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Evolution Of Primary Health Care Centres Concept In India - A Study

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Abstract: Primary healthcare is a critical component of health service delivery, serving as the foundation for protecting, maintaining, and restoring health. In India, the concept of primary healthcare was established by the Bhore Committee in 1946. Over the past six decades, there have been significant improvements in primary healthcare services, infrastructure, and related healthcare indicators. However, several challenges remain in achieving universal health coverage. This review article examines the evolution of India's primary healthcare system, highlighting current and future challenges. The study involved a comprehensive literature review of indexed and non-indexed journals, websites of important organizations, and national programs related to primary healthcare in India. Key findings and recommendations are discussed to address the identified challenges and improve the primary healthcare system.

Key words: Primary healthcare, evolution, challenges, India, Bhore Committee, Alma-Ata Declaration, National Health Policy

***Introduction*:** The primary healthcare 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 thatthe community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". The Alma-Ata Declaration also emphasizes that everyone should have access to primary healthcare, and everyone should be involved in it. The primary healthcare approach encompasses the following key components: Equity, community involvement/ participation, intersect orality, appropriateness of technology and affordable costs. Primary healthcare as defined above will do much to address many of the prerequisites for healthindicated earlier.

For this review article, search strategy involved a detailedliterature review on the subject of primary healthcare in India. Indexed and non-indexed journals, websites of important organizations, and national programs in the field were identified and searched for key words like primary healthcare, India, Challenges. Search engine included Google and PubMed. The most relevant 20 publications were reviewed in details and included in the article.

EVOLUTION OF PRIMARY HEALTH CARE SYSTEM IN INDIA

Primary healthcare is a vital strategy that remains thebackbone of health service delivery. India was one of the first countries to recognize the merits of primary healthcareapproach. Long before the Declaration of Alma-Ata, Indiaadopted a primary healthcare model based on the principlethat inability to pay should not prevent people from accessing health services. Derived from the recommendations of theHealth Survey and Development Committee Report 1946,under the chairmanship of Sir Joseph Bhore, the Indian Government resolved to concentrate services on rural people. This committee report laid emphasis on socialorientation of medical practice and high level of public participation. With beginning of health planning in India and first five year plan formulation (1951-1955) Community Development Programme was launched in 1952. It was envisaged as a multipurpose program covering healthand sanitation through establishment of primary health centers (PHCs) and sub centers. By the close of secondfive year plan (1956-1961) Health Survey and Planning Committee (Mudaliar Committee) was appointed by Government of India to review the progress made in healthsector after submission of Bhore Committee report. The major recommendations of this committee report was to limit the population served by the PHCs with the improvementin the quality of the services provided and provision of onebasic health worker per 10,000 population.

The JungalwallaCommittee in 1967 gave importance to integration of healthservices. The committee recommended the integration fromthe highest to lowest level in services, organization, and personnel. The Kartar Singh Committee on multipurpose workers in 1973 laid down the norms about health workers. Shrivastav Committee (1975) suggested creation of bands of para-professionals and semi-professional worker from within the community like school teachers and post masters. It also recommended the development of referralcomplex by establishing linkage between PHCs and high level referral and service centers. Rural Health Scheme was launched in 1977, wherein training of communityhealth, reorientation training of multipurpose workers,and linking medical colleges to rural health was initiated. Also to initiate community participation, the community health volunteer "Village Health Guide" scheme was launched. The Alma-Ata Declaration of 1978 launchedthe concept of health for all by year 2000. The declaration advocated the provision of first contact services and basicmedical care within the framework of an integrated healthservices. Several critical efforts outlined Government of India's commitment to provide health for all of its citizensafter Alma-Ata declaration. The report of study group on "Health for All: An Alternative Strategy" commissioned by Indian Council for Social Science Research (ICSSR) and Indian Council for Medical Research (ICMR) (1980) argued that most of health problems of a majority of India'spopulation were amenable to being solved at the primary healthcare level through community participation and ownership. Alma-Ata declaration led to formulation of India's first National Health Policy in 1983.

