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RECEIVED 26 April 2023

ACCEPTED 15 August 2023

PUBLISHED 25 August 2023

CITATION

Mor N (2023) Commentary: Developing technical support and strategic dialogue at the country level to achieve primary health care-based health systems beyond the COVID-19 era. *Front. Public Health* 11:1212271. doi: 10.3389/fpubh.2023.1212271

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Commentary: Developing technical support and strategic dialogue at the country level to achieve primary health care-based health systems beyond the COVID-19 era

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KEYWORDS

primary care, surgical care, maternal health, health systems design, developing country

A Commentary on

Developing technical support and strategic dialogue at the country level to achieve primary health care-based health systems beyond the COVID-19 era

by Cheong Chi Mo, J., Shah, A., Downey, C., Genay-Diliautas, S., Saikat, S., Mustafa, S., Meru, N., Dalil, S., Schmets, G., and Porignon, D. (2023). *Front. Public Health* 11:1102325. doi: 10.3389/fpubh.2023.1102325

Introduction

Cheong Chi Mo et al. (1) stress the importance of primary health care (PHC) as a central component of any health system's journey toward Universal Healthcare and discuss in detail the role that the WHO and its "large network of more than 130 health policy advisers" play in helping 115 countries build a PHC focussed pathway toward Universal Health Coverage (UHC). There is little debate about the importance of PHC within any health system. However, there are two views implicit in the position taken by Cheong Chi Mo et al. (1) which could benefit from some additional discussion: (a) if the government does not provide PHC, it does not exist; and (b) developing country governments with low health expenditures should invest in PHC as a priority. In this note, we debate both these perspectives and suggest a different approach toward prioritization that developing country governments must take.

Availability of care

All levels of healthcare are necessary, including essential public health functions, primary care, secondary care, and tertiary care. Ideally, the state government should spend enough money so their residents can easily access all of these levels of care with no added expense. However, with limited funds, this becomes impossible for most developing country governments, and they need to focus their investments on areas of greatest need.

Data, most recently from the state of Orissa in India (2, 3), suggests the presence of a profusion of easily accessible private primary care providers, even in the remotest parts of a largely rural country like India. Extensive research on primary care by Das et al. in multiple developing countries also suggests that availability is not as much of a challenge and that, on average, the quality delivered by these primary care providers exceeds that provided by the public sector (4).

There is no similar response from the private sector in the domain of secondary care. If a high-volume emergency procedure such as a Caesarean Section (C-section) is used as a proxy for the availability of secondary care against a norm of between 10 and 20% medically necessary C-sections (5, 6), during 2019–20, most of the northern and north-eastern states in India had total (elective plus medically necessary) C-section rates well-below 10% (7). In sub-Saharan Africa, a similar situation prevails, with average C-section rates at close to 5% (8), with Nigeria showing a number as low as 2.7% (9).

The importance of secondary care

Despite all the progress that has been made, most developing regions continue to face a high burden of disease relating to maternal and child deaths (10). In order to address this with the urgency that it needs, Nimako and Kruk (11) and Roder-DeWan et al. (12) suggest that given all the accumulating evidence, there is limited additional value to be gained from: (a) improving delivery care processes in primary care facilities (13); (b) strengthening prenatal assessment and risk stratification or movement of women needing emergency care to distant facilities since about 30% of women considered low risk develop unexpected complications during delivery (14). The way forward instead involves a comprehensive examination of the service delivery architecture, with a proposal for all mothers to give birth in or close to higher-level facilities that can provide definitive care for complications (i.e., capacity for C-Section, blood transfusion, care for sick mothers and new-borns), which offers the twin benefits of concentrating improvement efforts in fewer facilities and providing a mortality benefit through rapid access to lifesaving care (11, 15). This is also consistent with the work of Guilamoto and Dumont (16) who find that there is a strong association between increases in C-Section rates and declines in maternal mortality rates within Indian states which have C-Section rates below 20%.

Implementing these changes while presenting its own challenges is not as onerous and impossible a task in most places as might appear to be the case at first glance, even in relatively remote areas (17, 18). This may not be immediately possible for remote areas, but innovations such as hostels for birthing mothers may represent a partial solution (19, 20). The introduction of

high-volume “alongside midwife-led units” or AMUs (21) located within hospitals can also be explored to address the challenges of limited obstetrician availability and to reduce the risk of the over-medicalisation of deliveries, as has been seen in several of the southern Indian states (7) and countries such as Brazil (8).

Conclusion

The underlying message from this discussion appears clear. If a low-spending state wished to improve health outcomes for its residents, it would do well to invest in secondary care as a priority and ensure universal and high-quality availability of this care even in its more remote areas. For delivery care, it would need to build the required numbers of high-volume “alongside midwife-led units” or AMUs within these hospitals so that even as the quality of birthing care improves, the risks of moving in the direction of excessive C-Sections are minimized.

That is not to suggest that primary care is not essential but instead to recommend a different approach toward enabling and focusing it on the services it is best equipped to provide—moving away from delivery care and toward NCDs while continuing to provide ANC and PNC services. There is already a great deal of availability of such care from the private sector, and a state with limited resources could help improve the quality of services on offer instead of attempting to invest in building more of these facilities at the cost of leaving significant gaps in the availability of secondary care.

Author contributions

The author confirms being the sole contributor of this work and has approved it for publication.

Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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