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ANALYSIS

HEALTH IN SOUTH ASIA

Tackling the primary care access challenge in South Asia

Increased public financing for primary care and medical education as well as regulation of private services are vital to tackle the primary care crisis in South Asia, argue **Amit Sengupta and colleagues**

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Key messages

- Poor investment and shortages in the health workforce underpin the fragility of primary healthcare in South Asia
- Private providers are heavily relied on for primary care, albeit with little regulation of costs and quality of care
- Tackling the primary care crisis requires substantial increases in public provision and financing of primary care, medical education, and health worker training, and regulation of privately provided primary care services

Well designed and accessible primary care reduces the need for hospital based care and contributes to better overall health. Despite a large network of primary care facilities, large sections of the population in South Asia lack access to reliable and effective primary care. This is reflected in poor health indicators across the region.[1] The 2015 Human Development Report found that five of six South Asian nations (India, Nepal, Bangladesh, Pakistan, and Afghanistan) have higher mortality rates among under 5s and adults, greater prevalence of child malnutrition, higher mortality rates from tuberculosis, and lower life expectancy at 60 years compared with the global average.[2] Deficiencies in public funded primary health services have contributed to rapid expansion of private providers in the region. The growth of the private sector has largely been determined by market forces with minimal oversight and regulation, and there are concerns about both the quality and the cost of care. In this paper we reflect on the challenges of primary care in the region, the opportunities it poses, and the implications for public policy.

Challenges of primary care in South Asia

Lack of investment

Health policy in the region has been profoundly influenced by the 1978 Alma Ata declaration, which recognised primary care as the "central function and main focus" of a country's health system.[3] The declaration emphasised the provision of community oriented preventive, promotive, and curative health services "bringing health care as close as possible to where people live and work." As such, all countries in the region have endeavoured to create nationwide networks of primary care facilities, and most have ongoing national programmes that focus on primary care.[4-7]

However, primary care is often of poor quality or reduced to a series of selected activities and vertical disease oriented programmes, such as antenatal care, immunisation, family planning, and three or four disease priorities in the country.[8] Total government expenditure on healthcare in the region in 2015 was in the range of 0.4-2% of gross domestic product, which is among the lowest globally.[9] With low investment in healthcare, the infrastructure of primary health centres is often poor, with inadequate supply of drugs and equipment and shortages of health staff.

Health workforce crisis

Paucity of human resources underpins the fragility of primary care services in South Asia. The World Health Organization recommends a minimum of 2.28 healthcare professionals (doctors, nurses, and midwives) for every 1000 people.[10] There is a shortage of health workers across the region with the

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exception of Sri Lanka (table 1). These are crude estimates as precise data, especially for physicians who are active, are not available.[11 12] In India, more than 8% of 25 300 primary health centres have no doctor, 38% are without a laboratory technician, and 22% have no pharmacist. Over three quarters of first referral units (called community health centres) do not have surgeons, obstetricians and gynaecologists, physicians, or paediatricians.[13] A similar situation exists in other countries, with the exception of Sri Lanka. The problem of inadequate numbers is compounded by doctor and health worker absenteeism.

Reports from individual countries show a skewed distribution of health workers, especially physicians, with critical shortages in rural and less developed regions (box 1). This has greater implications for primary care compared with hospital care as health workers must ideally work close to the communities.

Box 1: Indicators of key challenges in primary care in South Asia

Skewed distribution of health workers

- In India, nearly 60% of all health workers practise in urban areas, where about a quarter of the entire population live
- Pakistan has around 14.5 physicians per 10 000 population in urban areas compared with 3.6 per 10 000 in rural areas. A smaller but similar discrepancy is noted in the availability of midwives, with 7.6 midwives per 10 000 population in urban areas compared with 2.9 per 10 000 in rural areas
- In Nepal, there is one physician for every 92 000 people in rural areas
- Bangladesh, has 1.1 physicians per 1000 population in rural areas compared with 18.2 per 1000 in urban areas. The figures for nurses are 0.8 compared with 5.8

Heavy reliance on the private sector for primary care

- India: About 80% of outpatient services are provided by the private sector
- Nepal: Over half of all patients access private facilities for acute and chronic illnesses
- Bangladesh: About 13% of patients use government health services, 27% see qualified practitioners in the private or non-governmental organisation sector, and 60% rely on unqualified private practitioners
- Pakistan: Only a third of curative primary health services are delivered by the public sector
- Sri Lanka: 35% to 50% of patients rely on the private sector for primary care

