Super Powers, China and India

I am in India for a few weeks and I have an urge to reflect on PHC in India. Last week's Astana Declaration marked the beginning of a better future for primary health care, which is still fresh in my mind and its application to China and India is significant. There is a widespread belief that the success of Universal Health Coverage (UHC) and achieving Sustainable Development Goals (SDGs) are dependent on effective delivery of primary health care (PHC). India and China put together forms more than third (37%) of the world's population. Any improvements in health in any one of these two countries will make a significant difference to the health of the people in the universe. One can imagine the combined potential.

Both countries have made inroads into health for its people. Comparing the progress made by these two giants in the last fifty years, India lags behind China by some distance (see figures below). Studies also show that health can be a causative factor for the aggregate economic growth of a country. The World Health Organization has estimated that a 10-year increase in average life expectancy at birth is associated with a rise in economic growth of some 0.3-0.4% a year. It is evident from the Asian countries such as China, Malaysia, South Korea and Thailand. Plotting their economic growth vis-à-vis two key health indicators reveals an astounding fact: They have succeeded in improving health as well as delivering sustained economic growth.
(**https://www.livemint.com/Politics/PuYLifV8TNzD13GqiK3JmN/Healthcare-and-economic-growth.html**)
Gro Harlem Brundtland (Lancet 25 Sep 2018) in a recent comment in the Lancet also sites example of India's neighbours, such as Thailand and Sri Lanka, have become known as global UHC success stories, largely because they have invested in universal free services, with a much greater focus on primary care.

Vikram Patel et al (Lancet 2015; 386: 2422–35) stated that assuring universal health coverage will require the explicit acknowledgment, by government and civil society, of health care as a public good on par with education. Only a radical restructuring of the health-care system that promotes health equity and eliminates impoverishment due to out-of-pocket expenditures will assure health for all Indians by 2022.

India's reaction to this is the plan to create 150 000 health and wellness centres across the country, which will provide primary care facilities to deliver universal health coverage (UHC). In addition there is the National Health Protection Mission (NHPM)—a system of health insurance that intends to cover 500 million people. Government believes that these two schemes will address the present poor state of health services to its people and provide UHC. However, experts think that there is a risk that India's new health reforms could distort public spending towards tertiary care and this may undermine the Indian Government's own target of increasing primary care spending to at least two-thirds of the national public health expenditure. India's UHC, the Ayushman Bharat will become synonymous with hospital insurance for many people in India. This perception could result in people bypassing PHC services as they use their gold cards to access specialist care in hospitals (Gro Harlem Brundtland Lancet 25 Sep 2018). This will be watched by the world in the coming months and years to see whether India is following a PHC-led route to UHC.

Why has India lagged behind, despite the economic growth experienced over the past decades?
My experience of working in India encourages me to comment on some of the reasons that are behind these stark differences.
India was the first to promote primary health care and call for addressing balanced prevention and illness care through Bhore Committee Report (see figure below). That was in 1947. In 1979 Alma-Ata

Declaration emphasised the need for PHC for Health for All. Since then the concept of PHC has been repeatedly visited, with a lot of lip service but little implementation. Those countries who have adopted comprehensive PHC as the starting point to health service delivery have demonstrated great improvements in the health of its people.

Leaving governance and accountability aside, which is critical to any progress in health service delivery; the most significant and fundamental issues which affect the implementation of PHC in India are:

1. Importance to illness care rather than Primary Health Care

Bhore Committee recommendations were to provide PHC based health system and India beautifully laid out the network of primary health centres in each development block and sub centres to cover the health needs of the population. The weakness of the system was in continuing to give importance to illness care and vertical programmes, rather than a comprehensive and integrated approach to the eight components of PHC; viz. Maternal and Child Heath (MCH), Immunisations, Safe water and Sanitation, Treatment of Common Diseases, Communicable Diseases Control, Provision of Essential Drugs, Food supply and Proper Nutrition and Health Education.

Very little attention is paid to prevention. Illness care is the centre of PHC activity. Throngs of people wait to be seen by a doctor or whoever is replacing the doctor, as the doctor is absent from health centre most of the time; for medicine which is to be bought outside health centre from pharmacies run privately. Prescriptions obtained after consultation are loaded with unnecessary medications, which patients have to pay out of their own pocket.

The problem has been that each one of the component of PHC is independently working with little cooperation with other sections. Even in MCH; family planning, care during and after pregnancy, child care and nutrition do not coordinate with each other. More than half of all Under-5s are underweight and sizable number of them are severely malnourished. Growth monitoring programmes are non-existent and malnutrition continues to be a major health problem in the country. Poor physical and mental development in children continues to reflect in educational achievements and poor economic performance later in life.

Health education, which was to bring all eight components of PHC together, remains poorly implemented. Involvement of communities and self-help is absent.

2. Community Health Workers (CHWs)

India started CHWs programme in early 1970s which has survived to date as ASHA. According to Rajani R Ved (June 3, 2015), ASHA is India's CHWs. With nearly one million women volunteers across the country, the programme is here to stay. ASHA was a part of health system reform initiative, the National Rural Health Mission (NRHM) launched in 2005. There is some evidence to show that the role of the ASHA in encouraging communities particularly mothers and children to health facilities for institutional deliveries and immunisation is significant.

However, ASHA workers are not really promoting and helping in the implementation of the PHC. For example, the emphasis is for ASHA workers to get women to hospital for delivery, for which both ASHA worker and mother is rewarded with a small payment, rather than following the mother right through pregnancy for effective antenatal and post natal care, which is likely to improve the outcome of pregnancy. They have little to do with the growth monitoring where half of all children in their community are malnourished. How much of breast feeding is promoted by ASHA remains to be seen and they might be the targets for baby formulas from baby food firms.

3. Data use at Primary Health Centres

Health information collection is mandatory for PHC workers to be forwarded to district headquarters. Their work is assessed from this data and there is a possibility of exaggeration. There is little feedback to health centre staff for evaluation, workload assessment or for teaching purposes.

4. Health expenditure

Financial catastrophe, or severe financial hardship, can occur in all countries at all income levels. However, its effect is greatest in low-income countries and is more severe in middle- than high-income settings. There is a negative correlation between the proportion of people experiencing financial catastrophe and the extent to which countries fund their health systems by some form of prepayment, such as taxes or insurance (Xu K, et al. Protecting households from catastrophic health spending. Health Aff (Millwood). 2007 Jul-Aug;26(4):972–83). (see figure below)
Financing health care through out-of-pocket payments results in catastrophic health expenditure and results in impoverishment in many Asian countries, *particularly India.* (http://dx.doi.org/10.1002/hec.1209)

India remains one of the lowest spenders on health. According to Economic Survey, India's public spending on health is well below global average, a "little over" one percent of GDP. Good chunk of it goes into curative services, leaving even less for PHC.

Given the scale of unmet need and the constraints of India's low government budgets, it will be essential that India's UHC strategy is efficient and equitable. India must invest heavily in primary health care (PHC) services, where health returns are greatest. This has been shown across the world.