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Transforming Primary Health Care in Delhi: A Policy Review of the Mohalla Clinic Model

Ishtiyaque Ahmed

Research Scholar, Faculty of Management Studies, University of Delhi

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ABSTRACT

Initiated by the Delhi government in 2015, Mohalla Clinics aim to deliver essential primary healthcare services within local neighbourhoods, particularly in underserved and remote areas with limited access to public health facilities. This study reviews the impact of Mohalla Clinics on strengthening primary healthcare and advancing universal health coverage (UHC) in Delhi. It highlights the clinics' role in addressing urban healthcare disparities, improving primary care access, and reducing out-of-pocket expenditure (OOPE). Demographic analysis shows that a significant proportion of clinic users are women, the elderly, and low-income individuals with primary-level education. High satisfaction rates are reported for service quality, doctor-patient interactions, and the likelihood of repeat visits. The majority of patients benefit from free consultations, medications, and diagnostic tests, reflecting the clinics' emphasis on affordability and accessibility. The study advocates for integration with existing public health initiatives, such as Urban Primary Health Centers (U-PHCs) under the National Urban Health Mission (NUHM), to further enhance healthcare delivery. Mohalla Clinics are especially beneficial to pregnant and breastfeeding women, positioning them as key players in advancing health reforms and achieving UHC. The findings underscore the need for sustained political support to expand these clinics and strengthen their role in delivering accessible and affordable healthcare to underserved populations in Delhi, significantly contributing to UHC goals in India.

Keywords: *Primary health care, Mohalla clinic, Universal health coverage, Accessibility, Affordable health care, Quality health services.*

INTRODUCTION

Every individual, regardless of race, religion, political affiliation, economic standing, or social status, possesses an inherent entitlement to attain the highest possible standard of health (WHO, 2017). The declaration by the World Health Organization (WHO) at Alma Ata in 1978, endorsed by India, underscores the importance of basic healthcare. Primary healthcare is tasked with addressing prevalent health issues within communities, offering services that encompass promotion, prevention, treatment, and rehabilitation to ensure comprehensive healthcare coverage (WHO, 1978). The provision of essential health services, primarily at the grassroots level, is defined as primary health care, distinct from the closely related term "primary care." While primary care is integral to primary health care, it represents only one aspect of the broader concept, which encompasses a holistic approach to health. The initial draft of the National Health Policy highlighted a significant challenge concerning access to healthcare services in rural areas, remote regions, and urban slums (AAP Guide, 2017). Key policy

tenets outlined in the National Health Policy include principles of equity, affordability, universality, and accountability, with a specific focus on addressing the fundamental healthcare needs of urban population (NHP, 2017). The underperformance of the primary healthcare system leads to a shortfall in meeting the healthcare demands of the populace (B. Banerjee, 2017). India's evolving health landscape has seen a rise in non-communicable diseases (NCDs) surpassing infectious diseases (Chaudhuri & Roy, 2017). These challenges arise from a shortage of qualified healthcare providers, inadequate services, lack of medication and diagnostic facilities, and inadequate referral and coordination practices (Delhi Census, 2011).

Universal Health Coverage and Primary Health Care: The World Health Organization (WHO) regards universal health coverage (UHC) as a fundamental principle in public health, offering comprehensive healthcare services through a holistic approach rooted in primary health care. The commitment of governments to enhancing the well-being of their citizens is enshrined in the WHO constitution and the Health for All initiative, both of which support the concept of universal coverage (World Health Organization, 2012). UHC seeks to ensure unhindered access to healthcare for all, eradicating financial barriers and guaranteeing universal access to high-quality care by removing financial impediments to accessibility. Projections suggest that the adoption of universal health coverage may initially increase healthcare spending in the short to medium term, particularly among lower socioeconomic groups expected to utilize healthcare facilities more frequently (A De Sutter et al., 2007, Lancet, (2002). Thus, universal healthcare is indispensable for sustainable development, poverty alleviation, and addressing social injustice, playing a crucial role in comprehensive societal advancement and equity. Primary health care is recognized as "the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals" (WHO, 2019). It constitutes a vital strategy, targeting health determinants through cost-effective, population-based interventions that prevent illness and enhance well-being. Acknowledged as essential for achieving universal health coverage, primary healthcare empowers communities, promotes social accountability, and integrates services holistically. Prioritizing cost-effectiveness and equity ensure inclusive healthcare for all, particularly those with the most significant health needs (WHO UHC Monitoring Report 2019). WHO and UNICEF outline how the key elements of primary healthcare—primary care, essential public health functions, multi-sectoral policy and action, and empowered individuals and communities—contribute to universal health coverage. This includes promoting financial protection and reducing out-of-pocket expenditure on health, improving service quality, and ensuring equitable access to services, medications, and vaccines. The Indian government is actively advancing universal health coverage by expanding health infrastructure through the enhancement of Primary Healthcare Centers (PHCs), Community Health Centers (CHCs), and district hospitals. Nevertheless, substantial shortfalls persist nationwide, ranging from twenty to forty percent (GOI, 2013).

