PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from Sri Lanka

Abridged Version

Alliance for Health Policy and Systems Research

World Health Organization

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Primary Health Care Systems (PRIMASYS)

Case study from Sri Lanka

Overview

Sri Lanka is an island located in the Indian Ocean, with a midyear population for 2016 estimated at 22.235 million inhabitants. It is situated a few degrees north of the equator, with a land area of 65 525 square kilometres, a length of 432 kilometres and a width of 224 kilometres. The gross national income per capita is US$ 3836 according to Central Bank Data 2015. In 2013, total health expenditure as a proportion of gross domestic product (GDP) was 3.24% and expenditure on public sector primary care hospitals was 6.4% of current health expenditure, according to National Health Accounts. The country has a tropical climate and is susceptible to frequent rains, floods and landslides, which increases the burden of respiratory illnesses, vector-borne diseases and injuries. Sri Lanka's health profile is dominated by noncommunicable diseases, and major causes of hospital deaths are ischaemic heart disease, neoplasms, zoonotic and other bacterial diseases, pulmonary heart disease and diseases of the pulmonary circulation and cerebrovascular diseases.[1]

This health profile demands, from the Ministry of Health, Nutrition and Indigenous Medicine, a new comprehensive, people-centred and continuous system of health care delivery.[2] Sri Lanka has a pluralistic health system, composed of modern allopathic and traditional ayurveda systems of health provision. The allopathic system, the main provider, comprises of public and private sectors. The public sector services are available islandwide, while private sector provision is based on market demand. Free access to health care is a priority of the Government of Sri Lanka, which has been committed to maintaining this policy.

Table 1 presents key demographic, macroeconomic and health data for Sri Lanka.

1 Annual Health Bulletin 2014. Medical Statistics Unit, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka; 2014 (http://www.health.gov.lk/enWeb/publication/AHB2014/AHB2014.pdf, accessed 7 March 2017). (http://203.94.76.60/AHB2003/Chapter%201.pdf, accessed 7 March 2017)..

2 Primary healthcare reforms in Sri Lanka: aiming at preserving universal access to health, 10th chapter in the poster book Health for all, the journey of Universal Health Coverage, 2014, (c) center for global health histories, university of York, ISBN 978 81 250.

Table 1. Key demographic, macroeconomic and health data for Sri Lanka

Indicator	Results	Source of information	Remarks
Total population of the country	20.7 million	Registrar General's Department[a]	Noteworthy are the successes in universal immunization coverage, reduction of maternal mortality and infant mortality, control of diarrhoeal diseases, elimination of malaria, filariasis and neonatal tetanus, and low prevalence of HIV
Distribution of population (rural/urban)	Rural 77.4%, urban 18.2%, estate 4.4%	Census of Population and Housing 2012[b]	
Life expectancy at birth (years)	Female 78.6, male 72	Annual Health Bulletin[c]	
Infant mortality rate	8.2/1000 live births (2013)	Health performance indicators (HPI), Ministry of Health, Nutrition and Indigenous Medicine[c]	
Under 5 mortality rate	10.0/1000 live births (2013)	HPI[c]	
Maternal mortality rate	32/100 000 live births	HPI[c]	
Immunization coverage under 1 year (excluding pneumococcal and rotavirus)	92–97% (pneumococcal and rotavirus N/A)	HPI[c]	
Income or wealth inequality (Gini coefficient)	0.48 (2012)	Census of Population and Housing[b]	
Total health expenditure as proportion of GDP	3.24%	National Health Accounts (NHA) 2013[d]	
PHC expenditure as % of current government health expenditure	2%	Primary Health Care Performance Initiative[e]	
Per capita public sector expenditure on primary health care	7,497 Sri Lankan rupees	NHA 2013[d]	
Out-of-pocket payments as proportion of total expenditure on health	40%	NHA 2013[d]	

a. Annual report 2015, Central Bank of Sri Lanka, Sri Lanka.

b. Census of Population and Housing 2012, Department of Census and Statistics, Ministry of Finance.

c. Annual Health Bulletin 2014, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

