WEEKLY EPIDEMIOLOGICAL REPORT

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Good care is about people (part 3)

A regular and trusted provider as entry point

Comprehensiveness, continuity and person-centredness are critical to better health outcomes. They all depend on a stable, long-term, personal relationship (a feature also called "longitudinality") between the population and the professionals who are their entry point to the health system. Most ambulatory care in conventional settings is not organized to build such relationships.

The busy, anonymous and technical environment of hospital outpatient departments, with their many specialists and sub-specialists, produce mechanical interactions between nameless individuals and an institution – not people-centred care. Smaller clinics are less anonymous, but the care they provide is often more akin to a commercial or administrative transaction that starts and ends with the consultation than to a responsive problem-solving exercise. In this regard, private clinics do not perform differently than public health centres. In the rural areas of low-income countries, governmental health centres are usually designed to work in close relationship with the community they serve. The reality is often different. Earmarking of resources and staff for selected programmes is increasingly leading to fragmentation, while the lack of funds, the pauperization of the health staff and rampant commercialization makes building such relationships difficult.

There are many examples to the contrary, but the relationship between providers and their clients, particularly the poorer ones, is often not conducive to building relationships of understanding, empathy and trust. Building enduring relationships requires time. Studies indicate that it takes two to five years before its full potential is achieved. Access to the same team of healthcare providers over time fosters the development of a relationship of trust between the individual and their healthcare provider. Health professionals are more likely to respect and understand patients they know well, which creates more positive interaction and better communication. They can more readily understand and anticipate obstacles to continuity of care, follow up on the progress and assess how the experience of illness or disability is affecting the individual's daily life. More mindful of the circumstances in which people live, they can tailor care to the specific needs of the person and recognize health problems at earlier stages. This is not merely a question of building trust and patient satisfaction, however important these may be. It is worthwhile because it leads to better quality and better outcomes.

People who use the same source of care for most of their healthcare needs tend to comply better with advice given, rely less on emergency services, require less hospitalization and are more satisfied with care. Providers save consultation time, reduce the use of laboratory tests and costs, and increase uptake of preventive care. Motivation improves through the social recognition built up by such relationships. ***Still, even dedicated health professionals will not seize all these opportunities spontaneously***. The interface between the population and their health services needs to be designed in a way that not only makes this possible, but also the most likely course of action.

Organizing primary-care networks

A health service that provides entry point ambulatory care for health and health related problems should, thus, offer a comprehensive range of integrated diagnostic, curative, rehabilitative and palliative services. In contrast to most conventional healthcare delivery models, the offer of services should include prevention and promotion as well as efforts to tackle determinants of ill-health locally. A direct and enduring relationship between the provider and the people in the community served is essential to be able to

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take into account the personal and social context of patients and their families, ensuring continuity of care over time as well as across services.

In order for conventional health services to be transformed into primary care, i.e. to ensure that these distinctive features get due prominence, they must reorganize. A precondition is to ensure that they become directly and permanently accessible, without undue reliance on out of pocket payments and with social protection offered by universal coverage schemes. But another set of arrangements is critical for the transformation of conventional care – ambulatory- and institution-based, generalist and specialist into local networks of primary care centres bringing care closer

- to people, in settings in close proximity and direct relationship with the community, relocating the entry point to the health system from hospitals and specialists to close to client generalist primary care centres
- giving primary care providers the responsibility for the health of a defined population, in its entirety the sick and the healthy, those who choose to consult the services and those who choose not to do so
- strengthening primary care providers' role as coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power

Bringing care closer to the people

A first step is to relocate the entry point to the health system from specialized clinics, hospital outpatient departments and emergency services, to generalist ambulatory care in close to client settings. Evidence has been accumulating that this transfer carries measurable benefits in terms of relief from suffering, prevention of illness and death, and improved health equity. These findings hold true in both national and cross national studies, even if all of the distinguishing features of primary care are not fully realized.

