

Primary healthcare policy implementation in South Asia

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ABSTRACT

Primary healthcare is considered an essential feature of health systems to secure population health and contain costs of healthcare while universal health coverage forms a key to secure access to care. This paper is based on a workshop at the 2016 World Organization of Family Doctors (WONCA) South Asia regional conference, where the health systems of Bangladesh, India, Nepal, Pakistan and Sri Lanka were presented in relation to their provision of primary healthcare. The five countries have in recent years improved the health of their populations, but currently face the challenges of non-communicable diseases and ageing populations. Primary healthcare should be a core component in restructuring health systems. However, there is a lack of understanding among policymakers of the unique contribution of primary healthcare to the health of populations. This results in insufficient investment in facilities and low priority of specialty training in the community setting. Regional collaboration could strengthen the advocacy for primary healthcare to policymakers and other stakeholders. Priorities were investment in community-based health facilities, and access to healthcare through professionals specialty-trained in the primary healthcare setting. This development fits the strategy of the WHO South East Asian Region to use community-based healthcare in achieving universal health coverage for the Asian populations.

Most countries experience major challenges to their health systems and the South Asian region is no exception. Factors behind this global trend are increasing health costs, and diminished returns on investment for ageing populations. Where the primary healthcare function is formally structured in the health system, and professionals are educated for their specific tasks, the performance of the system is often optimised: better primary healthcare leads to better population health at lower healthcare costs.¹ Strengthening primary healthcare for sustainable healthcare is a global strategy² that can benefit from international collaboration.³ A critical feature of this strategy is the adaptation of general principles to the prevailing local

Key questions

What is already known about this topic?

- ▶ Primary healthcare is an essential component of cost-effective healthcare. Insight into countries' health systems is important to plan effective ways to strengthen health systems. However, for most countries there is limited insight into the role and position of primary healthcare in their system.

What are the new findings?

- ▶ This paper provides field experience from five countries which populate a quarter of the world population. Demographic developments require a strengthening of their primary healthcare. However, low investment, poor planning and a lack of understanding of the unique contribution of primary healthcare for population health impede this development.

Recommendations for policy

- ▶ Regional collaboration and advocacy for primary healthcare can support countries in an appropriate investment in community-based health services and specialty training of professionals in the primary healthcare setting, and substantially improve access to healthcare.

conditions: primary healthcare has to be built-up from the community level where it has to operate.⁴ For this a good understanding of the existing health system is important in initiating reforms. There is growing insight in primary healthcare in Europe and North America,^{3,5} but for many countries or regions data are scarce.⁴ In response to this, the World Organization of Family Doctors (WONCA) took the initiative to document how primary care is organised around the world, and to create dialogues of how the values of primary healthcare can be addressed within different health systems.^{6,7} A workshop at the 2016 WONCA South Asia regional conference in Colombo, Sri Lanka, offered an opportunity to compare the health systems of five WONCA member



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countries: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

Universal health coverage (UHC) is a key to secure access to care. The WHO South East Asian Region has promoted a regional UHC strategy centred on community-based healthcare, with family physicians at its core.⁸ Services should integrate health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care. Stepwise implementation is designed to adopt the perspectives of individuals, families and communities, in the capacity of participants as well as beneficiaries. Strengthening primary healthcare is considered a cost-effective low risk approach, to make sure that full population coverage is realised ('no one is left behind') by 2030.

This paper is based on the findings of a workshop at the WONCA South Asia conference in Colombo in February 2016, where the field experience of primary healthcare development in five countries—Bangladesh, India, Nepal, Pakistan and Sri Lanka—was presented and discussed with the objective of identifying common strategies for strengthening primary medical healthcare, and priorities for regional collaboration.

Academic family physicians presented a case study of their country, using as a framework a set of 11 power point slides developed by WONCA,⁶ each focused on country demographics, the health system and the role and position of primary healthcare, the country's main health challenges, strengths and weakness of the system to address health needs and lessons others could learn from their country. Presenters were free to concentrate on what in their views were the most important information, and subsequently provided a summary of their presentation for this article. Discussion was directed towards regional planning for universal health coverage, how changes towards stronger primary healthcare could occur, and how international collaboration could support this.

