

Mohalla Clinics of Delhi, India: Could these become platform to strengthen primary healthcare?

ABSTRACT

The mohalla or community clinics in Delhi, India aims to provide basic health services to underserved population in urban settings. This article reviews and analyzes the strengths & limitations of the concept and explores the role these clinics can play in (1) reforming urban health service delivery, (2) addressing health inequities, and (3) strengthening primary health care. These clinics provide basic healthcare services to people, in underserved areas, in a responsive manner, have brought health higher on the political agenda and the governments of a number of Indian states have shown interest in adoption (of a variant) of this concept. Strengths notwithstanding, the limitations of these clinics are: curative or personal health services focus and relatively less attention on public/population health services. It is proposed that while setting up these clinics, the government should built upon existing health system infrastructure such as dispensaries, addressing the existing challenges. The new initiative need not to be standalone infrastructure, rather should aimed at health system strengthening. These need to have a functional linkage with existing programs, such as Urban Primary Health Centres (U-PHCs) under national urban health mission (NUHM) and could be supplemented with overall efforts for innovations and other related reforms. The author proposes a checklist 'Score-100' or 'S-100', which can be used to assess the readiness and preparedness for such initiative, should other state governments and/or major city in India or other countries, plan to adopt and implement similar concept in their settings. In last 18 months, the key contribution of these clinics has been to bring health to public and political discourse. Author, following the experience in Delhi, envisions that these clinics have set the background to bring cleanliness-health-education-sanitation-social sectors (C-H-E-S-S or CHESS) as an alternative to Bijli-Sadak-Paani (B-S-P) as electoral agenda and political discourse in India. The article concludes that Mohalla Clinics, could prove an important trigger to initiate health reforms and to accelerate progress towards universal health coverage in India.

Keywords: Health equity, health systems strengthening, India, Mohalla Clinics, primary health care, universal health coverage

Introduction

The healthcare system in India has experienced a few successes in the last decade including elimination of poliomyelitis, yaws and maternal and neonatal tetanus.^[1] Alongside, the traditional health challenges continue, i.e., low government expenditure on health, high prevalence of communicable diseases including tuberculosis, measles, emerging and re-emerging diseases; growing burden of non-communicable diseases including diabetes and hypertension; shortage of human resources for health and limited attention on primary healthcare (PHC) among other.^[1] The reality of health services in India is the unpredictable availability of providers, lack of assured services, medicines, and diagnostics, and poorly functioning referral linkage. Not surprisingly, a large proportion of people, even for common illnesses such as fever, cough, and cold, seek care at secondary and tertiary level of government health facilities/institutions. This leads to overcrowding, long waiting hours, poor quality of service delivery, and people being unsatisfied with public health facilities. With this experience, – rather than spending on transport, visiting multiple times without service guarantee, waiting for hours to be seen by a doctor, and then spending money on medicines and diagnostics – people including poorest quintile of population find public health facilities too much of hassle, “vote with their feet” and attend either nonqualified providers or private providers, even at the cost of spending money from their pocket.^[2,3]

Situation appears to have changed slightly in the last 10–15 years and yet there is much to be desired. On provision by the government, the National Health Mission of India has contributed to increased attention on health though not to the extent one would have liked to. Among state level health initiatives on service provision, the mohalla or community clinics of Delhi state, India, has received a lot of national and international attention and interest – mostly favorable – from media and health experts, alike.^[3,4] A number of Indian states, all governed by a different political parties than the one in power in Delhi have shown interest in establishing similar clinics.^[5,6]

This review has been written with objectives to document the concept, design, and evolution of mohalla clinics; to examine & analyze the strengths & limitations and suggest the way forward in a broader vision towards advancing universal health coverage (UHC) in India. It is expected that the learnings could guide the expansion in Delhi state and implementation and design of such facilities, for other settings.

Health Systems in Delhi, India

Delhi is a city-state in India, with a population of 1.68 crore (or 16.8 million) in 2011 with 97.5% of population living in urban area, 1483 km² geographical area, and population density of 11,297 (range 3800–37,346/km²). It has nearly 18 lakh (1.8 million) or 11% population living in slums^[7] and a large proportion of this

population is migrants from various parts of country. Delhi is the most populous urban agglomeration in India and the 3rd largest urban area in the world. The health services in Delhi are provided by 12 different agencies (if three municipal corporations are counted separately then the number would be 14) [Box 1]. The number of health facilities available in Delhi varies depending on sources. As on March 31, 2014, there were 95 hospitals, 1389 dispensaries, 267 maternity homes and subcenters, 19 polyclinics, 973 nursing homes, and 27 special clinics in Delhi.^[8] In addition, 15 government-run medical colleges in allopathic system of medicine.

