

2. Organization of Health Services

In Sri Lanka, both public and private sectors provide health care. The public sector provides health care for nearly 60 per cent of the population. The Department of Health Services and the Provincial Health Sector encompass the entire range of preventive, curative and rehabilitative health care provision.

The private sector provides mainly curative care, which is estimated to be nearly 50 per cent of the outpatient care of the population and is largely concentrated in the urban and suburban areas. The One-day General Practice Morbidity Survey in Sri Lanka, 1998ⁱ estimated that General Practitioners in Sri Lanka handle at least 26.5 per cent of primary care consultations per year.

Ninety five per cent of inpatient care is provided by the public sector. In addition to the services provided by the Department of Health Services, Provincial Councils and the Local Authorities, there are service provisions especially for armed forces and police personnel, and the estate population.

Western, Ayurvedic, Unani, Siddha and Homoeopathy systems of medicine are practised in Sri Lanka. Of these, western medicine is the main sector catering to the needs of a vast majority of the people. The public sector comprises Western and Ayurvedic systems, while the private sector consists of practitioners in all types of medicine. This provides the people an opportunity to seek medical care from various sources, under the different systems of medicine.

Sri Lanka possesses an extensive network of health care institutions. As such, the majority of the population has easy access to a reasonable level of health care facilities provided by both state and private sector through extension of services to every corner of the country. A health care unit can

be found on an average not further than 1.4 km from any home and free western type government health care services are available within 4.8 km of a patient's homeⁱⁱ.

2.1 National Health Policy

The broad aim of the health policy of Sri Lanka is to increase life expectancy and improve quality of life. This is to be achieved by controlling preventable diseases and by health promotion activities. However, the concern of the Sri Lankan Government is to address health problems like inequities in health services provision, care of elderly and disabled, non-communicable diseases, accidents and suicides, substance abuse and malnutrition.

Her Excellency the President appointed a Presidential Task Force in 1997 to formulate a health policy and to suggest strategies to address health problems and issues as mentioned above. After reviewing the recommendations made by the task force, the following thrust areas have been identified for immediate implementation.

1. Improve one hospital in each district in a planned manner, to reduce inequities in the distribution of services and to provide high quality facilities to people living in remote areas.
2. Expand the services to areas of special needs (e.g. the elderly, disabled, victims of war and conflict, occupational health problems, mental health and estate health services).
3. Develop health promotional programmes with special emphasis on revitalizing the School Health Programmes.
4. Reforms of the organizational structure, to improve efficiency and effectiveness, especially in the context of devolution.
5. Resource mobilization and management, including alternative financing mechanisms, resources sharing between private and public sectors and rationalized human resources development.

