Comprehensive and Primary Healthcare through Health and Wellness Centres under India's flagship scheme of Ayushman Bharat

Introduction:

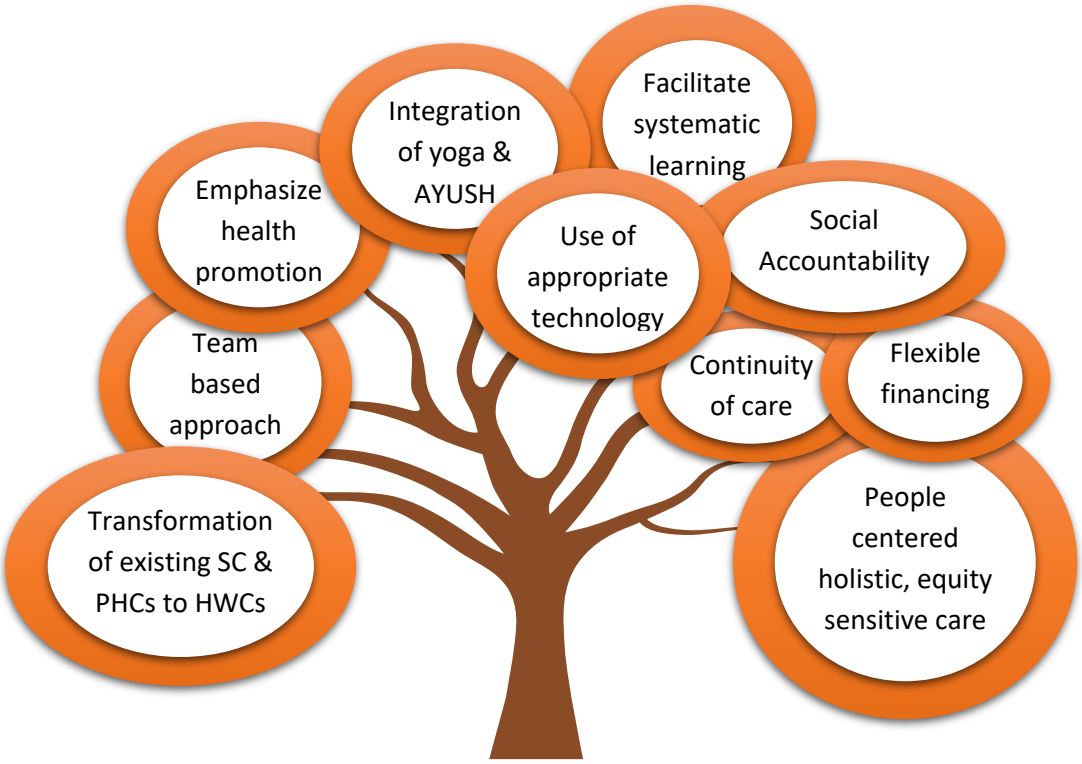
Comprehensive primary healthcare (CPHC) is a framework conceived as a global strategy to reduce inequities in health. It highlights social justice, equity, community control and social change. The emphasis of CPHC is on making a shift from selective care to provision of promotive, preventive, curative, rehabilitative and palliative services, in accordance to the needs of the communities. The strategy has become more relevant with epidemiological transition of diseases. India's commitment towards CPHC was highlighted in National Health Policy, 2017 and CPHC was imparted a realistic picture through the launch of Ayushman Bharat in 2018. The first pillar of Ayushman Bharat aims at provision of 12 packages of comprehensive primary healthcare through upgradation of existing sub-centres (SCs) and primary health centres (PHCs) to Health and Wellness Centres (HWCs). The second pillar (Pradhan Mantri Jan Arogya Yojana) is a national health protection scheme and focuses on increased accessibility and affordability of secondary and tertiary care. These two components of Ayushman Bharat have been envisioned to pave the way to achieve universal health coverage.

Interestingly, policy and programme debates in India are focusing on the need to provide Comprehensive Primary Health Care (CPHC) in both urban and rural areas. The implementation of CPHC through strengthened PHCs and SC- HWCs, is a new initiative, and several factors will determine their functioning and effectiveness. These factors will be determined by context and the nature of health systems across districts and states. In order to achieve what is intended out of AB-HWCs, efforts will be required in various domains, for example, the organisation of services, expansion of infrastructure and technical competencies, team and individual work processes, reporting and analysing information, financial flows, instituting performance-based incentive, community-based health services, action on social and environmental determinants, maintaining continuity of care, referral patterns, testing IT based venues for communication, understanding local epidemiological patterns, etc. This investment in primary healthcare will improve equity and access, heath care performance, accountability of health systems and health outcomes.

