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Analytical Study of Primary Health care in Developing Countries

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Abstract - There have been recurring issues between medicine (treatment) and public health (prevention). This is mainly due to heavy competition on the development of value-added medicines by most modernized pharmaceutical companies. Most of the medicines have been manufactured under the strict guidelines of international monitoring agencies, in order to keep safety and security. Medicines are for maintenance of health care at different stages of the life cycle. Irrespective of cost, medicines are used at primary, secondary, and territory levels of health treatment. Contemporary medicine applies biomedical sciences, biomedical research to diagnose, treat, and prevent injury and disease. But, due to the cost and market availability, it is not possible to use many lifesaving biologics. Primary health-care medical services are extended by physicians, physician assistants, nurses, or other health professionals who have the first contact with a patient seeking medical treatment or care. About 90% of medical visits can be treated by the primary care provider. These include treatment of acute and chronic illnesses, preventive care, and health education for all ages and both sexes. Availability of medicines and clinical practice varies across different geographic locations of the world, and the availability and cost of medicines vary accordingly. Biologic drugs are highly developed in the Western world. While in developing countries such as Asia-pacific and Africa, the population relies on traditional pharmaceutical medicines due to their low cost.

Keywords - Primary Care, Global Health, Universal Health Coverage, Health Equity Introduction.

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INTRODUCTION

Primary care has great potential to improve population health outcomes through early intervention in the disease process and coordinated provision of care. Strong primary care systems are associated with reduced morbidity, increased patient longevity, and increased equity in health outcomes in several countries. However, the standard model whereby primary care is the first point of contact for most health needs is being challenged by rapid urbanization, which results in a greater choice of providers, the growth of unregulated private providers, shifts in epidemiology that change the profile of the typical patient needing primary care, and people's increasing expectations for highly As the world marks 40 years since the Alma-Ata Declaration, little is known about the functioning of primary care in low-income and middle-income countries (LMICs). Most research about primary care performance has been done in high-income settings, and has been based on metrics that were not available in LMICs.

Many of the studies of measures of primary care done in LMICs have focused on specific health conditions and services, such as quality of family planning and sick-child care. Other studies focused on input-based (e.g., number of beds or health workers) and aggregated outcome-based (e.g., health-care access and quality index) measures. Input-based measures provide little insight into the practice of providers, whereas aggregated outcome-based measures can be confounded by the degree and severity of patients' clinical conditions. If quality of care is measured on the basis of outcomes only, providers might avoid handling patients with worse conditions because treatment of such high-risk patients would be likely to result in lower quality scores. Furthermore, these aggregated outcomes-based measures do not identify specific areas for improvement. Thus, exclusive focus on outcomes results in inadequate identification of disparities between access to care and quality of care received from providers. Process measures, which are based on the encounter between the patient and a health-care professional (e.g., diagnoses, treatment, referral, prescribing), are thus a valuable component of assessments of primary care. Although assessment of process-based measures in primary care in LMICs is crucial to track progress, too often the focus has been on access rather than on quality-of-care measures.

LITRATURE REVIEW

Basanta Kumara Behera et. al, (2020): Primary health care (PHC) is targeted to ensure the highest possible level of health and well-being and their equitable distribution by concentrating on the public needs for a sustainable healthy life without any financial burden on patients. It is also explained how to give special preference to women, families, and rural communities on a priority basis. The most impressive part of this chapter is the role of PHC in handling the COVID-19 pandemic, which is still beyond perfect control. In thisconnection, the role of WHO to bring preventive measures at the state and country level is also well explained**.**

PauliusŽvinakis et. al, (2021): Primary health care (PHC) addresses the majority of a person's health needs throughout their lifetime.High-quality PHC systems consistently deliver services that are trusted and valued by the people they serve and improve health outcomes. Within the primary health care performance initiative frameworkfive core functions underpin high-quality care delivery in PHC systems: first contact accessibility, coordination, continuity, comprehensiveness, and person-centeredness. There is no doubt that these functions are important. Nevertheless, continuity is a critical but often neglectedfunction of high-quality primary care. Continuityrefers to a long-term healing relationship between a person and his or her primary care provider or care team over time.

