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COMPANION PAPER

FAMILY PHYSICIAN-LED PRIMARY CARE WITH PRIVATE PARTICIPATION

A Conjunctive to "Preserving Growth Momentum"

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EXECUTIVE SUMMARY

While India is showing tremendous growth momentum, it is not without a few risks. The gravest risk to the country's economic future comes from the perilous state of public finances. Balancing the short-term relief for the deserving and long-term growth prospects requires governments to perform its core functions in a way that it addresses both, while protecting the country's fiscal future. Guaranteeing effective, accessible and affordable primary care, if conceived well, provides that unique opportunity.

Primary care must be designed around a Family Physician (FP), as we shift from treating ailments in isolation to patient-centric care. The FP, a publicly funded private practitioner, will be the first point of contact for all the health needs of a patient. By acting as a gate-keeper, the FP will not only contribute to de-congestion of higher level hospitals but also reduce the financial burden for the people. The resultant longer-term association between the FP and the patient will enhance the trust in the public system.

However, there is a need to alter incentives for the doctor so as to reward better performance. Unsatisfactory quality and lack of trust are the biggest reasons for low utilisation of public health facilities. Introducing competition (among a pool of FPs) and choice for the patient (to choose any FP from the pool), along with a fee-for-service model of payment to the FP will ensure quality and accountability. A pool of 10 FPs for a 'centre' of about 1,50,000 population would be reasonable to begin with. These 'centres' should be hubs of social and economic activity, frequented by the surrounding rural population.

Adequate support services must be ensured. Both diagnostics and drugs may be provided in public-private-partnership mode. The former must be pooled in order to be viable. Each 'centre' should have a Level I laboratory (basic tests) and Level II laboratories can be established based on economies of scale. Similarly, each 'centre' should have one drug dispensary to supply government procured drugs at government determined prices (allowing for a reasonable margin).

Further, an FP-led primary care system would provide the ideal platform for scaling and effectively sustaining such an ecosystem.

This system provides adequate opportunity for the FP to earn a reasonable income. Upon increased utilisation of public primary care (to about 1.5 annual per capita consultations), the average net monthly income of an FP would be around Rs. 1,00,000 (after deducting operational costs). Given the opportunity for enhancing skills and building reputation, this would be an attractive proposition for many of the fresh medical graduates in the country.

The annual incremental cost of rolling-out the proposed system will not exceed Rs. 15,000 crores. The implementation may be phased over three years. The model is a minimalist framework that can be adapted to the varying local needs across states, without impinging on the states' autonomy.

The FP-led primary care system as proposed would greatly benefit several millions of Indians without draining the government's resources. It also provides immense employment generating opportunities. Most of all, it will be hugely popular and the government will secure significant political capital that will make fiscal prudence more acceptable.

FAMILY PHYSICIAN-LED PRIMARY CARE WITH PRIVATE PARTICIPATION

Effective | Accessible | Affordable

I. Introduction

The world recognises that India is now at an inflection point. It is poised to achieve sustained high economic growth for the next two decades or more. In the process, the lives of millions of our people will dramatically change for the better. A large portion of the credit for preparing the ground for such a massive transformation lies with the current dispensation's efforts over the past eight years. It is an immense opportunity that we cannot afford to squander.

However, the gravest risk to India's growth momentum is the perilous state of public finances in the country. In a democracy where governments are, by definition, periodically elected based on a popular mandate, short-term political gain and long-term public good are bound to clash. There is no denying that welfare measures are necessary in a poor country. The key lies in balancing short-term relief for the deserving with promotion of long-term growth through adequate investment in areas that are primary responsibilities of the state. Given the need to curtail Individual Short-term Welfare measures (ISWs), it becomes politically imperative for the governments to provide an alternative to the voters that not only gives them relief in the short-term but also protects the fiscal future of the country and contributes towards long-term growth.