Paradigm Shift in provision of care:

Comprehensive primary healthcare aims to provide holistic care with the principle being that time to care should be less than 30 minutes. Under Ayushman Bharat, this will be achieved through transformed SCs, PHCs, mobile medical units, health camps, home visits and community-based interactions

Figure 1. Key Principles of Comprehensive primary healthcare



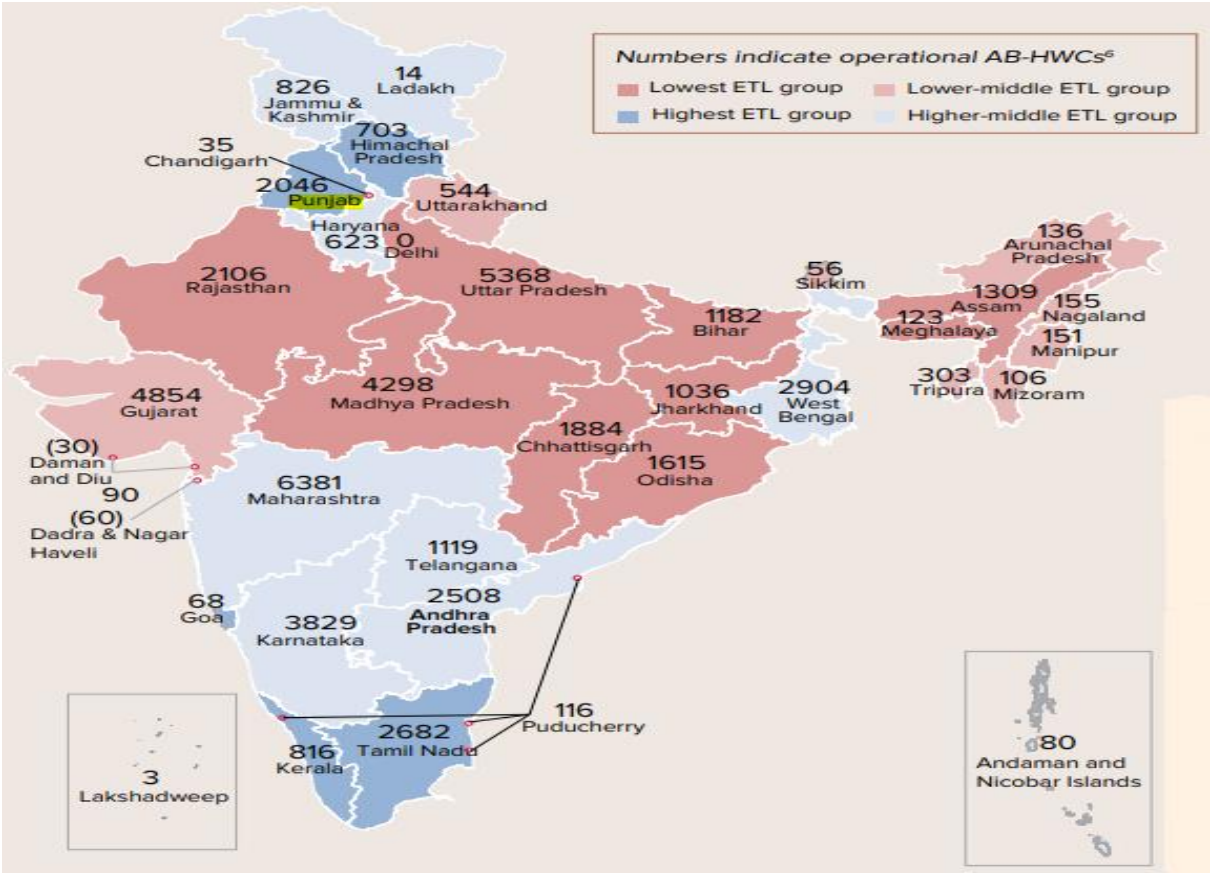
The first Health and Wellness Centre was launched by the Prime Minister at *Bijapur, Chhattisgarh* on 14th April 2018. Since then, the Government of India has signed MoUs with the 30 states and UTs and has started working on implementation of the mission.