These discussions were placed in the context of the regional planning of UHC policy.⁸

SUMMARIES OF COUNTRY CASE STUDIES

Sri Lanka has achieved low maternal and neonatal death rates and high immunisation coverage through the introduction of selective primary healthcare,⁹ spending 3.2% of their gross domestic product (GDP). Vertical programmes have been delivered as free primary healthcare by grass root health workers, public health midwives and public health inspectors. Currently, there is an increased impact of non-communicable and lifestyle-related diseases (NCD) on the health status of the population. To respond to this new challenge, the existing vertical programmes are insufficient: there is the need for a health system that is able to address a range of health problems and integrates health education, prevention and timely intervention directed at the whole person. An important barrier to realise this is that every medical specialist can

practice in the community, without specific professional training for primary healthcare competencies. As a consequence overuse of specialist care and episodic treatment of diseases in isolation stands in the way of continuity of care based on relation of trust over time. This makes the development of strong, comprehensive primary healthcare as the basis of the health system an urgency.

Nepal is a low-and-middle-income country, with significant disparities in health, education, wealth and access to care between Nepal's 126 distinct ethnic/caste groups, and between people living in different regions. The country is making slow but steady progress in improving its population health and well-being, focusing on equity and inclusiveness by health policymakers and professionals spending 1.8% of GDP on health. However, there is a shortage of resources, in particular in rural areas: with only one hospital for every 168 000 persons (a hospital bed for every 4000 rural persons) and a physician for every 92 000 persons (a health post for every 24 000 rural persons). In addition, the limited resources are not used in an optimal way: there is a lack of political commitment for primary healthcare that can respond to all relevant health problems, as the basis of the health system. This results in poor interaction between primary, secondary and tertiary care, and poor integration between government and the private sector with overuse and underuse of resources, and insufficient penetration of health programmes down to the community level, leading to avoidable, low health status of the population.^{10 11}

India is the second most populous country in the world. Though the total fertility rate has decreased over the decades, the overall population is steadily increasing. The health sector consists of both private and public providers. The health system is overtly privatised with more than 78% of care provided by the private sector and public investment, at a stable 1% of the total GDP, low.¹² Services are oriented towards tertiary and curative care and due to low insurance coverage care is covered by out of pocket payment. Catastrophic health-related expenditures are leading families into poverty. Services are concentrated in urban areas although 70% of the population live in the rural areas. This is exacerbated by the dual epidemic of NCD—currently accountable for 53% of total deaths—and infectious diseases. In 2005, the Government launched a National Rural Health Mission (NRHM) to strengthen human resources as well as infrastructure focusing on 18 poorly performing states. The NRHM has now evolved into the National Health Mission which also covers the urban health needs.¹³ To become truly successful, this mission has to be connected to UHC, but although discussions on UHC gained momentum during the past 5 years with the publication of a strategy for its implementation in 2011¹⁴ this may take some time before it is realised.

Bangladesh is the eighth biggest country of the World with a density of 1033.5/km² and with per capita

income of only \$1 314 00. The country is virtually homogeneous in ethnicity, with a landmass of fertile plains and a large delta prone to flooding. On average there is a physician for 3000 people, but this can vary to 1:20 000 and 3.7% of GDP is spent on health.¹⁵ Through vertical public health programmes and other societal interventions the health indicators have substantially improved. However, to achieve UHC and address non-communicable and lifestyle diseases, there is still a long way to go.

Most inhabitants rely on the private sector and have to pay directly out of their own pockets. Most physicians are 'general practitioners', who have not been professionally trained for primary healthcare competencies. In addition, there is large scale use of complementary and alternative healers. The government has developed a Government Health Delivery System which is inadequate to secure access for all. More recently, through public-private partnerships more than 10 000 community health centres have been established. This has relied substantially on the employment of nurses and hospital trained specialists. It appears the model for the future, but to fully benefit from it specialty training for 'general practitioners' is required as a qualification to work in the primary healthcare setting.

