2.6 HEALTH FINANCING, RESOURCE ALLOCATION, UTILISATION AND MANAGEMENT

(1) THE HEALTH FINANCING POLICY CONTEXT

There have been a number of recommendations made on how to improve resource mobilisation, allocation and utilisation since 1990.

In 1992, a Presidential Task Force developed and published a national health policy for the country. There were many items in the policy pertaining to health financing. First, it was suggested to introduce two earmarked taxes for use by the sector: taxes on items of consumption that pose danger to health, e.g., alcohol and tobacco, as a share of the total price of the product, and also a tax imposed on international travellers as they exit. Secondly, it was recommended to establish pay wards in governmental hospitals where fees would be charged for a higher bed and service quality. Third, auto insurance should include coverage for the medical expenses incurred if an accident were to occur. Fourth, the use of voluntary health insurance should be promoted. Fifth, the government allocation for health should be increased to 3.5% of GDP by 2000. Sixth, all international support for health should be directed to the support of the 1992 National Health Policy. Finally, local donations will be encouraged from the community only after an evaluation is conducted on how best to manage and allocate it.

In 1997, another Presidential Task Force study was conducted. It recommended many responsibilities to be devolved to local entities of government, including procurement; to encourage greater financial autonomy of most publicly owned health facilities especially hospitals; to develop alternative financing mechanisms. Finally, many other recommendations focused on facility management structures leading to greater autonomy.

Professor William Hsiao conducted a preliminary assessment of Sri Lanka's health sector in 1997 and made a number of findings. They included: a) the importance for the development of an overarching strategy to address issues of under-funding, and a public-private mix, and b) inefficiency is not a major problem such that management and organisational reforms would yield few gains. He also thought that a number of areas required more in-depth study. First, it is important to conduct an analysis of private sector financing, including the determinants of health care demand. Second, an analysis of the current funding of health care provided by the public sector, especially the resource allocation criteria used in the public sector along with reasons for emerging financing gaps between expected and required resources. Third, financing options including social health insurance should be assessed. Finally, an evaluation should be conducted of resource allocation for promotion, prevention, and community care, including options for improvement.

The Sri Lankan government recently completed a review to facilitate charting a public course of action regarding macro-economic reforms along with improving health status and strengthening governance and institutional reforms.[1] It sought to provide guidance for public action designed to achieve high economic growth and retain the social equity the country has been known for into the second decade of the 21st century. The document had many goals for improved macro-economic performances along with goals for health status improvement, many of which focused on health problems of ageing, and vehicles to mitigate those problems, especially via the private provision of specialised health care. It also addressed key constraints, which required reforms, including strengthened management of public financial resources, and establishing new systems of resource allocations, including in the MoH.

Finally, over the last several years there has been an ongoing dialogue between the Sri Lankan government and the international community via the development of a poverty reduction strategy paper known as the PRSP. This dialogue has noted a number of health policy issues generally, but specifically

1 See Visions 2010 (Colombo, Government of Sri Lanka, 2001).

targeted reform proposals to alter health financing, with better efforts to mobilise and manage financial resources in both the public and private sectors. It recommended the introduction of performance-based budgeting within the public health sector, the development of a medium-term budget framework, improving the targeting of subsidies to the poor, reducing the regional disparities in per capita public outlays, and increasing real public outlays for health to 8% to 10% of total government spending (equal to 2% to 2.5% of GDP).

Summary of Health Financing Policy

In summary, all policy reviews thought that it would be important for the future financial vitality of health care delivery systems to find new mechanisms for resource mobilisation, especially by employing some form of social health insurance. Further, most observers have thought that relationships between the public and private sectors made any assessment of financing options more complicated, as many private providers also worked within the public sector. Most thought the public sector operates relatively efficiently, but there were calls to review and assess the empirical evidence of those making that claim. Further autonomy of facility management and more decentralisation of decision-making have been advocated to improve efficiency and strengthen service quality. Finally, concern about the poor was raised and various recommendations were made to ensure high equity of access and financing, and to achieve that in the near term it required greater public allocations to at least 2% to 2.5% of GDP.

(2) TRENDS IN PUBLIC FINANCING

Trends of Public Health Expenditure as a share of GDP

Since gaining its independence in 1948, Sri Lanka has been globally known for the strong performance of its health sector in achieving very high health status indicators. Few countries have surpassed Sri Lanka's achievements in reducing infant mortality and maternal mortality, and raising life expectancy to more than 70 years. At the same time, the health care system operated by the government has been gradually deteriorating as financial support has been eroding. A record low level of financial support has occurred over the last four years as the MoH share of GDP has dropped to just above 1% during this period of economic stress as the country's economy has experienced its most severe recession since its independence (Figure 2.6.1).

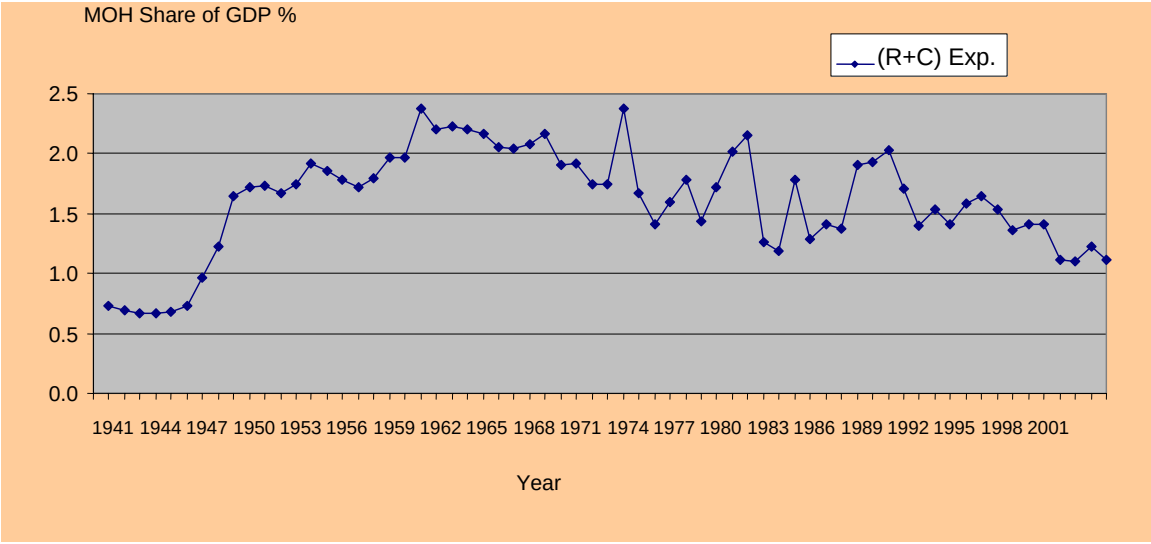


Figure 2.6.1 Trend in Government Financing of Ministry of Health Care Services Expressed as a Share of GDP, 1939-2003

Source: MoH, Data compiled by MoH-JICA Study Team

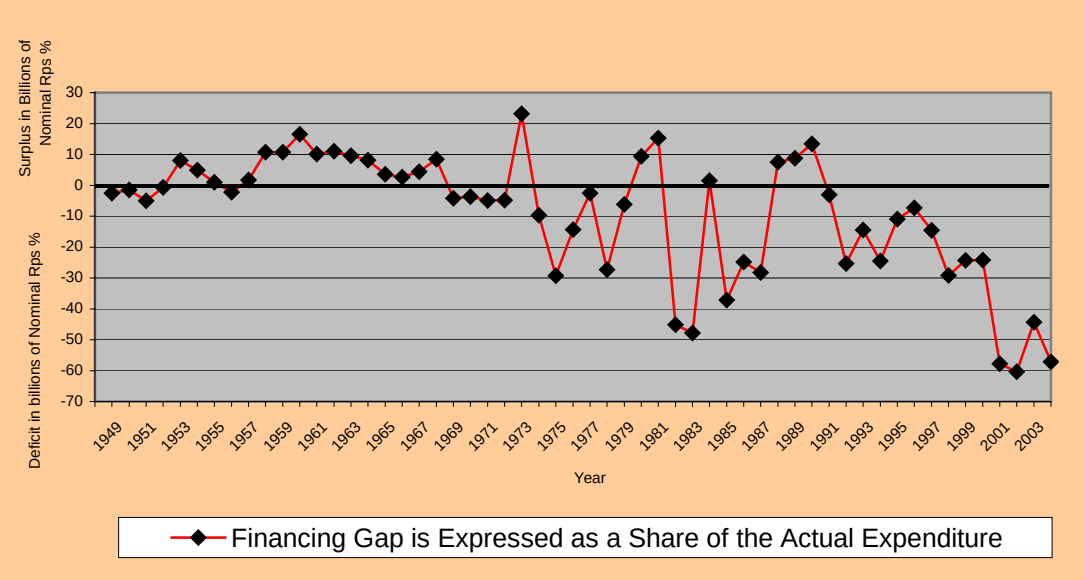


Figure 2.6.2 Public Financing Gap Expressed as a Share of Actual Expenditure.

Note: The Criteria for a Gap is defined as the average share of GDP spent by the MoH (1.76%) over the 55 Years since Sri Lanka's Independence, 1948-2003

Source: MoH, Data compiled by MoH-JICA Study Team

Right after Sri Lanka's independence and through the decades of the 50s and 60s, the MoH expenditure share of GDP gradually rose from about 1.6% to over 2.0%. However, after that period of growth, lasting into the late 1960s, its share of GDP has declined year by year, and has dropped to new lows after a rather stable period of funding during the 1990s when the MoH share was around 1.4% to 1.5% of GDP. The average share over the entire independence period of 55 years has amounted to nearly 1.8% (actual = 1.76%) of GDP. During the last three-year period from 2000 to the current year, 2003, has experienced only 1.1% to 1.2% of GDP allocated to MoH programmes and activities. This level of expenditure represents a financing gap relative to the historical trend over the last 55 years of nearly 60% for each year (Figure 2.6.2).

Trends of the MoH Expenditure as a Share of Total Government Expenditure

This declining trend in MoH allocations as a share of GDP is also reflected in its declining share of total government spending. Figure 2.6.3 shows a similar decline in the share of total government expenditures allocated to the MoH. In the early period to 1975, the government share varied between 8% and 10%. However, afterwards, it has generally declined to a current low around 4% over the last four years. The only time it reached this low level was during the beginning of the long period of civil strife, which started in 1981.

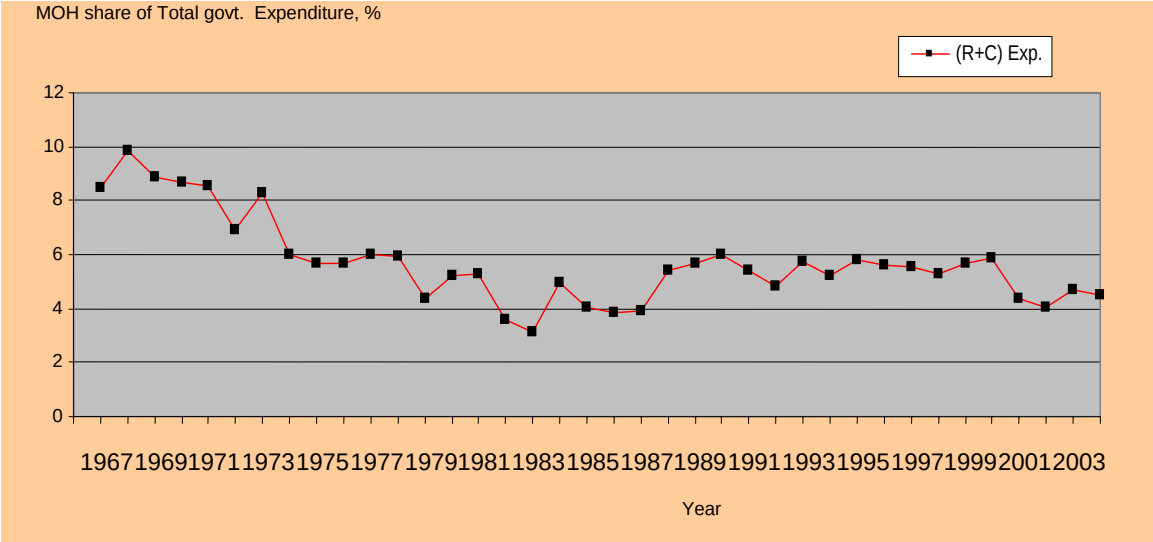


Figure 2.6.3 Trend of MoH Expenditure, Expressed as a Share of Total Government Expenditure, 1966-2003

Source: MoH, Data compiled by MoH-JICA Study Team

Given the above trends it is clear that publicly funded health care facilities and services have been systematically squeezed during the last 20 years of the 20th century. The funding gap can be expressed in various ways, but the main point is that financial resource scarcity has become a chronic health problem of the sector, and has undermined the capacity of the system to contribute to further improvements in the health status of the Sri Lankan people. This downward turn in health status indicators in the most recent period, e.g., the rise in age- and sex-specific mortality rates in 1996,[2] relative to earlier periods reflects the seriousness of the problem.

(3) RESOURCE MOBILISATION

Sources of Funds: Households, Central MoH and Provincial MoH

Who has been shouldering the increases in expenditure? Based on available data from 1990-1997, it seems that the **household**, through out-of-pocket payments, has been consistently the primary financier of health expenditure (Figure 2.6.4). The other top contributors are the **central MoH** (Ministry of Health) and **provincial MoH**[3]. Despite the decentralisation of health services in 1987, the purse of the Central MoH remains bigger than that of the provincial MoH. The combined average of the two government sources is even one percent short of the average for the share of households (Table 2.6.1). The other sources of funds to finance health expenditure were the employers, other government agencies, non-profit organisations, local governments, and insurance companies. It seems that, for every 100 rupees spent for health from 1991 to 1997, the households contributed 45 rupees, central MoH 27 rupees, provincial MoH 17 rupees, employers 4 rupees, other government agencies and non-profit organisations 2 rupees each, and local governments and insurance companies 1 rupee each (Table 2.6.1).

2 Annual Health Bulletin 2000, (Colombo: MOH, 2002).

3 Allocation fo funds to Province Councils from te annual nationa budget as considered adequated to meet the needs of the Province are made on the recommendation fo the Finance Commission on the basis of the estivates of expenditure submitted by the Provincial Councils. The block grants are under the following four categories;1, Block grant for recurrent expenditure, 2) Criteria based grant, 3) Matching grant, and 4) Province specific development grant.

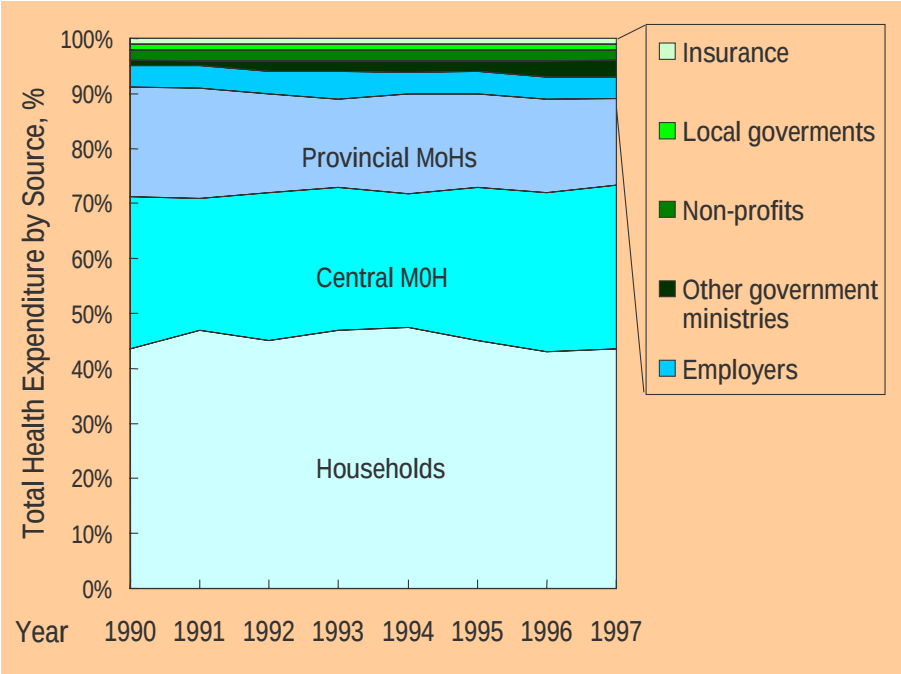


Figure 2.6.4 Trends in Total Health Expenditure by Source, 1990-1997

During the eight-year period, has the burden of financing health expenditure changed? Comparing the shares in 1991 and the average shares for the period, **three patterns** can be observed. One, the share of the provincial MoH declined by 3 percentage points and that of central MoH, by 1. Two, the **burden shifted mainly to the households** with their shares swelling from 41% to 45% of the total health expenditure and minimally to other government ministries, departments and agencies, which saw the rise in their expenditure by one percentage point. Three, the shares of the other sources of funds were essentially stable such that the average shares for the eight-year period were the same as those for 1990.

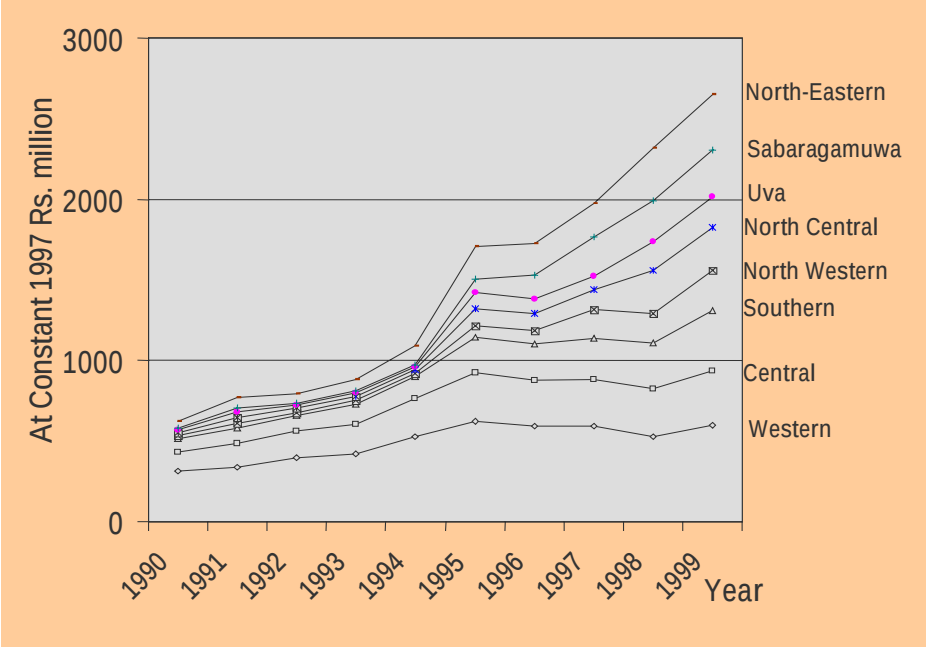


Figure 2.6.5 Trends in Per Capita Health Expenditure by Central Government at Constant 1997 Rupees, 1990-1999

Source: Sri Lanka National Health Accounts, June 2002.

Once more, despite the passage of the 13th Constitutional Amendment and the Provincial Councils Act No. 42 of 1987, the provincial authorities appear to be losing power over financial resources for health or it could also be that they themselves are investing less. The latter seems to be the case. On a per capita basis, the central government continues to increase its health investments in all provinces from 1990 to 1999 (Figure 2.6.5). On the contrary, only North-Eastern, Sabaragamuwa, Uva, and North-Central provinces have overall upward trends of health expenditures while the other provinces had relatively flat trend.

Public Financing

During the last decade, government spending on health was funded almost exclusively from central government revenues. The central revenues came from a variety of taxes (Table 2.6.2). They seemed to serve quite well to get more income from the more well-to-do, but also contained the paradox that the state partially depends for health revenues on sales of tobacco and liquor for support of MoH expenditures.

Table 2.6.2 Distribution of Payments by Major Type of Tax used for Health Services, by Decile (%), 1995/96 [4]

Income Deciles	Income tax	Sales taxes	Tobacco taxes	Liquor tax	Capital Tax
Lowest1	0	3	3	1	0
2	0	4	4	2	0
3	1	5	6	4	1
4	0	6	7	5	1
5	0	7	8	7	2
6	2	8	11	8	2
7	1	9	12	9	2
8	5	12	14	15	4
9	9	15	16	17	15
Highest10	81	32	21	34	72
Overall amount	Rs. 7.4 billion	Rs. 53.5 Billion	Rs. 12.2 billion	Rs. 5.9 billion	Rs. 14.2 billion
Share in total taxes	6 %	42 %	10 %	5 %	11 %

Note: For some taxes, insufficient data distribution of incidence. These taxes accounted for 58% of all taxes existed in the household survey to estimate.

Source: Sri Lanka HIES 1995/96

Private Health Insurance

Private health insurance in Sri Lanka still has quite small coverage (less than 2% of the total population and 1% of the total health expenditure) but it is growing. The 1997 study by IPS (Table 2.6.3) shows that most claims, 95.9%, cover health care in the private sector. Still IPS concluded that insurers have little power even over the private provision of health care. It also concluded that, in addition to oversupply of services, there is evidence of cost-escalation in the insured market, especially rapid increases in fees for those with private health insurance coverage.

Table 2.6.3 Utilisation by Type of Provider for Insured Patients

Provide Type	Percentage of Total Claims		
	Outpatient Claims (%)	Inpatient Claims (%)	All Claims (%)
Government Hospital	1.0	7.4	4.1
Private Hospital	**32.7**	**91.4**	**60.5**
Private Dispensary	**38.7**		**20.4**
Private Doctor	21.1		11.1
Ayurvedic Hospital	0.0	0.9	0.4
Ayurvedic Doctor	0.5		0.3
Other	1.7		0.9
Pharmacy	4.2		2.2
Foreign Hospital	0.0	0.2	0.1
Total	100.0	100.0	100.0

Source: IPS

4 The number shown relative to each income decile represents the share of the total tax payments of that tax paid by that income decile.

Community-Based Health Care Financing in Sri Lanka

In Sri Lanka, as described previously, the funding mechanism in health sector has been limited to taxed-based health care financing and "out-of-pocket" financing. Private insurance is not widely used among the population. However, in a review of rural credit institutional data, it was found that there are between 30,000 and 35,000 such societies throughout the country many of which finance health care to their members.

This review included information from the Annual Reports of the Central Bureau of Statistics, the 45th Annual Report of the organisation known as Sarvodaya and documents and reports from the organisation known as YASIRU (The All Ceylon Community Development Council (ACCDC) Mutual Provident Society). An interview with the chief executive of YASIRU, Mr Sunil Silva, has confirmed a rapidly growing provident mutual fund health and welfare insurance programme with death, disability and hospital benefits for its members.

YASIRU is close to finalising an arrangement with several large CBO groups, which will significantly expand its membership base. Most notably, the Sarvodaya NGO organisation of village-based development and micro-credit organisations will be entering into an agreement with YASIRU that will extend membership to about 350,000 of its current members. YASIRU has also held extensive discussions with a consortium of NGOs operating in the North-East area of the country, which will bring a number of other small funeral societies and micro-credit groups with at least 30,000 members into the YASIRU.

The future looks bright for this fund and it looks like a very intriguing programme that warrants the international community's support. The detail of community based health insurance are described in Volume 4, page 4-80 to 4-82.

Facility-Based Strategies to Generate Resources

The management of hospitals has not been duly emphasised in the health system because it was not necessary to give it much priority within a historical budgeting system. However, hospital directors who participated in the Study planning workshops expressed the need for them to be given more authority to perform their new devolved roles and responsibilities. When it comes to mobilising resources for health, some hospitals have actually engaged in one form or another.

A survey commissioned by JICA on resource generation and financial management was carried out in 2002[5] by the Institute of Policy Studies Sri Lanka. The survey identified three broad mechanisms of revenue generation at the level of the government health institutions. They are:

- Charging of user fees for all or selected patient services;
- Donation in money or kind to the institutions by households, enterprises and non-profit agencies; and
- Generation of income from non-patient treatment activities.

In the past, Government health services had levied user fees for patient services in some form or other; however, because means-tested user fees is difficult to implement in this country because the administrative machinery does not exist in government facilities to check patients' income, government health institutions relied on self-reporting of income. Also even a small amount of flat-rate system discouraged patient utilisation, therefore, the idea of introducing user fee has been abandoned in the last 30 years in this country.

Public opinion surveys since the mid-1990s have repeatedly demonstrated that a significant and increasing percentage of the public continue to oppose user charges for general services at government facilities.

There were several other fund raising mechanisms by public sector hospitals, leaving aside pay-beds. During the survey, it was noted that funds were generated by hospitals in 2001 through donations from

[5] JICA - MoH Survey No. 4.1.

individuals, charitable organisations, non-governmental organisations, and voluntary payments by patients. Donations were most likely in kind, such as hospital furniture, goods, consumables, drugs, equipment, patients' special diets, and services (e.g., painting of wards and buildings), because hospitals do not accept cash donations.

It was also noted that, in addition to donations, health institutions also generated funds through non-patient services. A few important sources of such funds are listed below:

1) Funds collected through hospital-affiliated organisations

   The important sources of additional funds include Hospital Committees, Hospital Development Committee, Seva Vanitha, Welfare Societies (mainly from renting out of building for hospital cafeteria), trusts for Specific Purposes (e.g., NSU Trust of the National Hospital, Suba Sara Fund of the Horana Base Hospital).

2) Commercial Establishments

   Many hospitals have links with garment factories, banks, tourist hotels, etc. On specific occasions, these establishments provide goods and services to the hospital as a token of appreciation. Some pharmaceutical companies sponsor training programmes, and donate books, stationary and brochures. Much of this depends on the head of institution to reach out to such organisations.

3) Leasing out space and buildings to commercial organisations (e.g., banks)

   This mechanism, which maximises returns from the Ministry of Health estate, is not systematically encouraged.

4) Foreign funds channelled through local agencies

   Some hospitals have received donations of ambulances, specialised units, wards and equipment through such agencies.

The survey[6] concluded with the following recommendations with regard to resource generation at government health institutions.

1) There is potential for additional resources to be raised at the facility level from donations, better management of hospital estate, and commercial exploitation of tangible and intangible assets. However, none of these mechanisms is likely to become a substantial source of revenue. In certain instances, they will have a significant impact on individual facilities, but not all facilities have the resources or the opportunities to benefit equally from these opportunities. Extensive reliance on these mechanisms will need to be accompanied by safeguards to ensure that equity between richer and poorer areas is not negatively impacted.

2) The MoH can and should support efforts to exploit these opportunities. It should provide more systematic guidance to hospital directors on the various opportunities, review administrative procedures to facilitate those which are beneficial, provide specific training to directors in managing these mechanisms, and disseminate knowledge on successful experiences and best practices within the service.

3) There is potential for continuous savings to be made in the routine operations of hospital services. For the most part these will rely on improving the general quality of management and administration. Without substantial improvements in management capacity, managerial autonomy at the facility cannot be enhanced, and this will be critical for substantial and sustained improvements in productivity, which rely on exercise of management discretion and initiative.

4) In the long-term, increased autonomy of management at the facility level is desirable in order to support improvements in productivity and resource use. However, this will conflict with parallel moves to political decentralisation and devolution of authority to provincial council level. The Ministry needs to develop a more coherent strategy for thinking about and dealing with autonomy for front-line managers in a context of political decentralisation. To the extent that the central ministry can do so, it should seek to develop national policies, which set standards for all public

[6] JICA - MoH Survey No. 4.1.

sector facilities at the provincial level, in the areas of financial and management audit, human resources deployment, procurement and maintenance, and estates management.

5) There is no new evidence to indicate that user charges, either for routine services or for selective paying-bed services, can provide significant new resources to subsidise the provision of services for the poor. All current services in this area continue to represent poor value for money, because they raise less revenues than the costs involved in delivering them, and in so doing worsen the ability of MoH to target its expenditures on the poor.

(4) PUBLIC ALLOCATIONS

In this section, the allocation of financial resources for health is analysed. Two components need to be examined: Administrative Resource Allocation and Service-based Resource Allocation.

Administrative Resource Allocation

Since 1992, provinces have received a share of these revenues to be spent on their public services according to specifications of the grants. The problems with this revenue sharing are multiple: a decreasing share goes to provinces, allocation and actual release are significantly different, mechanisms for equity in the share have been insufficient, and the poorest provinces have had to raise most of the necessary funds locally. Since 1992, the shares of the total revenue that were allocated to the provinces have been minimal and hovering between 9.9% and 10.2%.

Of total government health expenditures in 1999, 41% were allocated to central government (teaching) hospitals and 27% to provincial and district hospitals. Expenditures in provincial hospitals as a percentage of total government hospital spending showed a downturn throughout the nineties, decreasing from 40% to 31% at the end of the decade.

Table 2.6.4 shows that there is a significant difference between the amounts requested, recommended and actually released by the Treasury. In the late 1990s, Treasury disbursements were about 75% of the provincial councils' requests, which indicates that the central Treasury has also a cash flow problem that disturbs both central spending and provincial spending of public funds. For example, only a trickle of funds has been released for capital expenditures in recent years and since 2002, the government has imposed a freeze on capital expenditures.

Table 2.6.4 Amount of Grants Requested, Recommended and Released, 1996-1998 (Rs. Million)

	1996	1997	1998
Amounts requested by Provincial Council	23,207	25,108	27,481
Amounts recommended by Finance Commission	21,493	23,602	25,397
Amounts released by Treasury	17,193	18,347	20,594

Source: Finance Commission

Table 2.6.5 Criteria-Based Grants Per Head/Provincial Population 1997 and Per Capita/Provincial GDP 1998

Province	1997 Criteria based grants, (Rs. Million)	Per Head /Provincial Population (Rs.)	1998 Criteria based grants (Rs. Million)	Per Capita /Provincial GDP (Rs.'000)
Western	254	53	254	91.6
Central	166	71	166	47.8
Southern	177	73	177	41.1
North Eastern	165	60	139	23.8

North Western	138	63	142	48.3
North Central	75	66	75	57.4
Uva	61	53	79	45.9
Sabaragamuwa	131	73	131	42.6
Total	**1,167**	**63**	**1,163**	**54.6**

Source: Compiled from Ministry of Provincial Councils & local government data

The provinces' block grants represent more than 90% of the transfers. These block grants are "needs oriented" being the difference between the estimated recurrent expenditure and the estimated revenue collection of the Province. Provinces receive quite unequal grants whether looked at in total or per capita; they also have very unequal per capita income (Table 2.6.5). In 1998, Western and North-Eastern Provinces received the most and least block grants, respectively. When it comes to health expenditure, though, the reverse is true. The central government, provincial council and local government spent the least on a per capita basis in Western Province and the most in North-Eastern Province (Figure 2.6.5 and Figure 2.6.6).

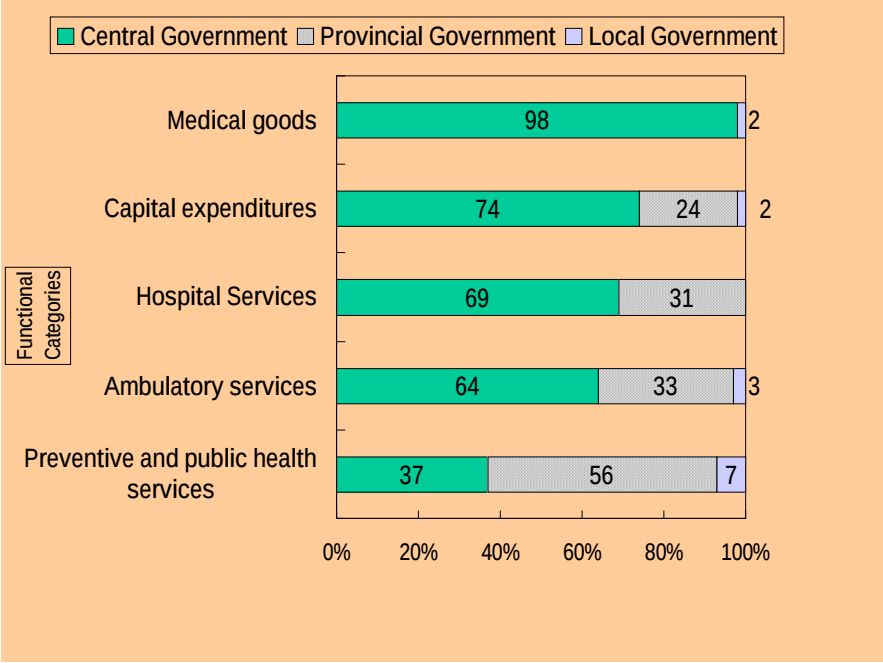


Figure 2.6.7 Relative Share of Funding by Central, Provincial and Local Governments of Selected Functional Categories in 1997

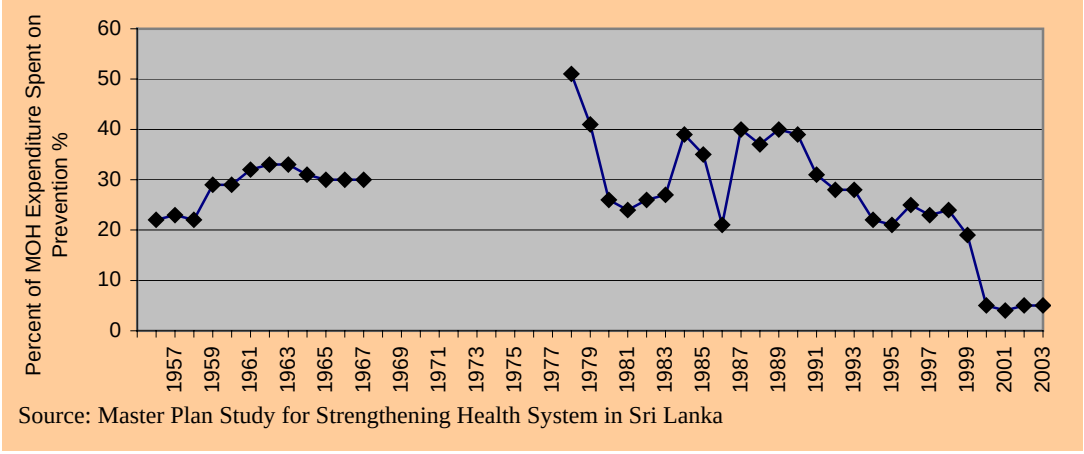
Source: Compiled from Ministry of Provincial Councils & local government data

By functional categories, how have the money for health been used (Figure 2.6.7) By virtue of the 13th Constitutional Amendment, the central MoH retains the major responsibility of drug management. As such, it accounts for 98% of the 1997 expenditure for drugs. The remaining 2% was on emergency purchases by provincial or institutional authorities. In 2002, the amount requested by the MoH for drugs and medical consumables had risen to 17% (Rs.4.8 billion) of total government health allocations.

While capital expenditure, hospital services and ambulatory services were mainly financed by central government, preventive and other public health services were shouldered by provincial government. The local government's share was highest for preventive services. Expenses for hospitals were shared only between the central and provincial governments because there is no hospital under the responsibility of local government.

Service-based Resource Allocation

Figure 2.6.8 shows the trend in the share of total MoH expenditures spent on identifiable prevention programmes. Like the other trends, the share of expenditures going to prevention is at a record low for the country. The high health status of Sri Lanka is largely based on the accomplishments of past priority given to preventive health programmes and focused curative programmes for past epidemiological priorities. Figure 2.6.8 shows that between one quarter to one third of total MoH expenditures were devoted to preventive programmes, but now it is 5%. The question here is how the country will grapple with the growing NCD problems with only 5% of a declining share of GDP.



Source: Master Plan Study for Strengthening Health System in Sri Lanka

Figure 2.6.8 Share of MoH Expenditure Spent on Identifiable Preventive Health Programmes[7], 1956-2003, excluding 1968-1977

(5) PRIVATE ALLOCATION

The total spent on health in the private sector was estimated to be equal to that of the Government service, at Rs.14.3 billion in 1997 rising to around Rs.30 billion in 2002. This fast rate of increase is attributed to several factors: 1) the trend towards private health care by people who can afford it; 2) the growth in private health insurance coverage, particularly low-cost/low benefits types; 3) the rise of new private hospitals; 4) branded drugs prescriptions; and 5) lack of restrictions or price controls on imports of drugs and consumables mostly for the private market.

While the public sector accounted for more than 80% of the expenditure for hospital services, preventive and other public health services, and capital expenditure, the private sector was responsible for 95% of the expenses for medicines and 61% for ambulatory services (Table 2.6.6). Considering that the overall patient load of the private sector is smaller than that of the public sector for both OPD and IPD, the substantial difference in expenses for drugs could be explained by the higher cost of prescriptions because of the use of branded products in the private sector. It could also be due to more medicines, including vitamins, being prescribed to private patients; although, this has not been scientifically documented.

[7] Preventive services in the Curative services such as secondary and tertiary prevention services are difficult to disaggregate from curative services expenditure, therefore, some preventive services expenditures are not included in this figures.

Table 2.6.6 Relative Share of Funding by Public and Private Expenditure to Selected Functional Categories in 1997

Functional Category	Public	Private
Hospital services	81%	19%
Preventive and public health services	87%	13%
Capital expenditure	99%	1%
Medical goods dispensed	5%	95%
Ambulatory services	39%	61%

Source: IPS

(6) FINANCE MANAGEMENT–BUDGET, ACCOUNTING AND AUDITING SYSTEMS

All hospitals have to abide by the Government Tender Procedures. Heads of decentralised units have the authority to incur expenditure between Rs.20,000/- to Rs.2,000,000/- through the local Tender Board, which consists of the Director of the hospital, and the Administrative Officer or Accountant. For specific major expenses, such as major improvement to buildings and purchasing of equipment, the limit is Rs.2,000,000, if the approval of the Technical Evaluation Committee is obtained.

In practice, almost all equipment and specific items are purchased according to the specifications prepared by Biomedical Engineering Services and other technical experts. All teaching hospitals and some general hospitals, all of which fall under the authority of the central government, function as decentralised units, with clearly defined budgets. Other hospitals come under the financial control and authority of the Provincial Councils. This second category of provincial institutions generally has less administrative and managerial autonomy and responsibility than the institutions run by the central government; and none have separately assigned budgets. The Government provides all decentralised institutions with funds for capital and recurrent expenditure through the health ministry vote. There is an Accountant and a Finance Division to manage the funds in decentralised units.

Most of the hospitals do not have a formal corporate plan. However, by April of each year, these organisations should prepare their annual financial estimates for the following year. Financial estimates are for expenditure only; sources of revenue are not indicated. Funds are allocated by the health ministry based on these estimates, and in practice, allocations to individual institutes are mostly based on historical budgets. The central administration does not make use of this budgetary information for effective decision-making; rather, financial estimates are used as rough guidance for expenditure control only. Expenditure control is exercised through the Financial Regulations and circulars issued by the Ministry of Health.

Shifting to Zero-Base Budgeting

Parliamentary control of public expenditure is an essential attribute of parliamentary democracy, under Chapter XVII of the present constitution. The parliament has full control of public finance. All revenues and receipts should be charged to the consolidated fund.

The budget of the Ministry of Health is prepared by two sections. The recurrent budget is prepared by the finance division. The capital budget is prepared by the Management Development & Planning Unit (MDPU). A consolidated budget is submitted to the treasury. The MDPU submits the capital budget to the National Planning Department of the General Treasury with a copy to the finance division. After reviewing the budget, the National Planning Department submits the budget with their recommendations to the Budget Department of the General Treasury.

According to the National Budget Circular No. 97, dated 11th of March 2002, the government has decided to introduce certain elements of the zero-base approach in the preparation of budgets for Ministries, Provincial Councils and Departments. The approach of zero-base budgeting requires that all

the functions of an organisation should be re-evaluated at periodic intervals. The main advantage of the approach of zero-base budgeting is that, unlike input-based incremental budgeting, it does not assume that the current allocation of resources is still necessarily appropriate.

The approach of zero-base budgeting will be adopted immediately through a comprehensive review of public expenditure. The review will include the following activities:

1) Review of missions, objectives and functions of Ministries/Provincial Councils and Departments and statutory boards to assess their relevance in the current context and to identify to relevant activities, duplications and gaps;
2) Review of the expenditure programmes of Ministries, Provincial Councils and Departments and statutory boards in relation to objectives;
3) Prioritisation of the expenditure programmes according to the government objectives and identification of irrelevant or low priority activities that can be eliminated; and
4) Preparation of restructuring plans where necessary.

Being a new approach, the zero-base budgeting system has yet to build the capacities of its implementers and develop the system to generate the information for evaluating the appropriateness of the budget.

Accounting System

The accounting system encompasses stages from a voucher to the preparation of the Annual finance accounts and appropriation accounts, which are audited and certified by the Auditor General and submitted to Parliament. This is a constitutional requirement and an instrument to ensure parliamentary fiscal control. All accounting units of teaching hospitals and main decentralised units coming under line ministry, such as family health bureau, blood bank, malaria control programme, are headed by accountants. Monthly account is submitted to the Ministry of Health by the decentralised financial units (teaching hospitals, family health bureau, malaria campaign, etc). The Ministry of Health compiles monthly accounts and submits a report to the Treasury.

During the past few years, significant improvement in the accounting system has been achieved through the introduction of the Computerised Integrated Government Accounting System (CIGAS) and payroll system. The treasury introduced two computer packages for payment activities and payment of salaries. The CIGAS facilitates activities related to bank reconciliation, writing of cheques and payroll activities. It enables the accounting units to provide accurate monthly accounts without any delay. Being in the pilot-testing stage, its weaknesses are being monitored through regular dialogue with end-users – the accountants.