We postulate that the increase in the number of private medical colleges has been an important factor contributing to this skewed distribution. Until the 1990s, medical education in most South Asian nations was largely provided by government institutions. The increasing need for health professionals and simultaneous slowdown in public investment in medical education have reversed this situation, and private medical colleges train over half of all medical graduates in India.[14] In Nepal, 19 of 23 medical colleges are privately owned. Until 1996, Bangladesh had no private medical colleges, whereas there are now 44 private medical colleges.[15] A similar trend is seen in Pakistan.[16] While these institutions have helped to fill the gap in training the health workforce and a few stand out for excellence in medical education in the region, unchecked commercialisation of medical education is problematic. Private medical colleges in India have earned a bad reputation for corrupt practices, such as charging huge sums of money to reserve a place and not meeting the required standards for accreditation. Graduates trained in high cost private institutions are less likely to work in public services and in remote underserved areas as they need to defray the investment in their education.[17 18]

Growth of private sector

A large proportion of people in South Asia depend on private providers for their primary care needs, owing to the gap in capacity and services provided through public services (box 1). Private care providers include specialists and qualified general practitioners with individual practices, maternity homes, polyclinics and laboratories, practitioners of traditional systems of medicine, and unqualified practitioners (often referred to as quacks) in more remote rural areas and in underserved urban slums.

Across the region, it is common for primary care physicians employed in the public sector to also do private practice.[19] For example, in Bangladesh it is believed that 80% of doctors employed in the public sector also practise privately.[20] Dual practice has been criticised for reducing the quality of public services by incentivising physicians to divert time, attention, and resources to their private practices. Physicians with dual practice have diverted patients from public services by direct referral to their practice or by employing more subtle means, such as increasing waiting times in the public sector to stimulate demand for their private practice.[21 22]

While the growth of the private sector has been driven by demand, markets in healthcare are notoriously imperfect because of uncertainties in outcomes, information asymmetries, and conflicts of interests. Considerable gaps exist between public health priorities, perceived needs, and the care delivered.[23] Private providers are seldom useful in closing gaps in public provision of primary care, except for unqualified practitioners, as they are less likely to serve “difficult to reach” populations in rural areas and the poor in urban slums. For example, almost a quarter of Nepal’s population lives in the country’s relatively less developed mid and far western regions, but only 6% and 2%, respectively, of the private health workforce serves these areas. The public sector performs relatively better, with 11% and 7%, respectively, of the public workforce available.[24]

Private providers are often not oriented towards primary healthcare as an integrated approach. Promotive and preventive health activities are not sufficiently remunerative. As such, private healthcare providers tend to exclusively provide curative care, while public facilities largely concentrate on preventive and promotive services. In Pakistan, for example, the public sector provides up to half of maternity services and is the major provider of contraceptives and routine immunisation services.[25] Given their variegated and dispersed nature, private facilities are not linked to secondary and tertiary levels of the health system. Referrals to higher centres for consultations and diagnostics are often linked to unethical kick-backs and commissions.[26]

In some instances, high quality integrated primary healthcare is provided in the private sector in remote areas by not-for-profit providers, which has filled the gap in public services. However, they cover less than 5% of the population in most countries. Because their success rests on a few special individuals or circumstances, and not on a model of care delivery, scaling up has generally not been successful.[27]

Little attention has been given to the regulation of private providers in primary care. Both the quality and cost of care are extremely variable, and no good model of regulation and accountability has emerged on the ground. The existence of a large number of unqualified providers practising illegally, despite protests by medical professionals, highlights the difficulties of regulation.

