

Investing in Primary Health Care Infrastructure: A Social Return on Investment Perspective on CSR in India

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Abstract

Primary health care (PHC) is fundamental to universal health coverage, equitable access to health services and achievement of health-related Sustainable Development Goals. However, gaps in infrastructure, workforce availability and financing continue to constrain the capacity of primary health systems in India. This paper examines the role and potential social value of Corporate Social Responsibility (CSR) investment in strengthening PHC infrastructure from a Social Return on Investment (SROI) perspective. A secondary data analysis and descriptive thematic review was undertaken using government reports, policy documents, programme guidelines, administrative data, institutional publications, evaluation reports and peer-reviewed literature. The findings indicate substantial gaps in PHC infrastructure, including a 42% shortfall of sub-health centres, a 33–55% shortfall of primary health centres and limited availability of essential medicines and other critical inputs. Financing constraints are compounded by high out-of-pocket expenditure, which accounts for 47.07% of total health expenditure. Strengthening PHC infrastructure can generate first-order health benefits and wider social and economic benefits, including reduced out-of-pocket expenditure, improved equity, productivity and employment. CSR can complement government efforts by supporting infrastructure, equipment, diagnostics. Strategic CSR investment, aligned with public health priorities, can therefore contribute to stronger, more equitable and sustainable PHC systems while generating measurable social value.

Keywords: Primary health care, Health infrastructure, Corporate social responsibility, Social return on investment, Universal health coverage; India

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1.Introduction

The Alma Ata Declaration, issued in 1978, was a landmark moment in the history of primary health care (PHC). In the quest for health and well-being, the declaration guaranteed health for all by recognizing primary health care as the cornerstone in achieving health goals.

The World Health Organization (WHO) describes PHC as a comprehensive approach to health and well-being that considers the needs and preferences of communities, families, and individuals. It focuses on providing healthcare services at the point of first contact, particularly for low-income and marginalized communities and segments of society, regardless of age, gender, or other (any) classes.

A comprehensive approach to care considers physical, mental, and social health, thus contributing significantly to providing comprehensive healthcare and well-being for all

Components of PHC

The multidisciplinary team at health centers that deliver PHC is concerned with the individual's health and the immediate health determinants affecting their health. The PHC team selects ways and technology that are evidence-based and tailored to the beneficiaries' preferences and cultures. They also collaborate with larger PHC networks for specialized services.

Coordination among government, civil society, and non-governmental organizations (NGOs) addresses health-related concerns, specific to broad determinants of health. The availability of information via a more widespread and local means of communication allows the community to choose the package of services that can be created by health centers that provide PHC. **Table 1** show the components of PHC in various healthcare settings:

Table 1: Components of PHC

Components of PHC	Description
Integrated Health Services	Includes comprehensive preventive, promotive, protective, curative, rehabilitative, and palliative care. It is aimed at individuals and communities. It covers the population through public health functions.
Multisectoral Action	It encompasses broader determinants of health (including social, economic, and environmental factors, as well as individual characteristics and behavior) through policies and actions across all

	sectors, informed by evidence.
Empowering Communities	It aims at empowering individuals, families, and communities to optimize their health. Individuals/Communities act as advocates for policies that promote and protect health and well-being. They act as co-developers of health and social services and as self-carers and caregivers.

PHC, sustainable development goals (SDGs) and human development index (HDI)

Comprehensive primary health care (CPHC) is the foundation for universal health coverage, the cornerstone for the health-related Sustainable Development Goals (SDGs), and the mechanism for ensuring integrated people-centered health services. It is the platform for enabling public health functions and essential health services. Social participation, community engagement, and empowerment are crucial elements of health system governance that promote the inclusiveness and sustainability of CPHC.

The Universal Health Coverage (UHC) Index evaluates essential health services, based on interventions that include reproductive, maternal, newborn, and child health, infectious diseases, noncommunicable diseases, service capacity, and access. The increase in human longevity (between 1990 and 2019), and the decrease in maternal mortality, neonatal mortality, and total fertility rate, reflect gains in public health. It also informs about improved access to primary healthcare services which is an integral part of sustainable development and the Human Development Index (HDI).

Figure 1 informs how SDG goals are achieved by the interplay of PHC and UHC, improving Human Development Indices (HDI). A few other components of SDG goals may require multisectoral action and citizen empowerment.

Health-seeking behavior and health assurance

The other side of the coin is that when people use services, they often incur high, sometimes catastrophic costs for availing the services. Some factors drive households to seek primary care as their first preferred option (**Figure 2**). Availability of preventive care, increased awareness coupled with improved accessibility of services, growing aging population, increasing urbanization with nuclear families, etc. compound the reasons for seeking primary care.

The primary health-seeking behavior thus is associated with some predisposing, enabling, and need factors. Strengthening the physical and technical capacity of PHC institutions, developing

the health assurance system and steadily improving the healthcare-seeking behavior among chronic disease patients enables the population access to PHC institutions for care. Primary health care and UHC advocate for the whole continuum of required health services, not only the first contactor ambulatory health services. However, While the primary-care system is focused on the good quality and coverage of essential health services, it does not address the issues of financial hardship in using these services. UHC includes protection from financial risk (to reduce OOPE) given the existing burden of diseases in India. Thus, capable infrastructure for providing primary health care services integrated with institutional mechanisms for health assurance is imperative.