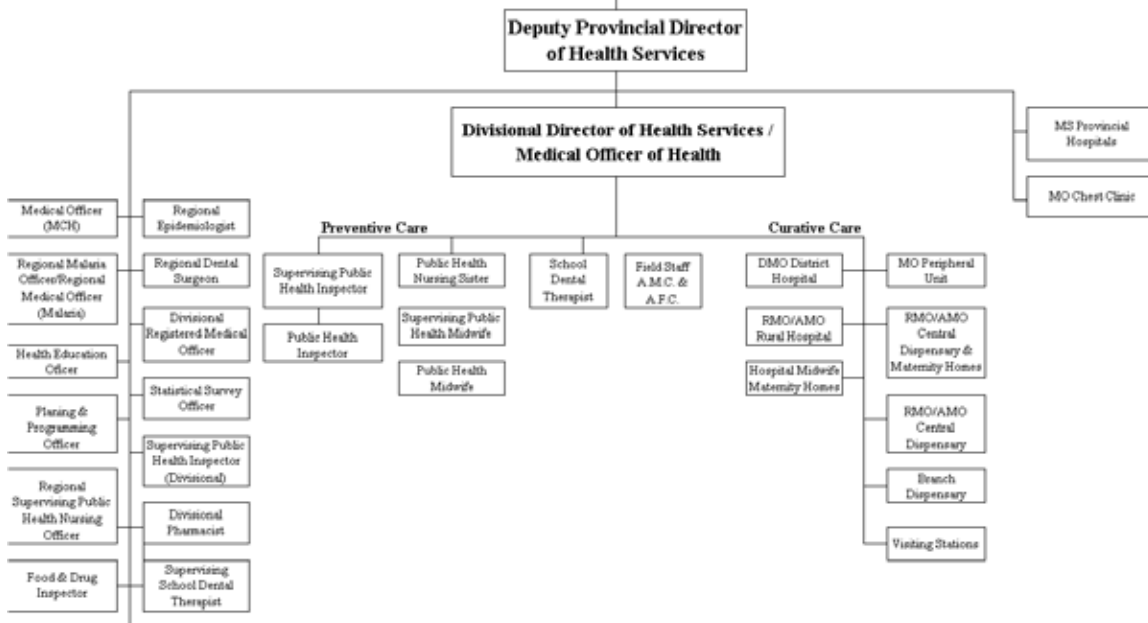
Figure 2.2

Organization Chart for the Health Services Under Provincial Councils

Provincial Level



Regional and Divisional Level



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The thrust areas will be addressed through Western, Ayurvedic and all other systems of medicine.

The government will take every effort to maximize the financial allocations on health development. This will enable the government to provide an efficient and cost effective health services throughout the country, accessible to the needy people.

The National Health Policy sets out to achieve certain measurable goals and objectives. Health development indicators, their bench marks and targets for the year 2002 are shown in Table 7.

2.2 Health Administration

The health services of the government function under a Cabinet Minister. With the implementation of the Provincial Councils Act in 1989, the health services were devolved, resulting in the Ministry of Health at the national level and separate Provincial Ministries of Health in the eight provinces.

The central Ministry of Health is primarily responsible for the protection and promotion of people's health. Its key functions are setting policy guidelines, medical and paramedical education, management of teaching and specialized medical institutions, and bulk purchase of medical requisites. The eight Provincial Directors of Health Services (PDHS) are totally responsible for management and effective implementation of health services in the respective provinces. The PDHS is responsible for the management of hospitals (Provincial, Base and District Hospitals, Peripheral Units, Rural Hospitals and Maternity Homes) and out patient facilities such as Central Dispensaries and Visiting Stations.

During 2003 there were twenty-six Deputy Provincial Directors of Health Services (DPDHS), to assist the eight Provincial Directors of Health Services. DPDHS areas are similar to administrative districts, except for Ampara district which is

sub-divided to form two DPDHS areas; Ampara and Kalmunai. Killinochchi DPDHS division which consisted of Kilinochchi and Mannar districts, started functioning as two DPDHSS from 2002. Each DPDHS area is sub-divided into several Medical Officers of Health areas (MOH/DDHS). The MOH/DDHS is responsible for the preventive and promotional health care in a defined area and carry out the action through the trained field staff working at field level. (Fig2.2)

According to the size of the population MOH can be grouped under five categories. There are five MOH areas with a population more than 200,000 each. About two third of the MOH areas have population above 50,000 but below 200,000. Another one third have population below 50,000.

| Size of Population | Number of MOHH* |
|--------------------|-----------------|
| Over 600,000 | 2 |
| 200,000 – 600,000 | 4 |
| 100,000 – 200,000 | 43 |
| 50,000 – 100,000 | 95 |
| Less than 50,000 | 75 |

*:Excluding Northern and Eastern Province and provisional

In January 1999, the Ministry of Health was restructured which resulted in the separation of the Department of Health Services from the Ministry of Health. The Director General of Health Services heads the Department and has immediate support from Deputy Directors General (DDG), each in-charge of a special programme area. They have, under their jurisdiction, a number of Directors responsible for different programmes and organizations. (Fig. 2.1) In mid 2001, there was a Cabinet decision to amalgamate the Ministry of Health and the Department of Health Services.

2.3 Health Facilities

The network of curative care institutions ranges from sophisticated Teaching Hospitals with specialized consultative services to small Central Dispensaries, which provide only outpatient services. The distinction between

hospitals is basically made on the size and the range of facilities provided. There are three levels of curative care institutions as shown below. However, patients can seek care in the medical institution of their choice.

