Leading Article

Role of Primary Health Care in the 21st Century

V. S. Ariyaratne¹

In December 2000, 1500 representatives from 91 countries gathered in Savar in Bangladesh for what was called the People's Health Assembly (PHA). The diverse groups from all over the world gathered together was the demand for "Health for All Now!".

22 years earlier, in October 1978, Government representatives from all countries of the world assembled in Alma Ata in Kazakhstan of former Soviet Republic and declared that they would ensure "Health for All by the Year 2000". This historic event where the concept of Primary Health Care (PHC) was conceived and adopted as the key strategy by governments to address the major health issues particularly in the developing world, was considered a watershed in public health.

What is known as the "Alma Ata Declaration on Primary Health Care", marked the beginning of a new public health movement. It called on the governments, communities and other stakeholders to come together, based on a set of core values and principles to address growing health problems in the world. PHC was considered a climax of a hard won battle by civil society groups and enlightened medical professionals who were disillusioned with the limitations of the bio-medical approach which was up until then, at the centre of decision making in the health sector.²

Over the years, there was a growing concern that the governments have ignored the principles of PHC to the point that they seem to have forgotten that they were even signatories to the Alma Ata Declaration. The Peoples Health Assembly held in Bangladesh in December 2000 was therefore, in a way, a protest by the people's movements across the world against what they felt as a betrayal by their own governments.³

In my Presidential Address today, titled "Primary Health Care in the 21st Century", I would explore the evolution of this revolutionary concept of PHC, its impact on the developing world in general and for Sri Lanka in particular, and think aloud of its future. The period that I cover in my analysis is the last 4 decades – from 1970 to 2010.

I would like to start by elaborating the rationale for the emergence of the Concept of Primary Health Care in the 1970s, analyze some selected important developments in the health sector over the years in 10 year time intervals and the think aloud on the future

of this important concept in the coming years particularly for Sri Lanka.

What factors led to the emergence of the concept of PHC?

The Global Context

The science of medicine and art of healing have evolved from ancient times.

The notion of "prevention" which is at the heart of public health, is not a recent phenomenon. It is as old as "disease" itself and there is ample historical evidence that the ancient man adopted preventive practices to protect himself from disease.

The "Why" of PHC

What was the context in which the concept of PHC emerged?

By the 1960s, most countries in the developing world which were under the colonial rule for centuries, were reaching the post-independence era. The leaders and people of those countries who were gradually taking control of their own governance, realized that most of the systems that were in place to meet their basic needs were not producing satisfactory results.

In the 1960s and early 1970s, there were great visionaries, clinicians as well as public health practitioners alike, who have gained first hand grass roots experience working within health systems, questioning the limitations of the "bio-medical model" prevailing at the time to address health problems in the developing world. Some practitioners described this Western model of health as an "engineering model".⁴ Whilst acknowledging that this "engineering model of medical care" has made significant contributions to alleviate human suffering, it has, by and large, failed to satisfactorily address the burden of disease in an equitable manner. They claimed that having complete faith on technology alone, based on the "engineering medical model", would not be in the best interest of the poor and marginalized communities who still comprised the larger proportion of the world's population.

Thus started the exploration on alternative models. In addition to studying the successes and failures of state health care delivery systems, the work of voluntary non-governmental development organizations and people's movements were also closely studied by the WHO and scholars interested in finding alternative approaches to the "bio-medical medical" model.

1. General Secretary, Sarvodaya Shramadana Movement

Correspondence : edsarvodaya.org

One of the documents prepared in 1975 for the 21st Session of the UNICEF-WHO Joint Committee on Health Policy, was a report on “*Community Involvement in Primary Health Care: A study on the process of community motivation and continued participation*”. This comprehensive study documented 9 different case studies from all over the world and the work of the Sarvodaya Shramadana Movement for which I work now, was one case study presenting the Sri Lankan grass roots experience in community mobilization for health.⁵

It is interesting to note that, Sri Lanka as well as the Southeast Asian Region of the WHO played a pioneering role in the global movement in search of alternatives in the 1970s. A great son of Sri Lanka, perhaps not known to the present generation of public health specialists, Dr. Herath Guneratne, was one of the key personalities who promoted the concept of PHC and did the background work which contributed to the historic Alma Ata Declaration.⁶

The decade of the 1970s therefore can be described as the decade in search of alternatives.

The Concept of Primary Health Care

Primary Health Care, often abbreviated as “PHC”, has been defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

In other words, PHC was defined as an approach to health beyond the traditional health care system that focused on health equity-producing social policy.

This ideal model of health care was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata in 1978 (known as the “Alma Ata Declaration”), and became a core concept of the World Health Organization's goal of *Health for all by Year 2000*. 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 ultimate goal of primary health care is better health for all. The WHO identified five key elements to achieve that goal:

- reducing exclusion and social disparities in health - universal coverage reforms

- organizing health services around people's needs and expectations - service delivery reforms
- integrating health into all sectors - public policy reforms
- pursuing collaborative models of policy dialogue - leadership reforms and
- increasing stakeholder participation.