The Government of Delhi owns nearly one-fourth to one-fifth of all health facilities with nearly 10,000 hospital beds, over 200 dispensaries and polyclinics, among many other. The health facilities run by the Government of Delhi examine around 3.35 crore (33.5 million) outpatients and treat nearly 6 lac (600,000) hospitalized patients, every year. There is high density of private providers and large private hospitals and small clinics in the city-state. Per capita government health expenditure in Delhi state was INR 1,420 in 2012–13 while the average for the major states India in that year was INR 737 per capita. Much of the remaining health expenditure is out of the pockets of the people.^[9] Nearly 55% of hospital care in urban areas (national average: 68%) is from private sector. In addition, 87% of males and 71% of females in Delhi attended private providers for their outpatient (national average 76% and 73%, respectively).^[10]

Mohalla Clinics: The Concept and Design

The mohalla or community clinics initiative was launched by the government of Delhi in July 2015, with one clinic in a slum locality.^[2,11,12] The idea had origin in the success of mobile vans or mobile medical units (MMU). It was then supplemented by desire of the top political leadership to fulfill electoral promise and commitment to strengthen health systems rather than providing *ad hoc* solutions [Box 2]. The key design aspects of these clinics are summarized in Box 3.

Evolution of Mohalla Clinics (July 2015–December 2016)

The first mohalla clinic of Delhi was inaugurated on 19 July 2015 at Peeragarhi area of West Delhi. It took another 9 months to set up additional 100 clinics. By December 2016, a total of 106 clinics were established across all 11 districts and in 55 of total 70 assembly constituencies of the state.^[11] The Government of Delhi had planned to launch 1000 such clinics. However, in spite of high political ownership and huge demand from the community, nearly 10% of the target numbers of these clinics could be established by the target timeline of December 2016.^[14,15] The delay in setting up of planned numbers of clinics has been attributed to factors, including insufficient advance planning (there was no operational plan developed till 1 year in the implementation), difficulty in selection of the sites (the land is not controlled by the state government), delay in approvals of proposals at various levels, and frequent change in technical leadership in health department among other.

Box 1: Agencies providing health services in Delhi, India

State Government of Delhi
 Government of India
 Central Government of Health Services
 Directorate General of Health Services
 Autonomous institutions (i.e., All India Institute of Medical Sciences)
 Employee's State Insurance Corporation
 Ministry of Defense
 Ministry of Railways
 New Delhi Municipal Council
 North Delhi Municipal Corporation
 South Delhi Municipal Corporation
 East Delhi Municipal Corporation
 Private Organizations and providers
 Voluntary organizations and nongovernment organizations

The first clinic was set up in Portacabin structure at government land, however, the plan to acquire land met hurdles and most of the subsequent clinics, nearly 100, were opened in private houses (rented and rent free, both). Another attempt to expedite the process by opening these clinics in government schools met administrative hurdle and could not materialize till 31 Dec 2016, pending approvals from authorities.^[16]

Majority of the clinics had been started in the early 2016 and became popular among the community, soon thereafter. An official release from the Government of Delhi reported that by July 2016, nearly 800,000 people had availed health services & 43,000 pathological tests were conducted in 5 months.^[17] Every clinic on average was catering to 70–100 patients per working day. In September–October 2016, when Delhi witnessed an outbreak of dengue and Chikungunya diseases and the health facilities were flooded with the patient, the mohalla clinics became a key entry point for patients to get examined and laboratory test for dengue done. This was considered a major relief for large health facilities and allayed the crisis in the city.^[18] By the end of the year 2016, around 1.5 million patients were examined at these facilities, most of which were functioning for less than a year till then.^[19]

These facilities became an area of interest for many external experts, opposition parties, and journalists, who visited the clinics, scrutinized the functioning and interacted with beneficiaries. Most of such visitors reported the high demand for services at these clinics and applauded the concept. Leading medical journal, *The Lancet* in editorial in December 2016 made observation that “a network of local mohalla clinics that are successfully serving populations otherwise deprived of health services.”^[20] Many international and Indian newspapers hailed the concept and suggested that these clinics meet core concepts of universal health coverage and increase access to quality healthcare services by poorest of the people and reduce financial burden associated with access to health services.^[22] The unpublished data from the government of Delhi highlighted that 40–50% of all patients who attended these clinics had come to a government health facility for the first time. Many unqualified providers, who has