The major goal of policy was to provide universal, comprehensive primary health services. Nearly 20 years after the first policy, the second National Health Policy was presented in 2002. The National Health Policy, 2002 set out a new framework to achieve public health goals in socioeconomic circumstances currently prevailing in the country. It sets out an increased sectoral share of allocation out of total health spending to primary healthcare. Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission in 2005 to carry out necessary architectural correction in the basic healthcare delivery system. The goal of the mission is to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children.

Landmarks in Primary Health Care:

2005: National Rural Health Mission (NRHM) launched, focusing on infrastructure, staffing, and essential drugs in rural areas.

2013: National Health Mission (NHM) combines NRHM and National Urban Health Mission (NUHM), expanding focus to urban areas.

2014: Ayushman Bharat Yojana launched, aiming for universal health coverage through various initiatives, including:

Ayushman Bharat Health and Wellness Centres (AB-HWCs): Replacing existing PHCs, aimed at providing comprehensive primary care.

Ayushman Bharat Digital Mission: Using technology to improve access and efficiency of healthcare.

Current Status:

India has a vast network of primary healthcare facilities (nearly 200,000), but accessibility, staffing, and service quality remain uneven.

Initiatives like AB-HWCs aim to address these challenges and provide comprehensive primary care.

Importance of Health:

Taking care of your physical body is good for your mental health. The mind and body interact and influence one another in complex ways. Physical illness can make managing your mental well-being more difficult. Stress, lack of energy, poor sleep, and other problems can also take a toll on how you feel mentally. This article discusses why you should take care of your body and how it can support your mental health. It also explores what you can do to take better care of health.

There are a number of reasons why taking care of your body is good for your mental health:

- **Health problems affect functioning**: Health problems, even minor ones, can interfere with or even overshadow other aspects of your life. Even relatively minor health issues such as aches, pains, lethargy, and indigestion take a toll on your happiness and stress levels.
- **Poor health habits can add stress to your life**: They also play a role in how well you are able to cope with stress. The stress that comes from poor health is significant.

- **Poor health interferes with daily living**: Health challenges also affect other areas of your life. Health problems can make daily tasks more challenging, create financial stress, and even jeopardize your ability to earn a living.
- **Stress can worsen health**: Stress itself can exacerbate health issues from the common cold to more serious conditions and diseases, so maintaining healthy habits can pay off in the long run. This article looks at some healthy habits that have a positive impact on your life.

Impact of Health on Economy:

The adequacy of physical and mental capacity of a person to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity is known as Health. It may be defined in terms of various health indicators such as life expectancy, infant mortality, crude death rate, etc. It is one of the fundamental rights of every citizen. Developing countries, including India, bear a disproportionate burden of disease due to lack of clean water, sanitation, food, shelter, employment, education and gender equality. The development of the society shows status of health also. It is influenced by different indicators like employment, income, educational attainment, social groups, level of awareness, accessibility to health care and availability of health services. Poor health leads to deficiency in human capabilities and it also shows the level of deprivation among the people. There is a close linkage between health and poverty and health and development but the relationship is very complex. As 'vicious circle of poverty' theory explains clearly "a nation is poor because it is poor" Nurkse1. Health has a great significance from economic point of view. Healthy population is an asset for an economy while ill and aged population is a burden. From the point of view of an individual, health performs dual functions. On the one hand, good health represents a value of its own target that needs to be reached as closely as possible. On the other hand, there are other aims in life as well such as good health gives good income in labour market.

Role of Health in Economic Development:

Health is both causes and effects of economic development. Investment in health is recognised as an important means of economic development. As the Commission on Macroeconomics and Health of the World Health Organization (WHO) has shown, substantially improved health outcomes are a prerequisite if developing countries are to break out of the circle of poverty. Good health contributes to development through a number of pathways:

1) Higher worker productivity: Healthier labours are more productive, earn higher wages, and neglect fewer days of work than those who are ill. This increases output, increases turnover in the workforce, and increases enterprise profitability and agricultural production.

