International Journal of Community Medicine and Public Health
Konki A et al. Int J Community Med Public Health. 2023 Aug;10(8):3016-3023
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20232401

Review Article

Strength, weaknesses, opportunities, and threats analysis on the current scenario of primary health care in India

Akshitha Konki*, Srinivas Pachava, Nijampatnam P. M. Pavani, Vasamsetti Divya Bhavani

Department of Public Health Dentistry, Sibar Institute of Dental Sciences, Guntur, Andhra Pradesh, India

Received: 05 March 2023
Revised: 09 July 2023
Accepted: 11 July 2023

***Correspondence:**
Dr. Akshitha Konki,
E-mail: akshithakonki16@gmail.com

ABSTRACT

The Indian public health system is organized as a three-tiered pyramid, with primary, secondary, and tertiary healthcare facilities. The cornerstone of healthcare delivery anywhere in the world is primary care. Even after primary healthcare reform, problems with poor infrastructure and a serious lack of medical staff and resources continued throughout time. The whole foundation of this study is secondary data acquired from various government publications, journals, and press releases retrieved from databases like google scholar, PubMed, science direct, and search engines like Google. An analysis of strengths, weaknesses, opportunities, and threats (SWOT) was carried out using the structure and dynamics of primary healthcare systems as well as literature searches. Upgrades should be made to PHC delivery service facilities, newer housing should be built to meet population expansion demands, and a bottom-up strategy should be employed with a focus on community empowerment, illness prevention, and health promotion.

Keywords: Achievements of primary health care, PHC, Primary care in India, Primary health centres, Subcentres, SWOT analysis

INTRODUCTION

World healthcare systems are shaped by political, economic, and geographical factors as well as by the historical trends of the respective nations. The Indian public health system is organized as a three-tiered pyramid, with primary, secondary, and tertiary healthcare facilities. The cornerstone of healthcare delivery anywhere in the world is primary care. Primary health care is made up of three interrelated and complimentary components, including comprehensive integrated health services that place primary care and public health as their central focuses; multisectoral policies and initiatives to address the upstream and wider determinants of health; and engaging and empowering individuals, families, and communities for improved social engagement and self-care and self-reliance in health. "Primary healthcare is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.[1] Three different types of medical facilities make up the primary tier: Sub centres (SC), Primary Health Centres (PHC), and community health centres (CHC). SC are the first contact point between health workers and the village community. IPHS is a set of uniform standards envisaged to improve the country's health care delivery quality.[2] The IPHS (Indian public health standards) documents have been revised keeping in view the changing protocols of the existing programs and the introduction of new programs.[3,4] Primary healthcare is a combination of tasks, methods, and levels of medical attention. It was composed of eight components known as "basic health care," which were to be carried out by equity, community involvement, appropriate technology, Focus on prevention, and

intersectoral coordination. The original eight PHC elements considered essential were immunization, health education, nutrition, safe water and basic sanitation, maternal and child health care including family planning, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.[5] With this context, the researchers sought to conduct a review with the query, "What is the current condition of PHC system and achievements that strengthen it"?

LITERATURE SEARCH

This study is entirely based on secondary information which was supplemented and supported by a thorough methodological review of the available literature and data. Searches were done in databases like Google Scholar, PubMed, Science Direct, and search engines like Google to collect materials for study using search terms like PHC, Primary care in India, achievements of PHC, Subcentres, primary health centres which provided articles from Press releases, peer-reviewed journals and government reports which were published with the latest information. There is a paucity of publications regarding internal and external factors that may do harm or benefit to the PHC system, hence the information collected was categorized into strengths, weaknesses, opportunities, and threats.

SWOT ANALYSIS

SWOT analysis consists of matrix (Figure 1), a structured, easy-to-read map that lists and arranges a program's strengths, weaknesses, opportunities, and threats. This analysis assisted in making use of the structure, dynamics, and reports already recorded. [6]