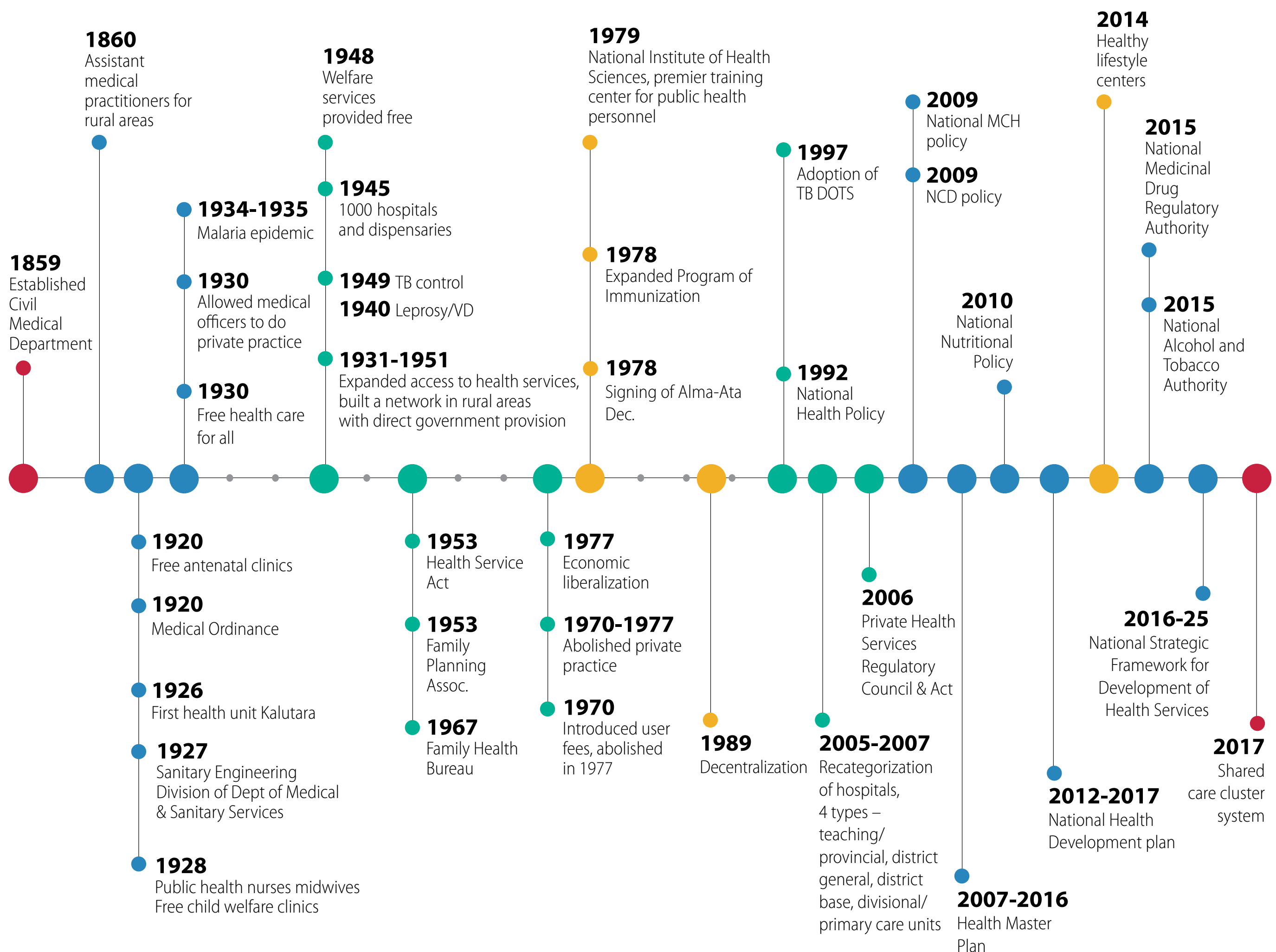
d. Sri Lanka National Health Accounts 2013, Health Economics Cell, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

e. Primary Health Care Performance Initiative: http://www.phcperformanceinitiative.org/south-asia/sri-lanka

Timeline of relevant policies to PHC

Figure 1 shows a timeline for the development of national policies and other events relevant to primary health care (PHC).