Generalist ambulatory care is more likely or as likely to identify common life threatening conditions as specialist care. Generalists adhere to clinical practice guidelines to the same extent as specialists, although they are slower to adopt them. They prescribe fewer invasive interventions, fewer and shorter hospitalizations and have a greater focus on preventive care. This results in lower overall health care costs for similar health outcomes and greater patient satisfaction. Evidence from comparisons between high income countries shows that higher proportions of generalist professionals working in ambulatory settings are associated with lower overall costs and higher quality rankings. Conversely, countries that increase reliance on specialists have stagnating or declining health outcomes when measured at the population level, while fragmentation of care exacerbates user dissatisfaction and contributes to a growing divide between health and social services. Information on low and middle income countries is harder to obtain, but there are indications that patterns are similar. Some studies estimate that in Latin America and the Caribbean more reliance on generalist care could avoid one out of two hospital admissions. In Thailand, generalist ambulatory care outside a hospital context has been shown to be more patient centred and responsive as well as cheaper and less inclined to over medicalization.

The relocation of the entry point into the system from specialist hospital to generalist ambulatory care creates the conditions for more comprehensiveness, continuity and person centredness. This amplifies the benefits of the relocation. It is particularly the case when services are organized as a dense network of small, close to client service delivery points. This makes it easier to have teams that are small enough to know their communities and be known by them, and stable enough to establish an enduring relationship. These teams require relational and organizational capacities as much as the technical competencies to solve the bulk of health problems locally.

Responsibility for a well-identified population

In conventional ambulatory care, the provider assumes responsibility for the person attending the consultation for the duration of the consultation and, in the best of circumstances, that responsibility extends to ensuring continuity of care. This passive, response to demand approach fails to help a considerable number of people who could benefit from care. There are people who, for various reasons, are, or feel, excluded from access to services and do not take up care even when they are in need. There are people who suffer illness but delay seeking care. Others present risk factors and could benefit from screening or prevention programmes (e.g. for cervical cancer or for childhood obesity), but are left out because they do not consult preventive services that are limited to service users often leaving out those most in need. A passive, response to demand approach has a second untoward consequence: it lacks the ambition to deal with local determinants of ill health whether social, environmental or work related. All this represent lost opportunities for generating health: providers that only assume responsibility for their customers concentrate on repairing rather than on maintaining and promoting health.

The alternative is to entrust each primary care team with the explicit responsibility for a well defined community or population. They can then be held accountable, through administrative measures or contractual arrangements, for providing comprehensive, continuous and person-centred care to that population, and for mobilizing a comprehensive range of support services from promotive through to palliative. The simplest way of assigning responsibility is to identify the community served on the basis of geographical criteria the classic approach in rural areas. The simplicity of geographical assignment, however, is deceptive. It follows an administrative, public sector logic that often has problems adapting to the emergence of a multitude of other providers. Furthermore, administrative geography may not coincide with sociological reality, especially in urban areas. People move around and may work in a different area than where they live, making the health unit closest to home actually an inconvenient source of care. More importantly, people value choice and may resent an administrative assignment to a particular health unit. Some countries find geographical criteria of proximity the most appropriate to define who fits in the population of responsibility, others rely on active registration or patient lists. The important point is not how but whether the population is well identified and mechanisms exist to ensure that nobody is left out.

Source: World Health Organization

to be continued

Table 1: Vaccine-preventable Diseases & AFP

04th - 10th September 2010(36th 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	01	00	00	00	00	00	00	01	02	02	65	53	+ 22.6 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	-
Measles	02	00	00	00	00	00	01	00	00	03	14	73	134	- 45.5 %
Tetanus	00	00	00	00	00	00	00	00	00	00	01	18	19	- 05.3 %
Whooping Cough	00	00	00	00	00	00	01	00	00	01	04	22	44	- 50.0 %
Tuberculosis	31	06	10	00	10	01	06	15	03	82	148	6612	7116	- 07.1 %