Indian Health Care System

India, the world's seventh-largest country with a land area of 3,287,263 sq km, has surpassed China to become the most populous country. With a 17.7% decadal growth rate and 31.14% of the people living in urban areas, its population was 1,210.8 million in 2011 (Census of India, 2011). Based on a slower annual growth rate of roughly 1%, the population is projected to reach 1.43 billion by 2024 (World Population Review, 2024). A greater proportion of the population now lives in cities due to urbanization, which has

expanded dramatically and is indicative of continued demographic transitions (United Nations, 2023). WHO underscores the significance of good health and well-being for an improved quality of life. It aids countries in developing healthcare facilities and policies, while advocating for increased health investments by governments (WHO). With over 70% of the population residing in rural areas, the National Rural Health Mission (NRHM) has established a three-tier rural healthcare system, comprising Sub-Centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs). The infrastructure includes 155,404 Sub-Centres, 24,918 Rural PHCs, and 5,183 CHCs. Under the Ayushman Bharat (PMJAY) initiative, there's a transformative agenda to convert Sub-Centres and PHCs into Ayushman Bharat Health and Wellness Centres (AB-HWCs). This initiative aims to deliver comprehensive primary healthcare services to the rural populace, emphasizing the critical role of rural healthcare facilities.

Table 1: Indian Public Health Standards (IPHS) Population Norm for Public Health Facilities

S. No.	Public Health Facilities	Plain Area (Population Norm)	Hilly/Tribal/Difficult Area (Population Norm)
1	Health Sub-Centre (SC)	5000	3000
2	Primary Health Centre (PHC)	30000	20000
3	Community Health Centre (CHC)	120000	80000
4	(First Referral Unit) FRU CHC	500000	NA

(Rural Health Statistics (GOI), 2019-2020)

Table 2: Current Situation of Average Rural Population Covered by Health Facilities in India (July 1, 2020)

S. No.	Public Health Facility	Population Norm (Hilly- Plain Area)	Average Rural Population Covered
1	Sub- Centre (SC)	3000-5000	5729
2	Primary Health Centre (PHC)	20000-30000	35730
3	Community Health Centre (CHC)	80000-120000	171779

(Rural Health Statistics (GOI), 2019-2020)

Delhi Health System

India's capital city, Delhi, is home to about 32 million people as of 2024, of whom 97.5% live primarily in urban areas (World Population Review, 2024). Covering 1,483 km2, it has a population density of between 11,000 and 37,346 persons per km2 (Census of India, 2011). Three to four million people, or around 10-15% of the population, live in slums; most are migrants from different states (Delhi Urban Shelter Improvement Board, 2022). As the world's third-largest urban region and India's most populous metropolitan city, Delhi accommodates 12 distinct organizations offering healthcare services. The healthcare landscape includes 27 specialty clinics, 973 nursing homes, 19 polyclinics, 267 maternity homes and sub-centres, 95 hospitals, and 1389 dispensaries, as of March 31, 2014. Additionally, there are 15 government-run medical colleges practicing the allopathic system. The Delhi government holds ownership stakes ranging from a quarter to a fifth in over 200 polyclinics, more than 200 dispensaries, and nearly 10,000 hospital beds. Annually, Delhi's government-managed health institutions attend to over 3.35 crore outpatients and treat nearly 6 lakh hospitalized patients. Delhi has a higher per capita government health expenditure of INR 3,474 in 2022-2023 than the national average for major states of INR 2,014 (National Health Profile, 2023) due to the substantial presence of private healthcare providers and small clinics in the city despite this. A considerable share of healthcare spending comes from people's out-of-pocket expenditure (OOPE). In urban areas, the private sector provides nearly 55% of hospital treatments, and outpatient

care from private providers is sought by 87% of males and 71% of females, exceeding the national averages.