Implementation of the AB-HWC scheme so far:

The Ministry of Health and Family Welfare, Government of India announced that 1.5 lakh Ayushman Bharat- Health and Wellness Centres will be established by December 2022. According to a recent report, one-third target of HWC operationalization has been achieved, with 50,069 upgraded centres in November, 2020. With the outbreak of COVID-19, the role of AB-HWCs in public health actions and primary health care service delivery has become more significant.

The national overview sheet portrays the variable progress made across the nation. Since 2018, when the initiative of AB-HWC was launched, few milestones have been achieved towards operationalization of AB-HWCs, with improved provision of expanded range of services, team-based approach for service delivery, uninterrupted supplies of medicines and diagnostics to restore and sustain the trust of the people in public health facilities. New initiatives as creation and adaption of IT systems for provision of tele-consultation services and for reporting have been initiated to improve access to services and ensure a culture of transparency and accountability.

Figure 2. Number of operational HWCs across states with different epidemiological transition levels (ETL)



Ministry of Health and Family Welfare, Government of India

There has been an increasing trend in footfalls in States and UTs, validating that the provision of Comprehensive Primary Health Care services close to community is a potent force in enabling the confidence and trust of the people in public healthcare facilities, especially in the most peripheral regions of the country There has been a substantial shift in philosophy of care, that is from curative to preventive care, through a wide range of wellness and health promotional activities.

As depicted in Figure 2, the northern and southern states show the highest or higher-middle epidemiological transition levels, whereas the eastern and western states are in low epidemiological transition stage. According to India State Level Disease Burden report, in 2017, Punjab is in highest epidemiological transition stage with non-communicable diseases (NCDs) contributing to 60% of the disease burden while communicable diseases, maternal, neonatal and nutritional diseases constitute 22% of the disease burden. The state of Haryana and Himachal Pradesh perform well for a range of maternal, new-born and child health indicators compared to national average, but are facing a high disease burden of NCDs. The expansion of health services through AB-HWCs could alleviate this disease burden and help the states tackle the transition in disease patterns.

Table 1. Operationalization of AB-HWCs in India and the northern states over the years

Year	2018-19	2019-20	Nov-20	Target till March 2021	Target till Dec 2022
India	17,149	38,595	50,069	76,589	1,50,202
Punjab	801	1,460	2,046	1,435	2,810
Haryana	435	614	623	1,237	2,474
Himachal Pradesh	7	655	703	983	1,925

Progress made by Punjab state:

The state initiated the transformation of its peripheral facilities in 2018 and has surpassed its target set by Government of India for March, 2021. Aspirational districts of Moga and Firozpur have the highest number of functional HWCs. The high level of utilization of services, reflected in increased daily footfalls, indicate the demand for comprehensive primary health care services close to community.

A range of new initiatives have been started by the state under the programme. In view of the high burden of diabetes, state has initiated diabetic retinopathy screening through HWCs with well-established referral linkages to district hospitals and medical colleges to facilitate early identification and minimising complications. One of the key principles of AB-HWC scheme has been leveraging appropriate technology to improve access to healthcare advice and

treatment initiation. In response to this, a telemedicine hub has been established in Sector 11, Chandigarh. Under this initiative, the Community Health Officers at HWCs connect with Medical officers at the hub through e-sanjeevani portal for medical consultations, thus saving patient's time and minimizing costs. This has proved to be beneficial and over 5000 tele-consultations have been conducted.

There are few areas which need to be addressed under the programme. Despite 37% of its population residing in urban areas, the state has a shortfall of about 93% urban PHCs. Another area for urgent action is targeted reductions in maternal mortality with attention to quality of care in public and private sector facilities. HWCs are a window of opportunity for the state to enhance its investments in primary health care and enable progress towards universal health coverage.

Progress made by Haryana:

The state initiated the roll out of Ayushman Bharat – Health and Wellness Centres (AB– HWC) in 2018 and so far, has been able to upgrade 25% of the target facilities as HWCs. All SHC-HWCs are being mapped with HMSCL Online Drug and Inventory Management System for improving the indent and management systems. Mewat, which is the only aspirational district in the State has been prioritized for HWC operationalization. The state is planning to roll out teleconsultation through the first hub at SIHFW Haryana on pilot basis and provide specialist services through teleconsultations.