Figure 1. Timeline of PHC-relevant policy development and other events



Governance

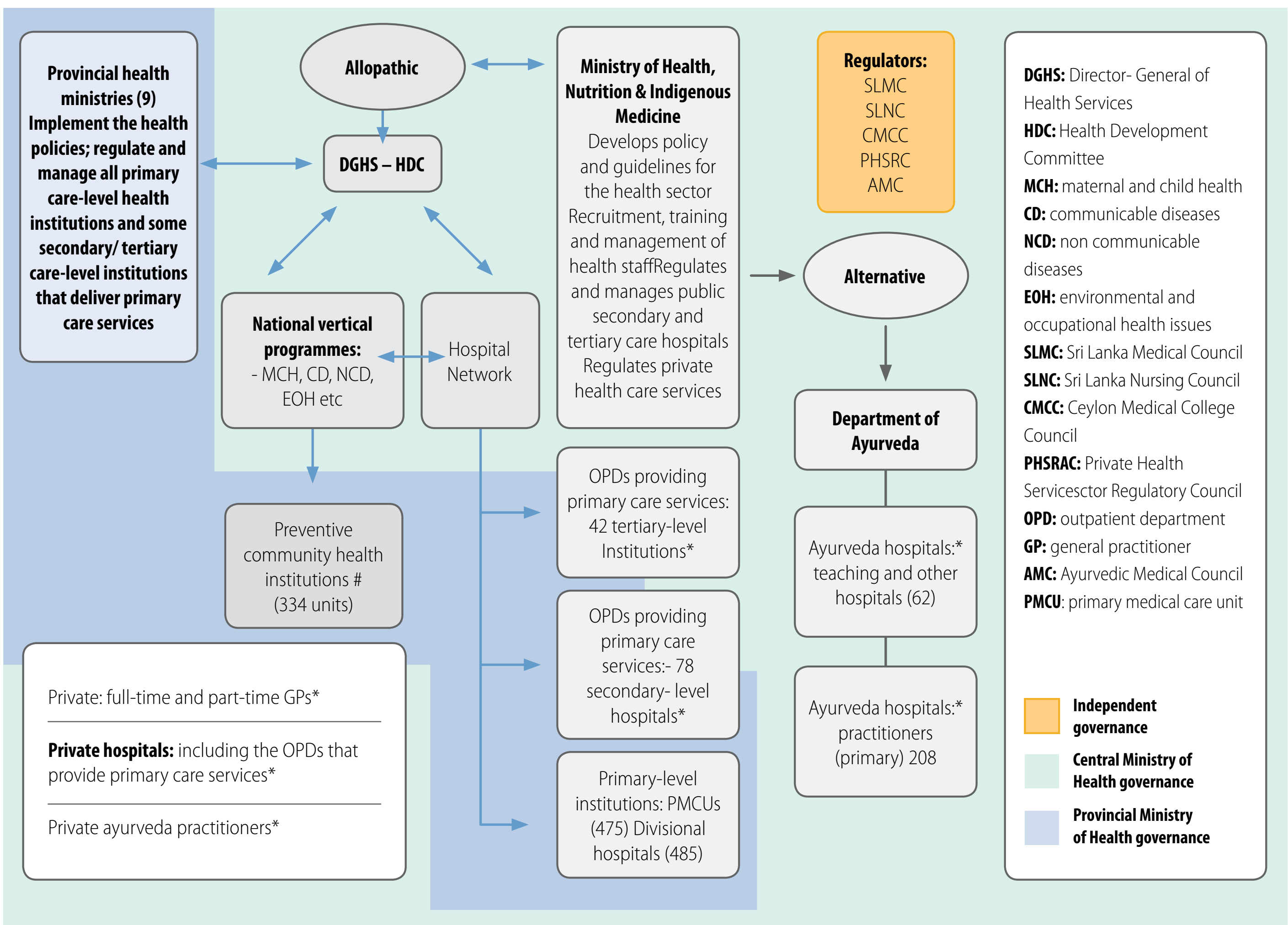
Health governance in Sri Lanka is, as mandated by the Constitution, led by the central Ministry of Health, Nutrition and Indigenous Medicine, together with nine provincial councils. Sri Lanka postulates health as a partially devolved sector, whereby the central Ministry of Health, Nutrition and Indigenous Medicine is the leading agency, responsible for formulating health policy and overseeing implementation of health services. In addition, the central ministry is responsible for management of the main hospitals, while the majority of hospitals at the secondary care level and PHC institutions are managed by the provincial health authorities. Provincial health authorities provide services accordingly while adhering to the policies and strategies developed by the central ministry. The central ministry is responsible for the recruitment of health staff, while provincial ministries have authority to recruit only minor staff categories through the permission of the central ministry. Transfers of health staff, grade promotions, retirement, and disciplinary actions are mainly handled by the central Ministry of Health, Nutrition and Indigenous Medicine, even with regard to the health staff of the provincial ministries.

There are several units within the central ministry that are responsible for managing and coordinating service delivery within the country. The Deputy Director-General Medical Services is responsible for the recruitment of doctors in the country. This directorate is also responsible for management of hospitals at tertiary care level and a few institutions at secondary care level. There is a Director of Primary Care Services within the Ministry of Health, Nutrition and Indigenous Medicine. This directorate is responsible for the development of primary curative care services within the country in coordination with the provincial ministries, who are responsible for managing the majority of secondary care hospitals and all primary care institutions.

Health care is delivered through two discrete services – curative and preventive. Curative care services are based in hospitals, which range from the National Hospital of Sri Lanka to primary medical care units. Preventive care services are mainly provided through health care units known as medical officer of health units. In 2014, there were 334 such units.As there is no gatekeeping function within the Sri Lankan health system, citizens can access any of the curative care institutions without any barriers. Therefore, all the health institutions provide primary care curative services at least through an outpatient department.When the required facilities are not available at lower-level health institutions, health staff can transfer patients to the nearest available facility for optimal management.

Figure 2 presents a visual map of the health service governance and delivery system.

Figure 2. Visual map of the health service governance and delivery system



* Patient has autonomy to visit any institution without any geographical barriers. # Geographically defined catchment areas.