Auditing System

The Auditor General is empowered by the Constitution to audit the account of the Ministry Department covering all decentralised units. Accordingly, branches of the Audit General Department have been established in the Ministry and the National Hospital. The auditors submit their report to the Auditor General and then to the Parliament. The Parliament also appoints a committee on public accounts with a chairman and members from both the government party as well as the opposition. This committee is empowered to summon the Chief Accounting Officer (Secretary to the Ministry of Health) and Accounting Officer (Director-General of Health Services) should their presence be required owing to some questions raised by the Auditor General in his reports. This implies that the Parliament, through its representative body, the OPA, examines critically all cases of financial irregularity or unauthorised excess on the financial provision allowed by Parliament in the Budget Estimates.

The Internal Audit Unit is set up to assist the chief accounting officer in accordance with financial regulations 133 and 134. A typical internal audit party is headed by a senior accountant; it includes a senior staff. The scope of activities of internal audit covers all categories of pay and accounts offices, and further examinations referred by the secretary. The internal audit checks initial records in pay and accounts offices and the drawing and disbursement officers verify that rules, regulations, systems and

procedures as laid down in various codes and manuals are being followed. All accounts records relating to fund accounts loans advances and records of physical verification of stores equipment, tools and plants are checked. Internal Audit seeks to ensure correctness in accounts keeping and efficiency in the operation of the accounting organisation.

One of the auditing activities that need to be given more attention is the value for money audit (VMA). The VMA look at the output and input of the MoH in monetary terms.

(7) SUMMARY AND CONCLUSIONS

The publicly owned and operated health care delivery system is suffering from a long-standing chronic under-financing problem, which has become more acute during the last four years. The delivery system is stressed out to deliver high technology inpatient care for an increasing share of the population over 55 years of age, as well as to provide a widely accessible primary health care package of care, which contributed to the high health status experienced throughout the country in 2002.

As the share of GDP has declined, service delivery has increasingly focused on preserving the inpatient services located in the large provincial and national teaching hospitals throughout the country. It has been found by conducting various statistical analyses that, as the MoH expenditure share of GDP has declined, the ratio of the number of OPD visits per inpatient stays declined. This finding suggests that the core priority of the health care system is to preserve its clinical inpatient care focus when times are financially rough. A more outward looking health care system exists only when its core mission is not financially threatened.

Greater resource mobilisation, better allocation and more effective financial management systems need to be a priority of the government to ensure the financial sustainability of programmes, which can yield health status gains through prevention and promotion. The NCD epidemic will require a new strategy for prevention that will be realised in the decade ahead, and without public resource mobilisation and allocation to financially support these programmes. Sri Lanka is at a crossroad.

2.7 STEWARDSHIP AND MANAGEMENT OF THE HEALTH SECTOR

The focus of this section is on the government's management capacity and performance in the health system. The World Health Organisation uses the term "Stewardship" to describe the health sector management as the MoH's responsibility including several elements such as vision and strategic direction for the health system, reliable, up-to-date information on current and future trends in health, regulatory framework, organizational structures and management systems that fit with policy objectives, and accountability of the health system for its actions including consumer protection (World Health Report, 2000). This chapter discusses the main findings of health sector management, specifically on the following aspects:

- Policy Formulation,
- Planning,
- Legislation and Regulation,
- Accountability,
- Coordination,
- Private-Public Partnership,
- Information Generation, Dissemination and Utilization.

(1) POLICY FORMULATION

National Level Policy Formulation: System and Procedures

1) System and Procedures

Even though there are no separate policy regulation activities at the National level, the government can convene a body for such activities as they please at any time. Examples of these are the Presidential Task Forces convened for policy formulation activities in 1992 and 1997. During these activities the involvement of the central ministry of health was minimal. Generally, the politicians decide the members of such committees. This factor has its advantages and disadvantages. In regulating the policies this would be a useful factor, as the politicians would accept the recommendations. On the other hand, the members selected for the committee may not be the necessary resource personnel.

2) Discussions

The question is whether there should be a separate health task force at national level outside the central MoH. Could they function purely on an advisory level and perhaps undertake research on policy matters that would complement the activities of the Policy Analysis and Development Unit? Ideally the Unit should be able to undertake research activities in concurrence with the provinces. But the present framework of the unit does not permit this as it is a small unit and the employed personnel are involved in the day-to-day work of the unit. Even if the unit does undertake research projects the scope of these projects would be limited, as quality research would involve total occupation with these projects.

It was recommended by the Presidential Task Force in 1992 to have policy measures for controlling the abuse of private practice by government doctors that would enable "better supervision and firm punitive action to control misuse of the privilege". Again, the Government would need to take a careful view on raising public sector salaries or on controlling private practice by government doctors and for avoiding uncontrolled cost/price inflation. If there was a separate health task force at the national level, could these issues be looked into more qualitatively?

Central Ministry of Health Level Policy Formulation: System and Procedures

1) System and Procedures

In Sri Lanka a dynamic mechanism that formulates a health policy framework on a continuum and changing basis seems not to exist. Communication between health information, policy formulation and implementation of these policies are poor.

The Management Development and Planning Unit of the Ministry of Health has a unit, which should be headed by a director for policy analysis, but for more than three years now the post of director has been vacant.

Generally, when policies need revision the central government convenes a group of experts who meet and review, revise existing policies, and formulate new policies. This group of experts at times may or may not be assisted by technical experts in the field that policy formulations are being done. This factor would generally impede implementation of such policies, as there would be a lack in ownership. Also, in the above mentioned policy formulation exercises, the involvement of the central ministry was minimal which resulted in lack of coordination by technical experts and also caused confusion and dissatisfaction during the implementation phases.

2) Discussions

The tendency of successive governments to abandon previous policy proposals and formulate new proposals is also a disadvantage as this results in unnecessary wastage of resources and time. **Would the more useful thing be to re-evaluate the existing policies from time to time? This should be an exercise shared by technical experts and administrators and the central ministry should take a pivotal role in bridging the two groups together and initiate the implementation of the formulated policies.** For this to happen there should be a dynamic office in the ministry to coordinate policy formulation activities which should also be a bridge between the provincial offices and technical experts in an advisory and strengthening capacity for implementation.

The Policy Analysis & Development Division ought to be open to constant suggestions for policy reforms by technical and managerial experts and have constant dialogues between these groups. Emerging problems such as accidents, tobacco, alcohol, domestic violence and expanding health care services to meet the needs of specific groups such as the elderly, victims of war and conflict and promoting specific areas of health care such as occupational health problems, mental health, estate health and geriatric services should be priority issues in considering policy reforms. The division should also take an active role in the monitoring and evaluation activities of policy implementation and build private-public partnerships as well.

As Prof. Hsiao pointed out in his report, “A preliminary assessment of Sri Lanka’s health sector and steps forward”, Sri Lanka does not have a policy as to the respective roles of public and private sectors in health financing, service delivery, and human resource development. This aspect would be very important for controlling cost/price inflation in the near future in Sri Lanka because the country’s health system is based on a fairly crucial balance of the two sectors.

Provincial Level Policy Formulation: Systems and Procedures

1) Discussions

The function of the Provincial Health Ministry is to implement the national health policies and the national and provincial health objectives for the benefit of the people. The Province itself does not get involved in policy formulation.

The fact that there is no policy formulations within the Provincial councils give uniformity to the health services in the country. However, it means that devolution of power is incomplete with the provinces having a separate cadre of people merely carrying out work that is dictated and laid out for them by the Central Government. In certain areas like Maternal and Child Health activities and epidemiological reporting of diseases such as the notification system, this factor is important as this means that the quality of work and services will remain Uniform Island wide.

But different provinces will have different problems in certain areas like environmental health and occupational health since different geographical locations will be depending on agriculture, other areas on fishing, etc., and also from time to time needs of provinces may change. In situations like this, would it be necessary to grant power to the provinces to formulate policies that would suit their needs? But in doing so it is necessary to keep in mind some coordinating mechanism between the central government and the provinces.

(2) PLANNING FUNCTION

Central Ministry of health planning function

1) MDPU

The Ministry of Health set up a separate planning unit in 1981 to coordinate the planning activities of the preventive and curative health sector. This unit was subsequently reorganized and re-designated in 1989 as the Management Development and Planning Unit (MDPU). In 1999, the ministry and the department of health were separated and the ministry planning activities were separated from the MDPU with a separate planning unit being set up for the ministry. In 2000, the ministry and the department were again amalgamated and planning function was returned to MDPU. However, the MDPU and Ministry Planning Unit have remained to be separated up to now.

This MDPU has appropriate technical planning capacities, in terms of its leadership and even some of the supporting professionals, but it needs to develop further organisational structure, team activities and mechanisms to maintain momentum in guiding the operational planning of Health Master Plan (HMP) programmes and projects and develop monitoring and evaluation mechanism useful to the implementers, the focal points and the overall management of HMP and stimulate technical capacity for planning in the different sections and directorates as well as provinces and districts and provide quality control on planning efforts by any MoH group.

2) Issues Identified regarding MDPU

Since the MDPU is the main planning unit in the health sector of Sri Lanka, there need to be overall coordination of all the sections and units in both the curative and the preventive sectors with the MDPU. However, this seem not be happening resulting in confusion and duplication of certain activities. Separate units in the health sector receive independent funding from different sources that makes it possible for these units to carry out their own plans of work without consultation or coordination with the MDPU. One reason for this may be inadequate knowledge of the functions of the MDPU.

Another issue that may need revising is that evaluations done by the MDPU is mainly on utilisation of funds, and not by the quality of work. Should there be some system for the MDPU to evaluate all the activities in the health sector in terms of quality of work prior to receiving the government funds? If this happens, could the planning unit together with the separate units be perhaps more able to focus on identification of priority issues?

The MoH during HMP undertook for the first time sector wide planning that involved all DDG and DG as well as all provincial health ministries and district offices. Yearly reviews of accomplishments and

adjustments of the rolling plan should similarly be sector wide and start creating a culture of mutual transparency and accountability for performance.

Prioritisation of health issues within the health sector does not occur in an organised manner. For a very long time communicable diseases and maternal & child health activities were given prioritisation in respect to the morbidity and mortality levels of the two areas. But within the ministry set up there are no regular consultations among experts on changing priority issues. With the changing demographic and epidemiological patterns, prioritising will need to be a key issue in distributing resources.

Provincial Level Planning Functions

1) Planning Division in Provincial Directorate

There is a planning division within every provincial directorate that formulates the plans for the specific area. The block grant consists of the total allocation given to each Province. This includes recurrent expenditure, the criteria-based grant and the medium-term investment plan.

The DDHS /MOH and the Divisional Secretaries develop the annual health plan for their area. This proposed plan is submitted to the DPDHS. The DPDHS then discusses this plan with the DDHS/MOH and prioritises the needs depending on the morbidity trends of the area, the requests from the people, the needs identified by the health staff and others and the availability of funds. This consolidated Annual Health Plan is submitted to the Provincial Director of Health Services (PDHS). The PDHS, in turn, submits this plan to the Central Ministry through the Secretary of Health.

The DPDHS sends its annual estimates to the PDHS office. PDHS consolidates the annual estimates of all the districts and through the Secretary of Health submits this to the Chief Secretary. The Chief Secretary of the Province is the Chief Accounting Officer. Chief Secretary prepares the annual draft estimates with the data given to him/her by each Secretary of the Province. He/she submits the draft estimates to the finance commission.

From the block grant the M.T.I.P money is released to the Central Ministry. Central Ministry releases funds to the Chief Secretary who, in turn, sends it to the PDHS through the Provincial Secretary. DPDHS finally releases the money to the DDHS.

2) Planning Unit in PDHS office

According to the Manual of Management for Provincial Directors, the PDHS may set up a planning unit or cell in his office to assist him / her in planning the health services. This should provide the guidelines and the necessary training for the Divisional Officers to prepare the Divisional Health Plan.

The planning and information unit of the PDHS office, when the PD decides to set up one, comes under the technical unit of the directorate. There is usually a medical officer attached to these units designated as medical officer/planning. They are sometimes supported by one or two staff members such as a Program Planning Officer (PPO) or a Survey Statistical Officer (SSO). Most of the PDHS offices have separate planning units.

Ideally, every planning unit of the province should have a consultant community physician, at least two medical officers, a PPO, a SSO, a data entry operator and a labourer for efficient and useful functioning. This factor should be taken into account in strengthening the health aspects of the provinces.

3) Provincial Plans

The Provincial Director guides the Divisional Directors in the preparation of a plan of action utilising the information obtained from assessment of needs to bridge the identified gaps and deficiencies in the quality and range of services and coverage of population groups.

These plans include,

a) Annual Health Development Plan,
b) Medium-Term Plan,
c) Perspective Plan, and
d) Project Plans.

The PDHS coordinates the preparation of these plans by conducting meetings with the MOH/ DDHSs periodically.

4) Drawbacks in the Planning Process

One specific drawback in the planning processes is the insufficient availability of information. There are certain routine data available such as the quarterly hospital morbidity and mortality return, notifiable diseases, EPI /CDD return – quarterly, and the monthly Vaccine / ORS stock return. But is it time to think of a mechanism that would assess the newly emerging important conditions such as mental diseases and accidents also on a routine basis for better planning?

The management committee of the provincial directorate conducts a technical review meeting every end of year prior to drawing up its plan of action for the following year. These plans are submitted to the Cabinet for funding. The planning activities do not involve the central ministry but an advisory relationship with the central planning unit exists to some extent.

National Level Planning Function

At the National level, planning for the health sector occurs through the Minister of Health and the Ministry of Health. It is very rarely that a health plan will be drawn outside the Ministry of Health.

(3) LEGISLATION AND REGULATION

Legislations

Law is described as the body of principles recognised and applied by the state in administration of Justice. Law is further defined as an obligatory rule of conduct. Legislation is commonly referred to as legislative instruments, enacted by the supreme law-making body or authority or by such other bodies, agencies or persons to whom the power of enacting legislation has been delegated. This could include principal enactments like Parliamentary laws, decrees or subsidiary instruments such as legislation and orders.

Health law on the other hand covers national laws, regulations and other related practices, judicial decisions, treaties, which could have direct or indirect effect on the health and well-being of individuals and the community.

Health law provides a legal basis for conceptual and operational matters and aspects and interventions relating to curative and prophylactic services and measures delivered or provided through the health services system.

The term Medical Law though used throughout the world to indicate the areas of law that governs the practice of medicine, according to the WHO digest of the Health legislation, no exact definition to this branch of law exists. Health Legislation expresses and formulates health policies and provides governments with a regulatory framework for its implementation.

The role of the health Legislation is very important to promote Health polices and action-oriented strategies. As health issues are getting more and more complex day by day owing to emerging new issues and to address and arrest the issues and situations, a closer link or cooperation, in the form of a link or alliance, is needed between law and medicine.

JICA commissioned a study with the general objective of collecting important legislation pertaining to health in order to develop a synopsis and to determine the opinion of frontline health care workers and community members on different facets of health/medical legislation.[1]

A few key findings are given below:

1) Important areas of health / medical legislation
   - Food and Drugs act
   - Nuisance ordinance
   - Control of Communicable Diseases
   - Environmental Act
   - Penal Code
2) New areas that should be considered for legislation
   - Legislation to regularise the private sector
   - Legalisation on compulsory medical insurance
   - Clear laws on litigation on medical malpractice
   - Abortion should be legalised
   - Prohibit private practice by government doctors
   - Legislation to eliminate “quacks”
   - Euthanasia should be legalised
   - SLS standards to be introduced to all food items
3) Reasons for not being satisfied with implementation of health legislation
   - Delays in implementing litigation
   - Lack of proper legal backing for the government
   - Unavailability of an official/supervisor at district level to provide technical support
   - Legislation not being fool proof
   - No training on legislation application
   - Lack of legislative power in the MoH
   - No participatory approach in bringing in new legislative amendments
   - Corruption within the system
   - Delays in implementing litigation
   - Lack of proper legal backing for the government
   - Unavailability of an official/supervisor at district level to provide technical support
   - Legislation not being fool proof
   - No training on legislation application
   - Lack of legislative power in the MoH

[1] MoH/JICA Study No. 30.

- No participatory approach in bringing in new legislative amendments
- Corruption within the system

The study gave the following conclusions:

- Presently, all new legislation and amendments to legislation are not brought to the notice of all frontline users of health/medical legislation; such users do not have all important legislation in their possession;
- It appears there is no formal system to enhance the uninterrupted dissemination of all relevant health legislation;
- Almost all users of legislation are facing difficulties in interrupting the legislation to a larger extent. In the present context, they do not have adequate in-service training opportunities, which will enable them to upgrade their competencies in using medical/health legislation;
- Some legislation cannot be considered as timely and up to date. They need to be amended in order to make them effective.

Regulations

There are about 30 different health and health-related enactments in Sri Lanka. Some of them have been amended to make them responsive to the current needs. Some of them are specific to one or more enactments, while some others are general. Majority of health legislation enactments come under environmental activities.

These are:

- Housing and Town improvement Ordinance No. 19 of 1915,
- Town and Country Planning Ordinance of No.13 of 1946,
- Thoroughfares Ordinance No. 10 of 1961,
- Urban Development Authority act No. 14 of 1978,
- Wells and Pits Ordinance No. 27 of 1884,
- Nuisance Ordinance No 15 of 1962, & Burial Grounds,
- Cemeteries and Burial Grounds Ordinance No. 9 of 1869,
- Food Act No. 26 of 1980,
- Bread Ordinance No. 10 of 1864,
- Registration of Dogs Ordinance No. 25 of 1901,
- Rabies Ordinance No. 7 of 1893,
- Animals Act No. 29 of 1958, and
- Butchers Ordinance.
-

Also the Factories ordinance and the Cosmetics Devices and Drugs Ordinance are issues handled by the MOH office.

Other than environmental issues, Quarantine services are mainly concerned with the implementation of the International Health Regulations, which serve to ensure the maximum security against international spread of diseases, with the minimum interference with world traffic

1) Legal Provisions of Local Authorities

There are three types of Local Authorities functioning in Sri Lanka at present. They are the Municipal Councils, the Urban Councils, and Pradeshiya Sabas. Pradeshiya Sabas have been constituted for areas other than Municipalities and Urban Council areas. Legal provisions for their constitution, powers and functions are incorporated in the Pradeshiya Sabas Act. A Pradeshiya Sabas is entrusted with the responsibility of performing several functions relating to public welfare in the area of the authority.

The local authorities have mandated to delegate Medical officers of Health the powers of the Chairman of the Local Authority, as is provided for in the Pradeshiya Sabas Act.

Certain health-related ordinances are not effectively enforced because of non-availability of enforcement officers. In view of their importance, suitably qualified officers from other government departments and agencies are empowered to enforce them.

2) Types of Regulations or Regulatory Instruments at Central Level

The central ministry does not on its own get involved in enactment of the above-mentioned environmental legislations. The enactments are enforced by the Medical Officers of Health through their Public Health Inspectors.

But there are deficiencies in a proper regulatory framework, as the Ministry of Health has no control over the private sector. Up to now the perceived need and pressure for regulation has been subdued mainly due to the professional culture of self-regulation.

Regarding regulating the practice of medicine by doctors in both sectors, some previous studies pointed out the weakness of the regulatory framework. Dr. Russell pointed out in his report, "The Role of Government in Adjusting Economies", the MoH has had difficulties to regulate the performance in the private sector due to both weak organizational capacity, and by wider social, political and economic factors beyond its control. This issue needs to be looked into in a detailed manner.

(4) ACCOUNTABILITY

Central Ministry of Health Accountability

1) Annual Health Bulletin

For the public service, the published Annual Health Bulletin is one channel of accountability, but it does not give comparative rates on a regional basis or by level of facility on which one could draw conclusions on the quality or performance of curative health service. It also does not include any information from the private sector. Moreover, the circulation is quite limited and it has not been used routinely as a basis of debate in parliament or the mass media on the strengths and weaknesses of the health system.

2) Systems and Procedures

All managers and institutions should be held accountable for the state resources they use and the outputs achieved. A system of individual and institutional performance management should be introduced to facilitate this. Individual performance management should be based on establishing clear roles, responsibilities, agreed performance targets and lines of accountability. Promotion and payment systems should be linked to performance. Institutional performance management should be based on agreed plans for each institution and annual reports produced to account for the use of resources and results achieved. Guidelines on planning should be prepared and separate plans should be drawn up for every major institution.

The Ministry of Health should hold annual formal review meetings with each province to review achievements, identify challenges and agree on an action programme for the following year. Such principles should apply equally to provision, and performance, of non-medical support services such as water supply, buildings, sewerage, communications, transport and waste management.

Institutional Level Accountability

The performance of key institutions in the health sector needs to be improved to enable them to meet the challenges they face. Good governance principles – in particular accountability, transparency, predictability and the participation of consumers – should be adopted. Governing Boards should be established in all hospitals with a clear responsibility to hold managers accountable for the delivery of high quality services. Annual accounts should be produced showing the sources of funds and what they were spent on and formal mechanisms to assess consumer satisfaction should be established.

It is obvious that the Local Councils and local health authorities would in their functioning, require periodic assistance from external sources. Such assistance would be required in a wide range of areas linked to the improvement of their performance, including the following:

- Training of personnel;
- Systems improvement;
- Organisational restructuring;
- Appraisal of performance budget;
- Investigation and evaluation of measures to expand the sources of revenue; and
- Relationships with the Central and Regional levels of health.

There is currently no single source to which local health institutions could turn to for such services. The Department of Local Government and Ministry of Health have lacked the capacity to provide such assistance. At times, international aid agencies have sought to provide such assistance, either directly or through consultancy arrangements, for areas that were perceived by them as being important.

Provincial Level Accountability

According to the Ministry of Health draft consultation paper of December 2002, the provinces will be made more accountable to consumers. At the moment consumers still see the central government as responsible for all actions. If provinces are to continue to receive state finance to provide state services, they must be accountable in terms of how well they do this; accountable to their consumers, and accountable to government in terms of national policy, targets and value for money. Field activities are to be supported with stronger referral and information systems. Provincial Governing Boards should be established in all provincial health units.

Divisional and Community Level Accountability

Provision of health services both public and private is a social contract promising quality diagnosis and care for the best possible results. Therefore, wherever there is health provision there should be accountability to the community about the actual performance and its effectiveness.

The political control of health budgets and votes has been credited to be the main factor that determined that the service would provide equitable and acceptable services. This public accountability should be maintained and strengthened. Accountability to the population could be heightened through popular health committees at village and district level. These would both serve as means for popular accountability at the local level as the main channel for community mobilisation and participation.

Drawback

One serious drawback in all the arrangements that have been used in the past is that they were not grounded in a continuing and on-going programme of research and study into the multifaceted issues that were germane to the local governance scenario of Sri Lanka. No such comprehensive effort at

research and study has been mounted. What Sri Lanka has, instead, are ad hoc inquiries and studies – reactive to problems that were encountered from time to time.

(5) MONITORING AND EVALUATION

Formalisation of Monitoring

The formalisation of monitoring relates especially to the frequency of observation, the choice of indicators, their critical value, who the data collectors or what the sources of secondary data are (the worker, the team of workers or a supervisor or a combination of both). When one approaches levels of alarm, the frequency of monitoring needs to be increased. There needs to be a quick assessment made of the reliability of the data and procedures for alarm need to be reviewed, so that one is fully prepared. The competence of the workers often needs to determine whether they can do all of this on their own or at an agreed pre-alarm level they call in for help.

There are no official documents found defining the whole system as mentioned above; only the Management Manual for Provincial level has some of this.

Monitoring and Supervision in Sri Lanka's Curative Services (Primary Through Tertiary) and Screening for Deficiencies or Diseases

Monitoring can play two different but complementary roles in curative care:

it serves to assure quality of care to the individual patient, whether an inpatient or an outpatient, by following vital signs, subjective well-being, fitness, and look out for complications and secondary effects of drugs as well as allergic reactions; and
it can serve as a tool for quality assurance in a service unit, a facility, a district, a province or the nation.

At level of patient care and screening, general practitioners, surgeons, anaesthetists, nurses and midwives as well as PHN, PHI and PHM practice monitoring. But it has been observed that the importance of close monitoring is not sufficiently recognised.

The following failures seem relatively frequent:

- Failure often occurs at the feedback level between professions or the timely translation into action by the responsible professional. For example, most Sri Lankan public hospitals use neither written nurse observations nor a written nursing plan. This may be an expression of the lack of importance attached to active nursing. This can lead to lack of feedback to the clinician on clinical evolution. In other countries, it has been shown that active competent nursing, in fact, contributes significantly to IPD survival;
- Missed opportunities in OPD to screen for nutritional deficiencies;
- Missed opportunity to gather minimal data on current condition of the patient that might render the attempted diagnosis and treatment more sensitive and specific;
- No monitoring of the patients understanding of his condition and of the treatment and follow-up as well as prognosis;
- Loss to follow-up chronic diseases in OPD and clinics (record loss, unclear addresses, no transport for workers, no referral or counter referral);
- Hasty history taking or referral to prior disease episodes, as records are not always available or patients change provider;
- Nurses, Midwives, PHM and PHI have learned to take the data for monitoring of birth weight and nutritional deficiencies or over nutrition but have not learned sufficiently how to take corrective action at the individual level, or they feel they have not been empowered to do so.

This shows up in the areas of nutrition of pregnant and lactating mothers and neonates, in school medical inspections, care of Hypertensive disease conditions and diabetes

Monitoring in Preventive/Promotive and Primary Health Care

The manager at Divisional level delegates field implementation of preventive/promotive services and PHC to individuals or teams that need to understand the objectives of the action, need to understand how to execute technically and how to monitor the context and themselves.

The manager delegates needed authority to execute and make corrective actions to keep on track. Nevertheless, the manager needs to monitor essential indicators of output and outcome that can inform her/him if there is an ongoing problem the team has been unable to correct. If so, the manager needs to do or order an investigation of the problem and correct its causes. Nevertheless, usually the manager is too far from the field to investigate these problems in a timely fashion.

HMIS in Sri Lanka

All management manuals of Ministry of Health (MoH) Sri Lanka have a section on Monitoring and Evaluation or on the use of information. One of the most complete texts on this subject is included in the Manual of Management for Provincial Directors of 1996. It discusses principles of construction of a provincial HMIS, the choice of indicators for annual reporting and feedback into planning. In terms of monitoring, it singles out input monitoring, compared to plans, even for this limited monitoring it does not specify who has the responsibility to do so or to whom feedback should go.

But the scheme for Provincial monitoring for planning has not been fully implemented, probably as it would really reach an optimal level only if comprehensive planning were instituted and devolved. Moreover, as will be shown below, monitoring for management needs to be designed using both HMIS and supervision as sources of information.

Obviously, the current HMIS is the result of decades of accretion of data to be collected and records to be kept and the system needs an overhaul to permit a leaner HMIS. There is a need to clearly define each record and information and to choose data for their importance in continuity of patient care, planning or in management. There is an urgent need to give full attention to HMIS and monitoring as well as reporting and to timely electronic analysis and reporting.

The health information system in Sri Lanka dates back to the early 1940s. At that time, certain health and health-related information in respect of MCH/FP activities was collected by the MoH. During the mid-fifties improvements were made to further strengthen the information system and a separate Medical Statistical Unit, (MSU) was established within the MoH to undertake the collection and processing of health data. This division was responsible for collecting health data from all medical institutions and health units within the country.[2]

In addition, most specialised units implementing preventive health programmes (Family Health Bureau, Epidemiology Unit, Malaria Control Programme, National Sexually Transmitted Disease Control Programme, National Cancer Control Programme, Respiratory Disease Programme, Leprosy Control Programme, etc.) have developed their own health information systems to monitor progress of implementation. The health information system has been periodically reviewed and revised.

An information system to collect family planning data was introduced in the early 70s with the Family Health Bureau (FHB) given the responsibility for data collection, processing and analysis. Following a revision of the MCH information system in 1985, collection, processing and analysis of MCH data was also entrusted to the FHB.

[2] JICA / MoH Survey No. 11.

(6) COORDINATION WITH OTHER GOVERNMENT AGENCIES

In the planning exercise, provincial stakeholders meetings were held to analyse the issues by local level counterparts. The discussions with stakeholders gave the impression that the provincial level officials perceive the positive effects of devolution. They perceived that managerial autonomy has improved, decision- making is quicker, and enhanced the accountability of the system to the community. Only problem perceived by them is that the Central government bypasses the provinces in implementation or the Central government intervenes into Provincial Ministries business unnecessarily.

Divisional level officials seemed to have different views on the devolution. For example, Divisional level officials feel that funds and human resources are not adequate, so that the people's expectations have not been fulfilled by the services provided. Another example of different perception between Province and Divisional level is that the sectoral coordination is perceived as improved by the provincial level officials, however, the divisional level officials and people from other sectors feel very differently. The table below shows perceived collaboration with other sectors by divisional officials. This is rather subjective statements; however, it shows the different view from the provincial officials who say the intersectoral collaboration improved since the devolution started.

Table 2.7.1 Perceived Collaboration with Other Sectors

Level	Organization	Deficiency
National	National Health Development Committee	Functioning well
	National Health Council	Not functioning well from 1998
Provincial	MoH monthly conference	Poor participation from curative institutions
	Provincial Health Committee	Not functioning well
Division	Divisional Health Committee	Not functioning well
Community	Village Health Committee	Not functioning properly

Source: Provincial Stakeholders Meeting in Hambantota

The divisional level perceive the system is not yet fully decentralised, the funds for human resources are not enough, and the provincial level is unable to plan out their health delivery system due to unnecessary interference from the politicians.

Intersectoral Coordination at Different Levels

Intersectoral coordination for health and development can be at different levels:

a) International Level.

This may be cooperation between countries for the betterment of the health status. It may sometimes be through provision of human resources (such as the JICA Study Team), and even through areas of equipment, training and fellowships and grants for research, etc.

b) National level

This can be categorized as interministerial and intraministerial coordination.

The interministerial level would be at the National Health Council which includes the Health Minister, Deputy Health Minister, and Ministers of other health-related ministries.

The intraministerial level would be coordination between the line ministry and provincial ministries. An example of this is the national Health Development Council chaired by the secretary / Ministry of Health and attended by the provincial health secretaries and directors.

c) Provincial Level

There may be differences in the strategies used on coordination of activities within different provinces. However, in each province there will be various committees and meetings chaired by the Chief Minister, Chief Secretary, Health Secretary, and the Provincial Director of Health Services respectively, where officials from different fields (e.g., Health, Agriculture, Social Services, etc.) get involved in coordinating their activities towards a common goal.

d) District Level

As in the Provincial Level, there are a number of committees at district level where there is representation from different disciplines. A good example of this is the District Coordinating Committee. The District Secretary plays a major role in coordinating activities, including that of health.

The DPDHS also plays a role in coordinating the activities of his own health staff (both field and institutional) as well as with other disciplines such as education, social services, etc. This also includes Non-Governmental Organizations.

e) Divisional Level

The DDHS/MOH plays a key role in coordinating the health activities in his area, as well as being an important member of the Divisional Secretary's team. The MOH/DDHS has to mobilise resources from other sources in addition to his own, through coordinating with other officials and non-governmental organisations.

f) Role of PDHS

In the case of Health services, the PDHS plays a role within the province similar to that of the Director General of Health services at National level. He is responsible for the provision of comprehensive health care to the population within the province. As the resources within the health services are limited, he has to devise ways & means of mobilising the resources of other governmental and non-governmental organisations to cover this gap. As this coordinating mechanism extend down to the divisional level, the PDHS has the important role of motivating the other health officials in the province with regard to intersectoral coordination towards achieving maximum results with available limited resources.

Central Ministry of Health Level Intersectoral Coordination

Since improving the health status of the nation will not occur simply by improving health services, the Ministry of Health has at all times to coordinate with other governmental organizations in many of their activities. Health is affected by many factors and there is a need to ensure good intersectoral coordination.

This intersectoral approach to health development is a critical strategy to ensure sustained development of the quality of life. The main sectors with which the health sector would have interlinks are agriculture, fisheries, irrigation, livestock, industry, housing, education, information, social welfare, water supply and sanitation.

Systems and Procedures

Policy measures that have been drawn up in the 1992 Policy Draft Proposals regarding intersectoral coordination and cooperation are:

- To foster intersectoral action, adequate and appropriate cooperation, between the Ministry of Health and other relevant Ministries, analogous bodies and non-governmental organizations to be brought about; Appropriate processes and procedures to be developed for joint planning and programming at all levels;
- Health objectives to be clearly identified in the plans and programmes of all health-related sectors at national level;
- The sectoral approach to training to be replaced by that of a multisectoral orientation to development; and
- A mechanism similar to National Health Council to be established at provincial level.

Even though these policies exist, in reality, intersectoral coordination occurs in a very haphazard manner. These processes should be more dynamic in order to achieve optimal collaboration and coordination. Over the last decade, a number of problems in the health sector were created unwittingly by other elite disciplines and development schemes. The health sector fought virtually a lone battle to fight diseases like malaria and environmental health problems. To in still a sense of ownership, the partners must be actively involved in the health project from the beginning.

Most health activities are community based. Media involvement and health education are necessary for community awareness and action.

The MoH has many sections, departments and units. There are no ready-made forums for them to debate on overlapping interests or to coordinate future plans, programmes and projects. This inevitably leads to overlaps and gaps and results in confusion in implementation, whether in peripheral units or related departments.

It is hoped that the Ministry will develop clear forums and channels for thematic ongoing coordination, such as human resources development, Nutrition, and Non-communicable diseases. There is also a need to develop team spirit and sharing of information between the DG and all DDGs, and each team headed by a DDG with his/her directors. Within the MoH sharing of information should be both a right and a duty, so that all decisions taken are based on all relevant facts known to someone in the Ministry of Health.

(7) PUBLIC/PRIVATE PARTNERSHIP

Situation

The private sector has been growing steadily. In 1990, there were 1,872 beds in private hospitals. The number increased to 2,305 in 1997. The number of Ayurvedic Practitioners increased from 13,284 to 15,076 during this period. There are approximately 800 full time, qualified private practitioners in allopathic medicine. Also a majority of government doctors do private practice in off-duty hours. However, this should not be seen as a form of partnership between the state and the private sector. In 1997, 204,000 admissions were reported from private hospitals, compared to 117,000 in 1990. The outpatient visits were 568,000 in 1990 and 1.617 million in 1997. A pattern of health utilising is

emerging with the private sector providing mainly outpatient care and the public sector dominating the inpatient services.

The current health system in Sri Lanka where the state sector provides most of the major health services and the majority of health personnel in the country belonging to the state sector is a good thing as this would mean equality in quality and services provided. However, the private sector, even though it lacks the volume of human resources of the public sector, has to provide a quality of services equal with the state sector.

A few base hospitals in the provinces operate private wards within the government hospitals. These include Kegalle Base Hospital, Kuliyapitiya Base Hospital, Kethumathi Maternity Home in Panadura and a few others.

Coordination Mechanism

The role of the MoH and the Provincial Directors in the private health sector in terms of quality assurance, setting up of a regulatory framework, sharing information systems and resources, and outsourcing clinical services and manpower training is almost non-existing in the country. The MoH and Provincial Directors have been neglecting their role in regulating the private sector to date, and nobody in the country knows about the precise situation of this sector. The MoH has been dependent on the self-regulatory mechanism of the private sector so far. However, from the consumer protection point of view, this aspect is one of the most crucial issues in the assurance of quality services.

The MoH has not attempted to set up even a minimum information system from the private sector to get necessary information in order to analyse the national health status. Outsourcing of services has been looked into and is gradually happening in some areas of non-clinical services. However, cost-effectiveness of outsourcing clinical services has not been properly looked into.

Within the central level there is at present a director in charge of private health sector development. But the main function of this directorate is training of paramedical staff within the national setup. Also this office has only the director, one PPA and one data entry operator.

Within the central level there is no other regulatory or supportive mechanism to monitor the quality and range of services within the private sector or any system where the private sector could call up the central level for supportive services.

Systems and Procedures

At present private medical facilities are few and far between in the provinces. Therefore, would it be feasible to incorporate separate private facilities within each government inpatient health facility in the provinces as a mode of income generation for the hospital? Nevertheless, in doing so, it would be important to do a feasibility study to find out whether the facilities would be utilised to the optimum by the people in the area. This would show which areas would adopt the system successfully and which area that it would fail. In areas where there are a majority of middle level income earners this should be a success, as most people do not mind spending a certain amount to obtain a few necessary comforts, such as a separate room where a bystander would be able to stay.

In this way the doctors and other paramedical staff who work in the government facility could also be assigned to work in the private health facilities and paid a separate allowance for such work, which would be an incentive for them. This would mean that they remain within the premises of the hospitals and could be mobilised for work within the government facilities if the need arises. This might also reduce individual private practice by doctors attached to hospitals. At present government hospitals have OPD services in the hospitals only up to 5.00p.m. Only emergency services and admissions to wards are

done after that time. Perhaps in the paying section these services could continue till later, with also dispensary services for the dispensation of drugs. In this way the government and private health facilities could work in partnership.

Discussions

The fact that the private sector has been totally neglected so far by the central ministry may be due to the fact that they had their own problems to look after in the past: communicable diseases control, expanding family planning, combating nutrition, etc. The concentrated and organised activities of the ministry in partnership with health personnel have resulted in improvement of the health indices of the country on par with many developed countries. Therefore, is it time now to concentrate on the quality of services given to the consumer? This would inevitably mean regulating and supporting the private health sector as it provides 60% of outpatient care as well as 10%-15% of inpatient care.

At present, private hospitals can be started by any company or body as a BOI project as they receive many tax concessions and other facilities through the BOI. Firstly, it would be necessary to convince the BOI that such projects or hospitals are to be approved by a separate national health council consisting of professional people within the health sector. It is also absolutely necessary to regulate the quality of services and the fees charged by the private hospitals. Certain individual private hospitals have their own insurance schemes to ensure that the person would enter that particular hospital when the need arises. Would it be more practical to propose a general insurance scheme that any individual could contribute to and go to any private hospital of their choice when the need arises? This would also mean equal utilisation of the beds in all the hospitals as if there were no available room in the particular hospital one wishes to be confined and the option exists that one could always be admitted to any other private hospital. This scheme could also pay for any investigation or procedure that might be necessary even if the patient is warded in a government institution.

Regulation of the qualifications and training of paramedical staff is also very important as the doctors'. All foreign qualified doctors have to sit for regulatory exam before they practice in this country. Similar procedures should be adopted in confirming the positions of all paramedical staff, be they work in the private sector or government sector. It may be necessary to set up a complaints bureau within the ministry to entertain any complaints regarding the private sector and a separate team to investigate such matters. Peer review committees should also be held regularly with the private sector hospitals. Regulations should be enforced strictly to ensure the quality of services within the private sector. Primarily for all these functions to occur effectively the Private Sector Development Unit in the Ministry should be strengthened with more staff.

The Ministry should also think of involving the private health sector in the HDC and NHDC meetings and work in partnership towards the health development of the country.

(8) INFORMATION GENERATION, DISSEMINATION AND UTILISATION

Importance of HIS/GIS in master plan and in system reform

Policy, management and clinical decisions in the health sector are unique in that they have impact on the life or quality of life of people. However, not all decisions in the health sector are based on accurate, up-to-date and complete information. At times, they are not even consistent with the existing information. In Sri Lanka, decisions are made and actions are taken according to a confluence of factors and information is simply one of them. Some of the non-informational considerations are the following (Figure 2.7.1): influence of stakeholders (e.g., donors, unions, peers, political parties, religious groups,

special interest groups, media, and community); budget constraints; and experience. Decision-making based on information is at times less common at the lower administrative levels.

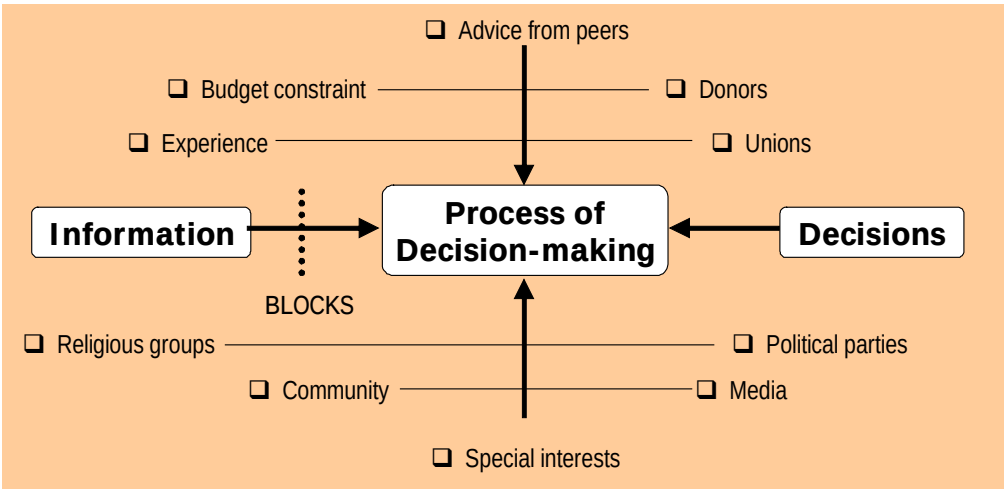


Figure 2.7.1 Non-informational Factors Influencing Decision-makers
Source: JICA Study Team

Decentralisation, one of the pillars of the health sector reform, implies transfer of decision-making responsibilities from the national to provincial and even divisional authorities. It requires involvement of more people in allocation of resources. With expanding demand for health services and rising cost of health care, optimum use of scarce resources becomes even more pressing. Herein lies the importance of providing decision-makers from the MoH central office to the divisional secretariat access to quality information. Herein lies the importance of strengthening the existing health information system (HIS).

Situational analysis

1) Policy context

What is the mandate for information generation by the government, in general, and by the MoH, in particular? On what grounds are health information systems reformed or developed? Does the national government have any plan to promote computerization in governance?