- The Central Dispensaries, Maternity Homes, Rural Hospitals, Peripheral Units and District Hospitals are primary health care institutions.
- The Base and Provincial Hospitals are secondary care institutions.
- The Teaching and Special Hospitals are tertiary care institutions.

As at December 2003, there were 607 medical institutions with inpatient facilities and 400 Central Dispensaries compared to 576 and 411 respectively in 2002. The number of beds in the hospitals increased from 59,144 in 2002 to 59,262 during 2003, indicating a 2 per cent increase. The national rate of beds for inpatient care is 3.1 per 1,000 persons as for year 2002. The districts of Colombo, Kandy, Anuradhapura and Jaffna had a higher ratio of beds, 5.0, 4.0, 3.6 and 3.5 per 1,000 persons respectively (Table 8).

In total, there are 16 Teaching Hospitals with 15,444 patient beds. There are few Specialized Hospitals for the treatment of chronic diseases like tuberculosis, leprosy, mental illnesses, cancer, chronic rheumatological diseases and infectious diseases.

The National Hospital of Sri Lanka (NHSL), located in the city of Colombo, is the largest hospital in the island. In 2003, it

had 2,777 patient beds. This hospital provides for a number of specialties, including subspecialties like neurology, cardio-thoracic surgery, but excluding paediatrics, obstetrics, ophthalmology and dental surgery. A renal transplant service is also provided by a Collaborative project of the University Surgical and Medical Units of the Hospital. During the period 1987 to 2003, a total of 225 renal transplants had been performed at NHSL by this unit. Of these, 10 were performed during 2003. The NHSL has a well-equipped accident service and several intensive care units. The specialties not found in the National Hospital are provided by the two Maternity Hospitals, Children's Hospital, Eye Hospital and the Dental Institute located in close proximity.

The number of Provincial Hospitals remained to be 6 in 2003. There were 38 Base Hospitals with a total of 10,240 patient beds. These institutions are situated in the large towns and are administered by the respective Provincial Ministries of Health, except for all the Provincial Hospitals and Base Hospital at Gampola, which are administratively under the Department of Health Services. The Provincial Hospitals have specialties like general medicine, surgery, obstetrics, gynaecology, ophthalmology, ENT and paediatrics and also have well-equipped pathological laboratories and other auxiliary services. Among the Base Hospitals, only a few institutions provide basic specialties.

The distinction between District Hospitals (DH), Peripheral Units (PU) and Rural Hospitals (RH) is made on their size and the range of facilities provided. The total care available in DHs and PUs, are far superior to

Table 2.1 Number of Health Institutions and Hospital Beds, 1975 - 2003

| Item | 1975 | 1980 | 1985 | 1990 ¹ | 1995 ² | 2000 | 2001 | 2002 | 2003 |
|----------------------------------|--------|--------|--------|-------------------|-------------------|--------|--------|--------|--------|
| Hospitals ³ | 458 | 480 | 490 | 422 | 467 | 558 | 569 | 576 | 607 |
| Patient Beds ³ | 40,761 | 43,389 | 44,861 | 42,079 | 47,665 | 57,027 | 57,946 | 59,144 | 59,262 |
| Patient Beds per 1000 Population | 3.0 | 2.9 | 2.8 | 2.9 | 2.9 | 2.9 | 3.1 | 3.1 | 3.1 |
| Central Dispensaries | 355 | 347 | 338 | 278 | 320 | 404 | 406 | 411 | 400 |
| MOH Areas | 102 | 105 | 111 | 110 | 213 | 252 | 265 | 261 | 280 |

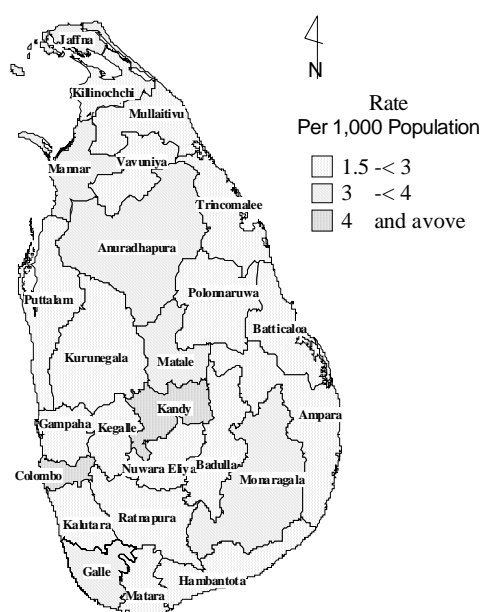
Excludes: ¹ Northern and Eastern provinces

² Jaffna, Kilinochchi, Mullativu and Ampara districts

³ Includes Maternity Homes and Central Dispensaries.