Figure 1 SDG 3, PHC & UHC: Synergies

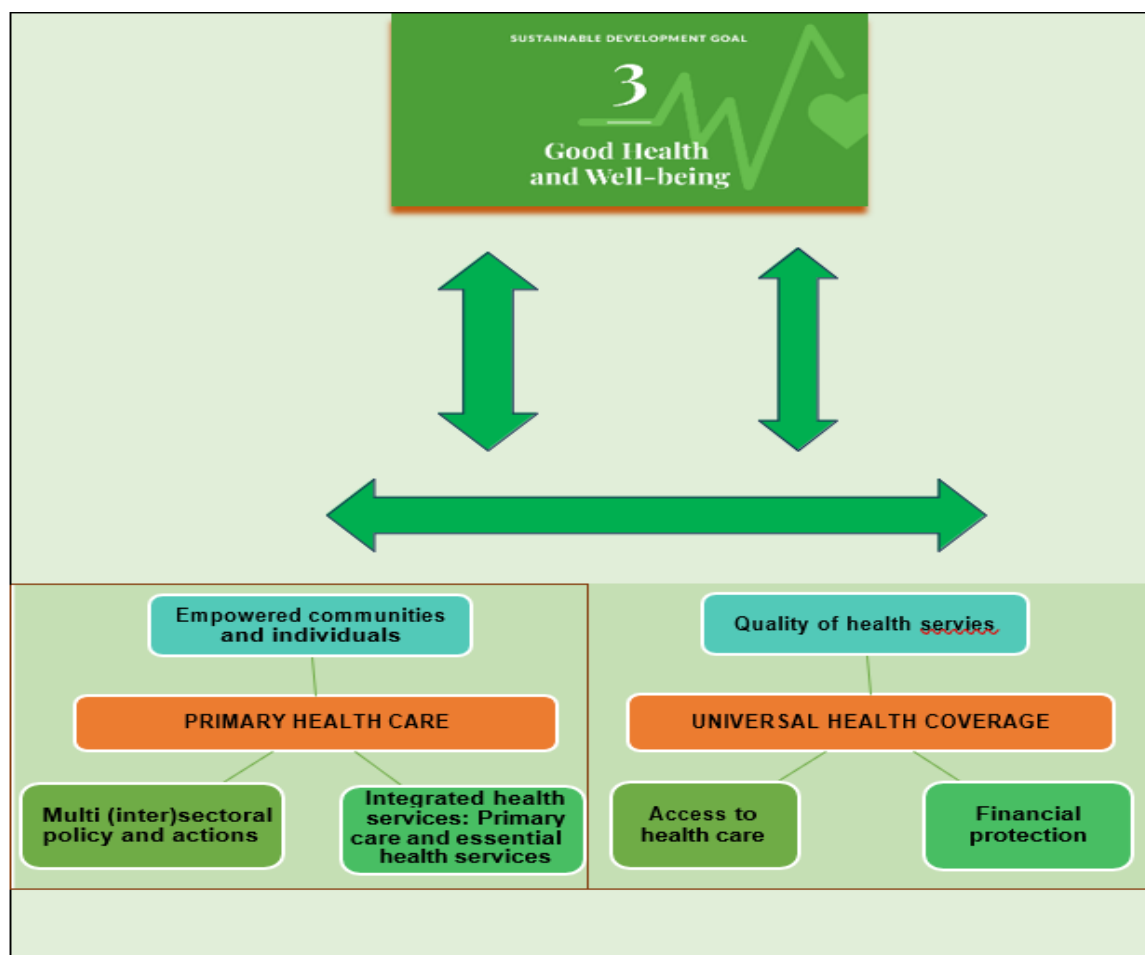
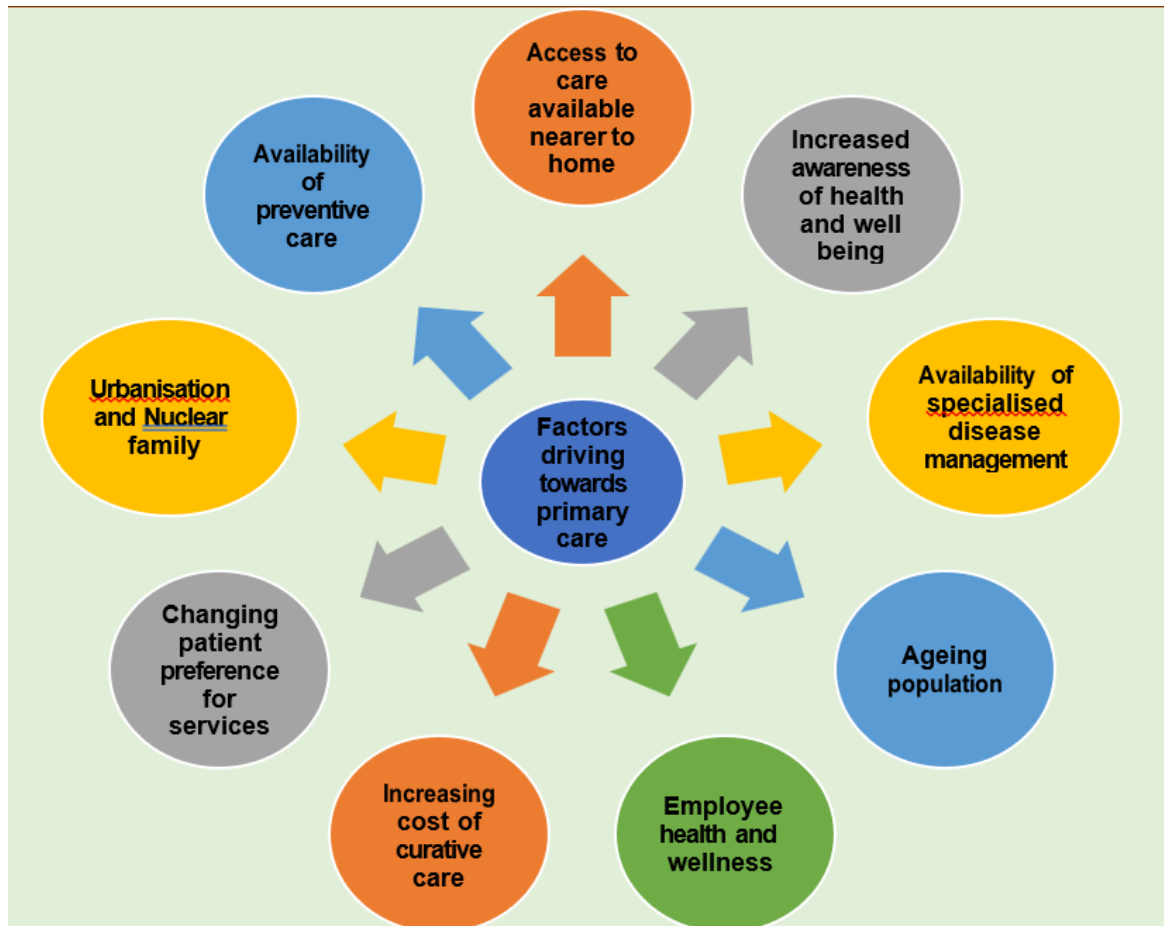


Figure 2 Factors driving households towards primary care in India



This paper examines the role and potential social value of Corporate Social Responsibility (CSR) investments in strengthening primary healthcare infrastructure in India, using a Social Return on Investment (SROI) perspective to assess their contribution to health outcomes, social benefits, and broader community development.

2.Material and Methods

Study Design

This study employed a secondary data analysis and descriptive thematic review design based exclusively on information obtained from existing published and publicly available sources. The methodological approach was designed to synthesise available evidence relevant to the objectives of the paper and to examine key developments, programme components, policy

directions, and trends within the study area. No primary data were collected for the purpose of this study.

Data Sources

Data were obtained from a range of credible secondary sources relevant to the subject. These included:

- Government reports and publications
- National and state-level policy documents
- Programme guidelines, operational frameworks, and implementation manuals
- Official government databases and publicly accessible administrative data
- Reports and publications of national and international institutions
- Peer-reviewed research articles and other published academic literature
- Evaluation and assessment reports, where publicly available

Preference was given to official, authoritative, and peer-reviewed sources. Where information was available from multiple sources, relevant sources were compared to improve consistency and contextual interpretation.

