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Can Primary Health Care Reinvent Itself to Impact Health Care Utilization?

The primary health care approach was described as “essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.”¹ Well-intended efforts were directed toward ensuring *universal accessibility* by developing norms for infrastructure expansion, followed by the subsequent creation of this infrastructure.

However, universal accessibility is not merely the creation of physical infrastructure. The services must be conveniently located and financially accessible. India has made slow but fair progress in the creation of new facilities. As of March 2009, there were 145,894 subcenters, 23,391 primary health centers (PHCs) and 4,510 community health centers (CHCs) functioning in the country.² These numbers are a steady rise from those two decades ago. Quantifying geographical access is difficult, but figures from the Bulletin on Rural Health Statistics report that the average rural subcenter caters to four villages with a service delivery radius of 2.61 km.² A comparison of the influences of access and economic status³ shows the latter emerging as a more crucial determinant in access to institutional delivery in rural India. However, the focus on physical infrastructure, its geographical accessibility, and affordability alone are inadequate to explain the current Indian public health paradigm.

This increase in the physical availability was expected to translate into increased utilization of the services, thereby improving the health status of the population. The figures of service utilization however took a nosedive with a considerable increase in the utilization of private facilities for outpatient care in rural (78.0%) and urban (81.0%) areas.⁴ The utilization of government facilities for inpatient care also declined from 60% in 1986–1987 to 40% in 2004.⁴ Instead of a commensurate increase in service utilization and access, the creation of physical infrastructure saw a secular fall in inpatient and outpatient

care utilization from government facilities. This paradigm must prompt all of us to sit up and take notice. We need to explore and understand the reasons that prompt people to visit health facilities and the reasons driving them away from free government care. Ubiquitous absenteeism, low client–provider interaction, poor referral systems, and a low perceived quality of care could emerge as possible reasons for this situation.

Private health care facilities provide tertiary care, with most functioning for profit. They have capitalized on the declining care seeking in government facilities and in spite of higher costs of care, they are emerging as the preferred choice for many Indians in urban as well as rural India. Will this correct on its own in the near future? We have limited evidence to make any predictions. If the growth of the medical insurance business is considered as a proxy indicator for the utilization of private health care in the future, we will witness an even starker shift-away from government health facilities. While the emergence of private health care can be considered as an externality, the setback to “brand” *primary health care* over the years is an internality. The very ethos of primary health care is lost when primary health care is equated to care provision in PHCs. Similar concerns were expressed in the Report of the National Commission of Macroeconomics and Health in 2004 about the reduction of the spirit of primary health care to just primary-level care.⁵

To bolster the existing public health services and augmenting a strong referral system, course correction is in order, and public health practitioners like us need to adopt a wider role in this situation. An increased synergy between the public health institutions engaged in teaching and training with the state health services would be mutually beneficial to both groups. The absence of a formal health area under the direct responsibility of a medical college should not be a barrier to this partnership. The first steps can be the provision of technical support from the public health institutes to the state services. This partnership can have three positive implications for the states: provision of technical support, temporary availability of staff with high visibility in the community,

and establishment of a strong referral linkage between the public health institute and the neighboring districts. The Indian Public Health Standards (IPHS) provide the benchmark for the quality of service provision in health centers. Public health institutions can participate by supporting the districts in adhering to these standards. The public health institutes and medical colleges will have an opportunity to step out of the proverbial ivory towers of disease and recognize and address true community concerns. A conjoint effort by the state and the institutes can thus be used to reinvent “brand” *primary health care* and bring it to the forefront. Several opportunities can be explored within the facilitating atmosphere of NRHM.

Addressing quality-of-care issues is wider than mere implementation of the IPHS. This is because when we talk about quality of care, we can assess quality on the basis of the availability of infrastructure, availability of drugs/equipment, regular presence of health personnel, and the treatment of patients. Moreover, when we talk about quality of care, quality is basically a subjective concept. Every individual has a different concept of quality and the concept can also show a variation between the client and the provider. We therefore, need to first explore whether the quality of care (or the lack of quality) can explain the utilization of government health care. Qualitative research into this area could yield lessons for the delivery of future services.

To summarize, well-intended efforts for the expansion of physical infrastructure over the decades have not witnessed a commensurate rise in service utilization in the government facilities. Research into factors influencing service utilization could lead us to developing a public health marketing strategy for care access. Quality of care is one such factor, and a local partnership between public health institutes and the state health services could go a

long way toward addressing quality shortfalls.

Senior public health practitioners have entrusted our generation with the responsibility of ensuring healthy communities. We need to understand that if proactive efforts and participation from the community is low, public health institutions have to redefine and reinvent strategies to reach out to them. Partnerships are the buzzword in public health, and our strategies must also be in tune with the times.

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