The national government promotes transparency in governance and free access to public information. However, it has yet to formulate a specific policy on management and use of public information, on involvement of the private sector, and on confidentiality issues.

The "Project Proposal to Develop a Management Information System for the Department of Health Services"[3] serves as the blueprint for strengthening the HIS from year 2001-2005. As the title implies, it is only for the Department of Health Services and excludes the two other agencies of the MoH – the State Pharmaceutical Corporation (SPC) and the State Pharmaceutical Manufacturing Corporation (SPMC).

The existing HIS has a mechanism for reporting of notifiable diseases. However, the MoH lacks the teeth to enforce it. There is still no legislation to compel or motivate compliance particularly of the private sector.

[3] S. Senanayake,. *Project Proposal to Develop a Management Information System for the Department of Health Services* (MoH, 2001).

So why is information generated by the MoH? The MoH has an international obligation or commitment to report to WHO and other international organizations. It has a local responsibility as well. It publishes the "National Health Bulletin" both for consumption within the ministry, other government entities and other stakeholders. Further analysis will be required to clarify the source, nature and justification for generating information.

The development of HIS must be driven both by its mandate and by other externalities. One of these externalities is the set of reforms in the area of governance. The decentralisation policy was adopted in 1992. Since then, however, the HIS has not been adapted yet so it will be responsive to the old and new decision-makers, to their new responsibilities and authorities. Another externality that should be considered is the rapid innovation in information technology. The five-year plan for the Department of Health Services incorporates application of local area networks to establish databases for the national, provincial, district, and hospitals with the ultimate aim of improving access to information. The question for further study here is the possibility of networking with other ministries not only for economic reasons but also for total sharing of information.

2) Management structure and resources

Preliminary findings revealed that at the national level, the MoH has the personnel to manage its HIS. It has a medical statistician, analyst/programmers and officers trained in development and management of information systems. However, its HIS Unit has an office space too limited to accommodate all the HIS staff under one roof. As such, the Statistics Section is housed in a separate compound. There are other offices, such as the Family Health Bureau, Logistics and Human Resources, that collect and process information. However, these units "lack resources to provide consistent, accurate and timely information or answers to ad hoc enquiries".[4]

Under the financial support of the WHO, the MoH is in the process of modernising its computer-based information/communication system with the provincial offices. However, no one among the HIS Unit personnel has the capacity yet to work with GIS and the office has no plotter. Only the Epidemiology Unit, Malaria Control and Filariasis Control use GIS.

At the provincial level, the design of information systems, monitoring of service provisions and submission of periodical reports to the national level and to the user level are part of the major functions of the Provincial Director Health Services (PDHS). Ideally, there should be an Information and Informatics Unit that is headed by the Provincial Statistical Officer or Statistical Survey Officer (or Information Technology Manager) for each province. Ideally, there should be close coordination between the Information Unit and the three other support units of the PDHS, namely, the Epidemiological Unit, Planning Unit and Health Education Unit. "However, manpower of the provincial units is not yet established fully."[5]

At the district and divisional levels, there is no specific unit, personnel, office space, equipment, or supplies appointed or allocated solely for HIS. As such, there is no budget earmarked for this purpose. The field staff who perform the various tasks related to data collection, compilation or consolidation had training on filling up the forms, had little training on making charts or tables and on data analysis, and had no training at all on report-writing and use of information they assist generate.

An inventory of resources, such as human, financial, hardware, and software (including availability, use and updating of manuals of procedures) for HIS is being conducted as part of the Study survey. Results will be available in the next Study phase.

[4] Ernst & Young,. *Final Report: Health Management Information System (HMIS) Study for the Ministry of Health, Highways & Social Services.* (1996).
[5] V. Rissanen, J. Fernando and D. Hettiarachchi, *Inception Report for the Technical Assistance of ADB: Management Information System Study*. (Colombo: Ministry of Health and Women's Affairs and Asian Development Bank, 1994).

3) Subsystems

There are at least five ways of categorising the subsystems of the MoH HIS.

- By the three major MoH agencies, the subsystems are as follows: Department of Health Services (DOHS), State Pharmaceutical Corporation (SPC), and State Pharmaceutical Manufacturing Corporation (SPMC).
- By type of institution, the subsystems are curative care institutions, preventive care institutions, training centres and research, and other special institutions (e.g., National Drug Quality Assurance Laboratory, Divisional Drug Stores, National Quarantine Laboratories, Office of Judicial Medical Officer, Office of School Medical Officer, etc.).
- By type of health services and activities provided, the subsystems include curative, public health, and special campaigns.
- By type of resources required for the services and activities, then the MoH has human resources, equipment, buildings and beds, medicines and other supplies, and finance subsystems.
- The HIS may also be subdivided by administrative structure - national, provincial, district, and divisional subsystems.

Inter-relationships among the first four categories of subsystems are represented in Table 2.7.2. In general, the same table can be used at provincial, district and divisional levels.

In the 2001-2005 Development Plan, the Curative or Medical Subsystem will contain the following modules: inpatients, OPD & clinic patients, operation theatre, accident & emergency, mental health, dental health, and nursing care. The modules under the Public Health Subsystem are as follows: MCH, epidemiology, occupational and estate health, food sanitation, health education, public health veterinary services (PHVS or anti-rabies), STD/AIDS, leprosy control, malaria control, filariasis control, respiratory diseases control, and cancer control.

Table 2.7.2 Inter-relationships among HIS Subsystems in Sri Lanka

		DOHS				SPC	SPMC
		Institutions					
		Curative	Preventive	Training & Research	Special		
Services	Curative	+		+			
	Public Health		+	+			
	Special Campaigns	+	+	+	+		
Resources	Human Resources	+	+	+	+		
	Equipment	+	+	+	+		
	Buildings & Bed	+	+	+	+		
	Medicines & Other Supplies	+	+	+	+	+	+
	Finance	+	+	+	+		

Source: MoH-JICA Study Team

Table 2.7.3 lists the modules for the Human Resources, Finance and Logistics Subsystems. A Laboratory Subsystem is also proposed that will include the National Blood Transfusion Service (NBTS), other diagnostic services, and the Medical Research Institute. Note that the Logistics Subsystem includes the module for the National Drug Quality Assurance Laboratory. The last subsystem in the Development Plan is that for Health Administration which will be composed of

geographical and demographic information as well as all the administrative information of all MoH institutions.

Table 2.7.3 Human Resources, Finance and Logistics Subsystems: Modules

Human Resources	Finance	Logistics
• Personal data • Training and examination • Cadre/job titles • Administration & educational institutes	• Budget • Expenditure • Bookkeeping • Staff loans & advanced accounts	• Transport • Buildings • Biomedical equipment • Non-medical equipment • Medical equipment • Medical supplies • National Drug Quality Assurance Laboratory (NDQAL)

Source: MoH-JICA Study Team

The various HIS subsystems and corresponding modules have varying degrees of maturity. The members of the MoH Working Group for HIS believes that the MCH and Filariasis Control modules are the most developed. The computerized Human Resources Subsystem (better known as the Human Resources Information System or HRIS) and the Curative Subsystem (or Hospitals Management Information System) are being pilot-tested currently.

In the next Study phase, a detailed comparative analysis will be conducted to identify the subsystems or modules that need the most support. It will describe the state of linkages, coordination or integration among the subsystems or modules. More importantly, options on unifying all the subsystems will be discussed with the view of facilitating access to information.

4) Quality of Information

The information generated by the existing information systems is incomplete and does not capture the entire picture of the health situation in the country. As a rule, the systems generate information only from the public sector. They do not include the following: for-profit private sector; not-for-profit private sector (e.g., missions, non-government organisations); and traditional medicine. The under-estimation may at times be crucial particularly if indeed the private sector provides about half of the health services, particularly outpatient ones. Even within the public sector, the overall coverage may be only 50% in some institutions although it may be as high as 90% in others.[6] Among the information collected from hospitals, only those about admitted patients are included in the HIS. There is no clinical data on OPD patients.

[6] Rissanen, Fernando and Hettiarachchi, *op.cit.*

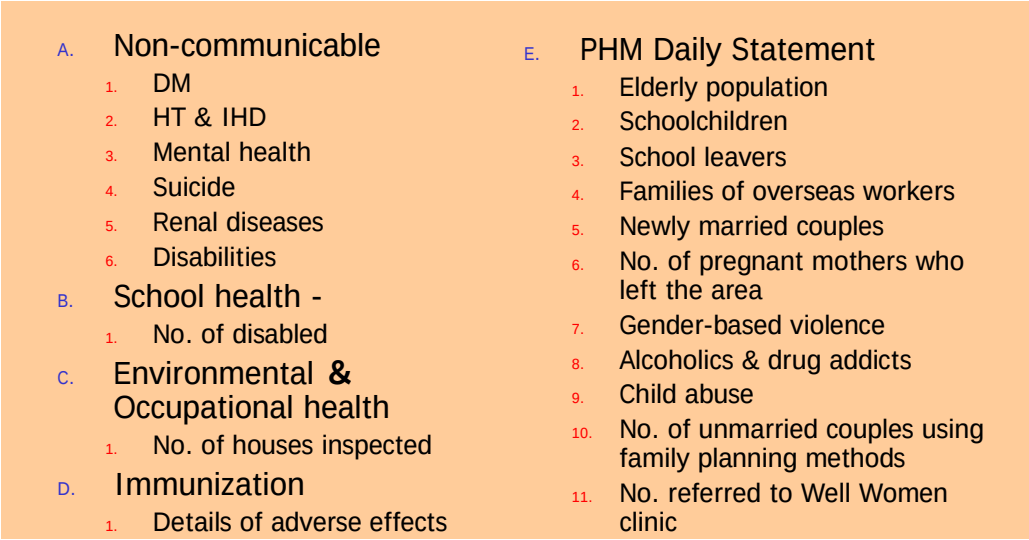


Figure 2.7.2 Information Gaps in the Current HIS: Divisional Public Health Services

Source: MoH-JICA Study Team

It seems the existing HIS does not generate all the essential information. On one hand, the returns are at times incomplete. On the other hand, there are items that were deemed important by some officials during a workshop but are not being collected or generated by any of the existing information systems. Examples of these data are the demographic data of patients seen at the OPD or clinics and those listed in Figure. 2.7.2 for the Divisional Public Health Services.

5) Use and users

"The Department of Health Services need a comprehensive Management Information System (MIS) to allocate resources, to monitor programmes and care given, future planning, policy-making, education, research and for many other requirements".[7] This is the most explicit statement on the intended uses of information for the MoH. This implies that the intended users of information include the policy-makers, planners, managers, providers of services (or care givers), and researchers. In reality, however, the information generated is "used more for reporting and analysis than for direct management and planning."[8]

Although none of the documents that were reviewed reported on deficiencies regarding the use of health information, preliminary field visits and workshops revealed a possible oversight because the not-so-common use of information seems to be a major issue within the MoH. "The system has been designed in the early 1960s and only Maternal and Child Health component has been revised in 1986. The system cannot cater to the present demand of information as the requirement for information has changed today. Therefore, to provide information to suit the present requirement using the current Information Technology a complete revision is urgently desired."[9] A hypothesis is even proposed that the problem gets worse at the lower administrative levels.

In the next Study phase, the intended users for each of the existing subsystem or module will be identified by reviewing operating manuals or rules and procedures. Then the information needs and appropriate indicators will be defined based on inputs from the HIS survey and MoH counterparts.

[7] Senanayake, *op.cit.*
[8] Ernst & Young, *op.cit.*
[9] Senanayake, *op.cit.*

Analysis of strengths and planning issues

This section looks at the entire HIS recognising though that there are peculiarities for every subsystem or module, exceptions to every major planning issue and alternatives to every hypothesised cause. A more detailed analysis of every subsystem and module will be attempted in the second phase of the Study.

What are the strengths of the HIS? What are the major planning issues for HIS? What are their causes? The first question is important to contextualise the development of the HIS. The second question builds on the first. It may be a set of unfinished agenda, a result of previous efforts or a response to new requirements for information. Nonetheless, it identifies and prioritises problems that the Master Plan is to address. The third question serves as a guide for formulating strategies, key directions or intervention measures.

1) Strengths

   a) Experience is the major asset of the existing HIS. Personnel are accustomed to collecting, compiling and submitting data up to the central authorities. With experience come expertise and experts, particularly at the national level, in designing and managing HIS. With experience come lessons and wisdom. In the next phase, there will be discussion on this area.

   b) There are subsystems or modules that can serve as models for the improvement of others or the entire HIS in general.

   c) As far as the hardware is concerned, all the national and provincial health offices have computer systems albeit, often, not being used for HIS.

2) **Opportunities** – Sri Lanka is an island country. Its communication network is advancing rapidly. It has a growing pool of workforce skilled in information technology even in districts outside the capital. Its new leadership will continue to require information to demonstrate its performance. Its leadership is steadfast in its commitment to providing for the health of its people.

3) **Threats** – On one hand, the decade-old policy on decentralisation may be an opportunity because there will be more public officials who will be expected to demand for information. On the other hand, if decentralisation is not designed properly, then there may be islands of local governments that may continue to collect health information but not necessarily share or submit them to the national government regularly as has happened in the Philippines.

Major Planning Issues

1) The existing policy framework for data collection and information generation has not accounted fully for reforms in governance such as decentralisation and promotion of public-private partnerships, reforms within the health sector and technological innovations.

2) Many of the existing subsystems and modules were designed independently from one another and have remained as such even in their implementation, thereby, leading to some information not reaching key health officials (i.e., Director General for Health Services and Provincial Director of Health Services) and partly even to overloading of some staff responsible for collection.

3) The capacity of organisational units responsible for managing the HIS varies across subsystems, modules, areas and even administrative structures, with support for training and resources most needed at the lower levels.

4) Although maps are produced in many facilities, the use of GIS for planning and management to analyse spatial variations in health needs, equity in allocation of resources and utilisation of services has not been optimised such that even the national and provincial HIS units have not worked with it yet.

1) Although there is variability across institutions and areas, the quality of primary data generally suffers in completeness, timeliness and, at times, accuracy. There is hardly any system for monitoring & evaluation of the information system itself at the divisional, provincial or national levels.

2) P In general, existing information is **seldom used** in formulating policies and in making management and clinical decisions.

(9) RESEARCH AND RESEARCH MANAGEMENT

Situation

The role of health sector research should be emphasised more in the area of active promotion of evidence-based decision-making at all levels of the health field to improve the health of the population. The main areas in urgent need of research are: health delivery system, health promotion, NCD, nutrition, indigenous medicine and health economy. The country has eminent academics and good research potential capacity. However, capacity strengthening in health and health-related research institutions should be looked into seriously in this country. Building national research capacity will be inevitable for leading the development of appropriate control strategies in the country as evidence-based decision-making. The mechanism of research sustainability including creation of suitable career structures, remuneration of researchers and the importance of building up suitable infrastructure for research to meet the increasing demand and competency should be discussed and planned as a national agenda.

Lack of a national consensual agenda for research and a willingness to mobilise national research capacity, principally from the MDPU, MRI, NIHS, FHB, and the Epidemiology Unit has resulted in even very basic questions of obvious utility being left unexplored. The National Research Council was established in 1992. However, there is no capacity to coordinate research activities. The NRC needs to be strengthened as a focal point of coordination of research activities.

Health Service Research

Research should drive health services development in Sri Lanka. Some NGOs Universities and consultant groups have done Health Services Research (HSR) Unfortunately research has not been very instrumental in Sri Lanka in health development. Too many research studies reflected rather narrow professional interests, done in the context of degree programs and some may have been donor driven.

Historically, the WHO has drawn attention on the need for quality assurance since the early 80s. The International Society for Quality in Health Care has extended and intensified this effort since 1993. Sri Lanka has participated in this effort. The Rockefeller Foundation initially supported NIHS. Then IDRC was supporting NIHS in capacity creation for health services research. UNICEF and the WHO have provided ongoing support for applied research and capacity creation.

The Manuals for Management for Provincial Directors have a whole chapter on HSR and one on Audit. What pilot efforts have been conducted and how this experience could be expanded to contribute to HSR will be explored later on in this report.

Between 1976-1995 NIHS was the focal point for research capacity building, but 95% of trainees were MD students preparing a thesis. NIHS having until recently full responsibility for services in Kalutura had been designed to be a field laboratory for operations and action research. So far, it has been unable to fulfil that dream. There has been a lack of sufficiently senior people with research capacity and full access to enough research funds; there has been confusion about the nature of the research to be done and how the agenda was going to be set. Both the training and the service sections of NIHS feel uneasy about research to be done on their work by a third unit. It is a good case study of how only consensual research agenda leads to full understanding and collaboration rather than being perceived as a threat. In an attempt to increase relevance and overcome these barriers between service delivery and research, the ministry became in 1996 the focal point and a DDG for Education, Training and Research.

The country has eminent academics, a good research capacity, and several research institutes, but lacks a national consensual agenda of research and a willingness to mobilise national research capacity, wherever it is. In MoH it seems to be principally in MDPU, Epidemiology, NIHS, MRI and FHB, and outside of MoH in IPS, academia and in some provinces. The actual HSR is limited in scope and relevance, even very basic questions of obvious utility have been left unexplored. Moreover, the relevant research done has no clear mechanism to feedback to relevant decision and policy makers. Publication in one of the 21 existing medical journals may reach only a small number of people. Presentation at the SLAAS conference is favoured by some, but is unlikely to reach many people in MoH.

Two steps have recently been taken towards solving these problems. An annotated bibliography of health, 1995-2000, has been published and the National Council for Health Research has been established and activated. So one can hope this is the start of a more planned approach to the stimulation of research relevant to health care delivery and health promotion and prevention as well as the encouragement to make evidence-based decisions.

Since 1990, a group of concerned individuals and donors has also launched the concept of “Essential National Health Research or ENHR. The methodology espoused by ENHR would seem eminently relevant to Sri Lanka to try to stimulate, organise and manage the efforts in HSR. The detail discussion of ENHR is described in the Supporting Document I.

2.8 INDIGENOUS SYSTEMS OF MEDICINE

The term indigenous medicine does not necessarily refer to practice of medicine indigenous to Sri Lanka. To both official statutes and the perceptions of the hierarchy of practitioners, indigenous medicine refers to a variety of medical practices of foreign origin together with an array of truly local tradition practiced by Sinhala and Tamil speaking practitioners using locally available herbs and medicinal substances. This knowledge has been transmitted from generation to generation verbally and through recipes (*vattoru*) written on *ola* leaves. The classical Ayurveda of India has influenced the thinking of medical practitioners in Sri Lanka. Its influence has been epochal commencing probably in the pre-Christian era facilitated through cultural interactions between the two countries that run through the entire history of Sri Lanka up to the present times. Such influence has been evident in the medical texts of the great tradition written throughout the history of Sri Lanka and in present times with the governmental formalisation of Ayurveda since 1958 as sector, when the practitioners were sent to Indian institutions for training.

In Sri Lanka, what is commonly referred to as indigenous medicine is therefore practices of Ayurveda, Traditional Practices (paramparika) Siddha, Unani and Homeopathy, and acupuncture. In other countries, it might go under the name of alternative medicine. In the meantime, there are attempts to ethnicise Siddha to Tamils of the North, Unani to Muslims of the East and Paramparika Ayurveda Practices to the Singhalese of the South, but ethnographic information on users and practitioners is grossly lacking to support such claims.

Systematic Ayurvedisation of the *paramparika* practices by the governmental sponsored programmes and the biomedicalisation of Ayurveda by the training institutions are ongoing processes to reckon with. Changes within the practices of Siddha, Unani and Homeopathy may be taking place but they are not known publicly.

(1) INSTITUTIONS AND HUMAN RESOURCES

Tables 2.8.1 and 2.8.2 present some human resource indicators in the sector over the nation. A total of about 16,000 physicians has been registered under the Ayurvedic Medical Council, Sri Lanka.

Table 2.8.1 Number of Physicians Registered under the Ayurvedic Medical Council, Sri Lanka

	As of 31st Dec. 2000	As of 31st Dec. 2001
Traditional (General) Graduates	4855	4707
BAMS	349	395
BSMS	189	209
BUMS	89	97
Diploma Holders	3607	3602
Diploma in Ayurveda Shastri	486	526
Sub total (1)	**9575**	**9639**
Special Traditional Physicians		
Snake Bites	2869	2832
Fractures & dislocations	1420	1415
Ophthalmology	573	561
Burns	30	35
Boils and Carbuncles	499	482
Rabies	166	159
Mental	84	83
Skin	262	259
Vidum Pilissum (Burning and penetrating skin with special tools)	67	7
Others	676	658
Sub total (2) -- specialists	**6646**	**6491**
Total 1 + 2	**16221**	**16130**

Notes: BAMS – Bachelor of Ayurvedic Medical Science; BSMS – Bachelor of Siddha Medical Science; BUMS – Bachelor of Unani Medical Science.

Table 2.8.2 Comparison of Numbers of Practitioners by Type of Practice in the Private Sector, December 2002

PRACTITIONER TYPE	PRACTITIONERS	SPECIALISTS
Ayurveda	8295 *(? 9825)*	6345 *(? 6570)*
Siddha	1246	204
Unani	265	40
Homeopathy	n.a.	n.a.
Acupuncturists	n.a.	n.a.
Totals *(incomplete)*	9806	6589

Note: These figures do not tally with figures of the previous table. (n.a. means not available)

Source: Compiled by N D Kasturiaratchi-2003-02-12-on information provided by the Commissioner of Ayurveda

It is clear from the above that general indigenous practitioners outnumber specialists in the private sector 10 to 6. Among the specialists, those specialising in snakebites are the most frequent and may reflect past, maybe current ,demand (see Chapter 4); next come bonesetters and specialists in eye care. The only category that seems to die out is the Vidum Pillisum.

Ayurveda and Siddha are the most prevalent categories of general practitioners. What is not apparent in this table is that most Siddha practitioners also use Ayurveda approaches and, in the last 20 years, they have experienced many problems with supplies.

(2) UTILISATION OF SERVICES

The data on Siddha, Unani, Homeopathy, Ayurveda and *Paramparika* are not available. Information or even indicators as to the utilisation in the private sector are lacking. Similarly, client perceptions regarding the sector are scanty and have been elicited through medical, sociological and health services research studies on health-seeking behaviour.

There is also much confusion regarding the claims of practitioners of the indigenous medicine sector to what degree indigenous medicine is *complementary*, *competitive* or *alternative* to biomedicine. No data are available on whether people use indigenous medicine in a complementary or alternative way. Very little is documented in Sri Lanka on therapeutic outcomes of indigenous treatment. Little information is available on the socio-economic background of the users.

A review of available literature on health-seeking behaviour is being undertaken. As a percentage of biomedical public services, the utilisation of public indigenous medicine is 10% for outpatients and 0.75% for Inpatients.

Table 2.8.3 Utilization of Services of Indigenous Medicine

Year 1999	Line Ministry	Provincial Government	Local Government	Overall Total For 1999
Institutions	03	46+121=167	230	
Outpatients	176,139 (Avg:4892/M/Ins)	2,111,239 (Avg:1053/M /Ins)	1,784,221 (Avgas: 646/m/Ins)	4,071,599
Inpatients	3236	25621		28,857

Source: Department of Ayurveda, MOH

The strengths of the Indigenous Systems of Medicine in Sri Lanka include the following:

A philosophy that supports particular lifestyles promoting health of persons of various age groups and communities stressing the food, dietary habits, morality, social interactions and the interactions with the environment, thus transcending beyond the health of the individual and the physical reality associated with it.
Approximately 16,000 practitioners spread out in rural and remote areas.
A large number of medicinal recipes for various types of ailments commonly found among Sri Lankans.
A knowledge based on herbs and other medicinal products available in and unique to Sri Lanka.
Intervention methods (e.g., massage and panchakarma) that are supposed to promote health in those people needing long-term care.
Ability to incorporate yoga and meditation to promote healthy living and stress relief.
Availability of approximately 6,500 specialists who claim success in using techniques and in treating special disorders.
Political commitment to advance the practice.
Public acceptance that “natural medicine” has little or no harmful effects.
Existence of large numbers of practitioners who have self-sustained practices (private sector).
A nascent pharmaceutical industry that produces for export and caters to private sector needs.

(3) NECESSARY CHALLENGES

The indigenous medicine sector, however, has to face many challenges. Some of those are ideological and conceptual in nature. They are scientific scrutiny, ayurvedisation, biomedicalisation, model for health, commercialisation, and communication impasse.

Scientific Scrutiny

Although the underlying philosophy of Ayurveda is not empirical methodology, its disease categorisations and intervention methods are now under scientific scrutiny. This process may have both negative and positive effects on the theory and practice of indigenous medicine.

Ayurvedisation

Given that personnel in training and research institutes are those trained in classical Ayurveda principles, there is a tendency to ayurvedise the traditional knowledge and parampika practices, which may have developed on different foundations. This process could destroy the specialist knowledge claimed by certain practitioners who have inherited such knowledge down family lines.

Biomedicalisation

This process may be taking place in training and research centres where biomedical knowledge is extensively used. Although this biomedical learning process may fulfil expectations of students and some academics who aspire for an image of a doctor similar to allopaths, it may have negative effects in terms of the practice and overall mindset of the indigenous medical services. However, the process of biomedicalisation may also help the indigenous medical practitioners to be reflective and overtime develop agendas for eventual research and good practice.

Model for Health

In the absence of the recognition of an articulated theoretical model for health that could compete or complement the biomedical model, indigenous medical services are under pressure to follow what exists, including the Western system of service delivery.

The attempts to expand and develop indigenous medicine in the public sector seem to have made little progress as they copy the administrative and practice patterns of the allopathic system leading to duplication of services and a lack of fit between the philosophy underlying users expectations, the nature of interventions and the actual delivery of services. This has left the indigenous medicine sector looking incoherent and with a lesser bargaining power for revenue and recognition. However, in Ayurveda, there is a holistic model for health, truly taking into account that health is not the absence of disease, but physical, mental, social and spiritual well-being. Ayurvedic interventions similarly address the physical, mental, social and spiritual.

Commercial Exploitation

Given the present day interests in bio-diversification and traditional medical knowledge, there is ample room for legitimate as well as unethical exploitation of the indigenous medicine sector by the pharmaceutical and tourist industry and practitioners of other systems of medicine and also from agencies and individuals within. Existence of a large number of medical "texts" giving thousands of recipes treasured by traditional practitioner families regarding herbs and other natural products of medicinal properties complicates any attempt at formulating a norm of safe and ethical practice.

"Communication Impasse"

In the last 10 years, there is hardly any communication on what Allopathic and Ayurvedic systems can offer jointly to solve health problems of an individual or of the community.

Some allopaths believe indigenous knowledge should be kept out of their sphere to either protect allopathy from a dangerous contaminant or protect indigenous medicine from being endangered. Even so, India and Japan are living examples of indigenous medicine that have survived and flourished in close dialogue with Western medicine since 1928. Major U.S. universities and its NIHS also develop research on mixed treatments between allopathy and “alternative medicine” such as yoga and acupuncture.

2.9 PEOPLE IN CONFLICT-AFFECTED AREAS

(1) DISPARITY OF HEALTH SERVICES

The two-decade-long fighting in the North-East province of Sri Lanka has affected the people in the province very badly and disrupted their pattern of daily living as well as the services they used to enjoy. It has also seriously impacted on the boarder districts of Puttalam, Anuradhapura, Polonnaruwa, and Monaragala. Health care service infrastructure and its system were disrupted heavily and have suffered heavy damage or destruction in some areas in the North and partially in others. The districts in the North were disrupted more than the ones in the East.

People were displaced from their homes during this violent period and now they are being encouraged to return to their homes, which , in most cases, the basic facilities of safe water and sanitation. As expected, it did affect the poor disproportionately and together with the re-surging of communicable diseases such as Malaria, this underprivileged group continues to face a serious threat to their health. Health services of border areas, especially of North Central province, were strained due to increased demand from displaced populations and war victims. Thus a huge disparity in health condition and provision of services exists between the people in conflict-affected areas and the rest in the island.

In these areas the accessibility to services was seriously curtailed due to shortage of human resources and degradation of facilities. It has been identified that the deployment rates of Medical Officers, Nurses and PHMs in the provinces are all significantly lower than the population share of the North-East Provinces, which is 13.1%.

(2) HEALTH STATUS

The aggravated health conditions of this province are evident from the information on various health indicators. The health status of the province has deteriorated to levels much below the national average. Although reliable statistical data are not available, Table 2.9.1 shows comparisons in a number of indicators among districts, referring to the national average. Sri Lanka's health gains in the past were associated with improved accessibility to a range of basic public health services provided by dedicated primary health care workers such as public health Midwives.

Maternal mortality rates in areas that were heavily affected by the war such as Kilinochchi stood at 158/10,000 live births, Mullaitivu: 123, Batticaloa: 117, and Mannar: 97, which is almost 5 to 7 times higher than the national average. This indicates serious distortion of not only health services but also social and economic distortions.

Table 2.9.1 Indicators of Northern and Eastern Province

	Sri Lanka	North & East	(%)	Northern					Eastern		
				Jaffna	Kilinochchi	Mannar	Vavuniya	Mullaitivu	Batticaloa	Ampara	Trincomalee
Area*1	64,454	17,724	27.5%	983	1,237	2,002	1,197	2,517	2,610	4,430	2,698
Population x1,000 (2001*1)	18,732	2,456	13.1%	491	127	152	150	122	486	589	340
Population Density*1	290.6	138.6		528	106	81	81	50	186	140	135
MO*2	7,963	576	7.2%	108	9	43	15	2	143	167	91
Nurses*2	14,716	1,159	7.8%	342	16	63	27	17	291	302	118
PHI*2	1,486	295	19.9%	52	6	14	12		67	99	45
PHM*2	4,798	393	8.1%	64	16	9	9		94	151	50
Crude Birth Rate (2000)*1	17.3	16.8		9.0	25.4	14.2	19.5	35.0	23.4	11.3	23.7
Crude Death Rate (2000)*1	5.7	2.6		2.2	8.5	2.1	8.77	11.3	5.6	2.1	3.9
Low Birth Weight (2000)*1	16.7	NA		13.7	19.8	10.1	12.3	18.6	20.0	10.0	12.6
Maternal Mortality Ratio(2000)*1	23 ('96)	81		62	158	97 ('96)	76	123	117	24	57
Infant Mortality Rate(2000)*1	15.4 ('98)	14.74		22.3	27.78	22.32	8.77	20.32	10.29	10.29	4.57
Total No. of Hospitals*3	558	87		18	4	4	3	5	8	11	9
Total No. of Beds*4	57,027	6743		2,020	252	320	260	283	1,186	1,615	807

Source: *1 : Health System and Health Needs of the North-East Sri Lanka, WHO
*2: Department of Health Service (2001), Annual Health Bulletin 2000
*3: No. of Hospitals (General Hospital, Base Hospital, District Hospital, Peripheral Unit and Rural Hospital), Health System and Health Needs of the North-East Sri Lanka, WHO
*4: Annual Health Bulletin 2000

(3) HEALTH SERVICE PROVISION

Both shortage of staff and the distortion of health facilities remain the number one concern in the affected areas. Most of health facilities have been wholly destroyed or substantially damaged. The seriousness of the damage varies; 55 health facilities are heavily damaged. Some of them are totally abandoned; however, some have been functioning at low levels. In some cases rented/ temporary buildings are used for provision of services.

Many of Central Dispensaries, Rural Hospitals, and MoH offices located in the rural, uncleared landmine areas have been destroyed. Many government health facilities in Kilinochchi and Mullaitivu districts bear the worst damage.

Table 2.9.2 Number of Damaged Health Institutions in Northern and Eastern Province

	General Hospital		Base Hospital		District Hospital		Peripheral Unit		Rural Hospital		Central Dispensary	
	ON	DD	ON	DD	ON	DD	ON	DD	ON	DD	ON	DD
Jaffna	1		1		6	**1**	6	**2**	4	**1**	24	**5**
Kilinochchi			0		1	**1**	1		3	**1**	8	**4**
Mannar			1		3		1		2	**1**	10	**3**
Vavuniya			1		0		1		1		7	**2**
Mullaitivu			0		1	**1**	2		3	**2**	4	**3**
Batticaloa	1		0		6		1	**1**	6	**1**	15	**5**
Ampara	1		1		1		1		1		5	
Ampara/Kalmunai			3		7		4				9	
Trincomalee	1		1		2		3		4		18	**4**
Sum	**4**	**0**	**8**	**0**	**27**	**3**	**20**	**3**	**24**	**6**	**100**	**26**

Note: ON: Original Number, DD: Destroyed or Damaged Seriously

Source: Health System and Health Needs of the North-East Sri Lanka, WHO

The routine public health services have been drastically cut down in the affected areas. Immunization rates are lower in general in these districts than the national average, and it is even lower in some poor, remote areas and among the migrant population. Even the statistics below might not be quite accurate and outcome of immunisation program may not be to the expectations of the program as the environment in which the program was conducted had the following deficiencies:

- Electricity service is irregular or does not exist;
- Generators of solar power is available only in some areas;
- Refrigerators and freezers are not available in all areas; and
- Vaccines are tightly packed, leading to high temperatures and the potential for efficacy instability.

The incidences of diarrhoea are higher in Northeast and border districts while the utilisation of oral rehydration therapy is lower among districts in North-East when compared to the rest of districts.

Table 2.9.3 North-East EPI Coverage, 2002

DPDHS	EPI Coverage of under 5 with card
Ampara	*71.8%
Batticaloa	*78.9%
Trincomalee	*69.0%
Jaffna	*73.5%
Kilinochchi/Mullaitivu	Not available
Vavuniya	*88.3%

Source: Dept. of Census and Statistics

(4) CHALLENGES

Inadequate and low quality public health services in conflict-affected areas are due to break down of infrastructure and shortage of staff, equipment and supplies along with reduction of management capacity to handle the transition. The challenges are listed below:

Damage to the infrastructure has brought essential services to stand still. Of the 400 institutions 55 are totally damaged and 49 are not functioning.

- Human resources in health have fallen to such low levels that this problem has interfered heavily with the provision of basic health services. Nearly 41% of the cadre is vacant. The challenge is to fill this cadre in the quickest possible time.
- There has been a break down of disease surveillance system and support services, such as blood transfusion & laboratory services, referral system, quality of care and the traditional health system.
- Contaminated water supplies, low standards of hygiene and sanitation, food insecurity and easy spread of communicable diseases especially among the displaced have added to the increased risk and deterioration of the health condition.
- The breakdown in the health information system has made it difficult to quantify the various conditions and trends over the last few years. In fact, data from North and East show heavy under reporting.
- Amongst the disease challenges faced by its people are the resurgence of Malaria, Anaemia among lactating and pregnant mothers and malnutrition among children under five years of age. In addition, health system failures have worsened the situation for the poor and those returning IDPs.
- Increased number of trauma-related mental & physical disabilities is a significant problem.
- It is a transition period for both the public and the health workers from a period of war to one of peace and adjustments would be difficult. Psychosocial problems are a new area of concern.
- Gender issues are yet another challenge. Women seem to bear the greatest burden in the family especially in families where the breadwinner has either died or become disabled as a result of the conflict. Targeting and improving the condition of women in communities to which they return and facilitation of family reunion have to be addressed.
- Accessibility to specialised care has been a problem but a greater challenge is the provision of basic health services to IDPs and to remote populations.
- Development of a sustainable health system that is more responsive to the people in the province stands as the greatest challenge under the present circumstance of uneasy peace.

(5) PRIORITY ISSUES AND NEEDS

In this section, priority issues and needs in the North and East districts are discussed.

District Health System Constrained by the Disorganised Public Health Services

The major problem is in the conflict areas of the North where heavy damage to the health infrastructure is observed. In addition, many of the PHC facilities in North-East are either devoid of or have insufficient staff. There are over 3,000 vacancies in the North-East alone. This has been a major obstacle in the recovery phase. Volunteers have been providing essential health services in these areas along with national and international NGOs. The peripheral hospitals are heavily affected, e.g., Chavakacheri Hospital has no electricity, has no basic facilities for treatment of patients and is acutely short of staff. Jaffna Teaching Hospital is the only hospital working in full gear though constrained by shortage of

professional and middle level technical staff. A health infrastructure development plan needs to be prepared for rebuilding the hospitals and health facilities in the area. There is a need to relocate or close down some facilities to address the imbalances and under-utilisation. Priority should be given to hospital reconstruction and rehabilitation, to reorganisation of numbers, levels and location of hospital beds. For example, the peripheral unit serving the population of North Western part of Jaffna needs upgrading. Infrastructure development of Jaffna Teaching Hospital and other secondary and tertiary care hospitals should commence immediately. The rationale behind this is that it would help to establish functional services of high quality at these levels as a precondition for establishment of comprehensive PHC services. Consideration should be given to future recurrent cost implications when planning and designing capital projects.

A planning framework for hospitals has to be developed, organisational culture changed and quality improved. The ability to revitalise the hospitals depends on success of other elements of strategy such as human resource development and quality improvement.

Inadequate emergency and rescue services including absence of an emergency preparedness and response system for health emergency are found to be a serious drawback and needs attention.

District Health System Constrained by Inadequate Management of Primary Health Care Services

The basic criteria for a good primary health care system are accessibility and availability of services close to home. A clear definition of services at each level should be available along with the minimal service package offered at each level. The health coverage plan provides criteria to identify the location of public health facilities within a district-based system.

The proposed package needs a thorough costing review to be undertaken. When designing and planning for the primary care system, equity of access and fully functional clinics should be reflected.

Poor Reproductive and Child Health Services

Maternal mortality and morbidity in the North and East have been particularly high due to break down of reproductive health services and emergency obstetric services. Malnutrition and anaemia among pregnant and lactating mothers as well as children under five years of age continues to be a major problem. Accessibility and quality of maternal and neo-natal health care services need to be improved through training of existing health care providers in specific areas, namely, essential obstetric care and neonatal care, midwifery services and improved referral services. Acute malnutrition in children is a major problem making them more vulnerable to disease and death. Community education in hygiene and nutrition, food supplementation, expanded immunisation program, and training of health workers on integrated management of childhood illnesses should help to ease this problem.

Comprehensive maternal and child health programme within a more integrated basic health services approach should be available including programme on early childhood development.

Weak Epidemiological Surveillance and Health Information Systems

The surveillance activities have broken down in the areas of conflict and data on disease conditions are not quite reliable. Epidemiological surveillance system operating in other parts of the country should be fully activated in the affected areas soon. At the same time a disease early warning and response system should be put in place.

The health information systems especially in the North have virtually collapsed and there has been no regular collection of health information. Health information systems are disorganised and information is patchy.

Functioning heath information systems are crucial for monitoring inputs, processes and outputs of all interventions. This area needs special attention and strengthening with information technology and training. The need is to re-establish the health information system and disease surveillance system. Developing methods for data collection that encourages greater community involvement in needs assessment, priority setting and selection of interventions is crucial for designing programmes.

Disease Burden and Deaths from Preventable Conditions

The incidence of communicable diseases such as Malaria, TB, Dengue, respiratory tract infections, diarrhoea, typhoid, infectious hepatitis and cholera have shown an increase while Dengue has caused several deaths in Jaffna peninsula. Dengue, Cholera and Encephalitis have been occurring as deadly outbreaks. The movements of populations and dynamics of war would allow spread of sexually-transmitted diseases and could serve as a vehicle for spread of HIV. Deepening crisis of acute malnutrition among children and the associated illness and deaths from respiratory infections and diarrhoeal diseases is a challenge especially due to shortage of food supplies, poor economic conditions, loss of agricultural land, unsafe water and sanitation in the affected areas.

Uncleared landmine areas have posed a significant risk to people who are returning to their homes, to children, and people engaged in cultivation. People with injuries due to landmines and unexploded ordnance need to be cared for and reintegrated into society.

Increase of mental illnesses, suicides and untreated residual mental diseases in the community is another concern. Mental health services need to be re-established.

Facilities for emergency care are grossly inadequate and this has caused several preventable pregnancy-related deaths of women. UNICEF is undertaking an assessment of emergency obstetric care in the conflict-affected areas. Accessibility, availability and quality of maternal as well as neonatal health care services need urgent attention followed by restoration of the system at least to reach earlier standards of care within the shortest possible time.

Unplanned Human Resource Development and Weak Management

Shortage and inequity in distribution of health personnel is a major problem in the districts. An assessment of immediate requirements and planning for needed training of staff are being undertaken now. Human resource development, deployment and skill mix have to be well planned especially at this transition stage as institutions open up with the resettlement of people. There should be in-service and continuing education training programmes, and sufficient incentives for professionals and other staff to work in difficult and remote areas. Hospitals, for example, need to be fully equipped. A provincial human resources plan, as an input to national human resources plan and staffing needs for implementation of PHC package, should be developed. Training schools have to be developed. Reorientation of the middle level health workers and public health field staff to the new challenges has to be undertaken.

Strengthening institutional capacity remains another area for priority action. Skills development in effective management is crucial both at management levels and operational levels. The decentralisation process and devolution of health to provinces have to be reviewed in order to establish clear division of responsibilities between the centre and the provinces and commitment and capacity to operationalise the devolved subjects. The coordination between the public and private sectors is required with the growth of the private sector in time to come.

Inadequate Provision of Support Services

Laboratory and diagnostic services, supply of essential drugs and vaccines, maintenance and supply of equipment, provision of essential supplies, communications, and ambulance services are not functioning satisfactorily. The worst affected are the remote institutions, serving the rural population. The laboratory services and blood transfusion services need reorganisation and strengthening to cope with the new demands.

Poor Access to Safe Drinking Water and Poor Environmental Sanitation and Hygiene

High levels of infant and child mortality from water-borne diseases as well as epidemics of diarrhoea have been reported. The conflict that has resulted in the large displacement of people and the institutional problem has affected water and sanitary facilities in many areas. The water collected from dug wells in some medical institutions was found to be polluted. There has also been no proper disposal of clinical and hospital waste. Sewerage disposal system for hospitals including Jaffna Teaching Hospital is not functioning properly. In fact none of the towns have sewerage treatment and disposal plants. A survey on water and sanitation needs of medical institutions would reveal more information.

