization are creating new challenges for India's primary healthcare system. Fragmentation of healthcare system in multiple programs and schemes, limit its impact on promoting health and wellness of the populations it serves. On the other hand, innovative ways of delivering and financing healthcare, and a greater understanding of need for integrated systems are creating new opportunities. Thus it is now imperative to develop new designs for delivering integrated and comprehensive healthcare that address the arising challenges and make use of the emergent opportunities.

Health System Transformation Platform (HSTP), in partnership with Basic Health Care Services (BHS), Post-Graduate Medical Education & Research (PGIMER) and Access Health International, convened a consultation to arrive at a common understanding of primary healthcare and its principles, and to identify key issues and elements of primary healthcare models for the future. The workshop also hoped to connect a group of like-minded professionals who work collectively to design, implement and evaluate such models. Over 40 practitioners, academicians, trainers, financing experts and health technology experts from various institutions participated and shared their expertise and insights.

The following section draws from presentations and discussions from the workshop, and articulates a vision and components of primary healthcare for the future. It presents the paradigm and critical design elements of primary healthcare models of the future, ending with an agenda for organizations like Health Systems Transformation Platform (HSTP) to enable the vision of robust and equitable primary healthcare systems of the future.

Attributes of Primary Healthcare

The participants identified following attributes of primary healthcare that will stay relevant for future models:

Key attributes of Primary health Care

1. Delivers care closer to the community, within 30 minutes walking distance from home
2. Is the most accessible arm of the system – financially, geographically as well as curatively
3. Provides preventive, promotive services in a cost-effective manner. Focuses on screening and primary and secondary prevention.
4. Ensures person and population-focus rather than disease oriented care
5. Is universal in reach but also meets the needs of the most marginalized people
6. Is closely integrated with advanced levels of care
7. Caters to the catchment population, assesses risk of individuals and delivers care accordingly
8. Integrates information systems to enable continuity of care and timely public health action
9. Impacts health and wellness of the catchment population

Paradigm shift

The primary healthcare models will move from current paradigm of reactive to proactive; and from fragmented to integrated and accountable care. This will require a cultural shift from hospital and physician centric care to person and population centric care. Such a shift will strongly integrate public health functions with primary care.

Scope of services

The scope of primary care services will continue to include preventive, promotive and primary curative services. However, focus on screening and prevention of diseases will have to be enhanced, thereby decreasing costs and improving health outcomes. Primary health care models of the future will empanel a defined catchment, stratify the population by risk, and will be responsible for providing comprehensive care to that population.

Changing epidemiology of disease burden in India necessitates expansion of scope of services to include prevention, screening and management of non-communicable diseases, mental health and palliative care. However, in view of continuing high and unacceptable levels of disease and death due to communicable diseases such as tuberculosis and maternal-newborn conditions, primary health care systems will also need to be equipped to deal with this double burden. Availability of diagnostics for screening as well as early detection will play an important role in this.

To become proactive, and to provide continued care, Clinic based services will need to be well supplemented with home based and outreach services, which will also be opportunities for promoting healthy best practices and behaviours. In urban areas, keeping in mind, high levels of workforce engaged in potentially hazardous occupations, urban primary services will need to have the ability to detect and manage occupational health conditions.

Finally, it will be critical for primary healthcare systems to be actively linked to advanced care facilities, to cater to those who may need it.

Primary healthcare teams

Human resources are the most critical resources for delivering primary healthcare and will remain so, even though technology will increasingly play an important role in this sector. Nurses and community health workers will continue to be crucial for service delivery, however, they would need to be skilled, trained and empowered to perform their role.

The reliance on a standalone provider, such as a physician, will change and move to a multi-disciplinary team that will, at least, consists of a family physician, nurses, and community health workers. There will be need for a much larger cadre of suitably trained primary care physicians, and primary care nurses to lead the primary healthcare teams. Family physicians and nurse practitioners are likely to fill that role. A care coordinator will be crucial to provide comprehensive care, integrate various primary care functions, and plan continued care. Depending on the need for specific services such as dentistry and palliative care, there also will be a requirement of other professionals in the ecosystem, such as physiotherapists, and dentists.

Innovative and technology enabled ways of motivating, training and mentoring primary healthcare teams will be crucial to optimize performance. Large numbers of training sites will be required to train large numbers of primary care professionals. Primary healthcare personnel will need to be skilled in management and coordination functions, as well as have clinical skills. Continued training and mentoring will be instituted to ensure maintenance and upgrading skills.

Quality of Care

Having more physicians per population (from the current 1:25,000 in public systems) will mean more time and attention per person, and would lead to improved quality. Besides this, an integrated Health Management Information system, which may be in the form of simple and well designed excel-sheets (as in the case of Massachusetts), can enable quality and continued care. Improvement of primary healthcare will also be contingent on improving quality of secondary and tertiary care to provide referral care. One of the ways to do so, as in the case of National Capital Territory of New Delhi, is to take primary care out of hospitals.

Delivering quality primary healthcare will require standardization of care protocols (including for referral) incentives based on high quality care, external audits to measure performance and continued medical and nursing education. Expanding the assured availability of drugs and supplies will be crucial to maintain quality. Primary care services will need to cyclically and continuously measure, report and improve.

Patients' rights will need to be defined, and redressal mechanisms set up wherever they are violated. In order to enforce quality, healthcare organizations will have to move from standardized reimbursement to performance incentives, based on coordinated and quality care. Government will have to ensure good governance, and enforce regulation, for public-run as well as private services.

Organizing healthcare

Populations will be serviced by a network of Family Health Units (with different names), each of them being responsible for an empanelled catchment population. A group of healthcare professionals (family physicians and paramedics) will organize themselves, and will be entrusted to provide healthcare to a given population.

Moving ahead, there are likely to be two parallel running paths: these family health units would be funded and managed by the government, or an association of professionals will be engaged by the government to provide services to a defined population. In urban areas, where there is limited state infrastructure, and greater availability of private players, there would be a tilt towards the latter.

Such an association will be reimbursed through a mix of payments: incentives for performance and capitation. Alternately, cross-subsidization-higher fees from those who can afford, to subsidize those who cannot, will also play a larger role. Government will have to substantially enhance its capacity to manage contracts, and to regulate.

Community participation and decentralized governance

Close engagement with families and communities will remain a fundamental element of primary health care models of the future. They would be located in communities and neighborhoods, and health workers from within the communities, would provide the interface between the community and health facility. In remote and impoverished areas, primary healthcare services will also address other socio-cultural barriers to improved health. For ensuring that healthcare providers are sensitive to the social and economic realities of the populations they serve, primary healthcare professionals of future will need to be immersed and trained in these communities. Primary Health Care Staff will maintain long term relationships and forge trust with the empanelled families. Mechanisms to ensure that communities can hold the service providers accountable for delivery and quality of care, and for service providers to engage communities in planning healthcare, will be instituted.

More and more states will adopt a decentralized form of governance of primary health services, as in Kerala, to ensure community participation and ownership in its true spirit. Such a form of governance will however need to be supplemented with strong technical oversight by the health systems.

