Delhi’s Mohalla Clinics
Maximising Potential

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The mohalla or community clinics run by the Delhi government could be termed populist but have the potential to meet the needs of the people, make basic healthcare accessible and decongest higher level health facilities. These could also prove to be a landmark in health service delivery in India.

One of the challenges in health services delivery in India pertains to poor performance by peripheral health facilities or the primary health-care system. Unpredictable availability of providers, lack of services, medicines and diagnostics and poorly functioning referral linkages are the key challenges. A large proportion of patients, even those with common illnesses seek treatment at the secondary and tertiary care facilities/institutions. This leads to overcrowding, long waiting hours, poor quality of service delivery and patient dissatisfaction. Many of these patients thus end up accessing either non-qualified providers or private providers, even at out-of-pocket (OOP) expenditure.

The bigger health facilities are always attractive to patients and politicians alike. The former want to go to them for even common illnesses and the latter wish to set up big institutions such as the All India Institute of Medical Sciences (AIIMS), without realising that unless the primary healthcare system is totally functional, AIIMS-like institutions would have neither the time nor the resources to treat cases requiring specialist care if they tend to every common illness.

It has been recognised since the late 1970s that a functioning primary healthcare system, which is accessible within a reasonable geographical distance, is likely to take care of the majority of the health needs of the people. This was acknowledged at the global level by the Alma-Ata declaration in 1978 and accepted in India’s National Health Policy, 1983 and 2002 as well.

Mohalla Clinics in Delhi

The Delhi government has decided to set up mohalla (community) clinics with each clinic being staffed by a doctor, a nurse, a pharmacist and a laboratory technician. These units will provide a package of services which include outpatient consultations, free medicines and diagnostics, immunisation, family planning, referral and counselling services. At a later stage, there are plans to have specialists such as gynaecologists and ophthalmologists on a weekly basis. The decision was announced in the state budget for the financial year 2015-16 and with the intention to set up 500 such clinics in the first year. The first such mohalla clinic was inaugurated on 19 July 2015 in Peeragarhi area of North-west Delhi. The government has promised to set up 500 to 1,000 clinics (or 14 clinics per assembly constituency).

The Peeragarhi mohalla clinic is situated in a jhuggi jhopri (slum) cluster. The two-room clinic, made of prefabricated material (porta-cabin), has been constructed in an area of approximately 50 square yards. It has access for an ambulance to approach and open space around the clinic with green surroundings. The clinic has a doctors’ room, a pharmacy, laboratory testing kits and there is also a provision for a token vending machine. There is a television set with cable connection, a drinking water dispenser, and a fully air-conditioned waiting area with chairs. The clinic reportedly cost the government Rs 20 lakh.

Will It Work?

The mohalla clinic concept could be easily dismissed as a mere political initiative by a new government and it could be argued that existing facilities should be strengthened before going in for a move such as this—at best a fragmented approach. However, these arguments are not backed by a thorough examination of the concept. This article proposes to do just that.

The concept of the mohalla clinic has a number of potential ingredients needed for successful strengthening of health service delivery. A few of these strengths include:

Increasing Geographical Access to the Health Service: The major challenge in India in accessing health services is long travel followed by waiting time at the health facilities (both of which have opportunity costs). These clinics would definitely increase the geographical access to health services and reduce time and...
cost involved in the transport and waiting period. The access to health services in a local setting would encourage people to access the facilities at an early stage of the illness, which would indirectly result in reducing the cost of the treatment.

Making Health Services Accessible: The idea of setting up these clinics in underserved localities such as the jhuggi jhopri clusters, resettlement colonies and where most of the migrant population lives has far-reaching potential. A majority of this population, being new to the city, feels uneasy going to the bigger health facilities until the illness turns serious. They also tend to go to unqualified providers. These clinics have the potential to alter health-seeking behaviour.

Reducing the Cost of Care: The cost of medicines and diagnostics amounts to nearly 70% of healthcare expenditure. The provision of free medicines for common illnesses and that of 50 diagnostics with linkages to the centralised government laboratories would make accessing public health facilities attractive and services affordable for the poor. In addition, easy access would reduce cost of transportation, and waiting time (opportunity cost of missing work).

