Primary vs Specialist Medical Care: Which is more equitable?

A. The Problem

Equity in health and equitable access to healthcare has been at the core of health policy in India. Time and again Governments have reiterated their commitment to improve access, by the poor and disadvantaged, to medical and health care. Achievement of this objective has been a key policy challenge. To start with, Primary Health Care (PHC) was pursued as a key public health strategy since the first five year plan (GOI 1952) and guided by recommendations of the Health Survey & Development Committee (Bhore et al, 1946). Over the years, extensive infrastructure has been built for Primary Health Care. Expansion of Rural Health infrastructure was a key component of the Minimum Needs Programme (MNP) introduced during the fifth five year plan. Primary health care was one among seven basic minimum services identified for priority attention during the Ninth Five Year plan. However, performance in primary health care provision has been lacking (Deodhar 2000). Disappointing performance of public healthcare delivery system and the search for feasible solutions has lead to the gradual adoption of various demand side interventions. Simultaneously, there has been growing recognition of social determinants of health. Public Health Programmes and policies ought to reduce inequities in health (Chatterjee 2013). By the beginning of this century, several health economists and reports from the WHO advocated protection from catastrophic out-of-pocket payments as a desirable objective of Health Policy (WHR 2000; Ranson 2002; Kawabata et al, 2002; Xu et al, 2003). Concerns about impoverishment of vulnerable sections from out-of-pocket expenditures on health have been addressed through health insurance schemes like Rashtriya Swasthya Bima Yojana (RSBY), Arogyashri, etc. These healthcare financing schemes did improve poor people's access to specialist medical care, mostly private sector, with primary medical care left to languish under existing supply side infrastructure in the public sector.

An important policy question in this context is the comparative efficacy of primary versus specialist medical care towards health equity. The Director General of WHO has observed that many health systems have lost their focus on fair access to care, their ability to invest resources wisely, and their capacity to meet people's needs and expectations (Chan 2009). In this context, there is a need for Indian Health Policy to refocus on enhancing access to Primary Medical Care.

B. Core Attributes of Primary Medical Care

Primary Medical Care or Primary Care, refers to first-contact care that deals with the majority of health problems as subsumed in the WHO's comprehensive definition of Primary Health Care (PHC) wherein the former is one component of the latter.

At the operational level various conceptions of primary care, boils down to the following four core characteristics (Starfield, 1998; Bynum & Fisher, 2010).

1. Providing first-contact care within easy geographic proximity and having an after hour availability without any barriers to access.

2. Continuity of care that ensures the totality of his/her health profile, while simultaneously dealing with the patient's presenting problem (longitudinal continuity of care). When more than half of ambulatory visits by a patient are to the same physician, the latter is said to have a majority-of-care relationship with the former (Rosenblatt et al, 1998). Primary care providers tend to have a majority-of-care relationship with the people served by them.

3. Coordination of care involving other Professionals, managing interface with Specialists and assuming advocacy role for the patient when needed.

4. Comprehensive services providing solution to a broad range of medical conditions.

C. Attributes of Speciality Medical Care

Specialists are highly skilled in the range of diagnostic categories related to their field. They may have skills in other areas. But, most specialists tend to concentrate their efforts within the domain of their speciality. Specialists rarely provide out-of-domain care. They do not usually assume principal care responsibility and are not so likely to provide preventive services like immunization. Considering that patients would resort to various specialties depending on the nature of their complaint, Specialists do not usually develop a majority-of-care relationship with their patients, except in a few specialties such as oncology, pulmonology and rheumatology (Rosenblatt et al, 1998).

D. Evidence Regarding Effect of Primary Vs Speciality Care on Health Equity and Outcomes

Studies have shown that improvements in availability of primary care physicians is associated with reductions in mortality, even after controlling for various socioeconomic determinants of health (Shi et al, 1999; Shi & Starfield, 2001; Gulliford, 2002, Shi et al, 2003). Moreover, good primary care experience has been found to reduce the adverse impact of income inequality on health disparities in self-rated health status (Shi & Starfield, 2002). There is enough evidence to suggest that primary care oriented health systems are more effective, more efficient and more equitable than is the case for Specialist-dominated health systems (Macinko, Starfield & Chi, 2003; Starfield & Shi, 2002; Starfield, 2006). Investments in primary care gives rise to more equitable health care than investments in health care system in general (Kringos et al, 2010). There is evidence to suggest that populations do not necessarily benefit from an over abundance of specialists in a geographical area (Starfield et al, 2005).

E. Why Primary Medical Care?

Multiple investigators from various disciplines have assessed the efficacy of easily available primary medical care supporting the following conclusions (Phillips & Bazemore, 2010)

1. When people have access to Primary Care, treatment occurs before evolution to more severe problems.

2. Preventable emergency department visits and hospital admissions decrease when people have primary care.

3. Primary care clinicians use fewer tests, and spend less money, and protect people from over treatment.

4. People with regular source of primary care receive more preventive services.

5. Having a primary care physician is associated with increased trust and treatment compliance.

A strong Health System is the best insurance developing countries can have against a disease burden that is shifting rapidly and in ways that history has not prepared us for (IOM, 2014). Any form of financing including tax funded health insurance is not sufficient to provide the benefits of comprehensive healthcare. For example, experiences in Mexico show that the effect of public health insurance on out-of-pocket health expenditure for emergency medical care depends strongly on the type of health facility to which the beneficiary has access to. Catastrophic expenditures were found to have fallen sharply for rural households with access to well-staffed facilities, but that they have fallen little at all for rural households depending on poorly staffed facilities (Grogger et al, 2014). If primary medical care resources are not well developed, then the healthcare financing scheme ought to provide built-in incentive for development of primary health care. Unfortunately, catastrophic Health Insurance schemes like the Arogyashri or the RSBY do not provide any such incentive.

F. Action Points for Improving Access to Primary Medical Care

1. Refocus policies and interventions to build strong health systems that provides for universal access to primary health care.
2. Strengthen Primary Medical Care component by appropriately upgrading the primary health centres and community health centres.
3. Harness the non-profit and for-profit private sector to expand access to primary medical care services by appropriate demand side healthcare financing scheme.
4. Introduce a Family Health Protection plan consisting of primary medical care at its core. Reorient existing government financed health insurance schemes around the family health protection plan. In other words, medical & health insurance schemes for the poor and needy should start with primary medical care for the family at its core and extend to specialist services depending on financial feasibility and specific state policy, instead of being the other way around.
5. Introduce Post Graduate courses in family medicine, to prepare adequate human resources for a balanced development of primary medical care speciality *pari passu* other specialities.

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