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LESSONS FROM KERALA

Relevant for: Health, Education & Human Resources | Topic: Health & Sanitation and related issues

Last year, in October at Astana, Kazakhstan, world leaders declared their commitment to ‘Primary Care’. They were reaffirming what their predecessors had done in Alma Ata in 1978. The Alma Ata Declaration, as it was called, had been criticised as wishful thinking without a clear road map on strategies and financing — an allegation that could be levelled against the present declaration too.

In 2016, Kerala had, as part of the Aardram mission to transform health care, attempted to re-design its primary care to address the current and future epidemiological situation. Lessons learnt from Kerala’s experience could provide insights into what needs to be done to ensure the objectives of the Astana Declaration do not remain a statement of pious intentions in India.

The Astana Declaration would “aim to meet all people’s health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care”. A representative list of primary care services are provided: “including but not limited to vaccination; screenings; prevention, control and management of non-communicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health”.

In the revamped primary care, Kerala tried to provide these services and more with mixed results. These services cannot be provided without adequate human resources. It is nearly impossible to provide them with the current Indian norm of one primary care team for a population of 30,000. Kerala tried to reduce the target population to 10,000. Even the reduced target turned out to be too high to be effective. Kerala’s experience suggests that providing comprehensive primary care would require at least one team for 5,000 populations. This would mean a six-fold increase in cost of manpower alone. Since supply of more human resources would generate demand for services, there would be a corresponding increase in the cost of drugs, consumables, equipment and space. So a commitment to provide comprehensive primary care — even in the limited sense in which it is understood in India — would be meaningful only if there is also a commitment to substantially increase the allocation of funds. It is sobering to remember that most successful primary care interventions allocate not more than 2,500 beneficiaries per team.

Providing the entire set of services, even if limited to diagnosis and referral, is beyond the capacity of medical and nursing graduates without specialised training. Practitioners in most good primary care systems are specialists, often with postgraduate training. The Post Graduate Course in Family Medicine, which is the nearest India has to such a course, is available in very few institutions. If the services are to be provided by mid-level service providers, as is planned in many States, building their capacity will be even more of a challenge. It would be a long time for this to be built. Kerala has tried to get over this through short courses in specific areas such as management of diabetes mellitus, hypertension, chronic obstructive pulmonary disease, and depression.

The primary care system will be effective only when the providers assume responsibility for the health of the population assigned to them and the population trusts them for their health needs. Both are linked to capacity, attitude and support from referral networks and the systemic framework. It will not be possible unless the numbers assigned are within manageable proportions. Access to longitudinal data on individuals through dynamic electronic health records and decision support through analysis of data will be helpful in achieving the link.

Discussion on primary care in India focusses only on the public sector while more than 60% of care is provided by the private sector. The private sector provides primary care in most countries though it is paid for from the budget or insurance. The private sector can provide good quality primary care if there are systems to finance care and if the private sector is prepared to invest in developing the needed capacities. Devising and operating such a system (more fund management than insurance though it can be linked to insurance) will be a major challenge but a necessary one if good quality primary care is to be available to the entire population. Negotiations to set up such systems in Kerala are only at the initial stage.

Achieving Universal Health Coverage — one of the Sustainable Development Goals to which India is committed — is not possible without universal primary health care. The experience of Kerala in transforming primary care reveals the steepness of the path India will have to cover to reach the goals committed to in the Astana Declaration.

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Tel Aviv believes that improved relations with Riyadh will serve many major strategic goals

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