Source: Medical Statistics Unit

**Fig 2.3 - Distribution of Hospital Beds
By District : December 2002**



Source : Medical Statistics Unit

Prepared by Medical Statistics Unit

RHs because of the availability of nursing personnel in these institutions. Among the primary health care institutions, the DHs are the largest. During 2003, there were 159 DHs of which more than 100 hospitals had less than 100 patient beds. District Hospitals at Udugama, Chavakachcheri and Eheliyagoda have wards to treat TB patients, while DHs Unawatuna and Tellippalai have wards for psychiatric patients. District Hospitals Tangalle and Marawila provide few basic specialties.

During 2003, Sri Lanka had 98 PUs with a total of 4,657 patient beds and 183 RHs with a total of 4,577 patient beds. The average size of a RH in 2003 was with 26 beds. More than 50 per cent of RHs had

beds less than the average amount. These institutions very often do not have a separate maternity ward. In the past, the RHs were manned by Assistant / Registered Medical Officers. During 2000, approximately 70 per cent of RHs were in charge of Medical Officers. In order to improve the health conditions of the estate workers, by the end of year 2001, 15 Estate Hospitals were acquired by the government and manned with qualified medical personnel. But, most of these hospitals were not functioning fully due to the lack of adequate buildings and equipment. These institutions are categorized as RHs.

In keeping with the recommendations of the Presidential Task Force to provide more facilities to people with mental disorders, by the end of year 2000 Mental Health Rehabilitation Units were setup at Deltota, Dematampitiya and Meedumpitiya in the Kandy, Kegalle and Badulla districts respectively.

The smallest type of institution with inpatient facilities is the Central Dispensary and Maternity Homes (CD & MH). During 1999, Medical Offices were posted to some CD & MHs. Many of these institutions have been upgraded by providing better facilities. Hence, in 2003 there were only 80 CD & MHs compared with 88 in 1986.

Based on the 2004 updation Two hundred and eighty (280) Health Units (MOH offices) headed by Medical Officers of Health, carry out preventive services in Sri Lanka. In 2003 the highest numbers of health units were in the districts of Kandy and Anuradhapura with 21 and 19 respectively (Table 8).

Table 2.2 Availability of Patient Beds by Type of Institution, 2003

| Type of Institution | Patient Beds (Range) | Average Number of Patient Beds | Number of Hospitals Having Less Than Average Number of Patient Beds |
|----------------------|----------------------|--------------------------------|---|
| Teaching Hospitals | 399 - 2,777 | 965.25 | 10 |
| Provincial Hospitals | 351 - 1,172 | 770.17 | 3 |
| Base Hospitals | 30 - 585 | 269.47 | 21 |
| District Hospitals | 25 - 672 | 91.14 | 92 |
| Peripheral Unit | 17 - 143 | 48.51 | 53 |
| Rural Hospital | 5 - 73 | 25.71 | 103 |
| CD & MH | 2 - 62 | 12.29 | 50 |

Source : Medical Statistics Unit

With the decentralization of health services in 1992, the number of Health Units almost doubled in number. The number increased from 131 in 1990 to 276 in 2004. Consequently, still many MOHs are faced with problems such as shortage of staff, buildings, vehicles, etc.

2.4 Health Manpower

In the area of health manpower, numbers in most categories have increased. The government has made a decision to absorb all Medical Graduates passing out from the universities. The total number of Medical Officers rose from 6,994 in 1999 to 9,549 in 2002. Accordingly, persons per doctor has improved. In 2002 this figure was 1992 as compared to 2,233 in 2001. The number of Nurses per 100,000 population has increased from 76 in 2000 to 84 in 2001. This has risen to 89 in 2002. A shortage of qualified paramedical staff, such as Pharmacists, Medical Laboratory Technicians, Radiographers, Physiotherapists and ECG Recordists still exists.