Financing primary healthcare

Primary health care services will require much greater financial resources, innovative funding mechanisms and leaner and more efficient operations. Aim will be to reduce out-of-pocket expenditure and prevent impoverishment on one hand, and increased equitable access to high quality care on the other.

While the central and state governments will need to, and have committed to, enhance their allocations to healthcare in general and primary healthcare in particular, limited fiscal space in future may prohibit some states to do so. Alternative financing mechanisms such as cooperative based financing (as in Canada), Sin taxes (as in Philippines), Employee State Insurance (for informal sector workers), and CSR funding would play a larger role. Alternative ways to engage and incentivize providers (especially to a group of providers) to provide ethical and quality services to a population will evolve, as will the mechanisms of greater community contribution.

Agenda for the future

To enable the above vision of a robust and equitable primary healthcare in India, Health System Transformation Platform (HSTP), its partner organizations and others may pursue some of the following agenda:

1. *Design, implement and evaluate futuristic models of primary healthcare:* These models will take into account the design elements of future primary healthcare. Organizations such as HSTP can help design, implement and evaluate such innovative models in different contexts: in rural and urban, in close partnership with state governments.

   A special effort should be made to design models for remote and tribal areas, as well as for urban areas. Radically new thinking will be required to design urban models, especially for the marginalized populations such as migrants, as there is a limited experience and no clear structures.

2. *Identify and advocate for removal of barriers to provide primary healthcare:* There are several barriers to production and deployment of primary healthcare providers. For example, there are legal barriers to nurses practicing independently in primary care settings, and there are administrative barriers to increased production of family physicians. Organizations should identify these barriers and work towards their removal through sustained advocacy.

3. *Help set up training sites for primary healthcare professionals:* Primary healthcare professionals need to be immersed and trained in community settings. Non-availability of good quality community based training sites will inhibit production of competent and committed professionals. Organizations such as HSTP can help set up such sites.

4. *Generate data on costs and effectiveness of different interventions:* Such data would specially

be critical to help states decide on optimal primary care package.

5. *Evaluate and introduce relevant technology:* A large gamut of technology for instituting information systems, affordable and reliable screening and diagnostic services and training of human resources is available. HSTP should catalogue, promote and adopt those that would be most suitable and appropriate for primary healthcare systems of the future.
6. *Forum on Primary health Care:* There is a need for creating a network of primary healthcare practitioners and academics to continue to exchange ideas, share resources and advocate for suitable policies. HSTP can help create such a network or forum.
7. *Evaluate Employee State Insurance for primary healthcare to informal workers:* Explore the potential of ESI to expand healthcare to informal sector workers.







INTRODUCTION

Health system of a country needs to have a balance of primary, secondary and tertiary healthcare. A health system that wishes to achieve universality, cost effectiveness and equity, needs to prioritize attention and resources focusing on preventive and promotive health.

Evidence from across the world indeed shows that the countries that have strong primary health care systems have better health outcomes, lower inequalities in these outcomes, and lower costs of care.

Primary healthcare reduces illness load in the community and through early detection and treatment, severity of illnesses. Reduced occurrence of illness and reduced severity leads to reduced costs to the system as well as to the families. Since primary healthcare service is located closer to the community, it encourages families to seek care early and with minimal disruption to their lives and livelihoods. A strong primary healthcare also reduces the load at secondary and tertiary health services, allowing them to become more effective and efficient.

Increased investments in Primary Health Care in India between the years 2005-2015 led to significant improvements in health related behavior, such as exclusive breastfeeding, and utilization of preventive interventions, such as immunization. There is also clear evidence that this improvement was equitable: gap between coverage of these interventions decreased between rural and urban areas. However, during the same period, most families in rural as well as urban India did not come to primary health centers or community health centers when they fell ill. They either did not seek care at all or sought care from private (informal or formal) providers and continued to pay a heavy price for doing so, contributing to almost 70% of total expenditure on healthcare.

In India, the primary healthcare system was designed based on recommendations of the Bhore Committee (1946) just before Indian Independence. The system consists of a network of Primary Health Centers, each covering a population of 20,000 to 30,000. Each PHC provides preventive, promotive and curative services, and is linked to a Community Health Center (CHC), equipped to provide secondary care. National Rural Health Mission added two significant elements: a village level volunteer to extend the reach of promotive care (ASHA); and an ambulance service that helps in transporting severely ill patients to the CHC or higher levels of care.

National Health Policy 2016 takes a two pronged approach for strengthening healthcare in India: improving access and quality of primary health care through strengthening 1,50,000 sub-centers (transforming them to health and wellness centers), and improving access to secondary and tertiary care through a near universal health insurance scheme. Ayushman Bharat, by combining these two objectives has created significant possibilities for improving healthcare. Besides, India's economy is growing well, rural infrastructure is improving and we have impressive access to technology, all of which have the potential to transform health status of its populations.

During last two decades, epidemiology of the diseases is changing rapidly. It is clear that insufficient decline in communicable diseases and a growing burden of non-communicable diseases has posed a double burden on India's healthcare system. Also, rapid urbanization and high levels of rural - urban migration is posing a significant challenge to healthcare systems.

India's primary healthcare designs were developed more than seven decades ago. Since then, new challenges and new opportunities, as described above have arisen. It is therefore imperative to develop new designs for delivering integrated and comprehensive healthcare that address the arising challenges and make use of the emergent opportunities.

Health Systems Transformation Platform (HSTP) aims to design, implement and evaluate innovative models of primary healthcare across large geographical areas to arrive at workable, effective and efficient models, which are suitable to take to scale.

As a first step, in partnership with Postgraduate Institute of Medical Education and Research, (PGIMER) Chandigarh, Basic Health Care Services (BHS) Trust and ACCESS Health International, HSTP is convening a series of workshops with primary healthcare practitioners and researchers and other stakeholders to design integrated models of primary healthcare for different contexts, including rural and urban. The first in the series, a design workshop was conducted on December 17-18 at New Delhi.

The workshop was conducted to arrive at a common understanding of primary healthcare and its principles, as well as to identify the key issues and elements of primary healthcare models for the future. It also connected like-minded professionals who could work collectively to design, implement and evaluate such

models. Over 40 practitioners, academicians, trainers, financing experts and health technology experts from various institutions participated and shared their experience, expertise and insights.

This report provides summary of the discussions and building blocks of primary healthcare, as well as key considerations for designing and implementing integrated primary healthcare models of the future. The report also lays down some of the key action areas that the Health System Transformation Platform and its partners should engage in to promote primary healthcare in India.

SETTING THE CONTEXT

Dr. M.K. Bhan is one of the India's leading biomedical scientists, academician and a technocrat. Amongst many other achievements, he has been instrumental in developing an indigenous rotavirus vaccine. He is Chair of the Board of HSTP, an organization that aims to bridge the gap between evidence and health policy in India.

