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ABSTRACT:

Primary Health Care (PHC) forms the cornerstone of an efficient and equitable health system. It serves as the first point of contact between individuals and the healthcare delivery structure, emphasizing accessibility, affordability, and preventive measures. In India, where nearly two-thirds of the population resides in rural areas, the PHC network is vital for achieving ***Universal Health Coverage (UHC)*** and ensuring the constitutional right to health. Despite significant policy reforms and investment through initiatives such as the ***National Rural Health Mission (NRHM) and Ayushman Bharat Health and Wellness Centres,*** India continues to face persistent challenges in strengthening its primary healthcare infrastructure. These challenges stem from multiple factors, including inadequate financial resources, shortage of trained medical professionals, poor infrastructure, and limited community participation. The digital divide, logistical inefficiencies, and administrative fragmentation further compound the issue. This paper seeks to analyze these constraints comprehensively while assessing governmental interventions and the evolving policy landscape. It also highlights comparative insights from other developing nations to identify practical solutions applicable to the Indian context. The study concludes with recommendations for enhancing human resources, infrastructure, and community-based approaches to achieve a resilient and inclusive PHC system. Strengthening primary healthcare is not only a health sector imperative but also a prerequisite for sustainable national development and human capital advancement.

I. INTRODUCTION:

Health is universally recognized as one of the fundamental pillars of human development and national progress. A nation's strength lies not merely in its economic or military capacity but in the physical, mental, and social well-being of its citizens. ***According to the World Health Organization (WHO), health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."***[1] This definition emphasizes the holistic nature of health, extending beyond curative care to include preventive, promotive,

[1] World Health Organization, *Constitution of the World Health Organization*, available at: https://www.who.int/about/governance/constitution (last visited Aug. 30, 2025).

and rehabilitative dimensions. In this context, the concept of ***Primary Health Care (PHC)*** assumes central importance as it focuses on delivering essential healthcare services at the community level, ensuring accessibility, equity, and participation. ***The Alma-Ata Declaration of 1978*** marked a historic milestone by recognizing PHC as the key to achieving ***"Health for All."***[2] It underscored that the highest attainable standard of health is a fundamental human right and that governments have a responsibility to build systems that make health services universally available. India adopted this philosophy early on, integrating PHC into its national health planning through the recommendations of the ***Bhore Committee (1946) and subsequent initiatives such as the National Rural Health Mission (NRHM, 2005) and the Ayushman Bharat Programme (2018)***.[3] Despite this policy commitment, significant disparities persist in the accessibility and quality of healthcare between urban and rural populations. ***Primary Health Centres (PHCs), Community Health Centres (CHCs),*** and Sub-Centres constitute the backbone of India's rural health delivery network. However, these institutions continue to face chronic shortages of manpower, inadequate infrastructure, and limited financial resources. The result is an uneven distribution of services and a growing dependence on secondary and tertiary care facilities for even minor health issues.[4] Moreover, the increasing burden of ***non-communicable diseases (NCDs),*** coupled with the challenges of communicable diseases, underscores the urgency of strengthening PHC systems. The Government of India's efforts toward decentralization, digital health integration, and community engagement have shown promise, yet systemic barriers remain.[5] The present study seeks to analyze the multifaceted challenges in strengthening primary health care infrastructure in India. It aims to identify the key structural, administrative, and socio-economic constraints that hinder effective healthcare delivery at the grassroots level. In doing so, it also explores policy innovations and comparative lessons from other developing nations

[2] World Health Organization, *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR (Sept. 6–12, 1978).
[3] Government of India, "Report of the Health Survey and Development Committee (Bhore Committee Report), 1946"; Ministry of Health and Family Welfare, "National Rural Health Mission Framework for Implementation, 2005"; Ministry of Health and Family Welfare, "Ayushman Bharat Programme Guidelines, 2018".
[4] Ministry of Health and Family Welfare, "Rural Health Statistics 2022–23", Government of India, New Delhi.
[5] Government of India, NITI Aayog, "Strategy for New India @75", 2018.

to suggest sustainable models for reform. Strengthening PHC is essential not only to improve health outcomes but also to ensure social justice and inclusive national development.

