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Health Policy and Healthcare System Strengthening: Evaluating the Role of Primary Healthcare in Reducing Health Inequities

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ABSTRACT

It is not a secret that primary healthcare (PHC) can be considered the key of any fair and properly structured health system, and in the countries of low- and middle-income, the unequal accessibility, affordability, and quality of the provided services is one of the most urgent questions. Health inequity can be reduced through the adoption of effective health policies coupled with combining service delivery, community based, and financing mechanisms to enhance the PHC in order to improve the overall health of the population. The paper is a critique of the role played by PHC in strengthening health systems on a wider basis and it uses the available evidence on the topic around the world to evaluate the role of PHC-based systems in facilitating equity, enhancing access to services by the marginalized populations and strengthening the resiliency of the system over the long term. The findings have indicated that the nations, which are more PHC oriented, have health indicators that are superior, financial hardship that is lower and unequal care usage. The study finds that it would be necessary to redesign the policies to concentrate on the PHC investments, community involvement, multisector cooperation, and universal health insurance.

Keywords: Universal Health Coverage; Health Policy; Health Equity; Healthcare Access; social determinant of health; Primary Healthcare; Health System Strengthening; Health Equity; Health Policy.

INTRODUCTION

The idea of primary healthcare (PHC) has been deemed to be the cornerstone of efficient health systems since the Alma-Ata Declaration of 1978 that elevated health to the primary human right of the healthcare system and considered primary healthcare to be the engine of equity and social justice (World Health Organization [WHO], 1978). Despite the universal dedication of the world to PHC, the issue of health inequity has been a challenge in the majority of countries because of socioeconomic disparities, ineffective management of health systems, and availability of the basic services in question. In low-resource environments, inequities are likely to be enhanced by geographic barriers, financial limitations, and the shortage of trained medical staff. The integration of PHC into the national health policies reform has therefore become a significant solution to the eradication of disparities and timely, affordable, and quality care to underserved groups (Kruk et al., 2018). The models of modern health system strengthening do not only focus on PHC as a model of service delivery, but as a model of structuring care depending on the needs of the population and emphasizing the community engagement, prevention, continuity, and coordination (WHO, 2020).

PHC may assist in reducing inequities of the nature of providing the required services in the area of the individuals that makes the healthcare facilities more accessible to rural and low-income groups as well as to the marginalized individuals. The reports have reported that highly PHC oriented health systems have presented better outcomes in regards of infant and maternal mortality, control of chronic diseases and preventable hospital admissions (Starfield et al., 2005). The other useful concept in increasing financial protection by reducing the utilization of unnecessary hospital-level services and reducing out-of-pocket expenditures, which is a considerable contributor to catastrophic health spending in the low- and middle-income countries (Wagstaff et al., 2018). Continuity of care, early disease detection and combined management of common health conditions have been known to be effective of PHC-oriented systems, and allow communities to be better engaged in the health system as well as increase provider-patient trust. Moreover, PHC enhances resilience, and it enables health systems to respond more effectively during emergencies, epidemics, and the ongoing threats on the population's health (Khan et al., 2021).

PHC reinforcement in most settings however, requires structural policy modulations of systemsic challenges of inadequate finances, lack of human resource and fragmented service delivery. One of the greatest barriers to equitable distribution of services has been poor governance and most health systems have largely relied on availability of tertiary facilities to the disadvantages of primary level (Bitton et al., 2017). The result of this imbalance is overcrowded hospitals, absence of care on the community level, which further enhances health disparities. Resource redistribution, the introduction of PHC into national insurance schemes, and expansion of community health worker initiatives have been discovered to boost equity and coverage, especially among the hard-to-reach groups of migrants, rural citizens, and poor urban populace (Perry et al., 2021). It also requires multisectoral approaches in the process of strengthening PHC, since social determinants of health like education, environment, income and housing are highly instrumental towards the identification of inequities. Countries that have integrated PHC plans with education and community development plans as well as social welfare have more declines on health inequalities and overall improvement in population health outcome (Solar & Irwin, 2010).

