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Good care is about people (part 2)

Understanding people: person-centred care

When people are sick they are a great deal less concerned about managerial considerations of productivity, health targets, cost effectiveness and rational organization than about their own predicament. Each individual has his or her own way of experiencing and coping with health problems within their specific life circumstances.

Health workers have to be able to handle that diversity. For health workers at the interface between the population and the health services, the challenge is much more complicated than for a specialized referral service, managing a well defined disease is a relatively straightforward technical challenge. Dealing with health problems, however, is complicated as people need to be understood holistically, their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live. Failure to deal with the whole person in theirspecific familial and community contexts misses out on important aspects of health that do not immediately fit into disease categories. Partner violence against women, for example, can be detected, prevented or mitigated by health services that are sufficiently close to the communities they serve and by health workers who know the people in their community. People want to know that their health worker understands them, their suffering and the constraints they face. Unfortunately, many providers neglect this aspect of the therapeutic relation, particularly when they are dealing with disadvantaged groups. In many health services, responsiveness and person centredness are treated as luxury goods to be handed out only to a selected few.

Over the last 30 years, a considerable body of research evidence has shown that person centredness is not only important to relieve the patient's anxiety but also to improve the provider's job satisfaction. The response to a health problem is more likely to be effective if the provider understands its various dimensions. For a start, simply asking patients how they feel about their illness, how it affects their lives, rather than focusing only on the disease, results in measurably increased trust and compliance that allows patient and provider to find a common ground on clinical management, and facilitates the integration of prevention and health promotion in the therapeutic response.

Thus, person centredness becomes the "clinical method of participatory democracy", measurably improving the quality of care, the success of treatment and the quality of life of those benefiting from such care.

In practice, clinicians rarely address their patients' concerns, beliefs and understanding of illness, and seldom share problem management options with them. They limit themselves to simple technical prescriptions, ignoring the complex human dimensions that are critical to the appropriateness and effectiveness of the care they provide.

Thus, technical advice on lifestyle, treatment schedule or referral all too often neglects not only the constraints of the environment in which people live, but also their potential for self help in dealing with a host of health problems ranging from diarrhoeal disease to diabetes management. Yet, neither the nurse in Niger's rural health centre nor the general practitioner in Belgium can, for example, refer a patient to hospital without negotiating, along with medical criteria, they have to take into account the patient's values, the family's values, and their lifestyle and life perspective.

Few health providers have been trained for person centred care. Lack of proper preparation is compounded by cross cultural conflicts, social stratification, discrimination and stigma. As a consequence, the considerable potential of people to contribute to their own health through lifestyle, behaviour and self-care, and by adapting professional advice optimally to their life circumstances is underutilized. There are numerous, albeit often missed, opportunities to empower people to participate in decisions that affect their own health and that of their families. They require healthcare providers who can relate to people and assist them in making informed choices. The current payment systems and incentives in community healthcare delivery often work against establish-

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ing this type of dialogue. Conflicts of interest between provider and patient, particularly in unregulated commercial settings, are a major disincentive to person centred care. Commercial providers may be more courteous and client friendly than in the average health centre, but this is no substitute for person centredness.

Comprehensive and integrated responses

The diversity of health needs and challenges that people face does not fit neatly into the discrete diagnostic categories of textbook promotive, preventive, curative or rehabilitative care. They call for the mobilization of a comprehensive range of resources that may include health promotion and prevention interventions as well as diagnosis and treatment or referral, chronic or long-term home care, and, in some models, social services. It is at the entry point of the system, where people first present their problem, that the need for a comprehensive and integrated offer of care is most critical.

Comprehensiveness makes managerial and operational sense and adds value. People take up services more readily if they know a comprehensive spectrum of care is on offer. Moreover, it maximizes opportunities for preventive care and health promotion while reducing unnecessary reliance on specialized or hospital care. Specialization has its comforts, but the fragmentation it induces is often visibly counterproductive and inefficient, it makes no sense to monitor the growth of children and neglect the health of their mothers (and vice versa), or to treat someone's tuberculosis without considering their HIV status or whether they smoke.

