Editorial

Universal health coverage and Sri Lanka: need for a third cycle of primary health care?

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This is a special year for Sri Lanka in many ways. It could be a year of abundant opportunities that could be utilized for further strengthening and reorienting the health sector to build on the gains we have made over the past decades, and meet the current and emerging challenges.

First, it is the 70th Anniversary of our Independence – an opportunity to celebrate past successes and plan for our common future. It is also the 40th Anniversary of the Alma Ata Declaration – an opportunity to re-affirm our commitment to health for all and to endorse our promise to deliver people-centred primary care, which must be the foundation to achieve universal health coverage. It is also the year that can determine what the health of Sri Lankans will look like in the future. Equally significant, it is the WHO's 70th birthday – an opportunity to commemorate our long collaboration with our most trusted health partner, celebrate our past successes and ponder our common voyage to health. Appropriately, the theme of this year's World Health Day on 7 April is 'universal health coverage'.

To mark the global occasion, as a special gesture, the Director-General of the WHO, Dr Tedros Adhanom Ghebreyesus had selected Sri Lanka to be the focal venue for the worldwide celebration – and will honour us with his presence on this landmark day. It is time for a noteworthy change in the thinking on how Sri Lanka can accelerate improvements in health and development in general. The 17 sustainable development goals (SDG) adopted in 2015 aim to encourage an integrated approach to sustainable development, with a focus on the most vulnerable. Health is well placed in the SDGs as, "Ensure healthy lives and promote well-being for all at all ages" and is framed as a contributor to, and beneficiary of sustainable development.

We enjoy a long track record of, and have been (justifiably) commended for, delivering good health at low cost. In particular, nearly over the past eight to ten decades, we have been able to offer almost universal coverage of maternal and child health services, effective infectious disease control, and have witnessed acceptable outcomes in these areas probably better than most countries with similar income levels. The infant and maternal rates and life expectancy, inter alia, illustrate this. With respect to communicable diseases, we have eliminated or are close to eliminating malaria, tetanus, measles, filarial disease and leprosy. These results have been achieved with relatively low government spending on health, when compared to the neighbouring countries such as Thailand, Vietnam and Maldives. Many will argue that the model of health care based on primary health care (PHC) principles that we had selected since the twenties in the last century, has played a major role in this success. Our health indicators in the twenties were similar, in certain cases even worse than our neighbours. The initiation of health units and the medical officer of health (MOH) divisions served as the breakthrough. One could refer to this as the **first cycle of PHC** in our country, and it seemed to have served us well for the needs of that period.

The **second cycle of PHC** was triggered by the Alma Ata Declaration and it was relieving to note that many of the principles enunciated in the Alma Ata Declaration had already been incorporated into the system. In fact, a couple of the background papers prepared for Alma Ata included at least two that drew lessons from Sri Lanka, particularly the WHO backgrounder on "good health at low cost" and a seminal paper from the Marga Institute. The Sri Lankan response was to build a comprehensive health care system based on PHC. Another key aspect of reorientation that Alma Ata facilitated was the conscious attempt to emphasize and ensure greater equity and social justice. This was timely and important for another reason as this was the time Sri Lanka was adopting neoliberal economic policies.

At present, our main health system challenges have become the need to address the issues resulting from the ongoing demographic and epidemiological transitions amidst the rising expectations of the population. Non communicable diseases (NCDs) already account for 80% of total deaths and 75% of disability-adjusted life years (DALY), the *healthy life expectancy* at birth being 10 years lower than the life expectancy at birth. The NCD challenge has proven especially difficult among men.

While our maternal and child health base remains intact and solid, our capacity to provide long term continuous care is limited and we are inadequately prepared for the changing burden of diseases and potential health emergencies. There are challenges in the quantitative and geographic balance and the qualitative relevance of the health workforce with gaps in the provision of frontline services, especially managing NCDs and certain common forms of curative care. Further, primary care facilities are characterized by the limited availability of laboratory services, drugs and equipment for NCD screening and often, many essential NCD drugs could not be dispensed at lower levels of care. Furthermore, the dominant public sector is being supplemented by a growing private sector, particularly in ambulatory care with resultant pressures of out-of-pocket expenses. In this context, it can be argued that Sri Lanka now urgently requires a **third cycle of PHC** to address the current transitions, one that will place universal health coverage as the centrepiece of our health care delivery model.

The contemporary internal discussions and also with development partners have resulted in a set of valuable recommendations and proposals for bringing about this transition. The draft strategy developed by the Ministry of Health entitled, "Restructuring PHC in Sri Lanka: preserving our progress, preparing our future" identifies the ways to reorient PHC in order to respond to the current and emerging challenges. This strategy identifies three actionable areas, i) Restructuring PHC to meet Sri Lanka's needs, ii) Information management to improve health services in real time, and iii) Strengthening the health sector through key system improvements. Further, with the rising consumer expectations, while reconfiguring service delivery to better manage chronic NCDs, it is important to empower citizens to actively engage in and interact with the public health services to narrow the existing gap in 'consumer experience'. Preparatory work on some of these actionable areas has already commenced, and implementation will follow later this year.

A key question that all of us would ask will be, "where would we like to be in 5 or 10 or even 25 years?" in terms of universal health coverage? Are our strategies 'fit for purpose', given the aim of improving frontline services and meeting the NCD challenges? It can be best answered by the faithful implementation of the strategies and plans, accompanied by a close monitoring of these plans, which will enable necessary mid-course corrections to be applied.

If we commit ourselves to make this third cycle of PHC to be successful, people of Sri Lanka can be cautiously optimistic that they and future generations will continue to receive good quality comprehensive health care at a relatively low cost, and that none of them will have to face severe financial hardships or be threatened by imminent bankruptcy. That could be our most noble, magnanimous and lasting contribution to posterity.