Moreover, the achievement of universal health coverage (UHC) also goes hand in hand with the reinforcements of PHC. UHC will not be a reality without the firm foundation of primary-level services that can access equitable services with the benefits of quality and financial safety. The other countries that have made significant progress in the path towards UHC, such as Thailand, Brazil, or Rwanda, have accomplished the goals by prioritizing strong PHC networks, particularly community health workers, decentralized governance, and people-centered models of care (Tangcharoensathien et al., 2018). These examples are evidences that PHC is not just a care delivery strategy but a disruptive platform of alleviating inequalities in the entire health systems. Some of the innovations that have already enhanced the possibility of PHC reaching vulnerable populations and delivering holistic care even more are digital health, task shifting, and integrated PHC networks (Levine et al., 2022). It has also been established that PHC improvement improves equity by removing differences between rural and urban communities, reducing gender barriers, and increasing access to low-income populations.

In total, the evaluation of the PHC role in the decrease of the health inequities indicates that it is the most important factor of the health system sustainability. PHC embodies the most important values of fairness, access, and people-centeredness that should be central to reduce the disparities and offer all people the necessary care. As the burden of chronic diseases, pandemic, and economic constraints continue to challenge the health systems of the world, PHC-based reforms become more challenging to implement. Evidence-based health policy empowerment of PHC through increased investments and community-based initiatives remains an effective strategy in the establishment of resilience systems and health equity facilitation at the global scale. The present paper considers these issues by evaluating the significance of

PHC in reducing inequalities, the global evidence of the efficacy of PHC systems, and the most significant policy implications under the low resources setting.

LITERATURE REVIEW

The world has suggested that primary healthcare (PHC) is one of the best interventions in reducing health disparities, improving the health outcomes of the population, and improving health systems. PHC was initially developed in the Alma-Ata Declaration as the universal path to realisation of Health for All, where the scientific emphasis is universal access and involvement of communities and equity. The subsequent researches have proven the concept that PHC-based systems are never less successful compared to the specialist-based ones particularly in the low- and middle-income countries, the inequality in healthcare access of which is deeply rooted (World Health Organization [WHO], 2020). Starfield, Shi, and Macinko (2005) confirmed that a lower number of health inequities, lower mortality, and the improvement of service coverage are attained in those countries with a strong PHC background. PHC reduces inequalities by making services that are considered as essential more accessible to the communities, reducing the financial burden, and promoting early intervention and prevention. According to the literature, the empowerment of PHC is capable of improving the performance even of the marginalized populations, including rural population, the poor, and ethnic minorities, who are likely not to be reached by the hospital-based care (Kruk et al., 2018).

In a bid to improve equity, structural determinants that establish access to PHC services should be addressed. Social determinants of health such as poverty, gender, education and geography are closely linked to inequality in service utilization and health outcome. Solar and Irwin (2010) opine that there exist social production of health inequities, which must be addressed through multisectoral intervention as opposed to clinical care. PHC systems that actively incorporate social determinants within its service delivery model stand higher chances of registering better equity. PHC programs based in the community and integrating health education, maternal care, nutrition support, and post-chronic disease follow-up have been indicated to demonstrate high-level of service uptake and preventable morbidity reduction (Perry et al., 2021). An analysis of the Family Health Strategy in Brazil found out that the number of teams of community health workers in disadvantaged communities increased, and infant mortality and hospitalization in all low-income families reduced significantly (Macinko & Harris, 2015). It is also shown that strong PHC networks can greatly reduce postnatal mortality and increase coverage of essential services in Rwanda with the assistance of community health workers and decentralization policies (Binagwaho et al., 2014). These examples have stressed the fact that the impact of PHC on equity is not only conditional on the availability of services, but also on the consideration of the social, economic and communal factors.

Financing is one of the main aspects of PHC performance and reduction of equities. The more PHC is invested in a country publicly, the more the financial security and reduced out of pocket expenditures, which are paramount in the creation of equal access. Wagstaff et al. (2018) have found that equitable financing that is specifically pegged on publicly funded health insurance reduces disastrously on health expenditure and enhances access of the poor to the essential PHC services. On the other hand, a health system that relies largely on spending by the rich possesses a greater probability of widening inequalities. The fact also implies that increased efficiency can be achieved through health budget allocation to PHC. Bitton et al. (2017) state that low PHC results in high hospitalization since most health needs are managed in the community. A definitive PHC investment has gained Thailand and other countries universal health coverage through raising insurance coverage, empowered the district health systems and saw to it that the most important services were available at the primary level (Tangcharoensathien et al., 2018). These

findings illustrate that PHC funding is one of the key determinants of minimization of inequities in populations.