I.II STATEMENT OF THE PROBLEM:

1. *Despite several health reforms,* ***India's Primary Health Care (PHC)*** *system continues to face gaps in infrastructure, manpower, and service delivery.*

2. *Uneven distribution of resources between urban and rural areas leads to disparities in healthcare access and outcomes.*

3. *Insufficient public investment and weak governance have limited the efficiency of PHC institutions.*

4. *The integration of digital technology and community participation in PHC remains inadequate, affecting the system's responsiveness and sustainability.*

I.III HYPOTHESIS:

The study hypothesizes that inadequate funding, poor governance, and uneven resource allocation are the primary barriers to strengthening India's Primary Health Care infrastructure, and that reforms in financing, human resources, and community engagement can significantly improve its effectiveness.

I.IV OBJECTIVES OF THE STUDY

1. *To examine the current status of Primary Health Care infrastructure in India.*

2. *To identify key challenges affecting the performance and accessibility of PHC services.*

3. *To analyze policy initiatives and international best practices relevant to PHC strengthening.*

4. *To suggest practical recommendations for improving the efficiency and equity of PHC delivery.*

I.V RESEARCH METHODOLOGY:

This study adopts a qualitative and descriptive approach based on secondary data from government reports, WHO publications, policy documents, and academic literature. Data were analyzed through content review and thematic comparison to identify systemic

challenges and propose suitable recommendations for strengthening India's Primary Health Care infrastructure

II. HISTORICAL BACKGROUND OF PRIMARY HEALTH CARE IN INDIA:

The evolution of Primary Health Care in India reflects the country's long-standing commitment to improving public health as an integral component of nation-building. The foundations of India's PHC system were laid well before Independence, but it was the ***Bhore Committee Report of 1946*** that gave the first comprehensive vision for a national health system. The committee, officially known as the Health Survey and Development Committee, emphasized that ***"no individual should fail to secure adequate medical care because of inability to pay."***[6] It recommended the establishment of a three-tier health infrastructure, comprising primary health units, secondary health units, and district hospitals, to ensure universal access to basic health services. ***Following Independence in 1947***, the Government of India sought to operationalize this vision through successive Five-Year Plans. ***The First Five-Year Plan (1951–56) prioritized rural health, emphasizing the creation of Primary Health Centres (PHCs) and Sub-Centres*** to provide integrated preventive and curative services.[7] Over time, the number of PHCs expanded, yet progress remained uneven due to inadequate funding, lack of trained manpower, and logistical constraints. The Mudaliar Committee (1962) further reviewed the system and called for strengthening the quality of PHC services rather than mere quantitative expansion.[8] ***A major international turning point came with the Declaration of Alma-Ata (1978), adopted by the World Health Organization (WHO) and UNICEF, which defined Primary Health Care as the key strategy to achieve "Health for All by the year 2000."***[9] India endorsed the Alma-Ata principles and restructured

[6] Government of India, "Report of the Health Survey and Development Committee (Bhore Committee Report), 1946".
[7] Government of India, Planning Commission of India, *First Five-Year Plan (1951–56)*, New Delhi.
[8] Government of India, "Report of the Health Survey and Planning Committee (Mudaliar Committee Report), 1962".
[9] World Health Organization, *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR (Sept. 6–12, 1978).

its health policy to align with global standards of equity, accessibility, and community participation. ***The National Health Policy of 1983*** explicitly recognized PHC as the core of India's health strategy, emphasizing inter-sectoral coordination and community involvement.[10] Despite these reforms, the implementation of PHC faced persistent challenges during the 1980s and 1990s. The focus on vertical disease control programmes—such as malaria eradication and family planning—often diverted attention from comprehensive PHC services. It was only with the launch of the ***National Rural Health Mission (NRHM) in 2005*** that a renewed effort was made to strengthen the rural health infrastructure.[11] The NRHM aimed to provide accessible, affordable, and quality healthcare to rural populations, particularly vulnerable groups, through decentralization, community participation, and improved financing mechanisms. ***The Ayushman Bharat Yojana (2018***) marked another milestone in India's PHC evolution. It introduced ***Health and Wellness Centres (HWCs)*** to transform existing Sub-Centres and PHCs into comprehensive care units offering preventive, promotive, and curative services. This initiative signifies a paradigm shift from selective primary care to a more integrated, people-centered approach. The historical trajectory of India's PHC system thus demonstrates a continuous, albeit uneven, effort to balance policy intent with on-ground realities. The journey from the Bhore Committee to Ayushman Bharat underscores the persistent aspiration to build a health system that is both equitable and sustainable.[12]