Behind these elements lies a series of basic principles identified in the Alma Ata Declaration that were to be formulated in national policies in order to launch and sustain PHC as part of a comprehensive health system and in coordination with other sectors:

- Equitable distribution of health care - according to this principle, primary care and other services to meet the main health problems in a community must be provided equally to all individuals irrespective of their gender, age, caste, color, urban/rural location and social class.
- Community participation - in order to make the fullest use of local, national and other available resources.
- Health workforce development - comprehensive health care relies on adequate numbers and distribution of trained physicians, nurses, allied health professions, community health workers and others working as a health team and supported at the local and referral levels.
- Use of appropriate technology - medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to the community (e.g. the use of refrigerators for vaccine cold storage).
- Multi-sectoral approach - recognition that health cannot be improved by intervention within just the formal health sector; other sectors are equally important in promoting the health and self-reliance of communities. These sectors include, at least: agriculture (e.g. food security); education; communication (e.g. concerning prevailing health problems and the methods of preventing and controlling them); housing; public works (e.g. ensuring an adequate supply of safe water and basic sanitation); rural development; industry; community organizations (including “Panchayats” as in the case of India or local governments, voluntary organizations, etc.).

Concept of PHC and Health Care in Sri Lanka

In order to fully understand the context of the introduction and the application of the concept of PHC in Sri Lanka, we need to briefly look at the evolution of the health care delivery system in country.

The ancient history of Sri Lanka provides strong evidence of advanced systems of medical care. Heavily influenced by Buddhist teachings, the ancient kings who ruled Sri Lanka gave a central place to public welfare which included health care. Health, as Buddhist teachings emphasize, is the greatest blessing a person or a community could enjoy, what is known as *Arogya Parama Labha*.⁷ Archeological evidence is abundant to demonstrate the equal importance given to both preventive and curative aspects of health care.

During the colonial period, we have seen the introduction of allopathic or Western medicine to the country. The Portuguese, the Dutch and the British, influenced greatly the preventive and curative health care structures that evolved in the country though they were initially created to cater to their own service personnel and administrators, and their dependents. In the 19th century, still under the British colonial period, we witness the establishment of formal systems to serve the local population which continued to get expanded and developed into the 20th century. These health care delivery structures along with other social welfare policies played an important role in the rapid mortality decline observed in Sri Lanka between 1930s onwards. The "Health Unit" system introduced in 1926 laid the foundation for the development of the preventive health care structure of the country.

However, it is also significant that the centuries old indigenous systems of medicine including Ayurveda remained as parallel systems co-existing with the rapidly developing Western medical system. As a cumulative result of all these developments, Sri Lanka was able to bring down the mortality substantially within a short period of time.

Therefore, when the concept was PHC was introduced in 1978, Sri Lanka was poised to perform much better than other countries with similar income levels. For Sri Lanka, PHC has not been a new concept. Many of the principles on which the concept of PHC was founded were already an integral part of the state health delivery system.

One member of the Sri Lanka delegation to the historic Alma Ata Conference commented, "Representatives from Sri Lanka did not go to Alma-Ata merely to listen but to present their experiences and contribute to the development of primary health

care strategy. The underlying philosophy of primary health care, the stress on equity and social justice in the health for all, had been the framework on which health care was provided to the people of Sri Lanka."⁸

Sri Lanka in 1976, with an annual GNP per capita income of approximately US \$ 140 at current prices ranked amongst the 20 poorest countries in the world. Yet, within the short period between 1950 and 1975, it has achieved considerable success. In this 25-year period, it has increased its average expectancy of life at birth from 48.3 to 64.7 years, reduced its infant mortality from 101 to 48.5 per thousand live births, the maternal mortality from 9.3 to 1.2 per 100 births, birth rate from 38.9 to 29.4, crude death rate from 14.3 to 8.5, and the rate of population growth from 24.6 to 17.9 per 100 mid year population.

A multitude of factors contributed to this phenomenal achievement often referred to as "Good Health at Low Cost". There was wide spread interest to study the success story of Sri Lanka as well as that of Kerala State in India, Cuba and China, which have also demonstrated similar achievements.

One such study carried out by the Rockefeller Foundation⁹ concludes as follows and quote,

"At the early stages of development, Sri Lanka was able to achieve satisfactory levels of physical well-being for the population which were exceptional for a low-income country. Whilst there is no doubt that delivery of health services and coverage of the population played a central role in the improvement of the health status of the population, it would not be correct to attribute this outcome exclusively or primarily to the health sector and the expansion of the system of health care. These efforts formed an integral part of broad social and political commitments leading to a process of development which was equity-oriented and high priority to the satisfaction of basic human needs.

The health system itself was part of a social welfare programme which included free education and subsidized food.

The system of health care was developed in a socio-cultural milieu which was conducive to the promotion of health. The values which were prevalent to society concerning human well-being and health contributed to health development, and the predominantly Buddhist ethos of the country gave a central place to the alleviation of pain and suffering and protection of life".

PHC in 1980s: Putting Concepts in to Action

Sanding on the successful model it has evolved, Sri Lanka then moved on to build on it further to integrate the core principles and strategies of PHC in to its curative and preventive health systems.

As it is evident from the literature published during this period, there was strong political will and commitment towards PHC. Concepts such as community participation, reaching unreached populations through the promotion of volunteer schemes, building partnerships with volunteer and non-governmental organizations were some of the salient features of the state health development plans.

Health Volunteers

The tradition of volunteerism is a deeply rooted tradition in Sri Lanka. The concept of PHC gave a central place to health volunteers. Taking inspiration from the experience of mobilizing volunteers for social action by social movements of the time such as Sarvodaya, the government health sector too, within the mandate of PHC, undertook large scale programmes to promote community participation in health interventions through health volunteers particularly in geographical areas where the government health services/resources/personnel were scarce. Within the State system, it was the Health Education Bureau (HEB) at the time was the apex organization designing training curricula and giving the necessary guidance.¹⁰

The Concept of PHC was also introduced to the largest government development project at that time the Mahaweli Scheme.¹¹

The plantation sector where most significant disparities were seen in terms of health status, also started to demonstrate positive trends and there was evidence that the PHC thinking was also influencing the delivery of services which were at the time provided through a separate structure.¹²

The PHC gave further opportunity, legitimacy, recognition and stimulus for different sectors to work together in addressing public health issues. The 1980s can be described as a period where true partnerships were built between government agencies and civil society organizations to jointly address some of the major public health problems. There was no competition. Each party recognized the unique strengths they had and the role they had to play within their own area of expertise. I would like to cite one example of a partnership that Sarvodaya had to address a specific public health problem.