Healthcare Administration in Delhi

Delhi's healthcare system operates within a complex political and administrative framework, involving the Government of the National Capital Territory of Delhi (GNCTD), the Municipal Corporation of Delhi (MCD), and the Delhi Cantonment Board (DCB) (Delhi Citizens Handbook, 2017). The GNCTD's Department of Health and Family Welfare oversees the city's healthcare, with various departments functioning under the Principal Secretary, who reports to the Minister of Health and Family Welfare (The State of Health of Delhi, 2017). Administratively, Delhi is divided into 11 districts and 12 zones, with Chief District Medical Officers (CDMOs) responsible for district-level health management. The Directorate General of Health Services (DGHS), the largest department under GNCTD's health ministry, plays a crucial role in delivering primary and secondary healthcare through a vast network of dispensaries, health centers, mobile units, and school health clinics (Delhi Citizens Handbook, 2017). The DGHS collaborates with governmental, non-governmental, and private entities to implement national and state health programs and expand infrastructure to meet growing demand. Delhi's healthcare infrastructure is diverse, encompassing super-specialty hospitals, primary health centers, dispensaries, mobile medical units, maternity homes, and specialized clinics. Both government agencies and private organizations, including autonomous institutions like AIIMS, play a role in ensuring comprehensive healthcare coverage across urban and rural areas. These efforts are supported by mobile units and urban welfare centers, providing extensive accessibility and contributing to Delhi's health service delivery (The State of Health of Delhi, 2017).

Mohalla Clinic Health Policy Model

Origin and evolution of Mohalla Clinic initiative in Delhi: The Aam Aadmi Party (AAP) has its roots in a grassroots anti-corruption movement. Many of its members have backgrounds in social activism, and it was a harsh reality for them to witness the absence of government healthcare in the narrow lanes of bustling cities. Numerous individuals are excluded from essential healthcare services due to the lack of facilities within their reach. Inspired by the concept of Swaraj, or decentralized self-governance, and the notion of Mohalla Sabha, or neighbourhood meetings, the idea of Mohalla Clinics emerged. These clinics, which began in 2015 during Arvind Kejriwal's second term as Delhi's Chief Minister, have since expanded to over five hundred locations across the city, marking a significant revolution in the healthcare sector. The concept of Mohalla Clinics draws partially from the traditional approach of Mobile Medical Units (MMUs) or Mobile Vans, which operate in underserved areas across India and other parts of the world. Initially, the Delhi government decided to augment the existing network of MMUs in the state by launching additional units in 2014. Unlike the previous approach, the state government sought funding from the Union Ministry of Health & Family Welfare for the operation of these MMUs, focusing on underserved clusters, unauthorized colonies, and migrant population colonies. While the mobile van-based clinics received a positive response, government authorities recognized inherent challenges. These included the unpredictability of healthcare services due to external factors like vehicle availability, staffing, and road conditions, as well as the lack of long-term sustainability. The administrative hurdles associated with purchasing and maintaining a large fleet of vehicles, along with hiring contract employees, particularly physicians, further underscored the need for a more sustainable solution. After consulting with independent professionals and discussing potential

alternatives, the Minister of Health in Delhi and other top-level officials concluded that a more sustainable approach was required. This approach would involve establishing healthcare services within communities, ensuring accessibility, continuity, and quality of care. Thus, the concept of Mohalla Clinics garnered immediate support and was seen as a viable long-term solution to address the healthcare needs of Delhi's residents.

Concept of Mohalla Clinic:

Targeted Population and Easily Accessible: To provide free healthcare services (financial protection) within a walking distance (about 2-3 km radius), as well as to ensure the availability of basic health services, medications, and diagnostic tests. Low-income people, migrant workers, Jhuggi Jhopri colony; each clinic aims to serve 10,000-15,000 people in nearby areas.

Affordable Primary Healthcare: In order to give the many urban neighbourhoods of NCT an affordable option for primary healthcare, many technological innovations were built into the design of Mohalla clinic. At the clinic, these changes were made to the buildings and systems that help manage the waiting line and the staff.

Freedom from Quacks or Neem Hakims: With no qualified health professionals available within neighbourhood limits for the people patients ended up with quacks which harmed the health instead of relieving the condition.

Financing and Establishment: Each clinic's construction was estimated to have cost around 20 lakh Indian rupees, or $30,000. However, up until December 2016, the majority of clinics were run out of rented houses, but nowadays, a large number of clinics are operated out of porta-cabins.

Location of Clinic: The surroundings and locations where such a deprived population resides, including the Jhuggi-Jhopri colony and declared slum areas, the first such clinic started at Jhuggi-Jhopri colony in North West Delhi. It was located in the middle of the town, around 400 metres from the main road. The local community, Resident Welfare Associations (RWA), a planning branch survey, and a team of health professionals who verify the sites are all considered while selecting the locations.

