



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health

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Vol. 38 No.25

18th – 24th June 2011

Health Systems' Responsiveness; Are nonmedical aspects of healthcare services important?

Good health is an asset to the individual and an investment to the nation. Few would disagree that much emphasis is laid and great wealth is spent globally, at all levels, to improve the physical, mental and social well-being of the people.

Today, on the whole, people around the world enjoy much healthier and longer lives than several decades ago. The development of medical and other related sciences and the socio economic development of countries saw the upliftment of general health and wellbeing of the people. Most governments around the world, irrespective of their political agendas, are committed to deliver the best possible health care to people through organised health care systems.

Still, health care systems have come under much public criticism over the past decades. Frequent legal battles between health systems and their service seekers as well as the media reports published almost on a daily basis provide ample evidence for it. The principal reason, in most occasions, has been lack of fulfillment of people's expectations on nonmedical aspects such as respect, autonomy and confidentiality of information and other ethical issues.

Nonmedical concerns are an integral part in health care service delivery. The main concern on the part of the healthcare service providers is to provide the best available medical service from a technical point of view. On the contrary, patients, while expecting the best technical service, are also concerned about the manner in which the service is delivered as well as the setting in which the service is provided. The health care service they receive is judged primarily by these *non-medical aspects* of service delivery and this is true even in the most resource constrained health care setting. It has been repeatedly emphasised that interpersonal and non-

medical aspects of the service delivery process is the vehicle by which technical care is implemented and on which its success depends.

In this background, there was much dialogue among the health-care service providers as well as patient rights organizations on the way patients are treated and the environment in which they are treated. The WHO formed a multidisciplinary panel, in the late 1990s, which continued the discussion and debates on non-medical aspects of healthcare. Much literature on patient satisfaction and quality of health care were reviewed and qualitative research, in the form of FGDs and in-depth interviews, were conducted. Following this exercise, the concept of "health systems' responsiveness" was originated and described for the first time.

The WHO defines health systems' responsiveness as "how a system performs relative to non-medical aspects, meeting or not meeting population's expectations of how the people should be treated by providers of prevention, care or non-personnel health services". It is not a measure of the technical competency as shown by other indicators such as health outcome indicators. This definition comprehensively covers all aspects of health services. It includes not only preventive and curative health services but also non-personnel service such as health promotion activities, vector control activities etc.

The primary objective of developing the concept by WHO was to assess the responsiveness of health systems of its member states, with the ultimate aim of identifying gaps and improving the performance of the health systems, providing better care to the people. The goal of 'good responsiveness is to reduce inequalities in service provision and improve people's health and it has been described in terms of 'goodness' and

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'fairness' with regard to health services. Goodness with regard to responsiveness means, "the health system responds well to what the people expect of it with regard to its non-medical aspects". Fairness is described as the system "responding equally well, without discrimination, to everyone". Hence improving the responsiveness of any health system is undoubtedly important and matters to all those who receive the services and benefit from it.

Although there is considerable overlap, responsiveness of health systems is not equal to quality of health care services. Quality of healthcare has been clearly defined and includes three components of medical care, namely technical quality (the ability to improve health outcomes), process quality (the management of the interpersonal process) and structure quality (related to the quality of amenities). Responsiveness, though consisting of aspects of process quality and structure quality, does not include the technical aspect of the health services.

Patients' satisfaction of the healthcare service received by them is another area with many overlapping components with responsiveness. Patient satisfaction captures client perceptions of the quality of care delivered by a health care provider or the system. Therefore, clients' perceptions of the technical or the medical aspect of the service received is included in the assessment. The research conducted globally bears evidence that technical competency is an essential component in the assessment of patient satisfaction with medical services.

Responsiveness, as described by the WHO, is a multi-domain concept. These domains, which are the various non-medical aspects, were identified after an elaborate review of literature published mainly on patient satisfaction and quality of health care. All domains included in the previous studies were pooled together and a comprehensive set of domains were identified by the panel. At the end of much research, eight domains were identified as being the aspects of health systems' responsiveness. These were,

- Prompt attention – travel time and waiting time
- Dignity – talked respectfully and ensured privacy
- Communication – clear explanations and time for questions
- Autonomy – treatment information and involvement
- Confidentiality – talked privately and confidentiality of records
- Basic amenities – cleanliness and space
- Choice of health care provider
- Social support – family visits and external contacts

The assessment of responsiveness, essentially, has to be made by the service seeker who is in the best position to state how the non-medical expectations were met by the health system. Making an assessment of the performance of a health system based on peoples' perspectives would be influenced by a number of socio demographic factors of the respondents as well as the socio cultural milieu. Nevertheless, it can provide valuable information with regard to service provision and as to which components of the service need further strengthening to improve the health status of the people by improving the performance of the healthcare system. Especially when the identified domains of responsiveness are adjusted according to the socio cultural differences of countries, responsiveness can be assessed to provide much information on health systems' per-

formance.

While assessing the responsiveness of the entire health system is important for improvement of healthcare, responsiveness could also be assessed with regard to a specific service or an institution. This has much practical value in the improvement of health care service delivery at institutional and specific service level.

Undoubtedly, Sri Lanka has achieved high standards with regard to health status and health care services. In an era when the nonmedical needs are considered as being equally important by the public, it is timely that the concept of responsiveness is examined and applied to health systems to further enhance the performance.

This assessment would be of great value for the policy makers, programme managers and medical administrators at the district, provincial and national levels. The policy makers and administrators could incorporate aspects of responsiveness into their policies and health care delivery settings, thereby improving the awareness of the service providers at the point of delivery of services. This information would also be of great use to the health care providers at the point of delivery of the services as it is primarily up to them to improve the way in which the people are treated and the setting in which they are treated. This would lead to better utilisation of services and better compliance on the part of those seeking health care services.