Malaria has been one of the major causes of morbidity and mortality in the North Central

province in the 1980s. Sarvodaya with its decades of presence in the area and with the vast experience gained in working with village communities, had accumulated knowledge which could be harnessed to address the problem of malaria.

An applied research project brought together the Anti-malaria campaign, the University of Peradeniya and Sarvodaya with the technical support of the Harvard University.¹³ This research project was one of the first sociological, anthropological and behavioral studies on malaria in Sri Lanka.

The sociological and behavioral study explored the possibility of using bed nets and larvivorous fish in the prevention and control of malaria. Early diagnosis through the establishment of village level centres for blood smear microscopy was another intervention under the research.

The results of this study gathered valuable information and elicited traditional knowledge which paved the way for major effective interventions even many years later. Today, 20 years later, as we distribute what are known as Long Lasting Impregnated Nets (LLINs) through the Global Fund in the same areas, we can clearly see the change in knowledge, attitudes and practices change that had occurred during the intervening period.

In addition to such partnerships emerging to address some of the key public health problems such as Malaria, there were other areas in which innovative programming were evolving. The development of Early Childhood Development (ECD) through the establishment of pre-schools in remote rural areas and programmes such as Community Based Rehabilitation or CBR for the disabled, were examples of other successful interventions initiated in the 1970s and further expanded in the 1980s.

At a global level, the concept of PHC re-energized and revitalized programmes that were targeted at the most marginalized groups. These countries were far behind in terms of their health and social care delivery systems. However, there is evidence to show that, through programming based on PHC principles, many low-income countries were able to bring down their morbidity and mortality substantially.

Therefore I would say the “golden era” of PHC was the 1980s. However, it must also be noted that there were also certain interventions such as “selective primary health care” which undermined the original values and principles of Alma Ata Declaration.

As far as major structural changes were concerned,

the attempt to have an integrated model based on Alma-Ata principles through a three-tiered structure called Primary Health Care Complex was considered a failure.¹⁴

There were several books on PHC that were published which referred to the experience of grass roots organizations in PHC. The Marga Institute published a book based on the Sri Lankan experience in “Intersectoral Collaboration”, one of 3 pillars of PHC, whilst Ebrahim and Ranken referred to the experience of grass roots organizations particularly as successful case examples of community participation.¹⁵ Key international development research organizations such as International Development Research (IDRC) of Canada, convened consultations to study the experience of different countries and contexts with the objective of learning from each other.¹⁶

The Family Health Bureau translated adopted into Sinhala the world famous book “where there was no doctor”.

What all these interest demonstrated was that a paradigm shift was taking place in terms of approaching world's health problems and a new movement was emerging.

If we look at the health indicators during this period in Sri Lanka, the positive trend continued. However, it must be noted that it was also during this period that the armed conflict started in Sri Lanka and for the first time the health system had to deal with phenomena such as large internal displacement and disruption of preventive and curative services which it has not experienced before.

PHC in the 1990s

Chart – Health Indicators between 1980 - 1990

The decade that started in 1990 was very significant for health development globally.

The decade marked the emergence of HIV/AIDS as a major global public health problem.

The trend of globalization peaked during this period with the trade liberalization agreements under the newly formed World Trade Organization (WTO) having serious implications to the health sector. Sri Lanka became a member of the WTO on 1st January 1995.¹⁷ It was the opinion of key international non-government actors working in international health that the Trade Related Intellectual Property Rights or TRIPS Agreement seriously undermined the ability of the developing nations to provide affordable medicines to their people.¹⁸

Furthermore, the WTO's General Agreement on Trade in Services (GATS) posed its own challenge particularly to children's right to health by way of shifting the focus and the resources of the state sector in developing countries to private providers.

The 1990s also marked the entry of the World Bank in to health sector as a leading player. Public health specialists felt that in the 1990s, the leadership role of the WHO was taken over by the World Bank. This marked the departure from an equity and social justice model of provision of health care to one based on the “market”. The World Bank's 1993 World Development Report, “Investing in Health” gave the blue print on the new direction for the health sector. The recognition given to Health by the Alma Ata Declaration as a basic human need and a fundamental right was seriously undermined. Large projects under long term concessional loans were dispersed to many countries at a rapid rate.

After analyzing World Bank's involvement in Bangladesh, Buse and Gwin concludes,¹⁹

“Clearly, the Bank has stepped in to fill a leadership gap in health-sector reform and financing. But the Bank does not have (and is in no position to develop) technical expertise across a whole range of health matters—which, over past years, has been the mandate of WHO. But there is reason for concern that, with the ascendancy of the Bank and the decline of WHO, technical know-how is being underused, particularly at the country level, and a constructive pluralism of views on global health is being lost. As the forces of globalisation and development alter the health status and health risks of people worldwide, more effort is needed to preserve and better employ essential technical expertise; to improve the operations and complementary interactions of the various international-health agents; and to protect the multiplicity of opinions that have a legitimate claim to health-policy development. A sharper and improved sector strategy on the part of the World Bank is one-but not the only-constructive element in this process.