Dr Bhan commented that it is an exciting time for healthcare in India, since it receives higher policy attention, and newer initiatives are being rolled out. Highlighting the issues of primary healthcare, which form the backbone of any healthy country, he suggested that it is critical to have a vision of the kind of health systems we want to see in the future and then to design and build components of such a system. This would have to be done step by step, as designing the entire complex system in one stoke is difficult and time consuming.

Laying down the objective of the workshop, he urged the group to collectively visualize the primary healthcare models for India that are futuristic, robust and will remain relevant for 8-10 years ahead. While designing such models, he suggested that it is critical to take a systemic and a comprehensive approach rather than a piecemeal approach. Such a model should be developed in partnership with governments. Once designed, their implementation should be demonstrated on a sufficiently large-scale, using the principles of implementation sciences. We should keep measuring processes as well as the impact, repeatedly and intensely. That would enable us to revise, and fine-tune models-in a few years' time, such a process would lead to reasonable models that can be scaled up.

Visualize the primary healthcare models for India-models that are futuristic, robust and remain relevant for 8-10 years ahead.

He set out his vision for HSTP, and described it as a platform, (unlike a standalone organization) that convenes interested and like-minded individuals and organizations to come together and work together for transforming healthcare in India. One of the possible methods of promoting innovation in health systems and primary healthcare, would be to create an innovation fund that fosters learning and experimentation of bold ideas, which inform the integrated design.

Dr Bhan shared the experience of DARPA an agency, of the United States Department of Defense that has interesting methodology of separating the process of designing and its implementation. The agency invites top experts to design projects on required areas of research as a collective and then the applications are invited for implementation of the design. He equated this to the envisaged process for designing and implementing primary healthcare models for future.

He concluded by saying that we should collectively enjoy building the future of India's healthcare, and as we do so, we should unleash the power of partnerships.

An exercise was conducted with the group to arrive at a common understanding of primary healthcare.

The participants were asked as share two words that come to their mind when they think of primary healthcare. Subsequently, several definitions of Primary Health Care were shared with participants and they were asked to identify the one that resonated most with them. From the exercise there emerged key characteristics of primary health care.

Key attributes of Primary health Care

- Delivers care closer to the community
- Includes preventive, promotive and curative services
- Is universal in reach but also meets the needs of the most marginalized people
- Ensures person and population-focused rather than disease oriented care
- Is the most financially and geographically accessible arm of the system
- Is closely integrated with advanced levels of care

Definition most preferred by the participants

Primary health care simply put is a community based health care system that provides entry into the system for all new needs and problems, provides person-focused (not disease oriented) care over time, provides for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others.

(Starfield 1998)

GLOBAL MODELS OF PRIMARY HEALTHCARE FROM REACTIVE, INDIVIDUAL FOCUSED, AND EPISODIC TO PROACTIVE, FAMILY FOCUSED AND CONTINUED CARE

Dr. Robert S. Jannett, Aceso Global, United States of America, serves as a Medical Director at the Mount Auburn Cambridge Independent Practice Association (MACIPA) a physician organization that provides quality improvement, care management, contracting and information management services to support better patient care.

Dr. Janett, presented experiences from MACIPA in US, and from his work in Brazil, Turkey and New Zealand, which could be relevant for India. He highlighted that while many countries are making important advances, they are unable to adequately deliver on principles of proactive, accountable and affordable healthcare.

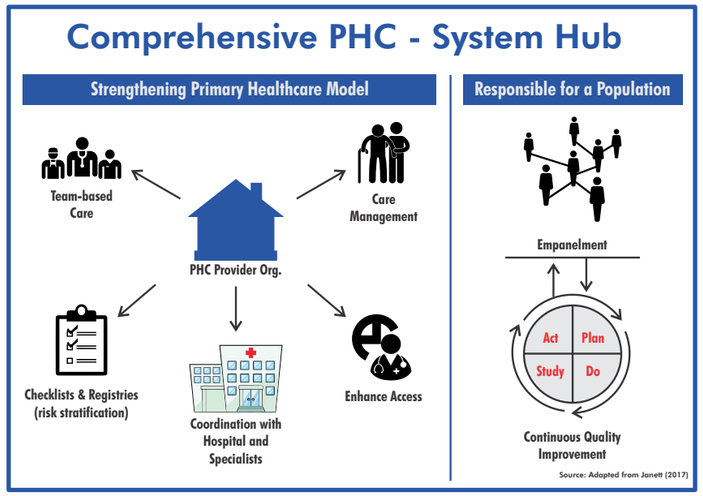
Dr. Jannet shared the three key healthcare challenges for India

1. **Focus on hospital based care:** which is episodic, discontinuous and ill-suited for changing disease burden
2. **Fragmented care:** Such a system prioritizes vertical management of diseases, does not promote horizontal integration
3. **Lack focus on quality:** Such a system results in resource crunch, knowledge gap, over provisioning of some services (such as antibiotics), and under provisioning of preventive health

A recent review of Primary Healthcare in Europe reveals that in most countries, the primary healthcare services still focus on individual based curative care. Only people with need and motivation seek healthcare services, and that these services are financed on a fee-for-service basis-this leads to a huge unfulfilled potential. There is inadequate focus on social determinants of health, and primary care delivery tends to be separated from other public health functions.[1]

His experience of aggregating an association of physicians and of setting up a person centered coordinated, proactive model in the Cambridge Massachusetts, which took responsibility of the health goals of the population has following features;

- Proactive and not episodic: that provides longitudinal healing relationships.
- Close engagement with the communities and families.
- Care provided by primary health care teams and networks
- Shift from provider incentives based on volume to incentives based on coordinated high quality care.



Primary Health Care team is multidisciplinary and comprises a physician, nurse, medical assistant, pharmacist, care coordinator and a community social worker. The team works relatively independently but is coordinated. Critical features of this system are:

- Multi-disciplinary team coordinated by a care coordinator
- Planned follow up care for chronic patients and
- Simplified processes using simple tools such as excel for continued care

The model recorded impressive improvements with one-third reduction in hospitalizations for diabetic complications in six years of work.

He also shared the primary healthcare models in three countries of Brazil, Turkey and New Zealand.

Key Design Features of Primary Health Care models of select countries

Family Based Primary Care Model in Brazil: Programa Saúde da Família

Brazil implemented a population-based family medicine model, where every citizen has the right to receive services from the family health team through the public system. Key design elements of the model are;

Scope of Services:

- Clinic based care
- Active outreach to identify untreated patients
- Community engagement

Empanelment: Each family health team empanels the surrounding population

Who delivers: A multi-disciplinary team

Quality of care: Standard care protocols are designed and implemented

Impact: The implementation of such a model has led to a reduction in infant and post-neonatal mortality, lower hospitalization rates for ambulatory care-sensitive conditions, reduced mortality from cardio vascular disease and lower diabetic complication rates.

Challenges: A key challenge faced by Brazil was lack of doctors to work in difficult areas. To address the shortage, 8000 doctors were invited from Cuba. With the new government coming in Brazil, the Cuban doctors have been sent back, which has adversely affected the program.