Unwelcome Environment for Child Growth and Development

Children had to grow in a war environment which is not conducive to satisfactory child growth and development. The situation did not allow sufficient attention by families and communities for early development of a child. This could affect the child's personality and intellectual capacity as well as cognitive and emotional functions. There is a need to implement an early childhood development programme.

Unhealthy Behaviour that Increase People's Risk of Preventable Diseases

The break down of family and community life, as well as the inadequate basic living facilities such as water and sanitary facilities, has led people to shift from good health practices to one with grave health risks. The risk factors include improper diet, increased consumption of alcohol and tobacco, lack of contraception and unsafe sex. In order to reduce these risky behaviours, a healthy lifestyles promotion programme for the vulnerable populations should be in place along with the required facilities, to encourage people make the necessary changes to a healthier lifestyle.

CHAPTER 3

INSTITUTIONAL CHALLENGES

3 INSTITUTIONAL CHALLENGES

This chapter examines some of perceived constraints that should be mitigated, removed or overcome. Innovative solutions will be needed to overcome the current and latent constraints pervading in the society and economy of Sri Lanka.

3.1 ADMINISTRATIVE AND MANAGERIAL ISSUES

Health management is a pivotal part of the entire health service delivery system. Although Sri Lanka has historically developed a good health delivery system covering the whole country supported by human and societal development and achieving a good reduction of infant and maternal mortality, the delivery system and societal arrangements need to be further improved to deal with the needs of the aged and the threat of non-communicable diseases.

Three kinds of constraints are briefly reviewed:

- Institutional system-related constraints;
- Function-based constraints; and
- Socio-cultural constraints.

(1) INSTITUTIONAL SYSTEM-RELATED CONSTRAINTS

Implementability of Radical Changes in Health Policy

Historically, since ancient times, Sri Lanka has always considered protection of the health of the people as a fundamental duty of the kings. Since 1948, the government has, as its constitutional mission, addressed people's well-being through the health sector policies and poverty reduction policies.

The above represents strength as well as opportunity. However it has to be noted that the decision-making process for implementation of any health reform is complicated, as it touches on access to resources for well-being and survival and is subject to strong political concerns rooted in various social values. Such political complexity makes it harder to expect that proposed health plans be implemented purely on technical grounds.

In the last decade, several health policies and plans were formulated internally and by externally organized task forces. Those are:

- National Health Policy by Presidential Task Force (1992-2000);
- The Perspective Plan for Health Development in Sri Lanka (1995-2004);
- Six-Year Development Programme (1994-2004);
- National Health Policy (1996); and
- Presidential Task Force/Proposals for Reform in the Health Sector, 1997.

All of these policy documents and plans are well documented, the considerations are clear and detailed, and the recommendations are rational. Unfortunately, none of them have been fully utilized as plans. The hesitation to implement reportedly had several reasons: a change in the governing political party, lack of a monitoring system to follow the implementation of the plans, or too little dialogue with relevant parties and stakeholders during the planning process. These historical lessons tell us that what

makes a plan really practical is not exclusively or perhaps even primarily the documentation of the plan, but the involvement of and appropriation by relevant decision-makers in the planning process.

Another observation is that, in Sri Lanka, as in many countries, administrative decisions tend to derive legitimacy from precedents rather than an active process of problem solving, so radical and rapid changes are hard to accept and the day-to-day reality is administration rather than management.

Less Comprehensiveness & Coherence of Health Management

A compartmentalised health administration is likely to be a hindrance to keep the comprehensiveness and coherence of the implementation of health policy and develop a coherent health service delivery system. It contributes to fragmentation, gaps and/or over-lapping both in and between facility-based and outreach services programmes, particularly severe at the rural level, thereby causing a waste of valuable resources and missed opportunities.

No programmatic quantitative and qualitative linkages have been established in resource mobilisation for health services. Procurement of drugs and supplies and human resources are not linked. The currently poor inter- and intra-ministerial coordination mechanisms need to be improved and further strengthened to formulate a comprehensive scheme of resource mobilisation and utilisation in particular.

Lack of Performance Appraisal Mechanism in MoH

So far, there are no official systems to evaluate budget performance and personnel productivity/workloads. There is no feedback. Therefore, motivation to improve the delivery or support services is difficult to maintain or stimulate, and also cost-effectiveness consciousness is not very well developed among medical practitioners and managers. In addition, the budgeting and human resource plan is not evidence based.

If the performance appraisal system, including appreciation of good practice, is not established, it will be a potentially critical constraint on rationalisation of health financing and hospital management as well as health resource utilisation in general.

Weak Regulatory Basis for Good Practice

There are Sri Lankan examples of good practice and successful accomplishments in hospital management but it has proven hard to disseminate these success-models to other hospitals. There has been too great a dependence on the staff making deliberately innovative efforts and too little on systemic facilitation and reward for good practice. The successful empirical practices need to be utilised to formulate the guidelines for "Good Practice" in the hospital management, and a regulatory framework based on the practices should be considered, building in rewards for good practice.

(2) FUNCTION-BASED CONSTRAINTS

Monitoring and Feedback

Monitoring and feedback are underdeveloped as a system and where the monitoring and feedback mechanism has been designed, it has been often underutilised. Sometimes useful information is gathered and archived but not analysed, and even some analysed data are not used for feedback but archived.

In service delivery, this seems to hold true in all OPD situations, in school health, in growth surveillance, in antenatal care and in most curative IPD. However, certain areas such as family planning, expanded programme of immunisation and maternal mortality are the exceptions where monitoring and feedback mechanism has been developed and is actively used.

In support services, the situation is no better. For example, MoH has the main responsibility for procurement of drugs and supplies at the national level and distribution to various levels of health

service facilities over the nation. This task is very important in terms of resource allocation and efficient management for appropriate health service delivery. The annual procurement list is planned, but not based on the monitoring results of the up-to-date use and need situation as well as space for storage, but in consideration of the preceding year's allocation and purchase. Moreover, as the orders exceed the meagre storage facilities at each level, the stock management systems of drugs and supplies become very poor. Some items are supplied in excess to one place and in insufficient amount to another place. Exchanges between surplus and undersupplied locations are very rare.

Obviously, a monitoring function with a built in feedback mechanism should be developed for the services delivery as well as for supplies management, to support an efficient and effective health service.

Lack of Appropriate Information Militating Against Resource Integration

Fundamental to the monitoring issue is another crucial issue, which is lack of appropriate information available to the right people at the right time. There is also not very much of eagerness to utilise information technologies to establish a total health resource management system accessible to decision-makers.

For example, no up-to-date inventory of health facilities and equipment exists; therefore, no information is available for rational decision-making on what, where and how health facilities should be renovated, built, repaired or improved Only case-by-case basis decision-making is available, usually under some political pressure, but this more often than not will undermine rational and equitable resource utilisation.

Lack of information linkages among relevant departments is thought to be another constraint. All departments in MoH should share the same database for their administrative and management decisions. The current information system, given the status quo, would be a crucial constraint to the health reform process.

(3) SOCIO-CULTURAL CONSTRAINTS

Providing health care or nursing care in the main religions of Sri Lanka has very personal significance: for the Buddhist it produces merit, for the Christians and Muslim it is charity. For the Hindu there are both very positive and negative connotations, Ganesh being the supreme healer, but contact with body fluids being considered ritually impure. People see their work as a deeply personal almost devotional commitment, but they may still be reluctant to handle body fluids and do physical examinations as much as would be needed for good clinical practice.

The main constraints are the diverse population groups and socio-cultural beliefs and practices, which adversely affect health.

Socio-cultural practices based on certain beliefs have a significant effect on pregnancy, childbirth and rearing of babies. The various pregnancy-related taboos such as on consumption of some types of food, avoiding hard labour, etc. are affecting pregnancy outcome while on the positive side consumption of some foods believed to augment production of breast milk is encouraged during pregnancy.

The *Ayurvedic* medical system, which has come to being from ancient times, has had a great influence in the socio-cultural practices towards health and illness of the Sri Lankan people.

Overcoming socio-cultural constraints or even finding strength in the culture to build quality care will call for a very careful approach of trial and error and above all dialogue.

3.2 REGULATORY ISSUES

There are about 30 different health and health-related enactments in Sri Lanka covering consumer protection, food safety, health service, nursing homes, dangerous drugs control, pesticides, and also factories ordinance, medical ordinance, mental diseases ordinance, etc. These were enacted at different times in the past and some have been amended to make them responsive to the current needs.

The issues identified in the Ministry's regulatory function and mechanisms are as follows.

(1) WEAK LINK BETWEEN LAW AND MEDICINE

The role of the health legislation is very important to promote Health Policies and action-oriented strategies. As health issues are getting more and more complex day by day owing to emerging new issues, arrest of such issues and situations requires a closer link or cooperation, in the form of an alliance between law and medicine.

(2) WEAK KNOWLEDGE OF HEALTH-RELATED LEGISLATION AMONG FRONTLINE HEALTH WORKERS AND AMONG COMMUNITIES

A survey conducted by the Master Plan Study Team revealed that presently, all new legislation and amendments to legislation are not brought to the notice of all frontline users of health /medical legislation nor to the community people. Such users do not have all the important legislations in their possession. Their enforcement is poor. The constraints are no formal system to enhance dissemination of all relevant health legislation and no in-service training for interpretation of legislation to enforce them.

(3) DELEGATION OF THE POWERS OF THE LOCAL AUTHORITY TO THE MEDICAL OFFICERS OF HEALTH.

Many of the ordinances are enforced by the local authorities based on the advice of health personnel such as a Medical Officer of Health or Public Health Inspectors. However, local authorities do not always accept the advice of health personnel since they are not the executives of the local authorities and do not come under their management. The local authorities should delegate to MoH the required powers related to health, now enjoyed by the Chairman of the Local Authority, as provided for by the *Pradesheeya Sabha* Act.

(4) MAKE NEW ENACTMENTS TO DEAL WITH PRIORITY HEALTH PROBLEMS

In Chapter 4, the future perspective of epidemiological changes identified some important health problems such as hypertension, diabetes mellitus, and ischaemic health diseases, which are related to lifestyle changes of people in this country. Appropriate legislation to regulate smoking and alcholism, etc. and control of environmental factors need to be made and enforced. Signing of the international tobacco treaty, the Framework Convention on Tobacco Control, is a step in the right direction.

Also some regulations should be in place urgently to regulate media including TV in terms of tobacco- and alcohol-related scenes and advertisements. Further, the use of carcinogenic substances, including food additives, pesticides, etc., should be regulated.

For issue of increasing road accidents, homicides, and suicides, inter-sectoral ministries policies and enactments are urgently needed.

(5) LEGISLATION FOR THE WORKER'S HEALTH

There are several enactments that relate to worker's health. The most important ones are Factories Ordinance, Medical Wants Ordinance and Diseases among Labourers Ordinance. A large part of the population of Sri Lanka is employed in the agricultural sector and in other occupations for which there is no organized occupational health service. In order to remove these inconsistencies, comprehensive legislation needs to be enacted to cover all categories of "people-at-work". This will include protection of health workers from occupational risks and litigation arising out of performing professional duties.

(6) LACK OF ENFORCEMENT ARM

Certain health related ordinances such as the Control of Pesticides Act, Factories Ordinance, and National environmental Act are not effectively enforced because of non-availability of enforcement officers. In view of their importance, suitably qualified officers from other government departments and agencies have to be empowered to enforce the provisions after appropriate and specific training.

(7) REORGANIZATION OF ENACTMENTS

There are a number of single purpose enactments such as the Butchers Ordinance, Bread Ordinance, Municipal/Suburban Dairies and Laundries Ordinance. The provisions under these enactments have to be suitably integrated into the existing enactments, for example, the Food Act.

3.3 FINANCIAL ISSUES

(1) FREE MEDICAL SERVICE POLICY

The free medical service policy is in line with the ethos and constitution of Sri Lanka; therefore, this policy should be maintained as far as possible. In reality, however, half of the health expenditures come already from out-of-pocket money of patient households. Thus, the coverage by tax money is limited.

As discussed in Chapter 3, future financial demands for health expenditures are anticipated to increase at a considerable rate, due to a combination of epidemiological and demographic changes, which require expansion of preventive services and increasingly expensive curative care.

Still a tax-based health budget is thought to be affordable within the period of forthcoming decade, taking into account the health expenditure comparative figures in terms of the GDP percentage, if economic growth is achieved as anticipated and peace holds. This would permit even a higher percentage of GDP to be put at the disposal of the health sector. However, it is a fact that the financial situation in the national health budget will get tighter year-by-year.

The question is, in view of the Government's precarious financial position, how long can the Government provide a free health service whose costs are rising much faster than the revenues that can be generated from taxes, without introducing measures to:

- Rationalise and make the system more cost/effective and accountable;
- Reduce the increasing rate of expenditure by improving on efficiency;
- Generate revenue from the system and/or;
- Encourage the people that can afford it to seek health care through private providers or through insurance or social security mechanisms, without compromising the service to disadvantaged groups, particularly the poor.

In other words, what are the future options for Sri Lanka, not only to maintain an adequate and free health service, vital for the poor and crucial for lower middle class people, but also to increase resources for health without damaging equity?

The question is even more acute in view of the poor economic situation of the country due in large part to the costs of the civil war (war spending reached US$ 1 billion annually, more than one-third of total government revenues) and, now, the need for massive reconstruction and rehabilitation. Sri Lanka's economy shrank last year for the first time since its independence in 1948.

Unless some measures are taken soon the free health service may one day become unaffordable consuming an ever-larger share of the national wealth, and needing massive tax increases just to maintain without improvement. The most important measures are:

- To stem the wastage and inefficiencies in the public sector which are becoming a huge drain on the national treasury;
- To raise revenue earmarked for health and supplement the national budget; and
- To rationalise services and emphasise on lifelong prevention for non-communicable diseases as well as intensify secondary and tertiary prevention in an integrated manner.

Because of advancing technology and momentum in expectations, modern health care has a tendency to become increasingly expensive. In the US, the average expenditure per year per person is now US$ 6,000.

With the continuing increase for the next 15-20 years of the prevalence of conditions such as asthma, liver cirrhosis, hypertension, diabetes, cancer and high cholesterol associated with life-long risks accumulating over increased life expectancies, all needing expensive, long-term treatments, it is questionable how the public sector can fund these interventions without some patient participation or other form of revenue raising. By way of comparison, the U.K. estimates that the cost of anti-cholesterol drugs to the NHS alone will reach more than US$2 billion by the year 2010.

(2) MAL-DISTRIBUTION OF PUBLIC FUNDS

As discussed in Chapter 2, huge regional and/or district disparities in health services and human resource have prevailed. This means that the financial resources are not equitably distributed. In other words, there exists mal-distribution of public funds for the health service delivery. There is a tendency to supply fewer resources to more remote and poor regions. This does militate against effectively using health services for poverty alleviation. This will need careful review and correction if health system reform is to be meaningful.

(3) NO DEMAND-/NEED-RESPONSIVE BUDGETARY SYSTEM

A considerable amount of the financial resources has been devoted particularly for tertiary large hospitals where a wide variety of curative services is available, thereby resulting in over crowding at the tertiary hospitals. On the other hand, lower level facilities are not sufficiently funded to function as expected or mandated, thereby resulting in underutilization of these facilities. This means that the current funding is based on a supply-driven mechanism, not a demand-/need-responsive mechanism.

Needs for health services include a wide range of care and activities that can be provided by different levels of facilities and systems. There are remarkable urgent needs for preventive and primary care services, which are more cost/effective.

These needs/demands of different kinds need to be monitored and assessed at the practical level, and the funding needs to be flexible enough to respond to the demands within a reasonable time schedule. This calls for an innovative budgeting system, in place of the conventional system.

3.4 HUMAN RESOURCE ISSUES

The concept of development of human resources for health in this country needs to be expanded from one of only production and distribution of human resources for the public sector health services to a supporting function in order to attain the key objectives of the health sector strategy for the nation. This means the whole public and private sector needs to be taken into account both on the supply and on the demand side. It also means that there is a need for an effort to maintain and improve competencies of people already employed in both public and private sectors.

Institutional constraints related to human resources are attributed mainly to three aspects:

- No rational framework to fulfil the gap between supply and demands;
- Imbalance in deployment; and
- Less access to training/education for appropriate knowledge and technology.

(1) LACK OF A RATIONAL FRAMEWORK FOR HUMAN RESOURCE DEVELOPMENT

Lack of Long-term National Policy & Plan for Human Resource

One of critical issues in human resources is that no overall human resources policy and plan exists in this country due to lack of capacity and structure at the national level to develop human resources policy and plans for the health sector.

Another issue is the existing mechanism for making decisions on strategic human resources, such as the future composition of the workforce and the numbers of specific cadres to be trained, does not involve any related stakeholders.

The third issue is that there is no central human resources unit or department, or a mechanism to connect human-resources-related functions in different places and levels existing within the Ministry of Health. Therefore, the decision-making is segmented and human-resources-related information remains fragmented and isolated from each other.

Lack of Rational Basis of the Cadre

Absence of a health manpower plan has curtailed a planned development of human resources and has led to shortages of cadres.

Chronic shortages of human resource are found in community-based health workers and paramedical professional staff cadres. Most categories including physicians are said to receive too little skill and competency training. The educational capacity to produce such health personnel also needs to be strengthened on a long-term rather than a short-tem basis.

Another mismatch is seen in the cadre for tutors and practical instructors of nurses and paramedical staff that bare no relationship to either present number of students or desired number of trainees. The defined cadre is not based on a scientific rationale. Less considerations for the work performance, targeted health service levels and practical workloads are given when specifying the composition of the cadre.

Regulatory Constraint for Private Sector's Contribution

Some large-scale private hospitals are capable of educating and training health staff, but they cannot legally provide such functions. By establishing an official qualification examination system for those who are educated in the private sector institutes, the private sector could contribute to develop human resources, as the practice in most other countries.

(2) UNBALANCED DEPLOYMENT OF HEALTH STAFF

Huge Disparity of Health Staff among Districts

There exists a significant imbalance in the distribution of current health staff. As discussed in Section 2.5, huge disparities in distribution of health personnel by district can be observed. Specifically, the number and the rate of deployment of health personnel in the underprivileged areas of the country and in Northern Province (exacerbated by conditions of war prevailing there earlier) are extremely low, while Colombo, Kandy and Galle have higher concentrations.

The reasons for this problem of unequal distribution of human resources are, firstly, the limited capacity at provincial level to improve its imbalance of health manpower. The provinces cannot recruit personnel for paramedical fields from their areas, but those who are recruited from other areas tend to avoid going to places far from their home areas. Shortage of health manpower in the rural areas is due to many disadvantages health personnel have to face for lack of proper facilities for career development, education of children and income. A more decentralised human development system is needed to overcome the problem of imbalance of staffing.

No Incentives & Career Ladder for Health Professionals

Neither institutional scheme of incentives or career ladder system has been prepared for those who dedicate themselves for serving in remote areas. As mentioned above, this is thought to be a reason behind the mal-distribution pattern in health personnel.

(3) LIMITED ACCESS TO APPROPRIATE KNOWLEDGE AND TECHNOLOGY

Continuing Education Programmes

Most health workers have no experience in following well-organised training and educational programmes after their graduation, because of lack of an official continuing educational system. Therefore, they have very limited access to currently prevailing knowledge, appropriate technical skills and state-of-the-art technologies, which are needed to cope with emerging needs at the practical level. Provision of well-organized continuing education programmes is most vital in human resource development.

Limited Management-Competency of Human Resources

Professionals who are competent in business administration, health economics and accounting are very few in number in the health sector at present. This will become a crucial constraint against pursuance of more efficient hospital management as well as in development of a new health financing mechanism.

3.5 INTERSECTORAL COORDINATION & ACTIVITIES

Healthy living is fundamental to quality of life. When disease strikes, curative measures need to be employed, however, other interventions, such as preventive measures, family planning, health education and social education measures in road safety and school health, and personal and environmental hygiene, play important role in the prevention of ill-health and promotion of well-being.

Recognizing the link between health and other development factors, the intersectoral approach to health development is a critical strategy not only to minimise attack by those agents that will eventually provoke ill health and threaten well-being but also to ensure sustained development of the quality of life. There is rich experience, nationally and internationally, on the tangible benefits that can accrue to people if the multi-sectoral approach is made a reality.

The identified issues in the area of inter-sectoral coordination and activities are as follows.

(1) WEAK CAPACITY OF THE MOH AS A COORDINATION BODY

To foster intersectoral actions adequate and appropriate cooperation between the Ministry of Health and other relevant ministries, analogous bodies and non-governmental organizations need to be brought into play. The role of Ministry of Health as a coordinating agency for development of health needs has to be further strengthened, at national, provincial, and divisional levels. Joint Planning and Programming is fundamental to intersectoral action. For this purpose, appropriate processes and procedures should be developed , at all levels, particularly at Divisional level and below. Further, bottom-up and multisectoral planning beginning at the community level, participated by the people themselves and supported by sectoral officials and NGOs, should be promoted. For this purpose, planning capacities at lower levels need also to be improved.

(2) WEAK FUNCTION OF HEALTH COMMITTEES AT DIFFERENT LEVELS

A mechanism similar to National Health Development Committees was established at different levels as Provincial Development Committee, Divisional Health Committee, and Village Health Committee. Some of the reasons given at a stakeholder meeting for mal-function of these committees are: 1) there is no clear roles and responsibilities spelled out for the committees, 2) selected representatives are sometimes not appropriate, 3) members are not aware of the processes and procedures, 4) there are rarely follow-up meetings. A clear agenda has to be set up and procedures need to be installed for these committees to be functional.

(3) LACK OF PROPER EDUCATION AND TRAINING FOR INTERSECTORAL APPROACH AND ON TOTAL HEALTH DEVELOPMENT

The efforts of human resource development (education and training) in health and health-related sectors need to be fine-tuned to include the concepts of and knowledge and skills in health development including development planning, and the management thereof. The principles, procedures and processes guiding “development “ shall cover behavioural aspects. The sectoral approach to training shall be replaced by that of a multi-sectoral orientation to development. For this purpose a special advisory group of experts should be established to identify the required inputs by sectors, the training needs under each sector for the purpose of developing a suitable curriculum for training.

3.6 POLITICS & HEALTH

(1) INTRODUCTION

Politics is primarily associated with art of government and activities of the State that are relevant to the well-being of its people. While politics have an effect on daily life of the people, it is also playing a significant role in responding promptly to health needs and demands of all communities. It is behind attempts to make services more accessible to the people. Both the government and the opposition political parties work towards this end. On the other hand, political interference in matters of the State offices has sometimes caused many obstacles to policy and implementation processes of government ministries.

Political system deliberates on best available information but this is less than expected mostly because the politicians get distorted information and usually yield to pressure from powerful key players such as professional bodies, trade unions and business groups. Corruption cannot be ruled out in any political system and it creates incentives that effect sensible decision-making.

(2) POLITICAL NATURE OF HEALTH

Various aspects in the field of health shows the political nature of health as can be observed in distribution of health, organisation, health determinants, health rights, globalisation and values.

Unequal Distribution

When it comes to approaches towards correcting health inequities, differing political opinions overshadow what is desirable. Politicians tend to concentrate on their own electorates and divert funds for its development at the expense of others. This would lead to an imbalance of health assets in the various parts of the country.

Health Determinants

Political action has a great influence in managing the determinants for health such as water supply and sanitation, housing and environment. However political decisions are influenced by the vested interests of groups close to the politicians in deciding on these services.

Organisation

Organised effort of society is needed for improvement of health and this organisation of society is the role of the state. It has the required power, but how this power is operated makes it political. Majority of those in the Ministry of Health and Provincial Ministries of Health staff have been used to and continue to please the politicians on certain policy matters, however unhealthy they find it to be.

Human Rights

Everyone has a right to a standard of living, adequate to the health and well-being of himself and his family. This includes food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, other lack of livelihoods in circumstances beyond his control (UN 1948). The implementation of the right to health has been and continues to be a source of political struggle.

Globalisation

It contributes to health both positively and negatively, due to closer interaction of human activity across a range of spheres. Some are of the view that it has widened the gap in wealth, health and qualities of life

both between countries and within them. The deregulation of trade and the unregulated search for profit have brought increasing inequalities in health.

Values

Politicians respond very well to highly visible emergency situations - floods, SARS in other countries. But certain health problems that are chronic and those that occur in small pockets are not very visible. So there is a comparative ineffectiveness on the part of politicians and decision-makers in combating such situations like the problem of malnutrition, for instance. This is partly because it is a complicated issue, needing inter-sectoral action. Capital investment in new technologies and new facilities appeal to politicians and to voters even when these investments are least cost effective. Politics is about values as well as about policies. There had been two policy reviews and policy formulations in 1992 and 1997. Such actions to review previous policies were based on political decisions with a view to having a new trust and a change in the policy direction by a new government. What remains to be seen is how far are these policies implemented.

Way Forward

The way forward would be evidence-based policies and politics. Despite its evident political nature, politics of health has not been exposed to much discussion and debate. One should acknowledge the political nature of health and need to develop a dialogue with the politicians in promoting the Mission and the Vision of the Health Maser Plan. Political mapping has recently been developed as a way of analysing political dimensions of health policy and in planning actions to manage the political environment.

CHAPTER 4

FUTURE HEALTH NEEDS AND DEMANDS

4 FUTURE HEALTH NEEDS AND DEMANDS

4.1 INTRODUCTION ON HEALTH NEEDS

Health needs are an interplay between professionally recognised needs and felt needs of the people, mediated by what the supply of services is and what the perceived cost and effectiveness of the services are.

Professionally recognised needs are object in epidemiology. The volume and nature of effective demand are determined first by **demographic characteristics,** such as total population having access to the facility and its age structure.[1] In Sri Lanka, falling level of fertility and considerable net emigration particularly during the 1970s have accelerated the ageing of the population. The current elderly population of over 60 is projected to increase from 7% to 14% in two decades. With rapid ageing rate of the society, Sri Lanka is going to face a new set of challenges in providing quality and efficient health care services to its people.

Second is the prevailing epidemiology. Together demography and epidemiology create the pool of professionally recognised needs. Looking at the current situation of diseases, according to the morbidity statistics, Cardiovascular Diseases, Cancer, Mental Illness, Accidents, Suicide and Homicide are on the increase and will continue into the 21st century. Malaria, Tuberculosis, Filariasis, and Respiratory illnesses are still public health problems but their mortality rate is declining over years. HIV infections and AIDS, Hepatitis B, Japanese Encephalitis and Dengue Haemorrhagic Fever (DHF) are challenging situations. Elimination of poliomyelitis and eradication of neonatal tetanus will be achieved by the end of the next decade.

Third are the **felt needs** and the degree of **active health seeking behaviour** of the population. These are discussed in Chapter 2. In this chapter, the discussion is focused on the demographic perspective, the epidemiological perspective and the potential financial constraints.

[1] Access in most cultures is very uneven by distance (the more people are normally mobile for markets and work and the cheaper and more convenient the transport, the longer the critical distance); most people will not use easily facilities more than two hours from home. Financial accessibility to care plays a role in delayed care as well as denied care and it relates to total cost to patient such as lost wages, transport cost, any fees and purchases of supplies and drugs. That is one of the main reasons why poor people utilise less than people with more resources and why the diseases of poverty are underrepresented in the effective demand. These problems are discussed more fully in Chapter 2.

4.2 DEMOGRAPHIC PERSPECTIVES

(1) DEMOGRAPHIC TRENDS AND PROJECTIONS

The Three Projections

In general, the population projections (Table 4.2.1 and Figure 4.2.1) do not vary significantly because of the minimal variations in the total fertility foreseeable (it has reached already very low levels and the small variations in mortality rate). The most likely scenario is the one with moderate economic growth.

Table 4.2.1 Total Projected Population (000s)

Year	Economic growth		
	Slow	Moderate	Rapid
2000	18,811	18,811	18,811
2005	19,686	19,688	19,677
2010	20,492	20,488	20,458
2015	21,130	21,115	21,075
2020	21,597	21,578	21,475
2025	21,971	21,937	21,763

Source: Population Division, MoH

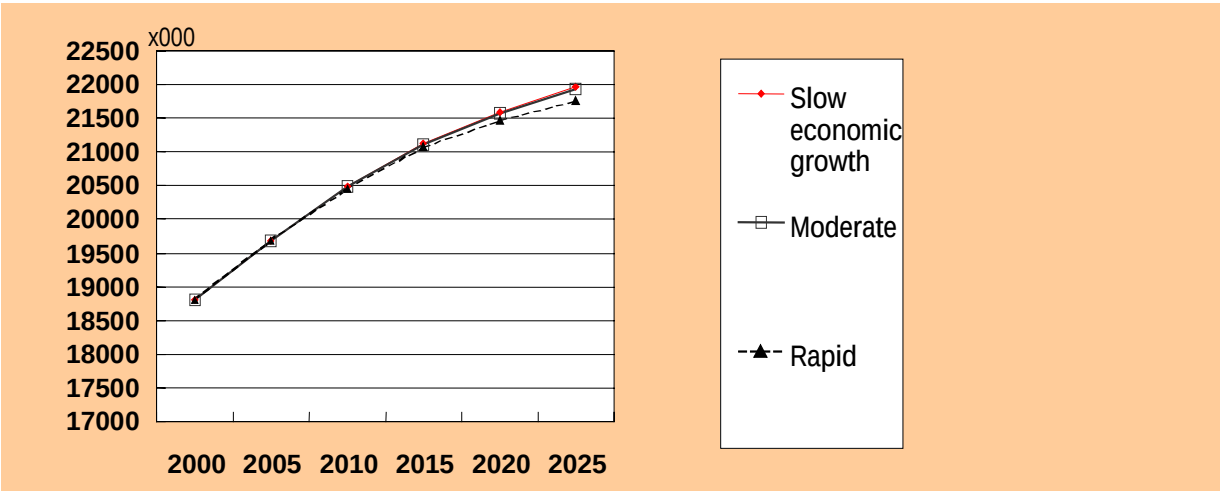


Figure 4.2.1 Projected Total Population

Source: Population Division, MoH

Growth Trend

Growth trend of total population from 1871-2025 follows an S-curve (Figure 4.2.2). The estimated population in 2000 is 18.8 million. It is projected to grow by 1.7 million by 2010 and another 1.1 million by 2020.

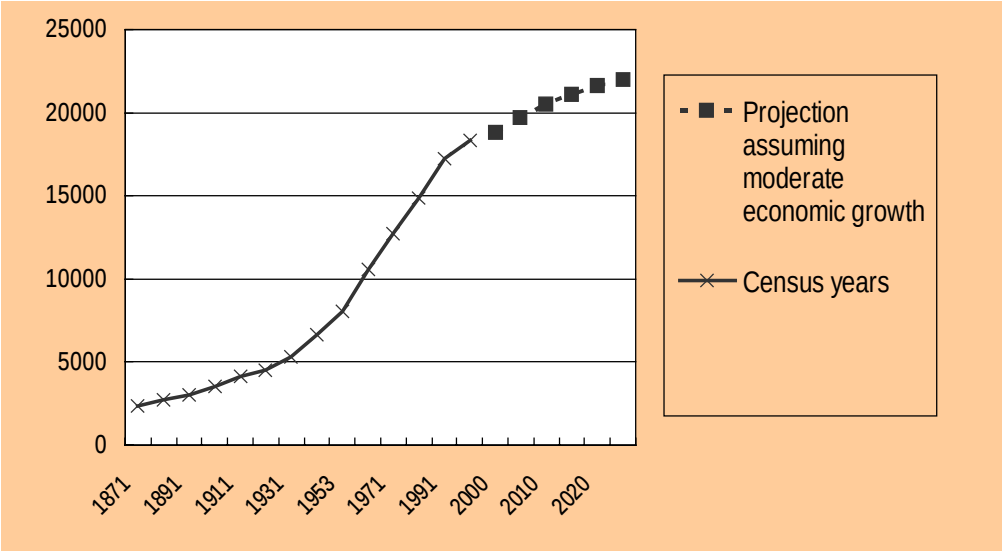


Figure 4.2.2 Total Population: Census & Projected

Sources: Statistical Abstract of the DSR SL 1999, Department of Census & Statistics, Ministry of Finance & Planning; Population Division, MoH

Ageing

The ageing of the population is exemplified by a shift in the median age from 29 years old in year 2000 to 35 in 2015. This is rapid compared to other countries. Doubling of the elderly population (aged 60 and over) from 7% will take 2 decades in Sri Lanka while it took about 12 decades in France and will take 8 decades in the United States (Figure 4.2.3).

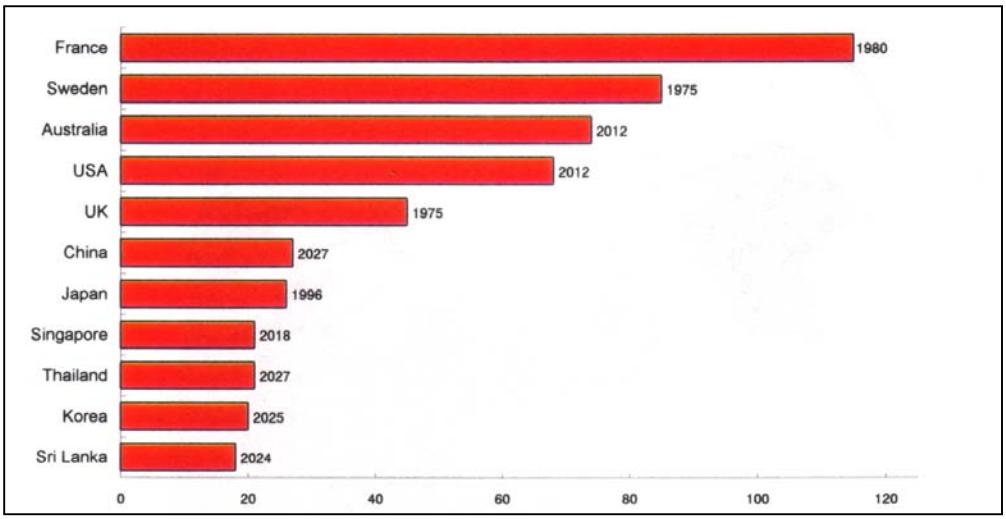


Figure 4.2.3 Ageing Rapidity

Source: Rannan-Eliya, et. al. Responses to Population Aging: A Review of International Experience, 1997, p. 11

Elderly

In 2000, 1 out of every 10 people in Sri Lanka is estimated to be elderly. This proportion will grow by one unit every five years such that it will be 1 of 9 in 2005, 1 of 8 in 2010, 1 of 7 in 2015, 1 of 6 in 2020, 1 of 5 in 2025.

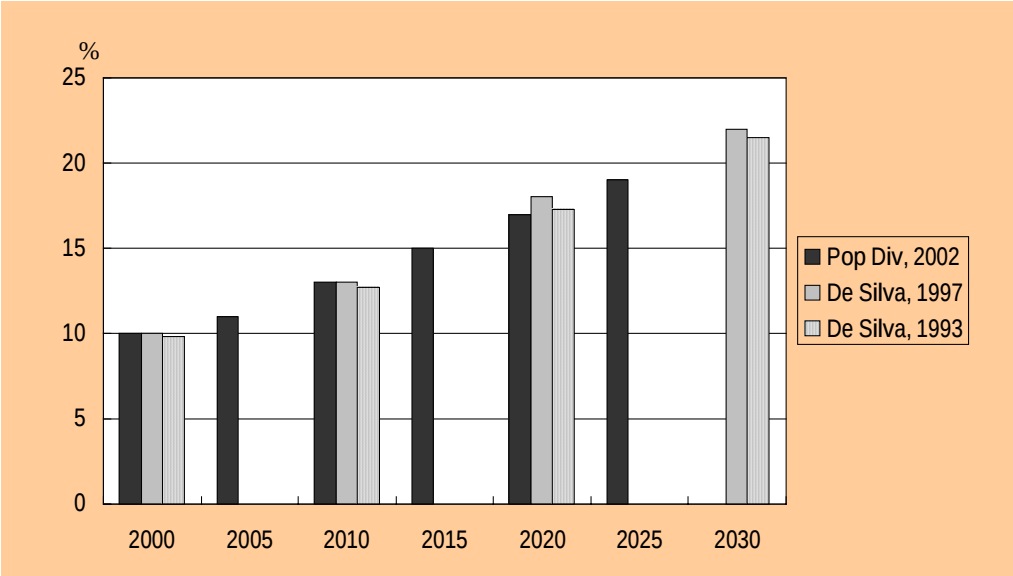


Figure 4.2.4 60 & Older: Projected Population

Source: Population Division, MoH

Moreover, Figure 4.2.5 shows that the fastest growing groups proportionately are the very oldest.

Children

The children under five years of age will decline by 1% every 10 years such that it will be 8% of the total population in 2000, 7% in 2010 and 6% in 2020. In terms of absolute number, 1.6 million children younger than five years old were estimated in 2000 (Figure 4.2.5). This number will be reduced by 100 thousand in 2010, by equivalent amounts in 2015 and 2020, when there will be only 1.3 million children younger than five years old.

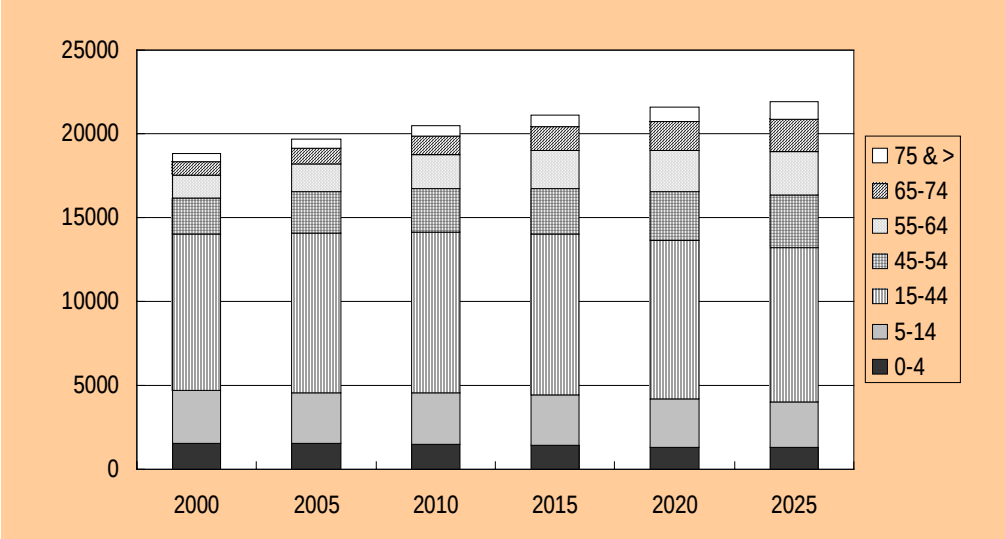


Figure 4.2.5 Population Age Structure in Absolute Values Assuming Moderate Growth

Source: Population Division, MoH

(2) PLANNING QUESTIONS

Health Services

Will the demographic scenario in the next 10 to 20 years have any bearing as far as the health service delivery and financing systems are concerned? Under-five care and maternity services will have to be delivered maintaining the present volume.

What curative, rehabilitative and palliative services for the growing number of elderly should be introduced in every type of health facility? How can we avoid chronic problems of an ageing population overwhelming the services? What preventive and promotive programs should be targeted for the younger population who will become elderly in the next decade or two? What are the preventive activities to be launched? What new programs should be initiated in the community to respond to the health and welfare needs of elderly?

Human Resources for Health

Does the existing workforce have the necessary skills to provide health and welfare services for the elderly? Is there a need to provide external technical assistance in assessing the needs of and developing programs for the silver community? Is there a need to revise the existing curriculum for doctors and in all the other health-related professional courses? Is the present cadre appropriate in its composition for the ageing society?

Medical Supplies and Equipment

Once the elderly are initiated to maintenance drugs to manage specific health conditions, then the therapy is for their lifetime more often than not. What measures should then be adopted to ensure that the prescribed essential medicines for the elderly will be available and, more importantly in the long run, affordable?

Some elderly require devices to maintain a certain level of quality of life. Others need special diagnostic and therapeutic equipment in the hospital and/or at home. How equipped are the health facilities to support the needs of a greying society? What should be done in the short, medium and long terms to ensure that the health system is not caught flat-footed?

Health Finance

If the existing system of financing, resource allocation and use are to continue in the next 10 to 20 years, will there be sufficient funds for the new services or programs, capacity-building activities, medical supplies and equipment for the elderly?

Health Facilities Network

What will be the systems delivering services for the elderly? What will be the linkage among the service providers in the private and public sectors, and in allopathic and indigenous systems?

4.3 EPIDEMIOLOGICAL PROJECTIONS

As the private sector grows and as more people avail themselves of services from this sector, data from the Medical Statistics Unit become more incomplete and the picture of the epidemiological time trends becomes hard to understand. For this reason, the MoH-JICA Study Team commissioned in 2002 a household survey on Knowledge, Attitudes and Practices (KAP) of urban, rural and estate residents on ill health. Although the respondents were asked to recall the events one month prior to the interview, the KAP 2002 Survey provides a possible scenario of the illnesses common at the community level and types of conditions that are brought to health facilities. Another study, entitled "Cost Analysis of Patients Management in Out Patient Department, 1996", reflects the types of diseases that are often handled in government OPD. From these two special studies, one may infer the burden of diseases on outpatient services.

There were three sources of mortality data: the Medical Statistics Unit that publishes the Annual Health Bulletin, the Registrar General Office and the Cancer Registry of the National Centre for Cancer Control. The first source reports mainly the deaths in government IPD while the second source has a broader base, which includes deaths that occur in private health facilities and in the communities.