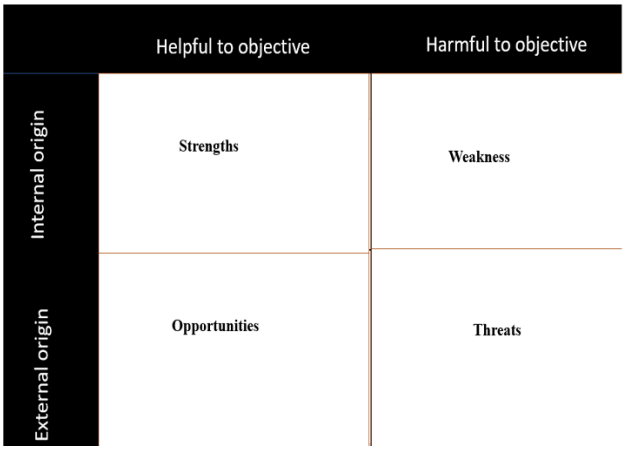

Figure 1: SWOT matrix, an adaptation from essentials of strategic planning in healthcare by Jeffrey P. Harrison (Health administration press, 2010).[6]

Strength

The government's commitment to launching new initiatives that increase life expectancy, decrease infant mortality rates, and improve vaccination rates widespread health care services across the country, reaching distant areas, significant volunteer force of accredited social health activists (ASHA's). Better outreach services, technological advancements. Greater access to health services. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana Scheme, the largest health insurance programme ever. Alternative healthcare programs like AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy).[7-13,23]

Weakness

To some extent, political and individual preferences contribute to the unequal distribution of healthcare services.[14] Lack of coordination between various departments has an impact on public health performance either directly or indirectly.[15] Population growth, rapid urbanization, and shifting demographics have led to an imbalance in infrastructure needs and distribution.[16] The share of India's GDP devoted to healthcare is only about two percent.[17] The reports show that compared to urban areas, rural areas suffer disproportionately from a lack of healthcare resources. [18] Organized service delivery infrastructure which is largely absent in cities/towns to specially address the healthcare needs of urban poor. [29] Low public spending. [19] A referral system should be established at the primary level to prevent overcrowding at the secondary and tertiary levels. [20] Poor community participation and impact effects in areas like sanitation causing disconnection from higher levels of care.[21] Uneven human resource distribution.[22] Gathering and utilizing data for planning and patient monitoring. [41]

Opportunities

The increasing number of medical colleges aids in pursuing better research.[23] The low doctor-to-patient ratio offers plenty of employment opportunities.[24] All involved government departments, if coordinated well, can help to quickly achieve better health for the masses.[25] The National Rural Health Mission (NRHM) has funds that are available, and states can use them to reduce their unapplied budgets.[26] Producing, and supplying medicines and equipment at a lower cost so they are accessible to a larger population.[27] To raise the quality at the foundational level, the government needs to investigate models like Public Private Partnership (PPP).[28]

Threats

Lack of funds, potential quackery, travelling over long distances is frequently not the most convenient choice, leaving only private facilities as an alternative.[29-31] In the country, there are reportedly 25 7781 public hospitals and 43 487 private ones.[27] Lack of awareness, lack of support, financial barrier.[32] Because government hospitals are frequently overcrowded, many patients frequently select privately run healthcare facilities.[33] India still falls short

of the WHO recommendation of 1 doctor per 1,000 people, with 1 doctor for every 1194 people.[34]

DISCUSSION

India's current PHC scenario

Currently, 31,035 PHCs, 1,61,829 SCs are functional in India, depicted in Figure 2. India's 2017 national health policy commits the government to invest a major proportion (>2/3rd) of resources in PHC.[35] The main tool to accomplish this is the 1,50,000 health and wellness centres (HWCs), of which are intended to become the main points of contact for PHC.[36] According to the National family health survey (NFHS)-5 report, 49.9% of Indian households don't typically use a government medical facility. However, this figure is less than 55% as of NFHS-4 in 2015-16. People from both urban and rural areas preferred private facilities to public ones.[37] The union cabinet approved the national urban health mission (NUHM) on May 1, 2013, as a sub-mission of the larger national health mission (NHM). The mission of the NUHM is to deliver equitable and high-quality primary healthcare services to urban residents, focusing on the community's rural and vulnerable groups.[38]