Counselling and Referral Services: The emerging burden of non-communicable diseases in all subsets of the population, including the poor, needs a lot of preventive and promotive services. Hypertensive and diabetic patients, for example, in addition to free medicines need counselling as well. The counselling would be adhered to more when access to clinical services is coupled with it. An effective referral from these clinics, which is accepted at the higher level of facilities, would be a big attraction for people to attend these facilities.

Appropriate Technology to Meet Local Health Needs: The use of the token vending machines’ system for patient queues and electronic data record for health records are examples of low-cost technology that serve people.

Meeting the Non-medical Needs of the People: The provision of drinking water, token vending machines and TV sets with cable connection reflect the detailed considerations in designing these clinics. The automated token generation system may be initially difficult to use but it would ensure that no one receives preferential treatment.

Highly Cost-effective Intervention: The one-time cost of these 1,000 clinics (approximately Rs 200 crore) would be less than what is needed for setting up a secondary hospital. Approximately, 2,500 mohalla clinics could be opened in the amount required to set up an AIIMS-like institution.

Likeliest Success in Delhi: Some of these attempts have been made in different settings; however, Delhi perhaps has a number of unique reasons why these mohalla clinics would succeed.

The Aam Aadmi Party’s key electoral promises related to provision of water and electricity and also improvement in the education and health delivery sectors. These intentions are reflected in the budgetary allocation where the education budget has been increased by 100% and health by 50%. At least, in intention the government appears determined to attend to its core constituency of the poor and marginalised.

Unlike other states which may find it difficult to garner financial resources, Delhi has the advantage of higher budgetary capacity to allocate additional resources for this allocation. Most of the time in India, the policy intentions are not always well supported by financial allocation. However, in this initiative there is apparently a higher planning to intention linkage as reflected in the fact that the state government has increased budgetary allocation to health by nearly 50% in the budget for 2015–16. There is line item allocation of nearly Rs 125 crore for mohalla clinics.

The state has a robust network of well-functioning secondary and tertiary care health facilities to absorb any amount of referral (such clinics would reduce the patient load at these facilities), which if properly respected would mean that people will increasingly use these clinics.

The challenge in setting up such clinics is finding additional human resources (doctors, nurses, pharmacists and lab technicians, etc), needed to run these facilities. However, Delhi has more number of per capita doctors, nurses and other category of staff than other states and it should not be a challenge to recruit the additional manpower.

The underserved settings with high population density and migrant populations, which are apprehensive about attending other facilities, make such clinics viable and potentially popular. Much of this population would go, otherwise, to nearby unqualified providers. This idea perhaps would not work in rural areas which have low population density.

These clinics would be set up on government land, thus cutting down on the cost of land which a private provider would have to shoulder. Moreover, having such clinics within a community gives the members a sense of ownership and empowerment. Community ownership would also bring in the much-needed transparency, accountability and improved efficiency in the health sector.

Possible Complementary Solutions: This is not a perfect concept and should not end up as merely a populist solution.

The initiative should be supplemented by effective monitoring mechanisms. Government health facilities often suffer from poor quality due to heavy patient load and the mohalla clinics would need sustained attention and focus. Attention should not waver from the core issues to non-core ones like smart cards or electronic health records or even political bickering. Every other state will be watching the progress of this experiment and even though it is most applicable to urban settings and aimed at the marginalised sections of society, it is one that should receive attention and resources.

While additional budgetary allocation would be needed, it could be supplemented by seeking voluntary work from a trained workforce. The government could utilise services of interns, postgraduate students and senior registrars in government health facilities for these clinics. Many of the health functionaries working in secondary and tertiary care set-ups are often not fully exposed to the trials and tribulations suffered by...
common people and this would be an opportunity to expose them to such experiences. In fact, considering that these clinics are only outpatient services, flexible timings and evening shifts should also be considered to optimally utilise the resources.

The mohalla clinic initiative is better designed than many earlier health interventions. It needs to be better implemented as well to ensure success. Rudolf Vircho said that “Medicine is a social science and politics is nothing else but medicine on a large scale.”

These clinics should not be seen as ends in themselves but as a new beginning in the journey to find workable solutions to improve healthcare in India. This concept could ultimately lead to universal health coverage at affordable cost.