Lack of effective and accessible primary care is currently causing immense distress to the people. About 5.4 crore people are descending into poverty every year on account of health care costs and loss of livelihoods due to illness. Further, India's DALYs burden on account of both communicable and non-communicable diseases (NCDs) is one of the highest in the world (see Table 1). Failure in guaranteeing effective primary care of high quality in the public healthcare system can potentially derail the country's march towards increased prosperity.

Table 1: DALYs in Select Countries (per 100,000 Population), 2019			
Country	**DALYs due to All Causes**	**DALYs due to CMNNDs**	**DALYs due to NCDs**
South Africa	49954	23778	20844
India	**37843**	**11801**	**22071**
Brazil	29427	4838	20309
Vietnam	27542	3910	20466
South Korea	17191	1217	13534
United Kingdom	20956	1380	18000
France	18781	1014	15461
Canada	19683	1254	16352
United States	26061	1597	21717
Germany	20075	1036	17277
Russia	31110	2740	23206
Italy	18185	944	15752
China	22270	1889	18058

Source: Institute for Health Metrics and Evaluation (IHME) – Global Disease Burden Database, University of Washington, Seattle.

With changing demographic profiles and epidemiological features, public healthcare systems across the globe find themselves in the need to continually adapt to evolving needs. Moreover, healthcare costs continue to rise as a result of technological advancements in medical care as well as increased incidence of NCDs. It is clear that the Government of India is cognisant of these challenges and is taking steps towards addressing them. Expanded range of primary care services being provided at Health and Wellness Centres (HWCs) with special emphasis on NCD screening and management is a step in the right direction.[1]

The primary care model proposed in the subsequent sections (dealt with in more detail in the accompanying book titled 'Towards Viable Universal Healthcare') builds on the government's initiatives. It is designed around the concept of a Family Physician (FP), with adequate availability of support services like diagnostics and drugs. It is a public-funded system with private participation. Further, it seeks to alter incentives to promote better quality services as well as enhance public trust in the system through elements of competition (between providers) and choice (for the patient).

[1] HWC Operational Guidelines, *available at:* https://ab-hwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

II. Family Physician-led Primary Care System

It is now reasonably well recognised that primary care can no longer be limited to the lowest level of basic health needs. Focus of primary care in India must shift from dealing with ailments in isolation towards more patient-centric care. A Family Physician (FP) lies at the heart of such an integrated and patient-centric primary care system. Being a trained doctor certified in family medicine, the FP will act as the first point of contact for all health needs of a patient, providing comprehensive healthcare services. The resulting longer-term association between the FP and the patient will both act as a psychological booster and also lead to better health outcomes through regular and timely check-ups. Over time, public trust in the system will improve.

Further, by acting as the gate-keeper for the rest of the healthcare system, the FP will ensure that only those ailments that require specialised care are referred for higher levels of hospital care. Not only will that result in decongestion of secondary and tertiary hospitals, but will also significantly contribute towards controlling healthcare costs. Right now, far too many patients with simple ailments needing primary care are forced to go to district hospitals and teaching hospitals. This involves needless travel, harassment and expense for the patients, and enormous overcrowding in tertiary hospitals. The vast majority of the poor in the country stand to benefit from reduced OOPE as the cost of availing treatment at a free primary care clinic will be considerably lower as compared to the treatment cost in a distant secondary or tertiary care hospital. At the same time, the cost of providing healthcare for the state exchequer will reduce as only a small proportion of ailments would require the more costly specialised care. Additionally, an effective FP system facilitates early detection of illnesses as patients do not have to wait till the illness worsens before seeking medical care. Therefore, fewer cases will need specialised care.