A wide disparity in the regional distribution of health personnel is evident (Table 11). The Colombo district has a high concentration of most categories of health personnel except public health staff. In Colombo, the municipal staff supplements these categories. Kandy and Galle districts, too, have comparatively higher numbers of health personnel. In September 2002, the Colombo district had 113 Medical Officers and 172 Nurses per 100,000 population. The Nuwara Eliya district had the lowest number of Medical Officers and Nurses except for some districts of the North East Province.

The distribution of Specialists in curative services as in September 2002 is presented in Table 12. Of the Specialists, 35 per cent are concentrated in the Colombo district. The districts of Kilinochchi, Mullaitivu and Mannar did not have a single Specialist, and again the absence of certain common specialties such as general medicine and surgery, obstetrics, and paediatrics in some districts is also noteworthy.

During 2002, the Department of Health Services recruited 253 foreign-qualified medical graduates.

2.5 National Institute of Health Sciences

The National Institute of Health Sciences (NIHS), located in the former health unit area of Kalutara was established in 1979. The mission of NIHS is to assist in accelerating, facilitating and supporting the government policy in establishing and extending an integrated PHC delivery system to serve the entire population and to mobilize community participation in this effort.

NIHS is the premier centre of the Department of Health Services in training health manpower required for the Primary Health Care programme. The NIHS carries out basic training for Assistant Medical Officers, Public Health Inspectors, Public Health Midwives, Medical Laboratory Technologists and Pharmacists. In addition, post-basic training for Public Health Nursing Sisters and Ward Sisters is also organized.

The NIHS provides continuing education courses ranging from one week to six weeks for several categories of health personnel, namely MOH, PHI, PHNS, PHM, Pharmacists and MLT. Teacher training programmes, management training for middle level supervisors of health workers, community orientation for MOH, Health system research methodology are some of the important training programmes conducted for local participants during 2002. Two training programmes were conducted for maldivians participants.

The field practice area of NIHS covers two Divisional Secretary areas namely Kalutara, and Beruwela. There are four hospitals, - a Provincial Hospital, a Rural Hospital and two Central Dispensaries - situated in the field practice area. There is a food laboratory at NIHS in addition to the service laboratory. These laboratories serve a dual function namely, service and training.

2.6 Health Manpower Training

2.6.1 Basic Training

The Government of Sri Lanka has provided for the training of Medical Officers, Dental Surgeons, Assistant Medical Officers, Nurses and other Paramedical personnel. The Medical Officers and the Dental Surgeons are trained at the Universities. The Assistant Medical Officers, Pharmacists and Medical Laboratory Technologists are trained at the universities and in other training institutions. All other paramedical personnel are trained at the training institutions coming directly under the purview of the Department of Health Services. The training capacities of institutions as well as the output of various categories of health personnel during the period 1999-2002 are shown in Table 13.

2.6.2 Postgraduate Training

Postgraduate training is conducted both locally and abroad. The Postgraduate Institute of Medicine follows the practice of awarding academic degrees, following the successful completion of the academic courses and the final examination. However, a further condition requires that a Board Certificate be obtained to ensure satisfactory professional competence. For this purpose, the trainees are granted fellowships, allowing them additional training abroad in recognized specialized institutions. Table 14 indicates the courses conducted by the Postgraduate Institute of Medicine and the output during 2003.

2.6.3 Post-Basic Training

Table 2.3 Post-Basic Training for Nurses During, 2002

| Nature of Training | Number Trained |
|--------------------------|----------------|
| Teaching & Supervision | 94 |
| Management & Supervision | 103 |
| Midwifery | 237 |

Source : Post Basic-School of Nursing

The Post-Basic School of Nursing (PBS) and National Institute of Health Sciences (NIHS) conduct post-basic training programmes for nursing personnel and public health staff

respectively. Details of programmes conducted by the PBS during 2002 are given in Table 2.3. There were no output during year 2003.