(1) EPIDEMIOLOGICAL TRENDS AND PROJECTIONS

Diseases and Consultations

One month prior to the KAP 2002 Survey, over 17% of the people reportedly fell ill. Almost 90% of the complaints could be attributed to only 12 conditions ranked in descending order (Table 4.3.1): 1) Acute Respiratory Tract Infection; 2) Hypertension; 3) Arthritis; 4) Asthma; 5) Diabetes; 6) Heart Failure; 7) Accidents; 8) Mental Illness; 9) Stroke; 10) Cancer; 11) Cataract; and 12) Food Poisoning. Among all of these, only the first is absolutely communicable and the last could be communicable in origin. All the others are non-communicable in nature.

Even if there is no one-to-one correspondence between the ranking of diseases that afflict urban and rural residents, it seems that the difference is not very significant. The ranking of diseases for estate residents though looks quite different. While diabetes is among the top five in urban and rural areas, it is one of the bottom for dwellers in the estates. Mental illness is the least concern in the estates but it is not for the others. As this relies on self-reported illness biases come from people's health seeking behaviour, their ability to understand the exact nature of their disease and the diagnostic skills and communication by the practitioners visited.

Even so, the differences observed could probably also be partly attributed to disparities in lifestyle and life conditions.

Table 4.3.1 Leading Diseases by Sector

Disease	Percentage of Patients											
	Urban n =2,500			Rural n =7,980			Estate n =1,564			Total=11,644		
	%	Rank	Prevalence Rate	%	Rank	Prevalence Rate	%	Rank	Prevalence Rate	%	Rank	Prevalence Rate
*Acute Respiratory tract infection	24.50	1	3.64	27.6	1	3.93	10.60	5	1.55	25.10	1	3.62
Hypertension	15.60	3	2.36	12.5	3	1.78	15.90	2	2.32	13.6	2	1.96
Arthritis	5.80	5	0.88	12.7	2	1.80	8.80	4	1.29	10.80	3	1.55
Asthma	8.50	4	1.28	8.6	4	1.22	18.20	1	2.66	9.50	4	1.37
Diabetes	17.20	2	2.60	6.5	5	0.93	1.20	11	0.17	8.40	5	1.21
Heart Failure	5.60	6	0.84	6.1	6	0.86	11.80	3	1.72	6.50	6	0.94
Accidents	4.00	7	0.60	4.9	7	0.69	5.30	6	0.77	4.70	7	0.68
Mental Illness	2.10	8	0.32	3.8	8	0.54	1.80	12	0.26	3.20	8	0.46
Stroke	1.60	10	0.24	2.4	9	0.34	2.90	9	0.43	2.30	9	0.33
Cancer	1.90	9	0.28	2.1	10	0.30	2.40	10	0.34	2.10	10	0.30
Cataracts	0.50	11	0.08	1.8	11	0.25	4.70	7	0.69	1.80	11	0.26
Food Poisoning	0.50	12	0.08	1.7	12	0.24	3.50	8	0.52	1.60	12	0.23
Total 1-12	87.8%		13.2	90.7%		12.88	87.1%		12.72	89.6%		12.91

Note: *ARTI = Self-reported Influenza or Viral Fever

Source: MoH-JICA Study Team KAP Survey, 2002

Causes of Admissions to Government Health Facilities

The seventeen[2] common causes of admissions to government hospitals from 1975-2000, in descending order, are as follows (Figures 4.3.1 and 4.3.2): Asthma, Abortions, Intestinal Infectious Diseases, Hypertensive Diseases, Diseases of the Liver, Ischaemic Heart Diseases, Malaria, Diabetes Mellitus, Anaemia, Measles, Tuberculosis, Viral Hepatitis, Nutritional Deficiencies, Septicaemia, Helminthiasis, Whooping Cough, and Rabies. Among the communicable diseases, only Measles and Septicaemia exhibit an upward trend. On the contrary, for most of the non-communicable diseases the number of admissions is increasing, with the exception of Abortions, Anaemia and Nutritional Deficiencies.

[2] Data reported on the Annual Health Bulletin did not include those for Traumatic Injuries or Accidents, Neoplasm and Poisoning.

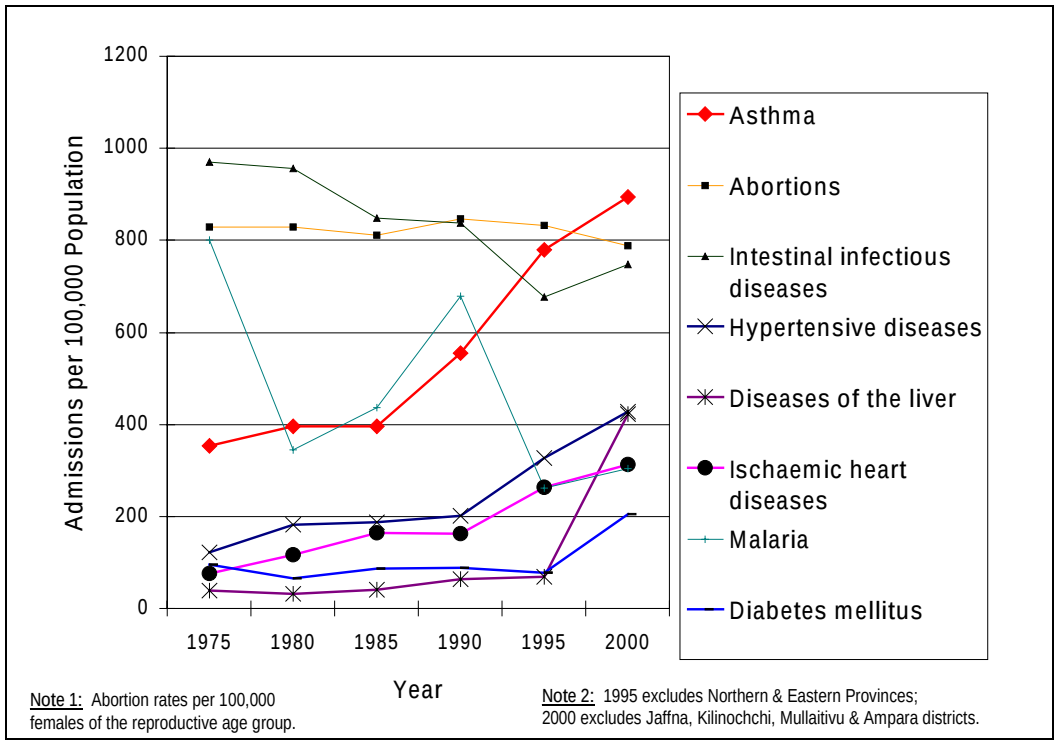


Figure 4.3.1 Causes of Admissions to Government Health Facilities (cont'd)

Source: Annual Health Bulletin 2000

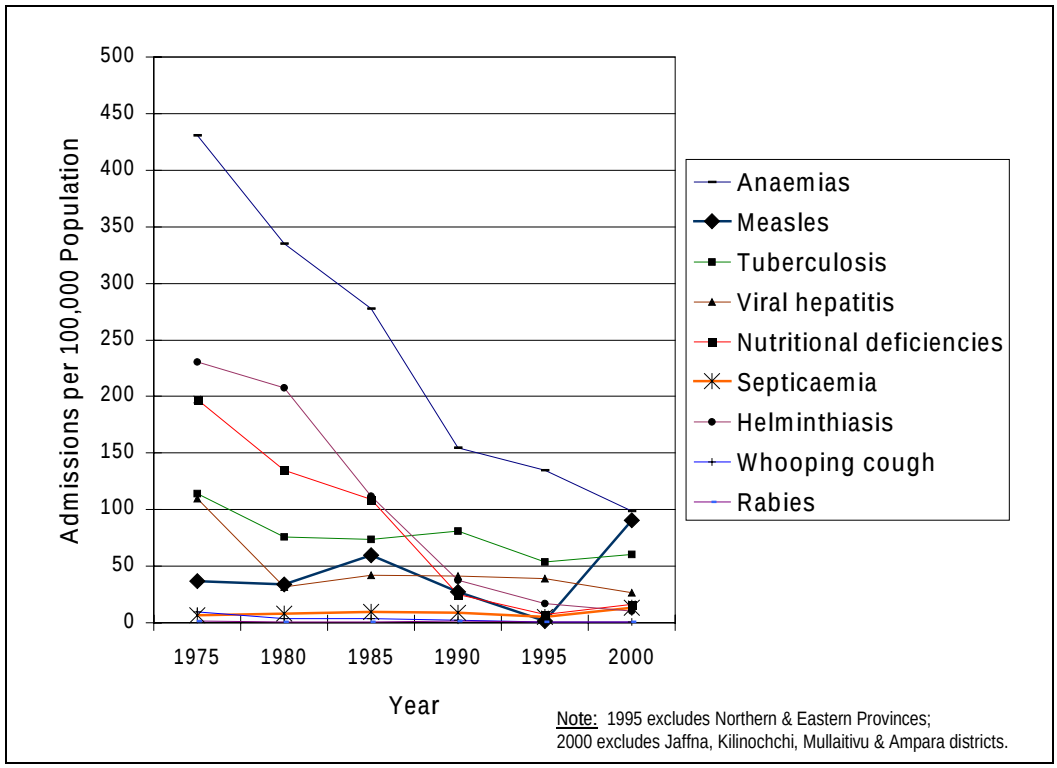


Figure 4.3.2 Causes of Admissions to Government Health Facilities

Source: Annual Health Bulletin 2000

While the admission rate for the selected communicable diseases combined is 1,300 per hundred thousand people, which for all selected non-communicable diseases is about 3,200 in year 2000. Putting it differently, for every person admitted for communicable diseases, there are three times more for non-communicable diseases. If the data for Traumatic Injuries, Neoplasm and Poisoning are included in the analysis, then the burden of non-communicable diseases on the health sector is clearly even heavier. If the upward trends of most non-communicable diseases were factored in, then hospital admissions would be more skewed. Assuming the current trends and socio-economic conditions will continue, then the admission rates by 2010 (Figure 4.3.3) will double at least for Hypertensive Diseases and Ischaemic Heart Diseases. It will increase by 1.5 times for traumatic injuries and poisoning. By 2020, the burden of some diseases will double; others will triple; cases of diabetes mellitus, whereas that of neoplasm will quadruple.

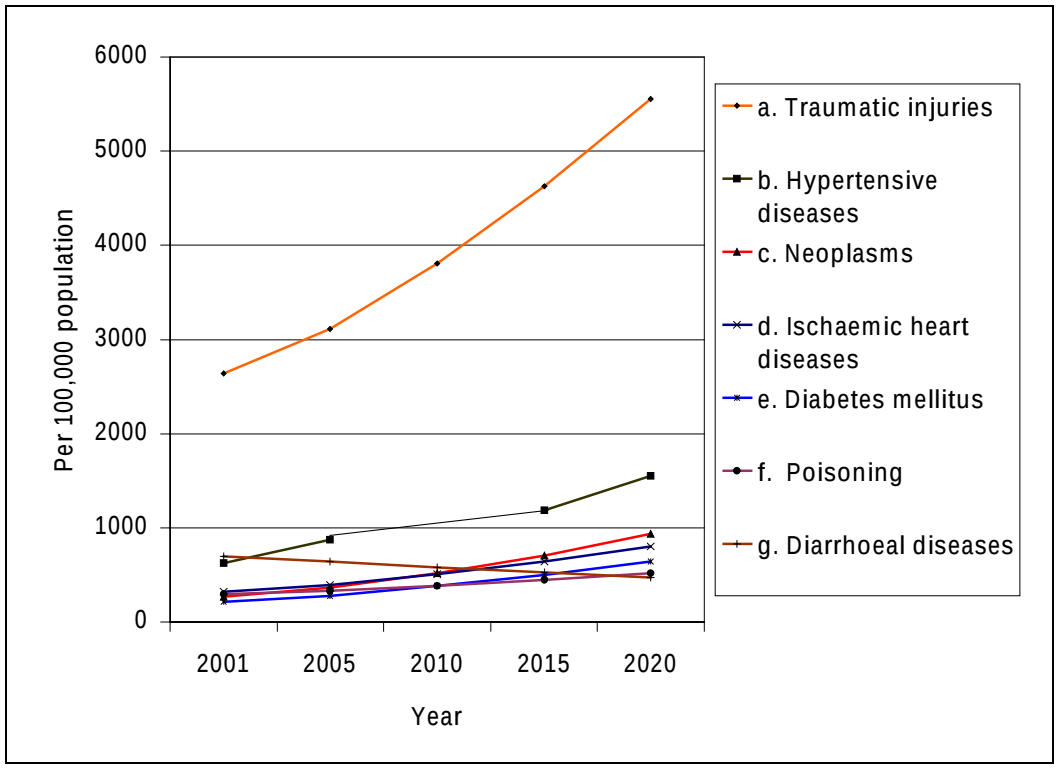


Figure 4.3.3 Projected Admissions to Government Health Facilities in Sri Lanka 2001-2020

Note: The Quadratic Trend Model was employed for projecting admission rates for Traumatic Injuries, Hypertensive Diseases, Neoplasms, and Ischaemic Heart Diseases whereas it was the Growth Curve Model that best fit the trends for Poisoning and Diarrhoeal Diseases.

Source: Historical data from Medical Statistics Unit and projections by MoH-JICA Study Team

Trends of Each Disease

1) Diabetes Mellitus

Increasing trends of Diabetes Mellitus (DM) are generally seen in all provinces. Interestingly, in Western Province (WP), the number of diabetes cases reaches 4.3/1000 in 2020, whereas for North-Central Province (NCP) and Sabaragamuwa Province this is more than 8.0/1000 in 2020. This indicates that diabetes is no longer a health problem only in urban dominant areas, but also in the rural areas. This needs special attention by the health planners.

If there will be some effective measures taken up immediately, this caseload could be reduced to 3.4/1000 in 2010 and 5.3/1000 in 2020. Similarly, in the absence of any strategic intervention, this may increase to 7.5/1000 in 2020.

2) Hypertensive Diseases

Similar to Diabetes, Hypertensive Diseases continue similar projection pattern in both national and province levels. By 2010 and 2020, respectively 11.8/1000 and 15.2/1000 cases will be expected in the country. In worst scenario this will be 9.4/1000 and 18.2/1000 in 2010 and 2020, and in favourable scenario only 8.1/1000 in 2010 and 12.7/1000 in 2020. Hypertensive Diseases will be an increasing health issue in all parts of the country, particularly in NCP (16.9/1000 in 2010 and 31.3/1000 in 2020) and Sabaragamuwa province (12.8/1000 in 2010 ad 24.9/1000 in 2020). This is expected, as both Diabetes and Hypertensive Diseases are closely related each other.

3) Ischaemic Heart Diseases

An upward trend in incidence of Ischaemic Heart Diseases (IHD) is seen in most provinces for the projected years. It will increase from 3.9/1000 in 2010 to nearly 8.0/1000 in 2020 in the country. In worst scenario, this increase is nearly three-fold. Again, IHD will be increasing in lesser rates in WP (3.6/1000 in 2001 to 5.1/1000 and 6.6/1000 by 2010 and 2020) compared with Southern Province (SP), North-western Province (NWP) and Sabaragamuwa. It shows that in these provinces, an increase of three-fold or more is seen for the given review period from 2001 to 2020.

4) Neoplasms

Neoplasm will increase nearly three-fold in the country from 2001 to 2020. An effective strategic intervention may lead to decrease these numbers by 2020 to 7.8/1000, whereas it is expected at 9.4/1000 if the present trend is continued. The WP will have the highest rate of 5.6/1000 in 2001 to 13.6/1000 in 2010 and subsequently 27.2/1000 in 2020. However, this result must be interpreted very cautiously. The main referral hospital for Neoplasm is located in WP (Colombo) and these results are reflected in this referral pattern (bias).

5) Traumatic Injuries

There will be a two-fold increase of traumatic injuries in the country from 26.3/1000 in 2001 to 55.6/1000 in 2020. This is very likely, as there are increasing numbers of road traffic accidents in the country. Also, this will be a result of changing socio-economic structures in the country. This will even worsen to 40.6/1000 in 2010 and 63.9/1000 in 2020 in absence of effective program activities in future. As there are many missing and incomplete data in all the provinces, a projection by provinces is not possible.

6) Poisoning and Toxic effects

Similar to the traumatic injuries, poisoning and toxic effects are increasing in the country. The projected rates for 2010 and 2020 are 3.8/1000 and 5.2/1000 respectively. As this is necessarily modifiable health issue, there is an urgent intervention to control this situation, where thousands of lives might be lost with unnecessary cost to the country. In favourable conditions, this will decrease to 3.5/1000 in 2010 and 4.1/1000 in 2020. However, in absence of active programme to control this situation, it might be increased to 4.2/1000 in 2010 and 6.2/1000 in 2020.

7) Malaria

The past trend for Malaria made it difficult to fit a time series model. However, it looks likely to increase in future.

8) Tuberculosis

Similar to Malaria, the limited data made it difficult to make any projections.

9) Diarrhoeal Diseases

Diarrhoeal diseases will be decreased in the country in the next two decades. It will drop from 699.4/1000 in 2001 to 581.3/1000 in 2010 and finally to 473.4/1000 by 2020. With the improvement of socio-economic factor, particularly sanitary conditions and with high literacy, this will be a more realistic projection. In such a situation, this will drop to 523/1000 in 2010 to 378.8/1000 in 2020.

10) Diseases of the Respiratory System

Though several attempts were made to fit a time series model into the respiratory diseases data, it was not successful, as the past trend of 20 years (observations) is largely inadequate to assume a reasonable rend. This limitation is discussed elsewhere in this report.

(2) MORTALITY

Mortality Trends

Analysis of the number of people reported to have died in 1980 and 1996 (Figure 4.3.4) indicates an upswing on the death rates per hundred thousand people towards the latter year. This is mainly due to increased numbers of homicide cases, which is nine times more in 1996 than in 1980.

Through the years, cardiovascular diseases have remained as the number one cause of death among the population in Sri Lanka. With a nine-fold increase in rate, homicide and other violence ranked second in 1996. Infectious and other parasitic diseases dropped to third place when its rate of 85 per hundred thousand in 1980 was reduced by more than half to 36. Many of the other causes of deaths are non-communicable diseases.

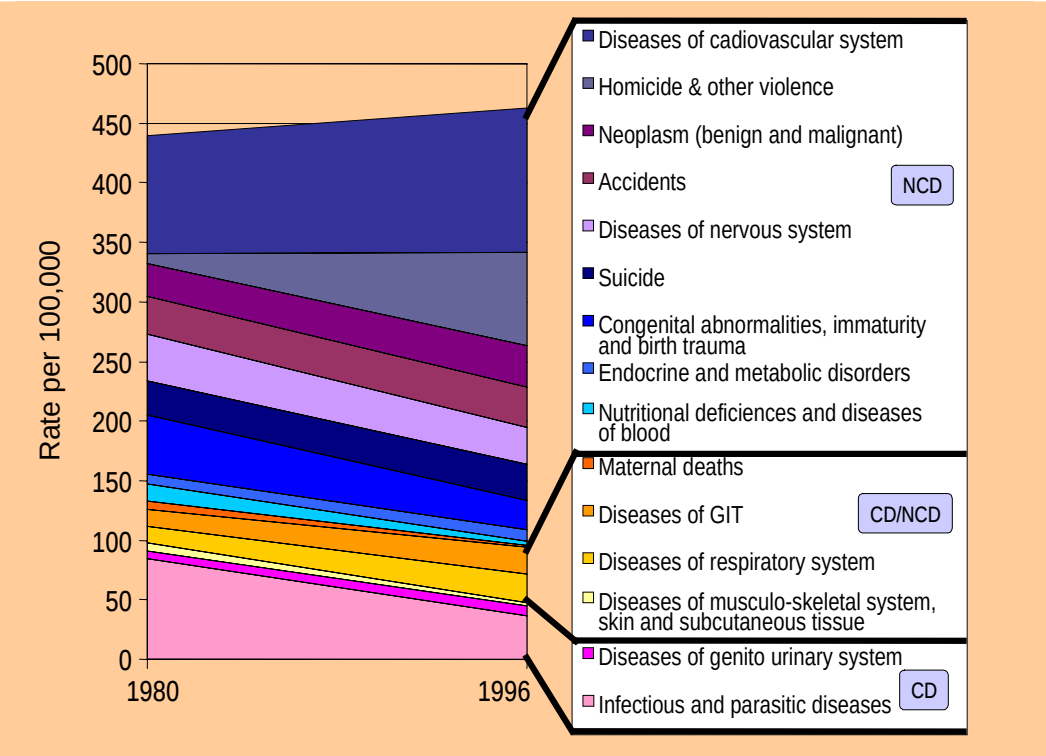


Figure 4.3.4 Causes of Mortalities by Diseases Grouped According to Communicable Diseases (CD) or Non-communicable Diseases (NCD), 1980 and 1996

Source: Registrar General Office

While the Registrar General Office reports possibly reflect the overall situation in the country, the burden of mortality on the health system could be reflected more by reports on deaths in government hospitals. According to the Medical Statistics Unit, the top 17 causes of hospital deaths in descending order are (Figures 4.3.5 and 4.3.6): Ischaemic Heart Diseases; Diseases of the Liver; Septicaemia; Asthma; Diabetes Mellitus; Hypertensive Diseases; Tuberculosis; Intestinal Infectious Diseases; Anaemia; Malaria; Rabies; Abortions; Viral Hepatitis; Nutritional Deficiencies; Helminthiasis; Whooping Cough; and Measles. Increasing trends are shown by the top five causes and Rabies; thereby implying that these conditions will more likely continue to demand more from the health sector assuming no major intervention is undertaken. The other causes of hospital deaths are on the decline.

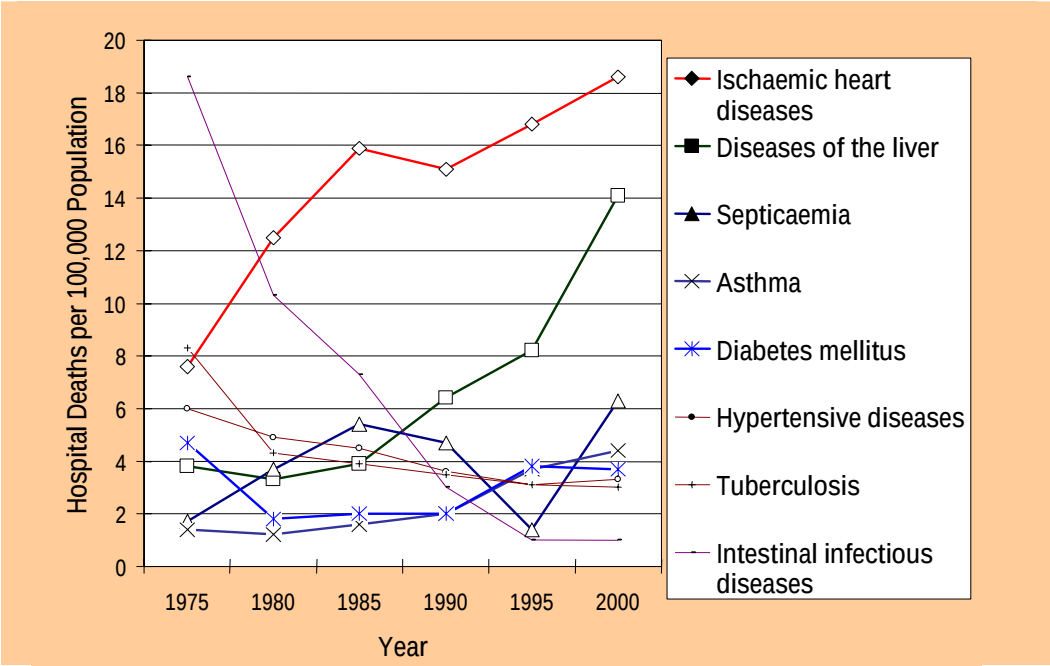


Figure 4.3.5 Causes of Deaths to Government Health Facilities (cont'd)

Source: Annual Health Bulletin 2000

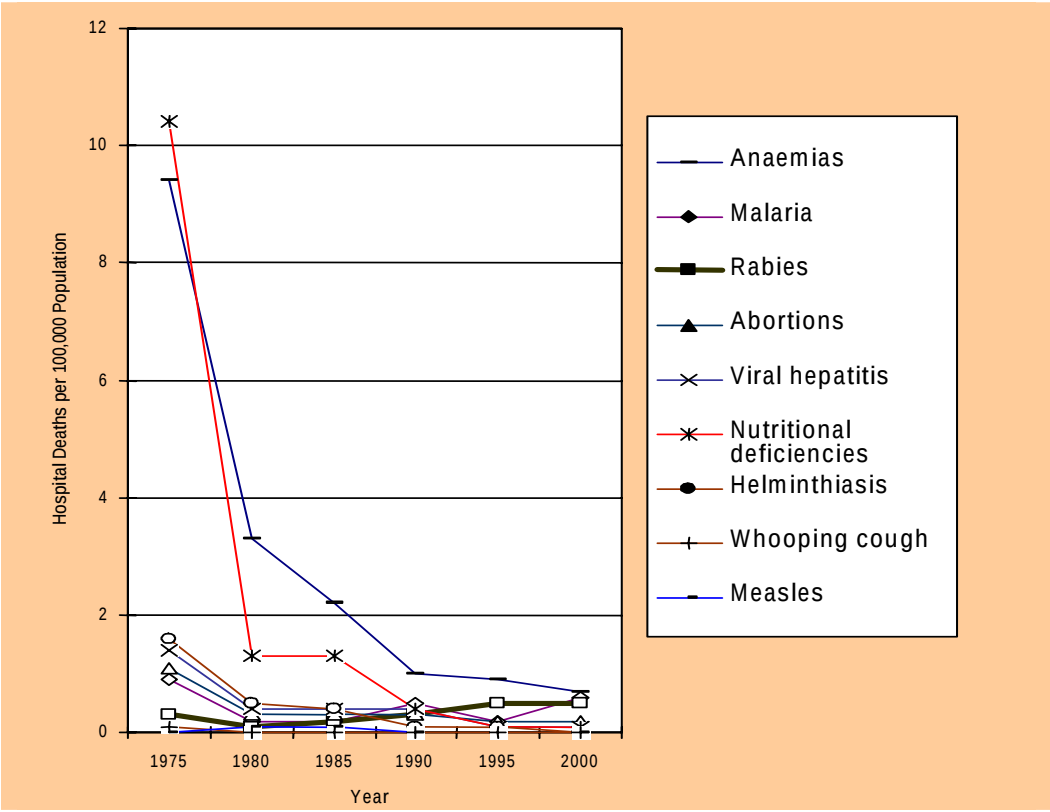


Figure 4.3.6 Causes of Deaths to Government Health Facilities

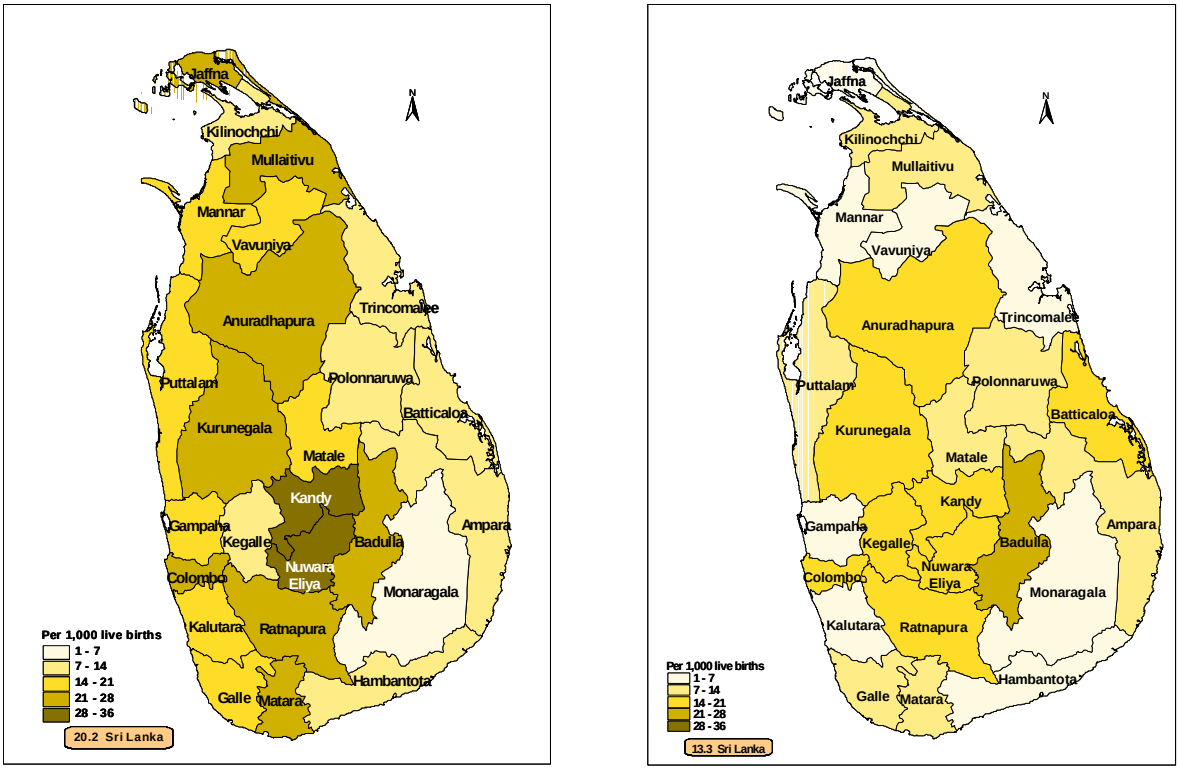
Note: - Abortion rates per 100,000 females of the reproductive age group.
- 1995 excludes Northern & Eastern Provinces
- 2000 excludes Jaffna, Kilinochchi, Mullaitivu & Ampara districts

Source: Annual Health Bulletin 2000

Geographical Variation of Infant Mortality and Maternal Mortality

The geographical variation on the burden of disease is demonstrated by Infant Mortality Rate (Figure 4.3.7), or IMR, and Maternal Mortality Rate (Figure 4.3.8), or MMR, reported by the Annual Health Bulletin, MoH and statistical Abstract, Dept. of Census and Statistics. Suffice it to say at this stage that, there seems to be significant decline in the IMR in every district over 10 years, except for some northern districts. However, there are differences that necessitate further analyses. Those districts that have higher IMR are Anuradhapura, Kurunegala, Kandy, Kegalle Nuwaraeliya, Ratnapura, Colombo, Galle, Badulla and Batticaloa. For more than 10 years, maternal mortality rate also shows improvement but the north and east districts have shown slight increase of MMR.

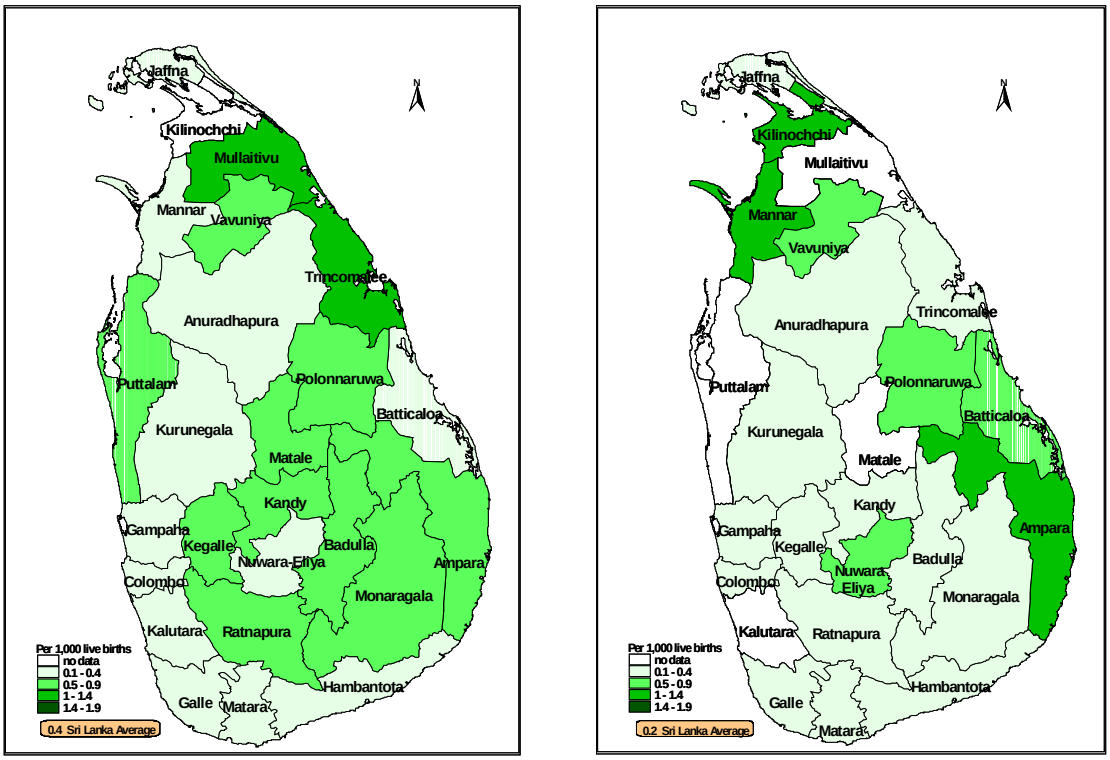
Epidemiological patterns of specific diseases will be correlated with geographical boundaries. Explanations for these patterns will also be investigated. A cursory review of the mortality rates below indicates relatively better conditions in most districts in the eastern districts in terms of infant mortality but not in terms of maternal death. According to the figure, Monaragala has better indicators, which is something contrary to expectations and may indicate underreporting or overestimation of the denominator or both.



IMR 1988 IMR 1997

Figure 4.3.7 Infant Mortality Rates by District -1988 and 1997

Source: Statistical Abstract 2001, Dept. of Census and Statistics, Annual Health Bulletin. 2000, MoH.



MMR 1984 MMR 1996

Figure 4.3.8 Maternal Mortality Rate by Province 1996

Source: Statistical Abstract 2001, Dept. of Census and Statistics, Annual Health Bulletin. 2000, MoH

Mortality Rates by Different Age Groups

Emerging conditions and diseases such as homicides, accidents and suicides are increasing in the last 20 years. In spite of a relative decline of mortality by accidents and suicides in young age, statistics show an increase in middle and old age as shown in Figure 4.3.9. A striking phenomenon is the surge of homicides in the young-age group in recent years.

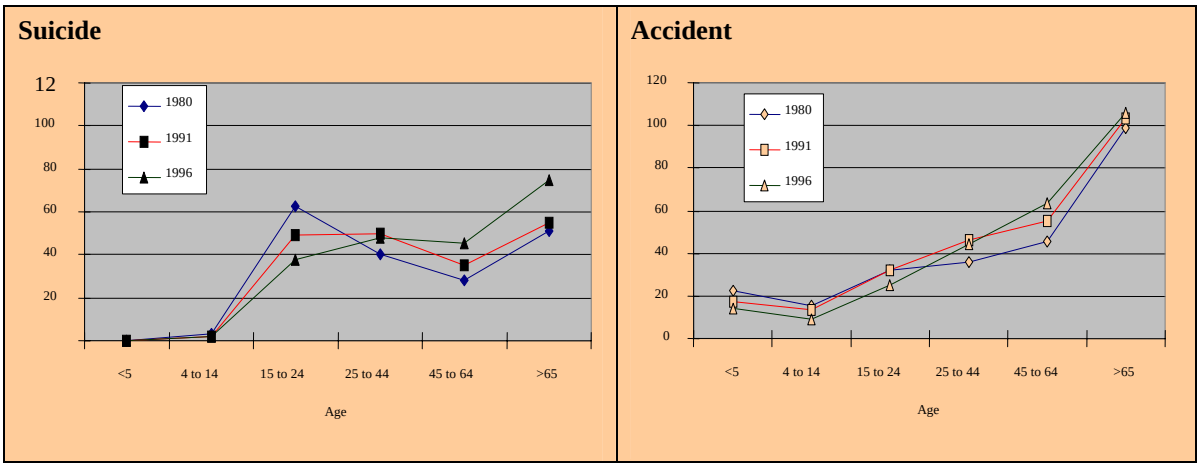


Figure 4.3.9 Trend in Rates of Suicides and Accidents by Age Group

Source: Sri Lankan Govt. Register General, Vital Statistics 1980-1995

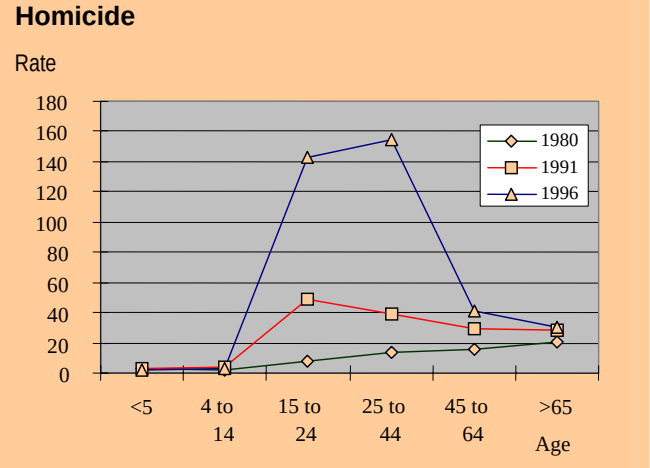


Figure 4.3.10 Trends in Rates of Homicides by Age Group
Source: Sri Lankan Govt. Register General, Vital Statistics 1980-1995

(3) IMPLICATIONS ON PLANNING

Although the overall health status of the people in Sri Lanka has considerably improved to a level better than many countries with similar economic condition, there are signs and symptoms that warn local planners and policy-makers against complacency.

Non-Communicable Diseases Control

The increasing trends in rates of hospital admission and deaths primarily due to non-communicable diseases might easily overrun the gains during the past decades. Considering that these conditions often require long-term medications and other therapies, doing nothing or adopting a business-as-usual attitude is not a planning option. If primary prevention were to be implemented, it might show a slowing down of the increase. However, most likely, even with successful primary prevention a real decrease is at least 15-20 years away. This means secondary and tertiary prevention need to be intensified soon to limit the damage done by non-communicable diseases and the quality of curative care needs would have to be strengthened to assure early detection in situations where secondary prevention has potentially the greatest impact.

Strengthening Surveillance System

Many communicable diseases that used to burden the health system have been controlled so that they do not serve as public health hazards anymore. As causes of admissions and deaths, many have been on the decline. If the trends of measles and septicaemia are to serve as examples, then any communicable disease may re-emerge at any time unless they are well understood by the population and workers or fully eradicated which is not possible for many, or they are well controlled which is possible for a few, or their outbreak consistently monitored. Herein lies the importance of keeping vigilant. Herein lies the critical role of maintaining a functional information and surveillance system with an expanded coverage that includes the public and private sectors as well as inpatient and outpatient activities.

Improvement of Hospital Services

If the rates of hospital deaths vis-à-vis admissions reflect even partly the quality of services the government health sector provides, then improvement in the management and delivery of hospital services need to be addressed in the Health Master Plan. The hospital admission and death rates seem to run similar trends (Figure 4.3.11), though not exactly, for some communicable diseases (e.g. Septicaemia, Tuberculosis and Malaria) and for some non-communicable ones (e.g. Asthma and Diseases of the Liver). Among the diseases analysed, there is at least one exception when an increase in

hospital admission rate was accompanied by a decrease in its hospital death rate. This was the case for measles (Figure 4.3.12). Improvement of health services, therefore, may include:

1) Consolidating promotive, preventive and curative actions towards managing the causes of child and maternal morbidities and mortalities;
2) Promoting healthy lifestyles among adolescents, young adults and families of patients with non-communicable diseases;
3) Attaining more equity of health outcomes among provinces and districts;
4) Investigating the increase in Septicaemia as to whether it is due to antibiotic resistance or so far belatedly recognised Meliodosis, Streptococcus and Staphylococcus and/or its link with Diabetes and Alcohol, HIV and Malnutrition as well as taking immediate interventions;
5) Providing emergency services, in and outside of health facilities, and ICU service;
6) Fighting the major factors that contribute to the climbing death rates related to homicides, accidents and suicides (Note: the factors include alcohol, drugs, sleep deprivation on the part of drivers, ignorance or carelessness with poisons, problems related to road design/condition and observance of traffic regulations, and absence of criminal charges for driving under the influence of drugs/alcohol).