High burden of out-of-pocket payments

The overwhelming reliance on the private sector for primary care is driving up out-of-pocket expenses. In India, evidence suggests that outpatient care is more impoverishing than inpatient care in urban and rural areas alike. A study done in three Indian states showed that 3.5% of the population fell below the poverty line on account of out-of-pocket expenses on healthcare, but this decreased to 0.5% if outpatient care was excluded.[28] In Pakistan, 90% of out-of-pocket payment is for outpatient services.[29] In Nepal, outpatient and curative care services accounted for 78% of out-of-pocket expenses.[30]

Emerging trends and reforms

Contracting in private providers

Attempts have been made to outsource management of primary health centres to private providers to tackle the health workforce shortage and improve coverage. A few Indian states have outsourced the running of primary health centres to a non-governmental organisation or private entity.[31] The effects of such an arrangement on improving access and quality of primary care have not been systematically evaluated. Reports suggest that curative services have improved in outsourced primary health centres, but at the expense of preventive and promotive activities[32] Support from the local public health department tends to be critical for their success. These experiences concern a small proportion of primary health centres (about 2%) in India and are difficult to generalise on.

In one of the world's largest contracting out initiatives, Pakistan outsourced management of 2490 basic health units across the four provinces to a non-governmental organisation under the Peoples' Primary Healthcare Initiative in the mid-2000s. Preliminary results indicate some increase in outpatient volume and in availability of staff and medicines at these facilities, but little improvement in quality of care and integration of preventive services.[33]

While contracting out to private providers can work in particular situations where dedicated ecumenical organisations and non-governmental organisations are willing to take up this work, these are unlikely to be a general solution to the problem of attracting and retaining health workers, especially doctors, in difficult areas.[34]

Social insurance schemes

To reduce the burden of out-of-pocket expenses on health, some South Asian countries have introduced state funded insurance schemes. However, these usually cover hospital services and not primary care. The Rashtriya Swasthya Bima Yojana launched in India in 2008 to protect low income families from catastrophic health expenditure primarily supported hospitalisation expenses.[35] In 2011, a pilot programme was introduced in a few states to support outpatient care under this scheme, including the doctor's consultation fee and medicines. However, low utilisation (3-14%) was noted across all locations, mainly due to non-participation of private providers.[36] This year the Indian government launched a revamped and ambitious nationwide insurance scheme, Ayushman Bharat. In 2015, the Government of Nepal announced a social health security scheme, which is being piloted in three districts; further details are not available.[37] The Prime Minister's National Health Insurance Program (PMNHIP) in Pakistan covers treatment in enlisted private hospitals for poor families with less than a certain income.[38] There are few experiences of using private providers for outpatient care through insurance schemes.

The way forward

To be effective, primary level care must be designed to:

- Ensure population coverage
- Integrate preventive, promotive, and curative services across a comprehensive range of healthcare needs
- Be adequately resourced with trained staff and necessary infrastructure
- Be integrally linked to secondary and tertiary levels of care in a networked health system.

We strongly believe that the public sector must be the principal provider of primary care in South Asia, and countries need to increase public investment in primary care to at least 2% of their gross domestic product.

Partnerships with private providers should be structured on terms where they can be protected from market forces and act more like public services. There are no good examples of such partnerships in South Asia, but experience from other regions, such as the National Health Service in the UK, need to be studied and adapted to local situations. Providers who operate on such terms could fill critical gaps in public provision of health services in certain areas. With a large private sector in the region, sustained engagement with private providers is important to improve quality of care. This can be achieved through promotion of continuing education and accreditation and regulation of private services to tackle quality and costs of care and to eliminate unethical practices.

State action is urgently needed in medical, nursing, and technical education policies to facilitate greater entry for local candidates and increased and sustained allocation of public funds. Measures to improve recruitment and retention of physicians in the public sector include fair compensation, priority entry to postgraduate studies for those working in non-urban settings, and adequate infrastructure ensuring availability of essential medicines, laboratory facilities, and medical consumables. Financial incentives must be provided for physicians working in difficult and remote areas, as well as facilities for housing and regard for security. Well trained and adequately remunerated cadres of non-physician community health workers are necessary to tackle the health worker crisis in primary care, as discussed in a linked paper in this series.[39]

Finally, investing in health systems research will be crucial to evaluate emerging models of care and strengthen primary care in South Asia.

Sadly, Amit Sengupta died just before publication of this article.

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Table

Table 1| Density of health workers (per 1000 population) in South Asian countries (data from 2007-16)

	Physicians	Nurses and midwives
Bangladesh	0.5	0.3
India	0.8	2.1
Nepal	0.6	2.0
Pakistan	1.0	0.5
Sri Lanka	0.9	2.8

World Health Statistics 2018, WHO, 2018.