Ceylon College of Physicians; Presidential Address 1994

DEVELOPMENT OF HEALTH - AN OVERVIEW

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I begin in the name of God. It is with immense pride, joy and happiness that I declare open the 27th Annual Scientific Sessions of the Ceylon College of Physicians. The Council of the College welcomes with open arms our Chief Guest Prof. Sir David Weatherall and every one of you to this inauguration of our main educational and scientific activity - the Annual Sessions. I propose to introduce our honoured guests to you and after brief remarks about our country and College give you a short address on "Development of Health - an overview". Education and Research are two subjects often spoken of at our Scientific Sessions but I wish to deviate and broadly explore some aspects of the "Development of Health - an overview" and share with you some thoughts which should concern all of us in the profession in the coming decades.

Health is a supreme asset and the basis for enjoyment of life. All great religious leaders have extolled the same sentiments. The many definitions of Health by International Bodies and Philosophers are all too well known to be repeated. The people of this country have ushered in a new era of political ideology with the hope that true development in all spheres of activity will take place and that we will move forward and be recognised as a Newly Industrialized Nation at the turn of the century. If that is to be, then, Development of Health must occur not only in absolute terms and but we must also keep pace with developments in other sectors. There is thus an overwhelming need for close coordination between the Health Sector and other related sectors to identify each others impact and roles in overall development. Major changes in socio-economic policies can have a secondary health impact. The Prime Minister as the Head of the National Health Council has a crucial role to play in promoting these very links and making sure of effective Intersectoral Action for Health and provide the necessary impetus for the Minister of Health and his Ministerial staff to implement their Master Plan for Health. Figure 1 on intersectoral health 'Horoscope' serves to illustrate this point.

Let us look at ourselves as Health Providers and what is our place in a global context. We have available now the World Development Indicators in the World Development Report 1993 which is dedicated to the theme "Investing in Health" and gives useful insights into how countries all over the world are performing with respect to provision of Health. Table 1 provides some data on Global Health Transition in Developing Countries from 1950 to 1990.

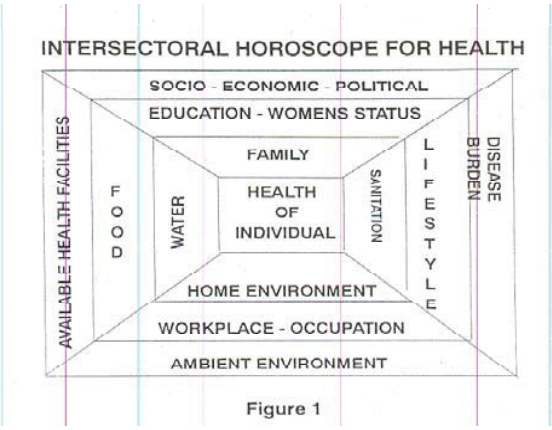

Figure 1

Table 1 Developing Countries

Table 1 Developing Countries GLOBAL HEALTH TRANSITION

	1950	**1990**
Life Expectancy (developing countries)	**40**	**63**
IMR<5y	28	10
Small pox deaths	5 million	Eradicated
Measles, Polio	Rampant	Drastic reduction

Workers, School children Healthier

World Development Report 1993

Sri Lanka although a developing country based on financial considerations has several reasons to be considered differently especially when one looks at the health/literacy/women status.

Table 2
Health Transition in Sri Lanka

*	Demographic	*	Epidemiological	*	Socio – Economic
*	Changes in Value Systems & Life styles				
*	Political	-	Macroeconomic Policy Changes		
		-	Development Projects		
		-	Environmental Issues		