a. Choice and Competition

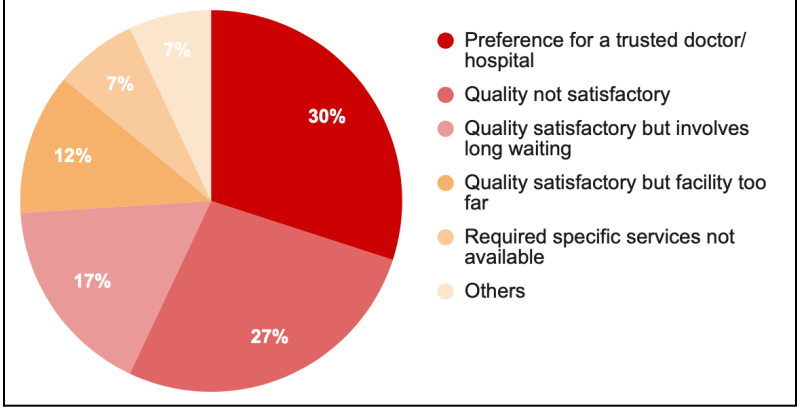
Low patronage for public health facilities in India is a long-standing challenge that needs to be addressed. Only 30% of visits to a healthcare facility in 2018 were towards a public healthcare facility.[2] Even amongst the poorest 20% of the people in the country, 64% preferred to avail paid healthcare services in the private sector.[3] The reasons behind the low preference for public

[2] *Ministry of Statistics and Programme Implementation, "Health in India", NSS Report No. 586, pg. A-758 (2018).*
[3] *Ibid, pg. A-761.*

healthcare facilities are several (see Figure 1). It is evident that the real shortcoming is in ensuring quality of services and thereby enhancing public trust in the system.

Increased investment in primary care infrastructure, better amenities and more healthcare personnel are necessary and welcome but will not be sufficient to guarantee improved utilisation of public facilities. Consequently, the intended benefits of better health coverage and reduced OOPE will remain elusive.

Figure 1: Reasons for not availing government services, % of people (India)



Source: "Health in India", NSS Report No. 586, July 2017 - June 2018, Ministry of Statistics and Programme Implementation, Government of India.

Therefore, there is a need to alter the incentives for the doctors in a manner that rewards better performance. Financial incentives play a crucial role. Introducing competition (among a pool of FPs) and choice for the patient (to choose any FP from the pool), along with a fee-for-service model of payment to the FP will lead to the intended outcomes. In a system where the FP is paid a fixed amount on a per out-patient visit basis and the patient can choose between several competing FPs, there is an incentive for the FP to provide high quality services. Accountability is inherent. In fact, these elements are the reasons behind the success of several of the government health insurance/assurance schemes in the country (see Figure 2).

Any system where the doctor and other healthcare workers are paid a fixed salary does not incentivise better performance. In addition to guaranteeing the quality of service, operationalising this model without placing a huge financial and administrative burden on the state necessitates private participation. Each FP, a private medical practitioner, will be responsible for establishing and running his/her clinic.

Figure 2: Elements of Choice and Competition

The remuneration should be fixed at a level to provide adequate economic incentive for participation in the programme. A mode of copayments may be devised in order to discourage frivolous consultations, with the poorer sections being exempt from any such requirement.

b. A Pool of 10 FPs for a 'centre' of 1,50,000 population

Along with enhanced public trust, the other critical element in making the FP system work is accessibility. Trust will improve when the patient can choose from a pool of competing providers based on reputation and personal experience and has the option of going to another doctor for better services.

Unwillingness of healthcare providers to work in rural areas has been a long-standing problem. Non-availability of qualified doctors at close proximity has meant that a large number of informal care providers currently act as first points of contact for a predominant section of the rural poor. Further, research has shown that the rural population tend to frequent the nearest urban or semi-urban centres for better healthcare instead of travelling to a nearby village with better facilities. Given the surplus supply of informal providers in India's villages and the people's preference for urban centres for health care, spreading doctors across villages is not a workable solution.