Box 2: Mohalla Clinics: Origin of idea

The concept of Mohalla Clinics partially originated from traditional approach of Mobile Medical Units (MMU) or Mobile Vans. These MMUs exist across almost all districts of India as well as in other parts of the world. The mobile vans as clinics provides health services in underserved areas, bringing doctors and other staff along with medicines and supplies to people through a suitably modified/adapted Tempo or other types of vehicles. In early 2014, then elected government in Delhi decided to rapidly expanded the network of MMUs in the state with launch of a few additional MMUs. Initially, the key difference from earlier approach was that state governments usually seek funding from Union Ministry of Health & Family Welfare for cost of running such MMUs/Vans and that the selection of areas where services by these would be offered i.e. underserved clusters, unauthorised colonies and cluster of migrant population colonies. The response to these mobile van-based clinics was overwhelming and there was high demand for services, by the communities. However, at this stage, the people who conceptualizing this idea demitted the power. A year later in Feb 2015, when the political party returned to power, the officials started thinking of rapid expansion of MMUs. At that point, the government officials realized that delivery of health services by MMUs is not only unpredictable and influenced by a number of external factors such as availability of vehicles, drivers, doctors, and road conditions but may not be sustainable in long run, as well. In addition, the administrative and procedural complexities in purchasing a large number of vehicles and recruitment of contractual staff including doctors were a considered limiting factors. The officials started looking for a suitable and sustainable alternative and a few experts were consulted. The Minister of Health in Delhi discussed this idea with a few independent experts, who opined that rather than *ad hoc* solution of MMU, there was need for a more sustainable solution, where services are based in the community, people know where to go for services, and there is component of assurance of availability of providers, medicines and service package, with sufficient community linkage and engagement. Much of this was not possible through mobile vans/MMUs, which at best were considered stop-gap solutions. Finally, after a few close room deliberations the concept shaped as Mohalla Clinics, got immediately support from top political leadership in the state.

Box 3: Mohalla Clinics of Delhi, Key concepts

The idea: To provide free healthcare services through a health facility within a walking distance (around 2-3 km radius or 10-15 min walking), open for at least 4-6 h of every working day, assured availability of identified basic health services, a medicines, and diagnostic tests. Estimated 80%- 90% of health problems are likely to be treated at this level reducing the numbers of patients in need for referral

Population targeted: Underserved, migrants, Jhuggi Jhopri colony; each clinic aims to serve approximately 10,000-15,000 population

Staffing: At least one qualified medical doctor, auxiliary nurse midwife, a pharmacist, and support staff as needed

Service provision: An assured package of health services include outpatient consultations, basic first aid services, maternal and child health services including immunization, antenatal and postnatal services, family planning, counseling, and referral to next level of facilities for specialized treatment. These clinics aim to implement national health programs as well

Specialist and referral services and continuum of care: Specialists proposed to be available on weekly basic (pediatrician, gynecologist, and ophthalmologist). A system of referral through a tiered approach to health facilities been proposed (though yet to be made fully functional)

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

Location: Settings and localities of migrant and poor population lives and demarcated areas called slums and Jhuggi Jhopri colony, where such underserved population lives. First such clinic was established in North-West Delhi in Jhuggi Jhopri colony and it was situated around 400 m walking distance from the main road, in the center of Jhuggi Jhopri settlement. The locations are decided with inputs from local community/Resident Welfare Associations (RWA)/survey by planning branch/verification of sites by team of health personnel

Physical infrastructure and accessibility: Proposed to be housed in two to three rooms. The rooms could be either made of prefabricated material (called portacabin) or in private houses with similar amenities. Of the rooms, one to be assigned to a doctor and for medical examination, sufficient enough to maintain privacy. The other or second room is used for laboratory functions, dispensing medicines, and the waiting seat for next patient to be seen by doctor. If there is a third room available, it could be used as waiting room; else the open space covered through a roof should be used as waiting area. The provision of drinking water dispenser and a washroom attached to these facilities. There has to be provision of air-conditioning and a television with cable connection is part of the design. These clinics to be located in a way to ensure easy accessibility by beneficiaries, with an all-weather road, accessible by an ambulance, and an open area

Financing: The construction cost of each clinic was estimated nearly 20 lakh Indian rupee (or US \$30,000). (However, till December 2016, majority of clinics were being operated in rented accommodations.) Reportedly, no analysis was done on estimating the operational cost of these clinics

Use of information technology: A token vending machine (similar to what one experience in a bank branch) for patient queuing; computer-based record maintenance for each of the patient; and use of tablets/software programs for prescription writing/data compilation and technology-based tablets are used for conducting a number of laboratory tests

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^[12,13]

Private sector engagement: The private doctors have been recruited to run these clinics at "fee for service" basis at the rate of Rs. 30 per patient as consultation charges. If a helper is positioned, an additional Rs. 10 per patient is paid. The fully ready chamber is made available to these doctors who are empanelled to manage them in 4-6 h shifts as an outpatient clinic. This is small but major policy step as most of the time, by public sector officials private doctors are seen with complete distrust and with profit motive. That notion could only be dispelled with sustained engagement between two sectors through top level political leadership

Timing and working days: Minimum clinic time of 4 h which can go up to 6 h. These are expected to be open in morning; however, time of clinic can be adjusted to patient needs and a few run in evening as well. Open six days a week excluding public holidays

Other features: A proposed strong and effective referral linkage with attention on continuity of care; financial protection (by free services); reduced cost of care by higher attention and investment on healthcare, ambulance and transport services

clinics in the settings where Mohalla Clinics have been set up, acknowledge the reduced patient load.