III. CURRENT STATUS OF PRIMARY HEALTH CARE INFRASTRUCTURE IN INDIA:

The health system in India is organized in a three-tier structure, consisting of ***Sub-Centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs)***. These institutions form the backbone of the country's rural health delivery network, intended to

[10] Government of India, "National Health Policy 1983", (Ministry of Health and Family Welfare, New Delhi).
[11] Government of India, "National Rural Health Mission Framework for Implementation", 2005 (Ministry of Health and Family Welfare).
[12] Government of India, "Ayushman Bharat – Health and Wellness Centres: Operational Guidelines, 2018", (Ministry of Health and Family Welfare).

provide comprehensive preventive, promotive, and curative services. The Sub-Centre serves as the most peripheral contact point between the primary health system and the community, while the PHC acts as the first point of contact with a qualified doctor. The CHC functions as a referral unit for four PHCs and provides specialized care. As per the ***Rural Health Statistics 2022–23, India has approximately 1,60,555 Sub-Centres, 24,935 Primary Health Centres, and 5,481 Community Health Centres.***[13] However, these figures fall short of the required norms prescribed by the ***Indian Public Health Standards (IPHS), particularly in states with high population density such as Uttar Pradesh, Bihar, and Madhya Pradesh***. The shortage of facilities is compounded by an uneven geographical distribution, with remote and tribal areas facing acute deficits in both infrastructure and human resources. In terms of human resource availability, the shortfall remains a serious concern. According to government data, ***nearly 5.2 percent of doctor positions at PHCs and 12.8 percent of specialist positions at CHCs were vacant as of March 2023***.[14] Moreover, many existing facilities function without essential paramedical staff, laboratory technicians, and pharmacists. The problem is further aggravated by absenteeism and lack of motivation among healthcare workers, particularly in rural and difficult-to-access regions. Infrastructure quality also poses a major challenge. A significant proportion of PHCs and Sub-Centres operate from buildings that are either rented or in poor physical condition. Only about 12 percent of PHCs meet all the criteria for infrastructure and service delivery under IPHS norms.[15] Many lack adequate water supply, electricity, sanitation, and functional labor rooms. In addition, the availability of essential drugs, diagnostic facilities, and equipment is inconsistent, leading to dependence on secondary or private healthcare providers even for basic treatments. The public health expenditure in India continues to hover around 1.3 percent of GDP, far below the global average of 6 percent for developing countries.[16] This low investment constrains the ability of state governments to maintain existing facilities and expand services to meet growing

[13] Government of India, "Rural Health Statistics 2022–23", (Ministry of Health and Family Welfare, New Delhi).
[14] *Ibid*.
[15] Government of India, Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres, 2021, (Ministry of Health and Family Welfare).
[16] Government of India, "Strategy for New India @75", (NITI Aayog), 2018.

demand. Furthermore, while programs such as the ***National Health Mission and Ayushman Bharat*** have infused additional funds, much of the expenditure remains skewed toward urban tertiary care rather than rural primary health services. The COVID-19 pandemic exposed both the resilience and fragility of India's PHC infrastructure. On one hand, it demonstrated the capacity of frontline health workers, ***Accredited Social Health Activists (ASHAs),*** and auxiliary nurses to respond effectively at the community level. On the other, it revealed the weaknesses in surveillance, logistics, and supply chain mechanisms essential for large-scale health emergencies.[17] Overall, while the numerical growth of PHCs and Sub-centres over the years indicates progress, the system continues to struggle with inadequate staffing, infrastructure deficits, and resource constraints. Addressing these gaps is crucial to realizing the goal of universal, equitable, and affordable primary healthcare in India.

IV. MAJOR CHALLENGES IN STRENGTHENING PRIMARY HEALTH CARE INFRASTRUCTURE IN INDIA:

Primary Health Care (PHC) in India remains the cornerstone of the country's health system, yet it continues to face numerous systemic and operational challenges that limit its effectiveness. While government initiatives have improved access and coverage, a complex interplay of financial, administrative, and social factors continues to undermine the efficiency and equity of PHC delivery.

The following subsections analyze the major challenges confronting the sector.