1. Health Systems Transformation Platform (HSTP) is an Indian not-for-profit institution headquartered in New Delhi and incubated by the Tata Trusts. The vision of the platform is to be an enabler of capacity to diagnose, redesign and strengthen health systems, with linkages to national policy.

Family Health in Turkey: Primary Healthcare organization and provision

In 2007, Turkey decided to implement a universal, publicly funded family health model. They deployed family health units throughout the country. Key design elements of which are;

Scope of Services:

"Comprehensive"Primary healthcare, including home and outreach services.

Empanelment: Each health facility empanels the catchment population ~3,500/family doctor

Who delivers: Family doctors supported by field coordinators

Contract arrangements & Payment mechanisms: Provincial Health Directorates purchase healthcare, and offer a package of salaries, capitation payment and operational expenses. In addition, government also offers performance incentives

- Contract duration is for a period of 2-years
- Contract sets clear rules for service requirements
- External Audits are built in to measure performance
- Patients' rights are laid down, and complaints communication units are set up in case of violations
- Failure to meet service delivery standards and targets can lead to contract termination

It is assumed that a well-organized system where the family health units are clustered and the services are strategically purchased and coordinated by province directorates and family health units will serve as incentives to improve the quality of care and the availability of care.

Primary Care in New Zealand

New Zealand has a four million population and implements a model that encourages individual or physician groups to be organized as Independent Practice Associations (IPA). Such an association is contracted by government to deliver primary care. Key design elements are

Scope of services:

Comprehensive Primary Healthcare and mental health

Empanelment: A well-defined catchment population is empanelled

Who delivers: Public Health Organizations: Statutory, private, non-profit, physician groups. Continuing education is offered to the staff.

Contract arrangement and Payment methods: Government provides following support in addition to the payments:

- Quality improvement support
- Service planning support
- "Back office"HR and financial management
- Management services
- Standards and protocols: Standard referral guidelines were prepared and implemented

Payment against services includes capitation fees supplemented with payment for performances, and special payments for specialized services

Key Takeaways

- Paradigm shift: The primary healthcare models need to move from current paradigm of reactive to proactive; and from fragmented to integrated and accountable care. This will require a cultural shift from hospital and physician centric to person and population centric care. Such shift will strongly integrate public health functions with primary care.
- Empanelment: The Primary health care service is responsible not only for providing clinical care to patients walking in, but to those specified numbers of families/ individuals in the catchment area. Each primary health care team or organization is responsible for screening this population, and based on screening, stratify the population by risk to provide proactive, continued care .
- Human resources: Primary healthcare is optimally delivered by a team of providers that include the Family Physicians, nurses and other paramedics, and community health workers. Role of care coordinator a critical element to coordinate across the spectrum of clinical and outreach services. An active effort is required to promote a culture of respect and collaboration in the team.
- Organization of services: The government in most countries funds Primary health care. In most of them however, the government contracts the services to a private healthcare organization. There are quite a few successful examples where physicians have organized themselves into groups that are entrusted/ contracted to provide primary healthcare to a defined population.
- Quality of care: Effective measures for enhancing and ensuring quality of care include:
  - Standard care protocols for common conditions (including referral)
  - External audits to measure performance
  - Continued medical and nursing education
  - Continuous quality improvement: constant measure, report and improve
- Integration with higher levels of care: To provide integrated care, coordination is required across primary care providers, and with higher levels of care.
- Payment methods: Most successful models use a combination of innovative payment methods; some form of capitation, performance incentives and payment towards salaries of core staff are often used.

HEALTH AND WELLNESS CENTERS IN INDIA

Dr. Rajni Ved, Executive Director - National Health Systems Resource Center provides technical assistance to the Ministry of Health & Family Welfare. She is at the forefront of the Government of India's plan to strengthen comprehensive primary healthcare.

Dr. Ved presented the design of the Health and Wellness Centers, (HWC) which are the centre of India's efforts towards strengthening primary health care. It builds on years of experience of delivering primary health care, supplemented with integration of new evidence. The Government of India has set a target to create 150,000 HWCs by 2022.

The HWC are located at the sub-centers and Primary Health Centers, and provide comprehensive primary healthcare for a population of 5000 in the plains and 3000 in hilly and tribal areas. The key shifts that HWCs make from the current way primary care is delivered, are:

1. Moving away from an individual led to a team approach. Each HWC will be managed by a team consisting of a Mid-Level Health Provider (MLHP) , one Multi-Purpose Health Worker (MPW) –Male, one MPW-Female and five ASHAs. The MLHP will be chosen from among BSc Nurse, Ayurveda Physician, or the new cadre of Community Health Officers. A change in the terminology from Auxiliary Nursing Midwife (ANM) to MPW highlights the expansion of scope of responsibility from maternal and child health to other areas of healthcare.
2. Training and skilling: Shifting from MCH to a wider package - It is assumed that the staff has adequate knowledge and skills to manage communicable and maternal-newborn illnesses. The training of HWC staff will be focused on screening and management of non communicable diseases, new package of services and information systems. New ways of imparting training with the use of information technology will be tested.
3. Expanding from selective to comprehensive primary healthcare: HWC will provide a set of 12 services, that, in addition to maternal and child services, will include management of communicable diseases, screening, control and management of non-communicable diseases, care for common ophthalmic and ENT problems, basic oral health, care of the elderly and palliative care, and screening and basic management of mental health conditions.
4. Expanding availability of medicines and diagnostics- HWC will have access to larger numbers of medicines and diagnostics to enable improved quality of care. It will do so by establishing a hub and spoke model, and introducing point of care diagnostics.
5. Information Technology platform – Progressively, a good IT infrastructure and connectivity will be developed at all HWCs. An application to record patient data to manage non-communicable diseases has been developed and it is being integrated with Reproductive Child Health application. The IT platform will also be used for promoting a two-way referral.
6. Transforming Infrastructure – To deliver comprehensive primary healthcare with quality and for an image makeover existing facilities are being upgraded and renovated.
7. Payment mechanisms: There are plans to link the payments to performance of a facility.

The above shifts seem ambitious in face of financial resources and operational constraints. Some of key operational challenges are

- Making skilled human resources available: to deliver comprehensive care with quality and dignity. In addition to the shortages, *there is reluctance to live and serve in the rural areas*. There are issues of adequate quality of pre-service training due to *lack of training centers and on-site training facilities*. A minimum of six months is required to train and prepare the mid-level workers to perform the expanded role. Further, *political interference* also makes it difficult to place the trained staff in remote and rural areas- unfortunately, this is true even for the newly trained cadre of mid-level providers.
- Under-equipped district hospitals: Dr. Ved also highlighted a critical challenge of ensuring a good quality of secondary and tertiary care at district level for the referred patients - once the health and wellness centers start screening populations for NCDs (including mental health and Cancers), a large number will be referred to the next level of care. Currently, district hospital themselves are not equipped to deal with such conditions. This presents an ethical dilemma of screening without offering the cure. Such a situation can affect not only the credibility of the health system but also the motivation of providers.
- Integrated IT platforms: A number of IT applications are being tested and developed, but are not yet integrated with each other, which is the bigger challenge. Institutions are developing these applications for specific purposes without a clause of transfer of cost codes for integration and adaption.