Urban areas

NUHM seeks to improve people's health by facilitating access to high-quality primary healthcare.[39] The NUHM covers all towns and cities with a population greater than 50,000, as well as district and state capitals with a population greater than 30,000. Currently, 6118 Urban Primary Health Centres (U-PHC) are operating in India as of March 31, 2022, which is less than the required percentage for the urban population. Out of these U-PHCs, 1734 PHCs have been converted into HWCs. The urban population's norms indicate that there is a roughly 44.4% shortage of U-PHCs, 70% or so of UPHCs are housed in government buildings, 27% are in rented buildings, and three percent are in rent-free buildings. The percentage of vacancies for female health workers (HW (F))/ANMs (Auxiliary Nurse and Midwife) at the PHC level is 13.4%. At the U-PHCs, there are 19.1% staff nurses, 18.8% open vacancies for doctors, 16.8% for chemists, and 18.8% for lab technicians. At the UPHC level, there is a shortage in every position. At PHCs, there is a 35.5% of ANM shortage. U-PHCs have a 5% fewer doctors, 24.5% fewer chemists, 29.1% fewer lab technicians, and 1.2% fewer staff nurses. 584 U-CHCs (Urban Community Health Centres) are operating in India's urban areas as of March 31, 2022. 4% of U-CHCs are housed in privately rented buildings, while 96% are in public buildings. 16820 HW(f)/ANM vacancies are open in urban areas. There are 5938 staff nurses, 4457 doctors, 3549 chemists, 1933 lab technicians, and at U-PHCs. There are 16.9% open positions for HW (F)/ANMs at PHC and SC levels. There is shortage of doctors in the U-PHCs by 19.1%, chemists by 21.4%, lab technicians by 29.8%, and staff nurses by 21.7%. There is a shortage in every position at U-PHC level. There is 44.3% ANM shortage at PHCs and 57 SCs. Doctors (16.7%), chemists (24.3%), lab technicians (50.9%), and staff nurses are in short supply.[40]

Rural areas

The number of allopathic doctors working in primary health centres has increased by more than 50% since the national rural health mission was founded in 2005. In comparison to 2005 (20,308), there will be 30,640 more Allopathic doctors employed at PHCs by 2022. In addition, the RHS (Rural health statistics) report highlights the country's severe shortage of specialists, with CHC reporting a shortage of nearly 80% of required specialists. To provide general medical care, surgical care, gynecological care, and pediatric care, CHCs are 30-bed, block-level medical facilities. There are 6,064 CHCs in India, but the health ministry has had trouble staffing the majority of them with specialists. The lack of specialized doctors is highlighted in the report, particularly in the specialties of surgery (83.2%), obstetrics and gynecology (74.2%), medicine (79.1%), and pediatrics (81.6%). A shortage of female healthcare professionals and auxiliary nursing midwives exists in addition to a lack of specialized physicians, with up to 14.4% of these positions going unfilled. At the end of March 2022, there were 157935 operational rural SCs in the country; since 2005, the number of SCs has increased significantly in the states of Rajasthan (3011), Gujarat (1858), Madhya Pradesh (1413), and Chhattisgarh (1306). Since 2005, 24,935 PHCs are operating in rural areas, the number of PHCs has increased significantly in the states of Jammu and Kashmir (557), Karnataka (457), and Rajasthan (420). [40]

Major achievements for primary healthcare

The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana scheme has authorized around 2.4 crore hospital admissions, costing almost Rs. 28,300 crores.

The 68,582 headmasters/principals and 1.34 lakh health and wellness ambassadors have been trained for the school health and wellness initiative in 24 States.

Every month from April 2021 to November 2021, 3.01 crore beneficiaries received benefits from the weekly iron folic acid supplementation programme (WIFS), including 2.64 crore students and 36.75 lakh non-student adolescent girls. There are currently 7135 AFHCs (Adolescent friendly health clinics) spread out across the country, 50.6 crore children were covered in the program.

More than 90 million prenatal examinations have been performed at sites where the program offers full services, and more than 5 lakh high-risk pregnancies have been recognized for prophylactic oral rehydration solution (ORS), ASHAs saw more than 7.0 billion kids under the age of five.

Maternal Mortality drop to 100/100,000 live births, and infant mortality rate drop to 30/1000 live births.

The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana scheme has authorized around 2.4 crore hospital admissions, costing almost Rs. 28,300 crores.

68,582 Headmasters/Principals and 1.34 lakh Health and Wellness Ambassadors have been trained for the school health and wellness initiative in 24 States.

Every month from April 2021 to November 2021, 3.01 crore beneficiaries received benefits from the Weekly Iron Folic Acid Supplementation Programme (WIFS), including 2.64 crore students and 36.75 lakh non-student adolescent girls.

There are currently 7135 AFHCs (Adolescent Friendly Health Clinics) spread out across the country. 50.6 crore children were covered in the program.