IV.I INADEQUATE FUNDING AND RESOURCE ALLOCATION:

One of the most persistent challenges in strengthening PHC is the inadequacy of public expenditure on health. India's public health expenditure remains around ***1.3 percent of its Gross Domestic Product (GDP),*** among the lowest globally.[18] This low level of investment constrains the ability of both central and state governments to provide essential services, maintain infrastructure, and ensure regular supply of medicines and equipment. Despite

[17] World Health Organization, COVID-19: *Lessons for Primary Health Care Systems,* WHO Country Office for India, 2021.
[18] *Ibid*.

various policy commitments, including ***the National Health Policy 2017 target of raising public health spending to 2.5 percent of GDP***, progress has been slow.[19] Moreover, the allocation of resources is often uneven across regions. States with weaker fiscal capacity, such as Bihar, Jharkhand, and Odisha, are unable to invest sufficiently in health infrastructure. This disparity results in unequal access to healthcare services across states and within rural–urban divides. In addition, a large portion of the budget is spent on salaries and administrative costs, leaving limited funds for infrastructure maintenance, community programs, or innovation.[20]

IV.II SHORTAGE OF HUMAN RESOURCES FOR HEALTH:

A severe shortage of qualified health professionals continues to undermine the functioning of PHCs and CHCs. According to the Rural Health Statistics 2022–23, nearly 5.2 percent of doctor posts at PHCs and 12.8 percent of specialist posts at CHCs remain vacant.[21] Additionally, there is a significant shortfall of nursing staff, laboratory technicians, and pharmacists. The distribution of existing health personnel is also highly skewed, with most preferring urban postings due to better living conditions, education, and professional opportunities. High absenteeism and poor retention in rural areas further weaken service delivery. Many doctors appointed to PHCs are either on deputation or engaged in private practice, limiting their availability. Training and capacity-building mechanisms for paramedical and community health workers are inadequate, leading to variable quality of services. Although programs like the ***Ayushman Bharat Health and Wellness Centres (HWCs) have introduced the cadre of Community Health Officers (CHOs),*** the pace of recruitment and training remains insufficient to meet population needs.[22]

IV.III INFRASTRUCTURAL DEFICIENCIES AND MAINTENANCE ISSUES:

[19] Ministry of Health and Family Welfare, National Health Policy 2017, Government of India, New Delhi.
[20] *Ibid*.
[21] Government of India, "Rural Health Statistics 2022–23", (Ministry of Health and Family Welfare, New Delhi).
[22] *Ibid*.

The physical infrastructure of ***PHCs and Sub-Centres often fails to meet prescribed standards under the Indian Public Health Standards (IPHS). As of 2023, only about 12 percent of PHCs meet all the IPHS*** norms for building, equipment, and staff availability.[23] Many facilities operate from temporary or rented premises, with poor water supply, sanitation, and electricity. The absence of diagnostic facilities, functional operation theatres, and delivery rooms discourages people from using public health institutions for even basic services such as child delivery or immunization. Inadequate maintenance and lack of periodic audits lead to the deterioration of infrastructure over time. Supply chain inefficiencies further exacerbate the problem, resulting in frequent stock-outs of essential drugs and consumables. The lack of proper waste management and bio-medical disposal facilities at many PHCs also raises environmental and public health concerns.

IV.IV GOVERNANCE, ACCOUNTABILITY, AND ADMINISTRATIVE FRAGMENTATION:

Governance and accountability issues have long plagued India's primary healthcare system. The overlapping roles of central, state, and local governments often result in administrative confusion and duplication of efforts. In many states, the delegation of authority to district or block-level health officials is limited, hindering local problem-solving and innovation.[24] Monitoring and evaluation mechanisms remain weak, with data often outdated or inaccurate. The absence of real-time health information systems prevents evidence-based decision-making. Additionally, corruption and inefficiencies in procurement and fund utilization lead to wastage of scarce resources. The lack of coordination between different vertical programs—such as those for immunization, maternal health, and communicable disease control—creates fragmentation rather than integration of services.

IV.V SOCIO-CULTURAL AND BEHAVIORAL BARRIERS:

[23] Government of India, Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres, 2021 (Ministry of Health and Family Welfare).
[24] National Institute of Health and Family Welfare, Governance and Accountability in Primary Health Care, NIHFW Working Paper, 2020.