According to Garret, “The WHO, once the conscience of global public health, lost its way in the 1990s. Demoralized and lacking in leadership, WHO floundered. Other international agencies, - Notably the World Bank - stepped up to the plate. By 1997, the World Bank was the biggest public health funder in the world, bankrolling \$ 13.5 billion worth of projects, primarily in developing countries.”

In 1994, the WHO itself, in a review of world changes in health development since Alma-Ata bleakly concluded that the goal of health for all by 2000 would not be met.²⁰ This was a major blow.

There was also another most significant development taking place. The grassroots health activists and practitioners who were receiving the brunt of adverse effects of a rapidly globalizing world, started to protest and agitate against what they felt as a crude injustice and gross violation of people's rights.

Here in Sri Lanka, the internal armed conflict intensified with significant disruption of health services in the Northern and Eastern Provinces and for the first time in the history of Sri Lanka, some vital national statistics were published without data from those two provinces. Most of the data collected, surveys that were conducted and projections that were made on various indicators, were based on figures and statistics which left out the Northern Province and a major part of the Eastern Province. In most tables of data and statistics, there was a footnote which said, "North and East not included".

During this period the private sector also expanded rapidly in Sri Lanka with the number of private hospitals increasing significantly.

By the end of the 1990s, as the world anxiously awaited the dawn of the new century, there was universal acceptance that a large segment of the world's population was not only excluded from the benefits of 'globalization' but was getting adversely affected by it.

It took time for policy makers in the governments of the developing world to realize what was happening. However, leading figures in public health medicine expressed their concerns with convincing evidence on this unfavorable trend. In 1999, the London School of Tropical Medicine dedicated its Annual Public Health Forum to the theme "Poverty, Inequality and Health"²¹ and called drew the attention of the decision makers to address these issues urgently and comprehensively.

The dawn of the new century, these enlightened public health specialists, activists, professionals also belonging to other sectors and ordinary citizens from many parts of the world demanded committed themselves towards a change.

PHC in the 2000s

I would like to again go back to the People's Health Assembly held in Bangladesh in December 2000 which I referred to at the beginning of my presentation.

Vast majority of PHC believers were convinced that the pledge made in 1978, at the Alma-Ata Conference to achieve 'Health for All by the Year 2000' with Primary Health Care as the best tool to achieve it, could not be realized. The health status of vast majority of the world's populations has not improved as per expected targets. They felt that in many cases it has even deteriorated further. We were facing a global health crisis, characterized by growing inequalities within and between countries. New threats to health were also emerging. This was compounded by negative forces of globalisation which prevented the equitable distribution of resources necessary for people's health, particularly the poor. It was also observed that within the formal health sector, failure to implement the principles of primary health, care as set out in the Alma-Ata declaration, has significantly aggravated the global health crisis. It was strongly felt that Governments and the international community were primarily responsible for this failure.

It was therefore felt essential to build a concerted international effort to put the goal of "Health for All" in its rightful place on the development agenda. There was growing consensus that genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality. Several international organisations and civil society movements, non-governmental organisations (NGOs) and women's groups decided to work together towards this objective. The People's Health Assembly of 2000 marked the culmination of this effort.

"Health for All" in its rightful place on the development agenda. There was growing consensus that genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality. Several international organisations and civil society movements, non-governmental organisations (NGOs) and women's groups decided to work together towards this objective. The People's Health Assembly of 2000 marked the culmination of this effort.

It was this man, none other than Dr. Hafden Mahler, the WHO Director General who co-chaired the Alma Ata Conference in 1978, who was one of the key figures giving leadership to PHA in Savar, Bangladesh. 1453 participants from 92 countries came to the Assembly which was the culmination of 18 months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section

of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

At the Assembly, they reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed what is called the **“People's Charter for Health”**.

People's Charter for Health is a **CALL FOR ACTION** to combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

The Charter considers **HEALTH AS A HUMAN RIGHT**. It calls for tackling broader determinants of health; economic, social & political, environmental as well as war, violence, conflict and natural disasters. It calls for action on the part of the people and for the creation of a people centered health sector and call for people's participation for a healthy world.

The Charter is now the common tool of a worldwide citizen's movement committed to making the Alma-Ata dream a reality. It has been translated into many local languages, including Sinhala and many civil society groups are putting the principles in to practice. The PHM – Sri Lanka has been active in promoting “Right to Health” and advocating for rational drug use, amongst other issues.

Global Health watch

Any social change requires understanding what is really happening around us and we rely on data and information for this purpose. Realizing that the dominant global institutions do not always gather correct information on health status of particularly the disadvantaged groups in the world, the “Global Health Watch”, An alternative World Health Report was launched. The Global Health Watch is a broad collaboration of public health experts, non-governmental organisations, civil society activists, community groups, health workers and academics. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact. It gives an evidence-based account of key health problems with a deep analysis on their structural determinants.

What was the response from the “mainstream”?

Whilst the grass roots people's movements were mobilizing their own constituencies, the “mainstream” also had to respond as it was quite obvious that the world was on a dangerous path. The new millennium has to be one of hope for future generations.

The global response included several significant

initiatives; The Millennium Development Goals (MDGs), Commission on Macroeconomics and Health (CMH), Commission on Social Determinants of Health (CSDH), new funding mechanisms such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), and the GAVI, Global Alliance for Vaccines and Immunization.