More than 90 million prenatal examinations have been performed at sites which offers full services, and more than 5 lakh high-risk pregnancies have been recognized

For prophylactic Oral rehydration solution (ORS), ASHAs saw more than 7.0 billion kids under the age of five.

Maternal Mortality drop to 100/100,000 live births, and Infant Mortality Rate drop to 30/1000 live births.

Decrease in Malaria mortality to 60%, Kala Azar mortality to 100%, Filaria reduction rate to 80%, Dengue mortality to 50%, Cataract surgeries increased to 46 lakhs annually, Leprosy Prevalence Rate decreased to less than 1 per 10,000, and Tuberculosis Control increased to over 70% case detection & 85% cure rate.

The National Programme for Palliative Care (NPPC) was declared as a fresh initiative.

More than 1.77 lakh patients have used the services provided by the Dialysis Program, accounting for a total of more than 19.15 lakh dialysis sessions.

The NHM (National Health Mission) has approved Rs. 1218.31 crores for the Free Diagnostics Services Initiative for 29 States/UTs.

Operational Guidelines for NCD (Non-Communicable disease) Screening and Management as Part of Comprehensive Primary Care under NHM have previously been created and released. As of September 2021, approvals had been given for about 170 districts across 16309 Sub-Centres, screening had started in about 60 districts across 12 states and 2 UTs(Union territory), and 20,15,474 people had been screened. 1,75,417 and 65,169 patients, respectively, had been enrolled.

As of November 2021, 44.54 lakh patients had benefited from AMRIT Pharmacies. The MRP cost of the prescription pharmaceuticals is Rs. 417.73 crores and savings from AMRIT stores of Rs. 231.34 crores minimize their out-of-pocket costs.

Under NRHM, there are currently 20,990 emergency response vehicles in use, along with 5,499 patient transport vans, particularly for "free pickup and drop back" services for expecting mothers and unwell babies.

As of September 2022, the Biomedical equipment maintenance and management program was implemented in 28 states.

Currently, 2.25 lakh healthcare facilities publish monthly data on their physical environment, staffing levels, and the provision of medical services.[40]

PHC across the world

Countries' primary healthcare systems, policies, and cultural environments vary from one another. Following are a few examples of basic healthcare strategies used in various nations:

Canada's public healthcare system is called Medicare. Primary care is provided by family physicians, nurse practitioners, and other allied health specialists. Primary care is widely available to the majority of the population, and emphasis is placed on providing complete, patient-centered care that includes preventive treatments and treating chronic conditions.[43]

In the UK, everyone has access to free medical care via the national health service (NHS). General practitioners (GPs), who are often the first point of contact for patients, provide primary healthcare. General practitioners provide a range of services, such as preventive care, treatment of common illnesses, and referrals to specialists as necessary.[44]

Australia has a mixed healthcare system, including both public and private providers. Primary healthcare is provided by doctors who specialize in general practice, nurses, and other medical personnel. The government promotes primary health networks (PHNs) in order to organize and improve primary care services, such as preventive care, chronic disease management, and mental health services.[45]

A social health insurance system provides health insurance to the vast majority of German citizens. The major responsibility for delivering primary health care falls on general practitioners, who function as gatekeepers and supervise patient care. Priorities include managing illnesses, promoting health, and providing preventive care. Furthermore, Germany promotes integrated care strategies that need collaboration between diverse healthcare organisations.[46]