2) Higher rates of domestic and foreign investment: Increased labour productivity creates incentives for investment. Besides, controlling endemic and epidemic diseases, such as HIV/AIDS, is likely to encourage foreign investment, both by increasing growth opportunities for them and by reducing health risks for their personnel.

3) Improved human capital: Healthy children have better cognitive potential. As health improves, rates of absenteeism and early school drop-outs fall, and children learn better, leading to growth in the human capital base.

4) Higher rates of national savings: Healthy people have more resources to assign to savings. These savings in turn provide funds for capital investment.

5) Demographic changes: Improvements in both health and education contribute to lower rates of fertility and mortality. After a delay, fertility falls faster than mortality, slowing population growth and reducing the "dependency ratio" (the ratio of active workers to dependants). This "demographic dividend" has been shown to be an important source of growth in per capita income for low-income countries.

6) Improved Utilisation of Natural Resources: Health investment contributes to better deployment of economic resources of a nation. Many developing economies waste huge sum of money on treatment o various diseases rather than their prevention. This leads of wastage of resources. Eradication of diseases also enhances labour productivity. The investment made in treating disease can be diverted to other productive uses.

7) Multiplier Effect of Health Expenditure Extending to Next Generation: Good health at the initial stage of life, i.e. among children from 1-6 years of age is a pre-requisite for future development of these children. A child who is physically and mentally fit at the age of 5 or 6 years is more likely to enrol for school and will develop a strong foundation through active learning and regularity in class. Again it is a well-established fact that a healthy and educated individual certainly generates more income than an uneducated individual, thereby making contribution to the national income of the nation.

8) Long run Reduction in Cost of Medical Care: Spending in healthcare for short run prevents and reduces the incidences of diseases in long run and results in giant savings in treatment costs. The expenditure pays for some diseases even when all the indirect benefits such as higher labour productivity, reduced pain and suffering are ignored for example Polio. In America prior to the eradication of polio showed that investing $22 million over 15 years to eliminate the disease would prevent 22,000 cases and save between $320 million to $1.3 billion in annual treatment costs.

In addition to their beneficial macro-economic impact, health improvements have intergenerational spill-over effects that are clearly shown in micro-economic activities, not least in the household itself. The "demographic dividend" is particularly important for the poor as they tend to have more children, and less to "invest" in the education and health of each child. With the spread of better health care and education, family size declines. Children are more likely to escape the cognitive and physical consequences of childhood diseases and to do better in school. These children are less likely to suffer disability and impairment in later life and so are less likely to face catastrophic medical expenses and more likely to achieve their earning potential. Then, as healthy adults, they have more resources to invest in the care, health and education of their own children.

Health and Economic Development:

It is considering, health to be a crucial aspect of human capital, and therefore a vital ingredient of economic growth. In order to explain the relationship between health and economic growth, it is necessary to understand the concept of health in a broad sense. Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. It is an asset individuals possess, which has intrinsic value as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example Healthier workers are physically and mentally more energetic and robust. They are more productive and earn higher wages. They are also less likely to be absent from work because of illness (or illness in their family). Illness and disability reduce hourly wages substantially, with the effect especially strong in developing countries, where a higher proportion of the work force is engaged in manual labour than in industrial countries. Health performance and economic performance are interlinked. Wealthier countries have healthier populations for a start. And it is a basic truth that poverty, mainly through infant malnourishment and mortality, adversely affects life expectancy. National income has a direct effect on the development of health systems, through insurance coverage and public spending, for instance. As per WHO Commission on Macroeconomics and Health11 for a panel of 167 countries, while health expenditures are determined mainly by national income, they increase faster than income. The effects of health on development are clear. Countries with weak health and education conditions find it harder to achieve sustained growth. Indeed, economic evidence confirms that a 10% improvement in life expectancy at birth is associated with a rise in economic growth of some 0.3-0.4 percentage points a year. Disease hinders institutional performance too. Lower life expectancy discourages adult training and damages productivity. Similarly, the emergence of deadly communicable diseases has become an obstacle for the development of sectors like the tourism industry, on which so many countries rely.