Progress made by Himachal Pradesh:

The state so far, has been able to upgrade 26% of the target facilities to HWCs. Chamba is the only aspirational district in the state with 51 functional HWCs. New initiatives by the state include launch of *Jeevan Dhara*, a mobile HWC with a team of Medical Officer, Staff Nurse, and Pharmacist intended to supplement services of those facilities (either Sub Health Center or Primary Health Centre) where MO/CHO are not yet in place. Himachal Pradesh has been a front runner in the use of IT systems at the primary health care level. It uses the state specific NCD application across the facilities. It is also among the first to use e-Sanjeevani OPD and e-Sanjeevani HWC portal. Three specialist hubs have been established in Medical Colleges for imparting specialist and super specialist consultation in Cardiology, Gastroenterology, and Neurology. This worked well during the COVID-19 pandemic, when other specialists, including psychiatrists, were also included. After the COVID outbreak, the HWC teams were

involved in surveillance for home quarantined individuals with the help of SYANU app. Geotagging with real time photographs was used to ensure that the high-risk individuals were home quarantined. In order to address the high level of chronic diseases, the state will not only need to stay on track with the existing efforts but also accelerate efforts to expand the range of services availability.

Critical appraisal and way forward:

Health sector is a distinct field where successful outcomes require correct design and implementation. Therefore, it is important to translate policies and intentions into practice, for attainment of principles set by Ayushman Bharat scheme. HWCs are only a part of primary healthcare system, and their successful functioning will require broader strengthening of the entire health system. The challenges that grapple the HWCs at this stage are as follows:

Human resource: The system is required to deal with recruitments of the new cadre (MLHPs), while also focussing on the shortage of multipurpose health workers, medical officers, pharmacists and lab technicians in the primary care teams.

Capacity building: The quality of care is directly proportional to the knowledge and skills of the human resources. With expansion of services and roles of the primary healthcare team, all the cadres require capacity building on newer packages, apart from refresher trainings on conventional services. Capacity building will not only be required at HWCs, but at all levels of healthcare. This may be accelerated through utilization of IT systems and online platforms.

Conflicts between different cadres of health care providers: The acceptance of the new cadre has been a concern all over India. This has manifested as breakdown of communication between the team members, hostility towards each other, non-cooperation in service delivery and organized protests at different levels. The theory of change management suggests that every change is accompanied by phases of denial and resistance. Measures to build teams along with clarity in roles of all the cadres can reverse the situation for better service delivery.

Availability of consumables: With introduction of new set of services at the HWCs, availability of required equipment and regular supply of consumables is important. Adequate human resources, sustainable financing, and coordinated institutions are chief components to ensure uninterrupted availability of essential medicines. A continuous supply of consumables is integral part of a strong health system; hence this area requires a continuous focus and efforts to ensure CPHC.

Continuum of care: Continuum of care for all kinds of illnesses is a key principle of CPHC. This shall require strategic modifications of components of health systems at all three levels of care. Effective delivery of services at HWCs will be essential for establishment of gate keeping role of primary health system. Also, services at PHCs are limited in terms of service delivery, as per IPHS guidelines and these facilities are the ones mostly left out of the care continuum cycle, with most referrals from SC-HWCs to sub-district hospitals and district hospitals. Diagnostic and technological innovation at PHCs to bring services close to communities can help achieve continuum of care cycle.

Urban primary healthcare services: Strengthening a number of ongoing initiatives, as free medicines and diagnostics schemes, scaling up services in urban areas, and strengthening of the referral linkages at all levels of facilities is important. Health outcomes in selected urban areas are often worse than rural areas and urban population faces additional challenges such as limited public space for physical activities, air pollution, over-crowding etc. In urban set-up, converting the existing urban PHCs into HWCs would not be enough and capital investment to expand PHC infrastructure is also needed.

Demand related factors: Focus on supply side factors is unlikely to generate demand, especially when the past experiences with public health system have not been pleasant. The reform in health services and scale-up will require emphasis on people's perspectives and needs. This can be achieved with enhanced and active community involvement; social accountability and involving local body representatives and civil society organizations in the process of transition.

Conclusion:

There is a global consensus that universal health coverage can only be achieved on the foundation of stronger primary health care system. There is a renewed attention on strengthening and delivering comprehensive primary health care services in India through health and wellness centres. While the AB-HWCs aims to address the existing challenges in primary healthcare system, the effectiveness and success will be dependent upon effective translation of policy to implementation and augmented focus on both demand as well as supply side factors. A leap is required to include services for health issues of all population sub groups and for laying the ground work for facilitating the rollout of the other packages, such as mental health, palliative and elderly care. Partnerships with technical agencies, complementary

initiatives by Indian states, sustained political will and consistent evaluations of the processes and outcomes of services will accelerate the process of comprehensive primary healthcare.

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