There is widespread acknowledgment that these clinics have improved access to health services by qualified providers, to the poorest of the poor, though this needs to be studied and documented in more systematic manner.

There has been a number of revisions/improvements/mid-course corrections in the design, all aiming to make these clinics people friendly [Table 1]. The government, alongside the mohalla clinics, made a series of policy interventions during this period to reform healthcare service delivery, which received less attention than the clinics [Box 4]. Some of these decisions, i.e., engagement of private sector, restructuring health service delivery in three to four tiers and abolition of any type of user fee at government facilities, were very much linked to effective utilization and increasing access to health services, making the services affordable and reducing out of pocket expenditure by people.

Analysis and Discussion

The concept has a number of widely acknowledged strength to become successful health intervention and a few limitations as well [Table 2]. Therefore, it is not a surprise that a number of Indian states, i.e., Maharashtra, Gujarat, Karnataka, Madhya Pradesh, and a few municipal corporations (i.e., Pune) have shown interest to start a variant of these clinics.^[5,6,22-24] There are at least two “proofs of concept” of success of these clinics. On demand side: people have “voted by their feet” and there is high demand for services at these clinics. Second proof is

political interest, (which is very important from political economy perspective) and inclination of a number of Indian states to start health facilities on similar design. The politicians and political leaders have a knack to feel pulse of people and this is one such initiative which is widely popular amongst masses. These clinics, analyzed from health systems perspective, performs well on accessibility, equity, quality, responsiveness, and financial protection, among other [Box 5].

On budgetary allocation, these clinics had been allocated INR 200 crore (approximately US\$ 30 million) for settings up 1000 such clinics (at INR 20 lakh [or US\$ 30,000] per clinic). which was approx 4% of total health budget of the Government of Delhi (Total health budget INR 5,259 crores (or US\$ 784 million) in the year 2016–17.^[25] However, there is need for detailed estimates on both capital and recurrent cost for making these clinics functional and get resources approved to ensure financial sustainability. While capital cost has been estimated, the recurrent cost of human resources, cost of diagnostics and medicines, and operational costs are not being discussed, which would be additional outlay of nearly 300 crore or US\$ 45 million per annum (author’s estimate).

For efficient functioning and success of initiative, it is important that user experience is good, across the continuum of care. One of the promised reforms in Delhi has been developing a four tier healthcare system (first mohalla clinics; second polyclinics; third multispecialty hospital; fourth super specialty hospitals and medical colleges.) with referral linkages, which is respected at every level. Alongside the mohalla clinics, the next level is polyclinics (150 of such clinics had been proposed by December 2016 and 23 have already been established). Hence, a well

Table 1: Evolution of Mohalla Clinics: (July 2015 to Dec 2016)

Started as	Change in provision over period of time
Housed in prefabricated porta cabins Initially planned as two rooms set up with open space for seating of the patients	Considering the local conditions (i.e., high temperature in summers and security issues), waiting areas to be closed and third room may be added and if possible air-conditioned Provision of washroom in the waiting area. In rented or rent-free places
All clinics with government doctors Select basic services with specialists such as gynecologists and ophthalmologists to visit once in a week Timing of 4 h in morning	Engagement of private doctors on fee for service basis as well Preventive and curative services as well. Became a designated facility /fever clinics for dengue during the outbreak Minimum 4-6 h, with flexible timing and evening shift as and when feasible

Table 2: Comparison of mohalla clinics with existing health facilities

Existing health facilities	Mohalla Clinics
Health posts: Very few facilities, dependent on funding availability, Limited package of assured services, poorly staffed, and poorly utilized by the community members, situated not necessarily in poor and underserved areas	Assured availability of a range of services and providers, state government’s dedicated funding, and wide network among other. Situating in slums and underserved areas,
Specialty facilities, i.e., mother and child welfare centers. Focused on specific target populations, far and few for cities such as Delhi	A range of personal healthcare services where any member of family can seek basic health services
Mobile Medical Units (MMUs) or Mobile Vans Would go to a specific area and provide services; mostly for underserved communities but services are unpredictable. Limited in numbers for states such as Delhi	Fixed site physical facility, so people know where to go for availing a health service
Dispensaries and polyclinics: These are often housed in multiple rooms and either overcrowded or underutilized or a few which are used by patients have limited (un)assured availability of services and provider	These clinics would be in 2-3 rooms and assured services. Efficiency in service delivery

Box 4: Key policy interventions in health sector, Delhi, India (2015-16)