That does not mean that entry point health workers should solve all the health problems that are presented there, nor that all health programmes always need to be delivered through a single integrated service delivery point. Nevertheless, the primary care team has to be able to respond to the bulk of health problems in the community. When it cannot do so, it has to be able to mobilize other resources, by referring or by calling for support from specialists, hospitals, specialized diagnostic and treatment centres, public health programmes, long term care services, home care or social services, or self-help and other community organizations. This cannot mean giving up responsibility the primary care team remains responsible for helping people to navigate this complex environment. Comprehensive and integrated care for the bulk of the assorted health problems in the community is more efficient than relying on separate services for selected problems, partly because it leads to a better knowledge of the population and builds greater trust. One activity reinforces the other. Health services that offer a comprehensive range of services increase the uptake and coverage of, for example, preventive programmes, such as cancer screening or vaccination. They prevent complications and improve health outcomes. Comprehesive services also facilitate early detection and prevention of problems, even in the absence of explicit demand. There are individuals and groups who could benefit from care even if they express no explicit spontaneous demand or people with undiagnosed high blood pressure or depression. Early detection of disease, preventive care to reduce the incidence of poor health, health promotion to reduce risky behaviour, and addressing social and other determinants of health all require the health service to take the initiative. For many problems, local health workers are the only ones who are in a position to effectively address problems in the community they are the only ones, for example, in a position to assist parents with care in early childhood development, itself an important determinant of later health, well being and productivity. Such interventions require proactive health teams offering a comprehensive range of services. They depend on a close and trusting relationship between the health services and the communities they serve, and, thus, on health workers who know the people in their community.

Continuity of care

Understanding people and the context in which they live is not only important in order to provide a comprehensive, person-centred response, it also conditions continuity of care. Providers often behave as if their responsibility starts when a patient walks in and ends when they leave the premises. Care should not, however, be limited to the moment a patient consults nor be confined to the four walls of the consultation room. Concern for outcomes mandates a consistent and coherent approach to the management of the patient's problem, until the problem is resolved or the risk that justified follow-up has disappeared. Continuity of care is an important determinant of effectiveness, whether for chronic disease management, reproductive health, mental health or for making sure children grow up healthily.Continuity of care depends on ensuring continuity of information as people get older, when they move from one residence to another, or when different professionals interact with one particular individual or household. Access to medical records and discharge summaries, electronic, conventional or client held, improves the choice of the course of treatment and of coordination of care. In Canada, for example, one in seven people attending an emergency department had medical information missing that was very likely to result in patient harm. Missing information is a common cause of delayed care and uptake of unnecessary services. In the United States, it is associated with 15.6% of all reported errors in ambulatory care. Today's information and communication technologies, albeit underutilized, gives unprecedented possibilities to improve the circulation of medical information at an affordable cost, thus enhancing continuity, safety and learning. Moreover, it is no longer the exclusive privilege of high resource environments, as the Open Medical Record System demonstrates: electronic health records developed through communities of practice and open-source software are facilitating continuity and quality of care for patients with HIV/AIDS in many low-income countries. Better patient records are necessary but not sufficient. Health services need to make active efforts to minimize the numerous obstacles to continuity of care. Compared to payment by capitation or by fee-for-episode, out-of-pocket fee-for-service payment is a common deterrent, not only to access, but also to continuity of care. In Singapore, for example, patients were formerly not allowed to use their health savings account (Medisave) for outpatient treatment, resulting in patient delays and lack of treatment compliance for the chronically ill. This had become so problematic that regulations were changed. Hospitals are now encouraged to transfer patients with diabetes, high blood pressure, lipid disorder and stroke to registered general practitioners, with Medisave accounts covering ambulatory care.

Other barriers to continuity include treatment schedules requiring frequent clinic attendance that carry a heavy cost in time, travel expenses or lost wages. They may be ill-understood and patient motivation may be lacking. Patients may get lost in the complicated institutional environment of referral hospitals or social services. Such problems need to be anticipated and recognized at an early stage. The effort required from health workers is not negligible: negotiating the modalities of the treatment schedule with the patients so as to maximize the chances that it can be completed; keeping registries of clients with chronic conditions; and creating communication channels through home visits, liaison with community workers, telephonic reminders and text messages to re-establish interrupted continuity. These mundane tasks often make the difference between a successful outcome and a treatment failure, but are rarely rewarded. They are much easier to implement when patient and caregiver have clearly identified how and by whom follow up will be organized.