Progress

Despite challenges, HWCs have made substantial progress:

- New training modules and protocols: New training modules and SOPs are being developed to enable appropriate use of available medicines and diagnostics.
- Increased funding: There is increase in budgets as well as allocations of untied funds.
- Tele-medicine and tele-training platforms: Some excellent models of tele-health are being tested. Project ECHO (Extension for community health outcomes) has provided an innovative platform to build skills of providers to manage chronic and non-communicable diseases at scale.
- Ongoing Learning: Innovation and Learning Centres (ILCs) have been set up at select institutions as a learning laboratory, to allow sieving out of lessons to concurrently inform the health systems.

Key Takeaways

- HWCs provide a significant platform for strengthening primary health care in India.
- There is clear policy intent to move from selective to comprehensive primary healthcare and to use technology.
- Success of HWC lies in skilling, placing and motivating healthcare providers who are organized in teams. It would also require strengthening of district and sub-district hospitals to provide a high quality referral care.

2. However this assumption is misplaced as is evident from several assessments and press reports of quality of maternal-newborn and child care in public systems in various states

PRIMARY HEALTHCARE DELIVERY IN KERALA

Dr. Rajeev Sadanandan is a medical doctor, a policy maker and bureaucrat. He has been active in the health sector reforms of Kerala. He is currently serving as the Additional Chief Secretary Health, Government of Kerala.

Dr. Sadanandan shared the experiences of organizing primary healthcare in Kerala - its journey and the challenges it faces, despite being one of the most progressive states of the country. Kerala was able to address several public health problems such as malaria, cholera, small pox and leprosy due to a good primary healthcare system, which is well supported by a widespread network of hospitals with facilities for clinical care and well equipped with competent staff and outreach workers. Kerala also benefitted from having high levels of education, and good governance. However, despite these achievements of Kerala, there was complacency in adapting the primary healthcare system to the changing epidemiological profile. There was delay in building response to non-communicable disease, mental health and elderly care.

He highlighted that over the last few years, there is a renewed focus to transform primary health care in Kerala. A strategic shift is to move from reactive to proactive approach, reaching out to the population. Kerala health department negotiated with the government to appoint one doctor for every 10,000 population instead of 30,000, which enabled the team of doctor and nurses to be accountable to a manageable population. The timing of PHCs was increased by additional five hours per day so doctors would spend more time at clinics (9am-6pm), leading to an increase in the footfall for PHCs services.

Further the role of nurses has been expanded. Every patient is first seen and counseled by a nurse before she sees the doctor- this enhanced the human interaction with the patient. The government has developed electronic health records, which is helpful to understanding the disease burden and in providing a continuum of care. For the tribal populations, local women from the area are trained as connect between community and system. Additionally there is a network of mobile medical units. However, he acknowledged that poor socioeconomic status and difficult terrain makes it difficult to provide optimal care in tribal areas. For the urban areas the state is following the guidelines of the national program.

Dr. Sadanandan highlighted the enabling role of the Panchayati Raj Institutions (PRIs) in strengthening primary care. The department encouraged competition among panchayats and recognized those performing the best in healthcare. The engagement of PRIs was also used to mobilize funds to impact the social determinants of health. The PRIs and municipalities started supporting projects, which encouraged wellness, such as organic food cultivation, rehabilitation, building the infrastructure etc.

Even after reducing the population coverage by a physician to 10,000, existing manpower will not be sufficient. There is also limited fiscal space to augment the required workforce. It would necessitate the need to engage other stakeholders such as communities and non-governmental providers in delivering healthcare.

Key Takeaways

- Strong and decentralized primary healthcare systems are key to improving health status of states
- Current norms of one doctor for 25-30,000 needs to be significantly reduced to provide quality care
- Enormous efforts are required to train and skill primary care providers to provide comprehensive primary healthcare – in medium term it would require strengthening pre-service education
- Integrated Health Management Information Systems are needed to improve quality and continuity of care
- Any complacency can reverse the gains
- For further improvement of healthcare of the populations, Kerala and other states with similar levels of development and health status will need to consider alternative ways to co-finance and co-provide healthcare

EXISTING MODELS OF PRIMARY HEALTHCARE IN RURAL INDIA: LESSONS FOR FUTURE DESIGN

The panel moderated by Dr. Pavitra Mohan was designed to sieve out lessons for the future from the existing rural primary healthcare initiatives in India. The panel comprised practitioners and academicians, who practice and/ or teach primary healthcare, in remote and rural areas. The section captures insights from the panelists and ensuing discussions.

INSIGHTS FROM THE PANEL

Basic Healthcare Services (BHS)- Dr Sanjana Brahmawar Mohan

Dr. Mohan shared her experience of setting up and managing AMRIT Clinics, which are Nurse-centered, community based model of primary providing primary healthcare in remote and tribal areas of South Rajasthan. Salient features of AMRIT Clinics are:

Context: remote, tribal areas with scattered habitation, limited resources and no health services

Population covered: each clinic covers about 15,000 population, total population covered: 90,000

Scope of services: Women and children's health, tuberculosis, malaria and other communicable disease, non-communicable diseases. Includes preventive, promotive and curative services

Who provides health care: Primary Health Care Team: Three resident primary care nurses, supported by a visiting physician and two community health workers

Community engagement: Strong, through community health workers & community volunteers, who also address other socio-cultural issues

Use of technology: Includes tele-consultation, rapid diagnostics and use of solar energy

Christian Medical College (CMC) Vellore-Dr Abraham Joseph

Dr Joseph explained the development of the rural health program of CMC Vellore and its salient features. Early on, CMC started involving the village leaders in the community in improving health. They also identified people from the community, trained them over two-years, and then deployed them as health-aide workers in the same community. The health-aides are supported by a public health nurse and a physician. This program is geared towards providing primary healthcare and has a strong linkage to referral care. It also engages the community on socio-economic activities, such as training tribal girls in nursing education.

The ability to penetrate the communities and help them solve other problems besides health, identify and train local youth as health aides and build a strong referral system has led to a significant impact on health status of populations.

MAHAN Trust - Dr Ashish Satav

MAHAN Trust works to improve the quality of life of the marginalized and underserved tribal population in the Melghat region of Maharashtra.

Context: Tribal areas of Maharashtra are similar to those in other parts of the country. There is high infant and maternal mortality and mortality in age group of 16-60 years and physicians are not available for primary or specialized care

Model of healthcare: In a situation like this, the model includes community level workers that provide care within communities, serve as nurses and use technology to ensure quality. At the top of the pyramid, a rural hospital provides advanced care. The critical role of nurses in provision of care, and thus training of nurses is the core strategy. Another strategy is to build linkages with government hospitals and scale their capacities.

Impact: In communities, intervention could reduce mortality by more than 67 percent and prevalence of malnutrition by around 64 percent. At the policy level, continuous advocacy, research and public interest litigation has led to change in many state government policies for improving tribal health.

