

Primary Health Care: Current Health Challenges and Way Forward

a. Primary Health Care and Non Communicable Diseases

Non-communicable conditions and diseases are second only to communicable diseases in terms of their contribution to the disease burden in India. These conditions include cardiovascular diseases, cancers, diabetes, respiratory conditions, and mental health diseases. Projections indicate that this group of diseases, largely affected by life style and dietary habits, will rise significantly in the near future, with the potential to cripple the already stretched public health system.

The National Commission on Macroeconomics and Health (NCMH) estimates nearly doubling of the cardiovascular disease cases from 380 lakhs in the year 2005 to 641 lakhs in 2015. Diabetes is also emerging as an important health condition in India, with an estimated 310 lakh cases in 2005. The diabetes load is expected to go up to approximately 460 lakhs by 2015. Cancers have been attributed to 3.3% of the disease burden in India and approximately 9% of all mortalities. The number of cancer cases in 2015 is expected to rise to 9.9 lakhs. Cancers of the cervix and the breast will continue to have the highest prevalence amongst cancers of females in India. Tobacco use, which is associated with a number of major diseases, including cancers and heart and lung disease, is prevalent among more than 50% men in India (NFHS 3, 2006), with the highest proportion belong to the lowest wealth quintile (22%). Mental health disorders are also on the rise, with approximately 650 lakh people in India requiring interventions for mental health.

Respiratory diseases such as chronic obstructive pulmonary disease (COPD) and asthma are also of significance with an estimated 1.5 crore chronic cases of COPD over the age of 30 years and 2.5 crore cases of asthma in 2001 in India. The increase is likely as per estimated projections. Analyses by the NCMH indicates that while there is limited evidence on the risk of NCD by economic status, the rural poor will face the threats of these conditions over time, particularly in the absence of any risk protection mechanisms. The current and projected estimates of NCDs by NCMH are presented in Table 5.1.

Table 5.1 : Disease Burden Estimation, 2005

Non-Communicable Conditions	Estimate of Cases/lakh	Projected number (2015) of Cases/lakh
Cancers	8.07(2004)	9.99
Diabetes	310	460
Mental Health	650	800
Blindness	141.07	129.96
CVDs	290 (2001)	640
COPD and Asthma	405.20 (2001)	596.36

Source: NCMH, 2005

Amongst the other non-communicable diseases blindness and deafness are major problems. As per survey conducted in 2006-07, the estimated prevalence of blindness has come down to 1% as compared to a prevalence of 1.48% found in 1986-89. As per WHO estimates in India, there are approximately 63 million people who are suffering from significant auditory impairment; this places the estimated prevalence of significant hearing loss in India at 6.3%. An even larger percentage of Indian population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

Programme Response to NCDs in India

The national response to address the challenge of these major conditions is discussed below for each non-communicable disease respectively.

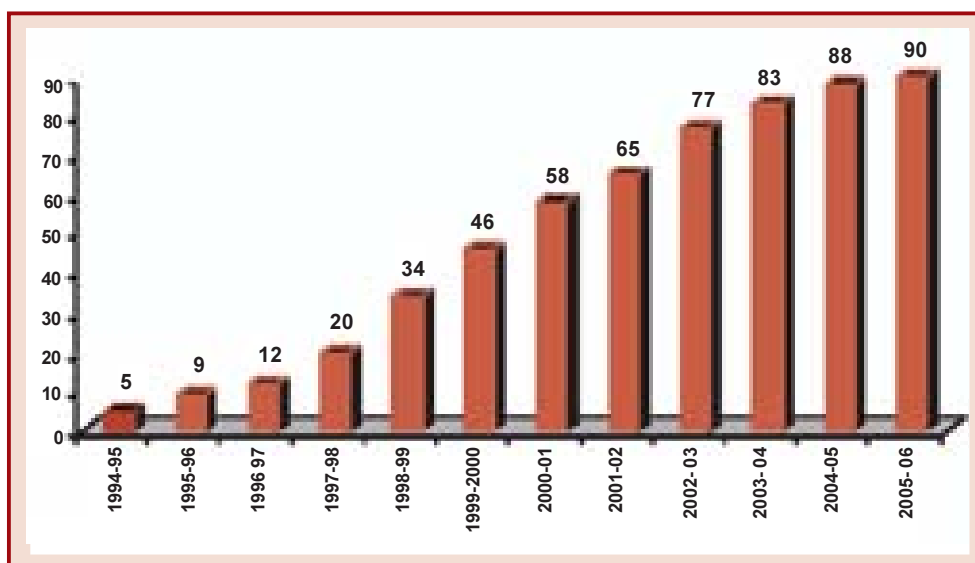
The Government of India has recently launched a pilot **National Programme for Prevention and Control of Diabetes, Cardiovascular diseases and Stroke** (NPDCS) on 4th January 2008 in 7 states covering one district each. The gamut of strategies included under this programme comprise of health promotion for the general population (community, school and workplace based interventions), setting up special clinics for detection of these diseases and specific interventions at the tertiary level to enhance capacity to respond to the needs of NCDs in India.