Human resources of health are also very important in the effectiveness of the PHC. In the majority of low-resource countries, PHC physicians, nurses, and community health workers are deficient, and this aspect compromises PHC delivery and promotes disparities in access. Increasing the spread of the workforce and its retention in underserved areas, in turn, is a significant point of PHC reforms. Research in Sub-Saharan Africa shows that the introduction and retention of community health workers especially enhance high percentages in maternal health, immunization and treatment of chronic diseases (Perry et al., 2021). Task-shifting, in which trained nurses or community workers perform tasks that were previously performed by physicians, has also been shown to improve access in those locations where there was a shortage of manpower (Levine et al., 2022). In addition, PHC teams, the team including clinical, preventive, and social services, have been defined to enhance patient satisfaction, continuity of care, and coordination (Kruk et al., 2018). Enhancing PHC by human resource is thus, still an important strategy of reducing the differences among the populations.

Service delivery model can also make a contribution to the extent that PHC can reduce inequity. The integrated PHC models that use both preventive, promotive and curative services are significant in making sure that populations are attended to holistically before the conditions escalate into other terminal diseases that require hospitalization. The evidence in the literature on health around the globe has demonstrated that fragmented service provision enhances disparities, and integrated PHC interventions yield better outcomes among those at risk (WHO, 2020). More specifically community based PHC was found to reduce the geographic inequities by providing services to homes and villages. According to the same study in Ethiopia, Pakistan, and Bangladesh, there is a booming positive impact of community-based maternal and child health interventions on immunization levels and skilled birth attendance and nutritional outcomes among households with low income (Levine et al., 2022). Access can also be reinforced with the use of digital health interventions in PHC as remote diagnosis, follow-up and health education can be used especially in rural environment where distance and transportation costs are major barriers. The findings of a study by Xiong et al. (2023) indicate that the digital PHC platforms are highly effective in the progress of continuity of care, chronic disease management, and patient interactions in underserved settings.

Governance and leadership are needed in the PHC reinforcing and health equity. Good governance embraces accountability, health planning and fair allocation of resources. According to WHO (2020), good PHC governance systems also imply that there is an equal distribution of health facilities and workforce, the coordination of both health levels and the system of community engagement. It is important to note that, according to Kruk et al. (2018), governance reforms such as decentralization, the power to make local decisions, and community control increase responsiveness and reduce disparities in service delivery. Good governance also increases resilience hence, PHC systems can absorb shocks which comprise pandemic, natural calamities and economic crises. The COVID-19 pandemic showed that stronger PHC networks in nations worked better in regards to testing, surveillance, and basic services regardless of the disruptions and were capable of reducing disparities in access and results (Khan et al., 2021). These findings highlight that one of the structural aspects of equitable PHC systems is governance.

Overall, PHC is strongly evidenced throughout the globe as a relevant method of reducing health inequities and health system improvement. Good results, resilience, and reduced inequalities between socioeconomic groups are something that always occur in those countries, which place PHC at the centre of the health policy. Accessibility, affordability, continuity, prevention, community involvement and people-oriented care are the equity-providing effects of PHC that are putting their focus. Proper investment, development

of workforce, integrated service delivery and good governance are however the determinants of the success of PHC. These structural determinants should be dealt with so as to ensure that PHC fulfills its potential as the foundation of equitable health systems. Most of the literature suggests that PHC strengthening is not only a reform in the health sector but also a social justice mandate that is central in achieving universal health coverage and reducing inequities in low-resource settings.

METHODOLOGY

The research design in this study was a mixed-method research design to determine how much primary healthcare (PHC) can reduce the health inequities in the healthcare industry in Pakistan. The mixed approach was selected because of the unfairness in health, which is brought about by the measurable structural variables and qualitative experiences that define how the individual receives and perceives PHC services (Creswell and Plano Clark, 2018).

The research was conducted in one of the districts (Multan District) in Pakistan and this was selected because of diversity in population and the presence of different functional PHCs. The community consisting of the PHC workers and the local health administrators was the target population. The sample size of 180 was estimated to be adequate to cover the population dispersion and remain feasible, as it matches the recommendations of the studies in the sphere of the public-health (Taherdoost, 2017).

Quantitative Component

The methods employed were a convenience sampling method on 150 community participants. The questionnaire was focused on the accessibility, affordability, quality of services and PHC satisfaction. The tools were validated through an adaptation of items as a part of health-systems research (Peters et al., 2008). The perception of equity, service availability, and financial security was measured in questions in the survey on a 5-point Likert scale.

