1. Empowering Primary Care Practitioners

Primary Health Care (PHC) System:

- It is the essential care based on practical, scientifically sound and socially acceptable method and technology made universally accessible to individuals and families in the community through their full participation and at a cost they and the country can afford to maintain in the spirit of self-reliance and self-determination.

Advantages of Primary Healthcare

- Achieving universal health coverage (UHC) with a comprehensive primary-care approach will ensure healthcare with higher coverage and at lower cost.
- Higher public spending in primary care alleviate household out-of-pocket expenditure (OOP) to a large extent.
- It can contribute to realising SDG Goal 3 of promoting Good health and well-being to all with adequate financial protection.
- These centres will help ameliorating basic health problems including early diagnosis and treatment of NCDs, thereby avoiding complications in the latter stage.
- This would translate into lower cost of treatments at the secondary and tertiary-care levels.
- Countries like UK have already achieved lower rate of mortality and better health outcomes by re-orienting their strategies towards primary care.

Japanese Model:

- What is special about Japan in the context of health-care services is that it managed to contain the clout of specialists in its health-care system and accorded a prominent voice to its primary care practitioners (PCP) in its decision-making processes.
- Hospitals, for the early part of Japan's history with modern medicine, catered only to an affluent few.
- The government limited the funding of hospitals, restricting them to functions like training of medical students and isolation of infectious cases.
- Reciprocal connections between doctors in private clinics and hospitals were forbidden, thwarting the possibility of the two groups creating a strong nexus; on the other hand, a sturdy lobby of clinic-based PCPs evolved to tip the balance in favour of primary health care.

- The Japanese Social Health Insurance was implemented in 1927, and the Japanese Medical Association (JMA), then dominated by PCPs, was the main player in negotiating the fee schedule.

Indian Model of Healthcare:

- In India, on the contrary, a hospital-oriented, technocentric model of health care took early roots. Building urban hospitals through public investment enjoyed primacy over strengthening community-based, primary health care.
- Alongside this, a private sector with rampant, unregulated dual-practice system (doctors practising in both public and private sectors simultaneously) flourished.
- This allowed doctors to constitute a powerful group held together by coherent interests.
- This influential doctors' community, which saw a lucrative future in super-specialty medicine, buttressed the technocentric approach, which also happened to concur with the tastes of the affluent and the middle class.
- This trajectory of events has had an enormous impact on the present-day Indian health care.

Focus on Hospitalization:

- While the well-to-do section has always rooted for 'high-tech' medical care, this preference has now trickled down to even the subaltern section, which lacks the wherewithal to pay for such interventions.
- Colossal health insurance schemes like Ayushman Bharat that harp on providing insurance to the poor largely for private hospitalisation, when the most impoverishing expenses are incurred on basic medical care — are at least partly influenced by the passionate popular demand for the so-called high-quality medical care and bespeak the deformity in the health-care system today.
- The way this has affected medical manpower and its dynamics also warrants attention. It took 37 years after the landmark **Bhore Committee report (1946),** which highlighted the need for a 'social physician' as a key player in India's health system, to finally recognize family medicine as a separate speciality — and another decade and a half to actuate a postgraduate residency in family medicine.

National Medical Commission (NMC):

- The highest professional body representing doctors in this country, the Medical Council of India (MCI), itself came to be dominated by specialists with no representation from primary care. There is a proposal to replace the MCI with a National Medical Commission (NMC) but the situation is unlikely to be much different with the new organisation.

- The current opposition to training mid-level providers under the NMC Act 2019 is another example of how the present power structure is inimical to primary health care. Despite the presence of evidence proving that practitioners of modern medicine (say medical assistants) trained through short-term courses, like those of a 2-3-year duration, can greatly help in providing primary health care to the rural population, any such proposal in India gets robustly opposed by the orthodox allopathic community. Proposals to train practitioners of indigenous systems of medicine, like Ayurveda, in modern medicine are also met with similar opposition.
- Such medical assistants, and non-allopathic practitioners, have time and again been written-off as 'half-baked quacks' who would only endanger the health of the rural masses.
- Such criticism ignores the fact that nations like the U.K. and the U.S. are consistently training paramedics and nurses to become physician assistants or associates through two-year courses in modern medicine.

Examples of U.K., Japan:

- Many countries, including the U.K. and Japan, have found a way by generously incentivizing general practitioners (GPs) in both pecuniary and non-pecuniary terms, and scrupulously designing a system that strongly favours primary health care.
- What this careful nurturing has meant is that while a community of professionals in our part of the world has thwarted positive change, professionals of the same community in these countries have helped defend that very positive change.

Way Ahead:

1. One, it is imperative to actively begin reclaiming health from the ivory towers called 'hospitals'. This could help in gradually changing the expectations of the layman and reversing the aspirations of medical professionals from being unduly oriented towards high-tech, super-specialty care. Given the current trends, however, this looks like a far-fetched possibility.
2. Two, we need to find a way to adequately empower and ennoble PCPs and give them a prominent voice in our decision-making processes pertaining to health care. This can create a bastion of primary health care professionals who can then fight to keep their enclave unscathed.
3. Three, a gate-keeping system is needed, and no one should be allowed to bypass the primary doctor to directly reach the specialist, unless situations such as emergencies so warrant. It is only because of such a system that general practitioners and primary health care have been able to thrive in U.K.'s health system.

4. In view of the current resurgence of interest in comprehensive primary health care in India, one earnestly hopes that these key lessons will be remembered.

Source: The Hindu