The **National Cancer Control Programme** was started in 1975-76, which initially focused on ten regional cancer centers and purchasing of cobalt therapy units for the treatment of cancer patients. From the year 1990-91, the government is supporting projects at district level for preventive health education, early detection and pain relief measures; development of oncology wings in medical colleges; and financial assistance to voluntary organizations for undertaking health education and early detection activities. A National Tobacco Control Cell has been set up in MOHFW for health education and advocacy against tobacco use.

The **National Mental Health Programme** was launched in 1982 with the objective to integrate mental health with primary health care; develop tertiary care institutions for treatment of mental disorders; and eradicate stigma and protect rights of patients through regulatory institutions. District Mental Health Programme (DMHP) covers 121 districts in 30 States/ UTs all over the country including 10 new DMHPs released during the current year. (MOHFW, 2007-08). Its main objective is to provide basic mental health services to the community and to integrate this with general health services.

The **National Programme for control of Blindness** was launched in the year 1976 as a 100% centrally sponsored scheme to reduce the prevalence of blindness to 0.3%. There has been a significant increase in proportion of cataract surgeries with Intra Ocular Lens (IOL) implantation from <5 % in 1994 to 90% in 2005-06 (Fig. 5.1). Most of the states have reached to cataract surgery rate of 400 operations per lakh population except Bihar, Jammu and Kashmir and northeastern states that have cataract surgery rate of 200 operations per lakh (MOHFW, 2007-08).

Figure. 5.1 :Trend of Cataract Surgeries with IOL Implantation



Source : Annual Report, Ministry of HFW (2007-08)

National Programme for Prevention and Control of Deafness has been recently initiated in the country to achieve a long-term objective of reducing the total burden of hearing impairment by 25% of the existing burden by 2012. The programme focuses mainly on capacity development at primary care level; strengthening the service delivery including rehabilitation and promotes outreach activities and public awareness through appropriate

and effective information, education and communication strategies with special emphasis on prevention of deafness.

While the primary health care system is struggling to provide interventions for MCH and communicable diseases, there is an emerging need for addressing NCD through the existing system. This presents a huge challenge to the current primary health care system. The public health system has to integrate elements for prevention and control of NCDs at all levels to safeguard the health of its people in the immediate future. Some efforts at such integration are being promoted through the NRHM.

b. Primary Health Care and Elderly

The proportion of elderly (aged 60 years and above), which was 6.5% (43.5 million) in 1981 (as per Census of India), grew to 6.8% in 1991 and 7.4% in 2001. With increase in life expectancy, Indians are likely to survive beyond 60 years. It is imperative for a primary health care system to meet the needs of elderly.

The 60th round of NSSO (2004) studied condition and health care of aged. The survey estimated that in the rural area, every 1000 persons in the working age had to provide support, physically or otherwise, to 125 aged persons (old age dependency ratio); the same was 103 in urban areas. 4 to 5% of elderly were living alone. 65% of the aged were found to depend on others for day-to-day maintenance. About 8% of the aged persons were either confined to their home or bed. The proportion of confinement increased with the age, being as high as 27 for persons aged 80 or more.

It was seen in the same survey that as high as 55 to 63% of the aged with sickness felt that they were in good condition of health. The proportion among the aged without sickness was 77 to 78%. Possibly they considered

their sickness as a problem of ageing. Disabilities in elderly have been reported by NSSO, 2002. The most common disability found in elderly was physical (55%), followed by visual impairment (26%), hearing impairment (20%), dementia-cognitive disability (6%) and urinary incontinence (1%).

Maintaining health is very important for the elderly, particularly for those from lower economic sectors who must continue to work for a living even when they have become senior citizens. Good health is central to their ability to work, to obtain food and money for themselves and families. However, many poor older people have little or no access to health services. Poor older people often cannot afford to pay fees and buy drugs (HelpAge International, 2002).