Karma Healthcare- Jagdeep Gambhir

Karma Health aims to solve the problem of lack of doctors in rural and remote areas through setting up E-Health Clinics, and use of telemedicine.

Context: Rural areas (Rajasthan, Haryana)

Model: The Clinic is managed by a nurse, who takes the medical history of the patient and then connects for a doctor's consultation through video-conferencing.

Scope of services: Curative care: five specialties are offered: medicine, pediatrics, gynecology and dermatology. Medicines are dispensed in house; for diagnostics, samples sent to city labs

Financing: Fee for service

Potential: The model is designed to provide curative care at the community level. It can be implemented in areas as the connectivity improves and has potential to reduce cost for delivering care. Can be integrated with other primary healthcare services

Training medial students in primary healthcare for rural areas: CMC Vellore Experience - Dr Anand Zachariah

The undergraduate program in medicine ensures that students serve in the community from the first year. There they learn how families access health care and earn livelihoods, and how health systems function in such settings. They also learn to plan and implement healthcare interventions. The course concludes with an internship where students work as primary care doctors.

Other innovations in medical education are:

- Clinical training-clerkship: Where students are posted in block hospitals as members of clinical teams, which trains them to function independently;
- Distance education in family medicine: Medical graduates who undergo a two-year period service obligation at rural mission hospital continue to learn while working, and translate their learning in practice.

The immersion training of the young medical graduates is possible because of a large network of CMC-affiliate rural hospitals.

Equipping Nurses for Primary health care in rural areas: Ms Shimy Mathew, Christian Medical Association of India (Nursing Wing)

Ms. Mathew spoke on the potential and challenges for training and placing nurses for delivering primary healthcare in rural areas, drawing on her own experience.

Current status of Nursing Education: Ms. Mathew highlighted the shortages of nursing staff across different categories. Currently there are General Nursing Midwifery, BSc. (Basic and Post Basic) and Post-Graduate courses available and offered in over 6000 colleges and schools across the country. However, the institutes are concentrated in six states of India only, and majority of the graduate programs are around major towns and cities. Annually more than 150,000 nurses graduate, and a majority of them do not want to go back to rural areas to work.

Challenges to prepare Nurses in Primary healthcare for Rural Areas

One of the critical challenges is inadequate emphasis and exposure of trainee nurses to community health, as most of the institutes do not have a community department attached. Another issue is the quality of the faculty: many faculty members have earned their post-graduation without themselves undergoing on-site clinical training.

Way ahead

She suggested a course for family nurse practitioners, which was announced in a Conference of Family Medicine in 2012. It was designed to be a one and a half years program with a six-month internship. These practitioners could then be placed as primary care providers in health and wellness centers. Similarly, prescription rights for nurses are not allowed. For that to be happen will require a law and amendments in the drugs and pharmaceutical act.

Key Takeaways

- Decentralization and community participation is a critical element of primary healthcare for rural areas.
- Nurses and Community Health Workers play a critical role in in rural and hard to reach areas.
- A primary care team consisting of nurses and community health workers, supported by a physician and enabled by technology appears to be optimal for delivering responsive and comprehensive primary healthcare.
- Primary care providers engaged from communities that they serve is likely to have longer retention.
- Innovative ways of educating and supporting medical and nursing students and resident is required to make them competent for and working in rural healthcare.
- An optimal model of primary healthcare needs to have functional linkages with good quality secondary and tertiary healthcare facilities.

Issues to be addressed

The ensuing discussion identified some of the key issues that need to be addressed to translate these lessons for transforming rural healthcare:

1. Need for a comprehensive human resource policy that guides production, training, placement, retaining and ensuring an optimal mix of human resources for healthcare, especially for rural areas.
2. Skilling and empowering nurses as Primary Health Care Practitioners
3. Identifying and addressing legal barriers that prevent optimal utilization of non-physician healthcare providers, and for use of technology especially telemedicine.

MODELS OF PRIMARY HEALTHCARE IN URBAN AREAS: DESIGN CONSIDERATIONS FOR FUTURE

Dr. Tarun Seem, former Secretary, Health & Family Welfare, Government of National Capital Territory of Delhi, played a critical role in design and early implementation of the Mohalla Clinics in Delhi. He moderated this panel and also shared his experiences of setting up Mohalla Clinics.

The panel included presentations and discussions on Mohalla Clinics (a government led model), Ross Clinics (private user paid model) and issues of delivering healthcare for the migrant communities in urban areas.

Mohalla Clinics

Background: The existing hospitals in Delhi receive a massive out- patient load-as much as 5000 per day- that significantly affects the quality of care they offer. It was therefore planned to take primary care out of the hospitals into the community. To meet this demand, it was planned to set up an estimated 1000 Mohalla Clinics, with an initial pilot of 100.

Design elements

Context: Each Clinic is located within a neighbourhood, First 100 clinics were located in slums, villages and areas with least access to healthcare.

Coverage: Each Clinic covers a population of 10,000 people.

Infrastructure: Rented accommodation, three sites were operated in a fabricated cabin.

Services

- Consultation and Counseling from 9am-1pm for 6 days a week.
- Over 200 Basic to Advanced Diagnostic Tests (outsourced)
- 80+ Medicines
- Specialist Referrals to Polyclinics and Government Hospitals

Who provides care: An empaneled private physician (MBBS)

Payment mechanism: The Government reimburses an amount of Rs 30 per OPD Consult and Rs. 10 for an assistant, to the physician.

Health Management Information System: A tailor-made Clinic management application has been adopted. Each Clinic is equipped with a tablet, Internet connectivity and a thermal printer. Doctors register and maintain the Electronic Medical Record. The application also includes inventory management and patient referral solution and allows the provider to submit a monthly invoice.

Cost to the patient: None (free of cost)

Impact: Over a period of time, over two crore client transactions have been recorded. The cost per transaction is less Rs. 50 per client.

Challenges

- Integration with public health functions, and population empanelment has been limited
- Governmental norms and rules make flexible operations difficult
- Doctors do not easily take to new technology
- Limited land availability in cities make it difficult to set up such Clinics

Dr. Seem concluded by highlighting that in future, hospitals would need to reform by reorganizing the ways in which they operate, making transactions efficient and increasing options for alternative health solutions for people. Health system in cities would also need to find creative ways to engage with the private sector.

Ross Clinics - User Paid Model of Primary Healthcare for Urban Areas

Dr. Devashish Saini is a medical and management graduate and an entrepreneur. He is a founder of Ross Clinics.

Background: Ross Clinics have been set up to provide personalized healthcare to the entire family. It aims to provide care to the entire community; irrespective of the ability to pay. Currently, there are 14 clinics in an urban neighborhood in Gurgaon.

Design elements

Who provides care: A family physician, a visiting dentist and physiotherapist. A clinic manager is in-charge of the clinic. A range of measures is taken to keep staff motivated.