The lowest unit of population for provision of primary care services ought to be 1,00,000-1,50,000 (corresponding to a small town and the population of villages in the

catchment area). This 'centre' would have a pool of ten FP clinics with competition in health care delivery. In other words, there will be one FP for a population of 15,000. The small towns serving as 'centres' should be chosen carefully based on amenities, population, floating population from surrounding villages and transport connectivity. They should be hubs of social and economic activity. It is recommended that two such 'centres' be identified per legislative assembly constituency to begin with. The model may be scaled up or down based on local needs.

c. Fee-for-service Model

Currently, only 0.5 per capita consultations annually are in the public sector.[4] It is reasonable to expect that the utilisation of public health facilities will significantly improve with time once an effective FP system is in place and public trust in the system is improved. If we assume that about 70% of the population depend on the publicly funded FP system, at a per capita annual consultation rate of 1.5, each FP on an average will cater to about 1250 consultations per month. In other words, each FP will have 40-50 consultations a day on average. If the FP is remunerated at the rate of Rs. 150 per consultation, the gross monthly income would be Rs. 1,80,000. The resulting net income of around Rs. 1,00,000, after deducting the operational expenditure of the clinic, is a reasonable incentive for fresh medical graduates. India produces over 80,000 new medical graduates every year[5] and the pipeline for post graduation in medicine is very narrow which means that a large number of graduates every year will be looking for opportunities. The FP-led primary care system provides ample training, enhanced skills and opportunity to build reputation. Suitable incentives for selection in post graduate courses may be offered to these FPs based on the duration of their participation in the FP system. These measures together will offer enough incentives for young doctors to serve as FPs for a few years each.

d. Diagnostic Services

The FP system should be supported by two levels of diagnostic services in public-private-partnership (PPP) mode, similar to the model adopted by Andhra Pradesh under the Union's Free Diagnostics Scheme. Provision of diagnostic services should also be pooled in order to be viable. Each primary care 'centre' will have one Level I laboratory that provides

[4] Calculated by FDR based on Number of Ailments Reported per unit population as given in *Ministry of Statistics and Programme Implementation, "Health in India", NSS Report No. 586, pg. A-758 (2018).*
[5] National Health Profile 2021, Ministry of Health and Family Welfare, Government of India, pg. 365.

sixteen basic diagnostic services (being provided by in-house laboratories in Andhra Pradesh) that would be required by 25% of the outpatients. Establishment of Level II laboratories, providing about 42 laboratory tests, should be based on local needs and considerations of economies of scale. The Andhra Pradesh experience indicates that about 10% of the outpatients will need Level II diagnostic services.

The cost of the diagnostic services shall be borne by the government – Level I services on a per-test basis (Rs. 100 per test) and Level II services on a per-patient basis (Rs. 235 per patient).

e. Prescription Drugs

One common drug dispensary may be set-up in each of the primary care 'centres' in PPP mode which supplies government procured drugs at government determined prices, allowing a reasonable commission to the dispenser to cover costs and earn a reasonable income. Existence of a captive market and a reasonable margin on sales would certainly attract many entrepreneurs.

The current practice of centralised procurement of generic drugs offers several benefits and should be continued. It is a highly cost-effective and efficient system that enables rational drug choice, reduces wastage and gives increased negotiating power to the government.

f. Digital Health Records System

Government of India's Ayushman Bharat Digital Mission aimed at building a comprehensive digital health ecosystem in the country marks a significant step forward for health care in the country. With over 29 crore health accounts created so far,[6] the digital system will support safe, timely and effective care for all. An FP-led primary care system would provide the ideal platform for scaling and effectively sustaining such an ecosystem.

III. Operationalising the Model

a. Cost estimates

The cost of operationalising the system has been estimated on the assumption that about 70% of the population will avail these services at a rate of 1.5 outpatient consultations per year per person. The fee-for-service per consultation has been assumed to be Rs. 150.

[6] Ayushman Bharat Digital Mission Dashboard, *available at:* https://dashboard.abdm.gov.in/abdm/ (last visited on 12/12/2022).