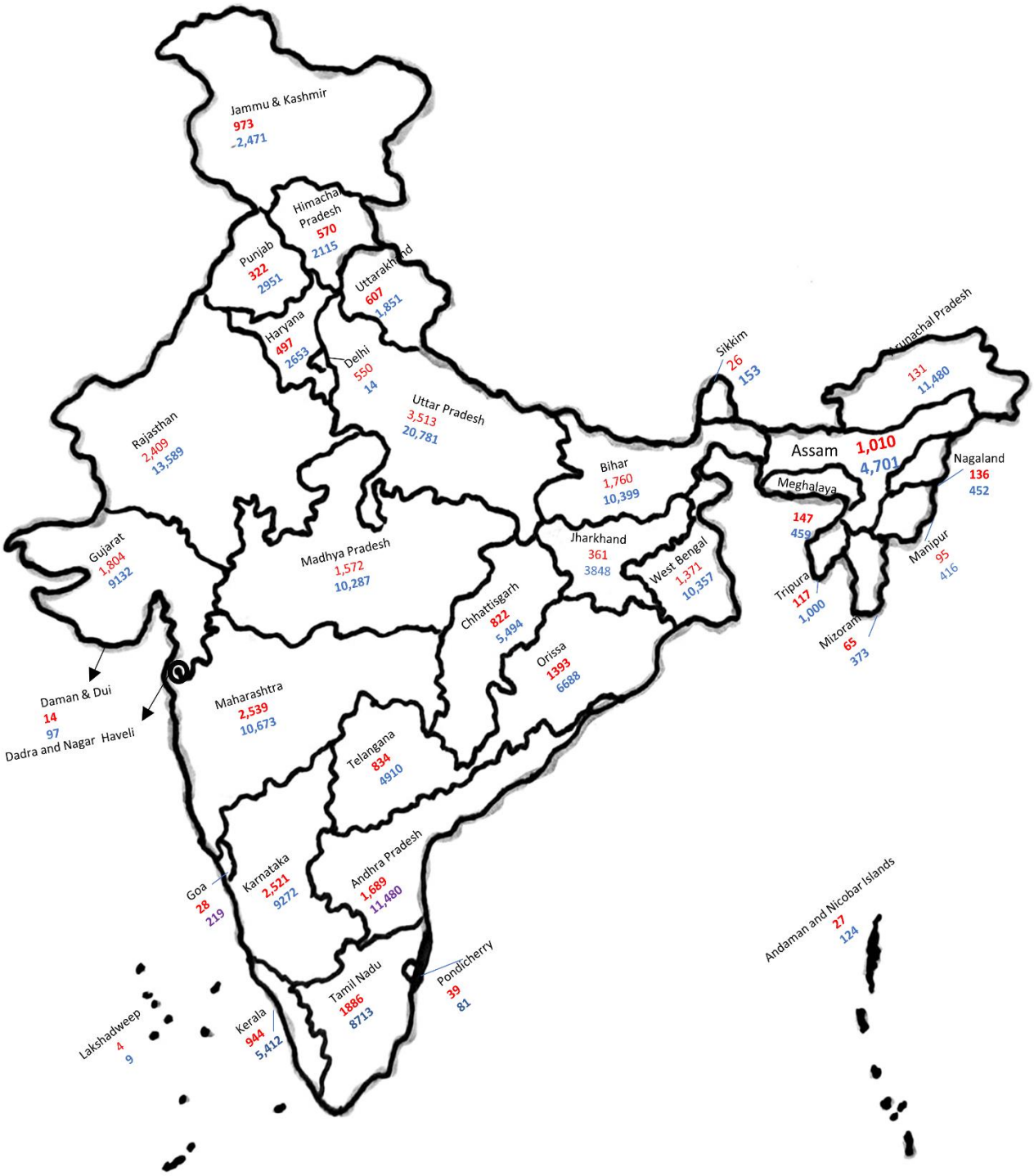

Figure 2: PHCs, SCs, currently functional in India, numbers in red are PHC and in blue are SC.

Everyone is guaranteed access to basic medical care thanks to the nation's national health insurance program in Japan. The emphasis is on comprehensive and coordinated care, and general practitioners are the principal providers of primary care services. In order to improve public health, Japan also puts a high priority on preventive care, health screenings, and health education.[47]

In the Netherlands, the required health insurance system in this nation is made up of both state and private insurers. PHC is given by general practitioners, who operate as the main coordinators of patient care. Continuity of care, preventive care, and patient and healthcare provider shared decision-making are given priority in the Dutch primary care system.[48]

The primary healthcare system in Cuba is distinctive and heavily emphasizes community-based care. The country aggressively emphasizes the need for preventive care, health education, and a comprehensive PHC policy. Family doctors and nurses are the main care providers in the primary care system, and they are responsible for treating certain demographic groups in their local communities.[49]

The US healthcare system, which consists of both public and private providers, is convoluted. Typically, primary care physicians, nurse practitioners, and physician assistants provide this kind of treatment. Access to primary care might be affected by factors including geography, cost, and insurance coverage. The focus of primary care includes immediate treatment and referrals to specialists in addition to managing chronic illnesses and taking prevention measures.[50]