Infrastructure: A well-appointed 300-400 square feet space

Scope of services: Medical consultation, medicines, test sample collection, minor procedures, vaccination of children and geriatric care. Home visits are also made by the family physician when required

Financing: Fee for services. There is cross-subsidy - higher fees is charged from the more affluent and less from the poor. Additional services also generate revenue, such as home based and palliative care to elderly, food quality checks at the restaurants and clubs, packages for domestic help and workers (paid by employers)

Community engagement: Long term relations through home visits and follow-ups

Use of technology: For efficient management and for training

Potential for Scale-Up: A possible scale up strategy will be to motivate doctors to start their own practice ethically, and build program to support them in this endeavor. Ross Clinics have taken initial steps in this direction

CHALLENGES OF PROVIDING HEALTHCARE TO MIGRANT POPULATIONS: MAKING MIGRANT FRIENDLY HEALTH SERVICES

Dr Pavitra Mohan is co-founder of Basic Health Care Services, an organization that provides primary healthcare to underserved populations. He also leads health services at Aajeevika Bureau that provides services and solutions to labour-migrant populations at source and destination.

Background: Migrant communities are critical inhabitants of the urban milieu, but remain a misfit in cities. In India about 139 million people move from rural areas to cities for work, most often seasonally. They do not get integrated in the cities despite living here for long periods of time. They are highly vulnerable because of high levels of malnutrition, exposure to occupational hazards, poor living conditions, and exclusion from local health systems; and stigmatized as perpetrators of carrying disease from one place to the other.

Considerations for designing healthcare for the migrants: There are limited experiences of addressing healthcare of the migrant populations. While designing health care programs for migrant communities it is critical to know where they live and work, time periods during which they can actually access healthcare, and helping them navigate the urban healthcare delivery system which is unfamiliar to them.

Discussion on migrant friendly services

Chandigarh: A study conducted by the Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh found that migrants are unable to utilize the public health services due to unreasonable bias and thus differential treatment by the healthcare provider. Unfamiliarity with health systems and language was another common reason. Based on the above, programs were organized to sensitize providers, identify ASHAs from their communities and providers denying services were penalised.

Kerala: The state provided free treatment to all migrants with multi-drug resistant tuberculosis, however found it extremely difficult to address the disease among migrant populations, because of frequent movement at their end. Migrants from Odisha, who live in Kerala, often utilize services from the public health system, but do not participate in the public health insurance program for migrants as they do not want to disclose their personal information, fearing some penal action.

Maharashtra: Mahan trust appoints tribal counselors in government hospitals, which acts as bridge between the migrant populations and the hospitals and helps navigate an unfamiliar health system.

Key Takeaways

- Primary healthcare services in urban areas need to be embedded within the neighborhoods.
- Strong primary health care services in urban areas improve access for people, and reduce load from tertiary hospitals.
- Sensitization of providers, suitable timings, portability of health insurance and availability of counselors are some of the design elements that make urban health services migrant friendly.
- Addressing social determinants of health especially safer living and working conditions are critical to improving healthcare of the urban poor and migrant populations.
- To ensure provision of preventive care and wellness (and not just treatment of disease), it is important that the primary healthcare clinics empanel the catchment populations and conduct active risk profiling.
- Whether healthcare is delivered by private operators, or public systems, the government needs to strengthen governance and regulation to ensure fairness, efficiency and quality

CHOICES FOR FINANCING PRIMARY HEALTHCARE IN INDIA

Dr. Shankar Prinja and Dr. Devadasan N. health financing experts led the session. Dr. Prinja is an Associate Professor Health Economics at the School of Public Health, PGIMER with considerable body of research on financing healthcare. Dr. Devadasan N founded the Institute of Public Health in Bengaluru and has been working in the area of health financing, access to healthcare and health systems management. The panel focused on options for financing primary healthcare, and presented evidence to choose from these options followed by a deep discussion..

Which financing mechanisms work for equitable primary healthcare?

A systematic review of evidence from Asia-Pacific aimed to identify the impact of different financing options on healthcare outcomes, was presented. The review revealed that:

- Financing interventions that lower out-of-pocket expenditure (such as tax-funding or state funded insurance) improves utilization, access and equity of primary healthcare.
- Incentives to users (such as conditional cash transfers or vouchers) also improve utilization and equity of primary healthcare.
- Contracting out of health services improve utilization but not equitably.
- Provider incentives have an uncertain benefit.

An important finding is that governance and context affects the direction as well as degree of impact.

Situation in India

Dr. Devadasan emphasized that four to five people in a 40000 population in urban India are selling their assets to pay for medical bills. This is on account of conditions such as diabetes or hypertension, where they wither they do not seek care or the treatment is irregular because they can't afford it, and then land up in hospitals due to complications. Such a situation arises because in India financing primary health care is predominantly out of pocket, and there is no incentive to provide quality care.

How much money is spent on primary healthcare in India? Who pays for it?

Dr Prinja, based on his analysis of National Health Accounts, informed that current spending on primary health care in India is Rs.1700 per capita, about 45% of the total heath expenditure. Out of that, Rs 565 per capita (about 1/3rd) is public and rest is private. Large part of this is the outpatient care including drugs and diagnostics.

How to decide on primary care package?

Defining a primary care package in a given setting requires understanding of the additional health benefits and costs of the proposed intervention. Commonly used criteria by different countries are:

- Cost-effectiveness,
- Situation analysis
- Impact on equity
- Political considerations

Such evidence becomes an important tool for policymakers to prioritize investments in different interventions within primary healthcare. We have limited evidence in India thereby making it difficult to decide the package and to prioritize investments.

Who finances and who provides healthcare in countries with robust primary healthcare systems?

Health Services are financed by the government: it can be social health insurance as in Western Europe or through taxes, as in UK or Australia. However, primary healthcare in these countries are provided by a range of providers: government (such as in NHS in England) and groups or associations of physicians as well as individual practices, such as in Australia or Western Europe.

In these countries, providers are paid a fee for the services given, but with a cap on the price of the service. Some countries in Latin America have experimented with capitation.

Key takeaways

- Providing comprehensive primary healthcare would require significant increase in public expenditure in healthcare.
- Financing interventions in healthcare in India should aim at reducing out-of-pocket expenditures, whether though tax financing or social insurance.
- There is a case for including primary care in benefit package of demand-side financing programs.
- There is a need for generating economic evidence to develop the primary care package, and efficient targeting of resources..
- There is a scope for greater experimentation with patient incentives for improving utilization and equity in primary healthcare (such as conditional cash transfers)
- Out of pocket payments and poor quality of care are impoverishing many families in urban India. There is scope for public financing and private provisioning of primary healthcare in India in urban areas, to reverse this phenomenon. There is also a case for using innovative payment mechanisms to healthcare providers in such models.
- There is also a scope of cross-subsidizing such services for greater equity, with the upper and middle class families subsidizing the poor.

Way ahead

The financing could be either entirely by the Government or contributions by high and middle-income families cross subsidizing the poor. One could begin with providing ambulatory care, phasing out to provide prevention and health promotion services with greater community ownership. One could use a mix of payment methods - vouchers or capitation depending on local context.

Discussion on Financing Primary Healthcare

Where does the money to finance comprehensive primary health care come from?