Source: World Health Organization

to be continued

Table 1: Vaccine-preventable Diseases & AFP

28th August - 03rd September 2010(34th 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	02	00	00	00	00	00	00	00	01	03	01	63	51	+ 23.5 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	-
Measles	00	00	00	01	01	00	01	00	00	03	07	70	117	- 40.2%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	17	18	- 05.6 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	21	40	- 47.5 %
Tuberculosis	219	121	123	03	02	23	05	14	78	588	294	6530	6968	- 06.3 %

Table 2: Newly Introduced Notifiable Disease

28th August - 03rd September 2010(34th 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	04	02	12	09	04	02	01	48	62	2330	11868	- 81.2 %
Meningitis	00	02 ML=2	02 GL=2	00	03 TR=3	00	01 P0=1	00	03 KG=1 RP=2	11	22	1201	764	+ 57.2 %
Mumps	04	04	08	01	00	04	02	02	01	26	29	800	1319	- 39.3 %
Leishmaniasis	00	00	00	00	00	03 KN=3	05 PO=1 AP=4	00	01 KG=1	09	06	234	490	- 52.4 %

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.

Influenza Surveillance at Sentinel Hospitals

Month	Human Surveillance (ILI)							Animal Surveillance		
	Number of Expected	No Received	Influenza A	Influenza B	Pan H1N1	H3N2	Other	Pooled Sample	Serum Samples	Positives
July	600	120	0	0	0	1	0	145	809	0
August	600	86	0	0	0	0	0	NR	NR	NR

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

28th August - 03rd September 2010(34th 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	111	5107	2	226	0	14	1	101	0	32	15	424	0	7	0	48	0	1	**92**
Gampaha	47	3502	3	119	0	19	0	36	1	19	13	295	0	12	2	76	0	4	**67**
Kalutara	26	1579	1	183	0	13	0	17	0	74	4	248	0	2	1	28	0	1	**58**
Kandy	37	1436	1	243	0	4	0	22	1	6	3	80	0	111	8	98	0	1	**74**
Matale	5	541	2	257	0	5	0	30	0	70	6	78	0	5	1	41	0	0	**67**
Nuwara	13	189	6	296	0	0	1	102	0	84	0	21	1	51	1	33	0	0	**92**
Galle	45	976	2	205	0	5	0	5	1	13	3	68	1	19	0	11	0	3	**95**
Hambanto	13	703	2	63	0	6	0	1	0	10	0	76	1	71	0	9	0	0	**73**
Matara	22	515	2	146	0	8	0	9	0	49	19	244	4	108	0	17	0	0	**88**
Jaffna	9	2654	7	213	0	3	1	470	0	8	0	1	0	110	0	52	0	2	**67**
Kilinochc	2	28	0	11	0	0	0	9	0	1	0	1	0	0	0	0	0	0	**100**
Mannar	8	464	0	35	0	1	1	38	0	10	0	0	0	1	0	16	0	0	**60**
Vavuniya	5	561	0	34	0	3	0	40	0	8	0	2	0	1	0	10	0	1	**50**
Mullaitivu	0	11	0	5	0	0	0	1	0	0	0	0	0	0	0	1	0	0	**40**
Batticaloa	2	1174	6	142	0	3	5	29	4	34	0	10	0	3	0	4	0	2	**86**
Ampara	1	132	1	66	0	1	0	6	0	6	0	30	0	0	0	10	0	0	**43**
Trincomal	3	917	1	124	0	13	0	4	0	11	0	20	1	18	1	14	0	2	**80**
Kurunegal	21	1262	4	237	0	17	0	28	1	10	4	242	1	49	1	98	0	3	**90**
Puttalam	8	896	5	108	0	6	0	46	0	124	0	63	0	0	0	20	0	1	**67**
Anuradha	9	941	1	61	0	6	0	10	0	37	1	68	0	22	2	40	0	3	**58**
Polonnaru	2	359	7	79	0	1	0	6	0	8	1	53	0	1	0	36	0	0	**100**
Badulla	44	1118	0	154	0	1	0	70	0	16	1	61	3	77	0	79	0	0	**53**
Monaragal	14	893	2	140	0	1	0	33	0	4	0	30	2	66	0	66	0	2	**82**
Ratnapura	63	2378	6	385	0	4	0	11	0	26	3	296	0	49	0	75	0	2	**44**
Kegalle	18	794	0	114	0	12	1	48	0	19	1	188	0	17	3	79	0	0	**64**
Kalmunai	4	504	5	224	0	3	0	6	0	6	0	2	0	0	0	11	0	1	**77**
SRI LANKA	**532**	**29634**	**66**	**3870**	**00**	**149**	**10**	**1178**	**08**	**685**	**74**	**2601**	**14**	**800**	**20**	**972**	**00**	**29**	**73**

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 03rd 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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