Socio-cultural barriers significantly influence healthcare utilization in rural India. In many communities, low health awareness, traditional beliefs, and gender inequality restrict access to PHC services. Women, in particular, face challenges in seeking maternal and reproductive health services due to social taboos, mobility constraints, and lack of decision-making power.[25] Furthermore, the social determinants of health—such as education, nutrition, sanitation, and income—continue to impact health outcomes at the community level. Many individuals prefer unqualified practitioners or private clinics due to perceptions of better care or shorter waiting times, even though such practices can lead to higher out-of-pocket expenditure and medical complications.

IV.VI TECHNOLOGICAL AND DIGITAL DIVIDE:

While the Government of India has introduced several digital health initiatives, including the eSanjeevani telemedicine platform and the Ayushman Bharat Digital Mission, technological penetration remains limited in many rural and tribal regions. Poor internet connectivity, lack of trained personnel, and inadequate digital literacy hinder effective adoption of e-health solutions. Consequently, the potential benefits of telemedicine and electronic health records are yet to be fully realized in the PHC system. The digital divide also affects data management and disease surveillance. Many PHCs continue to rely on manual record-keeping, which delays reporting and hampers public health planning. Building a robust digital infrastructure requires both financial investment and sustained training for healthcare providers.[26]

IV.VII FRAGMENTED HEALTH FINANCING AND PRIVATE SECTOR DOMINANCE:

Another major challenge lies in the fragmented nature of health financing. A significant portion of healthcare expenditure in India comes from out-of-pocket spending by households, estimated at nearly 48.2 percent of total health expenditure in 2021–22. This reliance on private spending exposes households to financial hardship and limits access for poorer

[25] United Nations Population Fund (UNFPA), *State of World Population Report,* 2022.
[26] Government of India, "Ayushman Bharat Digital Mission: Strategy Overview", (Ministry of Health and Family Welfare,) 2022.

populations.[27] The dominance of the private sector, especially in secondary and tertiary care, further complicates the landscape. The lack of effective regulation and quality control mechanisms often leads to exploitation, irrational treatments, and widening inequalities. ***While public–private partnerships (PPPs)*** have been promoted under schemes like the National Health Mission, the outcomes have been mixed due to inadequate monitoring and unclear accountability frameworks.

IV.VIII WEAK COMMUNITY PARTICIPATION AND LOCAL GOVERNANCE:

Community participation, a key principle of the Alma-Ata Declaration, remains underdeveloped in India's PHC framework. ***Although Village Health, Sanitation and Nutrition Committees (VHSNCs) and Rogi Kalyan Samitis (RKS)*** were created to enhance local involvement, their effectiveness varies widely. Many committees lack adequate funding, training, and decision-making authority. As a result, community ownership of health programs is limited, and local needs often go unaddressed. Revitalizing these local governance structures is essential to ensure that healthcare delivery aligns with community priorities. Without meaningful participation, top-down approaches to health planning are likely to remain inefficient and unsustainable.[28] India's Primary Health Care system faces a complex web of interrelated challenges spanning financial, infrastructural, human resource, and governance dimensions. The persistence of these issues reflects not only administrative shortcomings but also broader socio-economic disparities. Overcoming these barriers requires a multi-sectoral approach that integrates health with education, sanitation, nutrition, and technology. Strengthening PHC is not merely a policy goal but an ethical imperative to ensure equitable access to health as a fundamental right for all citizens.

V. GOVERNMENT INITIATIVES AND REFORMS:

[27] World Bank, *World Development Indicators: Health Expenditure Data*, 2023.
[28] Government of India, National Health Mission Framework for Implementation, (Ministry of Health and Family Welfare) 2015.

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The Government of India has implemented several initiatives and policy reforms to strengthen the ***Primary Health Care (PHC)*** infrastructure, enhance service delivery, and promote equitable access to healthcare across the country. Over the years, these efforts have evolved from basic infrastructure development to more comprehensive, people-centered, and technology-driven models of care.