In terms of global development policy, the dawn of the new millennium was marked by the UN Millennium Summit of September 2000 which was a significant global event. In what is claimed as to be the largest-ever gathering of world leaders, 189 in total, the Summit addressed a host of issues under the official theme, *“The United Nations in the 21st Century.”* The Heads of State adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to reduce poverty and hunger, tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

They established eight Millennium Development Goals (MDGs), with targets set for 2015, and identified a number of indicators to monitor progress, several of which relate directly to health. All the goals and their targets are measured in terms of progress since 1990. Reporting on progress towards the MDGs has underscored the importance of producing more reliable and timely data.

On the part of the WHO, during the 1st decade of the new century (2000 – 2010), whilst endorsing the MDGs, two initiatives marked its own response to the growing health challenges in the world – namely, the *Commission on Macroeconomics and Health* and the *Commission on Social Determinants of Health*.

The Commission on Macroeconomics and Health (CMH) was established by WHO in January 2000 to assess the contribution of health to global economic development. The Commission's report, presented to WHO in December 2001, concluded that health is a creator and pre-requisite of development. The Commission stressed that extending the coverage of health services and a small number of critical interventions to the world's poor could save millions of lives, reduce poverty, spur economic development, and promote global security. It argued that increased resources for health and a pro-poor focus could save 8 million lives a year by 2010 at a cost of US\$27 billion a year and that the resulting increased productivity would yield US\$186 billion a year.²²

Sri Lanka was quick to initiate action on Macroeconomics and Health. A series of useful studies on health financing and related issues were

commissioned and their findings were made available to policy makers. In August 2002, the National Health Council (NHC) decided to set up the National Commission for Macroeconomics and Health. The focus was on “Financing the Resource Gap for Public Health Provision”.²³ The Sri Lanka CMH, after an intensive study mainly on the economic dimensions of health status and the health care services, came up with a report which recommended increased government budget allocation for health.

Commission on Social Determinants of Health (CSDH)

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.²⁴

Responding to increasing concern about these persisting and widening inequities, the WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report was launched in August 2008,²⁵ and contained three overarching recommendations:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

Renewal of Primary Health Care – World Health Report 2008

The release of the Report of the CSDH also coincided with the 40th Anniversary of Alma Ata and the WHO dedicated its 2008 World Health Report to Primary Health Care. The Report, looking back 3 decades of PHC, observes that “*on the whole, people are healthier, wealthier and live longer today than 30 years ago*”.²⁶ However, whilst we could be satisfied about these achievements, there are other trends that are quite alarming. Even though the progress achieved in health outcomes over the recent decades are positive on the average and taken as a whole, this progress has been significantly uneven with a considerable number of countries lagging behind or losing ground. Furthermore, there is evidence that there are growing disparities within countries.”

It calls for a reformed approach to PHC and proposes a shifted focus and the main points are summarized in the Table below.

Challenge of Equity: PHC in the 2000 Sri Lankan Context

Now I come to some important developments in Sri Lanka during this period.

Table 1 How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

The decade 2000 – 2010 was very significant for Sri Lanka. The turn of the century marked a major change in its demographic scenario. We were also experiencing the epidemiological transition from communicable diseases to non-communicable diseases. The 2004 December Tsunami and the end of war in May 2009 were other important developments in the country.

At the beginning of the new millennium, Sri Lanka has almost completed the demographic transition – that is achieving low levels of births and deaths leading to a slower population growth. Key health indicators such as the Maternal Mortality and the Infant Mortality continued to decline.

The Age – Sex structure was significantly changed from what it was 20 years ago. The proportionate share and the absolute number of children between ages 0-4 were declining and the proportion of the elderly – those above 60 years of age, was on the rise.

However, these overall positive trends masked the significant variations that were observed between different geographic regions in almost all key health indicators. For example, if you consider 1000 children born in 2001 in Anuradhapura, the number at risk of dying before completing their 1st birthday will be twice (22) as high as when compared to Kegalle (10). Even more significant disparities are evident when one considers the North and East districts which were affected by the war for which for almost a decade and a half, complete data were not forthcoming.

Similar variations are observed for other indicators such as the Maternal Mortality (MMR), Low-birth weight and other nutritional indicators as well as food security.

When one closely observes the policy level debate in the health sector in Sri Lanka, it is clear that enlightened global thinking as well as local experience and evidence supporting such emerging global consensus on health matters, have also strongly influenced key decision makers and institutions.

Both initiatives of the WHO, Commission on Macroeconomics and Health, and the Commission on Social Determinants of Health, have received support at a political level at least initially. There was deep commitment from the Ministry of Health and the senior administrators towards their implementation in Sri Lanka.

It could be observed that the Health Master Plan 2007 – 2016 prepared by the Ministry of Health, has taken into account the knowledge, experience and

concepts coming out of both Commissions.

The medical fraternity, from the apex professional body, the Sri Lanka Medical Association (SLMA), to other colleges, including our College, the College of Community Physicians, and the College of Medical Administrators, endorsed the concept and held serious consultations on how to put the recommendations in to practice.

The SLMA chose as its theme for its last year's Annual Sessions(2010) “Achieving Equity for All” and brought together both national and international experts in the subject to critically review the Sri Lankan experience in this respect. There was enthusiastic participation of, not only policy makers and senior administrators, but of clinicians who recognized the importance of equity and social determinants of health. Hence, there is willingness on the part of the medical community in Sri Lanka to force ahead with a new paradigm.

Public Health Research

The decade also saw a fundamental shift in public health research. Growing interest in equity persuaded academics and researches to focus on population determinants of ill-health and inequalities. There were also strong calls for engaging the *public* in health research.