***Importance of Primary Health Care centres in India*:**

Primary care is the link between the patient and the health care system that provides the individual with access to the information and care services they need for optimal health outcomes.

The main purpose of primary care is to improve the overall health of the public and successfully prevent the spread of communicable diseases. It aims to avoid burgeoning pressures on the health system of the country by preventing diseases from spiralling beyond control.

Primary health care, in this sense, focuses on preventive measures. It also includes building the right infrastructure and creating enough awareness amongst the masses about public health and wellness so that they can make the most of the resources available to them and stay healthy in the long run.

From the Indian perspective, primary healthcare is important for more reasons than one. It supports the early detection of diseases and helps avoid epidemics or mass health contingencies from arising.

This also enables governments to tackle healthcare costs and prevent situations that can overwhelm the country's health centres and cause undue pressure on secondary and tertiary hospitals.

Having a robust primary healthcare system in place will enable the betterment of community health and thus lead to the betterment of the nation as a whole. It also has several benefits from the economic and business standpoint.

Guide lines for Primary Health care centres:

Ministry of Health and Family Welfare (MoHFW) revised the guidelines in 2022. Primary Health Centre is the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-Centers for curative, preventive and primitive health care. A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 6 indoor/observation beds. It acts as a referral unit for 6 Sub-Centers and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level. However, as the population density in the country is not uniform, the number of PHCs would depend upon the case load. PHCs should become a 24 hour facility with nursing facilities. Select PHCs, especially in large blocks where the CHC/FRU is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing number of Medical Officers, preferably such PHCs should have the same IPHS norms as for a CHC.

Standards are the main driver for continuous improvements in quality. The performance of Primary Health Centers can be assessed against the set standards. Setting standards is a dynamic process. Currently the IPHS for Primary Health Centers has been revised keeping in view the resources available with respect to functional requirements of Primary Health Centre with minimum standards such as building, manpower, instruments and equipment, drugs and other facilities etc. The revised IPHS has incorporated the changed protocols of the existing health programmes and new programmes and initiatives especially in respect of Non-communicable diseases. The overall objective of IPHS for PHC is to provide health care that is quality oriented and sensitive to the needs of the community. These standards would also help monitor and improve the functioning of the PHCs.

Facilities in PHC'S in India:

Primary Health Centres programmes are listed below:

- Provision of medical care
- Maternal-child health including family planning
- Safe water supply and basic sanitation
- Prevention and control of locally endemic diseases
- Collection and reporting of vital statistics
- Education about health
- National health programmes, as relevant

- Referral services
- Training of health guides, health workers, local dais and health assistants
- Basic laboratory workers
- First PHC established in 1952.

Infrastructure in PHC:

In the context of healthcare, infrastructure refers to the physical facilities and resources necessary for providing medical services. In the Indian context, the availability and quality of healthcare infrastructure vary widely across different regions and states. This variation can have a significant impact on the accessibility and effectiveness of healthcare services. According to the Indian Public Health Standards (IPHS), it is expected that all Primary Health Centers (PHCs) function in their own buildings. However, the status of ownership of designated PHC buildings varies across different states. For example, in Nellore district, the ownership of designated government buildings for PHCs is slightly lower compared to states like Assam and Karnataka, where the ownership is 100%. A study in tribal districts of Karnataka showed that only 32% of PHCs had their own building, indicating a significant disparity in infrastructure availability. Another critical aspect of healthcare infrastructure is road connectivity. In Nellore district, only 53.3% of PHCs had all-weather road communication, meaning that half of the PHCs could not be reached throughout the year, leading to severe access barriers. This is in contrast to the state average in Andhra Pradesh, where more than 90% of PHCs had all-weather roads. The lack of proper road connectivity can significantly impact the accessibility of healthcare services, especially during emergencies. Additionally, the presence of essential facilities like boundary walls, electricity, and water supply is crucial for maintaining cleanliness and ensuring the smooth functioning of PHCs. In Nellore district, 73.3% of PHCs had a boundary wall with a gate, and all PHCs had electricity. However, only 66.7% of PHCs had toilets with an adequate water supply, indicating a need for improvement in sanitation facilities. In terms of medical facilities, the availability of inpatient wards, laboratory facilities, and operation theaters (OTs) varies across different regions. In Nellore district, 73.3% of PHCs had an inpatient ward with four to six beds, and 93.3% had OTs. However, the availability of basic laboratory tests and essential drugs varied, indicating a need for standardization and improvement in medical infrastructure.