Brazil has a mixed healthcare system, including both public and private healthcare providers. Primary healthcare is provided by the Sistema Nico de Sade (SUS), a national healthcare delivery system with the goal of ensuring everyone has access to quality medical treatment. Family health strategy (Estratégia de Sade do Familia), a primary care program, emphasizes preventive care, health promotion, and community-based services.[51]

Chile has a healthcare system that includes both public and private services. PHC is offered by both individual private practices and a system of free clinics known as Consultorios. Managing illnesses, promoting health, and providing preventative care are given top priority in the primary care system. Chile has also adopted the family health model (Modelo de Salud Familiar), which places an emphasis on treatment continuity and the role of primary care teams in coordinating patient health.[52]

The healthcare system in Argentina is made up of the public, social security, and private sectors. Primary healthcare is delivered via a network of primary care centres, sometimes referred to as CAPS or Centros de Atención Primaria de la Salud (PHC Centres). A wide range of services are offered by these institutions, including preventive care, the treatment of common illnesses, and, where required, referrals to specialized care. Furthermore, in Argentina, emphasis is placed on programs for health promotion and community-based therapy.[53]

CONCLUSION

For many years, PHC has been seen as the foundation of stronger, more efficient healthcare systems. India started making efforts to enhance PHC in 1943 when the "health survey and development committee," led by Sir Joseph Bhore, was established. This paper attempted to provide insight into the PHC system's operation. Even though the flaws are obvious, many different things have led to this hopeless predicament. A general lack of resources is one. India is not a wealthy country, and as a result of the constant loss of medical professionals, the country has had great difficulty maintaining an efficient, comprehensive healthcare system. The implementation of a comprehensive, integrated PHC strategy is essential for achieving health in India, especially given the rising burden of chronic diseases. The Indian governments recently introduced Ayushman Bharat program aims to provide citizens with access to full healthcare services, including care provided close to their homes at health and wellness centres and through financial protection. India needs to capitalize on its current advantages and opportunities to improve its key health metrics. The continuation, modification, or even termination of these policies can be decided upon with accuracy and promptness by establishing a system of communication among all decision-making levels. Second, it is suggested that extra care be taken to evaluate the results in addition to keeping an eye on how current activities and programs are being carried out. Efforts must be made Increasing investment in PHC, enhance infrastructure and technology, expand access to medicines and essential supplies, focus on preventive care, foster public-private partnerships, community engagement, monitor and evaluation of implemented health programs, and address health inequalities. The last recommendation is that PHC delivery service facilities be upgraded, newer units be built to meet population growth demands, and a bottom-up approach be used with a focus on community empowerment, disease prevention, and health promotion because “Health is not everything but everything else is nothing without health”.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. WHO and UNICEF. A vision for primary health care in the 21st century: Towards UHC and the SDGs, 2021. Available at: https://www.who.int/docs/default-source/primary-health/vision.pdf. Accessed on 2 May 2023.
2. Indian Public Health Standards (IPHS). Guidelines for Primary Health Centres: Revised 2012. Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Available at: https://nhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidlines-2022/03_PHC_IPHS_Guidelines-2022.pdf. Accessed on 2 May 2023.
3. Indian Public Health Standards (IPHS). Revised 2022. National Health Mission. Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Available at: https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154. Accessed 2 May 2023.
4. Rana R, Bhardwaj P. Paradigm Shift in Peripheral Health Post. J Comp Health. 2022;10(1):41-3.