Table 2. Current expenditure towards health in Sri Lanka

Indicator	Value
Total health expenditure as proportion of GDP	3.24%
% of current health expenditure for public primary level care hospitals	6.4%
Public expenditure on health as proportion of total health expenditure	55%
Out-of-pocket payment as proportion of total health expenditure	40%
Voluntary health insurance as proportion of total health expenditure	2.1%
Annual per capita from total health expenditure	US$ 105.09
Annual per capita public sector expenditure	US$ 61.82
% development partner contribution to total health expenditure	0.01%

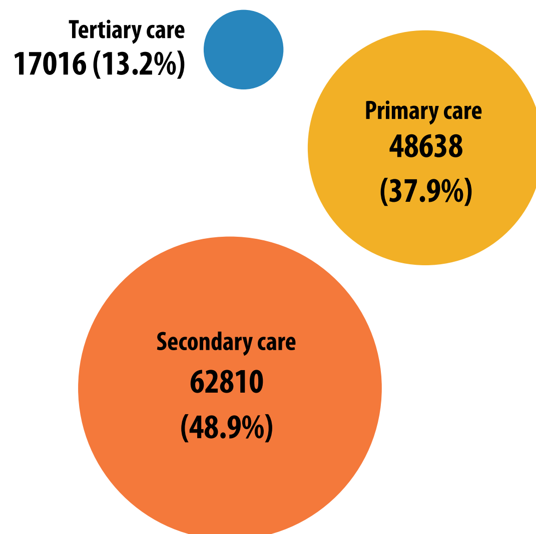
Source: National Health Accounts 2013.

Financing

The main funders of the Sri Lankan health system are the government and households. The government finances health services through general tax revenue. Households pay out of pocket to obtain services from the private sector service providers. In 2013, the government contribution was 55% of total health expenditure, while households contributed 40% (Table 2).

In addition to the Ministry of Health, Nutrition and Indigenous Medicine, the Ministries of Justice and Defence also operate health services to cater to their clients, funded by the government. The latest National Health Accounts show that 38% of the allocation for curative care services was spent on primary care delivered through all levels of hospitals consisting of primary, secondary and tertiary hospitals (Figure 3).

Figure 3. Curative care expenditure by all government hospitals by type of care, 2013 (million Sri Lankan rupees, %)



The two main financing schemes by which the government funds its health service provision are the central government scheme (under the Ministry of Health, Nutrition and Indigenous Medicine), which covers hospitals directly managed by the central ministries for health, defence and justice; and the provincial government scheme, which finances health services implemented by provincial governments. Following the decentralization plan, financial allocations for provincial health services are channelled through the provincial government scheme through government grants to provincial councils. In addition, the Ministry of Health, Nutrition and Indigenous Medicine contributes significantly to funding the health service provision in provinces to complement the limited provincial allocations. In 2013, the central ministry scheme contributed 10.83 billion Sri Lankan rupees to primary care hospitals, while the provincial government scheme contributed 5.77 billion Sri Lankan rupees.

The government health services are the primary providers of preventive health care to the people. However, only 4.5% of current health expenditure was invested in preventive care services, compared to nearly 91% spent on curative care services.

Table 3. **Categories of health care workers in the public and private sectors**

Sector	Allopathic health system		Alternative health system	
	Curative	Preventive	Curative	Preventive
Public	Specialists in family medicine Medical officers Hospital managers Nurses Pharmacists Dispensers Medical laboratory technicians Support staff	Specialists in community medicine Medical officers of health Medical officers Public health inspectors Nurses Public health midwives Field officers School dental therapists	Ayurvedic physicians Registered traditional medical practitioners	Community health officers Assistants Ayurvedic medical officers[3]
Private	General practitioners Government doctors in dual practice Medical officers in large hospital outpatient departments Nursing assistants Support staff		Ayurvedic physicians Registered traditional medical practitioners	

Human resources for PHC

The PHC workforce in Sri Lanka is employed for performing activities in both the preventive and curative sectors. While the public sector workforce is distributed throughout prevention and curative primary care services, the private sector operates mainly in the curative primary care service sector. With the current emphasis on PHC, more workers are assigned to preventive than to curative services. The preventive care network is efficient and it is led by medical officers of health, public health inspectors and public health midwives as supportive staff throughout the country.[4] Table 3 presents the categories of health care workers in Sri Lanka.