Setting up of Delhi Healthcare corporations
 Free medicines and diagnostics scheme
 Abolition of private beds in public hospitals
 Redesigning of three tier to a four tier system of service delivery and referral system
 Launch of Mohalla Clinics and polyclinics
 Removal of user fee at government health facilities
 Ban on gutkha and tobacco products in any form
 Centralized Accident Trauma Service ambulances
 Free trauma care services
 Doctors on call, for government health facilities, from private sector
 No administrative posts for doctors, allowing them enough time for clinical services
 Technical or subject experts as head of identified departments

Box 5: Mohalla clinics: key principle

Accessibility: Increase access to quality health services to all
Equity: Attention on poor and marginalized sections of the society who are at disadvantage while attending health services
Quality of services: Ensuring that services meet the expectations of the people and are delivered as per standard guidelines
Assured package of essential health services: Moving beyond limited package of services to expand coverage with services for additional diseases and illnesses all assured
Financial protection: 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
Community participation: Active engagement of community members in selection and identification of sites for these clinics, bringing out the necessary ownership

respected (at all levels) and functioning referral linkage should be given equal if not more attention. Bringing people to public health facilities is important but not enough, and providing them quality and assured care through the “continuum of care” is a must to retain them.

The health services in Delhi state are provided through nearly 25 different types of health facilities [Box 6]. At times, it is difficult to differentiate one from other, even program managers lack clarity on provision of services and many of these facilities which are more or less similar.^[26] In this background, as an outsider with limited information, some people may think mohalla clinics just another such health facility. However, well thought through design aspects makes mohalla clinics standing out, while compared with existing health facilities [Table 3]. Nonetheless, considering that the multiple health facilities make access to health services complicated, tedious, and difficult for common people, the harmonization/integration of function and the convergence/coordination of multiple types of health facilities run by different agencies is an area to be addressed, proactively. The focus of majority of the existing health facilities is curative or clinical or largely personal health services with limited attention and capacity to deliver public or population health services.

From other perspective, Mohalla clinics are often referred as a synonym for delivery of primary health care (PHC), which is not fully true, at least in the current design form. PHC is a comprehensive concept which offers a balanced mix of preventive-promotive-curative- diagnostic-rehabilitative or in other words – clinical and public health services. To make the point further, the public health works before the occurrence of diseases while clinical services aim to treat patients once they have acquired an illness. The public health needs vary with geography and a few areas need better sanitation, while other needs greater awareness about nutrition, or information on healthy lifestyle. The key issue is that in the current design of Mohalla Clinics, is limited attention on population or public health services at these facilities. These clinics do not sufficiently cover the services such as sanitation, drinking water, importance of hygiene, and awareness about nutrition. In short, Mohalla Clinics, at least in current form, focuses on clinical/curative services and can not be considered to deliver comprehensive PHC.

In this context, the urban PHCs (U-PHCs) under National Urban Health Mission (NUHM)^[27] could be complementary to these clinics, where mohalla clinics may focus on clinical/curative and diagnostic services while U-PHC in addition to curative services deliver public health services with clearly established referral linkage. The convergence between U-PHC and Polyclinics should also be considered. The U-PHCs and/or polyclinics along with three- four lower levels of facilities including mohalla clinics could be an effective hub to deliver comprehensive PHC to approximately 50,000–70,000 population. In any case, country such as India, where health is state subject and union government only guide the policy process, a sustainable solution for healthcare is “convergence” by design between state-owned initiatives and union MoHFW programs. One schematic of how mohalla clinics and U-PHCs and/or polyclinics converge to strengthen PHC systems is given in Figure 1. A related aspect of this convergence could be community participation. Mohalla clinics have higher community acceptance for the reason of being in community settings and offer clinical services, a preferred and felt need of community members. Similar response to public health services may not be given by the community members and that is where the proposed Mahila Aarogya Samiti (MAS) under NUHM can add value.^[27]

The health sector similar to other social sectors is considered inefficient and a well-functioning PHC system is expected to bring efficiency in service delivery by reducing the cost of care. Through PHC, 80–90% of illnesses can be treated and saving scarce specialist services available at higher level of government health facilities (i.e. District hospitals) for patients in need. Bringing efficiency in health sector requires coordinated actions at clinical and public health services.

In Delhi, there has been a number of innovations to improve health service delivery, i.e., doctors on contract for “fee for service” basis, rented premises for Mohalla Clinics, and flexible and variable timing of clinics, among other. Besides, a number

of other initiatives are in pipeline, i.e., optimal use of interns and postgraduate students from medical colleges for staffing of select facilities. There is need for optimally exploring the

use of information technology in these clinics and other health services and a linked innovation is medicine vending machines [Box 7].^[28,29]

