What can we learn from developments in primary health care in south Asia?

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The Lancet Regional Health–Southeast Asia and *The Lancet Global Health* joint Series offers a comprehensive review of primary health care (PHC) in south Asia. Focused on Bangladesh, India, Nepal, Pakistan, and Sri Lanka, the Series describes common challenges in the region including urbanisation, epidemiological transition characterised by the rising prevalence of NCDs, and expansion of the private sector in health care with uneven state response. The lessons that emerge from south Asia are relevant to advancing PHC globally. In this Comment, we consider what other nations can learn from south Asia's experience.

The overarching lesson that PHC in south Asia presents is a cautionary tale of incomplete political commitment. The relentlessness of the challenges, such as the rising NCD burden, continuing weak regulation of health systems, and growing private health-care sector activity, appears to outstrip the pace and substance of reforms to tackle them. Although promising case studies and pilots exist, addressing the challenges will require commitment to transformational macro-level change that health systems in south Asia have not historically shown. Substantive health system reforms have been similarly elusive in other regions, including in high-income countries.

Evidence from south Asia points to a policy–practice gap as noted of PHC reform globally.[1] Policies signal attention to PHC but without commensurate tangible efforts, such as legal and regulatory enforcement and investment in infrastructure, supplies, and human resources, suggesting a case of expressed political commitment but failure of substantive institutional and budgetary commitment.[2] Papers in the Series identify, for example, that NCD response in south Asia features high-level policy but inadequate health systems preparedness. Lapses in planning, infrastructure, workforce development, and monitoring contribute to shortfalls in implementation of NCD policies. This issue is coupled with a shortage of physicians, (particularly specialist) nurses, and other health-care professionals and neglect of multi-level education for health-care stakeholders and patients. States have commended community health workers for their contributions, but not robustly advanced community health workers' remuneration, training, and career progression. Urban development policies notionally promote city infrastructure, but without cohesive plans, budgets, and public participation to improve urban PHC.

Sri Lanka, where PHC and the social determinants of health have been prioritised not only in policy and political discourse but also in developing a PHC system with attention to disease prevention, is an exception. Sri Lanka's community health worker programme is exemplary for employing community health workers as state workers rather than volunteers. Sri Lanka has high mortality attributed to NCDs but low premature mortality from NCDs. The country leads the region in implementing policies to reduce urban air pollution. In addition to Sri Lanka's per capita expenditure on PHC being the highest in the region, another factor contributing to Sri Lanka's success appears to be the deliberate cultivation of clinic-community ties. One example is a program designed by the Department of Community and Family Medicine, University of Jaffna. In this program, designated community health assistants support NCD clinics, provide health education, make home visits, and maintain patient records on chronic disease care.

Notable in Sri Lanka's case is the more equal focus across preventive care, community engagement, and cross-sectoral components of PHC, as well as (rather than just) service delivery. These aspects stand in contrast not only to the approach of other south Asian countries, which place greater emphasis on primary care service elements, but also to the circumstances in many high-income countries, where insufficient investments in health systems committed to and capable of preventive and promotive care are increasingly apparent. Weaknesses in PHC systems in countries including the Netherlands, the UK, and Australia are becoming increasingly visible.[3] In some high-income countries, PHC investments have primarily aimed to improve access and quality of primary care services.[4] Meanwhile disparities in the social and political determinants of health and health outcomes remain across disadvantaged socioeconomic, rural

and remote, and minoritised groups. In these high-income settings and in some south Asian settings, PHC appears conflated with patient-focused primary care service delivery. Progress in comprehensive PHC, which would combine primary care with a population health focus on communities and neighbourhoods, has yet to overcome political hurdles inherent to tackling structural discrimination, empowering communities, and integrating fragmented social and health sectors.[5]

These hurdles highlight another lesson: contemporary challenges to health also present challenges to enacting health system reform. Political and economic imperatives for growth drive urbanisation in south Asia; they can also constrain urban administrative reform. Corporate interests drive commercialisation in medicine and, through medical professional lobbies, can also impede regulatory oversight.

Part of the solution is to better understand this dynamic. Although practice-relevant research is needed to evaluate and scale innovations, perspectives from the social sciences could help us more deeply investigate the challenges and their unintended effects. For example, a vigorous, unchecked private sector might not only displace utilisation of public sector services, but also subvert the motivation of public sector health-care providers and diminish patient–provider trust.[6,7] Wage differences and the transfer of qualified staff, as well as the selection of patients who receive services in the private sector, create additional problems of a divide between the public and private sector in terms of equity and quality of care. A weak regulatory environment can restrain providers from delivering medical care where they fear sociopolitical consequences, such as violence from patients.[8] Such insights into the social effects of an expanding health-care market require interdisciplinary research that spans the social and health sciences.

Evidence shows that investment in PHC can deliver equitable, efficient, and cost-effective care, and that insufficient investment can reinforce deleterious effects, such as low patient trust, underutilisation of primary care, and an undervaluation of PHC among both practitioners and the public.[9] Alongside this evidence, support for expanding and scaling successful pilots in south Asia should draw strength from the Sri Lanka case, which shows that even in a low-income context, sustained commitment to PHC can play a pivotal role in advancing population health and health care.

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*Radhika Gore, Stephanie M Topp, Maciej Banach, Onno C P van Schayck
radhika.gore@nyulangone.org

Department of Population Health, NYU Grossman School of Medicine, New York, NY 10016, USA (RG); College of Public Health, Medical and Veterinary Sciences, James Cook University, Townsville 4811, QLD, Australia (SMT); Ciccarone Center for the Prevention of Cardiovascular Disease, Johns Hopkins University School of Medicine, Baltimore, MD, USA (MB); Department of Preventive Cardiology and Lipidology, Medical University of Lodz, Lodz, Poland (MB); Department of Family Medicine, Care And Public Health Research Institute, Maastricht University, Maastricht, Netherlands (OCPvS)

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