Further, the total cost estimated pertains to the annual expenditure required once the services are fully rolled out, across the country.

Table 2: Annual Cost Estimates of the FP-led Primary Care System

Primary Care Facility	Expenditure (Rs. Crores)
FP Clinics	22,500
Diagnostics	7,300
Prescription Drugs	15,000
Total	**44,800**

Note:

1. The calculations are made based on the assumption that the annual consultations in the FP system will be 150 crores (per capita consultations of ~1.5 for 70% of the population, population taken as 140 crores as estimated by the UN in *World Population Prospects 2022*).
2. Cost of prescription drugs – Rs. 100/consultation
3. Cost of diagnostics –
    a. Level I: Rs. 100*0.25*150 crores (annual consultations)
    b. Level II: Rs. 235*0.1*150 crores
4. Total estimate includes expenditure currently being incurred on drugs and diagnostics.

b. Phased implementation in collaboration with states

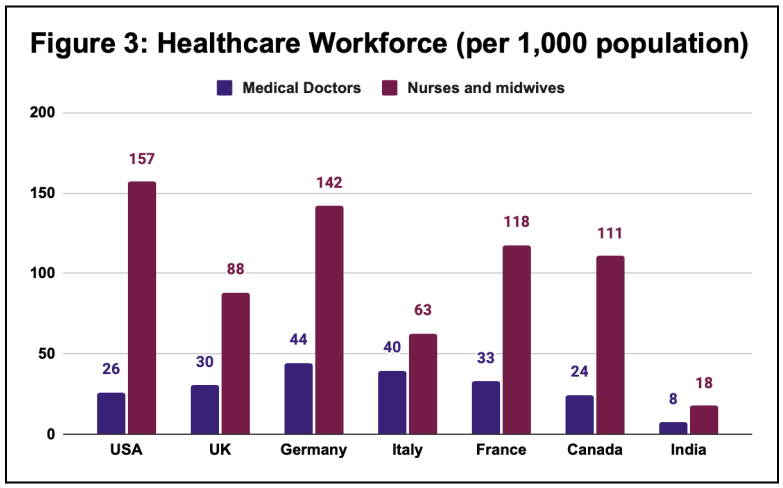
There may be a phased roll-out of the FP-led primary care system over a period of three years, duly ensuring that proper training, development of protocols and performance monitoring and accountability mechanisms are in place. The annual additional expenditure would not exceed Rs. 15,000 crores.

The proposed model is a minimalistic framework that is amenable to uniform and fair application across states. It is flexible enough to allow states to make modifications according to their local conditions and needs. It is a politically acceptable program that does not impinge on the states' autonomy in governance.

IV. Conclusion

The healthcare sector is one of India's great success stories. Our pharmaceutical industry is second to none. We provide complex, sophisticated, and high-cost services at some of the lowest prices in the world without compromising on quality. Increase in the number of foreigners seeking health care in India is a testament to our strengths. The foreign exchange earned through health care is expected to reach USD 13.6 billion by 2026.

If we make a few course-corrections, our public health care system can build on these strengths to provide quality health care to all. In addition, there is immense potential for employment generation in the healthcare sector. Currently, only 3.4 million skilled healthcare workers (doctors & nurses and midwives) are employed in India, with very low coverage per unit population (see Figure 3). In other words, there is potential to create 10-15 million jobs in the healthcare sector alone.



Source: Global Health Workforce Statistics, WHO

Provision of effective, accessible and affordable primary care is undoubtedly a core function of governments. Millions of Indians stand to benefit from a publicly-funded primary care system that provides high quality services. Such a system would provide substantial relief to the people both medically and financially, without unduly burdening the state exchequer. The model proposed above seeks to achieve these very objectives. Not only will the Family Physician-led primary care system garner massive public support, it will also give the government the political space needed to pursue long-term growth and poverty eradication. India cannot afford a misstep at this moment.

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