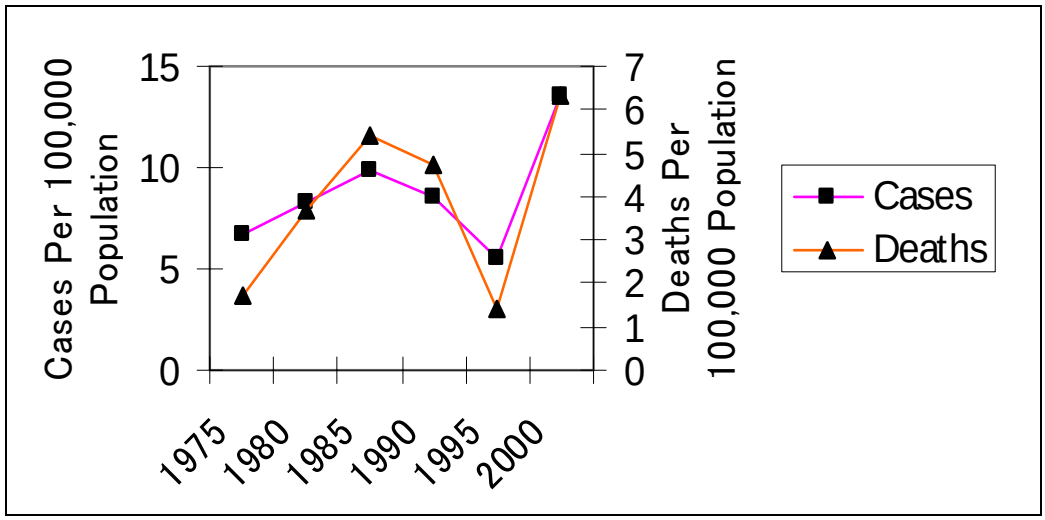


Figure 4.3.11 Septicaemia

Source: JICA Study Team

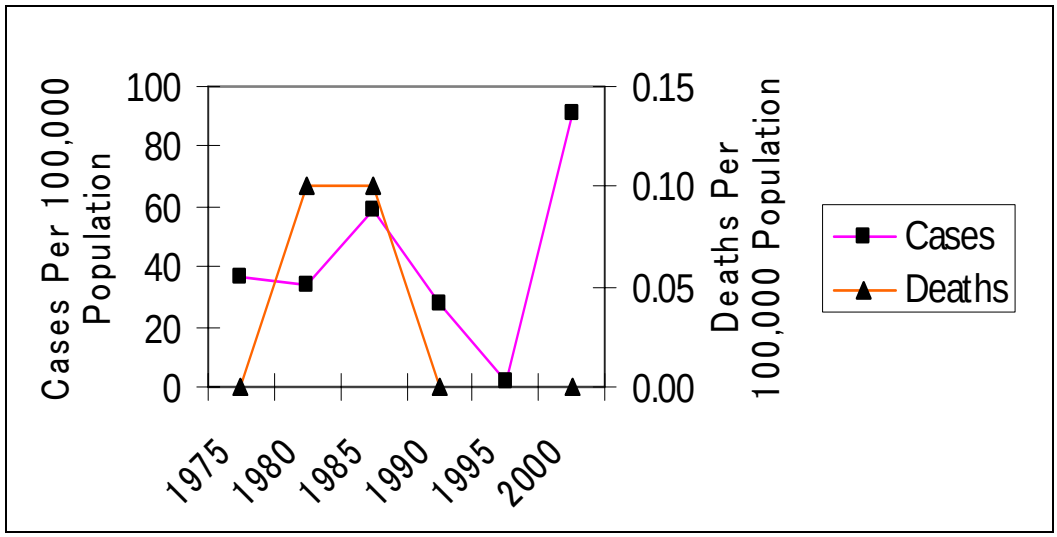


Figure 4.3.12 Measles
Source: JICA Study Team

Improvement of Health Information System

The analysis of epidemiological trends demonstrated the need for improving the health information system to provide policy-makers, planners, managers, and service providers with useful information. Whatever the reasons were in the past, excluding information on consultations must be reconsidered in health services. Moreover, the MoH should look at other sources of information especially the Registrar general data and special studies such as DHS as part of their patrimony and assure there is proper collaboration for timely analysis and dissemination of data.

Using a New Measure of Burden of Diseases

Finally, the traditional health indicators of morbidity and mortality remain important within the context Sri Lanka. However, there seems to be a need to use other measures of burden of disease particularly once a country has achieved a high state of health such that appreciable amelioration in traditional indicators would take a considerable amount of resources, including time, or would be more dependent on actions taken by non-health sectors. One wanting to include disability as an indicator unfortunately would face difficulty, mainly because the existing information system has not yet been designed to capture such burden, or at least age-specific morbidity and mortality for leading non-communicable diseases and some important communicable diseases.

Figure 4.3.13 shows major burden of disease in developing countries with low child and low adult mortality.

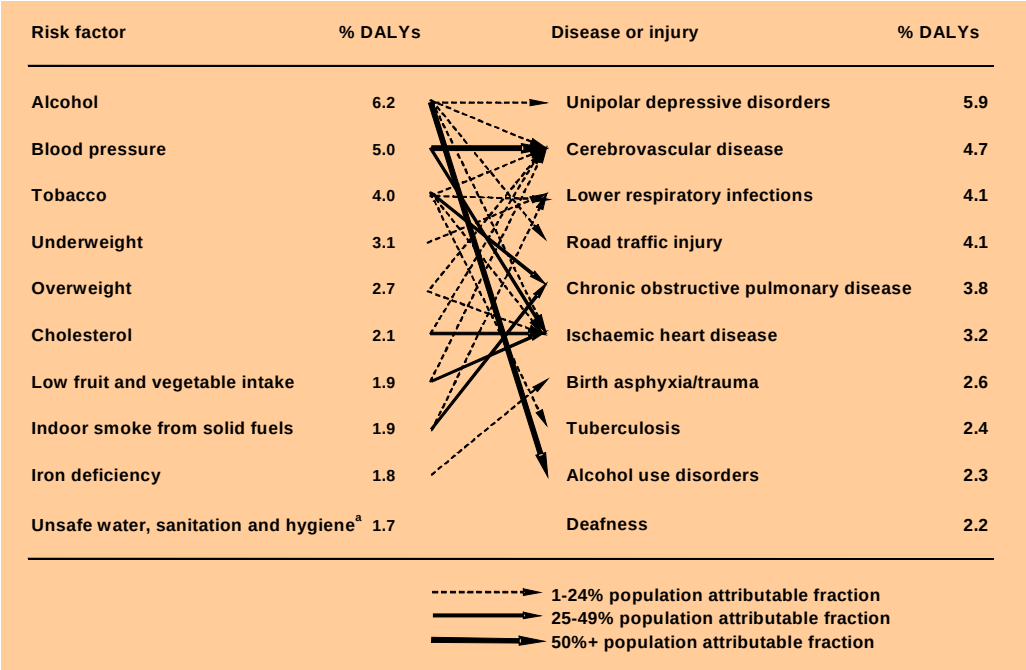


Figure 4.3.13 Major Burden of Disease for Developing Countries with Low Child and Low Adult Mortality (AMR-B, EMR-B, SEAR-B, WPR-B)

Note: DALY is disability adjusted life years and can be thought of as one lost year of healthy life and the burden of disease as a measurement of the gap between current situation and the ideal where everyone lives to old age in full health

a)Unsafe water, sanitation, and hygiene disease burden is from diarrhoeal diseases. The selected risk factors cause diseases in addition to those relationships illustrated, and additional risk factors are also important in the aetiology of the diseases illustrated.

Source: World Health Report 2002

Alcohol, hypertension, tobacco, overweight and cholesterol are the highest risks, which create the major burden of diseases. According to a WHO study on ageing, there is a critical window for the exposure of risk factors in the early stage of life to cause degenerative diseases at later age, proven by recent epidemiological data of life-course approach. So the appropriate preventive intervention in different age groups has to be designed to fit to these evolving diseases.

4.4 SERVICE PROVISION TRANSITION

(1) MAJOR FEATURES OF HEALTH TRANSITION IN SRI LANKA

7) The population is ageing rapidly such that the proportion of elderly will shift from one out of every 10 people in 2000 to one of eight in 2010 and one of five in 2025.

8) The number of children under five years of age (estimated in 2000 to be one and six million) will be reduced slightly by one hundred thousand in 2010, by another equivalent amounts in 2015 and 2020, when there will only be 1.3 million.

9) The burden of infectious and parasitic diseases on people's health has declined by nine percentage points of the total causes of deaths reported to/by the Registrar General Office from 14% in 1980 to 5% in 1996 (the latest available data) and the death rate per 100,000 population has reduced considerably from 85 to 36.

10) Non-communicable diseases continue to predominate as causes of deaths reported to/by the Registrar General Office. Cardiovascular diseases are consistently number one[3] overall from 1980 (16%) to 1996 (18%). Homicide as well as other violence is the number two in 1996. They show an alarming jump from 1% in 1980 to 12% in 1996 or from a rate of 8 to 78 per hundred thousand people. Neoplasm, Accidents, Diseases of the Nervous System, and Suicides are each responsible for 5% of the causes of deaths.

11) The mix of communicable and non-communicable diseases is verified when one looks at the top 10 causes of hospital admissions in 2000 and in descending order they are Asthma, Abortions, Intestinal Infectious Diseases, Hypertensive Diseases, Diseases of the Liver, Ischaemic Heart Diseases, Malaria, Diabetes Mellitus, Anaemia, and Measles.

12) The mounting burden of non-communicable conditions on people's health is supported further by the fact that among the top 17 causes of hospital deaths in 2000, many of the conditions that have demonstrated declining trends are communicable in nature whereas those that have shown increasing trends are non-communicable. Since 1975, those that are waning in importance are Abortions, Intestinal Infectious Diseases, Malaria, Anaemia, Tuberculosis, Viral Hepatitis, Nutritional Deficiencies, Helminthiasis, Whooping Cough, and Rabies. Those that are escalating are Hypertensive Diseases, Diseases of the Liver, Ischaemic Heart Diseases, Diabetes Mellitus, Measles, and Septicaemia.

[3] Disregarding ill-defined causes

(2) CHANGES IN SERVICE PROVISION

Considering the changing demographic and epidemiological conditions, the need for reforming the delivery of health services becomes apparent. Several considerations are proposed.

Prioritise diseases and carry out strategic interventions

1) Non-Communicable Diseases and Strategic Interventions

Many non-communicable diseases because of shared causation and metabolic pathways also should be detected in early stages in an integrated way and should have shared secondary prevention.

a. Life-Course Approach to NCD Prevention

This understanding of the nature of the non-communicable disease problem follow **a life-course approach to NCD prevention;** as Figure 4.4.1 demonstrates it should cover the risks at all ages. For the child and infant risks it's necessary to do so in collaboration with MCH and Nutrition programs**.**

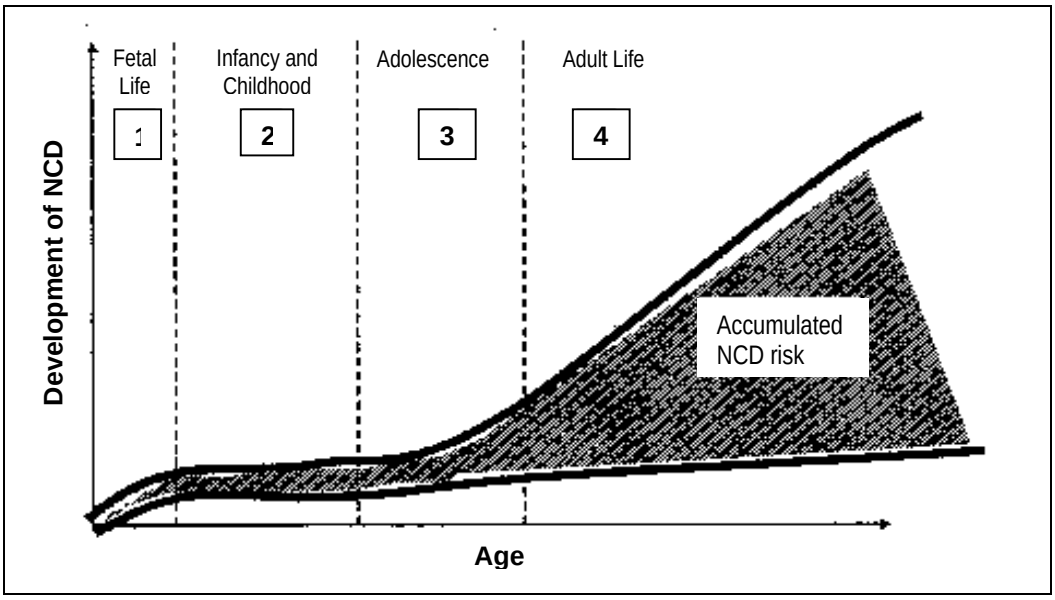


Figure 4.4.1 A Life-Course Approach to NCD Prevention

b. NCD interventions

During **foetal life** the maternal nutritional status, the foetal growth and the socio-economic status at birth are major risk factors. The antenatal care programs will try to deal with the maternal nutritional status during **infancy and childhood** non-exclusive breastfeeding, infectious diseases, unhealthy diets (over and under-nutrition), lack of physical activity, obesity and poverty. The interventions will come mostly through the MCH programs.

During **adolescence** unhealthy diets, lack of physical activity, obesity, tobacco and alcohol are the risk factors; interventions will mostly come through school health programs.

During adult life, lack of physical activity, obesity, alcohol, tobacco, high saturated fat diets, trans-fatty acids, lack of fiber and antioxidants in food, and stress are the risk factors. Loss of social status or status dissonance etc. could result from turning away from a lifestyle that promotes one or more of these factors.

2) Homicides and Suicides and interventions

It is known from the Registrar General's reports that homicides (3rd highest in the world) and suicides (7th highest in the world) need special attention in Sri Lanka. Both will probably decrease under the influence of the prevention program mentioned below or at least slow down their growth when alcohol and drug abuse is curbed. National correlates of homicides and suicides need to be studied and acted upon.

Possible interventions is a campaign to block the sudden surge of homicides and other violence particularly among the productive age groups of 15-24 and 25-44 years that have death rates of more than 140 per 100,000 population in 1996 whereas the age group of 45-64 has the next highest rate of only about 40 (the average rate is 55/100.000).

Attempted homicides and suicides or major violence should lead to counseling. Improved societal equity in access to basic needs and crucial resources such as education will also contribute to decrease their incidence. There is a need to open dialogue on the ferocity of the present competitive spirit and the need to cultivate cooperation, tolerance, mutual assistance and stress-coping mechanisms. Concomitantly, the health services will have to beef up the emergency services with first-aid relays, as too many die in transport or due to delayed care in ill-equipped or understaffed hospitals.

3) Accidental Injury and Road Accidents, Mental Health, and Oral Health and Interventions

The other subcomponents under non-communicable diseases such as accidental injury and road accidents, mental health and oral health will benefit too from the integrated prevention program but will have to tackle other risk factors specific to their groupings in the same spirit.

Improve quality and safety of services

The rates of hospital deaths due to septicaemia, tuberculosis, malaria, asthma, and liver diseases have increased with the rates of admissions from 1975 to 2000, implying that the hospitalisation hardly improve the chances of survival during the same period.

Such an ambitious strategy of disease management will ask very careful research consensus building on best practices in OPD/general practice, specialist clinics and IPD. Quality and safety will ask for increased specificity and sensitivity of diagnosis, therefore, better diagnostic procedures of both the episode and the underlying conditions, better early detection of chronic communicable and non-communicable diseases will ask for relevant personnel and supplies.

Rationalise health services network

To be responsive to the changing demands of a society that is ageing and in which non-communicable diseases prevail, the cost of providing services for chronic conditions is expected to be high, and the competition for public expenditure stiff.

Responding to Disparities

Although the national indicators show higher health outcome attainments, some districts/provinces/communities are worst off or simply exhibit different trends. It is now necessary to respond to health status discrepancies across geographical areas and socio-economic groups.

Forge functional public-private and public-public partnerships for health

Putting a break to the onslaught of homicides and other violence requires interventions partly in health facilities but primarily before they are referred.

Provision of quality essential drugs and equipment

Concomitant with the changing demands for services is the changing requirement for drugs and equipment.

Improvement in the delivery of health services will have to be balanced with financial constraints exacerbated by the growing demand in terms of volume and cost. Efforts would have to be directed towards strengthening human resources and organisation for health, administration and management as well as ensuring community participation and satisfaction. Central to all of these efforts would be resolving some cross-cutting issues such as strategies toward implementation of decentralisation policy as well as optimising resource mobilisation, allocation and utilisation. In other words, a comprehensive approach is advised for a durable enhancement of service provision.

(3) ESTIMATES OF HOSPITAL BEDS NECESSARY BY 2015

Assumptions and Methodology

Facility development for IPD will need to take careful account of population growth, and growing number of aged patients with chronic diseases. The following four methods will be adopted to estimate the volume of demands for inpatient facility in 2015.

Method-1: To estimate the total number of beds in 2015 needed by using the same rate of bed: 29 per 10,000 population as in 2002 and thus assuming unchanged health services and demand, and bed occupancy but the necessity to adjust to population growth, assuming constant average duration of 3.8 days.

Method-2: To estimate whether the increased demand due to population growth under 1) can be absorbed assuming a change in bed occupancy at district and lower levels, both by, expanding their functions and capabilities, counter-referral and by avoiding frivolous 1 night hospitalisation by having better OPD.

Method-3: To estimate the beds in 2015 by using the same rate of annual hospital admission: **206 per 1000 population**, same rate of bed occupancy, average duration of 5.5 days as prevails in developed countries, which have a load of chronic diseases.

Method-4: on the assumption that the nation's health conditions will be improved and OPD will be better able to deal with diagnostic tests, one could expect a lowered rate of annual hospital

admission (e.g. **154 per 1000 population**), or one (1) out of 6.5 population, but with 5.5 days duration and an average of 80% occupancy.

Results

Results are summarised in Table 4.4.1. Method 1 gives an estimate of an increase of another 8.600 beds needed. The 15% increase during 13 years is only an adaptation to population growth to maintain the current level till 2015. It implies no reorganisation of care. This gap might conceivably lead to more investment in private hospitals.

Method 2, no increase of number of beds may be needed, but presupposes decentralisation of services and better functioning of the network.

Method 3 leads to an enormous gap of 35% increase needed in the same period, which seems almost unattainable. It would only prevail if the same admission rate prevails with longer duration (5.5 days equal to national Hospital and most developed countries) would prevail).

Method 4 shows no increase would be needed, if and when prevention is done in an effective way and OPD care is good.

Result of Method 1 seems more moderate than Method 3, but it does not indicate any change in health conditions of the population in future. On the other hand, Method 2 and 4 show an interesting result.

It makes clear that the government does not need to increase bed capacity if either rationalisation of the network is successful with better utilization of district level facilities, or if the government can successfully lower the incidence rate of hospitalisation from 207 out of 1000 population to 154, or from 1 out of 5 to 1 out of 6.5 with a bed occupancy of at least 75% is achieved.

Table 4.4.1 Estimation of Hospital Bed Demand in Public Sector in 2015

	Index	Government hospital beds in 2002 (a)	Population Estimation in 2015 (middle)	Beds Demand Estimation in 2015 (b)	Gap between (a) and (b)
Method 1	31.1 beds per 10,000 pop.	59,635	21,937,000	68,224	+8,600
Method 2	206 admissions, 80% utilization also of district			57,200	2,435
Method 3	206 admissions per 1,000 pop, 75% utilisation			80,500	+21,000
Method 4	154 admissions per 1,000 pop.			59,889	Almost 0

Source: MoH-JICA Study Team

Compared with other South Asian countries, Sri Lanka comes out ahead in availability of hospital beds, but this does not match with the level of doctor-population rate or the share level of health expenditure to GDP.

Future demand of hospital beds will very much depend on the rationalisation of the network and the OPDs and the ability to lower the number of hospitalisations to maybe 154 can be assessed as more

achievable; and it must be much more desirable in terms of the Master Plan's goal of a Healthier Nation and more efficient delivery methods.

Then the next question 'How will the country be able to decrease the hospital admission rate in the population?' comes. Possible ideas which come to mind are: to strengthen preventive and promotive activities to cope with emerging NCDs, to improve the way hospitals operate after office hours to decrease unnecessary admissions, to set up standard admission and discharge criteria, or to review all the clinical procedures to shorten the duration of stay and strengthen the function of OPD.

4.5 ESTIMATES OF FUTURE HEALTH EXPENDITURES

This analysis explores what the trends may be in government expenditures and private payments for care. These two sources of financing represented about 90% of the total financial support for the health sector in 1999. They are expected to be the main sources of financial support in the near future. A third financing strategy, social health insurance, represents an alternative approach, which is expected to expand during the next fifteen years. However, it is difficult to project how it may evolve, as it currently does not exist in the country and the Study Team subsumed it under government expenditures because it would essentially fill the gap in tax support.

(1) ASSUMPTIONS AND METHODOLOGY

Two methodological approaches were used in conducting this assessment: macro and micro approaches.

Table 4.5.1 Assumptions for Health Expenditure Projections (macro approach) for Sri Lanka, 2000-2015

Macro approach variables	Assumptions (Sources)		
	Low	Medium	High
GDP growth	4.5% (1972-2002 Trend Analysis)	6% (Annual Report of the Central Bank of Sri Lanka)	8% ("The Future: Regaining Sri Lanka")
Population growth (Source: A.T.P.L. Abeykoon, 1998)	Slow	Moderate	Rapid
GDP share for health (defined by MoH)	1.5% by 2010 & 2015 (MoH-JICA Study Team)	2.0% by 2010 and 2.5% by 2015 (based on Consultation Meetings between World Bank and the GOSL)	2.5% by 2010 & 2015 (MoH-JICA Study Team)
Private household expenditure for health services: Health expenditure elasticity with respect to changes in household expenditure (Dunlop and Martins)	1.1	1.3	1.5

Source: Population Division, Ministry of Health, 2002

Table 4.5.2 Assumptions for Health Expenditure Projections (micro approach) for Sri Lanka 2000 & 2015

Micro approach considerations	Assumptions		
	2000	2015	Change
A. Total health service contacts per capita per year	6.0	6.5	
B. Share (%) of total health service use by source of care:			
1. Government outpatient Visits	41	48	+ 7
2. Self-medication	15	22	+ 7
3. Government inpatient stays			+ 1
4. Private inpatient stays			+ 1
5. Private outpatient visits	31.5	22.7	- 9
6 Ayurvedic medicine	6.5	0.5	- 6
7. Other sources of outpatient visits			- 0.5
C. Health expenditure by sub-sector and source of care	2002	2015	Change
1. If government outpatient visits increase			
a. Public sector expenditure (in billion Rs.)	20	58-63	
b. Private sector expenditure (in billion Rs.)	35	90	
2. If no change in utilisation of outpatient services between government and private sector			
a. Public sector expenditure (in billion Rs.)	20	57-60	
b. Private sector expenditure (in billion Rs.)	35	105-110	
3. If private outpatient visits increase			
a. Public sector expenditure (in billion Rs.)	20	50	
b. Private sector expenditure (in billion Rs.)	35	122-130	

Source: Central Bank Household Surveys in 1986/87 and 1996/97; World Bank Survey in 1991; and MoH-JICA Study Team in 2002.

The surveys provided the basis of estimating the total volume of service use and the relative shares of service use across the various public and private sources of care available. The results of the surveys were adjusted to reflect the actual service use data from the MoH. The basic results from these four surveys are presented in Table 4.5.3.

Table 4.5.3 Health Status, Care-Seeking Behaviour, Illness Episodes in a Year, and Service Use in Sri Lanka, 1986/87, 1996/97, and 2002

		1986/87		1991		1996/97		2002	
1	Total Population of Sri Lanka, in millions	16.135		16.449		18.444		19.156	
2	Estimated Number of Illness Episodes in Sri Lanka per Capita								
	a. share of the population reporting ill in recall period	12	two weeks	16.4	one month	13.2	two weeks	17.2	one month
	b. Estimated Number of illness episodes per person per year.	3.12		1.968		3.432		2.064	
	c. Total number of illness episodes in the population. (in millions).	50.34		32.37		63.30		39.54	
3	Estimated service Use by source of Service	1986/87 Share		NA in same format		1996/97 Share		2002 Share	
	A. No Care	3.1				3.5		NA	
	B. Self -Medication	5.8				2.2		16.2	
	C. Outpatient/Ambulatory/OPD	84.9				87.7		76.6	
	1. Private Western	34.8				32.6		30	
	2. Ayurvedic (all)	14.5				9.2		4.9	
	3. OPD/Govt	34.6				45.4		41.3	
	4. Other	1				0.5		0.4	
	D. Inpatient	6.2				6.6		7.1	
	1. Private Western	0.7626				0.8118		1.5	
	2. Public Govt.	5.4374				5.7882		5.6	
	Total	100.0				100.0		100.0	
		1986/87 Revised Use, Adj. for govt Use Statistics	Revised Share			1996/97 Revised Use, Adj. for govt Use Statistics	Revised Share	2002 Revised Use, Adj. for govt Use Statistics	Revised Share
	A. No Care	1.561	1.69			2.215	2.76	NA	
	B. Self -Medication	5.595	6.07			1.814	2.26	19.29	16.77
	C. Outpatient/Ambulatory/OPD	81.906	88.91			72.296	90.11	90.653	78.81
	1. Private Western	33.573	36.44			26.874	33.49	35.504	30.87
	2. Ayurvedic (all)	13.989	15.18			7.584	9.45	5.799	5.04
	3. OPD/Govt	33.38	36.23			37.426	46.65	48.877	42.49
	4. Other	0.965	1.05			0.412	0.51	0.473	0.41
	D. Inpatient	3.065	3.33			3.91	4.87	5.085	4.42
	1. Private Western	0.384	0.42			0.514	0.64	0.75	0.65
	2. Public Govt.	2.681	2.91			3.396	4.23	4.335	3.77
	Total	92.127	100			80.235	100	115.028	100
4	Revised Est. of Total per Capita Service Use	5.710				4.350		6.005	
5	Revised Est. of Total Illness Episodes per Cap.	5.807				4.470 Est. 6.02		6.240	
6	OPD/IP ratio in Govt Facilities	12.45				11.02		11.27	
7	OPD/IP ratio in Private Facilities	87.45				52.3		47.34	

Source: Compiled by JICA Study Team

(2) TOTAL HEALTH EXPENDITURE

Macro Approach

Given the various assumptions regarding a) the rate of GDP growth, b) the MoH share of GDP and c) the household health expenditure elasticity with respect to total household expenditure, total health expenditures will grow to varying levels. Figure 4.5.1 shows that, in 2002, they will be around 50 to 55 billion Rs. and climb to between a low of 169 to a high of 464 billion Rs. in 2015. The increase is a low of threefold to a high of nine-fold. These estimates show that, as a share of total GDP, this level of expenditures will grow from around 3% in 2000 to between 3.6 and 6.7% of GDP in 2015.

Table 4.5.4 Total Health Expenditure Projections (macro approach) for Sri Lanka by 2015

	Total Health Expenditure Projection		
	Low	Medium	High
2002 (in billion Rs.)	50-55 (3% of GDP)	50-55	50-55
2015 (in billion Rs)	169	267 & 326	464
2015 (as % of GDP)	3.6%	4.5% & 5%	6.7%

Source: MoH-JICA Study Team

If international standards of spending, based on the WHO Macroeconomics and Health Commission's findings are used as a norm to sustain priority health interventions,[4] Figure 4.5.1 shows Sri Lanka generally meeting or exceeding these suggested levels well before 2015.

The various upward sloping expenditure trends presented in Figure 4.5.1 represent various expenditure scenarios expressed in per capita terms. The horizontal lines represent various expenditure criteria based on various required expenditure scenarios as established by the WHO Macroeconomics Commission for Health and based on the disease burden and resource prices prevailing in each specific region of the globe. Where the lines cross, it represents when Sri Lanka's health expenditure levels will meet the required minimum expenditure level. The allocation of those expenditures to priority programs remains an issue for Sri Lanka over time to resolve.

[4] WHO, *Macroeconomics and Health Commission Report*, (Geneva: WHO, 2001).

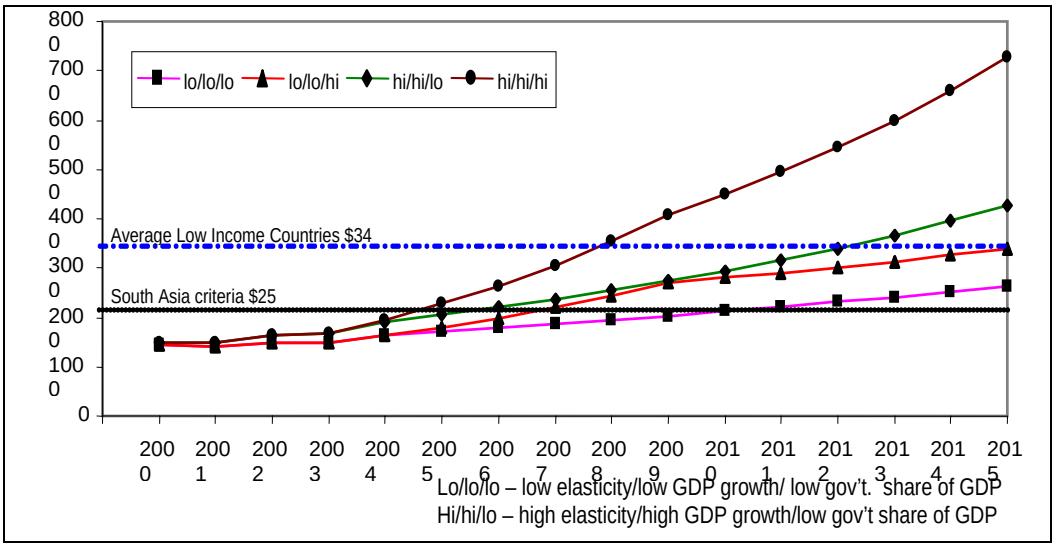


Figure 4.5.1 Estimated Total Health Expenditure Per Capital in Sri Lanka, 2000 to 2015 (Case of High Population Growth)

Note: Vertical lines are estimates of per capita health expenditures to sustain priority health intervention as defined by the WHO Commission on Macroeconomics & Health, December 2001. Exchange Rate is Rs.94.746 / US$

Source: MoH-JICA Study Team

These findings are based on trends of preferred source of care if sick or ill, estimates of expenditures per unit of service, and total expenditures according to source of care.

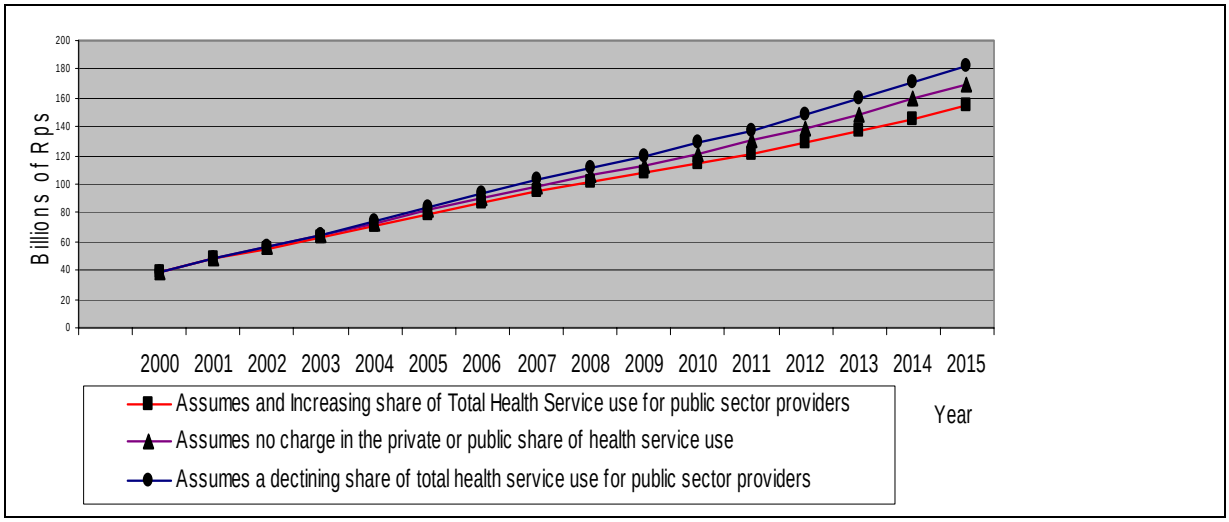


Figure 4.5.2 Summary of Projected Total Health Expenditure Based on Source of Care, Sri Lanka 2000 to 2015 (Case of High Population Growth)

Source: MoH-JICA Study Team

Figure 4.5.2 shows the difference in total health expenditures depending upon the trend in the source of care over the 2000 to 2015 period. Depending upon the trends in sources of care, total expenditures will be somewhere between Rs.155 and 180 billion. These results are in the low to medium range of the figures derived via the macro approach.

Figure 4.5.2 also shows the differences in the trends in the sources of care will lead to varying levels of expenditures depending upon whether the public seeks more care from government vs. private providers.

If the private provider share of total use grows, health expenditures will be about Rs.7 to 10 billion larger in 2015 than if there is no change in the utilisation shares. Similarly, if the public share of total utilisation grows relative to the private share, total expenditure will be about Rs.7 to 10 billion lower in 2015 than it would be if there was no change in the shares. The relative magnitude of these various estimates is based on differences between estimates of the expenditure per unit of service in the public and private sub-sectors. More in-depth information is required to assess whether the assumption made regarding price increases in the private health sector reflects reality. This matter is under further investigation.

(3) IMPLICATIONS ON PLANNING

Total health care expenditures will rise from around Rs.50 to 55 billion in 2002 to somewhere between Rs.170 to 465 billion, representing 3.6% to 6.7% of GDP. This implies that the share devoted to health will grow from the current level of about 3.0% of GDP. Most of the evidence presented in this analysis suggests that this share will grow from 4% to 5% of GDP. Both the macro and micro approaches tend to suggest this basic finding. As such, if the trends continue and the assumptions hold, then Sri Lanka will be able to provide the level expenditures equal to or even greater than international standards. This implies that the essential health services could be financed.

Even if high population growth were considered, both approaches however did not account for ageing of the population and epidemiological transition. They have not factored in the higher cost of providing health services for non-communicable diseases that often require long-term if not life-long interventions. As such, the results of the analyses using either approach may be an under-estimation of the total health expenditures. Nonetheless, further studies need to be conducted to refine the estimation and projections.

Caution must be observed when planning so as not to overspend, a natural response when one assumes availability of sufficient budget. Remember, the projections are as good as the assumptions. As such, there is a need to monitor the stability of these assumptions.

The issue for additional concern is where people in Sri Lanka will seek additional care, and how much will they pay directly or indirectly via taxes for this care. The micro approach suggests that if people tend to use private care more than public care, they will pay a larger share of GDP for the care they obtain. Where people go for care will be determined in large measure by the service quality of the care they obtain in the public sector. If that grows by spending a larger share of GDP in public facilities, the cost of that care can be reduced by at least Rs.20 billion per year. That sum would represent a good return on investment on public sector health expenditures. Does this imply that it is better to encourage patients to use public facilities? Does this further imply that the public sector needs to be responsive to the needs of the public to be more attractive?

PART II :

STRATEGIC FRAMEWORK AND PROGRAMMES

CHAPTER 5

STRATEGIC FRAMEWORK

5 STRATEGIC FRAMEWORK

5.1 VISION, MISSION AND GOAL

The Government of Sri Lanka recognises the need to invest in people to build the human resource base for a just and prosperous society. Ensuring that the basic needs of the entire population are met, and that each citizen is given the opportunities to realize his/her full potential, is central to the Government strategy to address poverty. It is now widely appreciated that better health has an important role in reducing poverty and promoting economic growth.

VISION:

A healthier nation that contributes to its economic, social, mental and spiritual development

MISSION:

To achieve the highest attainable health status by responding to people's needs, working in partnership, to ensure access to comprehensive, high quality, equitable, cost-effective and sustainable health services

GOAL:

A strengthened health system that strives for excellence to improve the health outcomes of the people in Sri Lanka

The vision reflects the fact that:

1) People can contribute significantly to their own health and the government should help them release this potential.

2) The role of Government is not just to deliver services but also to develop partnerships between Government departments and external agencies that contribute to improving health. Partners include:

   - Communities in the design, management and use of services;

- The private sector and Non-Governmental Organizations that play a key role in the delivery and financing of the health care; and
- Developmental partners (donor and other international agencies).

3) The Government would ensure that health services are:

- Accessible and affordable to the state and the public;
- State services are free of charge at the point of delivery;
- Comprehensive and serve the whole population;
- Are of an acceptable quality both in the state and private sectors;
- Responsive to emerging and changing health needs;
- Accountable to users and the population at large;
- Evidence based; and
- Sustainable.

5.2 STRATEGIC OBJECTIVES

The vision of improving the health status of the people will be achieved through addressing the following strategic objectives:

1. **To improve comprehensive health services delivery and health actions, which reduce the disease burden and promote health;**
2. **To empower community towards more active participation in maintaining and promoting their health;**
3. **To improve the management of human resources for health;**
4. **To improve health finance mobilization, allocation and utilization; and**
5. **To strengthen stewardship and management functions of the health system.**

Figures 5.2.1 shows diagrammatic representations of the dynamic relationships among the Strategic Objectives.

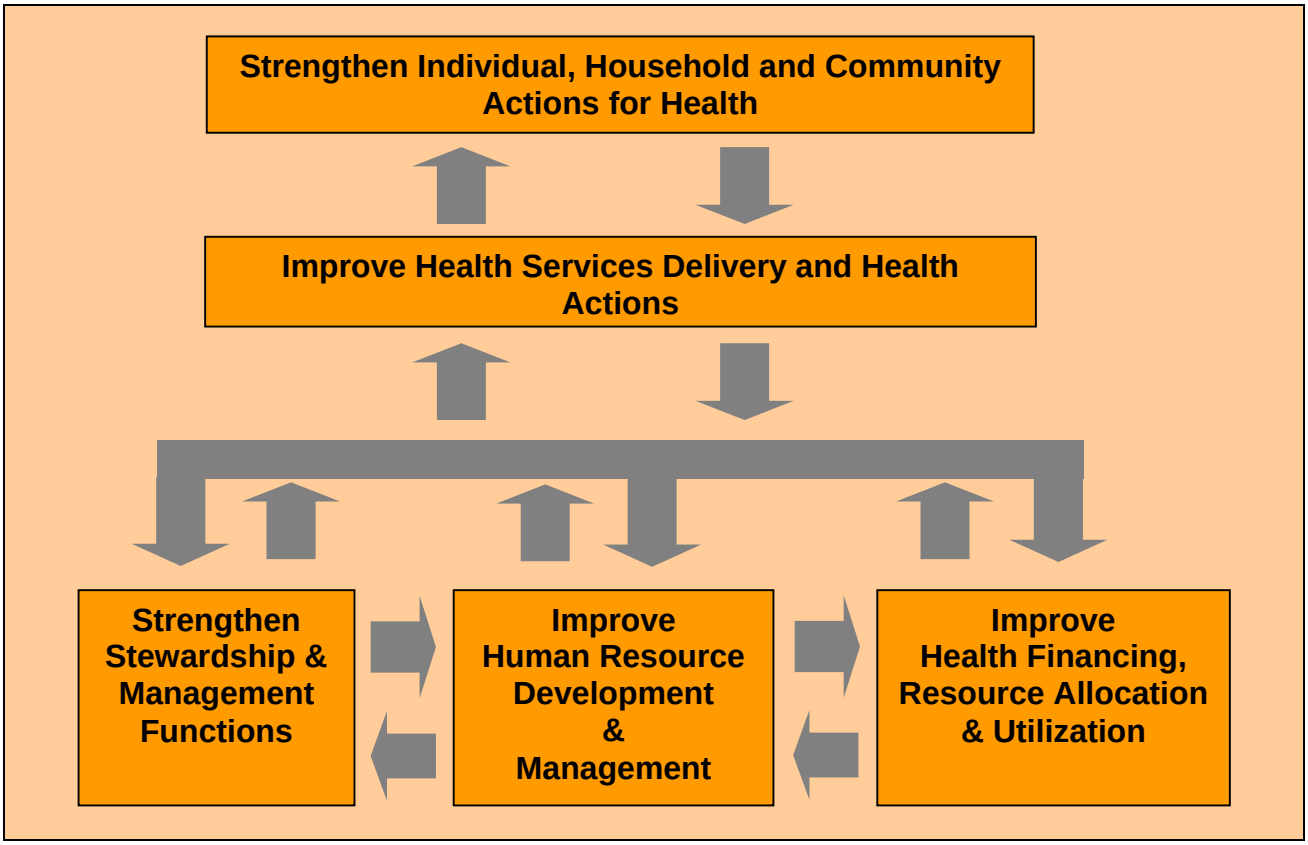


Figure 5.2.1 Inter-relationships among the Five Strategic Objectives

5.3 IMMEDIATE OBJECTIVES

The Immediate Objectives are the specific directions related to each of the five Strategic Objectives. They are described below.

(1) STRATEGIC OBJECTIVE: TO IMPROVE COMPREHENSIVE HEALTH SERVICES DELIVERY AND HEALTH ACTIONS, WHICH REDUCE THE DISEASE BURDEN AND PROMOTE HEALTH

Immediate Objectives:

4) To rationalize and strengthen the network of health facilities and services (that includes allopathic and indigenous as well as public and private services).
5) To introduce technology assessment at the central MoH and access appropriate technologies.
6) To ensure adequate drugs, other medical supplies and equipment are in place.
7) To enhance the quality of service delivery (assuring responsiveness to needs).
8) To reduce priority diseases/conditions through strategic interventions.
9) To improve the health status of vulnerable populations (including marginalized and underprivileged groups).
10) To promote inter-sectoral coordination for disease control and prevention.
11) To increase public confidence and patient/client satisfaction in the health services.

(2) STRATEGIC OBJECTIVE: TO EMPOWER COMMUNITY TOWARDS MORE ACTIVE PARTICIPATION IN MAINTAINING AND PROMOTING THEIR HEALTH

Immediate Objectives:

1) To monitor public perception of their needs and of the health system towards serving as input for improvement.
2) To improve participation of civil society and non-governmental organizations in promoting behavioural and lifestyle changes.
3) To improve public awareness of their rights, responsibilities and options for care as well as to establish an ombudsman system.

(3) STRATEGIC OBJECTIVE: TO IMPROVE THE MANAGEMENT OF HUMAN RESOURCES FOR HEALTH

Immediate Objectives:

1) To improve the technical and managerial competencies of health staff in both curative and preventive sectors.
2) To rationalize the development and management of human resources for health.
3) To improve the performance of human resources in the health sector.