Pakistan is the sixth most populous country in the world and consists largely of young people.^{16 17} On paper, the health system is well planned, but a lack of basic human and material resources stand in the way of functioning as designed. On top of this, lack of regulation, renders it non-functional, which results in avoidable, poor health status of the population. The private sector is the main provider of care, with about 80% of healthcare-related expense.¹⁸

NCD are rising, and related to lifestyle (tobacco smoking in 23% of males, elevated blood pressure in 25% and obesity 5.5% of the population and increasing alcohol consumption and physical inactivity): close to 2000 Pakistanis losing their lives to a preventable non-communicable disease every day and the probability of dying between ages 30 and 70 years from a NCDs is 21%.^{19 20} The Department of Health has responded through vertical NCD units, spending 2.8% of GDP on health. However, an overall lack of operational strategy, including the absence of evidence-based guidelines for its management hamper an effective approach through primary care. Owing to the low priority and limited resources primary healthcare is generally poorly developed, although there have been some excellent models developed through academic outreach.

The presented case studies focused at each country's specific situation. India, with its massive population, devolved state-based health systems, large private health sector and predominantly 'out of pocket' payment, presents a different challenge in securing effective primary healthcare than, for example, Sri Lanka with its historic countrywide approach to public health and population interventions that are free at point of use. These

differences will shape their developments in the coming years. However, at the same time, a number of common themes came forward.

The first is financial: the five countries spend <4% of their GDP on health. More importantly, this modest investment is spent in an ineffective way, with an emphasis on hospital—and specialist provided rather than community-based services. The resulting problems for access and equity are further exacerbated by the often substantial out of pocket payments. This emphasises the importance of a coherent strategy to introduce strong community-based primary care with family medicine under UHC.⁸

Second, there is an urgent need in the region for advocacy of a strong primary healthcare function. The WONCA–WHO partnership will help in approaching governments, provide leadership for regional collaboration and engage with other stakeholders (patients/service users, professionals, policymakers, insurers and community leaders) for health system change. A priority is to address the isolated position of primary healthcare and general practice.

Advocacy of health insurance and UHC should include funding conditions that are likely to ensure comprehensive primary healthcare with minimal access barriers for the poor and cover preventive and chronic disease management. There is a tendency to approach UHC without a view on primary healthcare policy.^{21 22} This may undermine its realisation, as primary healthcare makes health systems more robust²³ and results in greater equity and more cost-effective care.^{1 2} This makes the South East Asian WHO Strategy to combine UHC and primary health a powerful and timely one.⁸ It underlines the need of better markers of the complex and integrated contribution primary healthcare makes to population health.²⁴ Part of this complexity is its contribution to other sectors than healthcare (and healthcare related costs), in pursuing health.²⁵

The third point is the establishment of specialty training of general practitioners and other primary healthcare professionals in the primary healthcare setting, by primary healthcare professionals, as the accreditation for patient care in the community. Partnership with universities and regional collaboration through fellowships can help in building capacity and expertise, as has been demonstrated in the Primafamed project in Sub-Saharan Africa.²⁶

Among the stakeholders, engagement with patients is of particular importance. One of the problems is that often there are no patient organisations available to recruit from. An alternative, or initial step in helping patients to organise their voice, could be to collect their experiences with their health problems, their self-care and (primary) healthcare professionals. South Asian patients experiences can at the same time provide important qualitative data for cross-national and scholarly collaboration to inform policy towards care that is accessible, affordable, acceptable and effective.

Although the challenges identified from these comparative case studies follow from the specific South Asia context, there are at the same time substantial similarities with challenges encountered in other parts of the world: the importance of a stronger focus on research, teaching and training in the primary healthcare setting, under the leadership of primary healthcare experts through a primary healthcare academic outreach is universal. And this in turn underlines the importance of collaboration beyond the region and the contribution international experts and expertise have to offer for the challenges that are facing South Asia in implementing primary healthcare policy and pursue UHC.

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