V.I NATIONAL RURAL HEALTH MISSION (NRHM), 2005:

Launched in 2005, the National Rural Health Mission (NRHM) was a landmark step toward revitalizing rural healthcare delivery in India. The mission aimed to provide accessible, affordable, and quality healthcare to the rural population, particularly vulnerable and disadvantaged groups. It focused on strengthening the health infrastructure through upgrading ***Sub-Centres, Primary Health Centres, and Community Health Centres,*** ensuring adequate human resources, and improving the availability of essential drugs and equipment.[29] The NRHM introduced several key institutional mechanisms such as ***Rogi Kalyan Samitis (Patient Welfare Committees)*** for facility management and ***Village Health, Sanitation and Nutrition Committees (VHSNCs) for community participation. It also brought the Accredited Social Health Activist (ASHA)*** program into operation, creating a vital link between the community and the healthcare system. The mission's decentralized approach empowered local governance bodies to plan and implement health interventions based on local needs.[30]

V.II NATIONAL URBAN HEALTH MISSION (NUHM), 2013:

Recognizing the growing healthcare needs of the urban poor, the ***National Urban Health Mission (NUHM)*** was launched in 2013 as a complementary component to NRHM. The NUHM aimed to provide basic healthcare services to urban slum populations and other vulnerable groups living in cities. It introduced ***Urban Primary Health Centres (UPHCs)*** to deliver preventive and promotive health services, focusing on maternal and child health, immunization, and control of communicable diseases. The integration of ***NRHM and NUHM***

[29] *Government of India*, "National Rural Health Mission Framework for Implementation*"*, (Ministry of Health and Family Welfare), 2005.
[30] *Ibid*.

under the umbrella of the National Health Mission sought to ensure convergence of rural and urban health initiatives, promoting efficiency and continuity in service delivery.[31]

V.III AYUSHMAN BHARAT PROGRAMME, 2018:

The Ayushman Bharat Programme, launched in 2018, represents a significant paradigm shift in India's approach to healthcare reform. ***The program rests on two interlinked components: (a) the establishment of Health and Wellness Centres (HWCs), and (b) the Pradhan Mantri Jan Arogya Yojana (PM-JAY).*** The HWCs aim to transform existing Sub-Centres and PHCs into comprehensive care units offering preventive, promotive, curative, rehabilitative, and palliative care. These centers provide a range of services, including management of non-communicable diseases, maternal and child health, and essential drugs and diagnostics. The introduction of ***Community Health Officers (CHOs)*** at HWCs has strengthened the availability of trained health personnel at the grassroots level.[32] ***The PM-JAY,*** on the other hand, provides health insurance coverage of up to five lakh rupees per family per year for secondary and tertiary hospitalization. While PM-JAY focuses on financial protection, the HWCs strengthen primary-level services, creating a continuum of care across different levels of the health system.[33]

V.IV DIGITAL HEALTH AND TELEMEDICINE INITIATIVES:

The government has placed strong emphasis on integrating technology into primary healthcare delivery. ***The Ayushman Bharat Digital Mission (ABDM)*** launched in 2021 aims to create a digital ecosystem connecting patients, healthcare providers, and institutions through digital health IDs, electronic health records, and teleconsultation services.[34] The eSanjeevani telemedicine platform, introduced during the COVID-19 pandemic, has facilitated remote consultations across PHCs and HWCs, reducing the burden on secondary

[31] Government of India, "National Urban Health Mission: Framework for Implementation", (Ministry of Health and Family Welfare), 2013.
[32] Government of India, "Ayushman Bharat Programme Guidelines", (Ministry of Health and Family Welfare) 2018.
[33] Government of India, "Pradhan Mantri Jan Arogya Yojana: Annual Report 2022–23", (National Health Authority) New Delhi.
[34] Ministry of Health and Family Welfare, *Ayushman Bharat Digital Mission: Strategy Overview*, Government of India, 2021.

and tertiary facilities. By 2023, eSanjeevani had provided more than 100 million teleconsultations nationwide, making it one of the largest digital health platforms globally. However, sustained investments in digital infrastructure, training, and connectivity remain critical for its long-term success.[35]

V.V PUBLIC–PRIVATE PARTNERSHIPS AND INNOVATIVE MODELS:

The government has also encouraged ***Public–Private Partnerships (PPPs)*** to leverage private sector efficiency for public health goals. Under NHM and various state-level schemes, private hospitals and NGOs have been engaged in diagnostics, ambulance services, and facility management. States like Karnataka and Gujarat have experimented with PPP models for managing PHCs and diagnostic centers, showing mixed results. While PPPs have improved service reach in some areas, challenges of accountability, regulation, and quality assurance persist.[36]

