WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Healthcare and Nutrition

231, de Saram Place, Colombo 01000, Sri Lanka
Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@sltnet.lk
Epidemiologist: +94 11 2681548, E mail: chepid@sltnet.lk
Web: http://www.epid.gov.lk

Vol. 37 No.33 **14th – 20th August 2010**

WER SRI LANKA - 2010

Trends that undermine the health systems

Without strong policies and leadership, health systems do not spontaneously gravitate towards Public Health Care (PHC) values or efficiently respond to evolving health challenges. As most health leaders know, health systems are subject to powerful forces and influences that often override rational priority setting or policy formation, thereby pulling health systems away from their intended directions. Characteristic trends that shape conventional health systems today include a disproportionate focus on,

- Specialist, tertiary care, often referred to as "hospital-centrism"
- Fragmentation, as a result of the multiplication of programmes and projects
- The pervasive commercialization of health care in unregulated health systems

With their focus on cost containment and deregulation, many of the health-sector reforms of the 1980s and 1990s have reinforced these trends. High income countries have often been able to regulate to contain some of the adverse consequences of these trends. However, in countries where under funding compounds limited regulatory capacity, they have had more damaging effects.

Hospital-centrism: health systems built around hospitals and specialists

For much of the 20th century, hospitals, with their technology and sub-specialists, have gained a pivotal role in most health systems throughout the world. Today, the disproportionate focus on hospitals and sub specialization has become a major source of inefficiency and inequality, and one that has proved remarkably resilient. Health authorities may voice their concern more insistently than they used to, but sub specialization continues to prevail. For example, in Member countries of the Organisation of Economic Cooperation and Development (OECD), the 35% growth in the number of doctors in the last 15 years was driven by rising numbers of specialists (up by nearly 50% between 1990 and 2005 compared with only a 20% increase in general practitioners). In Thailand, less than 20% of doctors were specialists 30 years ago; by 2003 they represented 70%.

The forces driving this growth include professional traditions and interests as well as the considerable economic weight of the health industry technology and pharmaceuticals.

Obviously, well functioning specialized tertiary care responds to a real demand. It is necessary, at the very least, for the political credibility of the health system. However, the experience of industrialized countries has shown that a disproportionate focus on specialist, tertiary care provides poor value for money. Hospital-centrism carries a considerable cost in terms of unnecessary medicalization and iatrogenesis, and compromises the human and social dimensions of health. It also carries an opportunity cost: Lebanon, for example, counts more cardiac surgery units per inhabitant than Germany, but lacks programmes aimed at reducing the risk factors for cardiovascular disease. Inefficient ways of dealing with health problems are thus crowding out more effective, efficient and more equitable ways of organizing health care and improving health.

Since the 1980s, a majority of OECD countries has been trying to decrease reliance on hospitals, specialists and technologies, and keep costs under control. They have done this by introducing supply side measures including reduction of hospital beds, substitution of hospitalization by home care, rationing of medical equipment, and a multitude of financial incentives and disincentives to promote micro level efficiency. The results of these efforts have been mixed, but the evolving technology is accelerating the shift from specialized hospital to primary care. In many high income countries (but not all), the PHC efforts of the 1980s and 1990s have been able to reach a better balance between specialized curative care, first contact care and health promotion. Over the last 30 years, this has contributed to significant improvements in health outcomes. More recently, middle income countries, such as Chile with its *Atención Primaria de Salud* (Primary Health Care), Brazil with its family health initiative and Thailand under its universal coverage scheme have shifted the balance between specialized hospital and primary care in the same way. The initial results are encouraging: improvement of outcome indicators combined with a marked improvement in patient satisfaction. In each

Contents	*Page*

of these cases, the shift took place as part of a move towards universal coverage, with expanded citizen's rights to access and social protection. These processes are very similar to what occurred in Malaysia and Portugal: right to access, social protection, and a better balance between reliance on hospitals and on generalist primary care, including prevention and health promotion.

Industrialized countries are, 50 years later, trying to reduce their reliance on hospitals, having realized the opportunity cost of hospital centrism in terms of effectiveness and equity. Yet, many low- and middle-income countries are creating the same distortions. The pressure from consumer demand, the medical professions and the medico -industrial complex is such that ***private and public health resources flow disproportionately towards specialized hospital care at the expense of investment in primary care***. National health authorities have often lacked the financial and political clout to curb this trend and achieve a better balance. Donors have also used their influence more towards setting up disease control programmes than towards reforms that would make primary care the hub of the health system.