(4) STRATEGIC OBJECTIVE: TO IMPROVE HEALTH FINANCE MOBILIZATION, ALLOCATION AND UTILIZATION

Immediate Objectives:

1) To increase government financial support at all levels to strengthen the financial sustainability of the health sector.
2) To improve allocative efficiency and equity.
3) To identify and test alternative financing mechanisms (including various forms of health insurance, possible fees and others) with a view towards national implementation.
4) To make optimal use of financial resources (through cost-effective strategies that will be identified, adopted and re-evaluated for the management of priority diseases/conditions).
5) To optimise private sector contribution, initially establishing an information-sharing mechanism to include reporting on service use and quality as well as financing.
6) To strengthen financial management (including capacity, authority, monitoring and supervision, and use of available resources).

(5) STRATEGIC OBJECTIVE: TO STRENGTHEN STEWARDSHIP AND MANAGEMENT FUNCTIONS OF THE HEALTH SYSTEM

Immediate Objectives:

1) To institutionalise effective mechanisms for policy development within existing units.
2) To enhance efficiency, effectiveness and accountability of the MoH and decentralised units.
3) To strengthen managerial performance at national and decentralised levels.
4) To strengthen and introduce monitoring and evaluation of performance, which are related to health outcomes, in all health institutions.
5) To strengthen the system for regulating the services of public and private providers.
6) To strengthen health information system.
7) To strengthen capacity in health research.

5.4 DEVELOPMENT OF NATIONAL HEALTH OBJECTIVES & TARGETS

The Millennium Development Goals (MDGs) have set the agenda for social development in the 21st century. In the health sector, they encompass reducing of maternal mortality, under five mortality and malnutrition, halting and reversing HIV/AIDS epidemic and incidence of Malaria and Tuberculosis, and provision of access to affordable essential drugs. In addition it targets to halve by 2015 the proportion of people without sustainable access to safe drinking water and sanitation.

The Commission on Macroeconomics and Health has provided a framework for relating Macroeconomic policy and improved health status, focusing primarily on the poor. Considering these as well as future trends in the factors that go to influence the health of the people and health systems in the years to come, the Ministry of Health has undertaken an exercise of developing National Health Objectives and Targets for the next 10 years.

5.5 PROGRAMMING

This section describes the process of formulating, prioritising and sequencing of the programmes and projects. The summary of each programme/project formulated are discussed in Chapters 6 to 12. Volume III, Project Profiles, describes the details of formulated projects in the Allopathic and also Indigenous Sectors of Health.

(1) FORMULATION OF PROGRAMMES AND PROJECTS

Following the objective setting exercise, formulation of programmes and projects is recognized as the most important process in the whole exercise of master plan formulation. The strategic and immediate objectives show the direction and the object point by 2015 and the programmes and projects show what to do to get there, while monitoring and evaluation will show how to get there.

Strategic Programming

In the present Sri Lanka health sector context, the "programme" is defined as a set of activities which do not have limited time period to end and operated in a single subject like Malaria Control, HIV/AIDS control, etc. Therefore, the existing health programmes in this country are vertically operated ones such as "Malaria Control Program", "Maternal and Child Health Programme", etc, and even Health Promotion Program is operated vertically.

In the Health Master Plan formulation process, the new concept of 'Strategic Programmes' was introduced. 'Strategic Programmes' is defined as having a common managerial process and a focal point who overlooks the program and does monitoring and evaluation of a single programme, but can have many implementers who can have direct access to resources. Also these 'Strategic Programmes' should answer strategic questions such as how the health sector in this country should deal with emerging diseases coming along with the life-style changes. During the actual programming, many re-groupings were done by the implementers.

Planning Assumptions

Prior to the actual programming, some planning assumptions were made. These assumptions are as follows:

Planning Assumption 1: It is assumed that there are existing planning documents that will be taken into account.

Planning Assumption 2: It is assumed that the HMP will be used as a guide for government: investment, implementation, monitoring & evaluation. Also HMP will serve as a guide for donors.

Planning Assumption 3: It is assumed that all written policies will be considered. These include higher level policies such as the 13th Amendment to the Constitution and those appearing in circulars.

Planning Assumption 4: It is assumed that the Policy Dialogue will yield sufficient legal basis for agreed upon programmes.

Planning Assumption 5: It is assumed that the funding sources will be all inclusive: National Government, Provincial Government, Donors, and Local NGOs & Civil Societies.

Planning Assumption 6: It is assumed that the HMP will be implemented in the North & East Provinces and other geographical areas with special needs, and with whatever changes required due to special conditions.

Planning Assumption 7: It is assumed that the HMP will have the political commitment throughout its preparation & implementation.

Actual Programming Process

Actual programming process was taken up on June 5th and 6th in the workshop. Participants were guided on formulations of programmes/projects; they were then divided into five sub-groups according to the area and Strategic Objectives.

The participants were given the following instructions:

1. Look at the Strategic & Immediate Objectives for each group.
2. Group the Immediate Objectives to form Strategic Programmes.
3. Write the existing programmes & discuss their relevance/gaps in relation to the Immediate Objectives.
4. Write the items relevant to achieving the Immediate Objectives.
5. Group the items according to who could be responsible for each.
6. Review whether together the groups are sufficient to achieve the Immediate Objectives. If not, write some more items.
7. Discuss whether there are policy gaps that might hamper implementation. Write these gaps.
8. Formulate objectives for the Strategic Programmes.

The result of this exercise of programming is shown in the section (3) in this chapter.

(2) PRIORITISATION & SEQUENCING PROCESS: PURPOSE AND PROCESS

Prioritisation of a number of interventions to be identified in line with the overall strategic objectives is the most vital part of the Master Planning process. The priority should be considered, employing a rational procedure with stakeholders' participation as well as a logical phasing structure of inter-sector linkages.

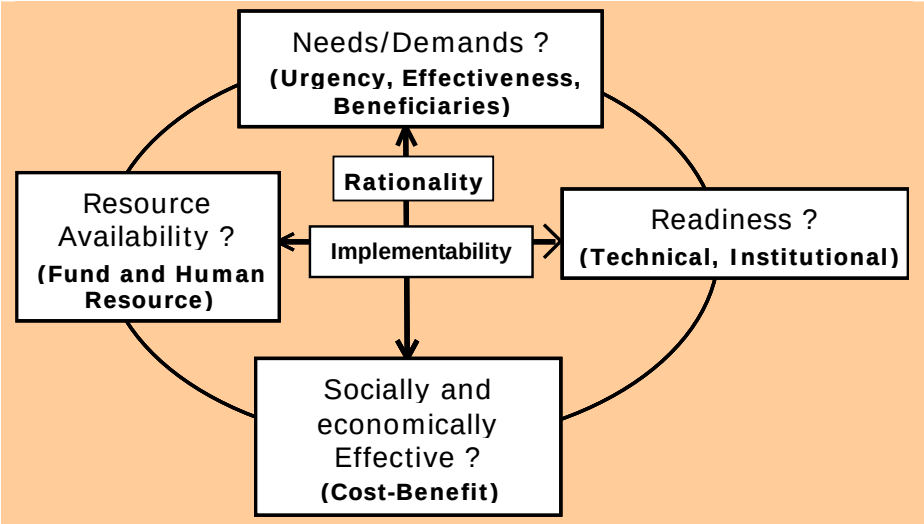


Figure 5.4.1 Four Key Elements to Address Priority Interventions

A conceptual scheme of prioritisation criteria is shown in Figure 5.4.1. Four elements are thought to be key, of which the following two are key factors to rationalize the intervention:

- **Needs/Demands**, represented by urgency, effectiveness and beneficiaries; and
- **Social and economic effectiveness**, implying the cost-benefit performance.

The implementability of interventions needs to be addressed in consideration of the following two points:

- **Readiness** of the implementation, meaning that the intervention in question would be free from critical technical and institutional constraints, or be accorded within the constitutional framework; and
- **Resource availability** in terms of funding and human resources, when mobilizing available resources including external ones.

Based on this concept, a Goal Achievement Matrix (GAM), as a methodology, will be designed to facilitate stakeholders' participation in scoring of listed interventions.

In order to keep a rational order of the implementation process, the above systematic approach needs to be reviewed from a planning rationale, taking into account inter-sector linkages of each intervention in a phasing process. For instance, even if an intervention (Program A) is given the highest score, if it is obvious that the intervention of Program A can only be effective when another intervention exists or even has preceded an intervention (Program B) which gained a lower score, the higher priority order should be given to Program B.

This discussion process will be facilitated, and eventually a priority package of interventions, including concrete programs, will be formulated for a **short-term action plan** of which the achievement shall be materialized in five years.

(3) LIST OF PROGRAMMES AND PROJECTS

Table 5.4.1 indicates the anchor projects given to the HMP Projects. Although all the projects are considered as priorities because of several reasons such as they are existing projects, they are pre-requisites for others to be started, they intend to build or reinforce capacities, and they will respond

to emergency needs, those with an anchor rating have the highest importance because they are new and should be started within the first two years of implementing the HMP.

Table 5.4.1 Programmes/Projects

Project No.	Programme or Project Title	Focal Point	Anchor Project
STRATEGIC OBJECTIVE 1 **To Improve Comprehensive Health Service Delivery and Health Actions**			
1.1	**Programme for Organisational Development**		
1.1.1	Functional Rationalisation by Developing a New Health Services Delivery Plan	DDG/P (assisted by DDG/MS D/TCS	**X**
1.1.2	Facility Development According to the Rationalised Health Services Delivery Plan	Director-General (assisted by All DDGs, Dir/Building, PDHS)	**X**
1.1.3	Strengthening of Services for Mother & Child	DDG/PHSII	**X**
	1.1.3.a. Strengthening of Maternal Health Services		
	1.1.3.b. Health Care Needs of Women with attention to Special Groups		
	1.1.3.c. Strengthening Emergency Obstetric Care & Neonatal care		
	1.1.3.d. Strengthening Logistic Management System		
	1.1.3.e. Child Health Programme		
	1.1.3.f. Family Planning Programme		
	1.1.3.g. IEC Programme for RH Services		
1.1.4	Re-organizing and Strengthening of Laboratory and Diagnostic Services in State Hospitals, Field & Private Sector Laboratories	DDG/LS	
1.1.5	Blood Safety	DDG/LS	
1.1.6	Technology Assessment	DDG/BES (assisted by DDG/MS)	
1.1.7	Emergency Preparedness & Response	DDG/MS1	
1.2	**Medical Supplies (including Drugs) & Equipment Programme**		
1.2.1	Medical Supplies (Including Drugs)	DDG/LS (assisted by DDG/MS)	**X**
1.2.2	Medical Equipment Management Improvement	DDG/BES (assisted by DDG/MS)	**X**
1.3	**National Quality Assurance Programme**		
1.3.1	Improved Quality of OPD & IPD Services	DDG/MS	
1.3.2	Development of Emergency Services Network for Injuries, Accidents, Poisoning & Disasters	DDG/MS	
1.3.3	Total Quality Control/Management of Hospital Services	DDG/MS	**X**
1.3.4	Total Quality Control/Management of Promotive & Preventive Services	DDG/PHS	X

Project No.	Programme or Project Title	Focal Point	Anchor Project
1.4	**Diseases Control Programme**		
1.4.1	Non-Communicable Diseases Control	DDG/MS	
	1.4.1.a. Integrated Non Communicable Diseases Control		**X**
	1.4.1.b. Injury Prevention & Management		
	1.4.1.c. Renal Diseases		
	1.4.1.d. Thalassemia		
	1.4.1.e. Oral Health Services Management Improvement Project		
	1.4.1.f. Mental Health (including Substance Abuse, Suicide & Poisoning)		
	1.4.1.g. Cancer Control		
1.4.2	Communicable Diseases Control	DDG/PHS	
	1.4.2.a. Respiratory Diseases Control (ARI & TB)		**X**
	1.4.2.b. STD/AIDS Control		**X**
	1.4.2.c. Vector-Borne Diseases Control 1) Malaria Control 2) Filariasis Control 3) Dengue/DHF Control		**X**
	1.4.2.d. Immunisable Diseases Control 1) Immunisable Diseases Control 2) Elimination of Measles 3) Hib Prevention & Control 4) Viral Hepatitis Prevention & Control 5) Prevention of Rubella 6) Poliomyelitis Eradication Initiative		
	1.4.2.e. Rabies & Other Zoonotic Diseases Control		
	1.4.2.f. Food- and Water-Borne Diseases Control Prevention & Control of Diarrhoeal Diseases		**X**
	1.4.2.g. Integrated Management of Childhood Illnesses		
	1.4.2.h. Leprosy Control		
	1.4.2.i. Area-Specific Diseases 1) Leptospirosis Prevention & Control 2) Japanese Encephalitis Prevention & Control		
	1.4.2.j. Emerging & Re-emerging Communicable Diseases (e.g., SARS, Ebola, Nipa virus) Control – Strengthening Surveillance System		
	1.4.2.k. Strengthening of Disease Surveillance and Management	Epidemiological Unit	
1.5	**Programme for Vulnerable Populations**		
1.5.1	Estate Health	DDG/PHS	
1.5.2	Elderly Health	DDG/PHS	
1.5.3	Disabled Health	DDG/PHS	
1.5.4	Adolescent Health	DDG/PHS	

Project No.	Programme or Project Title	Focal Point	Anchor Project
1.5.5	Occupational Health	DDG/PHS	
1.5.6	Health of People in Urban Slums	DDG/PHS	
1.5.7	School Health	DDG/PHS	
1.5.8	Health in North - East and Boarder Provinces	Secretary	X
	1.5.8.a. Strengthening Health Services for People in Conflict-Affected Areas and Displaced Populations		
	1.5.8.b. Development of Human Resources for Health, North - East Province		
1.6	**National Nutrition Programme**		
1.6.1	Development of National Food, Nutrition Policy & Plans including Strengthening of Coordinating Mechanisms	Addl. Secretary (Nutrition / Medical Services)	X
1.6.2	Establishment of Mechanisms to implement the National Nutrition Programme	DDG/PHS	X
1.7	**Health Promotion Programme**		
1.7.1	Development of National Policy & Plan on Health Promotion including Strengthening of Coordinating Mechanisms	DDG/PHS	
1.7.2.	Establishment of Mechanisms to implement the Health Promotion Programme	DDG/PHS	
	1.7.2.a. Establishment of implementation mechanism for Health Promotion program	D/HEB	
	1.7.2.b. Capacity building in Health education and promotion		
	1.7.2.c. Health Promotive Setting Approach		
	1.7.2.d. Lifestyles Programme		
	1.7.2.e. Programme for improved community involvement in Health Promotion		
STRATEGIC OBJECTIVE 2 To Empower Community for Maintaining & Promoting Their Health			
2.1	**Programme for Improved Community Involvement for Health Development**		
2.1.1	Strengthening the Capacity of Key Concerned Government Officials, Community Groups & Political Leaders in Improving Community Involvement in Health Development	Secretary	X
2.1.2	Raising Awareness of the Community Regarding Health Needs & Services	DDG/PHS	X
2.1.3	Expansion &/or Revitalisation of Local Joint Actions for Health	DDG/P	X
2.1.4	Review & Improvement of the Role & Performance of Hospital Committees & Health (hospital) Development Committees	Secretary (assisted by Provincial Secretaries)	X
2.2	**Programme for the Promotion & Protection of Human Rights with Relevance to Health**		
2.2.1	Establishing a System of Improving People's Access to Regularly Updated Information on All Public & Private Facilities	DDG/P	
2.2.2	Development of a Health Charter, Necessary Legislation & Implementation Plans to Protect Communities, Households &	DDG/MS	

Project No.	Programme or Project Title	Focal Point	Anchor Project
	Individuals		
2.2.3	Establishment of the Ombudsman System within the Central & Provincial MoH to Promote/Protect Health Rights	Secretary	
STRATEGIC OBJECTIVE 3 To Improve the Management of Human Resources for Health			
3.1	**Programme for the Production & Strengthening of Human Resources for the Health Sector**		
3.1.1	Strengthening of Basic Training in Public Sectors by Improving Basic Infrastructure and Supplies as well as by Providing Additional Qualified Trainers	DDG/ET&R	
3.1.2	Establishment of a Network Between Central and Regional Training Institutions and Within the Latter Level		
3.1.3	Establishment of Academic Degree Programs for Nurses & Selected Paramedical Categories		
3.1.4	Strengthening of In-service Training and Continuing Education System in Both Public and Private Sector		
3.1.5	Providing Incentives & Career Guidance to All Medical Officers Undertaking Post-graduate Studies with Special Reference to Specialities in High Priority Areas	DDG/MS	
3.2	**Programme for the Rationalisation of Human Resources for the Health Sector**		
3.2.1	Formulation of an HRD Policy	Secretary	**X**
3.2.2	Establishment of an HRD Division at Central Level and HRD Units at Provincial Level with Clear Demarcation of Roles, Responsibilities & Authorities	Director General	**X**
3.2.3	Development, Implementation & Monitoring of a Comprehensive HRD Plan Based on the Approved HRD Policy	Director General	**X**
3.2.4	Establishment of a Mechanism to Coordinate HRD Activities with the Private Sector with Specific Reference to Training & Continuing Education	Director General	**X**
3.3	**Programme for Improving Job Performance of Health Personnel**		
3.3.1	Establishment and Implementation of an Improved Supervisory System, including Improved Performance Appraisal System	DDG/P	
3.3.2	Development and Implementation of a Career Development Scheme for All Categories of Health Personnel	DDG/P	
3.3.3	Strengthening of Central Regulatory Controlling Bodies to Maintain Standards & Performance Auditing Activities	Secretary	
3.3.4	Regular Review of Activities & Output of Training Institutions at Central and Provincial Levels to Strengthen the Management Capacity of these Institutions	DDG/ET&R	
STRATEGIC OBJECTIVE 4 To Improve Health Finance Mobilisation, Allocation and Utilisation			
4.1	**Programme for the Development of Health Finance Policy For Equity, Efficiency & Sustainability**		
4.1.1	Development of a Health Finance Policy for National, Provincial & District Levels	Secretary	**X**

Project No.	Programme or Project Title	Focal Point	Anchor Project
4.1.2	Development & Implementation of a Plan to Reorient Procedures & Formats Towards Performance-based Planning & Budgeting	DDG/F	X
4.2	**Programme for Strengthening of the Health Financial Management System**		
4.2.1	Strengthening & Reorganising the DDG Finance Office and DDG Planning for Health Service Delivery & Intersectoral Health Issues within the Context of Health Economic Reality and with Full Accountability	DG	
4.2.2	Strengthening & Reorganising the Financial System & Capacity of the PDHS Office	PDHSs Provinces	
STRATEGIC OBJECTIVE 5 To Strengthen Stewardship and Management Functions			
5.1	**Effective Policy Development Programme**		
5.1.1	Capacity-building of National & Provincial MoH Officials in Effective Policy Development Processes	DDG/P	X
5.1.2	Establishing a Mechanism for Advocating Commitment of National & Provincial Political Leaderships toward Ownership of Health Programmes	Secretary	X
5.2	**Management Development Programme**		
5.2.1	Establishing an Improved Management System/s and Building the Capacities of Management Teams	DDG/P	X
5.2.2	Strengthening the Management Development & Planning Unit & the Planning Units at the Provincial & District Levels in Areas of Policy Analysis, Project & Plan Formulation, Monitoring & Evaluation, and Finance	DDG/P	
5.2.3	Developing Systems & Capacities for Monitoring & Evaluation as well as Introducing System/s to Recognise Good Performance of Institutions, Individuals & Communities at National, Provincial, District, & Divisional Levels	DDG/P	
5.3	**Health Regulatory Mechanism Programme**		
5.3.1	Institutionalising Mechanisms to Introduce New as well as to Review, Harmonise and Amend (if Required) Existing Legislation/Regulations Related to Health at and between National & Provincial Levels	Secretary	X
5.3.2	Strengthening of Enforcement of Legislation & Other Regulations at National & Provincial Levels	Secretary	
5.4	**Strengthening of Health Information System Programme**		
5.4.1	Development of Policy, Implementing Guidelines and Plans for Health Information System for Public & Private Sectors	DDG/P	X
5.4.2	Strengthening of the Provincial Health Information System in Less Developed Areas Initially and Nationwide Thereafter	DDG/P	X
5.5	**Health Research Programme**		
5.5.1	Enhancement of Capacities in Health Research & Research Management at Central & Provincial MoH	DDG/ET&R	
5.6	**Inter-Sectoral Programme**		

Project No.	Programme or Project Title	Focal Point	Anchor Project
5.6.1	Strengthening the Existing Health Development Network at National, Provincial & Local Levels	Secretary	
5.6.2	Public-Private Partnership Development at National & Provincial Levels, including Private sector Information System	Director General	X
6.1	**Strengthening Stewardship and management Functions in ISM**		
6.1.1	Restructuring of the Ministry of Indigenous Medicine	Secretary of MIM	**X**
6.1.2	Setting up of an Ayurveda Pharmacopoeia Commission	Secretary of MIM	
6.1.3	Planned Development of Private Sector partnership in ISM Project	Secretary of MIM	
6.2	**Strengthening of Service Delivery in ISM**		
6.2.1	Development of ISM Pharmaceutical Industry	Secretary of MIM	
6.2.2	Development of ISM Pharmaceuticals	Bandaranaike Memorial Ayurveda Research Institute	
6.2.3	Facility Development Project	Secretary of MIM	
6.2.4	Strengthen the Service Sector of Indigenous Systems of Medicine	Secretary of MIM	
6.2.5	Non-formal "*Paramparika*" Knowledge Base Project	Planning Division of MIM	
6.2.6	Conservation and Sustainable Use of Medicinal Plants Project	Project Management Unit, MIM	
6.3	**Strengthening Integration of ISM and Allopathic Sectors**		
6.3.1	Development of Home-based and Community-based Services	Secretary of MIM	
6.3.2	ISM Health Promotion Program	Proposed Ayurvedic Health Education Bureau	
6.3.3	Systematisation of ISM Rehabilitation Care Services	Secretary of MIM	
6.4	**Human Resource Development in ISM**		
6.4.1	Human Resources Development in ISM	Secretary of MIM	
6.5	**Strengthening Research Capacity in ISM**		
6.5.1	Strengthening of Research & Development in ISM	Bandaranaike Memorial Ayurveda Research Institute	

Acronyms:

Secretary	Secretary of Health Service, MoH
DG	Director General of Health Service, MoH
DDG/BES	Deputy Director General of Biomedical Engineering Services, MoH
DDG/ET&R	Deputy Director General of Education Training & Research Branch, MoH
DDG/F	Deputy Director General of Finance Branch, MoH
DDG/LS	Deputy Director General of Laboratory Services, MoH
DDG/MS	Deputy Director General of Medical Services Branch, MoH
DDG/P	Deputy Director General of Management Development & Planning Unit, MoH
DDG/PHS	Deputy Director General of Public Health Services, MoH

D/HEB	Director of Health Education Bureau, MoH
D/MCH	Director of Maternal and Child Health, MoH
D/N Med Ser	Director of Nursing (Medical Service), MoH
MIM	Ministry of Indigenous Medicine and Disaster Relief

CHAPTER 6

STRATEGIC PROGRAMMES FOR HEALTH SERVICES DELIVERY

6 STRATEGIC PROGRAMMES FOR HEALTH SERVICES DELIVERY

This chapter discusses issues related to the development of health services delivery in Sri Lanka. Further, it proposes strategic directions towards the development of comprehensive health services delivery in the next 10 to 12 years.

6.1 PROGRAMME JUSTIFICATION AND LINKAGES

The seven programmes that are envisioned to improve comprehensive services delivery and health actions are as follows:

- Programme for Organizational Development;
- Medical Supplies and Equipment Programme;
- National Quality Assurance Programme;
- Diseases Control Programme;
- Programme for Vulnerable Populations;
- National Nutrition Programme; and
- Health Promotion Programme.

(1) EQUITY ISSUE

Geographical accessibility of primary and secondary care in general is good in most provinces, but due to understaffing and lack of supplies in many places, it is not always meaningful. Moreover, for some marginalized or underprivileged population, and working poor population, the accessibility in terms of working hours and waiting time is not good at all. Cultural and linguistic accessibility has too often not been taken into account. By intensifying efforts to cover disadvantaged/marginalized groups, which is about 30% of the total population, a gain of about 20-30% of health outcome is expected.

“Programme for vulnerable population” addresses this issue and aims to uplift the health status of vulnerable population.

(2) EFFICIENCY ISSUE

One of the major constraints/problems existing in the health sector of this country is the inefficiency at the primary level health care services. Because of the inefficiency of primary level health service delivery, most of health facilities are underutilized and it causes overcrowding of higher-level health facilities. Drugs and other medical supplies are also inefficiently managed so that it causes understocking at the primary level health service facilities. Lack of cost effective treatment protocols at the primary level health service is also one of the causes of the inefficiency.

“Programme for Organizational Development” and “Medical Supplies and Equipment Programme” address this issue of inefficiency of health care system and aim to strengthen primarily the primary level health care service delivery system to be more efficient.

(3) RESPONSIVENESS ISSUE

Issue of efficiency and issue of responsiveness of the health services are both sides of a coin. Because of the inadequate quality of health services due to lack of adequate health facilities at the primary level health care, lack of effective strategic interventions for priority diseases, weak support services to provide quality care, and poor attitude of health care providers are lowering the responsiveness to needs.

"Programme for Organizational Development", "Medical Supplies and Equipment Programme", "National Quality Assurance Programme", and "Disease Control Programme" address this issue and aim to strengthen the responsiveness of the health services in this country.

(4) INTEGRATION ISSUE

Sri Lanka so far has had strict division between preventive and curative services: Preventive services by and large have been delivered on a population basis and proactive and curative services have been on a one-to-one basis in response to demands. The Master Plan proposes to have some patient-based prevention programs as well as some population-based curative services such as secondary prevention and tertiary prevention of Non-Communicable Diseases as well as primary prevention in families with NCD cases. This will only be possible if both service integration and planning and management coordination is actively pursued.

Table 6.1.1 Integration of Services in All Settings

	Public Health= Population-Based	Clinical Health =One to one
Prevention	EPI, MCH, etc	Primary, Secondary and Tertiary Preventive services
Curative Care	Deworming of school children, MDA	Curative care services

"Disease Control Program" has this new approach to have some patient-based prevention programs as well as some population-based curative services.

MoH has many sections, departments and units, however, there are no ready-made venues for them to debate overlapping interests or to coordinate future plans, programs, and projects. Within MoH sharing of information, plans and monitoring data should be both a right and a duty, so that all decisions taken are based on all relevant facts known to officials in the MoH.

"Diseases Control Programme", "National Nutrition Program" and "Health Promotion Program" address the issue of coordination within and between Ministries and aim to develop clear forums and channels for thematic ongoing coordination among related agencies/sections/units.

6.2 DISEASES MANAGEMENT PROGRAMME

(1) PROGRAMME OBJECTIVE

To reduce the incidence and prevalence of priority diseases.

(2) PROJECTS

Project 1.4.1a

Title: Integrated Prevention of NCD (CVD, DM, HT, Cancer, Asthma, Emerging & Re-emerging Non-communicable Diseases)

Summary:

The most cost effective way to control the increasing trend in Non- Communicable Diseases (NCD) is to launch a comprehensive NCD prevention programme. An integrated approach on prevention of NCD will be adopted by this project.

The project comprises 4 major components:

- 1) Baseline risk factor survey;
- 2) Social marketing programme to glamourize healthy lifestyle as the effective means of preventing major NCD;
- 3) Community-based intervention project in pilot areas; and
- 4) Formulation of best practices in prevention and management of NCD.

Project 1.4.1b

Title: Injury Prevention & Management

Summary:

The project comprises 2 major areas:

1. An integrated injury prevention programme through coordination and collaboration between government departments and other organizations; and
2. Effective injury management programme.

The priority types of injuries are Road Traffic Injuries, Occupational Injuries, Home accidents (including burns) and Poisoning.

Project 1.4.1c

Title: Area-Specific Diseases: Renal Diseases

This project will address the following 3 areas.

- A careful analysis of the probable reasons

- Proper management of predisposed conditions and
- Preventive measures

Specific measures will have to be implemented in North-central province as described under the justification.

Project 1.4.1d

Title: Area-Specific Diseases: Thalassemia

Summary:

The Thalassaemias, the commonest inherited diseases, occur at a variable frequency in different parts of Sri Lanka reaching the highest frequency in the Kurunegala district. It is estimated that there are 2000-2500 severe cases, whose adequate care will consume about 5-8 % of the Island's health budget. A control program requires the following developments

1) A short training program for Paediatricians, Haemotologists, Nurses, Public health staff on the genetics and clinical aspects of thalassaemia
2) A public education and awareness program
3) A pilot study of the most cost effective screening methods
4) The establishment of simple laboratory screening methods in laboratories in several regions
5) The establishment of one reference laboratory to identify different types of Thalassaemia in one clinical reference centre
6) Establishment of voluntary screening program, for the whole Island, supported by counseling service
7) Discuss future possibilities for prenatal diagnosis program

If well established, this program will provide the basis for the better control and management of Thalassaemia with the incorporation of new advances in future years in most prevalent provinces; North-western, North-central; and Uva

Project 1.4.1e

Title: Area-Specific Diseases: Fluorosis / Oral Health Services Management Improvement

Summary:

The Oral Health Services Management Improvement Project aims to improve efficiency of the oral health care delivery system through the provision of promotive, preventive, curative and rehabilitative services of high quality, so that the entire population will achieve high level of oral health.

The following activities are implemented by Central Ministry of Health and Provincial Ministries of Health with the assistance of local and international agencies:-

- Preventive programmes directed towards improvement of Oral Health of the school-going population.
- Provision of latest developments in Dentistry in the field of Restorative Dentistry to people who cannot afford its high cost in the private sector.
- Improvement of curative dental services in the country by updating equipment in hospitals and

having more Dental Specialist Services.

- Dental Services made accessible to remote areas in the country.
- Alleviate sufferings of youth affected by dental fluorosis in high fluoride areas.
- Reduce the disease burden caused by oral cancer.

Project 1.4.1f

Title: Mental Health (including Substance Abuse, Suicide & Poisoning)

Summary:

The present mental health services are predominantly hospital based. In keeping with WHO recommendations, and as a long felt need it is necessary to make the services available in the periphery. Patient care and treatment, rehabilitation, social support should be available in the community. Many mental disorders are not recognised because of social stigma and due to lack of awareness among the people. This project aims at addressing these issues by improving quality of care, infrastructure facilities, human resources, awareness through proper treatment, rehabilitating and promotive activities in the community so that disease burden due to mental diseases are minimised.

Project 1.4.1g

Title: Cancer Control

Summary:

The World Health Organization (WHO) developed Cancer Control Programs in various countries starting 1980 in order to reduce Morbidity and Mortality of cancers in the world. National Cancer Control Programme of Sri Lanka is one such organization developed with the support of the WHO by the Ministry of Health in Sri Lanka. It works under a Director and has a Field staff including Doctors. One of the main functions is Surveillance and Monitoring of the disease burden. It maintains a cancer registry database of Pathology, Epidemiology and Public Health Related data. From time to time publications are released from these.

The second aspect of cancer control is primary health care with health education and tobacco control within the island, and the Advisory Committee on Tobacco Control to the MoH monitors these activities and the director of the National Cancer Control Programme is the Secretary of this committee, Ex-Officio. Other Health Education work is done with the collaboration of Health Education Bureau, Family Health Bureau, UNFPA, Ministry of Education, Rotary Club and other non- government organizations.

Secondary prevention of early detection and screening is carried out for most common malignancies and Mobile Clinics, Local Health Personnel Training, Development of Health Care Volunteers and Management of Project-Based Screening Campaigns are carried out with the Plantation Health Trust, UNFPA and with other NGOOs. Tertiary Care Management and Palliative Care Planning are done through the advisory committee for cancer control where the Secretary is the Director, National Cancer Control Programme.

Rehabilitation work and hospice care is promoted through various NGOOs.

Research and development activities also are promoted by the NCCP.

The following project proposal for the next six years will be mainly centered around the Guidelines by the WHO to increase the Monitoring and Surveillance of cancer burden in the country by developing the databases in Pathological Diagnosis, Initial Registration at Treatment, Monitoring of Follow up of cases and Mortality due to cancer.

Health Education Programme will be local area based with the development of local resource personnel and volunteers. Early detection programmes will center on development of a central referral screening laboratory and clinics centre. Mobile clinics will be conducted and peripheral cancer control units will be developed to promote screening facilities.

Project 1.4.2a

Title: Respiratory Diseases Control (ARI & TB)

Summary:

This project aims at reducing the morbidity and mortality from Tuberculosis and other communicable and non-communicable respiratory diseases and minimizing the disability caused by them by strengthening the most national programme. The following activities are implemented.

a) Enhance case detection of TB by

- establishing microscopy centers in all the Out Patient Departments of Teaching Hospitals, Provincial Hospitals& Base hospitals and in all District & Peripheral hospitals
- establishing sputum collection centers in all other primary care health institutions
- active screening of high risk groups
- enhancing X-ray facilities.

b) Expansion of DOTS to increase the cure rate of TB.

c) Enhance indoor care services of good quality for TB and non TB respiratory patients.

d) Enhance diagnostic facilities so that the early and accurate diagnosis of respiratory diseases is possible to start therapeutic measures early.

e) Measures to diagnose occupational lung diseases early and to reduce the incidence.

f) Enhance the human resource in number and improve their knowledge and skills so that the service delivery by them would increase patient satisfaction.

g) Enhance the human resource in number and improve their knowledge and skills so that the service delivered by them would increase the patient satisfaction.

Project 1.4.2b

Title: STD/AIDS Control

Summary:

The primary objective of the project is :

- to assist the Government of Sri Lanka in curbing the spread and transmission of HIV infection
- to reduce personal and social impact of HIV on the infected persons and their families (stigma and discrimination)
- Limit the spread of HIV infection in Sri Lanka among its highly vulnerable groups, particularly adolescents and youth
- Strengthen multi-sectoral involvement and capacity.

This project would enable Sri Lanka to make rapid progress towards the Millennium Development Goals of halting the spread of HIV and TB associated mortality.

Project 1.4.2c

Title: Vector-Borne Diseases Control

Summary:.

Vector Borne Disease Control Programme aims to achieve better control of the four main vector borne diseases: Malaria, Filariasis, Dengue & Japanese encephalitis. The control activities will be planned and coordinated by the Vector Borne Diseases Control Programme of the Central MoH and implemented through the Provincial Ministries of Health.

The Programme will endure to

- Interrupt disease transmission where and when feasible
- Maximize the use of eco-friendly control strategies and minimize dependence on chemical vector control methods.
- Increase case detection facilities in medical institutions in affected areas of the country
- Strengthen Laboratory diagnosis of vector borne diseases

1.4.2.c 1) Malaria Control

2) Filariasis Control

3) Dengue/DHF Control

Project 1.4.2d

Title: Immunisable Disease Control

Summary:

Provision of financially sustainable, safe and high quality immunization Programme while sustaining the gains achieved and adhering to the eradication, elimination and control strategies according to the national and international needs is the objective of the national immunization Programme.

Introduction of new vaccines in to the Programme should be based on correct technical evidence supplemented by disease burden and cost benefit studies.

The need for high quality, thorough surveillance supported by laboratory confirmation, is heightened by the fact that EPI target disease incidence is very low in Sri Lanka. To maintain the high coverage achieved provision of very high quality service is important with close monitoring and supervision at every level.

1.4.2.d 1) Immunisable Disease Control

2) Elimination of Measles

3) Hib Prevention & Control

4) Viral Hepatitis Prevention & Control

5) Prevention of Rubella

6) Poliomyelitis Eradication Initiative

Project 1.4.2e

Title: Rabies & Other Zoonotic Diseases Control

Summary:

Rabies has been a significant health problem in Sri Lanka for a long time. The social and economic losses from this public health problem have not been computed but would be substantial. It is a matter for concern that mortality is highest among the younger age group, in whom the nation has invested heavily by way of human resource development. Being an island Sri Lanka can achieve great economic benefits as well as save human lives through rabies elimination, due to the fact that once eliminated, an island will find it easier to prevent reintroduction of rabies from other countries. Hence, it is imperative for the government to invest in a rabies control program. The knowledge base with regard to control and prevention of rabies has expanded substantially over the recent past. A sound technical base therefore exists for the launching of new national initiatives for rabies elimination. Goal of National Rabies control program is to eliminate Human Rabies first and secondly to eliminate canine rabies. In all provinces capacity is lacking for the implementation of a comprehensive rabies control program.

Project 1.4.2f

Title: Food- and Water-Borne Diseases Control /
Prevention & Control of Diarrhoeal Diseases.

Summary:

During the last 20 years admissions to government hospitals due to diarrhoeal diseases has been fluctuating between 676 and 961 cases per 100,000 population. It was the 5th leading cause of hospitalization in year 2000.

With the implementation of National Programme for the Control of Diarrhoeal Diseases the death rate due to diarrhoeal diseases has reduced remarkably. But the morbidity rate has remained at same.

So it is very important to have special programme for control and prevention of diarrhoea.

- Strengthen the surveillance of diarrhoeal diseases
- Outbreak prediction and prevention
- Training of hospital staff and PHC staff on prevention and control of diarrhoea.

Project 1.4.2g

Title: Integrated Management of Childhood Illnesses

Summary:

Under five population in Sri Lanka is approximately 1.5 million and of them about 6600 die at a rate of 4. 4 / 1000 population under five per year. Apart from that very large number of children suffer from common illness like pneumonia, diarrhea, malaria, measles, and malnutrition causing considerable disease and economic burden. Research evidence show that these illnesses as the cause of more than 70 % of the deaths in children under five years of age.

It has been identified that delay in recognition of severely ill children by parents, caretakers and resulting delay in seeking care leads to death and severe suffering. Further delay occurs due poor skills in the health care workers at primary level of care in recognition of severely ill children. Improving the skills of health care workers at primary care level in recognizing and managing children with above problems and also in educating parents through them are important strategies in addressing these problems.

Integrated management of childhood illnesses (IMCI) is a well-established method of using holistic approach in the management of sick children with one or more problems. IMCI strategies formulate common guidelines for effective management of a sick child deviating from usual diagnosis based approach. Hence it prepares set of guidelines that are presented in charts, which show the sequence of steps to follow at the clinic or the hospital.

This project, aims to adopt this strategy to Sri Lankan context and prepare training modules, IEC materials, and to train relevant health staff. The project will initially focused on the relatively deprived districts where mortality & morbidity rates are high. Approximately 3500 PHC service providers will be involved in this project.

Project 1.4.2h

Title: Leprosy Control

Summary:

Leprosy Control/Elimination activities in Sri Lanka were implemented through the vertical programme, Anti Leprosy Campaign (ALC) for many decades. Due to successful implementation of MDT programme since 1983 and Social Marketing Campaign since 1990, Sri Lanka was able to achieve the elimination target set by WHO at national level in 1995, five years ahead of the targeted year. Since then ALC involved in strengthening the infrastructure for the integration of leprosy services into General Health Service.

In 2001, Integration was launched. Experience two years after integration showed that regional authorities have taken the ownership of the programme which is functioning smoothly. With the total integration of leprosy services, ALC aims to reach elimination target in remaining few districts and sustain the achievement made so far by constantly monitoring the programme with regional epidemiologists.

Actions have already been taken to repeal the Leper's ordinance 1901 which made admission to these hospitals compulsory and to delete obsolete clauses with regard to leave for leprosy patients in the establishment code. To sustain the achievement made so far and to maintain the continued surveillance, ALC may need additional funds from the Ministry of Health in the event of two funding agencies leaving the programme

Project 1.4.2i 1)

Title: Area Specific Diseases : Leptospirosis Prevention & Control

Summary:

Leptospirosis is emerging in Sri Lanka and has been identified as a potential public health issue in the country. Leptospirosis is reported in both rural and urban parts in the country and case fatality rate is increasing. Therefore it is important to focus on following activities to control and prevent Leptospirosis in the country:

- Assess burden of Leptospirosis in the country
- Establish a National Programme on control & prevention of Leptospirosis in Sri Lanka
- Strengthening laboratory and epidemiologiacl surveillance of Leptospirosis
- Improved facilities for case detection and patient care management at the Medical institutions
- Strengthening veterinary surveillance activities, in order to prevent and control Leptospirosis

- Awareness campaign emphasizing disease transmission, prevention, control, and early referrals to minimized complications
- Chemo prophylaxis for person at a higher risk of leptospirosis
- Strengthened social mobilization programme in leptospirosis control and prevention activities

Project 1.4.2i 2)

Title: Area Specific Diseases :Japanese Encephalitis Prevention & Control

Summary:

Sri Lanka adopted immunization against J.E. as the main strategy, for prevention and control of the disease in high-risk areas in 1988. The target population is children between the ages of 1-10 years.

It is important to strengthen the existing national programme on prevention & control of Japanese Encephalitis (J.E.) further with following components;

- Strengthen the surveillance of Japanese Encephalitis
- Improve the coverage and quality of immunization programme
- Improve laboratory surveillance

Project 1.4.2j

Title: Emerging & Re-emerging Communicable Diseases Control
- Strengthening Surveillance System

Summary:

Disease surveillance system in Sri Lanka has four major sources of information i.e. the data is collected from

1. Indoor morbidity & Mortality reports
2. Notification system
3. Vertical campaigns
4. Medical Research Institute (laboratory data)
5. Registrar General (Mortality data)

All the Hospitals in the Government Network where inpatient facilities are available send their Indoor morbidity & Mortality data quarterly to the Medical statistician.

According to an official notifiable list of diseases the communicable disease are notified to the respective Medical Officer of Health. There are 260 such MOOH in the country.

The seven vertical disease control programmes i.e. AMC, AFC, ALC, RDCP, STD/AIDS, Veterinary Service & Cancer control programmes collect their data using their own mechanisms.

The laboratory data is derived through the information collected when various specimens are received at the MRI and the information is available on request.

There is no standard system to collect data from the OPD of Government hospitals, the private sector including their laboratories, from the laboratories other than the MRI and the other systems of Medicine such as Ayurvedha. This project is aiming at rectifying some of the problems in the existing system and try & improves further.