Box 6: Types of health facilities functioning in Delhi

1. Apex or super specialty hospitals
2. Specialty hospitals
3. Tertiary care including Medical College Hospitals
4. Referral hospitals
5. District hospitals
6. Subdistrict hospitals
7. Primary health centers
8. Dispensaries
9. Maternity homes
10. Polyclinics
11. Nursing home
12. Special clinics
13. Chest clinics
14. Venereal diseases or sexually transmitted diseases clinics
15. Mobile mother and child welfare units
16. Mother and Child Welfare (MCW) center
17. India population project clinics
18. Postpartum units
19. Urban welfare centers
20. Urban health post
21. Urban primary healthcare Centres (U-PHC)
22. Mobile medical Unit (MMU) and/or Mobile Vans
23. Maternity centers
24. School health units/clinics
25. Mobile dispensary

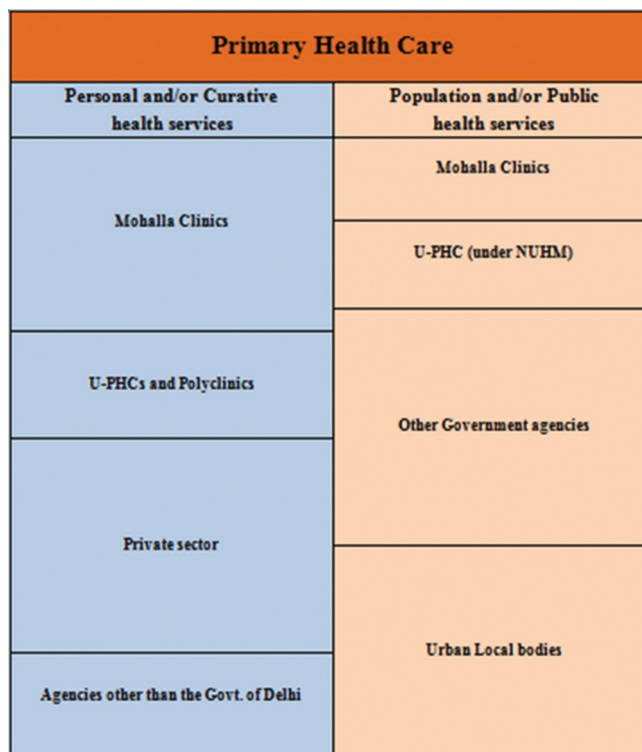


Figure 1: A conceptual model for coordinated delivery of primary health care services in urban areas

Table 3: Mohalla clinics: Strengths and limitations of the concept and design

Strength	Limitations
<p>High political ownership: The state government seems committed to provide assured quality health services to the people. These clinics have been announced as flagship scheme alongside education sector, possibly a first for an elected government by Indian states, to prioritize health in such a way</p> <p>Budgetary allocation: The prioritization of health and Mohalla Clinics was supplemented by increased budgetary budgetary allocation to health sector</p> <p>Fiscal strength of the state and planning and financial allocation linkage: Delhi has advantage of higher budgetary capacity. This initiative is apparently has appropriate planning to intention linkage. The state has financial ability to rope in additional doctors (one each) for these clinics, which might not be possible for other settings even if the states have the desire to recruit and allocate funds (due to shortage of doctors)</p> <p>Equity in service delivery: Clinics targets underserved population and in areas with limited access to health services</p> <p>Large network secondary and tertiary care facilities: To absorb referral from lower tier of health facilities However, referral under these clinics has been proposed and yet to be made fully functional</p> <p>Availability of trained human resources: Delhi has higher number of doctors and other staff per 1000 population and the challenges in recruitment of workforce would be financial and administrative and not the availability</p> <p>Larger target community: The poor and migrant community being key constituency in need for health services</p> <p>Responsiveness of health system: Token vending machine; medicine vending machine</p>	<p>Limited focus on public health service: These clinics, at least till now, have focus on personal or curative, diagnostic, and a few preventive health services</p> <p>Limited linkage with community and outreach services: The preventive and promotive health interventions based at community should be part of the services being delivered</p> <p>Limited linkage with existing mechanisms for service delivery: There are multiple agencies delivering basic health services in the Delhi state and unless there is improved coordination among these agencies, the effectiveness of mohalla clinics is going to be a challenge</p>

Table 4: Mohalla Clinics: Analyzing from perspective of universal health coverage and health systems approach

Increasing population coverage	Increasing availability of quality health services	Financial protection and efficiency
<p>Increased geographical access: Reduces travel and waiting time (opportunity cost) Convenient clinic timings. Encourage people to attend facilities at the early stage of illness</p> <p>Increased access by unreachable and marginalized populations: Located in underserved areas such as Jhuggi Jhopari (JJ) clusters, resettlement colonies, and migrant basti's</p> <p>Appropriate technology to meet local health needs: Token vending machines system for patient queuing (fairness) and electronic data maintenance for patient health records</p>	<p>Providing assured package of quality healthcare by qualified practitioners: Give choice to the people to select a provider; potential to eliminate unqualified practitioners</p> <p>Bring underserved population to mainstream health system: Potential to alter health-seeking behavior</p> <p>Meeting the nonmedical needs of the people (responsiveness): The provision of drinking water and token vending machine and patient waiting area reflects detailed design consideration</p>	<p>Reduced cost of the care through provision of assured free medicines and provision of diagnostics: The cost of medicines and diagnostics contribute to nearly 70% of healthcare cost by the people</p> <p>Making services affordable for poor: Easy access reduces cost of transportation, waiting time (opportunity cost of missing work)</p> <p>Cost-effective interventions: The cost of services would be low. By establishing an effective referral linkage in which nearly 80 - 90% of health problems can be addressed at community level, it has potential to de-congest higher levels of health facilities</p>