I think we have many reasons to be proud of our Health System and indeed many areas in which the reverse applies and needing improvements. In general however I believe we are moving in the right direction with respect to having given priority to PREVENTION, THE PRIMARY HEALTH CARE CONCEPT, THE MOTHER AND CHILD, IMMUNISATION PROGRAMME, FAMILY PLANNING, EDUCATION OF WOMEN in particular and LITERACY in general. The thrust on clinical services island wide has been the provision of The Essential Clinical Package (Table 3) available to all and more sophisticated care is in short supply and restricted to teaching centres here and provincial hospitals. Many young clinicians who are trained in sophisticated tertiary centres here and abroad have initial difficulty and frustration in settling down to work with the available essential clinical packages in the Base hospitals. The College has recommended that young trainees should be sent to serve in the periphery for a few months before they are Board Certified as consultants as a familiarisation exercise to be sensitised to cope with overcrowding and basic facilities. The private sector is rapidly growing to fill this void of the need for secondary and tertiary care especially Discretinary Clinical Services (Table 4) the growth of which has been slow in the public sector. The Family Practitioners and Private Practitioners are making a significant contribution to clinical services islandwide. Those of us interested in promoting quality clinical care have great difficulty in convincing the ministry especially as quality often goes along with increasing health costs.

Table 3 Package of Essential Clinical Services
5 interventions (Minimal)

*	Pregnancy Related Care	*	Family Planning Services
*	Tuberculosis Control	*	STD Control
*	Care of Common & Serious Illnesses of Young – diarrhoeal, LRTI, malaria, malnutrition,		

VARIABLES - COUNTRIES HEALTH NEEDS, LEVELS OF INCOME

Highly Cost Effective < US$ 50 per DALY gained

World Development Report 1993

Table 4
Discretionary Clinical Services ; Less Cost Effective Measures

* Heart surgery / Plastic surgery
* Special Treatment of Highly Malignant Cancers of Lung, Liver, Stomach
* Expensive Drug Treatment for HIV Infection
* Intensive Care of Severely Premature Babies

HARD TO JUSTIFY USING GOVERNMENT FUNDS FOR ABOVE WHEN FUNDS ARE LIMITED

World Development Report 1993

Our extensive Health Care System has brought free health care within easy access to all segments of the population. The infant mortality rate has come down to 17.5 per 1000 live births. The maternal mortality

rate has declined to 0.6 per 1000 live births. The expectation of life at birth has increased to 71.7 years for females and 67.8 years for males (Figure 2). Universal free education has enabled our people to attain the present literacy rate of 87.2%. Thus although our per capita income level is low we are proud to have made major achievements in the health sector after independence (Table 5). However, there are changing trends in the health needs of our society witnessed in the last 4 decades since we became independant. This is not peculiar to our country but there is a global health transition and in our setting some factors needs to be identified and addressed. We need to sensitise our undergraduate and postgraduate populations to these changes in the years ahead.

Sri Lankan Life Expectancy at Birth

	1920	1946	1953	1962	1967	1971	1990
Male	32.7	43.6	58.8	61.9	64.8	64.2	71
Female	30.7	41.6	57.5	61.4	68.9	67.1	74.8

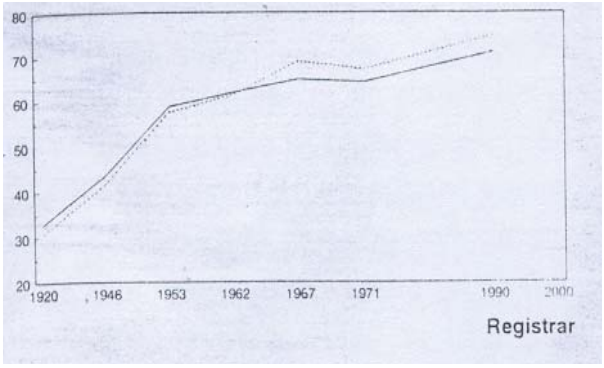

Figure 2

Table 5 Development Indicators – Basic

	Population X 10^6	GNP CAPITA US	Annual growth Rate %	Adult Literacy F T	IMR	Life Expectancy
Sri Lanka	17.2	500	2.5	83 88	18	71
India	866.5	330	3.2	34 48	90	60
Pakistan	115.8	400	3.2	21 35	61	59
Australia	17.3	17,050	1.6	>95%>95%	8	77
United Kingdom	57.6	16,550	2.6	>95%>95%	7	75
New Zealand	3.4	12,350	0.7	>95%>95%	9	76
Singapore	2.8	14,210	5.3	? ?	6	74