V.VI RECENT REFORMS AND FUTURE VISION:

The Fifteenth Finance Commission (2021–26) has recommended higher devolution of funds to states for health infrastructure development, with specific grants earmarked for PHCs and CHCs. Additionally, the government's vision document, ***"India @100,"*** emphasizes ***Universal Health Coverage (UHC)*** through the strengthening of PHC systems, integration of traditional medicine ***(AYUSH),*** and expansion of digital health services.[37] Several states have also undertaken innovative reforms. ***Kerala's Family Health Centre model, Tamil Nadu's*** robust drug procurement system, and ***Rajasthan's Mukhya Mantri Chiranjeevi Yojana*** offer valuable examples of state-level initiatives that can inform national strategies. The integration of such best practices within the broader framework of Ayushman Bharat could significantly improve the effectiveness of PHC across India.[38] The cumulative impact of these initiatives reflects the government's recognition of primary healthcare as the foundation of an equitable

[35] National Health Authority, *eSanjeevani Telemedicine Dashboard Report*, 2023.
[36] NITI Aayog, *Public–Private Partnership in Health: Policy Framework and Guidelines,* Government of India, 2020.
[37] Finance Commission of India, Fifteenth Finance Commission Report (2021–26), Government of India, 2021.
[38] *Ibid*.

and efficient health system. However, implementation challenges persist due to financial constraints, administrative bottlenecks, and uneven capacity among states. Strengthening PHC requires not only continued investment but also reforms in governance, accountability, and community engagement. If effectively implemented, these initiatives can transform India's healthcare landscape, moving it closer to the goal of universal and inclusive health coverage.

VI. COMPARATIVE INSIGHTS:

A comparative analysis of Primary Health Care (PHC) systems in other developing countries provides valuable lessons for India. Nations such as ***Sri Lanka and Thailand*** have achieved impressive health outcomes despite limited resources, primarily due to strong investments in primary care and effective governance. Sri Lanka's health system is often cited as a model for universal access at low cost. The government's focus on preventive and promotive healthcare, coupled with free medical services and high literacy rates, has led to remarkable achievements in maternal and child health indicators. The country allocates a higher proportion of its health budget to primary care, ensuring that PHCs are adequately staffed and equipped.[39] Thailand offers another instructive example. Through its ***Universal Coverage Scheme (UCS)*** introduced in 2001, Thailand expanded PHC services nationwide, emphasizing community-based care and financial protection. The government invested heavily in local health infrastructure, training village health volunteers, and integrating digital health systems. As a result, Thailand achieved near-universal health coverage with significant reductions in out-of-pocket expenditure.[40] For India, these examples highlight the importance of sustained investment in PHC, strong community participation, and effective decentralization. Adopting lessons from such countries could guide India's ongoing reforms under Ayushman Bharat and the National Health Mission.

[39] World Health Organization, *Primary Health Care Systems: Case Study – Sri Lanka, WHO Regional Office for South-East Asia*, 2020.
[40] World Health Organization, *The Kingdom of Thailand Health System Review, Health Systems in Transition,* Vol. 10 No. 1, 2015.

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VII. RECOMMENDATIONS:

Strengthening Primary Health Care (PHC) in India requires a multidimensional approach that addresses structural, financial, and human resource challenges while promoting innovation and community participation. The following recommendations are proposed to enhance the effectiveness and sustainability of PHC infrastructure in the country.

VII.I INCREASE PUBLIC INVESTMENT IN HEALTH:

India must significantly raise public expenditure on health to at least ***2.5 percent of GDP as envisaged in the National Health Policy 2017***.[41] A higher proportion of funds should be directed specifically toward PHC infrastructure, maintenance, and capacity building. Allocations to states should be based on need and performance indicators to ensure equitable distribution of resources.

VII.II STRENGTHEN HUMAN RESOURCES FOR HEALTH:

Adequate staffing and skill development are crucial for improving PHC services. Recruitment and retention of doctors, nurses, and paramedical staff in rural areas can be encouraged through financial incentives, career advancement opportunities, and better living conditions.[42] Continuous professional training and refresher courses should be institutionalized. Expanding the role of ***Community Health Officers (CHOs) and ASHA*** workers can enhance community-level outreach and service delivery.