Prof. Saroj Jayasinghe, a clinician and a strong advocate of the concept of Social Determinants of Health, in an article published in the Ceylon Medical Journal (CMJ) in September 2010, exploring the question of how we implement the CSDH recommendation and strategies in Sri Lanka, recommended certain strategies at the national level including the appointment of a Commission on Social Determinants of Health and facilitating institutional arrangements for action at different levels. At the grass roots level, he proposes to revitalize PHC as a key strategy towards multi sectoral action at the grass roots level.

These were all exciting positive developments and we could describe this 10 year period from 2000 – 2010 as a period “in search of equity”.

2010 and beyond

Where do we stand now in terms of how we address our future health challenges?

In order to define our path, we need to understand the key health challenges that we are faced with in Sri Lanka today. I would like to briefly summarize the key health challenges faced by Sri Lanka as we start the 2nd decade of the new century and the new millennium.

WHO defines Health as a “state of physical, psychological, social, spiritual well-being, and not merely the absence of disease”, then we see the challenges arising out of four distinct but interrelated areas of transition. They are namely; demographic transition, epidemiological transition, socio-economic and political transition and lastly environmental/ecological transition.

Demographic Transition

Sri Lanka's population is ageing - the percentage of the elderly population is increasing. Consequentially, if this trend continues both the number of elderly and the percentage of elderly will increase, even though the size of the population will stabilize by 2030.

Ageing population

The proportion of the Sri Lanka's population aged 60 and above increased from 0.79 million, or 6.3 percent of the total population in 1970, to 1.6 million, or 9.8 percent of the population in 2000, with an annual growth rate of 2.7 percent. Moreover, the country is expected to have a considerably higher proportion of elderly population aged 60 and over, about 22% in 2030. Therefore it will be essential that we develop health care strategies that provide more services and care to the elderly population in the near future (IHP, 2011).

Demographic Bonus

However, while this is a vision for the future in relation to the population there are more contextual issues that must be focused on. Sri Lanka is uniquely positioned now to exploit what is termed as the “demographic bonus”. A demographic bonus is characterized by an increase in the percentage of people who are of a 'working age' in the population. It is a very rarely experienced opportunity for any country and it only lasts for particular periods in any country's history. The benefit of this is dualistic, because it also means that the share of the number of dependents or non-working people (who are too young or too old) in the population remain low during that period. Prof. Indralal de Silva, an eminent demographer makes a strong argument that this opportunity could be used to raise national economic growth. Sri Lanka is currently experiencing this rare opportunity. He urges that the authorities take advantage of this golden opportunity immediately, as it is diminishing at a much faster rate than originally expected due to a **rising Fertility Rate** that was observed in the last Demographic and Health Survey of 2007. In our visions for long term strategic policy planning, it is essential that we use our demographic bonus to build a 'surplus' of economic growth which will aid us to weather the 'storm' of an ageing population that will arrive at our shores in the future.

Furthermore, with these changes, we need to think in contextually and creatively in relation health care policy. The Ministry of Health has already begun *Well Women's Clinics* to cater to the specific needs of women's health issues not related to child bearing. It is essential that we also begin *Well Men's Clinics*. The key point I wish to emphasize here is that we need to engage our population in an inclusive manner from a preventive health care school of thought by making health care interventions at the 'lifestyle' level of society.

Epidemiological Transition

As in nature, in our society, most issues are interconnected. As we look at how epidemiological transitions affect us, a rapidly ageing population and success in combating the major communicable diseases, will mean that the disease burden has already started to rapidly shift towards non-communicable diseases – diseases that are not transmitted from person to person and not caused by a micro-organism. These include mental illness, accidents and injuries. Nutrition status has improved but remains a serious problem among the poorer and the vulnerable communities and even on the average, it is unsatisfactory.

The leading causes of death (by percentage and of total mortality for the year 2003) are is ischemic heart disease (12.5%), diseases of the intestinal tract (10.8%), cerebrovascular disease (9.1%), pulmonary heart disease and diseases of the pulmonary circulation (9.1%) and cancer (4%). Over time infectious and parasitic diseases have declined in importance, while cardiovascular diseases and homicides have increased in a proportionate manner. In 1996, violence (accidents, suicides and homicides) accounted for 22% of the deaths, while cardiovascular diseases and diabetes accounted for another 24% which indicates that the epidemiological transition is also rapid.

I would like to emphasize that there are significant disparities which can also be observed in the prevalence of non-communicable diseases which call for addressing the determinants that are responsible for such differences.

There is wide support for adopting a PHC approach towards responding to the growing challenge of NCDs. The recent launch of 4 x 4 x 4 Approach by the Government is commendable. The strategy is directed at the 4 diseases – Heart Disease and Stroke, Diabetes, Cancer and Chronic Lung Disease. The risk factors are Tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol. The 4 commitments to include Addressing Risk Factors through multi-stakeholder partnerships, health systems strengthening, essential medicines &

technologies and monitoring and evaluation leading to accountability.

However, we should not ignore the other NCDs which are also taking a high toll. Road traffic accidents, injuries, malnutrition should not be given any less priority in our efforts.

Socio-economic and political transition

Health care is not an entity by itself, it is affected by socio, economic and political transitions and changes at the domestic level. There are some significant areas that need to be considered when planning a common health care future.

Sri Lanka is currently graduating from a low income country to a middle income country status. This has implications at the domestic and international level. Internationally, Sri Lanka will receive less funding from the international community in relation to addressing health care needs and combating disease. But what is essential to understand is that we will be equal partners with other middle income countries health care challenges worldwide. At the domestic level, people's expectations in relation to healthcare have also changed, even at the village level. If there are higher income levels and more knowledge within communities, they will be expecting a better quality of health care service. We are looking at a entirely new 'paradigm of health care service providing'. We need to make this critical shift in a consultative and participatory manner.

