WEEKLY EPIDEMIOLOGICAL REPORT

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Renewal of Public Health Care

Why a renewal of primary health care (PHC), and why now, more than ever? The immediate answer is the palpable demand for it from Member States, not just from health professionals, but from the political arena as well.

Globalization is putting the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should. People are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations. Few would disagree that health systems need to respond better and faster to the challenges of a changing world. PHC can do that.

There is a recognition that populations are left behind and a sense of lost opportunities that are reminiscent of what gave rise, thirty years ago, to Alma-Ata's paradigm shift in thinking about health. The Alma-Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors.

The translation of these values into tangible reforms has been uneven. Nevertheless, today, health equity enjoys increased prominence in the discourse of political leaders and ministries of health, as well as of local government structures, professional organizations and civil society organizations.

The PHC values to achieve health for all require health systems that "Put people at the centre of health care". What people consider desirable ways of living as individuals and what they expect for their societies i.e. what people value constitute important parameters for governing the health sector? PHC has remained the benchmark for most countries' discourse on health precisely because the PHC movement tried to provide rational, evidence based and anticipatory responses to health needs and to these social expectations. Achieving this requires tradeoffs that must start by taking into account citizens' "expectations about health and health care" and ensuring "that voice and choice decisively influence the way in which health services are designed and operate"8. A recent PHC review echoes this perspective as the "right to the highest attainable level of health", "maximizing equity and solidarity" while being guided by "responsiveness to people's needs". Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of PHC.

Responding to the challenges of a changing world

On the whole, people are healthier, wealthier and live longer today than 30 years ago. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This difference of 6.7 million is equivalent to 18329 children's lives being saved every day. The once revolutionary notion of essential drugs has become commonplace. There have been significant improvements in access to water, sanitation and antenatal care.
This shows that progress is possible. It can also be accelerated. There have never been more resources available for health than now. The

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global health economy is growing faster than gross domestic product (GDP), having increased its share from 8% to 8.6% of the world's GDP between 2000 and 2005. In absolute terms, adjusted for inflation, this represents a 35% growth in the world's expenditure on health over a five year period. Knowledge and understanding of health are growing rapidly. The accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better-educated and modernizing global society. A global stewardship is emerging: from intensified exchanges between countries, often in recognition of shared threats, challenges or opportunities; from growing solidarity; and from the global commitment to eliminate poverty exemplified in the Millennium Development Goals (MDGs).

However, there are other trends that must not be ignored. First, the substantial progress in health over recent decades has been deeply unequal, with convergence towards improved health in a large part of the world, but at the same time, with a considerable number of countries increasingly lagging behind or losing ground. Furthermore, there is now ample documentation not available 30 years ago of considerable and often growing health inequalities within countries.

Second, the nature of health problems is changing in ways that were only partially anticipated, and at a rate that was wholly unexpected. Ageing and the effects of ill managed urbanization and globalization accelerate worldwide transmission of communicable diseases, and increase the burden of chronic and non communicable disorders. The growing reality that many individuals present with complex symptoms and multiple illnesses challenge the service delivery to develop more integrated and comprehensive case management. A complex web of interrelated factors is at work, involving gradual but long term increases in income and population, climate change, challenges to food security, and social tensions, all with definite, but largely unpredictable, implications for health in the years ahead.

Third, health systems are not insulated from the rapid pace of change and transformation that is an essential part of today's globalization. Economic and political crises challenge state and institutional roles to ensure access, delivery and financing. Unregulated commercialization is accompanied by a blurring of the boundaries between public and private actors, while the negotiation of entitlement and rights is increasingly politicized. The information age has transformed the relations between citizens, professionals and politicians.

In many regards, the responses of the health sector to the changing world have been inadequate and naïve. Inadequate, insofar as they not only fail to anticipate, but also to respond appropriately: too often with too little, too late or too much in the wrong place. Naïve insofar as a system's failure requires a system's solution not a temporary remedy. Problems with human resources for public health and health care, finance, infrastructure or information systems invariably extend beyond the narrowly defined health sector, beyond a single level of policy purview and, increasingly, across borders: this raises the benchmark in terms of working effectively across government and stakeholders.

While the health sector remains massively under resourced in far too many countries, the resource base for health has been growing consistently over the last decade. The opportunities this growth offers for inducing structural changes and making health systems more effective and equitable are often missed. Global and, increasingly, national policy formulation processes have focused on single issues, with various constituencies competing for scarce resources, while scant attention is given to the underlying constraints that hold up health systems development in national contexts. Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction.

Today, it is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata. Health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money. Three particularly worrisome trends can be characterized as follows: health systems that focus disproportionately on a narrow offer of specialized curative care health systems where a command-and-control approach to disease control, focused on short term results, is fragmenting service delivery health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish.

These trends fly in the face of a comprehensive and balanced response to health needs. In a number of countries, the resulting inequitable access, impoverishing costs, and erosion of trust in health care constitute a threat to social stability.

Growing expectations for better performance

The support for a renewal of PHC stems from the growing realization among health policy-makers that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems, and an alternative to the assorted quick fixes currently touted as cures for the health sector's ills. There is also a growing realization that conventional health care delivery, through different mechanisms and for different reasons, is not only less effective than it could be, but suffers from a set of ubiquitous shortcomings and contradictions such as inverse care, impoverishing care, fragmented and fragmenting care, unsafe care and misdirected care.

The mismatch between expectations and performance is a cause of concern for health authorities. Given the growing economic weight and social significance of the health sector, it is also an increasing cause for concern among politicians: it is telling that health care issues were, on average, mentioned more than 28 times in each of the recent primary election debates in the United States. Business as usual for health systems is not a viable option. If these shortfalls in performance are to be redressed, the health problems of today and tomorrow will require stronger collective management and accountability guided by a clearer sense of overall direction and purpose.