Physical Infrastructure: The Mohalla Clinics are proposed to have two to three rooms, with one room for medical examinations and the other room for laboratory, pharmaceutical dispensary, and patient waiting area. If available, a third room can be used as a waiting area. The clinics should also have easy access, an all-weather road, an open area, and be ambulance-accessible. The rooms can be prefabricated porta-cabins or privately rented houses and should have facilities like cable TV and AC.

Timing and Working days: The minimum clinic duration is 4 hours, with a daily maximum of 6 hours. Although they are usually open in the morning, the time of the clinic can be changed depending on the requirements of the patients; some of them are also open in the evening. Open on all days of the week, except on public holidays.

Health care services provision: Outpatient consultations, basic first aid, maternal and child health services, antenatal and postnatal (not currently functional) services, family planning, counselling and referral to higher levels of facilities for specialised treatment are all included in an assured package of health services at these clinics. A proposed referral system for healthcare facilities uses a tiered approach.

Medicines and Laboratory services: Sufficient supplies of medicines and diagnostics services, free of cost to the people availing these facilities, from an approved list of 108 medicines and provision of more than 200 diagnostic tests.

Reduced Patient load on Multi-Speciality Hospitals: An estimated 80% to 90% of health problems are expected to be treated at this clinic level, which would ease the patient burden at multi-specialty hospitals in both the public and private sector.

Private sector engagement: To operate these clinics on a "pay for service" basis, private doctors have been hired. Consultation fees are charged at a cost of Rs. 30 per patient. An additional Rs. 10 is paid each patient if a helper is hired. Since private doctors are usually considered with complete distrust and a profit motive by public sector authorities, this is a significant policy change. Lab also used on public private partnership model with WISH foundation NGO.

Leadership and Governance: Initiative led by the Minister of Health and other Senior Government officials; being implemented through specially enacted agency called Delhi Healthcare Corporation, led by Principal Secretary (health), the top health bureaucrat in the state.

Staffing or Manpower: At least one qualified Medical Doctor, ANM (auxiliary nurse midwife), a pharmacist, and support staff as needed by doctor at clinic.

Use of Tablets (Information Technology) and Token Vending Machine: Tablets with software programmes for writing prescriptions and compiling data, tablets with technology for conducting a variety of laboratory tests and Computer based record keeping of each patient visited clinic. For patient queuing, a token vending machine (similar to what one finds in a bank branch) is used.

BOX

Principles of Mohalla Clinic:
Accessibility: *Increase access to quality health services to all.*
Equity of services: *Attention on poor and marginalized sections of the society who are at disadvantage while attending health services.*
Financial protection or Eradicate financial hardship: *Reduces all possible cost to the people and make health services affordable, so people do not get poor because of accessing these services. No direct or indirect payment at the time to access health services.*
Coverage of essential health services: *Moving beyond limited package of services to expand coverage with services for additional diseases and illnesses all assured.*
Quality of health care services: *Ensuring that services meet the expectations of the people and are delivered as per standard guidelines.*
Community participation and Decentralisation: *Active engagement of community members in selection and identification of sites for these clinics, bringing out the necessary ownership.*

Current Status of Mohalla Clinics in Delhi

The Delhi government established Mohalla Clinics in the first year following the Aam Aadmi Party's (AAP) election to office in 2015. The clinics operate under a "Zero Cost Model," providing free consultations, medications, and diagnostic and pathological testing to patients. (Chandrakant, 2016). The Mohalla Clinics aim to provide primary healthcare services that are available, accessible, and affordable to all people, especially those from underdeveloped areas in Delhi, in order to achieve universal health coverage. (Sharma, 2016). The Mohalla Clinics were created to ease the burden on multi-speciality and tertiary care hospitals and reduce out-of-pocket expenses for patients in Delhi. The clinics serve as the base of the urban health care spectrum, with polyclinics providing secondary care and government hospitals providing tertiary care. This reorganization was implemented by the new government, replacing the previous system of dispensaries and polyclinics as the primary level of care (India Today, 2019). The Delhi government allocates 14% of its budget to public health, which is the highest among all states in India. Previous governments allocated only 3% to 8% of their budget to health, resulting in poorly equipped public

hospitals and clinics. The current administration, led by AAP's Arvind Kejriwal, has prioritized public health, resulting in a corruption-free and fiscally responsible administration that invests in staff, expenses, and infrastructure. This has led to the development of a public health model that benefits the public. (mohallaclinic.in). Delhi's healthcare infrastructure is supported by a network of 518 Mohalla Clinics, serving its diverse population across different districts. Here's a detailed breakdown of the number of clinics by district.