2.6.4 In-service Training

In-service training programmes are conducted for most categories of staff. Some of the courses are conducted on a regular basis. Some courses are conducted on an ad-hoc basis, through workshops and seminars, organized by the respective programmes and organizations.

2.7 Health Finance

The health expenditure for 2003 was Rs 27,292 million, which is an increase of 6.5 per cent over the previous year. This increase is lower compared with the increase in 2002 (12 per cent) over 2001. During 2003, the proportion of public expenditure on health services was 1.57 per cent of the GNP and 4.1 per cent of the national expenditure. The per capita health expenditure was Rs. 1,417 in 2003.

The Recurrent expenditure accounted for 81 per cent of the total expenditure.

A major proportion of the health expenditure is utilized by the patient care services. In 2003, patient care services utilized 56.6 per cent of the health expenditure, while community health services utilized only 9.2 per cent. Of the balance 11.2 per cent were for general administration and 3.8 per cent were spent on training and scholarships (Table 17).

2.8 Sri Lanka National Health Accounts System

During 2001, the Department of Health Services of the Ministry of Health released the first estimates from the Sri Lanka National Health Accounts System (SLNHA). This system was developed to establish a permanent expenditure monitoring system for the country and also to meet international standards for reporting of health expenditure data. Its framework is based on the "System of Health Accounts" published by the Organization of Economic Development and Cooperation (OECD) in 2000.

SLNHA reports total national health expenditures in the country, including both public sector and private sector expenditures. Its framework classifies all expenditures according to the three dimensions of the International Classification for Health Accounts (ICHA), which are by source of funding, functional use of expenditures, and provider entity.

The first release of SLNHA consist of final estimates for 1990-1997, and provisional estimates for 1998-1999. In future, updates will be issued on an annual basis. Unlike previously published figures, the SLNHA estimates are comprehensive for the government sector, including expenditures by all ministries, provincial councils, and local governments.

The private sector estimates include both household out-of-pocket expenditures, employer spending, insurance payments and non-profit institutions.

2.8.1 Total National Health Expenditures

Total Expenditure on Health (TEH) is defined to include all expenditures on personal health services, community (public health and preventive) health services and gross capital formation in health care providers. Total expenditures on health (TEH) were estimated to be Rs. 28.4 billions in 1997, with per capita spending equivalent to Rs. 1,530. This was equivalent to US \$26 per capita, or 3.2 per cent GDP (Table 18A).

2.8.2 Funding of National Health Expenditures

Public expenditures on health grew from Rs. 5.6 billion in 1990 to Rs. 14.0 billion in 1997. Private expenditures grew from an estimated Rs. 5.6 billion to 14.3 billion. Throughout the decade, government and private sources accounted for approximately 50 per cent each of total financing, or about 1.7 per cent of GDP (Table 18B).

Central government ministries and departments accounted for a growing share of total public sector expenditures during 1990-1999. The provincial councils share declined to

31 per cent. The bulk of central government expenditures are from the Ministry of Health.

Household out-of-pocket spending accounts for the largest share of private spending (43 per cent of national total). Employees and insurance expenditures account for less than 5 per cent of total national spending.

2.8.3 Expenditures by Provider and by Functional Use

Personal health services account for the largest share of total spending (78 per cent). Inpatient expenditures account for 23-25 per cent (Table 18C). Preventive and public health expenditures declined as a share of the national total from 11 per cent in 1990 to 6 per cent in 1999. The bulk of preventive health expenditures, and most inpatient expenditures are funded by the government sector. Most private expenditures are for outpatient primary care services, and purchase of medicines from pharmacies and shops.

2.9 Foreign Aid Utilization

Each year, the Ministry of Health receives foreign aid in the form of money, materials, drugs, medical equipments and technical inputs. During 2002, foreign aid component of the health expenditure was Rs. 1218.6 million. This accounted for 4.5 per cent of the health expenditure. There is a marked decrease over the previous year. The foreign aid component during 2002 was 10.7 of the total health expenditure.

ⁱ De Silva N and Mendis K. One-day General Practice Morbidity Survey in Sri Lanka. Family Practice 1998: 15: 323-331. Oxford University Press

ⁱⁱ Health Manpower Study 1971-1973.