Regular in-service training programmes and regular supervision are hallmarks of the preventive branch of the PHC system, and this has undoubtedly contributed immensely to the successes the country has achieved in preventive health. However, there are inequities in distribution of human resources for health in different parts of the country. Soon after the inception of the Civil Medical Department, a cadre of assistant medical practitioners were trained to overcome deficiencies in the availability of medical doctors in rural areas through staffing of central dispensaries. Their training was discontinued in 1995 after an appreciable level of medical officers were deployed.[5]

The supply of human resources for health in Sri Lanka has grown substantially over the years. According to the Annual Health Bulletin 2014, Sri Lanka had 84.8 medical officers, 185.1 nurses, 7.3 public health inspectors and 28.7 public health midwives per 100 000 population. The exact numbers of different staff categories working in PHC are not available.Government medical officers, public health inspectors and public health midwives constitute the major category of health staff working in the PHC sector. Medical officers working in the public sector are free to work in the private sector on a part-time basis, and anecdotal evidence indicates that around 40% of medical officers undertake part-time general practice. About 500 full-time general practitioners are registered with the Private Health Services Regulatory Council, in accordance with the relevant Act.[6]

3 Ayurveda Medical Council performance report 2013, Sri Lanka.
4 National Health Strategic Master Plan (2016–2025), Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.
5 De Silva V, Strand de Oliveira J, Liyanage M, Østbye T. The assistant medical officer in Sri Lanka: mid-level health worker in decline. Journal of Interprofessional Care. 2013;27(5):432–3.
6 Private medical institutions (registration). Private Health Services Regulatory Council website (http://www.phsrc.lk/).

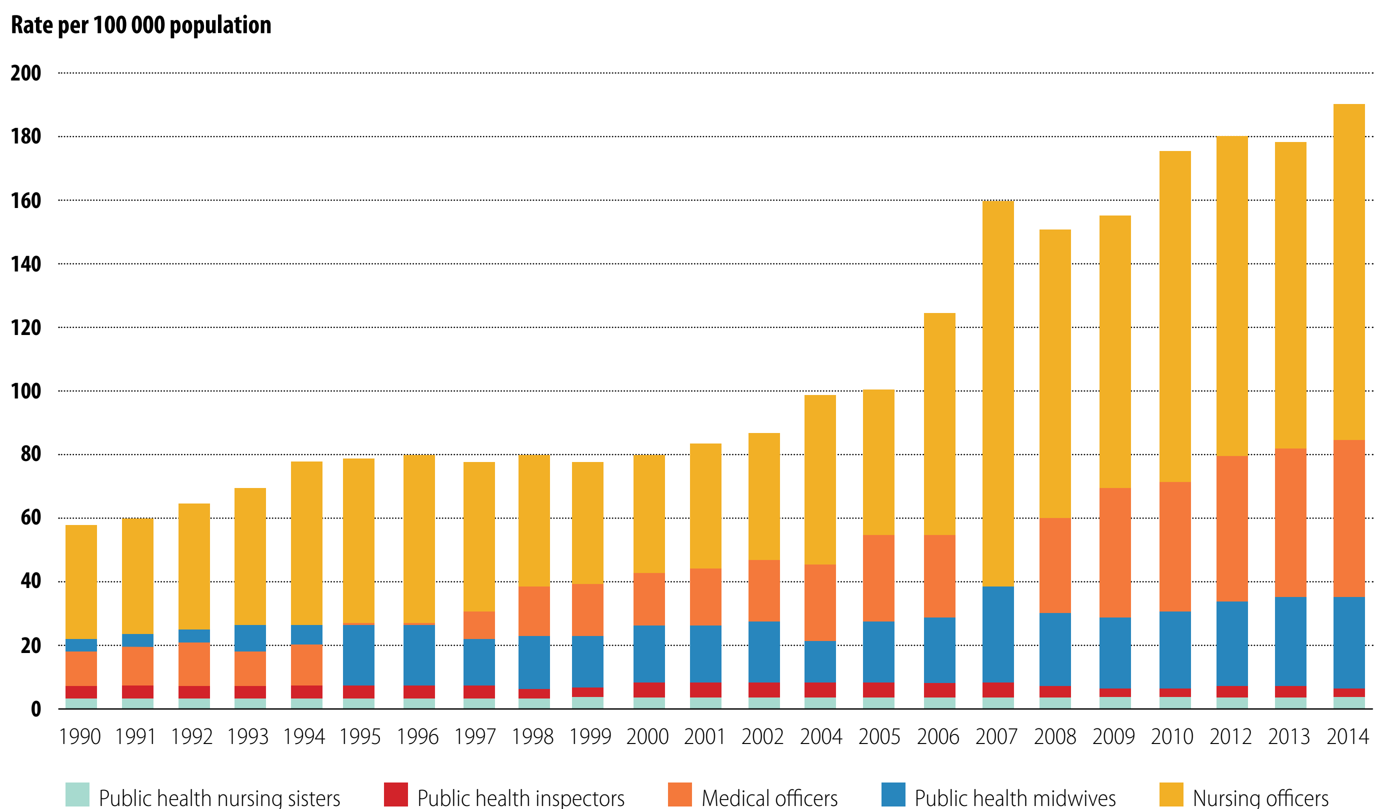
Graduate training for medical officers is provided by nine faculties of medicine, which include universities of Colombo, Sri Jayewardenepura, Kelaniya,Ruhuna, Peradeniya, Jaffna, Rajarata, the Eastern University and Kotalawala Defense University.