Tariq N. Al-Dwaikat, (2020): Primary healthcare (PHC) is an essential component of public healthcare. Services of PHC cover health promotion, disease prevention and protection, treatment, rehabilitation, and palliative care and are delivered at an individual or population level [1]. The Alma-Ata Declaration, which is an international conference that was conducted in 1978, focused mainly on PHC to achieve health for all. PHC was defined as "the health care that is based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"

R. Bangalore Sathyananda et. al, (2018): During the last three decades, significant achievements have been made in improving the health of the world population. This can be attributed in part to the Millennium Development Goals and is further augmented by the launch of the Sustainable Development Goals in September 2015. In developing countries, however, still more progress needs to be made. In these countries, still far too many women die during childbirth too many children die from preventable causes and too many adults die from treatable infectious and non-communicable diseases Reducing mortality and morbidity is the main focus of primary healthcare.

Mala Rao and Eva Pilot (2014): This chapter provides an overview of the role of primary care in the context of global health. Universal health coverage is a key priority for WHO and its member states, and provision of accessible and safe primary care is recognized as essential to meet this important international policy goal. Nevertheless, more than three decades after Alma Ata, the provision of primary health care remains inadequate, indicating that primary care has not received the priority it deserves, in many parts of the world. This is despite the proven health benefits that result from access to comprehensive primary health care. We highlight some examples of good practice and discuss the relevance of primary care in the context of health equity and cost-effectiveness. Challenges that influence the success of primary care include the availability of a qualified workforce, financing and system design and quality assurance and patient safety.

METHODOLOGY

India is the first country to implement primary health services before the Declaration of Alma-Ata. The basic motto for adapting primary health service is to serve the people to maintain health without spending money from the pocket. On the basis of the Health Survey and Development Committee Report of 1946, the Indian Government implemented primary health service in rural community. Many projects such as the most acclaimed The National family planning programmed (launched in 1952) and the policy of one community health worker per 1000 people in the 1970s have been implemented for bolstering its health-care scenario. In 2005, the UPA Government launched the Rural Health Mission (NRHM), as a move to improve access to quality health care, especially for poor rural women and children. These entire health-care-related projects resulted in a remarkable decline of maternal mortality ratio (MMR) by 77% from 556 per 100,000 live births in 1990 to 130 per 100,000 live births in 2016. Since the late 1960s and early 1970s, the concept on primary healthcare has emerged in the United States for the first time, fighting against malaria at the community level. The government initiated a health-care project at the community level. WHO staffmembers conducted a survey and studied the experiences of medical auxiliaries in developing countries and argued that "a strict health sectoral approach is ineffective". In 1874, Canadian Lalonde report de-emphasized the importance attributed to the number of medical institutions and proposed determinants for health biology, health services, environment, and lifestyle.

ANALYSIS

Figure 1: Primary health-care center and services to community population (view from an Indian village). Primary health care (PHC) refers to a broad range of health services provided by medical professionals in the community. This means universal health care is accessible to all individuals and families in a community. General health-care practitioners, nurses, pharmacists, and allied health-care providers are exclusive components of the primary health-care team. Basically, the PHC service is the process and practice of immediate health services, including diagnosis and treatment of a health condition, support in managing long-term health care, including chronic conditions such as diabetes. PHC also includes regular health checks, health advice when an unhealthy person seeks support for ongoing care In India, the government has fixed specific norms for primary health center, based on of community structure and population