5. World Health Organisation. Primary Health Care: 25 years after Alma-Ata: WHO regional office for Mediterranean region, 2003. Available at https://apps.who.int/iris/bitstream/handle/10665/122156/em_rc50_8_en.pdf. Accessed 2 May 2023.
6. Harrison JP. Essentials of Strategic Planning in Healthcare. Gateway to Healthcare Management. Paperback 2016;31.
7. Adhikari UR, Paria C. Utilization of health services and its perceived barriers regarding infant care among tribal mothers in selected areas of West Bengal. Int J Community Med Public Health. 2022;9:1766-73.
8. Mane Abhay B, Khandekar Sanjay V. Strengthening primary health care through Asha Workers: a novel approach in India. Prim Health Care. 2014;4(149):2167-1079.
9. Jana S. Primary Health Care Strengthening in India: Imperative to Providing Inclusive Health Care. Int J Eng Stud. 2023;71-9.
10. Chandramohan A, Krothapalli V, Augustin A, Kandagaddala M, Thomas HM, Sudarsanam TD et al. Teleradiology and technology innovations in radiology: status in India and its role in increasing access to primary health care. Lancet Reg Health-Southeast Asia. 2023;1-14.
11. Persai D, Balu RK, Singh K, Prabhu RR, Lahoti S, Rout S, et al. Patient Satisfaction with Quality of Primary Care Health services-findings from India. Int J Health Plann Manage. 2022;37(4):2256-65.
12. Prasad S. Pradhan Mantri Jan Arogya Yojana (PM-JAY): The scheme and it's potential to reform India's healthcare system. Dvara Research. 2021.
13. Rudra S, Kalra A, Kumar A, Joe W. Utilization of alternative systems of medicine as health care services in India: Evidence on AYUSH care from NSS 2014. PloS one. 2017;4;12(5):e0176916.
14. Lakshminarayanan S. Role of government in public health: Current scenario in India and future scope. J Fam Community Med. 2011;18(1):26.
15. Dhyani A. Health and wellness centres strengthening primary health care in India-challenges and way forward. World J Pharm Med. 2022;1701-14.
16. Kasthuri A. Challenges to Healthcare in India-The Five A's. Indian J Community Med. 2018;43(3):141-3.
17. Budget Documents of Union and State Governments, Ministry of Finance, Government of India. Available at: https://www.indiabudget.gov.in/. Accessed on 2 May, 2023.
18. Basu J. Research on Disparities in Primary Health Care in Rural versus Urban Areas: Select Perspectives. Int J Environ Health Res. 2022;19(12):1-5.
19. Harshit K, Mahek N. Why most Indians not using Public Health Facilities is a Matter of Concern. Available at: https://www.news18.com/news/opinion/why-most-indians-not-using-public-health-facilities-is-a-matter-of-concern-5573389.html-. Accessed on 28 April 2023.
20. Saleem SM, Jan SS. Strengthening primary health care through private players: Adream "so near, yet so far". J Family Med Prim Care. 2022;11:399-402.
21. Dakhode SU, Gaidhane AM, Choudhari SG. Policy, programs, and activities for promotion of water, sanitation and hygiene practices in schools of India. J Family Med Prim Care. 2022;11:4310-8.
22. Roy K, Dutt B, Patel JM, Raithatha SJ. SPARSH electronic sub-health centres (e-SHCs)-A model of nurse-run SHCs supported by general practitioners through telemedicine. J Family Med Prim Care. 2022;11:5556-62.
23. Press Information Bureau, Government of India. Available at: https://pib.gov.in/PressRelese Detailm.aspx?PRID=1908049. Accessed on 28 April 2023.
24. Ugargol AP, Mukherji A, Tiwari R. In search of a fix to the primary health care chasm in India: can institutionalizing a public health cadre and inducting family physicians be the answer? The Lancet Regional Health-Southeast Asia. 2023;3:1-11.
25. Chitra M, Pradeepan S. Preparedness of Public Health Care System in India- A Case Study. Shanlax Int J Economics. 2022;10(04):1-8.
26. Roger J. Health policy and federalism in India. Territ Politic Gov. 2022;10(1):67-85.
27. Estimated number of public and private hospitals across India in 2019. Available at: https://www.statista.com/statistics/1128425/india-number-of-public-and-private-hospitals-estimated/- Accessed on 28 April 2023.
28. Ghasemi M, Amini-Rarani M, Zadeh NS, Karimi S. Role of public-private partnerships in primary healthcare services worldwide: A scoping review. Health Scope. 2022;11(3):e129176.
29. Hanson K, Brikci N, Erlangga D, Alebachew A, De Allegri M, Balabanova D et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Global Health. 2022;10(5):e715-72.
30. Jain, A. Dental quackery in India: an insight on malpractices and measures to tackle them. Br Dent J. 2019;226:257-9.
31. Mustafa A, Shekhar C. Is quality and availability of facilities at Primary Health Centres (PHCs) associated with healthcare-seeking from PHCs in rural India: An exploratory cross-sectional analysis. Clin Epidemiology Glob Health. 2021;9,293-8.
32. Rudra S, Kalra A, Kumar A, Joe W. Utilization of alternative systems of medicine as health care services in India: Evidence on AYUSH care from NSS 2014. PLoS one. 2017;12(5):2-20.
33. Yadav R, Zaman K, Mishra A, Reddy MM, Shankar P, Yadav P et al. Health Seeking Behaviour and Healthcare Utilization in a Rural Cohort of North India. Healthcare. 2022;10(5):757.
34. Abantika G. India's doctor-patient ratio better than WHO norm of 1:1000, government tells Rajya Sabha, Available at: https://theprint.in/health/indias-doctor-patient-ratio-better-than-who-norm-of-11000-