Qualitative Component

To provide additional quantitative evidence, 30 interviewees were selected purposely and were to have in-depth interviews, including PHC staff and community residents. The topics that were addressed during interviews included access problems, equity perceptions, and experience of PHC delivery. This strategy allowed considering a wider range of socio-cultural, gender-based, and economic factors of inequities (Green and Thorogood, 2018). The interviews were tape recorded and verbatim transcribed.

Data Collection Procedures

The used data were taken within six weeks. The ethics was approved by the institutional review board and an informed consent was obtained among all participants. In order to allow the collection of survey data, it was conducted in person in local languages to make sure that it will be comprehensible, and leave low-literacy respondents, which is according to the principles of community-based health research developed by WHO (WHO, 2022). There was no information that was given.

Data Analysis

Quantitative data analysis was conducted using SPSS Version 26 that applied the descriptive statistics, cross tabulation, and regression analysis to answer the question about interrelations between socio-

demographic factors and the PHC utilization patterns. Qualitative data were analyzed by thematic analysis; this involved coding transcripts and finding patterns and classifying them as big themes, equity, access, and performance of the system (Braun and Clarke, 2006).

Validity and Reliability

Alpha Cronbach has been calculated to ensure internal consistency of the survey scales and all the significant constructs score above 0.70 and that is regarded as the acceptable level (Nunnally, 1978). The triangulation of the quantitative and qualitative results were used and this assisted the research to become more believable and less one sided.

Limitations

The study did not also address numerous districts, which might restrict the external validity. The self-reported information may be at risk of recall bias. These shortcomings were however reduced through good sampling and mixed methods.

DATA ANALYSIS AND FINDINGS

Their analysis procedures were performed on the basis of descriptive statistics, cross tabulations and thematic categorization which were performed with the use of data obtained on 180 participants in one city district. The analysis would have attempted to receive an answer on how individuals interpret the healthcare system, access to primary healthcare services, and whether the services reduce health inequities. The results are presented in a quantitative and qualitative format to have a full picture of the situation, which is characteristic of a mixed-methods approach to analysis that can be followed in a study of the health system (Creswell and Plano Clark, 2018; Palinkas et al., 2015).

Quantitative Findings

Demographic Characteristics

The demographics of the participants are presented in a summary in Table 1. Majority of them were female (60 percent) and most of them were between the ages of 26 and 45 years. About 70 percent of the respondents were of low to middle socioeconomic status that fits the demographic composition of the district.

Table 1

Demographic Characteristics of Participants (N = 180)

Variable	Category	Frequency	Percentage
Gender	Female	108	60%
	Male	72	40%
Age Group	18–25	32	18%
	26–45	94	52%
	46 and above	54	30%
Socioeconomic Status	Low	68	38%

	Middle	59	33%
	Upper	53	29%

Utilization of Primary Healthcare Services

It is found that 78 percent of the respondents indicated that they use primary healthcare centers (PHCs) as the initial point of care. It shows a rather high degree of dependence on PHCs, which means that they play a crucial role in healthcare access and disease prevention also supported by the WHO (2021). Nevertheless, even when the utilization levels are high, almost half of the respondents (47%) said they were dissatisfied with waiting times and lack of resources.

Table 2

Utilization and Satisfaction with Primary Healthcare Services

Indicator	Yes	No	Percentage Yes
Uses PHC as first point of care	140	40	78%
Satisfied with waiting times	95	85	53%
PHC has adequate staff	102	78	57%
PHC provides preventive health education	118	62	66%

Health Inequities Indicators

The statistics show that those with lower incomes have much greater impediments in getting quality care access, including the cost of transport, accessibility of medicine, and the scarcity of diagnosis opportunities. These results are consistent with the available literature that indicates that health inequities are highly connected with socioeconomic variables (Marmot, 2020; Kruk et al., 2018).

Table 3

Barriers to Healthcare Access by Socioeconomic Status

Socioeconomic Group	Transportation Barriers	Medication Cost Barriers	Diagnostic Service Barriers
Low Income	58%	64%	72%
Middle Income	39%	40%	51%
Upper Income	18%	22%	28%

Qualitative Findings

In addition to surveys, 20 semi-structured interviews were conducted in the form of thematic analysis. There were three themes that kept reoccurring:

Theme 1: Primary Healthcare as a Life-Line.

Multiple respondents detailed PHCs as their first and only choice because it was affordable and geographically accessible. This is the essence of the principle of PHC based systems as absolutely necessary in the achievement of equitable health access (Starfield, 2012). Respondents pointed out that PHCs provide free or low prices of check-ups, vaccinations, and maternal care, which in other private clinics are not available.

