POLICY BRIEF
June 2021
#02

LESSONS FROM PRIMARY HEALTH CARE DELIVERY MODELS IN INDIA: PRIMARY RESEARCH FINDINGS RELEVANT TO UNIVERSAL HEALTH COVERAGE

Dorothy Lall, Priya Prabhu*, Swathi S Balachandra*, Dharmendhar Kumar*, Preeti Singh#, Sarang Deo#, N Devadasan^*

Introduction

The World Health Organization states that "by providing care in the community as well as care through the community, primary health care (PHC) addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations."[1] There is substantial evidence to support that PHC contributes to strong health systems and better health outcomes.[2,3] In the context of a dual burden of disease that India and other LMICs face, strong PHC has become an imperative. The Government of India recently launched the Ayushman Bharat program that focuses on providing financial protection as well as strengthening PHC through health and wellness centers. It is in this context that the study sought to identify lessons we can learn from successful examples of primary health care delivery in India. The insights gained may be useful to policy makers and planners of PHC in India.

KEY MESSAGES

- This study used quantitative and qualitative methods to assess models of PHC delivery with the aim of identifying lessons to learn. Each of these are described as cases, a taxonomy developed for the models and key lessons identified that emerged as strong themes.
- Hospital/ clinic with community outreach and social franchising were identified as two dominant models of PHC delivery in India.
- Community engagement and responsiveness to community needs, comprehensive services and addressing social determinants were identified as difficult but essential ingredients to achieving health outcomes.
- Individual level, financial, organizational and contextual factors emerged as challenges to good quality PHC delivery in India.

Executive Summary

A case study approach was used to study examples of successful primary health care delivery in India. We studied 13 organizations in detail using qualitative and quantitative methods. The two models of PHC prevalent in India that emerged from the analysis were hospital/ clinic with community outreach and a social franchising model. These can also be thought of as urban and rural models of PHC. The major themes essential to good quality PHC that emerged from the inquiry were comprehensive services, community engagement, responsiveness to community needs and leadership that enables team approach. Training relevant to PHC delivery and motivated individuals were a constant challenge to PHCs as was financial stability and local contextual factors.

Research Method

A desk review was conducted and public health experts interviewed to identify 72 organizations that deliver primary health care in India. The criteria included years of service, comprehensiveness of services, among others to identify 16 models for further study. Thirteen organizations were contacted and in-depth interviews conducted with the founders and leaders of the organizations. The secondary data routinely collected by these organizations to assess outcomes of PHC delivery was also collated. We used the Primary Health Care Performance Initiative (PHCPI) framework to guide data collection and analysis.

Research Findings

It was found that all the organizations studied could be classified as two models of service delivery—hospital/clinic with community outreach and the social franchising model. The hospital/ clinic with outreach was the most common and largely rural although we studied one example of this in a semi-urban context as well. The social franchise operates on a contractual relationship wherein an independent coordinating organization offers individual independent health care providers the ability to join a franchise network for the provision of primary care over a specified area in accordance with an overall blueprint devised by the franchisor. This seems to work well for the urban context in India.

Themes that emerged from the qualitative data reinforced comprehensive service delivery, community engagement, responsiveness to community needs, need for generalists such as family medicine physicians to lead teams, importance of nurse led or team-based approaches and financial support to ensure that the poor are not left out. Based on these findings some recommendations have been outlined for policy makers as they strategize for PHC in India.

Policy Recommendations

Based on the findings we make the following recommendations for primary health care in India:

1. Primary care needs to be comprehensive and responsive to the needs of the community. A needs assessment is a starting point to ensure that the care provided is relevant to the context.
2. All efforts to engage the community in a dialogue regarding their health should be made and several successful strategies have been used and reported in these models.
3. Team-based care and nurse-led models of care need to be strengthened for effective PHC.
4. Leadership of primary health care needs to be developed to influence positive work cultures and motivated workforce. Attention to the motivation of the workforce for primary care is urgently required.
5. Protocols and standardized guidelines for primary health care and basic health care needs should be made available. Systematic investments in quality assurance procedures is required.
6. Generalists, family medicine physicians need to increase in number and appropriate measures such as increase in the availability of training opportunities need to be made.
7. Career pathways and progression need to be thought through and opportunities created to raise the profile of all staff working at primary care level.
8. Investments in information systems that are critical to quality of care need to be made.
9. Primary health care will need investments. Primary health care will not be able to sustain itself from what users pay without excluding the poor and those who cannot pay. The government is best positioned and mandated to make these investments.
10. Opportunities and platforms for those in primary care to learn from each other need to be created. Collaboratives based on geography seem to be a good way forward and can be replicated. Many innovations and best practices that emerge could be documented and a database made available for all primary care practitioners to learn across collaboratives.
11. Evaluation of PHC needs to be standardized to enable comparisons across different models. The indicators ought to be relevant to the Indian context and experience. Creative assessments of community empowerment need to be explored.

REFERENCES

1. World Health Organization. "Primary health care". https://www.who.int/news-room/fact-sheets/detail/primary-health-carehttps://www.who.int/news-room/fact-sheets/detail/primary-health-care (accessed November 21, 2020).
2. J. Macinko, B. Starfield, and T. Erinosho. "The impact of primary healthcare on population health in low- and middle-income countries," *J Ambulatory Care Manage.* 32, no. 2 (June 2009): 150–171.
3. B. Starfield, L. Shi, and J. Macinko. "Contribution of primary care to health systems and health," *Milbank Q.* 83, no. 3 (2005): 457–502.

The India Health Systems Collaborative (IHSC) is a growing network of health systems researchers in India. IHSC is envisioned to be an integrated ecosystem of researchers that work in close collaboration with decision-makers, public, donor as well as big philanthropic organizations.

Founded in 2018, the collaborative was built with the dual purpose of responding to policy questions that are critical to India's health system and fostering a well-connected community of health system researchers in the country and strengthening research capacity in the process. IHSC aims to provide an interdisciplinary platform for collaborative research to generate evidence for policy interventions on challenges confronting the country's health system.

The authors would like to express gratitude to all the officials who participated in the interviews and provided the information/ data requested for the study.

The authors are associated with *Institute of Public Health, Bangalore; #International School of Business (Max Institute of Healthcare Management); ^Health Systems Transformation Platform.

The corresponding author can be reached at dorothy@iphindia.org

IHSC thanks Maulik Chokshi, Tushar Mokashi and Arun Nair of the Research & Policy Team at ACCESS Health International for providing techno-managerial support for this work.

Policy Brief Design Credits: Tushar Mokashi & Guneet Kaur Ghai

For any query please contact us at maulik.chokshi@accessh.org or tushar.mokashi@accessh.org