Box 7: Medicine vending machine (MVM): Use of technology to facilitate access

An automated medicine vending machine (MVM) at Todapur Mohalla Clinic in Rajendra Place, Delhi was set up on August 22, 2016. The MVM can stock up to fifty different types of medicines, both tablets and syrups and uses sensor technology to dispense medicines based on a doctor's prescription. With MVM, a patient can collect the prescribed medicines directly, which prevent human interventions and reduces risk of medicines not being dispensed while still in stock. The machine dispenses medicines only when a doctor prescribes on a connected tablet and cut the need for a full time pharmacist. Till December 2016, there was only one such machine with a plan for nine additional in coming months

There are design elements in these clinics which are desired in any health system, i.e., potential to eliminate unqualified providers; decongestion of higher level health facilities, making specialists available for those who need them, and thus bringing efficiency in health service delivery. These are challenge for health systems in most of Indian states, so the concept is applicable across the spectrum and not to state of Delhi only. These clinics are fixed site facilities which patients visit to seek healthcare. However, in months ahead, the provision/mechanisms have to be established, to offer preventive and promotive health services to community members for emerging non communicable diseases and associated risk factors (i.e., diabetes, hypertension, various types of cancers and ophthalmic issues to start with), counsel them, and bringing to health facility for medical attention. An unsuccessful attempt to set up clinics in schools should not be a deterrent and government should continue to explore the way through these clinics to strengthen school health services. With nearly 40 lakh students^[26] in schools across Delhi an effective linkage of mohalla clinics with schools could become a game changer for better health of younger generation.

The global experience shows that standalone reforms are not enough and it is always better to have a series of linked reforms. The policy decisions and proposed reforms initiated by the government [Box 4] need to be accelerated to get a holistic advancement in healthcare. Mohalla clinics could prove an important tool to advance universal health coverage (UHC) & health systems strengthening in India [Table 4].

These clinics have placed healthcare higher in political discourse, which is already a partial success; however, this is

Box 8: Suggestions to strengthen mohalla clinics and primary health care in Delhi, India

- **Develop a detailed road map and operational plan:** Addressing key aspects including technical, financial, and administrative. Government may consider making this available in public domain with monitorable indicators and timelines
- **Establish mechanisms for performance monitoring and evaluation:** Use data from these facilities for real-time analysis
- **Do not duplicate even if that is politically attractive:** Use the existing dispensaries either as mohalla clinics or polyclinics. The functioning of these dispensaries should be studied and then assigned an appropriate place in the system of health service delivery in Delhi
- **Develop convergence with existing and proposed health facilities:** Where mohalla clinics focus on clinical services and other facilities such as urban primary health centers (U-PHC) of National Urban Health Mission deliver complementary public health services
- **Ensure political ownership and financial sustainability:** Political ownership is required for bold decisions and address the implementation issues in real time
- **Engage with key stakeholders:** Including political parties, community leaders, and councilors and other stakeholders. Develop consensus or at least attempt to build consensus

still far from what was the case with Bijli-Sadak-Pani (BSP) (or electricity-road-water) nearly 15 years ago. It is possible that with more of similar initiatives on health (and education) by increasing number of states in India, Swachhata-Swashthya-Shiksha– Safaai-Saamaajic kshetra (cleanliness-health-education-sanitation-social sector or CHESS, in short) becomes the next electoral agenda, replacing B-S-P. This could be the CHESS, Indian people would not mind if politicians start to play more frequently.