Identification and Selection of Sources

Secondary sources were identified based on their relevance to the objectives and scope of the paper. The identification process involved reviewing available literature, policy and programme documents, official reports, databases, and institutional publications. Sources were considered for inclusion when they contained information directly relevant to the research questions or analytical domains of the study.

The selection of information was guided by the following considerations:

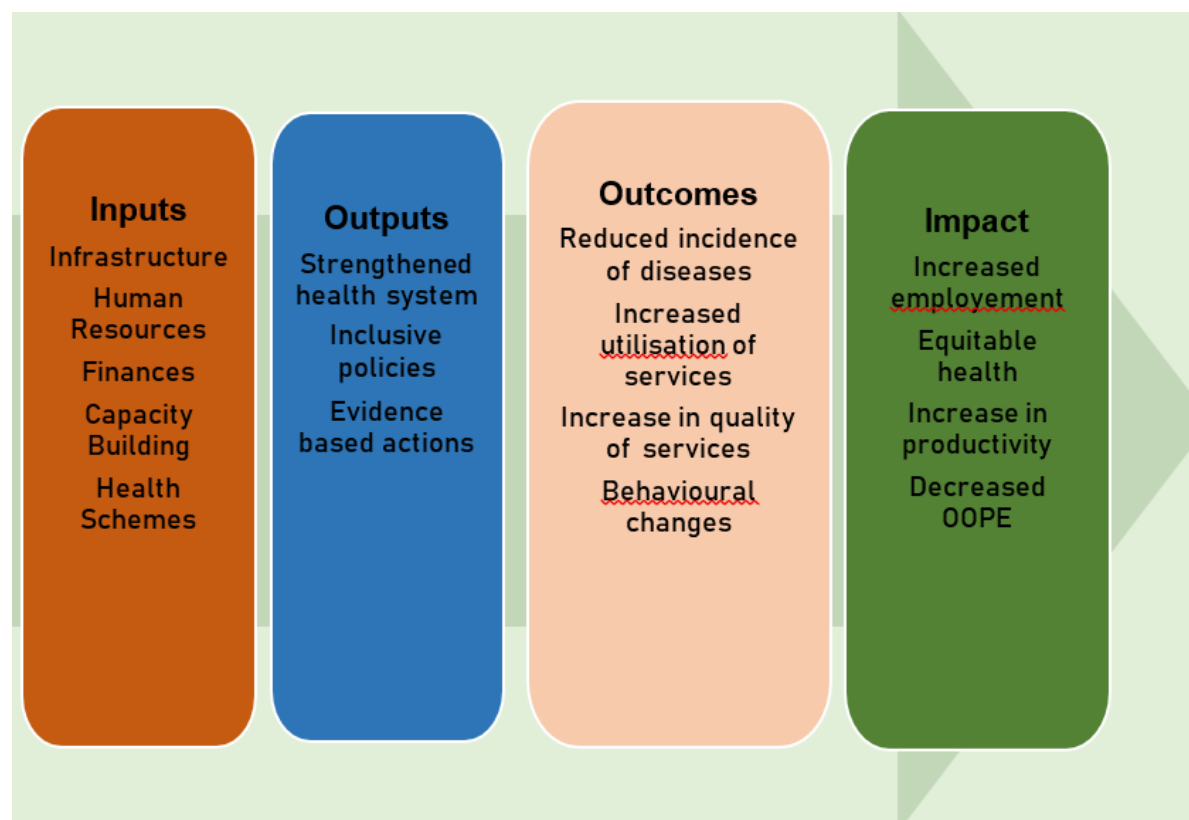
- Relevance to the objectives and scope of the study
- Credibility and authority of the source
- Recency, where current information was required
- Availability of sufficiently clear and verifiable information; and
- Contextual applicability to the population, programme, policy, or geographical setting under consideration.

Sources that were not directly relevant to the study objectives or did not provide sufficiently reliable or interpretable information were not considered in the final analysis.

Analytical Framework for PHC Interventions

Figure 3 describes the logical framework for PHC interventions. **Figure 4** provides an activity model for strengthening infrastructure for PHC and the theory of change it brings along.

Figure 3 Logical framework for PHC Intervention



3. Results and Discussion

Need invest in PHC

The wide-ranging impact of PHC interventions develops substantial health benefits and builds upon the infrastructural and human capital. The following are the reasons to invest in PHC:

- A. **PHC addresses** over 80% of common health needs, prevents ill health, reduces the need for high-end care, and provides cost-effective, equitable, accessible, and affordable services. Its community-based approach reaches rural, remote, and disadvantaged populations, improving participation, cultural sensitivity, service use, and health outcomes. As disease patterns shift toward NCDs, comprehensive and locally adaptable PHC can reduce disease burden and costs, protect productivity, and improve the quality

and safety of health-care delivery.

B. Second-order benefits: PHC interventions generate direct health benefits as well as longer-term second-order social and economic benefits, including improved equity, employment, literacy, women's empowerment, income, productivity, wealth, and lifestyle. These benefits can reduce out-of-pocket expenditure, poverty, and socio-economic, geographic, and gender inequalities, although they may take longer to become visible and remain under-researched. Strengthened primary care infrastructure can reduce OOPE by improving accessibility and availability, freeing household resources of money, time, and energy for broader development. WHO (2018) found that every dollar invested in cost-effective interventions can yield a \$7 return. These wider benefits may also include tax revenue, government transfers, tourism revenue, improved well-being, and averted intangible costs associated with grieving.

There is also a persistent gap in India's key health indicators. Maternal mortality (103 per 100,000 live births), neonatal mortality (30.4 per 1,000 live births), and life expectancy (67.7 years) remain below the stated 2030 aspirations, while the Universal Health Coverage (UHC) Service Coverage Index stands at 61 out of 100, indicating continuing gaps in access to essential health services. India's relatively low global rankings across these indicators further underscore the need to strengthen comprehensive, accessible, and equitable primary health care.

Strengthening PHC infrastructure-including water, electricity, sanitation, equipment, medicines, and human resources-is fundamental to facility readiness, quality and patient-centred care, infection prevention, and emergency preparedness. Adequate infrastructure also protects healthcare workers, supports workforce retention, and builds community trust and continued care-seeking. Investments should incorporate environmentally sustainable and renewable solutions while preparing facilities for current and future health challenges. Beyond health gains, stronger PHC infrastructure can generate social and economic returns through improved productivity, employment, women's empowerment, reduced costs and resource use, and better overall community well-being, making infrastructure investment a long-term development investment (**Fig 5**).