Table 3 District Wise Distribution of AAMC

S. No.	Name Of District	No. of Clinics
1	East Delhi	33
2	North East	33
3	South East	51
4	North Delhi	40
5	North West	79
6	West Delhi	56
7	South West	71
8	South Delhi	46
9	Central Delhi	42
10	New Delhi	15
11	Shahdara	52

(mohallaclinic.nic.in 31-03-2022)

From the table we found that North West Delhi has the highest number of clinics, with 79, while New Delhi has the lowest with 15. The distribution indicates that North West Delhi and South West Delhi have the highest concentration of clinics, together making up nearly 29% of the total clinics in Delhi. Conversely, New Delhi and Central Delhi have the lowest percentage of clinics, each contributing less than 3% to the total.

Table- 4 Year wise fund status of AAMC Project (Grant in Aid to DSHM)

Year	Allocated Funds	Received	Expenditure
2018-19	93 Cr	93 Cr	127994662
2019-20	100 Cr	100 Cr	843240370.72
2020-21	150.56 Cr	125.25 Cr	1494728025.21
2021- Till Feb 2022	345 Cr	190.37 Cr	136 Cr

(Govt. of Delhi)

Over the years, the government of Delhi allocated and received varying amounts for healthcare expenditure. In 2018-19, it allocated and received 93 crore rupees, but the expenditure exceeded this amount, reaching 127,994,662 rupees. The following year, the allocation and receipts increased to 100 crore rupees, with total expenditure 843,240,370.72 rupees. By 2020-21, the allocation rose to 150.56 crore rupees, of which 125.25 crore rupees were received, with expenditures escalating to 1,494,728,025.21 rupees. As of February 2022, a substantial allocation of 345 crore rupees was made, but only 190.37 crore rupees were received, with expenditures reaching 136 crore rupees. This data reflects the evolving financial dynamics and priorities in Delhi's healthcare sector.

Table-5 Year wise OPD and Lab Tests of AAMC

Financial Year	OPD (No of Patient)	Lab Test (No of Patient)
2015-16	6616	3588
2016-17	3709139	141108
2017-18	4443351	707872

2018-19	5739547	390664
2019-20	10507129	934111
2020-21	15258440	535666
2021-22 (Up-to Jan 2022)	15230703	870131

(mohallaclinic.nic.in)

Over seven fiscal years, the Aam Aadmi Mohalla Clinics (AAMC) experienced a significant surge in healthcare engagement. Beginning with 6,616 OPD visits and 3,588 lab tests in 2015-16, the utilization of services increased dramatically, reaching 10,507,129 OPD visits and 934,111 lab tests by 2019-20. Despite disruptions caused by the COVID-19 pandemic, OPD attendance peaked at 15,258,440 in 2020-21, with 535,666 lab tests. By January 2022, the trend remained strong, with 15,230,703 OPD visits and 870,131 tests for 2021-22. This year-wise data reflects a marked increase in reliance on AAMC services, highlighting their growing role in providing accessible primary healthcare and emphasizing the need for robust infrastructure to meet the evolving demand.

LITERATURE REVIEW

Patel and Pant (2020) highlight the success of Mohalla Clinics in providing primary curative healthcare services, noting that they have improved access to basic healthcare while saving users valuable time. These clinics have proven to be a significant step towards achieving universal health coverage for Delhi's ordinary and low-income residents. However, for greater effectiveness and sustainability, the authors advocate for a shift in policy formulation and execution from a top-down approach to a more participatory, bottom-up model. They propose that Mohalla Sabhas in local communities should play a central role in this process, facilitating true democratic decentralization and minimizing political conflicts. This inclusive approach would empower communities and enhance the impact of the Mohalla Clinics.

Hazarika N, et al. (2016) Studies highlight a lack of awareness about public healthcare, preventive measures, and government initiatives. While Mohalla clinics offer primary curative healthcare with reduced waiting times compared to private clinics (15-20 minutes), they currently lack comprehensive preventive and public health services. Patients express satisfaction with the availability of doctors, infrastructure, and diagnostic services. However, residents recommend introducing evening clinics, collaborating with NGOs and ASHA workers, and establishing connections with other departments to enhance preventive and public health offerings.

Agarwal, et al. (2020) found that women and the elderly used Mohalla clinics more if they were closer to home and had good awareness. Proximity, waiting time, doctor interaction, performance, and treatment success influenced return visits. Clinics empower older population and address social health concerns. Increase awareness, physician availability, and interaction time to boost usage.

Sah et al., (2019) highlights that Mohalla clinic in India offer accessible and affordable primary healthcare services that reduce the burden on government and private hospitals. Patients, especially women and the elderly, appreciate the convenience, shorter distances, reduced waiting times, and good doctor-patient interactions. The clinics need to expand services such as nutrition and immunization, and provide evening clinics to cater to daily wage earners. Patients are satisfied with the hygiene, care, and prescription quality at the clinics, indicating the success of the supply-side financing strategy.