Theme 2: The Systemic paucity minimizes the quality of the services.

Health workers and patients alike continuously cited medication shortage, understaffing and overcrowding. These structural limitations decrease confidence in the public health system, and is not new by Sheikh et al. (2010) who point out systemic issues in low-resource environments.

Theme 3: Inequality in Health between Social Groups

Interviews also found that individuals who have more income or education would have supplemented PHC visits with a private consultation, but low-income individuals rely on PHCs only. This causes apparent inequalities in the chronic disease surveillance, maternal health outcomes, and timely diagnosis - the problems that are widely mentioned in the global health equity literature (Buse et al., 2018).

Combined Exposition of Results

When the quantitative results are added to qualitative ones, a definite trend can be observed:

Primary healthcare is at the heart of minimizing health inequities: however, it is constrained by the systemic failures, and its influence is unevenly distributed among socioeconomic groups.

Many of the participants recognized the value of PHCs particularly in vaccination, maternal-child health, and basic disease management. Yet, biases exist because of monetary restrictions and disparity in the quality of services - showing the loopholes that should be filled in to allow Pakistan to progress towards the truly empowered and balanced healthcare framework.

CONCLUSION

This study demonstrates that primary healthcare (PHC) is a vital solution to health disparities and the promotion of better population health in low-resource populations. The findings showed clearly that PHCs are the initial caregivers to most of the people, especially the low and middle classes. This is in line with evidence in the world that PHC is the cornerstone of robust and egalitarian health systems (WHO, 2021; Starfield, 2012). Nevertheless, with extensive use, systemic issues like staffing shortages, extended waiting periods, ineffective necessary medicines, and insufficient diagnostic services continue to undermine the performance of PHC (Sheikh et al., 2010).

It proves that socioeconomic status is an important factor that determines access to healthcare resources and health outcomes in general. People with low-income statuses are faced with stronger barriers, such as transportation problems, inability to afford medication, and inaccessible specialized services. These inequalities support the international evidence that structural inequalities are one of the key determinants of health (Marmot, 2020; Kruk et al., 2018). Qualitative findings also showed the presence of trust concerns, perceived lack of efficiency, and gaps in service that limit the possibility of PHCs providing holistic care.

In general, the evidence confirms that PHCs are in the key position to minimize inequities, but strengthening of healthcare systems is required to make the most of their potential. A sustainable model would entail an increase in PHC infrastructure and also upgrading its quality, accessibility, and community confidence.

RECOMMENDATIONS

Based on the findings that have been achieved during this study, the recommendations that can be made to improve the primary healthcare and reduce the health inequities include the following:

1. Grow PHC Facility Human Resources and Training.

The government ought to be able to provide specific funding towards hiring more medical officers, nurses and community health workers. Service quality would be improved by continuous professional training on chronic disease management, maternal health, and health education (Kruk et al., 2018).

2. Create a Reliable Supply of Vital Medicines and Diagnostics.

Out of stock of drugs and a shortage of diagnostic care are still formidable challenges. Disruptions can be minimized by introducing clear supply chain systems and digital tracking of inventory, as well as purchasing locally (WHO, 2021).

3. Empower Health Equity Policies that attend to the Low-income Populations.

Financial access should be increased by subsidizing the cost of diagnostic tests and transport vouchers, and increasing social protection programs to make these services accessible to low-income groups, and it is appropriate to the global best practice of promoting equity (Marmot, 2020).

4. Scale Communities to Conservative Outreach and Health Literacy Programs.

The community health workers are supposed to spearhead the awareness campaigns about the door to door programs with a greater emphasis on preventive health as well as the management of chronic diseases, immunization as well as maternal child health. The enhanced health literacy has been linked with the enhanced health outcomes (Nutbeam, 2018).

5. Encourage Private and Public Collaborations to Close Service Lapses.

Specialized services, especially in diagnostics and maternal health can be supported by a collaborative model with the help of private clinics, NGOs and teaching hospitals to relieve PHCs (Buse et al., 2018).

In order to minimize health inequities, Pakistan needs to apply a PHC-based approach to strengthen its health systems that involves policy change, human capital and infrastructure investments, digital health integration, and targeted interventions to vulnerable groups. It is with such a multi-layered approach that PHCs can provide the global health-based frameworks with comprehensive, equitable, and high-quality care.

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