Figure 4 First and Second-Order Benefits of PHC Intervention

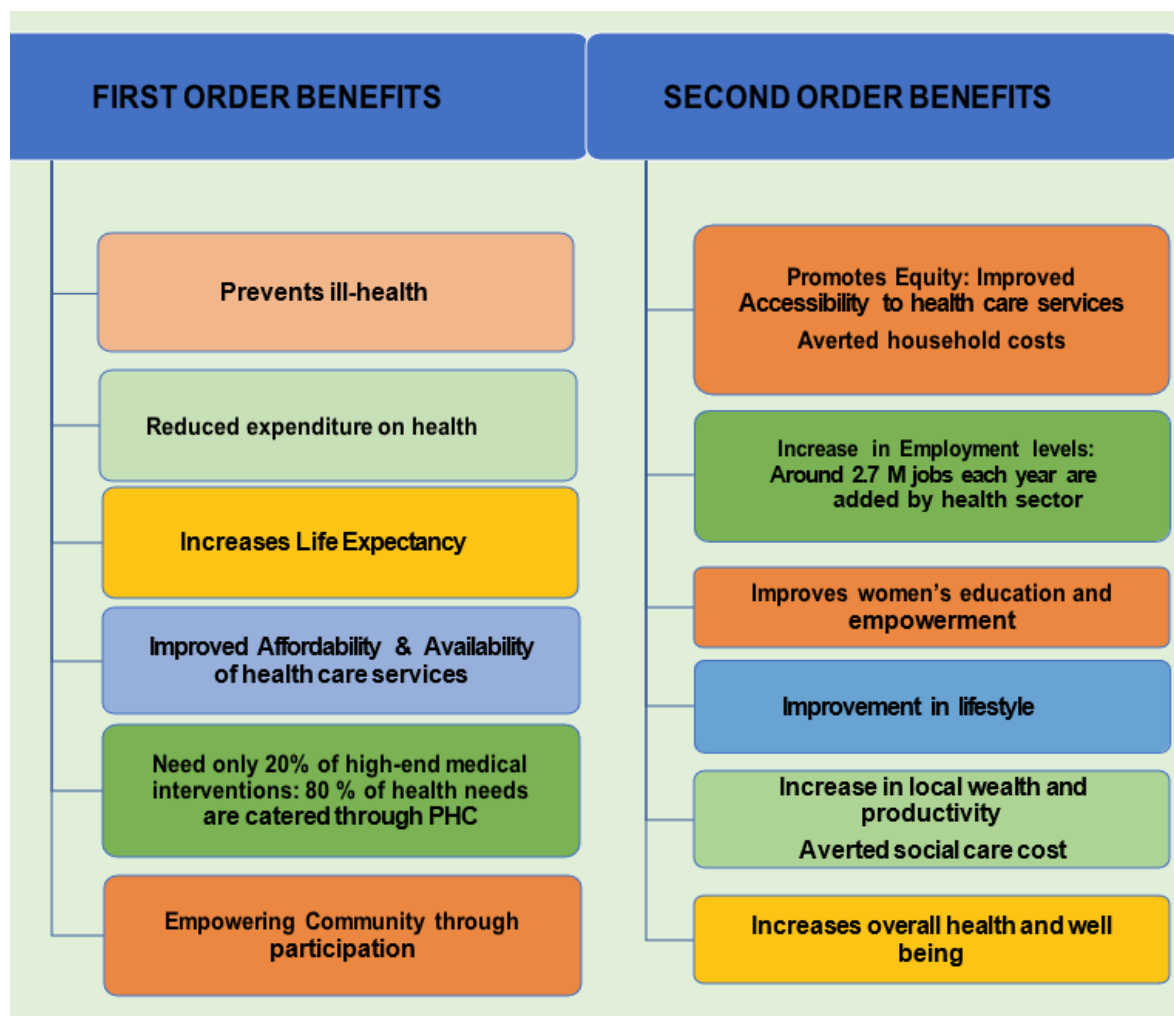
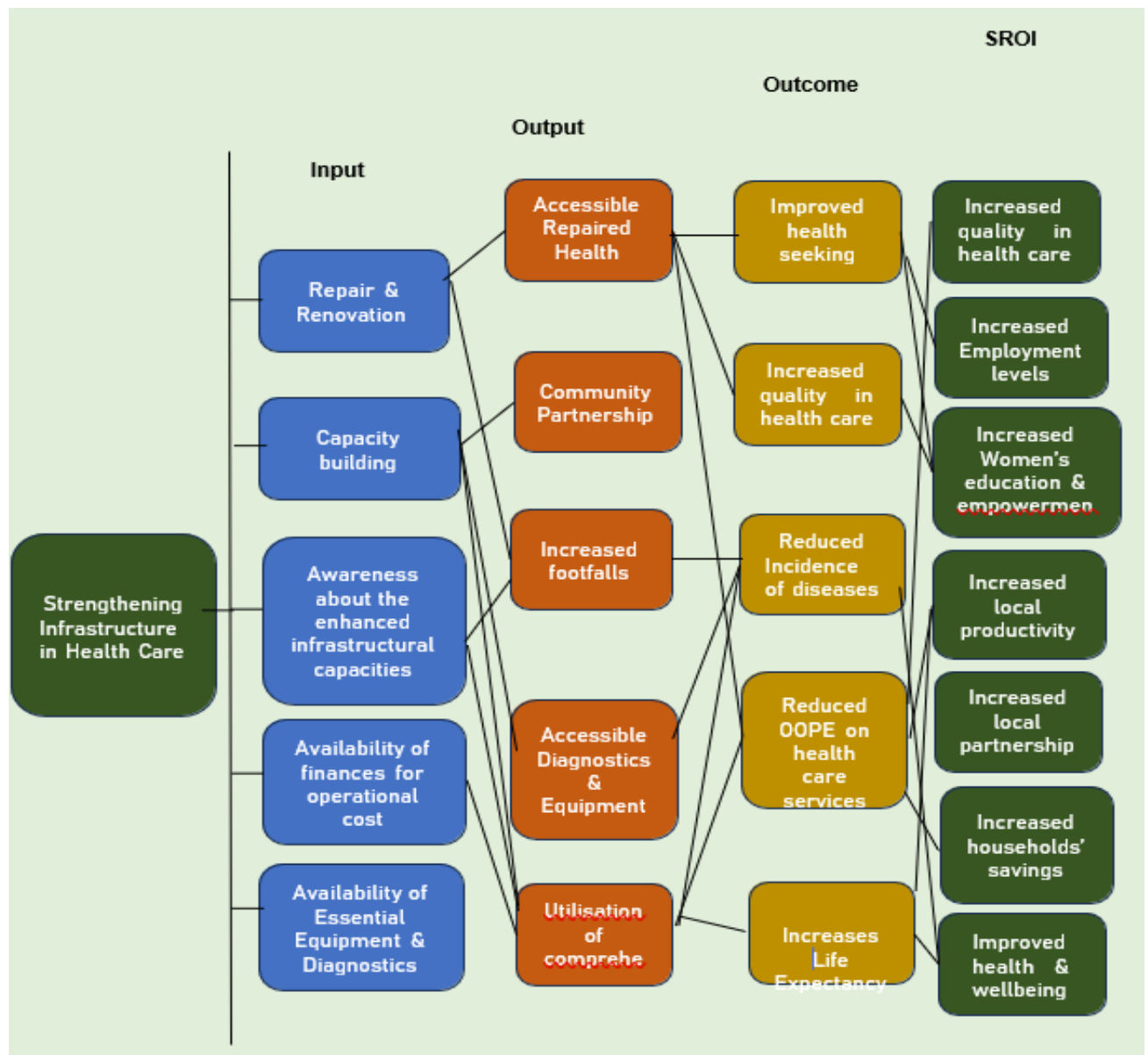