government-tells-rajya-sabha/1273080/-. Accessed on 28 April 2023.
35. National Health Policy, 2017, Ministry of Health and Family Welfare, Government of India. Available at: https://main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf. Accessed on 1 May 2023.
36. Operational guidelines for AB-CPHC-HWCs, Ayushman Bharat, Comprehensive Primary Health Care through Health and Wellness Centres, Ministry of Health and Family Welfare, Government of India. Available at: https://www.nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Comprehensive_primary_health_care/letter/Operational_Guidelines_For_CPHC.pdf- Accessed on 1 May 2023.
37. National Family Health Survey (NFHS-5), Ministry of Health and Family Welfare, Government of India. Available at: https://main.mohfw.gov.in/sites/default/files/NFHS-5_Phase-II_0.pdf-. Accessed on 01 May 2023.
38. S Goel. From Bhore Committee to National Rural Health Mission: A Critical Review. The Internet j health 2007;7(1):1-4.
39. Orientation Module for Planners, Implementers and Partners NUHM, National Urban Health Mission, Ministry of Health and Family welfare, Government of India. Available at: https://nhm.gov.in/images/pdf/NUHM/Orientation_module_for_planners_implementers_and_partners.pdf- Accessed on 1 May 2023.
40. Department of Health and Family welfare, Ministry of Health and Family welfare, Government of India. 2021-2022 Annual report. Available at https://main.mohfw.gov.in/sites/default/files/FinalforNetEnglishMoHFW040222_1.pdf. Accessed on 1 May 2023.
41. Vlassoff C, Tanner M, Weiss M, Rao S. Putting people first: a primary health care success in rural India. Indian J. Community Med. 2010;35(2):326.
42. Rural Health Statistics, Government of India, Ministry of health and family welfare statistics division,2021-2022. Available at: https://main.mohfw.gov.in/sites/default/files/rhs20-211.pdf. Accessed on 2 May 2023.
43. Hutchison B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. The Milbank Quarterly. 2011;89(2):256-88.
44. Roland M, Guthrie B, Thomé DC. Primary medical care in the United Kingdom. J Am Board Family Med. 2012;25(1):S6-11.
45. Briggs DS, Nankervis R, Baillie J, Turner C, Rigby K, Livingstone L. Innovation to improve patient care in Australian Primary Health Network: an insider's perspective. Public Administration Policy. 2019;22(2):111-24.
46. Luque Ramos A, Hoffmann F, Spreckelsen O. Waiting times in primary care depending on insurance scheme in Germany. BMC Health Services Res. 2018;18:1-9.
47. Bloom G. Universal health coverage and primary healthcare: Lessons from Japan: comment on" achieving universal health coverage by focusing on primary care in Japan: Lessons for low-and middle-income countries. Int J Health Policy Management. 2017;6(4):229.
48. Faber MJ, Burgers JS, Westert GP. A sustainable primary care system: lessons from the Netherlands. J Ambulatory Care Management. 2012;35(3):174-81.
49. Whiteford LM, Branch LG. Primary health care in Cuba: the other revolution. Rowman and Littlefield Publishers. 2008.
50. Solheim K, McElmurry BJ, Kim MJ. Multidisciplinary teamwork in US primary health care. Social Sci Med. 2007;65(3):622-34.
51. Carvalho MN, Álvares J, Costa KS, Guerra AA, Acurcio FD, Costa EA, et al. Workforce in the pharmaceutical services of the primary health care of SUS, Brazil. Revista de Saúde Pública. 2017;51.
52. Romero AM. Perspective of family medicine in Chile: Challenges for professional practice. Cadernos de Saúde Pública. 2019;35.
53. Elorza ME, Moscoso NS, Blanco AM, Gentili JO. Estimating need, demand and supply in primary health care services: a local application in Argentina. MEDICC Rev. 2018;20:36-44.

Cite this article as: Konki A, Pachava S, Pavani NPM, Bhavani VD. Strength, weaknesses, opportunities, and threats analysis on the current scenario of primary health care in India. Int J Community Med Public Health 2023;10:3016-23.