The undergraduate training in family medicine is not uniform among these faculties. Medical graduate training relevant to primary care is currently under review. Its emphasis has been on public health and community medicine, and the attention given to primary curative care is variable and needs further improvement.[7] Other specific health worker cadres that receive basic training on PHC are public health inspectors and public health midwives, through the Ministry of Health, Nutrition and Indigenous Medicine.

The Ministry of Health, Nutrition and Indigenous Medicine offers several in-service training opportunities relevant to primary care service delivery from time to time. There are no structured, regular,continuous professional development programmes or reaccreditation processes for medical officers or any other cadre, at present. Only few postgraduate diploma-level training courses are available for medical officers, for example in family medicine. By 2016, approximately 1500 had received the Diploma in Family Medicine. However,a definite policy is not applied to deploy them in primary care institutions.Only a few specialists in family medicine are available and they mostly serve in primary care-level divisional hospitals and in the universities. Specialty training in family medicine leads to a board-certified specialist in family medicine. In addition, preventive aspect of primary health care is emphasized in the postgraduate training programmes in Community Medicine.

Figure 4 shows the availability of key health staff categories in the allopathic public sector, 1990–2014.

Figure 4. Availability of key health staff categories in the allopathic public sector, 1990–2014



Source: Annual Health Bulletin 2014, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

7 National Health Strategic Master Plan (2016–2025), Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

Planning and implementation

The government provides overall policy directions to guide the organization of health services in the health sector. The national health sector policies are formulated by the Ministry of Health, Nutrition and Indigenous Medicine, in accordance with the government's mandate to meet overall social and economic goals. These policies are translated into strategic policy directives in the Master Plan of the Ministry of Health, Nutrition and Indigenous Medicine, which outlines the envisaged health service development and organization for the next 10 years.[8] A drawback for the decentralization in Sri Lanka has been the reliance on central Treasury funds, rather than on provincial funds. Deficient financial allocation to provincial councils has resulted in meagre funds being available for improvements at primary level compared to the funding available for facilities at secondary level, which include specialized hospitals. There is a central procurement system for medicinal drugs, which are procured based on the requirements of individual institutions, including primary care facilities. As reported by the Annual Health Bulletin 2014, a Medical Supplies Management Information System has been established and was fully functional by 2014.

The Ministry of Health, Nutrition and Indigenous Medicine develops a five-year midterm plan to implement the strategies outlined in the Master Plan. All provincial ministries of health and institutions and vertical programmes under the purview of the central ministry are expected to align their annual action plans with the health Master Plan and midterm plans. The financial performance of the health sector is reviewed regularly by the Management Development and Planning Unit under the Deputy Director General/Planning of the Ministry of Health, Nutrition and Indigenous Medicine. The ministry conducts regular meetings to discuss issues relevant to implementation, including the Health Development Committee meeting and the hospital directors' meeting. The latter is mainly for large institutions and primary level institutions are represented by provincial and regional directors of the provincial health system.[9]

The Ministry of Health, Nutrition and Indigenous Medicine makes available various guidelines to improve health service provision on its website, which are accessible to the private sector also. Although provision is made for regulating private medical institutions through the Private Medical Institutions (Registration) Act No. 21 of 2006 there is little influence over the individual organizational plans of private institutions with regard to patient care.[10]

A National Health Performance Framework has been developed to monitor effectiveness, efficiency and equity in health service delivery.

User engagement is a notable feature that has been identified for health improvement, largely due to the high literacy rates observed. Participation in immunization programmes, antenatal care and growth monitoring has been made possible with the use of patient-held health records, which also convey participatory health messages and instructions.

The development of a referral system has been planned for a long time; however, health sector development plans have not strictly embraced this. Policies for development of health institutions in every district have favoured equity in access and referral mechanisms, but without gatekeeping.[11] Officially, referrals are made from the primary care hospitals to the nearest hospital with specialist services. The patient is at liberty to access care at a specialist hospital of their choice.

The current health system was put in place during a time when health priorities were in the areas of maternal and child health and communicable diseases. Today, changes are required to better respond to the changing disease burden which includes chronic noncommunicable diseases, elderly care, accidents and injuries and rising mental health problems. The chronicity of these conditions require more comprehensive and continuing care, also involving family members. Health services are being reoriented towards these needs.[12]

8 Strategic Framework for Development of Health Services and Strategic Master Plan, volumes 1–4 (2016–2025), Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

9 Management, Development and Planning Unit, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka (unpublished data).

10 Private medical institutions (registration), Private Health Services Regulatory Council website (http://www.phsrc.lk/). Also see the Provincial Councils Act No. 42 of 1987, in The Acts of Sri Lanka 1997, No. 1–51, Government Publication Bureau.