Figure 5 SROI Matrix for PHC Infrastructure Strengthening



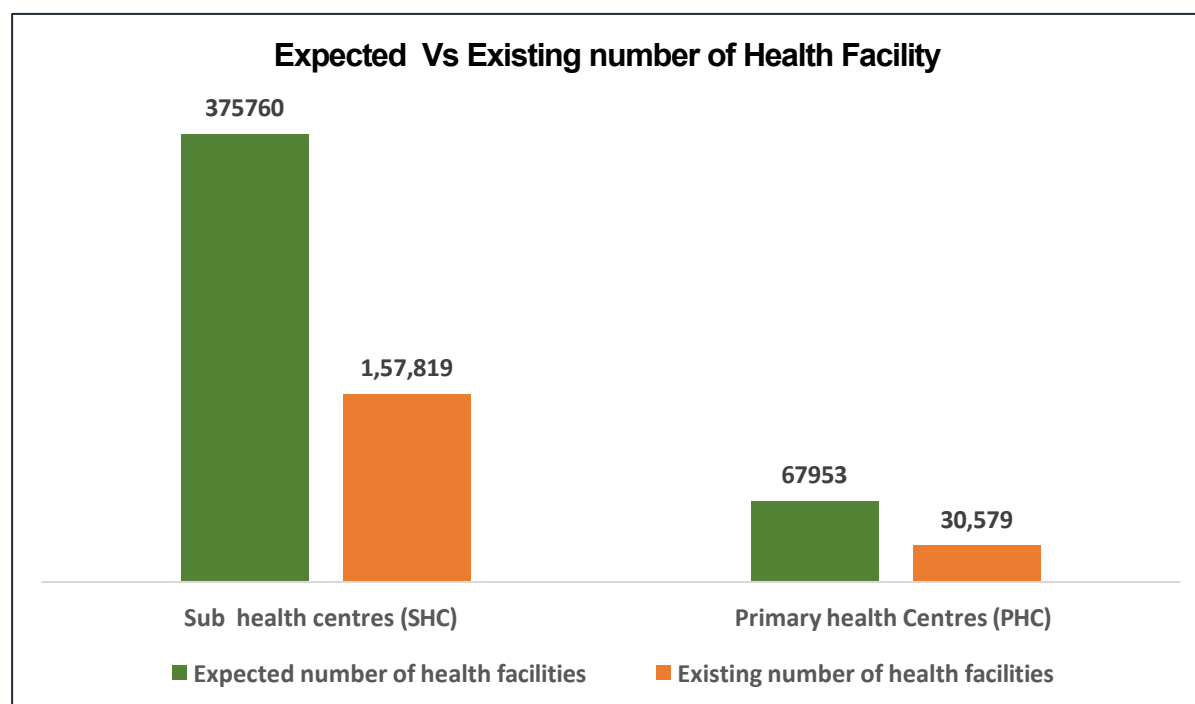
Existing Infrastructure for Providing Comprehensive Primary Health care Services in India

Burden of Disease Vis A Vis health infrastructure

The change in disease burden has increased the prevalence of noncommunicable and lifestyle illnesses in mortality and morbidity. However, development in the key indices of infrastructure availability has not been proportionate. Nonetheless, because health facilities and human resources are concentrated in cities, the uneven distribution hurts bed availability and doctor availability, particularly in rural areas. The red tape and engrained corruption identified in the

procurement procedures for infrastructure improvements have exacerbated the delay, resulting in a bigger disparity. India has a total of 1,96,359 healthcare facilities. **Figure 6** depicts the types of facilities that provide primary health care and their current status.

Figure 6 Existing number of health facilities for PHC



In the current health care system, primary health centers provide a broader range of services and serve as the first point of contact for referrals from sub-health centers. As a result, primary healthcare facilities must be equipped with key services and equipment to provide effective primary care. However, the survey data from IIPS states that while 34 percent of PHCs have less than 40 percent of crucial inputs, 60 to 80 percent of all necessary inputs are present in about 28 percent of PHCs. This is true even though the Indian government committed to allocating a sizeable portion of its budget- more than two-thirds - to primary healthcare in the country's 2017 National Health Policy. It keeps pushing for cross-sector cooperation to enhance infrastructure and overall facility preparedness. Service outages can be caused by a variety of factors, and a comprehensive solution requires addressing these gaps

The flagship program of Ayushman Bharat intends to improve service availability by upgrading existing health centers to HWCs. These 1,50,000 Health and Wellness Centres (HWCs) are designed to provide around 70% of out-patient care, including noncommunicable illnesses and mother and child health services. HWCs would provide free critical medications

and diagnostic services, which account for the majority of OOPE spending. Key concerns in the status of infrastructural availability are described in **Figure 7 and Table 2.**

In India, tax-funded public outpatient facilities account for 30% of the total facilities, with the bulk of PHC is provided by the private sector and paid for out-of-pocket by households. The government supports 51% of current PHC expenditure, with Health and Wellness Centers receiving 3% of the NHM budget. Nevertheless, access to public hospitals is limited (51% of outpatient care is sought through private hospitals). As a result, even if the government spends more on PHC, there is little evidence of a link between public spending on healthcare and how people use the health system.

India boasts the most medical schools, produces the most medical graduates annually, and is the world's third-largest pharmaceutical manufacturer, despite accounting for 20% of the world's disease load. This contradiction means India **must reallocate** its resources to provide better service coverage.

Figure 7 Key facts on infrastructural availability for PHC

Key Facts on Existing Health Infrastructure availability				
Based on recommendations of the Indian Public Health Standards, there is a 42 per cent shortfall of SHCs, 33 per cent to 55 per cent shortfall (average 45%) of PHC in India, indicating the need for more healthcare infrastructure providing primary health care.	In India, in major 15 states, around 89 percent Primary Health Centres (PHCs) are functioning, out of that around fifty-five percent of the total required PHCs have its own building and around 9 percent are rent-free or donated. The rest are rented, are under construction, or are to be constructed (IIPS, 2019).	India needs to add another 1.54 million doctors and 2.4 million nurses to meet the growing demand for healthcare in India as per the guidelines (NHP 2020)	As of 12 May 2021, there were only 1.4 beds per 1,000 population with 0.5 public hospital beds, which is much lower than the WHO recommended number of 2.9 beds per 1,000 population	As per a United Nations report, approximately 73% of resources in terms of healthcare infrastructure and medical specialists are concentrated in urban areas, leaving only 27% available in rural region

Gains in health care vis-a-vis investment

Investment in public healthcare spending will improve the quality of all healthcare services by making low-quality providers uncompetitive, ensuring that high-quality services are accessible to India's poorest patients, and promoting greater health access and equity toward achieving UHC. With over 142 crore population and less than equitable access to health care, India needs to work on upgrading health care, especially for marginalized populations. The cost of providing primary care through Health and Wellness Centres (HWCs) is much lower than at higher-level facilities. The efficiency gain here could also result in improving fiscal space for providing more care to other patients at higher levels of public institutions.