VII.III UPGRADE INFRASTRUCTURE AND ESSENTIAL SERVICES:

Physical infrastructure should be upgraded to meet Indian Public Health Standards (IPHS). Every PHC must have functional diagnostic laboratories, maternity care facilities, and uninterrupted power and water supply. Strengthening the supply chain for essential medicines

[41] Government of India, "National Health Policy 2017", (Ministry of Health and Family Welfare) New Delhi.
[42] Government of India, "Human Resources for Health in India: Policy Options, 2021" (NITI Aayog) New Delhi.

and consumables through centralized procurement systems, as implemented successfully in Tamil Nadu, can ensure regular availability of supplies.[43]

VII.IV PROMOTE DIGITAL HEALTH AND DATA INTEGRATION:

Expanding digital health platforms such as the ***Ayushman Bharat Digital Mission (ABDM)*** and eSanjeevani can improve efficiency and monitoring.[44] Training healthcare workers in digital tools and ensuring internet connectivity in rural areas are essential. Integrated health information systems will help in data-driven planning, real-time disease surveillance, and better coordination across levels of care.

VII.V ENHANCE GOVERNANCE AND ACCOUNTABILITY:

Decentralization of health governance to local bodies should be strengthened. Empowering Village Health, Sanitation and ***Nutrition Committees (VHSNCs) and Rogi Kalyan Samitis (RKS)*** with decision-making powers and independent budgets can foster local accountability. Transparent mechanisms for monitoring fund utilization and facility performance should be instituted through digital dashboards and public audits.[45]

VII.VI FOSTER COMMUNITY PARTICIPATION AND HEALTH LITERACY:

Building community ownership is key to the sustainability of PHC. Community awareness programs on preventive health, sanitation, and nutrition should be expanded through schools, local media, and self-help groups.[46] Encouraging public participation in health planning and monitoring promotes inclusivity and trust in the system.

[43] Government of India, "Indian Public Health Standards (IPHS): Guidelines for Primary Health Centres, 2021" (Ministry of Health and Family Welfare.)
[44] Government of India," Ministry of Health and Family Welfare, Ayushman Bharat Digital Mission: Strategy Overview, 2021" (Ministry of Health and Family Welfare.)
[45] National Institute of Health and Family Welfare, *Governance and Accountability in Primary Health Care, NIHFW Working Paper, 2020*.
[46] United Nations Development Programme, *Health Literacy and Community Engagement Report*, 2022.

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VII.VII INTEGRATE TRADITIONAL MEDICINE AND INTERSECTORAL COLLABORATION:

Integrating **AYUSH** services into PHC can broaden the scope of care, especially for preventive and promotive health.[47] Collaboration between health, education, sanitation, and nutrition sectors is necessary to address the social determinants of health comprehensively. Inter-ministerial coordination at central and state levels can help align objectives and resources. These recommendations emphasize that the future of India's healthcare system depends on the strength of its primary healthcare base. By focusing on investment, governance, human resources, and community engagement, India can move closer to achieving universal health coverage and ensuring that quality healthcare is available to all citizens, irrespective of geography or income.

VIII. CONCLUSION:

Primary Health Care (PHC) remains the cornerstone of India's health system and a vital pathway to achieving Universal Health Coverage. Despite notable progress in expanding infrastructure and implementing major health initiatives, India continues to face persistent challenges related to inadequate funding, uneven distribution of resources, human resource shortages, and weak governance. These gaps have hindered the efficient delivery of essential health services, especially in rural and underserved regions. To ensure equitable and accessible healthcare, India must reaffirm its commitment to strengthening PHC through sustained investment, effective decentralization, and community participation. The lessons from successful international models such as Sri Lanka and Thailand demonstrate that political will, strategic resource allocation, and local empowerment can transform primary care delivery even with limited resources. A robust primary healthcare system not only improves health outcomes but also contributes to broader socio-economic development by reducing poverty, improving productivity, and fostering social equity. Moving forward, the

[47] Government of India, "Integration of Traditional Medicine in Primary Health Care, 2020" (Ministry of AYUSH) New Delhi.

emphasis must remain on building resilient, people-centered PHC systems capable of responding to both routine and emergent health needs. Only then can India realize the vision of ***"Health for All"*** as enshrined in national policy and global commitments.