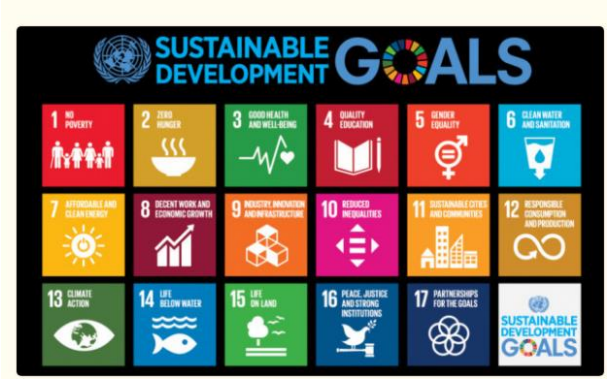

Figure 2: Sustainable Development Goals (17 goals) to be completed by the end of 2030.Since the last four decades, PHC Provision has moved from simple planning to action. Alma-Ata Declaration, is still crucial in current global health like COVID-19 pandemic, especially for developing countries. To achieve this, initially, the United Nations (UN) announced eight Millennium Development Goals (MDGs) by 2015. But looking at the progress, the UN announced 17 Sustainable Development Goals (SDGs), with the strong hope of achieving the same by the end of 2030.

Figure 3: SDG3 showing healthy lives and promote well-being for all ages.SDG3 includes the provision of universal health coverage (UHC; SDG3.8), which aims to provide access to good-quality health services for all, without financial hardship. SDG3.3 is targeted at ending the prevalence of neglected tropical diseases. But, multisectoral action to address poverty, control disease vectors and the environment, and improve access to clean water and sanitation are key components of neglected tropical disease programs.SDG 3 consists of 13 targets and 28 indicators to have accountability of progress. The first nine targets are known as "outcome targets" which include reduction in maternal mortality; completely stop of maternal death under 5 years of age; prevention of communicable diseases; ensure reduction of mortality from noncommunicable diseases and promote mental health; prevent and treat substance abuse; reduce road injuries and deaths; sexual and reproductive care, family planning and education; achieve universal health coverage; and reduce illness and deaths from hazardous chemicals and pollution.

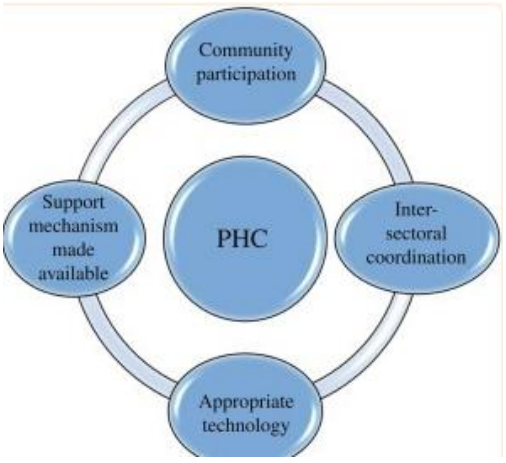

Figure 4: The primary health-care system is the key factor for community improvement and balance socioeconomic conditions. It reduces the inequalities between different groups of a

community. The primary health care is basic health care with applied, scientifically sound, and universally acceptable methods and technology, which should be available and accessible to all individuals and families in a community, on a priority basis. Successful primary health care can only be possible through an integrated system being coordinated by different workforces who are well-trained in health-care management. The primary health-care outline is built on four key pillars

CONCLISION

In conclusion, primary care offers much more than simple reduction of costs of a country's health. Experts in the field of primary care research have summarized a number of mechanisms by which intervention at the primary care level can benefit the population: these include increasing accessibility of health to deprived populations, improving overall long term patient care and health, preventative and educational measures (e.g. smoking cessation, early treatment of diabetes), appropriate and focused direction of care (i.e. correct specialist referral) and a reduction in unnecessary, inappropriate medical care. It also helps to narrow the gap between socially deprived and socially advantaged populations. The continuity and doctor–patient relationships offered by family oriented primary care, alongside the patient education, early intervention and treatment, chronic disease management, counselling and reassurance offered to patients would be impossible to provide in a secondary care setting. Against a background of the recent global economic downturn, massive demographic shifts and increasing health impacts of climate change adding to the health challenges facing humanity, it is abundantly clear that all countries will need to invest in a primary-care-centred health delivery system, if universal access to health care is to be realized In 2008, Greenhalgh described the dramatic epidemiological change which has taken place in Alma Ata, now renamed Almaty, where the burden of disease has shifted from a 'third-world' pattern to a 'transition country' pattern, with high levels of obesity and diseases associated with smoking, alcohol and drugs, as well as accidents and violence.

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