India has developed a strategic financial security plan for the elderly, including the expansion of the old age pension plan for the elderly poor. GOI also formulated the National Policy on Older Persons (1999) that envisaged medical and paramedical personnel in primary, secondary and tertiary health care facilities and institutions be given training and orientation in the health care of older persons. This led to plans within the Plan of Action 2000-2005, formulated by the Government for the implementation of the National Policy on Older Persons, on the training of health personnel specific to elderly care. The primary health care system is to be strengthened and oriented to be able to meet the health care needs of elderly.

c. Primary Health Care and Urbanization

According to the State of the World Population Report 2007, for the first time in history, more people will begin to live in cities than in villages in the year 2008. India, too, has been witnessing rapid urbanization, particularly in the recent decades. The 2001 census places India's urban population at 285

million in comparison to 742 million rural population. Currently, one-fourth of the urban population lives in slums with severely compromised health and sanitary conditions. Unless this trend is abated, it is projected that the Indian urban population will reach 576 million in 2030, of which a significant proportion will live in slums and slum-like settlements.

A close analysis of the health of the urban poor reveals that the average data conceals the health disadvantages suffered by them. Comparisons between urban and rural populations commonly indicate that urban groups have better health status than rural people. However, analysis of data disaggregated by Standard of Living and Quintile (Siddharth A, 2004) reveals that the urban poor fare as poorly as or sometimes even worse than their rural counterparts on several health indices. On the other hand, primary health infrastructure and services offered by the public sector is grossly inadequate to meet the health needs of the burgeoning urban population.

The primary health care system has been predominantly rural-based and facilities in urban areas have been too few and far between. There is one government primary health facility for approximately 2.38-lakh urban populations. It was only after the turn of the millennium that health care for the urban poor was recognized as a thrust area by the government under the National Population Policy (2000), National Health Policy (2002), RCH II, and the 10th Five Year Plan. Taking cognizance of the non-availability and substantial under utilization of the available primary health care facilities, the National Health Policy -2002 envisages setting up of an organized two-tier urban primary health care structure. The Ministry of Health and Family Welfare (2004) has formulated guidelines for developing city-level urban slum health projects, which suggest setting up a primary health care delivery center for every 50,000 population manned by 3-4 ANMs.

A Task Force on Urban Health, constituted under the National Rural Health Mission, has recommended strategies for improving the health of the urban poor. According high priority to the health needs of the urban poor, the Government intends to provide impetus to urban health initiatives in the country by launching the "**National Urban Health Mission**" (NUHM). This will cover all cities with a population of more than 100000. It would cover slum dwellers; other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or on sites. The existing Urban Health Posts and Urban Family Welfare Centres will continue under NUHM. The mission will deploy one Urban Social Health Activist (USHA) in each center. (Eleventh Five-Year Plan, 2007-12).

d. Primary Health Care and Privatization

The private sector in India has grown phenomenally from the time of independence to being the dominant health provider and financier, even for primary health care. Approximately 80% of all doctors, 75% of all dispensaries, and 60% of all hospitals in India belong to the private sector (Narayan et al, 2003). Individuals spend a disproportionate share of health care expenditure (76%) as out-of-pocket costs, with households in UP and Bihar meeting almost 90% of their health care needs through personal means. In the absence of risk-pooling mechanisms for 90% of the population, the economic impact of an illness necessitating hospitalization can be catastrophic for poor families. One-quarter of the Indian population falls below the poverty line as a result of disproportionately high levels of out-of-pocket expenditures (World Bank 2001). Free or subsidized public health services are also associated with indirect costs of transportation, loss of wages, and informal paying charges.

Weak public provisioning has resulted in the unregulated private sector taking a dominant role in health care delivery. NFHS 3 reports that the private sector remains the primary source of health care for the majority of households both in urban (70%) and rural (63%) areas. Non-use of public facilities is attributed to the perceived poor quality of care (58%), distance of facility (47%), and long waiting hours (25%).

Owing to scarcity of resources that limit public provisioning of health care, the need to integrate the private sector, including NGOs, in the delivery of health services, has been endorsed by the Government in recent policy documents. In the last decade, many State Governments have explored options for involving the private sector by handing-over, out-sourcing and contracting-out services to improve equity, quality, access and efficiency of services. However, the NCMH concedes that these efforts have been largely "programmatic, sporadic, disjointed, and tentative", while strongly endorsing the increased participation of the private sector in health. The Commission also recommends the formulation of appropriate public health laws and regulations, as well as institutional mechanisms to govern the private sector.