11 National Health Strategic Master Plan (2016–2025), Vol. IV: Health administration and human resources for health, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

12 Annual Health bulletin 2015 Ministry of Health and Nutrition

Regulatory processes

Key bodies that are responsible for regulation of the health care delivery system are the Sri Lanka Medical Council,[13] Ceylon Medical College Council, Sri Lanka Nursing Council,[14] Private Health Services Regulatory Council, National Medicinal Drug Regulatory Authority, Ayurvedic Medical Council, Ayurveda Education and Hospital Board, Ayurvedic Research Committee and Ayurveda Formulary Committee.[15]

The Medical Ordinance, enacted in 1924, sets standards for training and qualification of different types of health professionals – doctors, pharmacists, nurses, midwives, dentists and others – and has laid down rules on professional conduct.[16] The Sri Lanka Medical Council is a statutory body established for the purpose of protecting health care seekers by ensuring the maintenance of professional and academic standards, discipline and ethical practice by health professionals who are registered with it. The Sri Lanka Medical Council requires renewal of registration every five years as per the Medical (Amendment) Act No. 30 of 1987, though it is not linked to any continuous professional development.[17]

The private health sector is regulated by the provisions of the Private Health Services Regulatory Council established by the Ministry of Health, Nutrition and Indigenous Medicine under Act No. 21 of 2006 to develop and monitor standards to be maintained by the registered private medical institutions. The Private Health Services Regulatory Council is also responsible for ensuring the minimum qualifications for recruitment and minimum standards for training of personnel by all private medical institutions, and ensuring the quality of patient care services delivered by these institutions through formulation of quality assurance programmes for patient care and monitoring their implementation. However, there are deficiencies in implementation, and registration of individual practices is not strictly enforced at present.

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Statutes have been passed by Parliament to ensure consumer protection, including the Food Act[18] and the Consumer Affairs Authority Act.[19] The former resulted in the formulation of a Food Advisory Committee at the Ministry of Health, Nutrition and Indigenous Medicine, and the chief food authority is the Directorate-General of Health Services. The Consumer Affairs Authority Act has resulted in the establishment of a consumer authority for protection of consumers. This Act also deals with fair trading and price regulation. Numerous directives have been issued under the Consumer Affairs Authority Act. At primary level, it is the public health inspector (from the preventive care team) who is appointed as the authorized officer with provision for prosecution in a court of law.

The Cosmetic Devices and Drugs Act[20] ensures the quality of drugs and cosmetic devices. Any complaints can be made to the Cosmetic Devices and Drugs Technical Advisory Committee, which is chaired by the Directorate-General of Health Services. The authorized officers who are empowered to investigate violations under this Act are medical officers of health, public health inspectors and food and drug inspectors. Violation of these regulations can result in the offenders being sued by the affected individuals under civil law and being prosecuted under criminal law.

13 Sri Lanka Medical Council (www.srilankamedicalcouncil.org).
14 Sri Lanka Nurses Council (Amendment) Act No. 35 of 2005.
15 Ayurveda Act No. 31 of 1961.
16 Medical Ordinance of Sri Lanka. Legislative Enactments of the Democratic Socialist Republic of Sri Lanka, Vol. VI, Chapter 113.
17 Sri Lanka Medical Council: about us (http://www.srilankamedicalcouncil.org/aboutus.php).
18 Food Act No. 26 of 1980, amended by Acts No. 20 of 1991 and No. 29 of 2011.
19 Consumer Affairs Authority Act No, 9 of 2003.
20 Cosmetic Devices and Drugs Act No. 27 of 1980, amended by Acts No. 38 of 1984, No. 25 of 1987 and No. 12 of 1993.

Monitoring and information systems

Gaps exist in monitoring of the curative system. A performance indicator system has been recently introduced. At present, for primary-level hospitals these indicators are being tested out for feasibility by the Management Development and Planning Unit of the Ministry of Health, Nutrition and Indigenous Medicine. Information systems are largely paper based and do not support robust monitoring. Drug information systems are being developed and are currently under the central procurement system. The central ministry is able to monitor the drug situation up to district level. Primary-level drug availability is monitored only by some provincial authorities. A quality secretariat has been established and has developed quality standards for primary care, though their implementation requires further attention.[21]

Primary care services are a key mandate of provincial health authorities and come under their purview. Institutional reviews and public health reviews are conducted by provincial health directors, with more focus on preventive health services.[22] Citizens' voices are represented at almost all state primary care hospitals by a committee consisting of members from the community. The functioning of these committees depends on the leadership of the institutional managers at primary care level. Field officers in the preventive health system have greater ability to mobilize civil society involvement than their counterparts in primary care hospitals because of their close relationship with the families that they follow up.