CHALLENGES FOR PRIMARY HEALTHCARE SYSTEM IN INDIA

Delivering quality primary care to large populations is a significant challenge in India, where communicable diseases, maternal and perinatal health issues, and nutritional deficiencies remain major causes of death. Additionally, non-communicable diseases (NCDs) like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are on the rise. Mental health disorders are also increasing, taking a substantial toll on human lives. The health issues related to the elderly population are common due to an increase in life expectancy. India has experienced rapid urbanization, with one-fourth of the urban population living in slums with compromised health and sanitary conditions.

The current primary healthcare system in India faces the challenge of addressing these issues. Preventive medicine in old age is crucial to compress the time spent in dependency. Regular, complete health check-ups

for the elderly should be embedded in the essential elements of primary healthcare. Patient satisfaction is a key marker for the quality of healthcare delivery and should be continuously studied to improve healthcare systems. However, there is a poor level of client satisfaction in both rural and urban areas regarding primary healthcare services, with complaints of rude and discriminatory behavior by health workers.

The primary healthcare infrastructure and manpower in India are deficient. According to the Rural Health Survey (RHS) 2011, there are shortfalls in the number of health workers, doctors, and specialists required for adequate coverage. India requires more primary health centers (PHCs) to meet the needs of its population, especially in rural areas. There is an urgent need to address inadequate infrastructure and manpower to improve the delivery of primary healthcare services.

The current primary healthcare structure in India is rigid and unable to respond effectively to local realities and needs. Lack of resources, especially in some states, contributes to the poor performance of the primary healthcare system. Factors such as absenteeism, low client-provider interaction, poor referral systems, and low perceived quality of care drive people away from free government healthcare. There is a need for local adaptation of healthcare services to cater to the diverse population of India.

To improve the primary healthcare system, reforms should focus on revitalizing and resourcing primary health systems to deliver different levels of service aligned with local realities. Accountability and access should be monitored at the district level by an independent agency. Research into factors influencing service utilization and client satisfaction can lead to the development of a public health marketing strategy for care access. The success of health systems depends on tapping existing potential and making appropriate structural changes.

India has made considerable progress in education and economic growth but has been slow in improving health indicators. Further efforts and redesigning of outreach strategies are needed to achieve the Millennium Development Goals (MDGs) related to health. The Sustainable Development Goal (SDG) 3 includes targets for universal health coverage, ending the prevalence of neglected tropical diseases, and improving access to healthcare services. Multispectral action is crucial for addressing poverty, controlling disease vectors, improving access to clean water and sanitation, and achieving these goals.

Conclusion

In conclusion, India's primary healthcare system faces significant challenges in delivering quality care to its large and diverse population. Communicable diseases, maternal and perinatal health issues, and nutritional deficiencies remain major concerns, alongside the rising burden of non-communicable diseases, mental health disorders, and healthcare needs of the elderly. The rapid urbanization and compromised living conditions in slums further strain the healthcare infrastructure.

Addressing these challenges requires urgent attention to improve infrastructure, increase manpower, and enhance the quality of care. Client satisfaction and local adaptation of healthcare services are crucial for the effective delivery of primary healthcare. Reforms should focus on revitalizing and resourcing primary health systems, ensuring accountability, and monitoring access at the district level.

India's progress towards achieving the Millennium Development Goals related to health has been slow, highlighting the need for intensified efforts and redesigned strategies. The Sustainable Development Goal 3, which aims for universal health coverage and ending neglected tropical diseases, underscores the importance of multispectral action and improved access to healthcare services.

By investing in primary healthcare and implementing necessary reforms, India can address its healthcare challenges and improve the health and well-being of its population.

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