Table 2: Newly Introduced Notifiable Disease

04th - 10th September 2010(36th 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	06	02	09	01	04	07	05	05	08	47	255	2390	12344	- 80.6 %
Meningitis	04 GM=2 KT=2	02 ML=2	01 MT=1	00	00	01 KN=1	03 P0=1 AP=2	00	00	11	28	1224	802	+ 52.6 %
Mumps	08	01	01	00	01	03	01	00	06	21	20	830	1348	- 38.4 %
Leishmaniasis	00	00	01 MT=1	00	00	01 KN=1	04 AP=4	02 MO=2	00	08	08	243	521	- 53.3 %

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

04th - 10th September 2010(36th 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	50	5170	4	230	0	14	1	102	2	34	9	434	0	7	3	51	0	1	**69**
Gampaha	29	3548	2	122	1	20	2	39	0	19	14	312	0	12	3	80	0	4	**60**
Kalutara	16	1638	1	188	0	13	0	18	0	74	4	254	0	2	1	30	0	1	**58**
Kandy	15	1467	2	247	0	4	0	23	0	6	3	83	1	112	2	100	0	1	**70**
Matale	8	550	1	260	0	6	0	31	1	72	0	79	0	5	3	46	0	0	**83**
Nuwara	0	190	6	302	0	0	0	102	0	84	0	21	0	53	0	33	0	0	**69**
Galle	13	991	6	215	0	6	0	5	2	15	1	69	0	19	0	12	0	3	**84**
Hambanto	13	725	0	63	0	6	0	1	0	10	0	76	2	73	1	10	0	0	**82**
Matara	13	528	2	148	0	8	0	9	0	49	8	252	4	113	0	17	0	0	**94**
Jaffna	8	2667	1	215	0	3	2	475	0	8	0	1	0	110	1	53	0	2	**67**
Kilinochc	7	35	0	11	0	0	1	10	0	1	2	3	0	0	1	1	0	0	**25**
Mannar	12	484	1	37	0	1	1	41	0	10	0	0	0	1	0	16	0	0	**33**
Vavuniya	1	563	2	36	0	3	0	40	0	8	0	2	0	1	0	10	0	1	**50**
Mullaitivu	2	13	0	5	0	0	1	2	0	0	0	0	0	0	0	1	0	0	**33**
Batticaloa	2	1176	0	143	0	3	2	31	0	34	0	10	0	3	0	4	0	2	**93**
Ampara	3	136	2	69	0	1	1	7	0	6	0	30	0	0	0	11	0	0	**43**
Trincomal	5	927	0	124	0	13	0	6	0	11	0	20	0	18	0	14	0	1	**55**
Kurunegal	21	1286	5	242	0	17	1	29	0	10	1	247	0	49	0	98	0	3	**90**
Puttalam	5	904	1	112	0	6	0	46	0	124	1	65	1	1	0	20	0	1	**78**
Anuradha	15	959	5	68	2	9	1	11	0	37	2	73	3	25	0	41	0	3	**84**
Polonnaru	10	369	3	82	0	1	0	6	0	8	0	53	0	1	2	38	0	0	**100**
Badulla	18	1175	1	167	0	1	0	70	8	24	0	63	0	81	2	83	0	0	**73**
Monaragal	10	917	1	141	0	1	0	33	2	6	1	31	1	67	1	67	0	2	**64**
Ratnapura	21	2429	7	397	0	4	2	13	0	26	0	297	0	49	2	77	0	2	**56**
Kegalle	10	819	2	118	1	13	1	51	0	19	8	199	2	19	4	89	0	0	**100**
Kalmunai	0	504	6	233	0	3	0	6	0	6	1	3	0	0	0	11	0	1	**62**
SRI LANKA	**307**	**30170**	**61**	**3975**	**04**	**156**	**16**	**1207**	**15**	**701**	**55**	**2677**	**14**	**821**	**26**	**1013**	**00**	**28**	**72**

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 10th September , 2010 Total number of reporting units =311. Number of reporting units data provided for the current week: 234
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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