Way forward and policy considerations

The allopathic system envisages a reform in reorganization of health services with effective linkages between primary and specialized care through a model known as the "shared care cluster system". The aim is to provide universal health access through a family doctor who is responsible for a smaller population in the curative system, similar to the successful system for community health services. Figure 5 shows key recommendations for this reform by the Management Development and Planning Unit of the Ministry of Health. Other pertinent requirements include greater regulation of the private sector.

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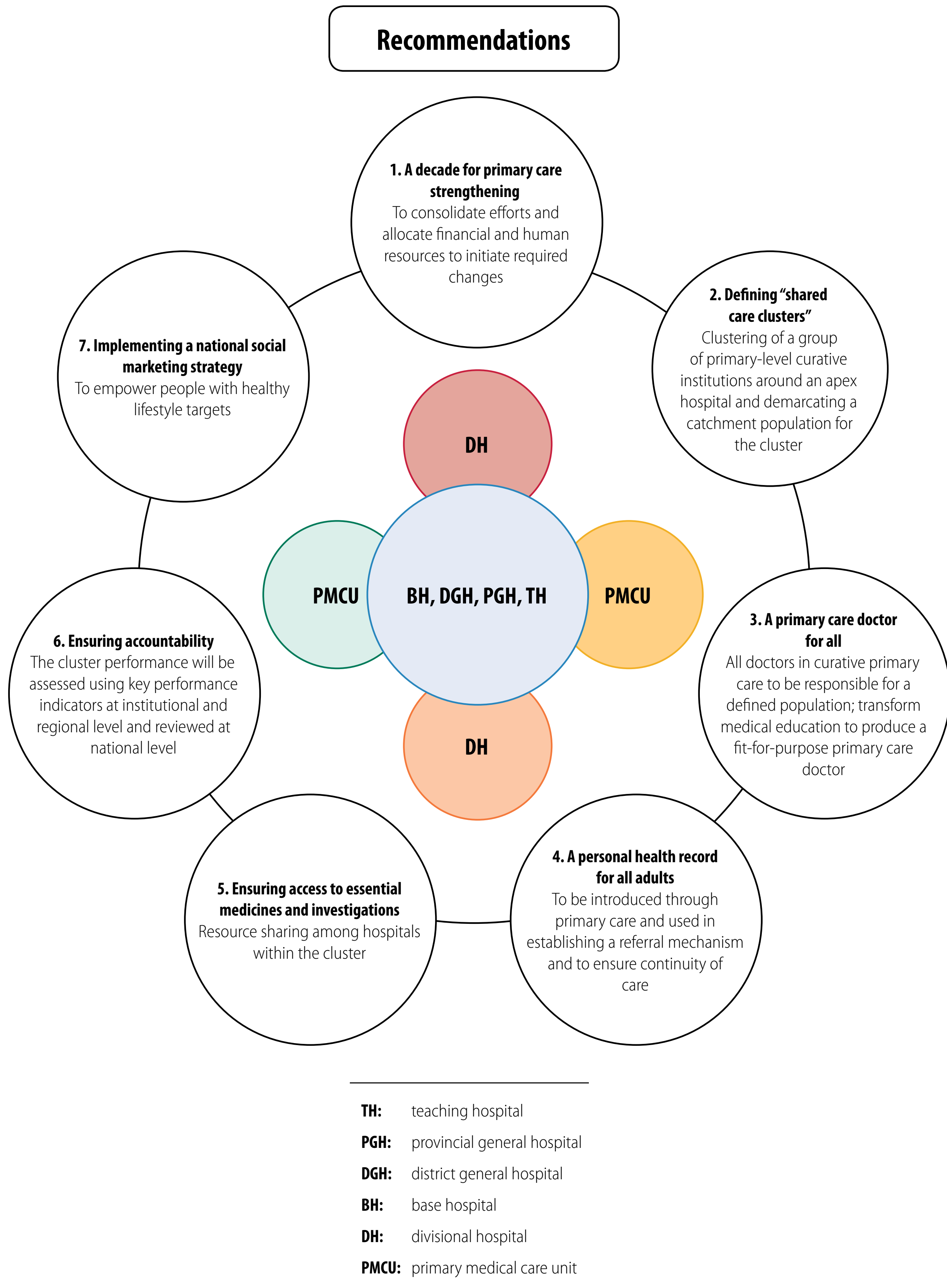
21 Annual Health Bulletin 2014, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

22 Wanasinghe S, Gunaratna H. Organisation and financing of public sector health care delivery in Sri Lanka. Institute of Policy Studies of Sri Lanka; 1997.

Figure 5. Way forward and policy considerations



TH:	teaching hospital
PGH:	provincial general hospital
DGH:	district general hospital
BH:	base hospital
DH:	divisional hospital
PMCU:	primary medical care unit

Source: Perera S. Advances in primary care strengthening in Sri Lanka. Sri Lankan Family Physician. 2016;32 *(2)*.

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