Opinions vary about whether the private sector can complement or jettison Government efforts towards providing "health for all." On the one hand, the largely unregulated private sector is seen as exploitative, unethical, and expensive, often pushing families into increasing financial hardships; on the other hand, private providers enjoy enormous trust with communities, are more accessible, have suitable timings, communicate better, maintain greater confidentiality, and have the capacity to reach the unreached. A body of experience from the health sector reforms initiated in the 90s is now available with regard to engaging with the private sector in health. The challenge lies in how efficiently the Government is able to learn from these reforms and build its own capacity to regulate the private health sector, as well as nurture and sustain partnerships with them to augment the flagging public health sector

services. Concurrently, health care insurance mechanisms that reduce the out-of-pocket liabilities of the poor need to be established.

e. Primary Health Care and Health Action in Crisis

India due to its geographical location is one of the most emergency disaster prone countries in the South East Asia. India faces continuous threat of natural disasters (Flood, cyclone, draught, tsunami, earthquake) and complex emergencies (ethnic/ caste/ religious violence, bomb blast and bio-terrorism). Apart from these, there lies constant threat of newly emerging infectious diseases like Avian Flu. The Orissa supercyclone (1999), the Gujarat Bhuj earthquake (2001), the Asian Tsunami (2004) and Himalayan Earthquake (2005) necessitated multiple sector response to combat these threats. A number of measures have been initiated by the Government to effectively respond to disasters. These include regular monitoring of the situation, coordination and review of response and relief at various levels, issue of early warnings, and strengthening the preparedness by capacity building of multiple stakeholders including Panchayati Raj Institutions Government of India has drafted a National Policy on Disaster Management that adopts a holistic and pro-active approach towards prevention, mitigation, and preparedness. It urges a strong community involvement and awareness generation, particularly that of the vulnerable segments of the population including women. It emphasizes the need of community empowerment for facing crisis situations effectively and efficiently. It expresses need for involving corporate sector, NGOs and media in vulnerability reduction and prevention. It envisages formulation of standard operating procedures (SOPs) and disaster management plans at local levels.

There is a need for primary health care to handle these challenges effectively in coming period to mitigate and to deliver an adequate health response.

The Way Forward.....

In the ensuing years after the Alma Ata in 1978, various strategies have been formulated for human development, stressing equity and the wellbeing of populations and the alleviation of suffering and ill health. India too is striving to ensure the health of its people by focusing on improving the health infrastructure, reducing inequity and regional imbalances (especially for the health of women and children). However, there has been uneven progress in achieving the goals set at the Alma Ata. In light of the changes in the health sector, it is critical to revitalize the understanding and implementation of primary health care as well as re-visit the nature of regulatory and oversight functions that need to be performed by the government. The challenge is to operationalize the values of Alma-Ata by developing, on the one hand, sustainable health systems for managing PHC and by establishing, on the other hand, complementary systems for governance that will ensure equity and inter-sectoral response to health needs of people. It is evident that a coherent policy framework for service provision is needed. Also, issues relating to human resources, including performance incentives and accountability continue to be difficult challenges in improving service delivery quality. A range of inputs, across levels are required for strengthening of the public health systems, with a focus on human resources, health workforce strategies, evolving needs of sectoral skills and relevant management issues. There is also an increasing need to strengthen public health education in India. One of the main challenges is to develop an interface with the community and health care delivery system, especially in light of advances in the health sector. Furthermore, today, increasingly information from research is being sought and used to support decision-making at policy and local levels. There is an urgency to develop and strengthen the capacity to conduct research that is directly responsive to information needs of those who manage health services.

Health service today have benefited from technological advances. There exists a need today to govern the introduction as well use of health technology. Similarly, globalization and trade liberalization can affect health directly and indirectly. Hence, it is important to take into account the global environment when developing national and domestic strategies. The impact of the new trade regime on health needs to be considered and it is increasingly critical to assess accurately and respond rapidly to the risks and opportunities for population health. Furthermore, healthy environments are a major determinant of health and thus a concern for the primary health care agenda. Various aspects of environmental health, especially in face of emerging challenges of climate change need to be spelt out and country-level strategies to address environmental health issues to be formulated. In an increasingly changing health landscape, there is a need to focus on health promotion, moving away from a 'disease-focus'.

Adequate capacity - including infrastructure, technical expertise and political will - is critical for the revitalization of the commitment to primary health care. Building on existing partnerships, as well as developing new partnerships and alliances, is crucial to this process. The challenge is to marshal and organize potential support in ways that are practical, effective and sustainable. Finally, it is clear that India's diverse health problems, needs, and health sector capabilities require multiple approaches.