Thus, it is imperative to invest in primary health care, more so in the development of the infrastructural mechanisms related to it, to reap intersectoral benefits.

Table 2 Status of key infrastructural availability for PHC

Key Indicators	Status	Remarks
Bed availability per thousand population: Health facility density (including primary care)	1.4/1000 Population	Current Bed Deficit of 1.7/1000 population. A total of 3 million beds is in shortfall. Around 70 % of available beds are concentrated in urban areas.
Doctor Patient ratio	1:834	The required ratio is 1:1000. Around 73 % of existing healthcare staff centered around urban areas
Provision of primary care packages* through health center	7 primary care Service Packages	A total of 12 primary care comprehensive packages is needed to be served. An existing gap of 5 Packages is under progress to be rolled out
Availability of essential medicines, Contraceptives & Vaccines	31%	Across major 15 states of India, primary health centers have the availability of 31% of essential drug lists.

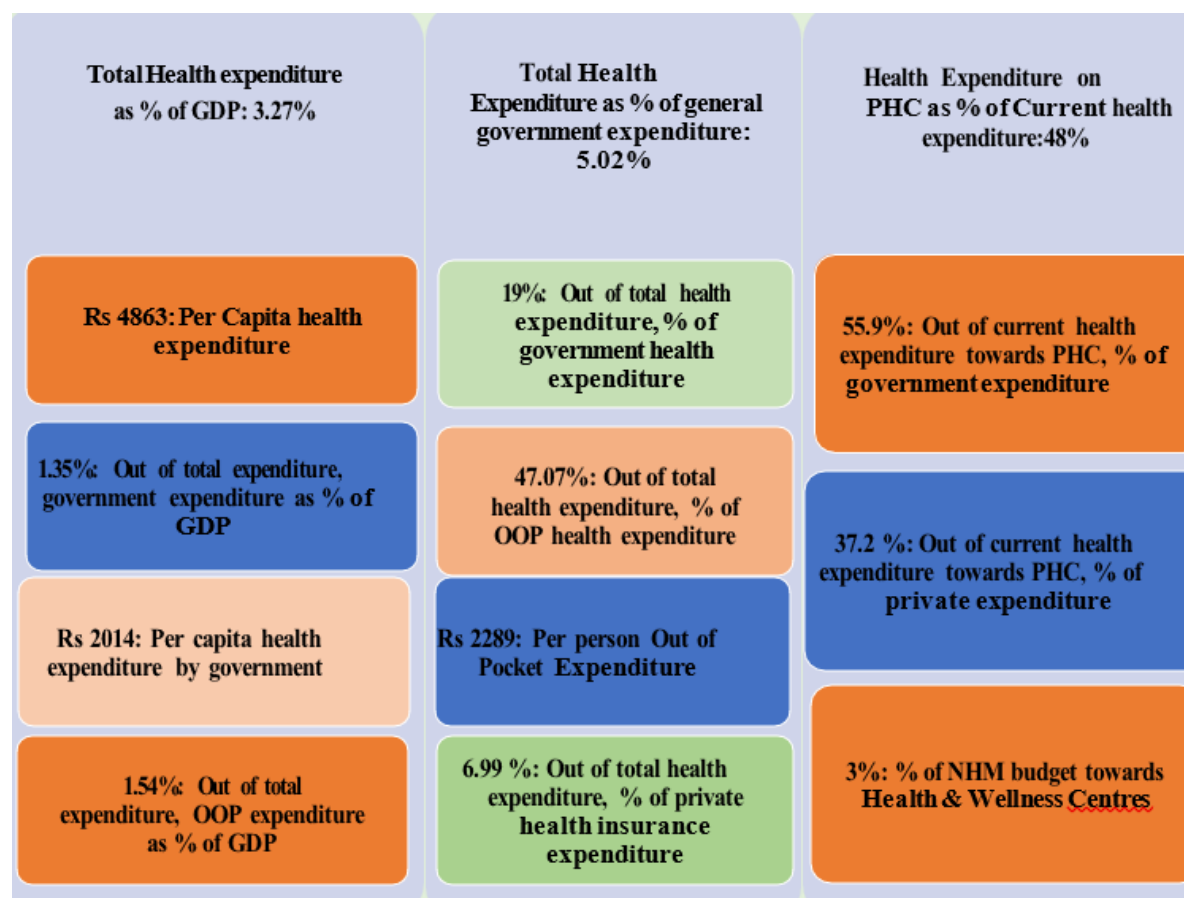
Availability of basic WASH amenities	Available at 24000 PHCs	The functional status of available WASH amenities is unknown.
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Economic Context and Scope to Invest

Status of Health Expenditure

India spends nearly 3.27% of its GDP on health care, out of which share of the government is 1.35 % of the total spent. India is 153rd in overall spending on health and well-being at a global level. Across the world, the percentage of government expenditure ranges from 1.67% to 21.54 %. The Indian government expenditure as a percentage of GDP is among the lowest 15 countries with a rank of 169th among 195 countries. Alternately, this means that the major part of health expenditure is borne through private expenditure. However, there are inter-state variations observed in per capita health expenditure. For example, while Bihar spends Rs 491 per capita per year on health, Mizoram records an expenditure of Rs 5862 per person per year. **Figure 8** presents the existing status of health expenditure in India, in terms of total health expenditure, current health expenditure (excluding capital expenditure), and proportion of government & private expenditure.

Figure 8 Status of Health Expenditure in India



Thus, India needs additional funding to cater to the health needs of its burgeoning population given our expenditure as a percentage of GDP is 1.35 %. and OOPE is 47.07%. Such a huge gap in funding health needs, if not met from the pooled funds through government sources, leads to high out-of-pocket expenditure (OOPE), which includes household expenditure and private health insurance expenditure.

Out of pocket expenditure (OOPE):

Of the total health expenditure, 47.07 % is OOPE and 6.99 % is private health insurance expenditure. If we exclude the capital expenditure by the government, 59.34 % is the OOPE (household's share) in current health expenditure. The share of state governments and the union government is only about 32%.