While many participants spoke of the need for the government to enhance the allocations to primary healthcare as committed in the National Health Policy, others questioned the ability of the government to do so. Some pointed out the need for alternative financing mechanisms such as -

1. Cooperatives: In Canada, occupation based co-operatives pre-pay for healthcare as part of their membership fees)
2. Sin Taxes In Philippines sin taxes are levied on consuming products that adversely affect health (such as alcohol and tobacco) and are used for funding primary healthcare.
3. Earmarked CSR funding: In India, CSR policy mandates the corporates to allocate 2% of their profits in social development initiatives. A large fund-pool is available which can be used creatively to fund primary healthcare.
4. Expanding coverage through Employee state insurance (ESI); ESI has been under explored as a strong potential mechanism for financing and providing health care for informal sector workers and their families in India.

How do we build up a case for investment in primary care?

Some of the ideas discussed were:

Build an economic case: Some participants asserted that a case for investment for primary care lies in advocating improvement of productivity in healthy people and reduction in number of hours spent in generating revenue due to sickness - a clear link in terms of gains in GDP and economic growth makes for a good case. Prevention of impoverishment could make a case, but probably can be corrected by cash transfers - a better mechanism to deal with poverty than by health interventions. We need to advocate for a good health care system for everyone.

Build a political case: How does healthcare become a political issue? How does primary care impact the electorate and how could the government get credit for rebranding it? In some states, healthcare is increasingly becoming an election issue.

Challenges in purchasing primary care: Purchasing primary care requires an understanding of the Indian private sector (distinguishing informal from formal provider; private from public provider) and provider behavior. Providers in this segment are mostly from the informal sector or solo practices or small nursing homes. Mechanisms to aggregate formal providers into group practices and associations need to evolve. Further, defining a primary care package and pricing requires information on cost effectiveness of interventions, situation analysis, disease burden, equity and severity of the disease etc., that are being developed by the health technology assessment board instituted recently.

Cautions in engaging formal private sector: There are lessons to be learnt from all the publicly financed insurance schemes where despite having paid fee for service or case based payment for a treatment, there have been cases of extra billing, under provision, poor quality, re-admissions, etc. If price of the stent/ drugs is under price control, the providers just increase the prices of other services to ensure that the overall cost of the service remains the same. The problem is that while we debate on models we need to strengthen regulation, as resources for health care are finite.

Alternate mechanisms to engage and incentivize providers: In Mehsana, private providers were incentivized to notify tuberculosis cases - they could send sputum sample to the government for diagnosis using a Gene-Xpert. If diagnosis is positive, the providers are supplied TB drugs free of cost, with the condition that they do not charge the patient for these drugs. If the patient is MDR, then Government provides all the necessary treatment. This significantly increased

TB notification by private sector in Mehsana. There were discussions around possibility of contracting out primary care of a given geography to a private provider, providing free drugs and supplies, and getting an assured service to the families in return.

Key takeaways

- While there is a need to enhance public expenditure on primary healthcare, alternative financing mechanisms must be explored in future.
- There is a need to build a political and an economic case for investments in primary healthcare to leverage additional investments.
- There is significant potential to engage and incentivize non-government providers to provide high quality and equitable primary healthcare. However, it would require mechanisms to aggregate private providers into groups, and to strengthen regulatory capacities.

ANNEXURE 1
CONSENSUS ON ESSENTIAL ELEMENTS FOR A PRIMARY HEALTH CARE MODEL

The Section below captures the consensus around the key element of primary healthcare model, which will be relevant for next 8-10 years. Around 12 design elements were identified and discussed as essential and consensus agreed.

	Elements	Key Takeaway
1	Population coverage	• Universal coverage of population through empanelment is critical, however the option of opting out must be available with the person. • Located within and closer to the community. Existing population-based norms should also factor time taken to reach the healthcare facility. In most situations a population between 3000-5000 should be the geographical catchment. • Ensure equity – affirmative actions to reach out to the underserved.
2	Community ownership	• Important shift from supply side to demand side, to bring voice to the voiceless and ensure community has mechanisms to hold service providers accountable. • Community participation and accountability through decentralization so that the villages are engaged in health and well being of the community.
3	Organization of services	• Organization of services that is patient centric and will include alternatives for home based care, to facility based services, which are accessible within 30 minutes, with a link to the larger hospitals. • Specific design to be based on expected caseload and characteristics of the geography and population (e.g. tribal settings, migrant populations). • Need to consider strategies for including informal providers.
4	Service package	• Package of services to be contextualized to local needs and epidemiological realities. • For treatment of primary healthcare related issues, medical consultation, medicines and diagnostics, which are available free of cost. • For prevention focus on increasing risk perception, awareness, access to screening and a referral to appropriate secondary and tertiary care.
5	Manpower, skilling and training	• Need for a multidisciplinary team comprising of a physician, nurse, medical assistance, pharmacist, laboratory technician, care coordinator, community work and epidemiologist. The last function is critical for future to identify the emerging health issues of the communities and solutions to address. • Placing a "Care coordinator" who provides the administrative support and coordinate between various functions of the facility, which is usually the responsibility of the physician. • Positioning and empowering nurses as practitioners and caregivers for primary care. • Improving the profile of General Practitioners to encourage aspiration to be primary care physicians. • Transforming the medical education system and continuous in-service training to build skills, motivation and vision of the health workforce. • Developing human resource policy for health that encouraging a system of career growth and development. • Reorganizing the roles and responsibility of different cadre of healthcare and empowering them

	Elements	Key Takeaway
6	Payments	• No fee for service at the point of care, which discourages health-seeking behavior. • Develop models for pre-payment, which could be paid by government, employer or individual.
7	Cost optimization	• Focus on preventive and promotive services, and reduce overuse of clinical care • Aim to reduce unit costs of care over time
8	Digital health	• Leveraging new block chain systems that records and store client health records to build modern systems. • Integrated IT platforms are essential to enable continuity of care, and to enable good monitoring and governance • Building regulatory clarity on provision of healthcare using technology (telemedicine).
9	Quality improvement	• Design a quality improvement strategy that focuses on continuous improvement and assurance of basic standards • Quality improvement can be used as a motivator to attract more clients for providers
10	Process and impact measurement	• Institute routine program and impact monitoring • Engage a third party agency for this function
11	Innovation	• Build a platform for local solution design and innovation by creating an Innovation Fund. • The aim of the Fund is to continually lead to improvement, learning and scale up of effective models.
12	Governance	• Transforming systems will require building independent and autonomous governance structures. A trust that manages primary health delivery. The institutional structure should have technical, administrative, financial and monitoring capacities. • Shift toward single or efficient purchasing of care • Test models for capitation based payments
13	Cross-cutting themes	• Build appropriate institutional systems to manage complex, pluralistic health systems • Consider that primary care has the potential to create jobs and support employment • Need to address social determinants of health, the over-medicalization of care and integrate services between allopathic and AYUSH systems • Consider our impact on the environment / climate change as we design health systems

ANNEXURE 2
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