Fragmentation: health systems built around priority programmes

While urban health by and large revolves around hospitals, the rural poor are increasingly confronted with the progressive fragmentation of their health services, as "selective" or "vertical" approaches focus on individual disease control programmes and projects. Originally considered as an interim strategy to achieve equitable health outcomes, they sprang from a concern for the slow expansion of access to health care in a context of persistent severe excess mortality and morbidity for which cost effective interventions exist. A focus on programmes and projects is particularly attractive to an international community concerned with getting a visible return on investment. It is well adapted to command and control management a way of working that also appeals to traditional ministries of health. With little tradition of collaboration with other stakeholders and participation of the public, and with poor capacity for regulation, programmatic approaches have been a natural channel for developing governmental action in severely resource constrained and donor dependent countries. They have had the merit of focusing on health care in severely resource constrained circumstances, with welcome attention to reaching the poorest and those most deprived of services.

Many have hoped that single disease control initiatives would maximize return on investment and somehow strengthen health systems as interventions were delivered to large numbers of people, or would be the entry point to start building health systems where none existed. Often the opposite has proved true. The limited sustainability of a narrow focus on disease control, and the distortions it causes in weak and under-funded health systems have been criticized extensively in recent years. Short term advances have been short lived and have fragmented health services to a degree that is now of major concern to health authorities. With parallel chains of command and funding mechanisms, duplicated supervision and training schemes, and multiplied transaction costs, they have led to situations where programmes compete for scarce resources, staff and donor attention, while the structural problems of health systems funding, payment and human resources are hardly addressed. The discrepancy in salaries between regular public sector jobs and better funded programmes and projects has exacerbated the human resource crisis in fragile health systems. In Ethiopia, contract staff hired to help implement programmes were paid three times more than regular government employees, while in Malawi, a hospital saw 88 nurses leave for better paid nongovernmental organization (NGO) programmes in an 18 month period.

Eventually, service delivery ends up dealing only with the diseases for which a (funded) programme exists overlooking people who have the misfortune not to fit in with current programme priorities. It is difficult to maintain the people's trust if they are considered as mere programme targets: services then lack social sustainability. This is not just a problem for the population. It puts health workers in the unenviable position of having to turn down people with "the wrong kind of problem" something that fits ill with the self image of professionalism and caring many cherish. Health authorities may at first be seduced by the straightforwardness of programme funding and management, yet once programmes multiply and fragmentation becomes unmanageable and unsustainable, the merits of more integrated approaches are much more evident. The re-integration of programmes once they have been well established is no easy task.

Health systems left to drift towards unregulated commercialization

In many, if not most low and middle income countries, under resourcing and fragmentation of health services has accelerated the development of commercialized health care, defined here as the unregulated fee for service sale of health care, regardless of whether or not it is supplied by public, private or NGO providers.

Commercialization of health care has reached previously unheard of proportions in countries that, by choice or due to a lack of capacity, fail to regulate the health sector. Originally limited to an urban phenomenon, small scale unregulated fee for service health care offered by a multitude of different independent providers now dominates the health care landscape from sub Saharan Africa to the transitional economies in Asia or Europe.

Commercialization often cuts across the public private divide. Health care delivery in many governmental and even in traditionally not-for-profit NGO facilities has been de facto commercialized, as informal payment systems and cost recovery systems have shifted the cost of services to users in an attempt to compensate for the chronic under funding of the public health sector and the fiscal stringency of structural adjustment. In these same countries, moonlighting civil servants make up a considerable part of the unregulated commercial sector, while others resort to under the counter payments. The public-private debate of the last decades has, thus, largely missed the point: for the people, the real issue is not whether their health care provider is a public employee or a private entrepreneur, nor whether health facilities are publicly or privately owned. Rather, it is whether or not health services are reduced to a commodity that can be bought and sold on a fee for service basis without regulation or consumer protection.

Commercialization has consequences for quality as well as for access to care. The reasons are straightforward: the provider has the knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient. Without effective systems of checks and balances, the results can be read in consumer organization reports or newspaper articles that express outrage at the breach of the implicit contract of trust between caregiver and client. ***Those who cannot afford care are excluded; those who can may not get the care they need, often get care they do not need, and invariably pay too much***.

Unregulated commercialized health systems are highly inefficient and costly they exacerbate inequality, and they provide poor quality and, at times, dangerous care that is bad for health (in the Democratic Republic of the Congo, for example, "*la chirurgie safari*" (safari surgery) refers to a common practice of health workers moonlighting by performing appendectomies or other surgical interventions at the patients' homes, often for crippling fees).

Thus, commercialization of health care is an important contributor to the erosion of trust in health services and in the ability of health authorities to protect the public. This is what makes it a matter of concern for politicians and, much more than was the case 30 years ago, one of the main reasons for increasing support for reforms that would bring health systems more in line not only with current health challenges, but also with people's expectations.