Indeed, this is what people expect to happen. As societies modernize, people demand more from their health systems, for themselves and their families, as well as for the society in which they live. Thus, there is increasingly popular support for better health equity and an end to exclusion; for health services that are centered on people's needs and expectations; for health security for the communities in which they live; and for a say in what affects their health and that of their communities. These expectations resonate with the values that were at the core of the Declaration of Alma-Ata. They explain the current demand for a better alignment of health systems with these values and provide today's PHC movement with reinvigorated social and political backing for its attempts to reform health systems.

Source: World Health Report 2008, WHO

Table 1: Vaccine-preventable Diseases & AFP

14th - 20th August 2010(33rd Week)

Disease	No. of Cases by Province									Number of cases during current week in 2010	Number of cases during same week in 2009	Total number of cases to date in 2010	Total number of cases to date in 2009	Difference between the number of cases to date in 2010 & 2009
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	00	00	58	49	+ 18.3 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	-
Measles	00	00	03	00	00	00	00	00	00	03	07	65	99	- 34.3 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	16	18	- 11.1 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	01	20	37	- 45.9 %
Tuberculosis	93	03	16	16	24	27	04	21	08	212	68	5580	6426	- 13.2 %

Table 2: Newly Introduced Notifiable Disease

14th - 20th August 2010(33rd Week)

Disease	No. of Cases by Province									Number of cases during current week in 2010	Number of cases during same week in 2009	Total number of cases to date in 2010	Total number of cases to date in 2009	Difference between the number of cases to date in 2010 & 2009
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	09	05	06	01	00	05	01	00	08	35	109	2214	11641	- 81.0 %
Meningitis	02 KL=1 GM=1	00	00	00	01 KM=1	03 KN=3	01 AP=1	03 BD=3	01 RP=1	11	19	1153	685	+ 68.3 %
Mumps	04	01	02	00	01	09	00	02	12	31	27	711	1231	- 42.2 %
Leishmaniasis	00	00	15	00	00	00	12 AP=5 PO=7	00	00	27	05	219	496	- 55.8 %

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

Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them free of water collection.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

14th - 20th August 2010(33rd Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Re-
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	171	4775	6	213	0	14	4	96	0	31	9	396	0	7	4	47	0	1	**77**
Gampaha	64	3321	1	112	0	19	0	36	0	18	4	266	0	10	0	72	0	4	**47**
Kalutara	49	1495	1	176	0	13	1	17	0	74	6	240	0	2	1	27	0	1	**58**
Kandy	33	1351	3	238	0	4	1	21	0	4	3	70	4	110	30	76	0	1	**74**
Matale	9	521	1	249	1	5	1	29	0	70	1	71	0	4	2	38	0	0	**58**
Nuwara	4	165	3	282	0	0	2	97	0	84	0	21	0	49	2	31	0	0	**69**
Galle	34	891	10	201	0	5	0	5	0	12	0	64	2	18	0	10	0	3	**79**
Hambanto	25	659	1	59	1	5	0	1	0	10	0	73	5	68	0	7	0	0	**100**
Matara	21	474	2	138	0	6	0	5	2	49	6	204	1	100	0	16	0	0	**82**
Jaffna	18	2605	2	193	0	3	9	454	0	8	0	1	1	109	1	51	0	2	**75**
Kilinochc	5	24	1	11	0	0	0	8	0	1	1	1	0	0	0	0	0	0	**100**
Mannar	34	433	1	35	0	1	0	37	0	10	0	0	0	1	0	16	0	0	**80**
Vavuniya	5	549	0	33	0	3	0	38	0	8	0	2	0	1	0	10	0	1	**50**
Mullaitivu	0	5	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**0**
Batticaloa	4	1148	6	126	0	3	0	18	0	30	0	10	0	3	0	4	0	2	**86**
Ampara	2	123	0	65	0	1	0	6	0	6	0	29	0	0	0	10	0	0	**43**
Trincomal	3	895	3	118	0	13	0	4	0	11	1	20	2	17	1	13	0	1	**60**
Kurunegal	40	1192	8	226	1	16	0	27	0	9	7	236	7	45	5	91	0	3	**95**
Puttalam	9	866	3	99	0	6	3	45	0	124	0	63	0	0	0	20	0	1	**56**
Anuradha	7	920	5	58	0	6	0	10	0	37	1	66	0	22	1	37	0	3	**63**
Polonnaru	5	354	1	64	0	1	0	6	0	8	1	52	0	1	1	36	0	0	**100**
Badulla	38	998	1	142	0	1	0	69	0	16	2	56	0	69	0	79	0	0	**40**
Monaragal	12	813	0	128	0	1	0	31	0	4	0	29	1	59	0	63	0	2	**36**
Ratnapura	45	2186	4	363	0	4	1	11	0	26	2	288	0	47	0	73	0	2	**56**
Kegalle	27	753	6	110	1	12	3	47	0	19	3	183	0	14	2	72	0	0	**91**
Kalmunai	3	499	16	210	1	3	0	6	2	5	0	1	0	0	0	11	0	1	**77**
SRI LANKA	**637**	**28015**	**85**	**3651**	**05**	**145**	**25**	**1125**	**02**	**674**	**47**	**2442**	**23**	**756**	**49**	**910**	**00**	**28**	**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 20th August , 2010 Total number of reporting units =311. Number of reporting units data provided for the current week: 221
A = Cases reported during the current week. B = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@sltnet.lk.

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