Poverty has been reduced according to official statistics. However, the economic development in Sri Lanka is not equitable, and this affects the level of health care that a person can afford or have access too, especially in the changed epidemiological context, in which the kinds of medical interventions required to diagnose and treat are of a different character, more expensive and sophisticated. The key problem is that although Sri Lanka's Per Capita Growth increases, economic growth and is not geographically equitable. Sri Lanka has 'pockets of economic inequality'. We must work in a manner that addresses inequality, and not work in a manner in which your economic worth determines the level healthcare you have access too. Even, in most developed countries this is the case. Sri Lanka has a socio culture in which we help each other as neighbours. Our health care policy must also reflect this aspect of our culture.

Sri Lanka has a large migrant population, nearly 2 million people. Our foreign policy and health policy must work in tandem to ensure that our citizens abroad and their families are ensured the best quality of health. After all, they provide our country with a large share of our national income. We have not

adequately addressed their health needs and the health needs of the families they leave behind. It is an economic and political imperative, and more than anything else, a moral obligation.

We cannot ignore, that there is a high level of gender based violence and child abuse in Sri Lanka. The health sector has a very important role to play in this regard.

There is a large amount of work that the health sector must do, in relation to aiding Sri Lanka's post war recovery. The physical and psycho social needs of a large civilian population that have been affected by years of brutal war must be addressed for us to move forward as a nation. We are rebuilding basic health infrastructure, while we do this, it is also essential that we rebuild people. This will be essential in rebuilding bridges of reconciliation amongst our people.

Environmental/Ecological transition

The frequency, intensity and the impact of natural disasters are increasing. There are also many ways in which human health is affected by climate change. We need to foresee what aspects of climate change and natural disasters will affect Sri Lanka and custom design our health care service system to tackle specific problems.

Way forward

We have built a comprehensive health infrastructure which is hailed as a model in the world. The socio-cultural milieu which enabled us to achieve this remarkable success is still intact.

However, to meet the challenges we face today, we have to find even more effective structures and strategies. We need to build on the positive elements of the unique systems of health care, including traditional systems that exists in Sri Lanka and taking cognizant of the failures or interventions are not worked well to improve the health and wellbeing of our people.

If human ingenuity and the resources that are available to us could be utilized to reduce communicable diseases, then what is preventing us from becoming the pathfinder in the world in the 21st century for combating NCDs?

As CSDH reminds us, we need to focus more on health equity issues, expose the differences in health outcomes that are unnecessary, avoidable and unfair, propose ways of more effectively addressing differences in need; assess the extent to which different groups in society have the power and means to make choices over health issues; monitor health equity levels, the impact of globalization and macro-

economic policies on health; enable participation by beneficiaries in their research by using participatory research methods that involve the affected groups more directly; and more direct link research and action on problems in the communities. Research can give direction to the changes being called for by communities in all economic and social processes that affect them.

In 2008, the CSDH sets the target to close healthcare gap within a generation. The time span for a generation is usually taken as 20 years. The impact of health interventions of the 1930s were evident only by the 1950s. In the same vein, if we are to “close the gap within a generation”, we should start now! If we take 2008 as the base year, then we should aim to eliminate all inequities by the year 2028 in Sri Lanka.

It is **ACTION** that is needed. We know enough in terms of knowledge, information and data. We also have enough in terms of financial and human resources. What we lack is commitment; societal as well as political. People need to take a lead and galvanize our polity through their action. Often people say, we cannot act because the policies are not in place. But if you carefully analyze there are enough and more policies in place in every sector. In the health sector we have policy documents ranging from – population to food security, to nutrition to medicinal drug use etc. etc. But what is missing really is ACTION.

I believe that we can use the key principles of primary health care once again to re-invigorate our response to the health challenges we face in the 21st century. What is required is ACTION! The same way, the entire country was mobilized around the vision of PHC in the 80s, we need to now rally around to address the current and emerging issues in a reinvigorated manner.

For years, as a low income country a well organized hierarchical structure in relation to health care delivery has brought results, it has resulted in vast disparities as we have seen earlier. This is not only at the provincial, district and divisional levels, but often, also between villages in the same area. Therefore, our action must be targeted at a smaller geographical unit.

As we improve economically, we must channel our economic growth in a more effective and inclusive manner and not make existing disparities wider. Hence, what we really need is a village to village bottom up approach, which will empower our people to address the determinants of health at a primary level. The health unit system that has brought significant results can support such a bottom up process to address new health challenges that have

been described earlier, such as non-communicable diseases and malnutrition.

Primary health care also promotes the use of appropriate technology. We can use information and communication technology (ICTs) for prevention, early detection, referral, treatment and follow up of disease events.

What would be the role of the Community Physician in this fresh approach to public health?

As community physicians we have come a long way. Many generations of community physicians have contributed to the successes we have seen in combating disease and making Sri Lanka a healthy place to live. Our own members have effectively carried out as well as experimented interventions that have made a significant difference on the ground. During the aftermath of the 2004 Tsunami disaster and during the massive displacements that took place in May 2009, members of our College were at the forefront of service delivery working under trying conditions. The rhetoric and slogans would have changed over the last 4 decades. But the fundamental challenges of health and their roots causes remain the same.