Improving the responsiveness hardly creates a strain on the available resources. The budgetary constraints are not a barrier in taking measures to improve the various components of responsiveness of the health system. Minimal finances are necessary to improve the way the patients are treated and the settings in which they are treated as it is the awareness of the service providers that needs to be addressed in order to treat the patients better and reorganise the already available resources.

As described, the advantages of the health system being responsive to the nonmedical expectations of the people are many. Therefore, this is a concept that could be conveniently adopted into the Sri Lankan health system to improve the health and wellbeing of the people which is the primary objective of the health system.

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(Work was done as a research for MD in Community Medicine)*

Table 1: Vaccine-preventable Diseases & AFP

11th – 17th June 2011(24th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	01	00	00	00	00	00	00	00	01	02	45	42	+ 07.1 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	03	00	00	00	00	00	00	00	00	03	01	70	43	+ 62.7 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	10	12	- 16.7 %
Whooping Cough	00	00	00	00	00	00	00	01	00	01	02	17	14	+ 21.4 %
Tuberculosis	45	02	19	08	06	09	00	24	14	127	114	4059	4205	- 03.7 %

Table 2: Newly Introduced Notifiable Disease

11th – 17th June 2011(24th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	14	01	10	01	07	08	04	02	04	51	40	2335	1797	+ 29.9 %
Meningitis	01 GM=1	01 KD=1	02 GL=1 HB=1	00	00	07 KN=5 PU=2	01 PO=1	02 MO=2	01 RP=1	15	28	430	858	- 49.9 %
Mumps	09	05	04	01	06	04	02	01	04	36	15	1207	470	+ 156.8 %
Leishmaniasis	00	00	02 HB=2	00	00	00	03 AP=3	00	00	05	02	310	155	+ 100.0 %

Key to Table 1 & 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.
DPDHS Divisions: CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

Thoroughly clean the water collecting tanks bird baths, vases and other utensils once a week to prevent dengue mosquito breeding.

Table 4: Selected notifiable diseases reported by Medical Officers of Health
11th - 17th June 2011(24th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received Timely**
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	384	3419	3	105	1	5	1	70	0	9	4	218	0	6	1	26	0	2	85
Gampaha	80	1115	2	70	0	10	0	28	0	16	2	318	1	16	2	53	0	3	53
Kalutara	37	559	1	78	0	4	1	28	1	15	2	139	0	0	0	4	0	0	75
Kandy	14	251	9	215	0	4	0	16	1	29	4	91	3	62	1	32	0	0	96
Matale	9	136	1	66	0	3	3	14	0	8	4	123	0	12	0	4	0	0	92
Nuwara	1	69	16	202	0	3	4	31	2	89	3	28	0	44	2	12	0	1	77
Galle	24	275	1	44	0	5	1	4	0	5	8	93	0	16	0	7	0	1	89
Hambantota	9	243	0	22	0	4	0	2	0	14	5	383	1	30	1	5	0	0	92
Matara	9	219	2	43	0	1	0	8	0	10	2	186	2	42	0	12	0	1	94
Jaffna	5	155	8	99	0	3	4	143	5	47	0	2	3	172	0	16	0	1	82
Kilinochchi	0	35	0	11	0	3	0	5	0	9	0	2	0	8	0	3	0	0	25
Mannar	1	21	0	10	0	0	4	14	3	78	0	11	0	29	0	2	0	0	100
Vavuniya	1	51	1	21	1	10	0	7	0	36	0	34	0	2	0	1	0	0	50
Mullaitivu	3	10	0	28	0	1	0	2	0	0	0	5	0	1	0	2	0	0	50
Batticaloa	23	578	5	442	0	4	0	5	0	10	1	20	0	1	0	2	0	4	64
Ampara	4	70	1	53	0	0	0	7	0	21	0	51	0	1	0	7	0	0	71
Trincomalee	1	93	6	467	0	1	0	2	0	8	1	79	0	3	0	6	0	0	42
Kurunegala	20	359	11	174	0	6	0	53	1	37	7	1318	0	46	1	19	0	3	57
Puttalam	7	265	1	100	0	0	0	17	0	5	0	86	0	13	0	6	0	1	58
Anuradhapu	2	120	4	74	0	1	0	2	0	22	1	226	0	16	0	8	0	0	32
Polonnaruw	2	158	0	69	0	1	0	9	0	12	0	70	0	1	0	9	0	0	57
Badulla	11	169	6	125	0	5	1	39	0	5	1	33	1	37	2	24	0	0	71
Monaragala	0	114	2	33	0	4	0	21	0	10	2	157	2	45	0	35	0	0	73
Ratnapura	16	405	11	282	0	4	1	26	0	13	7	296	0	22	0	24	0	2	67
Kegalle	6	224	0	58	0	11	1	41	0	18	1	200	0	15	1	51	0	0	36
Kalmunai	1	19	4	387	0	0	0	0	0	12	0	4	0	2	0	2	0	1	54
SRI LANKA	670	9132	95	3278	02	93	21	594	13	538	55	4173	13	642	11	372	00	20	69

Source: Weekly Returns of Communicable Diseases WRCD).

*Dengue Fever / DHF refers to Dengue Fever / Dengue Haemorrhagic Fever.

**Timely refers to returns received on or before 17th June , 2011 Total number of reporting units =320. Number of reporting units data provided for the current week: 226

A = Cases reported during the current week. B = Cumulative cases for the year.

PRINTING OF THIS PUBLICATION IS FUNDED BY THE WORLD HEALTH ORGANIZATION (WHO).

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