Sharma & Jyoti (2018) analyse that Mohalla clinic in Delhi was established to achieve universal health coverage by reducing costs for primary health care services. The study found that clinics were easily accessible to patients and reduced their reliance on family members or quacks for medical services. Patients were satisfied with the doctor's

interaction and prescription. The clinics also reduced the burden on government and private hospitals.

Khanna A. & Srivastava (2021) examined that Mohalla Clinics are perceived by patients to be convenient, accessible, and affordable, leading to cost savings for patients. Patients also expressed a need for improved infrastructure and more time for consultations. The clinics have the potential to reduce the burden on secondary and tertiary care hospitals in Delhi, and an awareness campaign is needed to inform the public about the free health services provided. Linking ASHA workers, ANM, and AWW to the clinics could improve community mobilisation and health outcomes towards achieving universal health coverage.

Bhandari A, et al. (2017) found that a significant number of people who attended Mohalla clinics had previously visited dispensaries, government hospitals, or private facilities. Over 80% of patients reported no cost for transportation or other expenses. However, only 16.4% of patients attending government hospitals were aware of the Mohalla clinics, which were launched a year ago. Additionally, 93% of these patients were not aware of government schemes for free healthcare such as Delhi Arogya Nidhi and Delhi Arogya Kosh.

Seem T. & Nandraj (2021) analyses that the Mohalla Clinic model can enhance primary health care without costly infrastructure or specialized personnel, and it may be applied to rural areas with the help of allied health care professionals and e-health. Political commitment and administrative leadership are required for this model to be replicated, and professional health managers with competence in health management and technology would need to conduct transactions and monitor activities based on technology.

Khanijou &Sundararaman, (2017) outlines the methods used for sample collection, laboratory function outsourcing, and private sector involvement in Delhi's Mohalla clinics. The initial establishment of the clinics was based on community and demographic needs, but subsequent clinics were not established this way. Patients were highly satisfied with the services, all of which were provided at no cost, and the registration slip was valid for one year. However, frequent doctor changes at some clinics were noted as a challenge. Almost 28 lakh people attended these clinics between April 2016 and February 2017.

Lahariya C. (2021) found that the Telangana government's Basti Dawakhana is playing a vital role in strengthening the primary healthcare system in urban areas, established through the 74th constitutional amendment, which transferred primary healthcare responsibility to urban local governments (ULB). The study concludes that Basti Dawakhana, along with Mohalla Clinics, can provide a better foundation for strengthening India's urban health system and achieving universal health coverage.

Mishra, (2020) examined healthcare governance and the impact of transformational leadership and street-level bureaucrats on patient satisfaction. The results suggested that transformational leadership is associated with good governance and higher levels of public satisfaction with healthcare.

Chopra M. & Ganjoo (2021) determined that there were several obstacles to the efficient and timely operation of Mohalla clinics, including doctor absenteeism at some clinics, a lack of space and cleanliness, a heavier patient load on doctors, and a scheduling difficulty with clinical hours. To attain universal health coverage in Delhi, these clinics should also offer public health services and preventative care in addition to curative treatment.

Sharma M. & Makkar (2018) examined that Mohalla Clinic initiative has improved the health status of residents by providing high-quality healthcare at lower costs. The study recommends changes to clinic hours, greater infrastructure, including additional washrooms, and the inclusion of ANC and PNC facilities at all clinics. It also suggests

the need for more female doctors due to the majority of patients being female.

Lahariya (2019) emphasized the urgent need for reforms to bolster primary healthcare, aiming for a system that is comprehensive, equitable, and predominantly government-funded. To achieve universal health coverage (UHC) and meet Sustainable Development Goal 3 (SDG), the government should prioritize basic healthcare and consider adopting models like the Mohalla clinic. Swift policy decisions are essential to realize these healthcare goals.

Lahariya C. (2016) suggests that user fees in public hospitals should be abolished in low and middle-income countries, as their main objective to reduce unwanted hospital visits is not effective. The closure of private wards in public hospitals is also recommended to reduce inequality and improve health outcomes. Transformation of the health system through executive management and innovation, involving professionals and policy experts, prioritising public health services, and strong political will and leadership are necessary for improving health outcomes.