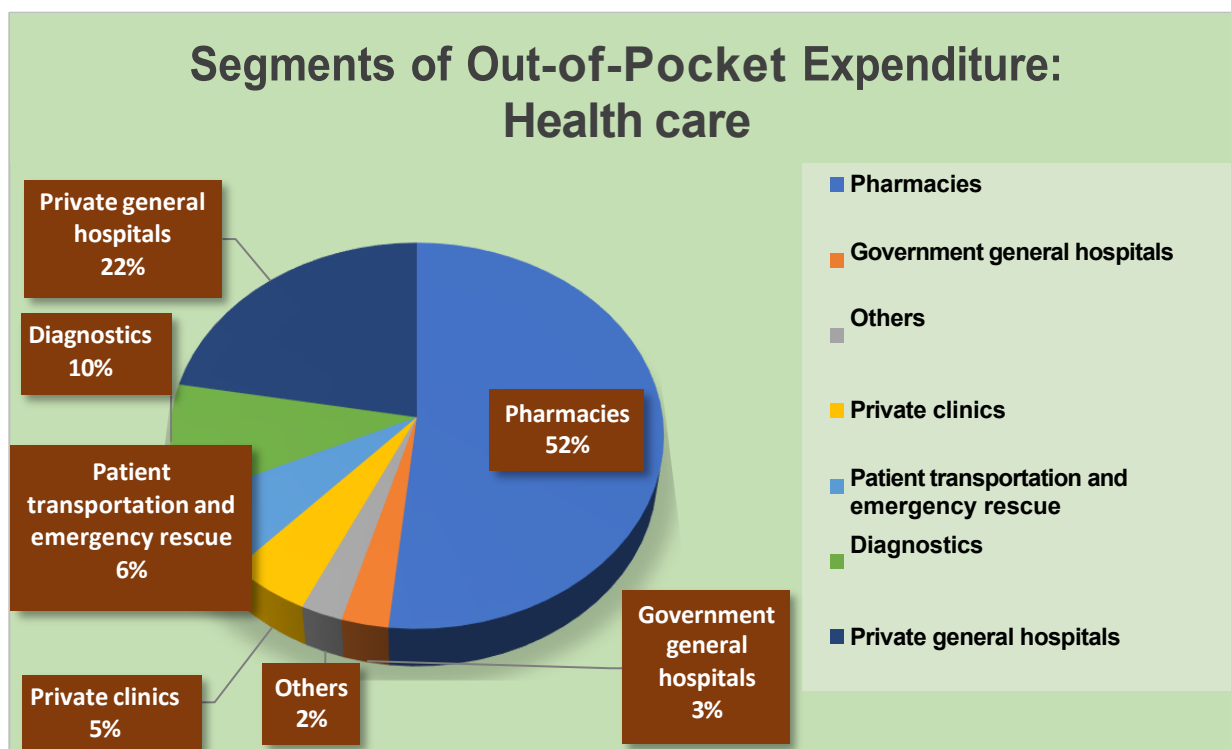
To simplify, the government is currently spending Rs 3.85 per person per day on health and OOPE is Rs 6.5 per person per day. Despite investing 55.9% of current health expenditure in PHC, which provides health care, along with drugs, diagnostics, and equipment without any

burden to beneficiaries, the major source of funding for health needs remains the OOPE. The impact of this expenditure is higher when the household income is low or the OOPE incurred is huge, especially in events of inpatient care or critical illnesses.

OOPE, especially among low-income households reduces their spending on other essential and basic needs such as food, shelter, clothing, education, etc. It also forces households to borrow or loan money from friends' / relatives/ money lenders, which further pushes the household into debt. Households OOPE usually higher than 10% of total household consumption expenditure is catastrophic and it might push the household below the poverty line leading to impoverishment.¹⁸ This cycle continues and the households remain in the perpetual web of poverty which has implications for social and economic activities.

It thus becomes imperative to **A)** efficiently utilize the resources available to PHC and **B)** finance the deficient health care infrastructure through alternate sources of funding.

Figure 9 Where does OOPE go: NHA 2019-20



Role of CSR in strengthening healthcare infrastructure

The government designates the health sector as a priority due to resource limits and shortages, including poor infrastructure, a lack of supplies and drugs, labor shortages, antiquated technologies, and developments in healthcare. India's prominent health endeavors encompass Ayushman Bharat and its allied efforts. The basic goals of the program are to decrease the risk of financial disaster and increase the accessibility of primary healthcare. Nevertheless, there is little use of government facilities even though the government spends half of its overall health spending (current health expenditure) on primary care. Households (OOPE) pay about 47.07 percent of the overall health expenditure, which traps them in a cycle of poverty.

Given that there is a shortage of primary care health centers by 32–55% and that 70% of health facilities, including HR, are located in urban areas, corporate social responsibility (CSR) initiatives can help improve the demand and supply balance in the public health infrastructure, particularly in underserved areas. More people are dying as a result of the poor quality of treatment that the inadequate infrastructure provides than from the actual lack of infrastructure.¹² Reaching the overall Sustainable Development Goals in health care would require another thirty years of advancement at the current rate. Achieving the health objectives outlined in the NHP 2017 and enhancing primary healthcare can be facilitated by optimizing the current infrastructure. A solid relationship with CSR will expedite upgrading infrastructure to its optimal level as a supplement to the health plans. With the correct goal and process in place, CSR partnerships can assist local infrastructure that requires immediate assistance. Partnerships through CSR can play a crucial role, as shown below:

Expeditious implementation of Infrastructure strengthening at Government primary healthcare centers: Issues such as layered administrative compliance, increased and costly technological advancements, implementation of international quality standards, and substantial community dependence make the infrastructure strengthening by the Government, time-consuming. When CSR activities come forward to fill the gap, the time consumed for upgrading sustainable health and healthcare systems is reduced. CSR partnerships can facilitate quick and efficient strengthening of health infrastructure, under the overall umbrella guidelines of CSR. The following examples show that the CSR processes were quick in upgrading infrastructure.

Optimizing healthcare delivery, reducing the imbalance, and improving equity: As per the estimates by the WHO, around 80% of the disease conditions can be addressed at the

primary/preventive care level The frontline healthcare staff providing primary care, however, either do not have the desired critical equipment or the expertise to deliver care effectively. In India, where 70 % of the population resides in rural areas, and 30% of expert doctors serve in rural areas, the CSR investment in healthcare would help create an effective foundation for service delivery. This will make it easier to attract and retain qualified personnel. CSR is a broad term that includes a range of voluntary commitments and activities carried out by for-profit companies to improve the social return on investments made in primary healthcare services. The Indian government believes that there are approximately 582 chances for \$32 billion worth of investments in medical infrastructure, including hospitals. The mentioned examples provide information on how CSR activities can bridge the gap of deficiency in the readiness of facilities:

Buffering the high cost of medical equipment & consumables: Corporate houses can facilitate not only the capital cost /initial cost but the recurrent expenditure and the cost of consumables through CSR funds as the costs are prohibitive and the government might not always have the resource envelope for high-end procurement. The diagnostic centers by private entities offering subsidized diagnostic services can significantly contribute to infrastructure enhancement. Personalized PPP management agreements and mobile clinics are cutting-edge ways to improve healthcare accessibility, particularly in rural areas.