Table 5: Score-100 or S-100 checklist to assess preparedness and readiness for introducing or scaling up an intervention (i.e., the concept similar to mohalla clinics)*

S.No.	Criteria	Score (0-10)
1	High level of political leadership and ownership for the process/idea. The Chief Minister and/or Health Minister of the state own the idea. In case of urban local bodies, Mayor or other senior elected representative. The concept is used in their public discourse, part of stated or agreed plan	
2	State and district level multi-stakeholder coordination committees and/or other institutional mechanism established and made functional Engagement mechanisms for all key stakeholders: In urban areas, there are many stakeholders including local self-governments and all of them have to be on board. Consider setting up such committees and people's representative could be involved Consider establishing institutional mechanisms approved through legislative assembly and/or parliament that this process is not disrupted once a new government comes to power	
3	Independent subject experts engaged in the process There are enough experts available at most settings. These could be from medical colleges, academic bodies, or subject experience. Experts are likely to join the process, if they perceive this as a serious effort by governments	
4	A detailed operational plan approved by top level policy makers available. There has to be clarity on the objectives, intended target population, services to be offered and timeliness etc.	
5	A detailed vision document for medium (3–5 years) to long-term (10–15 years) available for health sector with linkage to broader health policy Establish institutional mechanisms approved through legislative assembly and/or parliament that this process is not disrupted once a new government comes to power. This document could be approved by Cabinet and may have focus on health in all policies and social determinants for health	
6	Finances required have been estimated and approved by the concerned departments and ministries For example, through a budgetary announcement, sustainable for medium to long term. This would require detailed operational plan with costing, for both capital and recurrent cost. Ministry of Finance has been engaged as per need.	
7	Package of health services offered at a level of facility, agreed, defined, and understood. With combination of curative, diagnostic, and public health services, with flexibility and mechanisms for adding on services during the course. Although initial package could be limited, there has to be a written plan for adding on services in due course	
8	Flexibility for innovative approaches to address system challenges; reflected in the process. This has to be disruptively innovative. These new initiatives have to be built in a system with existing challenges including those related to human resources, etc., consider all possible innovative solutions which have not been explored for other interventions would continue to strengthen health systems	
9	A monitoring and evaluation system designed and being implemented Use information and technology for collecting data, use data for information and corrective actions. Take criticism constructively, be accommodative and flexible and ready for initial criticism. Do mid-course corrections if need be	
10	Accompanying complementary health-sector reforms have been initiated and/or are being implemented One-off intervention, no matter how popular and effective will make limited difference in overall health scenario. A popular reform should be used as platform for wider reform to health sector. Explore how existing fragmented interventions can be converged in medium (3–5 years) to long-term (10–15 years)	
	Total (of 100)	

*Each criterion could be scored on 10-point scale, for 0 being no preparedness at all, and 10 for maximum possible readiness. Use of this scale over period of time can be used in identifying areas for action and monitor progress as well for a new initiative or assessing progress of an ongoing one. This S-100 could be applicable for Delhi state as well as for any other settings (Indian state or any part of part) to oversee implementation of new health interventions

How Mohalla Clinics could be Strengthened?

The clinics delivering assured health services to 70 odd patients per facility every day, six days a week, free for beneficiaries and at nominal cost to government requires limited additional proof of success. However, the real success of these clinics would be in delivering health outcomes with long-term sustainability. To further strengthen the implementation and ensure that these clinics remain on agenda, adopted by additional states and sustained in Delhi even when the government change, and meet the needs of people, a few points could be considered by top policy makers [Box 8].

The roll-out of such initiatives is a process, which needs to be guided, monitored with on course corrections. This is possible when the policy makers and program managers have a comprehensive approach to implement and monitor such

initiatives. To facilitate this, the author proposes a checklist "Score100" or 'S-100', which can be used by policy makers and program managers to assess the readiness and preparedness and then monitor the progress for effective implementation [Table 5]. The checklist could be used at multiple levels of planning (ward/block, district and state).

Finally, most of the evidence from these clinics are unsystematic and experiential. For one, experience and learnings from these clinics needs to be documented in detail, supported by data collected through mechanisms part of these clinics. Second, once there is sufficient expansion of these clinics and enough time given for system to establish, it would be useful to conduct detailed, rigorous and independent evaluation of these clinics and other reforms, to derive lessons and to take corrective actions.

Conclusion

The mohalla clinics have brought health higher on the political discourse and agenda in Delhi states and there is high level of interest by Indian states. These clinics are delivering personal (curative and diagnostic) health services; however, strengthening of PHC would require a holistic approach and more attention on population and/or public health services through targeted initiatives. While some people would like to consider the mohalla clinics as another type of health facility, the concept has potential to initiate reform in health sector in India. It is proposed that in addition to establishing new facilities, a lot can be built upon existing health system infrastructure such as dispensaries, and convergence of functioning of these clinics with other existing/planned mechanisms such as U-PHC under NUHM. In addition, such initiative has to be supplemented with health system innovations and reforms. The Mohalla Clinics are a good start; however, the bigger success of this concept would be when it (1) brings attention on need for stronger primary health care across the country (2) health services acquire the ability to influence electoral outcomes and (3) catalyze efforts to strengthen health systems, amongst other. These steps would be essential as India aims to advance towards universal health coverage. Mohalla Clinics may prove one such small but important trigger in this remarkable journey.

Disclaimer

The opinions expressed in this article are solely of the author and should not be attributed to any institution/organization, he has been affiliated in the past or at present.

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