Sardesai & Mohanti, (2019) examined that in the last five years, 31% of respondents or someone in their family visited Mohalla Clinics at least once. One-third of people who visited these clinics had visited them five or more times. 91% of Mohalla clinic visitors were satisfied with the services, with 55% fully satisfied. Those who visited a government institution (hospital or Mohalla clinic) rated the overall performance of the government clinics as better than those who did not. The study asked participants to rate the government's performance on health on a scale of 10; the mean score was 7.06, the median was 7, and the mode was 8.

Lahariya C. (2021) reports that the majority of patients at Mohalla Clinics are women, elderly people, and those with low education levels, and they are highly satisfied with the services and doctor-patient interaction. However, there are challenges with medicine supply and incomplete record-keeping. Mohalla Clinics can be expanded to provide full primary health care to disadvantaged populations and are part of the government's agenda to achieve universal health coverage. The article recommends improving data keeping and reporting systems, advertising clinic locations, and extending public health services.

Lahariya C. (2017) discussed the potential of Mohalla clinics to improve healthcare services in metropolitan areas and reduce healthcare disparities. It emphasized the need for better coordination with other healthcare initiatives and highlighted the importance of a holistic approach to healthcare. The article concluded that Mohalla clinics have placed health at the top of Delhi's political and policy agenda and could be a model for other Indian states to achieve universal health coverage.

Bhuvan et al., (2019) examines the successful launch of Mohalla clinics in Delhi, offering cost-effective healthcare services. However, it also underscores the obstacles the government encountered in setting up the intended 1000 clinics to cover the entire city. The Delhi government has grappled with political and bureaucratic disputes with the central government over the establishment and structure of these clinics. Despite the government's initial plan to place clinics in government schools, this was vetoed by the central government, resulting in clinics being established in rented or portable facilities instead. Achieving the desired healthcare outcomes requires enhanced cooperation among national, state, and local governments.

Komal &Rai P. (2017) discusses patient satisfaction with Mohalla clinics in Delhi, which mainly serve low and middle-income families, infants, housewives, and the elderly. Patients have experienced reduced out-of-pocket expenses, but there are challenges such as the lack of weekly specialists, a physiotherapy facility, and dissatisfaction with the sitting arrangement and medication delivery. There is a need for

better coordination with other healthcare institutions and programs like NDHM, U-PHC, Ayushman Bharat, and ASHA workers to improve disease detection and prevention.

Neha et al., (2020) found that Mohalla clinics in Delhi have not been utilized for dealing with the COVID-19 pandemic, unlike primary health centers in Himachal Pradesh and Kerala. The authors propose that the Delhi government should have used the Mohalla clinic infrastructure for testing and awareness to reduce the spread of COVID-19 cases. However, the Delhi government ignored the use of Mohalla clinics during COVID-19, with only 15-20 clinics operating.

Akshay et al., (2021) examined that during the COVID-19 pandemic from April to July 2020, a study was conducted to measure community perception and satisfaction with Mohalla clinics. The availability of doctors and medicine had the greatest impact on patient satisfaction, and the Delhi government should prioritise these factors to increase patient satisfaction.

Lahariya et al., (2016) analyse that policymakers in India need to pay more attention to the urban health system and work together to develop a roadmap for improving health outcomes and achieving universal healthcare in cities. The urban health system requires reforms at both policy formulation and execution levels, and cooperation among diverse stakeholders is crucial for achieving better outcomes.

DISCUSSION AND FINDINGS

The Mohalla Clinic (MC) initiative in Delhi has undeniably made substantial progress in improving access to primary healthcare services for uninsured urban populations. Despite these successes, the program faces several significant challenges that hinder its ability to reach its full potential and maximize its effectiveness. One of the most pressing issues is the limitation of infrastructure and space. Establishing clinics in densely populated urban areas presents logistical difficulties, while the constrained infrastructure often compromises both the quality and range of services available. The clinics primarily focus on curative and diagnostic care, leaving a critical gap in preventive and promotive healthcare services, which are typically provided by urban primary health centers.

Financial sustainability is another critical concern. Budget limitations may impede the program's scalability and restrict efforts to expand services. Additionally, supply chain management issues, particularly with the availability of medicines, threaten the continuity of care, creating inconsistencies in service delivery. Weak integration with secondary and tertiary healthcare facilities for referrals disrupts the envisioned tiered healthcare approach, complicating patient management and care coordination.

Staff shortages and retention challenges exacerbate these problems, straining clinic operations and potentially undermining service quality and efficiency. Sustaining political and administrative support is crucial for the initiative's long-term success, but shifts in leadership or changes in administrative priorities could jeopardize its future growth and continuity. Weak administration, coupled with inadequate maintenance and a lack of technological integration, further emphasize the need for strategic operational planning and investment in healthcare technology infrastructure.