Firstly the **demographic transition**. Our population is visibly drifting from a largely young population to

a more elderly population. This has resulted from the declining population growth and the increasing life expectancy. We will have to grapple with non-communicable diseases like diabetes, hypertension, ischaemic heart disease, cerebro vascular disease, hematological diseases and chronic renal diseases in various combinations in the aging population (Table 6). Our health system needs to address this more seriously. Our College is seriously concerned with the uplifting of clinical services to meet these demands and we are in constant dialogue with the government. Our literate population is demanding reasonable follow up services for these chronic diseases and we make a strong case for National programmes to address specific non communicable diseases which leads me to...

Secondly, the **epidemiological transition**. We are moving from high mortality communicable diseases which consumed our population in large numbers 50 years ago being replaced by the more chronic morbid illnesses which reduce quality of life. We are at the crossroads right now having a double disease burden of the diminishing communicable diseases and the new emerging health issues which are increasing. If we do not make plans to combat the emerging health problems now we will be overwhelmed by these diseases at the turn of the century.

Thirdly the **socio-economic transition** has as a result of industrialization, urbanization, education and increase of household income brought with it a new set of problems (Table 7). Diseases of over indulgence and those associated with it and as alcohol abuse, tobacco, drug abuse and sexually transmitted disease has taken its toll on the young adults in particular. We cannot leave these problems to be attended by sympathetic non governmental organizations but the government sector must provide a solid network of infrastructure and use the non government sector to advantage. It is often stated that in economies which operate on free market forces promotes the gap between the rich and the poor to widen. It therefore becomes of utmost important to identify vulnerable groups and special groups like those unfortunate ones in refugee camps and urban slum dwellings and the very poor and destitute and offer them special safety net programmes of health, care.

Table 6 Health Transition

HIGH MORTALITY		HIGH MORBITY	
COMMUNICABLE DISEASES	→	NON COMMUNICABLE DISEASES	
FOCUS			
Mother and Child		Young People	Elderly
ISSUES			
Infant Mortality		Tobacco	Degenerative diseases
Maternal Mortality		Alcohol	Cardiovascular
Diarrhea		Sex	Cerebrovascular
Acute		Accidents	Diabetes
Resp. infections		Suicides	Hypertension
Malnutrition		Poisoning	Rheumatological
			Renal diseases

Fourthly the **changes in value systems and life styles** of our people must necessarily have an impact on their health behavior. There is erosion of the extended family systems which we treasure and of traditional gender relationships. Mass media/television etc promoting commercial culture must surely have positive and negative influences in our life styles and these resulting changes must be acknowledged by the profession and we must as a profession need to constantly kept vigil and be on the lookout for any activity with a negative Health Impact. A good case in point is Tobacco advertising. We have in particular to pay special attention to our School Health Programmes in this connection. There is increasing information and awareness of patients “right to know”. More Health Consumer groups are discussing “their health needs”. Ethnical aspects of human research concern us very much. Environmental issues have provoked mass action. Litigation against doctors is in the horizon. Insurance companies and some lawyers are keen to make capital out of medical Liability issues. We have therefore as a profession a responsibility to society to give them more Health Information and have greater dialogue with them so that we can build up and maintain mutual trust.

This will keep at bay the possible explosion of the dreaded drift towards defensive medicine and attended soaring health costs.

Table 7
Sri Lankan Indicators of Socio-Economic Change

	1970-75	1980 - 85	1990
GNP / capita US dollars	290	390	540
Poverty			
% of population	27	27	22
Urban			
% of population	22	21.1	21.8
Growth rate of Urban population	1.7	1.0	1.8