Corporates may be able to cover the program's operating expenses. The mentioned examples provide information on innovative ways of providing diagnostics through CSR.

Improving community participation & ownership: Community-oriented participatory activities, supported by corporates, will capacitate and prepare community partners to take over ongoing support at the end of the project cycle. Community ownership, undertaken by the community in partnership with external organizations or corporates, empowers individuals and groups of people by providing these groups with the skills they need to effect change in their communities. Also, investment through activities in the community can reduce healthcare procedural costs which are prohibitive to larger sections of society.

Enhancing Social Returns of Investment: Social returns on investment in health care include an increase in equity, employment, literacy level, women's education and empowerment, income, productivity, local wealth, and lifestyle. These may also lead to a decrease in out-of-pocket expenditure, poverty, and socio- economic, geographic, and gender inequalities (**Figure 8**). Fostering local partnerships with communities, innovations, and implementation of

technology, upscaling of human resources and infrastructure development, and opportunities for advancement and career development are also included as second- order benefits.

Encouraging Continuing Innovation: The private sector's involvement in delivering innovative solutions and enhancing service provision is key to overcoming challenges like limited coverage, ineffective management, and healthcare staff shortages

Contribution towards Digital India: CSR activities can also address demand and supply matches in increasing financial and technological support to the healthcare sector and reducing barriers to healthcare and access to the maximum number of people.

Benefits to corporates from CSR in health care:

The Companies Act of 2013 and the Companies (Corporate Social Responsibility Policy) Rules of 2014 establish India's Corporate Social Responsibility (CSR) mandate and requirements. Companies must design a CSR policy that outlines the actions to be taken, execution methods, and monitoring techniques. While CSR is required by law, firms can reap additional benefits by strategically investing in CSR, notably in health care. Higher social and economic returns enable firms to pursue their intended activities with greater benefits. Some of the advantages are stated below **(Figure 8):**

Increased social acceptance: CSR initiatives will promote goodwill not just in the corporate sector, but also in the communities where they are carried out. The far-reaching spillover impact of healthcare activities strengthens community trust and enhances general societal acceptance. Due to the gap in bed availability per 1000 population, private businesses can extend their presence in India's healthcare market through community-based healthcare services.

Brand amplification: Inclusion in healthcare activities promotes visibility and sets up a challenge to competitors. It improves their trade and commerce. CSR collaborations in healthcare provide a wider chance to enter new markets with a lower risk profile while contributing to the public good. For instance, working with the government to build mobile clinics or diagnostic centers could increase brand recognition and present new revenue streams. These healthcare facilities treat a wide range of patients and welcome many visits from the neighborhood, which increases brand exposure and amplification for the business. This raises the desire of investors and shareholders to be aware of the brand and increase their share of investment.

Builds partnership with community: CSR initiatives in healthcare will increase goodwill, and recognition from government and international stakeholders, and build on community ownership.

Encourages innovation: Healthcare solutions cannot be generalized to all populations. It necessitates adaptation based on regional needs and contextual arrangements, which frequently entails novel solutions that foster innovation and enthusiasm.

Cost-effective services: Private providers can offer affordable diagnostic services within existing health centers or independently using subsidized user service fees. This not only benefits the community by increasing access to healthcare, but it also enables private companies to provide cost-effective services.

4. Policy recommendation

1. Prioritise infrastructure as the basis of readiness for care- Water, electricity, sanitation, equipment, medicines and human resources should be treated as non-negotiable requirements at PHC facilities, with basic infrastructure prioritised where human resources are sparse and environmentally friendly options considered in all new investment.
2. Close the rural–urban and state-level gap- Investment should be directed to underserved areas, where rural areas bear three-quarters of the healthy life years lost, and interventions should be designed specifically for the communities and states concerned.
3. Use existing PHC resources efficiently- Because Health and Wellness Centres are upgraded versions of existing health centres and can work only if the older centres are operational, gaps in existing facilities and delays in procurement for infrastructure improvement should be addressed first.
4. Link PHC with financial risk protection- PHC services (including free essential medicines and diagnostics) should be integrated with institutional mechanisms for health assurance, so that financial hardship and out-of-pocket expenditure are reduced alongside improved service coverage.
5. Channel CSR towards government PHC infrastructure- CSR partnerships should be used for repair and renovation of Health and Wellness Centres, public–private partnerships in the management of primary health centres, provision of equipment and diagnostics (including support to biomedical equipment maintenance), and digital and telehealth solutions, aligned with the National Health Policy 2017 and the SDGs.
6. Strengthen community participation and ownership- CSR-supported, community-oriented participatory activities should prepare community partners to take over ongoing support at the end of the project cycle.
7. Measure social returns- Because little research has assessed the second-order benefits of PHC interventions, SROI-based assessment should be built into CSR-funded PHC infrastructure projects to inform decisions and raise awareness of their wider impact.

5. Conclusion

Primary health care (PHC) is the foundation of universal health coverage and of the health-related Sustainable Development Goals, and it can address more than 80 percent of people's common health needs at a lower cost than referral care. However, the findings show that India's PHC infrastructure has not kept pace with the shift in the burden of disease towards non-communicable diseases. There is a shortfall of 42 per cent of sub-health centres and 33 to 55 per cent of primary health centres, only 31 per cent of the essential drug list is available at primary health centres, and the doctor-patient ratio (1:834) and bed availability (1.4 per 1,000 population) remain below the required levels. Key indices, including maternal mortality, neonatal mortality, life expectancy and the UHC index (stagnant at 61), remain short of the 2030 SDG targets.

The financing evidence points the same way. Government expenditure is only 1.35 percent of GDP, while 47.07 percent of total health expenditure is out-of-pocket, with about 52 percent of out-of-pocket spending going on medicines. Such expenditure reduces household spending on food, shelter, clothing and education, and pushes households into debt and poverty. Strengthening PHC infrastructure is therefore both a health and an economic investment: the paper shows that its first-order benefits are followed by second-order benefits such as reduced out-of-pocket expenditure, higher employment, women's empowerment, local productivity and household savings, and that the long-term benefits outweigh the costs.

Given the limited public resources, corporate social responsibility (CSR) offers a practical complement to government effort. CSR partnerships can speed up infrastructure strengthening, meet the high cost of equipment and diagnostics, build community ownership, support innovation and digital health, and contribute to SDGs 1, 3, 9 and 17. The social returns reported for CSR-supported health programmes (for example, Rs 3.32 per rupee invested in i4We, INR 12.57 of social value per rupee in EMBED, and a 13:1 return in the Mumbai child health programme) indicate that such investment can also yield measurable returns, while corporates gain social acceptance, brand amplification, community partnership, innovation and cost-effective services.

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