Community awareness and involvement are essential for the sustained success of Mohalla Clinics. Public education campaigns are necessary to ensure that residents are well-informed about the free services available at the clinics. Moreover, the initiative must strive for better integration with the broader healthcare system, including public and private healthcare facilities. This will require greater coordination and collaboration among stakeholders to build a seamless healthcare network. Strong government commitment, active engagement of healthcare professionals, increased community participation, and continuous

evaluation and adaptation of the Mohalla Clinic model are essential. By addressing these issues proactively, the Mohalla Clinic initiative can unlock its full potential, improving healthcare access and delivering better health outcomes for underserved urban populations in Delhi.

Policy Challenges

Even as the MC scheme made primary healthcare services accessible exclusively to the uninsured urban households residing in Delhi, the implementation of the scheme suffered many challenges.

Infrastructure and Space Limitations: Adequate space for setting up clinics in densely populated areas can be a challenge. Limited infrastructure may hinder the establishment of fully equipped clinics, impacting the range and quality of healthcare services provided.

Narrow Scope for Preventive and Promotive Healthcare Services: The Mohalla Clinics in India provide limited curative and diagnostic healthcare services but do not offer preventive and promotive healthcare services, unlike urban primary health centers (PHCs) that cater to pregnant women and infants under national immunization programs. This limits the effectiveness of the Mohalla Clinics in meeting the healthcare needs of uninsured urban households.

Financial Sustainability: Ensuring the financial sustainability of Mohalla Clinics is essential for their long-term success. Budget constraints may affect the scalability of the initiative and its ability to cater to a growing population.

Supply Chain and Medicine Availability: Ensuring a consistent supply of essential medicines and medical supplies poses a logistical challenge. Issues related to procurement, storage, and distribution can impact the continuity of care and availability of necessary resources.

Poor Linkage with Secondary and Tertiary Healthcare Services for Referrals: The Mohalla Clinic model was intended to have a tiered approach to healthcare services, but the system of referrals was not fully operational. The functioning of secondary and tertiary services in the NCT was controlled by multiple departments and agencies, resulting in disagreements between the Center and State governments and a lack of clarity on the governance of MC. These issues led to inadequate patient referral management.

Political and Administrative Support: The continuity and success of Mohalla Clinics depend on consistent political and administrative support. Changes in leadership or administrative priorities may impact the sustained growth and development of the initiative.

Weak Administration and Maintenance: The Mohalla Clinic scheme aimed to set up 300 clinics in Delhi, but a lack of detailed operational planning made it challenging to maintain them. Issues with staff recruitment and management, medicine supply, utility services, upkeep, and land availability for new clinics emerged due to weak operational planning. (Bhuvan et al., 2019).

Technological Integration: Implementing and maintaining electronic health records and other technological systems for efficient patient management and data tracking can be challenging. This requires investment in technology infrastructure and ongoing training for staff.

Community Awareness and Participation:

Generating awareness among the community about the existence and benefits of Mohalla Clinics is crucial. Encouraging regular utilization of these services, especially for preventive and primary care, may face resistance due to existing healthcare practices and beliefs.

Integration with Existing Healthcare System: Achieving seamless integration with the broader healthcare system, including public and private facilities, is critical. Coordination and collaboration are necessary to ensure effective referrals, follow-ups, and a comprehensive continuum of care.

Addressing these challenges requires a multi-stakeholder approach involving the government, healthcare professionals, community engagement, and ongoing evaluation and adaptation of the Mohalla Clinic model.

CONCLUSION

The Mohalla Clinic (MC) model has emerged as a commendable healthcare reform, significantly contributing to the pursuit of universal health coverage in the National Capital Territory (NCT) of Delhi. Garnering recognition from both national and international public health experts, the model has been endorsed for its effectiveness. Such experts advocate for its replication not only in various Indian states but also in countries grappling with health coverage challenges among their low-income populations. Noteworthy medical periodicals have extensively studied and reported on the MC model, underscoring its appropriateness for scaling up public healthcare in regions marked by privatized and inequitable healthcare structures and a sizable uninsured population. However, the sustainability and scalability of the Mohalla Clinic schemes hinge on adeptly addressing implementation challenges. Furthermore, considerations for expanding this community healthcare initiative to other states involve factors such as the socio-economic status of the community, political ownership, budgetary constraints, and the establishment of robust quality control mechanisms. The initiative led by the AAP Arvind Kejriwal government in Delhi has become a beacon for other states, prompting them to adopt a similar model. This trend reflects a growing acknowledgment of the success and potential impact of the Mohalla Clinic model, offering hope for improved healthcare access and outcomes for millions of Indians across the country.

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