World Development Report 1993

The World Development Report sets out many policy measures for developing countries to benefit the user. Is the existing system capable of handling these issues in the coming decades? The National Health Policy the drafting of which I was also closely involved in is accepted for implementation last year and it addresses several of these issues in greater detail. The National Health Policy has quite independently taken into consideration the health transition in Sri Lanka, what I have very briefly outlined and it is flexible enough to accommodate differing views and firm enough in its commitment towards its directives for upliftment of health services to the people. We would like to see the National Health Policy implemented in the next 10 years. We would like to see more efficient managerial capability by doctors in charge of institutions, units and in administrative positions. Health Trade Unions should work in unison with the needs of the country and not marely act to safeguard professional boundaries. The Universities must play a greater role in Health Development and the links between the Faculties and Hospitals greatly strengthened. We would like to see health accountability by professionals and more clinical audit. The rising cost of health care caused by the demographic and epidemiological transition should also concern every doctor as we should at all time work towards cost efficiency and cost effectiveness. Rational use of drugs, especially antibiotics in this connection is of paramount importance and needs very urgent attention.

As physicians we are thought of as Healers. We have to come face to face with real problems of people. It is heartbreaking to consciously avoid advising people with renal failure that no treatment is available. I think our administrative colleagues must understand our plight and make at least modest services possible. Our people are literate and we cannot reason out Health economic policies at their times of need. We as a nation are at the crossroads as the population ages the cost of a year of healthy life gained rises sharply leading to difficult choice between increased spending and lower health gains as I pointed out before.

In this scenario we cannot discourage strengthening the private sector for discretionary services which the state cannot afford to the public. The poorer people will then have to depend on private services funded by well meaning organizations or philanthropists. At some point a line has to be drawn to balance what is available and what the state can afford to give free to all its people. We clinicians would also be advised to be responsible about overuse of expensive drugs or procedures.

I have personally visualised this worsening scenario in our setting for renal failure in the last 10 years. We are now crying out for modest state sponsored renal services which I hope will be forthcoming. This scientific session on “Renal Failure - Who cares?” is therefore timely.

On Monday our Satellite Meeting is devoted to occupational and sports medicine under the theme of “Health at Work and Play”. This highlights the concern of the College of the health care of the work force vis-a-vis environmental health. The College intends to create a Faculty of Occupational Medicine within its fold to educate the profession and enlighten the worker. We are constantly reminded of emerging health issues. AIDS is one such disease we are working hard on preventive measures before it gets the better of us. We cannot afford associated drug interventions or treatment of rare opportunistic infections. Malaria once brought under control has raised its ugly head again and we have thought it fit to have an oration on this subject today.

Our main responsibility therefore is to educate our undergraduates, postgraduates and health personnel giving them the right health perspectives so that our health care workers are sensitive to the needs of contemporary society. Our immediate Past President Dr. Selvie Perera in her address last year reiterated the need for a C.M.E. Programme and Recertification. The College is actively pursuing it this year.

Research, into all areas I have mentioned is a crying need and the College has a small fund for modest projects. Health Service Research has great potential for upgrading our services although highly sophisticated research like molecular research is only available in a few centres in the country. I have requested our Chief Guest who is in the forefront of molecular medicine to give us of his expertise on "Research in medicine and its relevance to the Clinician".

However excited each one of us may be with our own sphere of activity/discipline or research we must not forget that out there are our patients who are our final judges. Our health system must be developed to be user friendly and benefit the user even more than it is today. I must make the final plea on behalf of them for user dignity as my take home message. We must at all times remind ourselves that "Free Health Care" is not misinterpreted as "Care Free Health" and therefore finally.

My Prayer is for User Dignity

Let us be kind and caring to our patients in addition to giving cure, relief and comfort.
Let us be understanding and be reasonable with grieved relatives.
Let us make sure that our juniors do the same.
Let us ensure that the rest of our health care team uphold these values.
Let us portray ourselves as health care providers and not merely be an arm of the health care delivery system.
Let us add a personal element and a family centred approach to our patient care and they appreciate our services much more.
Let us urge our administrators to help us deliver the goods for them and work closely with us in the public interest.
Let us give our selfless service as demanded of any professional and pray true to the dictum.

Dictum

"That there is no limit to
what you can do to help
people as long as you do
not care to whom the
credit goes to"

Figure 3

I started this short address in the name of God and ended it with a prayer and so my sermon has ended.