Source: World Health report 2008, WHO

Table 1: Vaccine-preventable Diseases & AFP

07th - 13th August 2010(32nd 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	00	00	00	01	00	00	00	01	05	62	91	- 31.9 %
Tetanus	00	00	00	00	00	00	00	00	00	00	01	16	18	- 11.1 %
Whooping Cough	00	00	01	00	00	00	00	00	00	00	00	20	36	- 44.4 %
Tuberculosis	37	06	12	07	04	36	09	06	57	184	429	5668	6358	- 10.9 %

Table 2: Newly Introduced Notifiable Disease

07th - 13th August 2010(32nd 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	05	03	10	00	01	07	05	01	06	38	207	2170	11489	- 81.1 %
Meningitis	02 KL=2	01 NE=1	00	02 JF=1 MU=1	02 KM=1 MT=1	01 KN=1	00	03 BD=3	08 KG=1 RP=7	19	26	1127	657	+ 71.5 %
Mumps	04	02	01	02	00	03	02	03	06	23	27	675	1197	- 43.6 %
Leishmaniasis	01 GM=1	01 ML=1	00	00	00	02 KN=2	02 AP=2	00	00	06	04	189	490	- 61.4 %

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.

Dengue Prevention and Control Health Messages

Reduce, Reuse or Recycle the plastic and polythene collected in your home and help to minimize dengue mosquito breeding.

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

07th - 13th August 2010(32nd Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	270	4597	3	207	0	14	6	92	2	31	8	3887	0	7	2	43	0	1	**92**
Gampaha	81	3151	1	111	0	18	2	36	0	18	5	257	0	10	2	67	0	4	**87**
Kalutara	33	1448	6	173	0	13	0	16	0	74	4	227	0	2	0	25	0	1	**83**
Kandy	57	1316	4	235	1	4	0	20	0	4	0	67	3	105	3	46	0	1	**87**
Matale	8	499	7	240	0	3	3	27	0	69	0	68	0	4	2	35	0	0	**92**
Nuwara	15	160	1	264	0	0	0	88	0	84	0	21	0	49	0	27	0	0	**69**
Galle	30	842	7	191	0	5	0	5	0	12	3	63	1	16	0	10	0	3	**89**
Hambant	28	630	3	57	0	4	0	1	0	10	4	71	2	63	0	7	0	0	**82**
Matara	24	452	2	136	0	6	0	5	0	47	2	198	0	98	0	16	0	0	**82**
Jaffna	13	2583	4	190	0	3	6	444	0	8	0	1	0	108	2	50	0	2	**75**
Kilinochc	9	19	0	10	0	0	2	8	0	1	0	0	0	0	0	0	0	0	**100**
Mannar	84	399	0	34	0	1	1	37	0	10	0	0	1	1	1	16	0	0	**80**
Vavuniya	6	544	2	33	1	3	0	38	0	8	0	2	0	1	0	10	0	1	**75**
Mullaitivu	2	5	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**40**
Batticaloa	8	1144	8	120	0	3	0	18	0	30	0	10	0	3	0	4	0	2	**86**
Ampara	0	118	0	64	0	1	0	6	0	6	0	30	0	0	0	10	0	0	**14**
Trincomal	5	891	0	115	1	13	0	4	0	11	0	19	1	15	0	13	0	1	**70**
Kurunega	35	1148	8	217	0	15	0	27	0	9	1	229	0	38	0	86	0	3	**90**
Puttalam	12	848	2	95	0	6	0	42	0	124	3	63	0	0	0	20	0	1	**67**
Anuradha	4	907	2	52	1	6	0	10	0	37	2	65	0	22	1	36	0	3	**53**
Polonnar	1	348	2	63	0	1	0	6	0	8	0	51	0	1	0	35	0	0	**100**
Badulla	112	956	3	141	0	1	0	67	0	16	1	52	1	69	0	79	0	0	**87**
Monaraga	39	794	3	128	0	1	1	31	0	4	1	29	3	54	1	63	0	2	**82**
Ratnapur	91	2132	12	359	0	4	0	10	0	26	8	286	1	47	2	73	0	2	**67**
Kegalle	9	717	0	100	0	11	1	43	0	19	1	179	0	14	2	70	0	0	**64**
Kalmunai	1	494	11	182	0	2	0	6	0	3	1	1	0	0	0	11	0	1	**62**
SRI LANKA	**977**	**27142**	**91**	**3518**	**04**	**138**	**22**	**1088**	**02**	**669**	**44**	**2376**	**13**	**727**	**18**	**852**	**00**	**28**	**78**

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 13th August , 2010 Total number of reporting units =311. Number of reporting units data provided for the current week: 248
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).

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.**

ON STATE SERVICE

Dr. P. PALIHAWADANA
CHIEF EPIDEMIOLOGIST
EPIDEMIOLOGY UNIT
231, DE SARAM PLACE
COLOMBO 10