I personally feel that we find ourselves at a cross-road. Going by popular economic arguments, health can be considered as a commercial product; alternatively it can be considered as a human right. But we cannot take a comfortable middle path and say that health is both a commodity in the market and a human right as well. This is the choice before the Government, the Ministry of Health and the People. What is chosen will decide whether Sri Lanka is a country where the citizens have a right to health and patients have their rights or a country which has consumers with or without purchasing power.

In her Presidential Address in 2004, Prof. Lalini Rajapaksa, raised the question, “*do we go down the narrow path of addressing the proximal risk factors of ill health or do we go down the broader road that would address, the socio-cultural and ecological foundations of health?*”

We took up the challenge as Community physician to bring the broader determinants of health into our agenda. The theme of our Annual Sessions this year was “Holistic Approach to Health” which reflects this fresh outlook for the future.

In Sri Lanka, can we by the catalysts of change that can help Sri Lanka lead the way once again, in “closing the gap in a generation?”

References

1. Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, Jointly Sponsored by the World Health Organization and the United Nations Children's Fund, Geneva, World Health Organization, 1978.
2. Banergi, D., "Primary Health Care: An overview, Guest Lecture for National Seminar on Health for All in the New millennium, NIHF, February 24-26, 2003.
3. Health for All Now!, The People's Health Source Book, The National Committee for Jan Swasthya Sabha, AID India, New Delhi, 2004.
4. Macdonald, J.J., Primary Health Care - Medicine in its place, Earth Scan, 1993, p.30-53.
5. "Community Involvement in Primary Health Care: A study on the process of community motivation and continued participation", Report for the 1977 UNICEF-WHO Joint Committee on Health Policy, UNICEF-WHO Joint Committee on Health Policy, JC21/UNICEF-WHO/77.2
6. Gunaratne, V.T.H., Challenges and Responses: Health in the South-East Asia Region, Tata McGraw-Hill, New Delhi, 1977.
7. Dhammapada,
8. Fernando, M., Sri Lanka: deep roots in primary health care, in: Achieving Health for All by the Year 2000, Midway Reports of Country Experiences, Edited by Tarimo, E., Crease, E., WHO, Geneva, 1990.
9. Halstead, S.B., Walsh, J.A., Warren, K.S., Good Health at Low Cost, Conference Report, The Rockefeller Foundation, Bellagio, 1985.
10. Patrick, W.K., Community Participation in Health, Volunteer Health Worker in Sri Lanka, Health Education Series No.4, Health Education Bureau, Colombo, November 1978.
11. Patrick, K.W. (Ed), Primary Health Care in Mahaweli, Health Education Bureau, Colombo, 1983.
12. Health and Health Services for Plantation Workers, Evaluation and Planning Centre for Health Care, London School of Hygiene and Tropical Medicine, EPC Publication No. 10, London, 1986.p.45-62.
13. Silva, K.T., Malaria Control through Community Action at the Grass-Roots: Experience of the Sarvodaya Malaria Control Research Project from 1980-1986, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases(TDR), TDR/SER/PRS4. Accessed 2nd September 2011, http://whqlibdoc.who.int/hq/1988/TDR_SER_PRS_4.pdf
14. Herath, H.M.M.S.D., A brief history of the development of the public health services in Sri Lanka, Public Health Development in Sri Lanka, Millenium Supplement, The Journal of the College of Community Physicians of Sri Lanka, College of Community Medicine, 2001.
15. Ebrahim, G.J., Ranken, J.P., (Eds), Primary Health Care, Re-orienting Organizational Support, Macmillan, London, 1988.
16. "Rural Health Needs", Report of a Seminar held at Pokhara, Nepal, 6-12 October 1977, International Development Research Centre, Ottawa, 1978.
17. http://www.wto.org/english/thewto_e/countries_e/sri_lanka_e.htm (accessed 9th September 2011).
18. Hilary, J., The Wrong Model, GATS, trade liberalization and children's right to health, Save the Children, London, 2001.
19. Buse, K., Gwin, C., The World Bank and global cooperation in health: the case of Bangladesh, The Lancet, Volume 351, Issue 9103, Pages 665 - 669, 28 February 1998.
20. Return to Alma-Ata, Dr Margaret Chan, Director-General of the World Health Organization 15 September 2008.
21. Leon, D., Walt, G., (Eds), Poverty, Inequality and Health: An international perspective, Oxford University Press, Oxford, 2001.
22. <http://www.who.int/trade/glossary/story008/en/index.html> (accessed 11th September 2011).
23. Macro Health Sri Lanka, Newsletter published by the NCMH Secretariat, Sri Lanka, Issue 1, 2004.
24. http://www.who.int/social_determinants/en/ (accessed 11th September 2011).
25. Closing the gap in a generation: Health Equity through Action on Social Determinants of Health, Final Report of the Commission on Social Determinants on Health, World Health Organization, Geneva, 2008.
26. Primary Health Care, Now More Than Ever, The World Health Report 2008, WHO, 2008.
27. Health Master Plan, Healthy and Shining Island in the 21st Century, 2007 - 2016, Ministry of Healthcare and Nutrition, Colombo, 2007.
28. Engaging Public in Health Research, heathexchange, Summer 2010.
29. Jaysinghe, S., Narrowing health inequalities in Sri Lanka: issues and challenges, The Ceylon Medical Journal, Vol. 55, No.3, September 2010.
30. Beaglehole, R., Epping-Jordan, J., Patel, V., Chopra, M., Ebrahim, S., Kidd M., Haines, A., Alma-Ata: Rebirth and Revision 3, Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care, The Lancet, Vol 372, September 13, 2008.