6.3 PROGRAMME FOR ORGANIZATIONAL DEVELOPMENT

(1) PROGRAMME OBJECTIVE

To strengthen availability, accessibility and cost effectiveness of health services by systematizing and reorganizing the health system, both structurally and functionally, through networking of facilities and by an appropriate referral system and through a health facilities plan.

(2) PROJECTS

Project 1.1.1

Title: Functional Rationalisation by Developing a New Health Services Delivery Plan

Summary:

Systematizing and reorganizing the health system, both structurally and functionally, through networking of facilities and by an appropriate referral system is essential in order to strengthen the availability, accessibility and cost effectiveness of health services. A new health services delivery plan with a clear definition of levels of care and rules for referral and counter-referral will be developed.

The new heath service delivery plan shall be responsive to the current epidemiology, patients' expectations and efficiency of the system as a whole.

This new plan will be pilot tested in one District. Best practices for OPD, IPD & Community Services will be defined.

A referral system will also be pilot tested in one District and extended countrywide after evaluation.

Gradual adjustments of delivery systems to people's health seeking behaviour can be made in the light of the pilot test.

Project 1.1.2

Title: Facility Development According to the Rationalized Health Services Delivery Plan

Summary:

The Facility Development Project aims to develop health facilities according to the rationalized health service delivery plan in order to reduce the heavy demand at the higher level of health facilities and make the system more efficient by taking the following measures.

1) According to the health service plan, develop facilities at primary, secondary, and tertiary level as a pilot base with standardized service facilities and equipment.
2) Ensure the quality of each level services by introducing quality measures.
3) Periodical survey on responsiveness
4) Evaluation

Project 1.1.3

Title: Strengthening of Services for Mother & Child

Project 1.1.3.a.1)

Title: Strengthening of Maternal Health Service ’

Summary:

Maternal health programme aims to improve the well-being of the mother and the newborn. In the past few decades Sri Lanka's maternal mortality ratio has made a significant decline from 1650 per 100,000 live births in 1946 to the current level of 58 per 100,000 live births. Deliveries in health facilities has become established practice(96%).In spite of all these achievements, issues related to quality of service delivery, management practices within hospitals and quality of care given to clients continued to remain major challengers in delivery of maternal health services in Sri Lanka. Significant differences also exist between socio economic groups as well as between geographic areas. Although the antenatal coverage is high, (90%) the quality is not satisfactory. Still anemia is a common problem among pregnant mothers (30%) and it is seen that maternal weight gain during pregnancy is not adequate as majority of mothers gain only 7-8 kg and around 30% of them have less than 18.5 BMI at first trimester. However maternal under nutrition together with a high incidence of anaemia has resulted the high prevalence of low birth weight babies (16%).

Therefore interventions are needed to Improve the quality of antenatal care. Reduce the prevalence of anaemia among pregnant mothers, achievement of adequate weight gain during pregnancy and sustainable supply of micronutrients are some of the major concerns in the present situation in order to improve the quality of maternal care. It is a felt need to introduce new strategies on improving the antenatal and post natal services.

Introduction of referral system, surveillance system on maternal morbidity and sensitize the communities on male participation on family health is another important component that should be addressed in near future. Women's right to life and health is also an important issue that will enhance the quality of maternal health services.

Project 1.1.3.a.2)

Title: Strengthening of Management information system on MCH/FP

Summary:

Since the establishment of the Family Health Bureau in the late 1960s, a separate section was developed (the Evaluation and Research Unit) to undertake the function of continuous monitoring and evaluation of the MCH/FP programme. Parallel to this a series of returns, records and registers were carefully developed to collect information on MCH/FP activities right from the Public Health Midwife areas through the health information system. A computerized database was developed for MCH/FP information as early as 1979. This was the first computerized database established in the Ministry of Health.

Since 1980's a well-established Management Information System (MIS) is existent in Sri Lanka. This system provides vital information on service delivery of Maternal & child health and family planning in all the districts of the country. It yields data on outcome and impact indicators, which are being used by national and international agencies in setting targets, developing policies and strategies and also selecting priorities for donor assistance. The information derived from the system is used by divisional/ district & provincial supervisors and programme managers to uplift the service delivery in deficient areas.

This project proposal is developed on strengthening of Management Information System aims at human resource development, improving logistical support, strengthening supervision, monitoring and evaluation of Maternal and Child Health activities at periphery. It also focus on conducting operational

research in relation to MCH/FP services with a view to improving service delivery system in Sri Lanka.

Project 1.1.3 b

Title: Health care of needy groups of women

Summary:

Several important issues that cause considerable burden of disease of death, had been identified in relation to health of women in several specific categories. Te categories include 1. Migrant women and their families 2. Female workers in free trade zones. 3. Females who experience domestic violence. 4. Teenage pregnant women. These women experience problems specific to heir own contexts and special programs has to launched to address these problems.

The women migrating to Middle East countries experience numerous health problems, mental health problems, sexual health problems, etc. In addition to that the family member left behind especially children face numerous problems such as sexual abuse, nutrition problems, mental health problems etc. Under this project awareness programmes, development of IEC material, training of PHC staff will be carried out.

Female workers in FTZ area are reported to be experiencing number of reproductive health problems and mental health problems. Lack of awareness, attention and training of these females give rise to catastrophic results to them. Training of public health staff, health clinics at free trade zone and printing of education manuals are some of the activities undertaken under this project.

Information on Intimate partner violence is yet to discovered. The current situation related to violence against women due to various social factors are primary disadvantageous to the victims and their families when such cases are reported to the authority. Taking necessary policy decisions with male partnerships and training of trainers to reduce IPV are some of the important steps in reducing violence and will be undertaken in this project.

Last but not the least the importance of reproductive health problems among teenagers are addressed under this project. Teenage pregnancies, abortions, sexual problems and other health related issues of this group should be studied and addressed promptly. Identification of problems by undertaking small scale surveys, development of health education material, training of public health staff are some of the activities carried out within this project.

Project 1.1.3.c

Title: Strengthening the Emergency Obstetric Care & Neonatal care

Summary:

Provision of Emergency Obstetric care and New born care aims at reduction of Maternal mortality and morbidity and New born morbidity and mortality in Sri Lanka. Improve Emergency Obstetric care and ensure a safe delivery will have impact not only on maternal health. It has a greater impact on Newborn health. Provision of EMOC services can further reduce the case fatality rates due to hemorrhage and other major obstetric complications.

Infrastructure development allocation of Human resource and other recourses is a major activity in this project.

Improvement of Quality of care is a major activity to be carried out.

Maternal death is a tragedy and also a social injustice for individual women, their families and their communities. Most maternal deaths are avoidable, and thus unacceptable. A woman dies from the

complications of pregnancy and childbirth due to many factors. Availability of adequate health services to treat life saving complications is curial. However if deaths are to be avoided women must have access to these services. Maternal mortality is also closely linked with health of children. It is known that the same factors that cause maternal mortality and adversely influence child survival effecting a healthy early start fro the baby.

It is now acknowledged that risk factors such as parity and age while identifying groups of women who are more likely to have complications; will not necessarily predict which individuals will have complications. While most obstetric complications can neither be predicted nor prevented, they can be successfully treated if access to quality emergency obstetric care services is available. "Interventions that reduce maternal mortality have often been confused with what improves maternal health. Emergency obstetric care is essential and life saving for complications that may arise with pregnancy and childbirth. Also needed are interventions that improve women's health and wellbeing, such as providing quality antenatal care, sharing information, treating anaemia and improving nutrition".

Evaluation of maternal programmes in most countries in South Asia show that management and leadership are the most critical issues that affect programmes. Thus the project: "Women's Right to Life and Health" will mainly address leadership and management issues related to implementation of maternal care programmes at all levels of implementation. The project is based on the epidemiological praise that:

- Maternal mortality is a result of complications that develop in pregnancy,
- That these complications cannot be reliably predicted or prevented,
- Death from complications can be averted with timely medical care.

It mainly supports the third delay of the "3 delays mode" namely the delay in the hospital. The reasons include lack of motivation, teamwork, commitment, leadership and management as well as lack of resources and technical skills.

Project 1.1.3.d

Title: Establishment And Maintenance of A Developed Logistic Management System for Strengthening of Family Health Services

Summary:

The Family health Bureau is the central organisation responsible for the planning, coordination, direction, monitoring and evaluation of Family Health Programme in the country. Therefore establishment and maintenance of a proper logistic management system, so as to have an uninterrupted supply of contraceptives, micronutrients, equipment and supplies for the Family Health Programme is essential to enhance and strengthen the Family Health Services of the country.

Establishment and maintenance of a developed logistic management system can be achieved by:

- Establishing a proper logistic management system at national and provincial, district and provincial level.
- Establishing a computerized and linked information management system
- Improving procurement, storage, and distribution of contraceptives at national, district and MOOH level.
- Improving procurement, storage, and distribution of micronutrients, equipment and supplies needed for the implementation and delivery of Family Health activities at the provincial, district and divisional level.

Hence, establishment and maintenance of a proper logistic management system throughout the country, and maintenance of a proper flow of information from the centre to the periphery and a feed back so as to have an uninterrupted supply of contraceptives, micronutrients, equipment and supplies for the

Family Health Programme is essential to enhance and strengthen the Family health Services of the country.

Project 1.1.3.e

Title: Child Health Programme

Summary:

Provision of service delivery for children aged five and under focuses on improving the quality and coverage of service delivery with special emphasis on vulnerable groups such as those living in urban slums, conflict areas, institutions, rural remote areas, street children and those in the estate sector. It aims at strengthening the existing services while identifying and implementing new strategies to address the unmet needs of children. The following major activities would be implemented by the Central and Provincial Health Ministries in co-operation with local and foreign consultants.

- review and revise existing Child Health Policies, Child Health programmes and guidelines.
- Implement the Early Child Care and Development programme in all Provinces.
- Provide services for differently abled children.
- Provide sustained services to those living in vulnerable areas and belonging to vulnerable groups.
- Establish a system to investigate all deaths occurring in infants and children aged 1-4 years.
- Establish a surveillance system to identify the morbidity patterns of under 5 children.
- Enhance coverage and quality of EPI programme to improve child survival.

Project 1.1.3.f

Title: Family Planning

Summary:

Even though Sri Lanka has already achieved a replacement level fertility, it was estimated it would take at least next 30 years to reach zero growth rate due to the presence of a larger number of females in reproductive age groups. There fore it is very important to sustain the effective family planning program through out near future.

The success of the family planning program has been the main factor behind the current fertility pattern. Providing family planning counselling to the women in reproductive ages at their homes by PHMs and providing continuous supplies of contraceptive commodities free of charge to the fertile couples has been the main fillers of the success. The training of PHC workers in family planning methods and counselling has been proven to be effective interventions. These activities have to be continued to sustain effective family planning program. Further it is very important to ensure the continuous supply of contraceptive commodities to this large number of fertile couples in near future.

Apart from that about 10 % of couples are sub fertile and there is no standard health management systems in place for them. Therefore the project also will look in to this problem as well

Project 1.1.3.g

Title: Information, Education and Communication Support to Reproductive Health Services (IEC support for RH)

Summary:

Sri Lanka has performed better than most developing countries with regard to population reproductive

health and women empowerment.

Despite the favourable overall national demographic and social indicators of Sri Lanka, there are vulnerable groups of population and underserved geographic areas where the indicators are much less favourable than the national averages.

Under the 5th country programme cycle of support to Sri Lanka which implemented in 1997 – 1998 IEC activities were aimed at general public, health workers as out of school adolescents and youth.

The 6th country programme cycle has build upon the experiences and lessons learned of the previous project and further focus on undersweved areas and vulnerable groups.

The objective of the project is to have increased awareness of sexual and reproductive issues, including responsible and gender sensitive behaviour among adolescents and youth.

In order to achieve this five IEC implementing agencies which are dealing with youth and adolescents have been identified and a series of IEC activities have been scheduled..

Among these IEC implementing agencies HEB plays a leading role in providing technical guidance and support and as a monitoring body too.

HEB activities mainly focus on increase awareness among youth and adolescents through capacity building in health staff and media personnel production of IEC materials both print and electronic media.

Project activities are evaluated at periodical intervals as annual, mid term and final.

Project 1.1.4

Title: Strengthening of Laboratory and Diagnostic Services

Summary:

To practice the science of medicine either in the hospitals or on field, one needs a consistent support from laboratory services.

The Project is aimed at providing quality laboratory services by ensuring efficiency in the functioning and equity in the clustering of laboratories in public hospitals and on field as well as in the private sector.

To achieve its objective, the Project will formulate clear, coherent and practical policies, standards/norms and regulations based on lessons learned from local and international experiences in improving laboratory services. The following will be pilot-tested to assist the formulation or amendment of existing policies, standards and regulations: clustering of government laboratories; public-private partnerships; and Laboratory Investigation Data System. Once approved, the policy, standards and regulations will be used for the nationwide implementation of mechanisms to improve intra- and inter-sectoral partnerships, strengthening the human, financial, equipment and logistic resources to the maximum capacity for the needs of the patients. Furthermore, an accreditation system will be established that will encourage and not police laboratories so that they will consistently strive for quality and excellence. Considering the cost of maintaining and replacing equipment, an improved equipment accountability system will be adopted.

Project 1.1.5

Title: Blood Safety

Summary:

The Blood Safety projects aims to increase blood safety through provision of adequate amounts of safe blood and blood products and better utilization of blood through use of blood components and plasma fractions as well as appropriate clinical use. The following activities will be implemented by the National Blood Transfusion Service with help from Ministry of Health and local and international

consultants.

1 Implementation of Blood Policy in both state and private sectors

2 Improvement of testing, processing, storage and transportation of blood and blood products

3 Introduction of plasma fractionation with help from international partners

4 Establishment of an IEC unit on Blood safety

5 Improvement of Quality Assurance through introduction of Quality systems and bio safety techniques

6 Improvement of Human Resource Development with introduction of training programmes

Project 1.1.6

Title: Technology Assessment

Project 1.1.7

Title: Emergency Preparedness & Response

Summary:

Emergency Preparedness and Response (EPR) project aims at the provision of standard and quality emergency management service specially to people affected by a disaster, man-made or natural and also to provide immediate care to the patients brought to hospitals in moribund stages. At present, there is no proper system or national policy in this regard. With the implementation of this project, a system of emergency care will be available which is nationally accepted. EPR, once implemented, would be supported, controlled, and regulated by frequent monitoring at the central and provincial levels. This regulation would be to maintain the standard of the quality of services. Following will be the main activities:

- Baseline need assessment in all health institutions including District Hospitals (DHs) and above in respect of EPR facilities;
- Actions will be taken to establish EPR units in all DHs and above;
- Existing EPR units/ facilities will be improved according to the level of institution;
- All the units will be provided with appropriate basic equipment, skilled personnel and other basic infrastructure required for EPR management (provision of equipment will be planned by the respective group);
- Equipment will vary according to the level of institution;
- National policy/Plan will be formulated in order to ensure quality and the uniformity of EPR services;
- Curative health care will be integrated with primary health care services in respect of EPR to form an emergency primary health care complex;
- EPR services will be directed towards the provision of immediate care and the aspects of rehabilitating and restoring the health of the people of a conflict- and/or disaster-affected area;
- Provision of safe drinking water, foods and nutritional support, latrine facilities control of possible outbreak of communicable diseases among the refugees will be ensured;
- Routine medical/surgical emergency services will be in all health institutions; and
- Disaster management plan will be prepared to ensure the uniformity of service in each level.

6.4 MEDICAL SUPPLIES (INCLUDING DRUGS) AND EQUIPMENT PROGRAMME

(1) PROGRAMME OBJECTIVE

To improve the accessibility of the community to required drugs & medical equipment for standardized diagnosis & treatment.

(2) PROJECTS

Project 1.2.1

Title: Medical Supplies (Including Drugs

Summary:

Ministry of Health is committed to ensure the availability of good quality, safe and effective essential drugs to the people. The aim is to make sure efficient supply with continuous availability of life saving, essential drugs and vaccines in all health institutions.

This project covers supply and distribution of all essential drugs and all other medical supplies except medical equipments to all govt and semi govt health institutions by the Medical Supplies Division. Also the latter is responsible to the supply of narcotic drugs to both public and privet sector. Prime problems at present the project is facing are incompatibility of physical drug estimates with the financial allocations. Increased receipt of poor quality drugs, delay of supply as per agreed schedules leading to extra expenditure on local purchases and absence of good guidelines for re-imbursement for quality failed drugs.

The "First in First out" principle is hardly practiced due to failure in quick identification of batch numbers & expiry dates on outer packages because of labels containing small illegible letters & figures. As a result ledger entries cannot be made as per batch amounts & no cross sectional age analysis of stocks can be made.

Reliable most recent information should be collected regularly on drugs & use of drugs from planers & consumers to improve the rational use of drugs to make the project efficient & effective.

Planning for future developments should take into consideration the adequate additional requirements of medical supplies in estimates in advance to avoid delays & problem of exceeding allocations.

Project 1.2.2

Title: Medical Equipment Management Improvement

Summary:

The Medical Equipment Management Improvement project aims to increase efficiency, efficacy and cost-effectiveness of medical equipment in utilization in the country, by further enhancing capacities of management in responding to the needs and expectations of patients and the other clients.

This project aims at the following major areas in order to improve the performances of medical equipment in the country:

- Establishment of efficient and cost-effective medical equipment maintenance system for public health sector;
- Establishment of evidence-based medical equipment procurement planning system;
- Establishment of medical equipment management system including a computer-based medical equipment information system;
- Establishment of a training center for continuous training on healthcare technologies and clinical engineering for end-users, maintenance staff and decision makers; and
- Establishment of public-private partnerships.

Successful implementation of this project will be expected to deliver the following benefits to the healthcare delivery system in the public sector:

- More than 90% of the available equipment are in proper working condition at any time;
- Only required equipment are purchased and all the equipment are utilized in their optimum capacity; and
- End-users and maintenance staff are well-trained on their jobs and decision makers know on what they make decisions and their impacts to the health sector.

6.5 NATIONAL QUALITY ASSURANCE PROGRAMME

(1) PROGRAMME OBJECTIVE

To enhance the quality of preventive, promotive & curative service delivery including improved responsiveness to community needs.

(2) PROJECTS

Project 1.3.1

Title: Improved Quality of OPD & IPD Services

Summary:

The project of improving quality of Out Patient Department Services & In Patient Department Service is designed in a objective of developing standards, protocols on best practices & also upgrading facilities at OPD & IPD to improve structure & process care including diagnostic services & establishments of a medical audit system through which ensure high quality of care. In view of achieving this objective various activities such as developing policies, treatment protocols & standards regulatory frame work for medical audit, logistical plan for each institution as an establishment of an information network.

Project 1.3.2

Title: Development of Emergency Services Network for Injuries, Accidents, Poisoning & Disasters

Summary:

Analysis of mortality patterns due to injuries, accidents, poisoning and disasters over the years have clearly shown that the delays of attending to these emergencies have been the route cause of mortality in this country. Hence, with the objective of organizing an emergency services network, improving intensive care services in secondary and tertiary care services and strengthening ambulance services with the communication network, the following activities such as developing rules and procedures for emergency services network, setting up guidelines for prioritizing manpower development etc. have been developed. This project will be implemented throughout the country on priority basis by the Ministry of Health.

Project 1.3.3

Title: Total Quality Control/Management of Hospital Services

Summary:

The project aims to improve the performance of the hospitals through improving the overall management. All aspects of performance including quality of care, financial management, employee satisfaction and productivity and innovation are targeted.

Six hospitals representing distinct facilities will be selected; TQM activities will be initiated at these organizations. Project duration is two years. Five-S is planned as the first step of the implementation process. Based on the project experience implementation guidelines will be developed for all public hospitals.

MoH is expected to act as the facilitator and the personnel of respective hospitals are expected to be given significant autonomy to practice TQM.

Project 1.3.4

Title: Total Quality Control/Management of Promotive & Preventive Services

Summary:

The project aims to improve the overall performance of the promotive and preventive health aspects. Improvements are expected in health care, employee satisfaction and productivity, and financial and innovative aspects of the performance.

All districts of Sri Lanka are targeted. Project duration is five years.

Major activities planned include standardization of promotive and preventive activities, organization of better MIS and implementation of CQI activities through TQM teams established at each DPDHS level. The MoH and Provincial MoHs are expected to evaluate and monitor the progress.

The project is expected to improve the overall health of the nation by stimulating good promotive and preventive health practices of the public through a high quality service delivery system.

6.6 PROGRAMME FOR VULNERABLE POPULATIONS

(1) PROGRAMME OBJECTIVE

To improve the health and nutritional status of vulnerable populations.

(2) PROJECTS

Project 1.5.1

Title: Estate Health

Summary:

The Health Ministry policy is that the health services in the Estate Sector should be integrated with other state health care services and the disparity that exists between the plantation sector and the other sectors of the country in provision of basic health services and the social behaviors should be reduced.

The project is to bring the health standards of the estate sector to the national level enjoyed by the rest of the population with involvement of Provincial Health authorities and Ministry of Community Development by doing need assessment, analysis, and developing and implementing the required plan with due consideration to accessibility, availability and the quality of the care and their living conditions.

The population benefited will not only of the larger estates, which are managed by private companies and monitored by PHDT but of the smallholdings, which are not monitored by anyone.

The major outputs will include improved quality and accessibility of curative care, development of preventive services, improvement of the health seeking behavior and utilization of health services, empowering the women by community participation also developing a mechanism for collaboration and coordination between estate management and estate health sector, promotion of health research and its applications specially related to social issues in the estate sector and establishment of the management information system which is used in other parts of the country.

Project 1.5.2

Title: Elderly Health

Summary:

The division of Youth elderly, disabled and displaced persons of the Ministry of Health, in collaboration with other relevant divisions of the Ministry of Health, other governmental, non governmental and private agencies working for elders aims to improve the well being of elders and to prepare the future generation of elders for a more healthy active and productive life.

Project 1.5.3

Title: Disabled Health

Project 1.5.4

Title: Adolescent Health

Summary:

The division of youth, elderly, disabled and displaced persons in collaboration with other sectors in the Ministry of Health & with other relevant governmental & non governmental agencies, aims to improve the overall health of youth in the country by creating a safe & supportive environment, by enhancing their knowledge attitudes & values and improving their skills to make responsible decisions an actions leading to healthy behaviour and by providing youth friendly services

Project 1.5.5

Title: Occupational Health

Information on the occupational health situation prevalent in Sri Lanka, in terms of diseases, injuries and risks is very limited. Existing surveillance mechanisms and services have to be further strengthened to promote a safe and healthy working environment. Awareness on occupational health, safety and hygiene among employers and employees has to be developed and inculcated as a safety culture, to promote safety consciousness among workers and safety supervision in work places. Institutional capacity for hazard identification, risk assessment and enforcement of standards needs enhancement. This project aims to achieve the above by developing an institutional mechanism and a national plan of action, which would ensure a sustained and productive inter-sector collaboration for programme development, implementation and enforcement.

Project 1.5.6

Title:: Health of People in Urban Slums

The health problems of urban people are mainly related to their life style such as food habits, sanitation, etc and resource constrains. However, not much data is available. High risk groups specially the poor, living with in the urban that need special care. As such we have to identify the major health problems and issues, and presently available services and develop a policy and strategies to provide better health services to these under privileged urban slum people.

This project includes.

1. Situation analysis and the health problems of those who live in the urban slum.

2. Development of a policy and strategies for the Urban Health.

3. Identifying Major areas and issues for service delivery.

4. Identifying mechanisms to implement those strategies and activities.

Project 1.5.7

Title: School Health

Summary:

The school population in Sri Lanka consist of about 4.2 million children of the age group of 5-18 yrs. Of this about 60% belong to the adolescent age group of 10-18 yrs. The goal of the school health programme is to ensure that children are healthy, capable of promoting their own health and health of the family and the community and are able to optimally benefit from the educational opportunities provided. This includes opportunities provided to obtain correct information and develop life skills to prevent reproductive health problems including teenage pregnancy, HIV/AIDS, nutritional problems, substance abuse, stress, violence & suicide which are the common problems among these children. A

major area of service delivery in the project is providing school health services for detection of health problems and correction, referral of needy children to specialist clinics and follow up, immunization, school dental services & counseling services for reproductive health problems. By providing a healthy school environment and life skills based health education, behavioral changes which are necessary to improve the health of the school child can be achieved. Also the burden caused by most of the prevailing health problems in the country including the non communicable diseases could be addressed in a cost effective manner through this. Community participation for this has to be developed for mobilization of resources. These services are delivered by the Medical Officers of Health & their staff at the Primary Health Care level. In addition to this some urban areas there are School Medical Officers designated to deliver these services. Since the health of the school child is a shared responsibility of the Ministries of Health & Education a close collaboration is maintained between the two sectors. Monitoring & evaluation of these activities is achieved through the Management Information System of the Family Health Bureau .

6.7 HEALTH PROMOTION PROGRAMME

(1) PROGRAMME OBJECTIVE

To provide the health sector, including NGOs and civil society, with technical assistance on health promotion as well as on developing materials together with health programmes particularly in nutrition, family health, disease control, and environmental health.

(2) PROJECTS

Project 1.7.1

Title: Development of National Policy & Plan on Health Promotion including Strengthening of Coordinating Mechanisms

The health system in Sri Lanka has realized the importance of health promotion to achieve its goals. **The Key Stake Holder Forum** will bring together a number of influential people with key roles in health promotion in Sri Lanka. They will articulate **a vision for health promotion:** how they would like to see health promotion in Sri Lanka and formulate **policy** statements for health promotion.

Establishment Leadership Coalition for specific health issues will enhance partnerships, pool resources and avoid duplication of work. They will develop a **Strategy Coordination Framework** for specific issues, which identify key elements of all major strategies and hence facilitate linkages. Respective Coalitions will review and re-focus existing health programmes to address more on health determinants than individual behavior change.

Project 1.7.2.a

Title: Establishment of Implementation Mechanisms for Health Promotion Programme

In Sri Lanka there is a well established infrastructure setting for Health Care and Health Promotion. There are five(5) national programmes for prevention of communicable diseases and a unit for implementation of specific programmes and timely action for preventive interventions. There is a reasonable PHC network and institutional care system. Behaviour Change Communication(BCC) interventions and health promotional strategies need to be strengthened for prevention of communicable diseases. Community participatory and extension education techniques need to be effectively adopted for preventive action, intervention, need to be planned monitored and evaluated with active participation of relevant infrastructure facilities – personal and institutions and the community. Community and social mobilization interventions need to be intensified.

Project 1.7.2.b

Title: The health promoting Religious places project

Health education and health promotion needs a group of competencies and skills, which are relatively new for officers coming from different educational background and qualification. Therefore periodic tanning of officers including new recruitment is an essential component in the HEB

Following strategies should be adopted to face above challenge.

1. Establishment of training unit in the HEB

2. Development of distance education modules for officers

3. Organized periodic and fixed training programme

Project 1.7.2.c

Title: Health Promotive Setting Approach.

The concept of health promotion (HP) and the "settings approach" to health promotion is used as strategies by developed countries to achieve health of the population. This is a new development in the health field of Sri Lanka and Health Education Bureau has identified 'settings' such as schools, hospitals, workplaces, estates, religious institutions and communities for HP programme planning and implementation. HP activities such as individual capacity building through training and education for HP in one end to Advocacy, Facilitation, and social mobilisation to promote supportive environments and health literacy to improve the health and social outcomes of the general population is done through a "settings approach"

1. Health promoting schools program
2. Health promoting estates
3. Health promoting workplaces program
4. Health promoting hospitals
5. Health promoting communities

Project 1.7.2.d

Title: Lifestyle Programme

Lifestyle related diseases are on the increase in Sri Lanka. The 10 commonest causes for hospital deaths are related to unhealthy lifestyles of people.

The commonest causes for these are wrong dietary habits, poor physical exercise, stress, alcohol and smoking.

A comprehensive health program to address all the issues related to this problem is needed to improve the lifestyles of the people to reduce the mortality and morbidity related to LSR Diseases.

- Nutrition improvement and weight control program
- Promotion of Physical activity program
- Alcohol and smoking prevention program
- Stress reduction and relaxation program

Project 1.7.2.e

Title: Programme for improved community involvement in Health Promotion

Planning, Implementation and evaluation of voluntary health worker programme is a major community participatory and extension education technique adopted in health promotion in Sri Lanka. Initially the activity to be implemented in five communities (five villages) in selected areas of public health midwives in each MOH division and subsequently extend the programme to another five communities and implement activity in the fifty villages in each MOH areas within the period of 10 years. Within this 10 years of project period nearly about forty thousand villages in the country to be covered with the programme.

The following activities are implemented by central Ministry of Health (MoH) and Provincial Ministries of Health with corporation of international agencies.

- Implementing policy and implementing guidelines.
- preparation of updated training plans and materials.

- orientation of health managers and workers.
- implementation of activities at community levels .
- Recording, reporting and evaluation.

6.8 NATIONAL NUTRITION PROGRAMME

(1) PROGRAMME OBJECTIVE

To improve the nutritional status by integrated service delivery in preventive & curative sectors & community-based activities.

(2) PROJECTS

Project 1.6.1

Title: Development of National Food, Nutrition Policy & Plans including Strengthening of Coordinating Mechanisms

Summary:

Formulation of a Food and Nutrition Policy for Sri Lanka with special emphasis on the following;

- Examine the present nutritional status of the population highlighting the incidence of malnutrition and the prevalence of nutrition imbalances.
- Examine the status of the food security of the population in relation to nutritional value of the main food items, dietary habits/food consumption patterns and assess their impact on the nutritional status of the people, in order to determine the necessary interventions.
- Review the present food and nutrition policies, strategies and programmes and their implementation at household level to determine their adequacy and efficacy to achieve the desired food and nutrition levels and standards.
- Develop food and nutrition policies, strategies and programmes for the improvement of household food and nutrition security to the required standards during the period 2004 to 2010 with special emphasis on health sector interventions.
- Identify the means of mobilizing resources for the implementation of food and nutrition policies, strategies and programmes, which are coming under the purview of the health sector.
- Propose an effective coordination, monitoring and evaluation system at the operational level and the policy making level to ensure effective implementation of the health sector food and nutrition policies and programmes.

Project 1.6.2

Title: Establishment of Mechanisms to Implement the National Nutrition Programme

Summary:

This project is designed to encompass all sectors responsible for improvement of nutrition Sri Lanka and is primarily with a focus on the department of health services nutrition care delivery programs.

Integration of services provided through the hospital and field health system has been emphasized o strengthen the existing programs and also minimize duplication of services. Focus on population groups

which are not emphasized in the current program such as the adolescents, elderly and disadvantaged groups have been included. Management of nutrition in crisis situations has shown a disarray as well as catastrophy after the disaster. A scientific basis for early warning & also management during disaster including mobilizing donor assistance systematically has been included. Nutrition Information is conducted as a routine requirement with the significance of such information not been realized and utilized for improvement of services at field level. Use of the triple A process in information management has been included in this project

Collaboration and also utilizing services of the private sector for improvement of nutrition has been included. Food fortification in accordance with national nutrition policies is a certain method of improving the micro nutrient deficiency status in the country. Recognition of priorities of the private sector and developing mechanisms for bilateral benefits are important for successful implementation of this project.

Community based organizations which often operate independently of the government sector will provide services which are concrete efforts to improve the nutritional status of the communities which they serve. Partnership in growth promotion & monitoring will definitely ensure a much more successful coverage of children and also promote growth which is an identified fall back in the field based system.

Collaborative promotion of nutrition services delivered through other government sectors such as agriculture (to promote household level of food security) has been included in this health sector plan as the health (field) nutrition delivery system has to operate with a holistic view on nutrition. The close contacts the field health system has with the communities will help in promoting these services.

CHAPTER 7

STRATEGIC PROGRAMMES FOR COMMUNITY-EMPOWERMENT AND CLIENT-SATISFACTION

7 STRATEGIC PROGRAMMES FOR COMMUNITY-EMPOWERMENT & CLIENT SATISFACTION

This chapter discusses issues related to the development of community empowerment and client satisfaction in Sri Lanka. Further, it proposes strategic directions towards the development of comprehensive health services delivery in the next 10 to 12 years.

7.1 PROGRAMME JUSTIFICATION AND LINKAGES

The two programmes designed to empower communities towards more active participation in maintaining and promoting their health and enhancing client satisfaction are as follows:

- Programme for Improved Community Involvement for Health Development, and
- Programme for the Promotion and Protection of Human Rights with Relevance to health.

(1) ISSUES OF PRESENT HEALTH SERVICE MODEL

Health services of Sri Lanka are mainly structured on the medical model. Even the public health sector follows a consumer - provider model of service delivery. In this model, an expert, in possession of special knowledge, prescribes information/consumables the consumer or service user needs and expects compliance. Furthermore, administrators, politicians, and other leaderships in health and other sectors used to view 'health' as something to be delivered right into consumers' hand. As a result, many health projects and initiatives designed to empower community are tuned out to be service provider projects.

(2) CHALLENGE TO COMMUNITY EMPOWERMENT

Community empowerment challenges the traditional medical model. An empowered approach calls for professionals to unlearn much of the traditional approaches. They need to learn new competencies such as negotiation, communication facilitation and coalition building. Therefore, capacity of government officers, community leaders and politicians needs to be enhanced to obtain their commitment for community empowerment process.

(3) COMMUNITY EMPOWERMENT PROCESS

Empowerment is viewed as a process; 'the mechanism by which people, organisation and communities gain mastery over their lives' (Rappaport, Swift, Hess, 1984). Andreson has defined empowerment as ' a social process of recognising, promoting and enhancing peoples' ability to meet their own needs, solve their own problems and mobilise necessary resources to take control of their own live.

Empowerment is not something that can be 'done to' some one. People can only empower by themselves (Lanonte 1989).

(4) COMMUNITY PARTICIPATION IN HEALTH ACTIVITIES

Improved community participation in health has several advantages. It leads to better decisions, high accountability, good compliance and sustainability of health efforts. The degrees of participation observed in health sector activities vary. In the lowest degree of participation, community is told nothing. In majority of community health project, community receives information for compliance, consulted or take advice after planning. There are hardly any project that has joint planning and delegation of authority indicating high level of participation. Many health projects experienced low community participation, which affect sustainability at large. One of the reasons is lack of opportunity for participation. Therefore, local joint action for health development needs to be encouraged and expanded. Other opportunities for community participation in health development need to be explored. For example, already existing mechanisms such as Hospital Development Committee and Health Development Committee need to be strengthened.

(5) HEALTH AS A RIGHT

Primary health care concept is adopted by the government of Sri Lanka for few decades. Equity and social justice is the basic for PHC strategies. PHC also emphasised the need for access to resources by the people irrespective of their social or economic status. As a policy, government has responsibility to secure health of the people. Therefore, health issues could be viewed as human right issues. People have a right to access health information they need, and right to make health choices. Further, their right to express views on the services they received should be preserved.

Presently, there is no uniform system for dissemination of health information. Further, it is not considered as a role or responsibility of health care system. Therefore, not all people have equal access to their own information needs. Up to date and easily accessible information base and dissemination system needs to be established.

Health service is subjected to the effects of economic rationalism. In addition, private partnerships for health are given high priority in new health development process. Both these could affect the consumer rights. Therefore, policies, laws and legislations need to be established to protect health consumers.

(6) VALUE OF EMPOWERMENT IN HEALTH

Community empowerment is the centre of focus in health promotion and the key to community development. A core value of community development is high participation of communality in health care. Empowerment approach in health development has two major elements. First, it involves facilitating the process of individual growth and development, for example, enhancing self-control, self-efficacy, self-esteem, developing social skills, and providing access to new information. This should be accompanied by a second element that is 'a commitment to challenging or combating injustice and oppression'. Therefore, empowerment approach to health promotion recognises the right of individual, and communities to identify their own health needs, to make their own health choices and to take action to achieve them.

The programmes of Community Empowerment: ***Programme for Improved Community Involvement for Health Delivery*** and ***Programme of the Promotion and Protection of Human Rights with Relevance to Health,*** aim to achieve these two major elements of the empowerment approach in the health development.

Regarding the programme linkage, several programmes are interlinked. The community empowerment will enhance the programmes such as inter-sectoral programmes, health promotion programme, nutrition program and programme for vulnerable population. The linkages are shown in the following diagram.

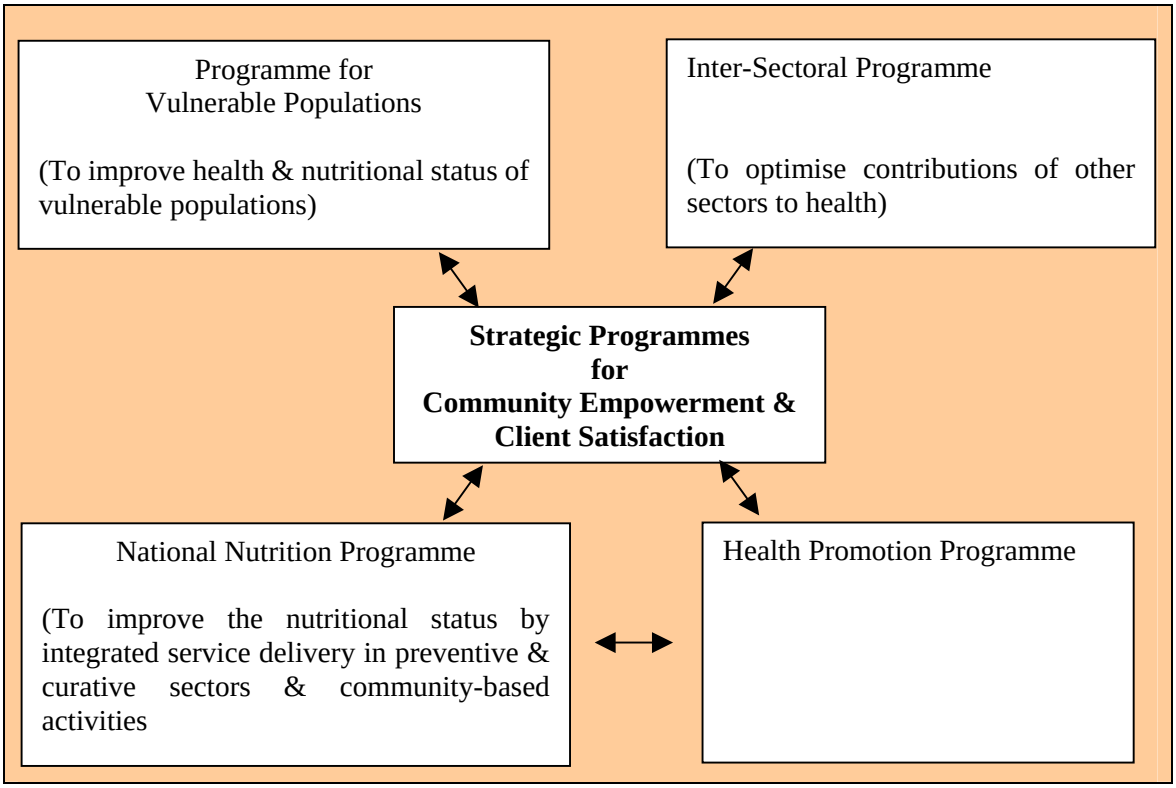


Figure 7.1.1 Programme Linkage

7.2 PROGRAMME FOR IMPROVED COMMUNITY INVOLVEMENT FOR HEALTH DEVELOPMENT

(1) PROGRAMME OBJECTIVE

To achieve a better maintenance of health by the community and responsiveness of the services.

(2) PROJECTS

Project 2.1.1

Title: Strengthening the Capacity of Key Concerned Government Officials, Community Groups & Political Leaders in Improving Community Involvement in Health Development

Summary:

The project for strengthening the capacity of key concerned government officials aims to achieve a better maintenance of health by the community and responsiveness of the services. The major measures to strengthen the capacity of key concerned government officials are;

- Raising awareness of the community regarding health needs and services
- Expansion & /or revitalization of local joint actions for health
- Review and improvement of the role & performance of hospital committees and health development committees.

Project 2.1.2

Title: Raising Awareness of the Community Regarding Health Needs & Services

Summary:

Strengthening of the community through identified mechanisms could be the key to their active involvement in health activities for their benefit.

To develop a suitable environment to achieve the above objective a proper process to disseminate information through both modern & traditional medium is needed.

It also needs to stimulate the health workers for this purpose by updating their knowledge & skills.

The use of media to disseminate the information to public too will need highest priority

Establishment of “Health Circles” at community level, Work place level, Estate level, Religious places level, school level etc.

Formation of Media, Clubs at community level with active participation of youth, to respond to media programme.

Development & publication of journals, newsletter, brochures etc. for health workers, youth clubs, volunteer health clubs, journalists etc.

Development of Traditional Media programme such as puppet shows etc.

Conduction of competitions among various categories of public.

eg: School children, youth, housewives etc.

Development of Exhibition panels and conduction of exhibitions at various settings.

Conduction of research studies on community involvement & the usefulness of the various strategies made to important the community involvement.

Establishment of a training mechanism and award scheme for media personnel

Project 2.1.3

Title: Expansion &/or Revitalization of Local Joint Actions for Health

Project 2.1.4

Title: Review & Improvement of the Role & Performance of Hospital Committees and Health (Hospital) Development Committees

Summary:

The present hospital community system has to be amended to suit the present needs of the hospital setup. The functions and the role of the hospital community should change accordingly. Therefore, the MoH has decided to take legislative steps to amend the act. To ensure wide participation MoH expects to get the public's views and ideas. The MoH also intends to introduce a new series of training programmes to educate its staff members. The main objective of the exercise is to upgrade the quality of the hospital community system to serve the present needs.

7.3 PROGRAMME FOR THE PROMOTION AND PROTECTION OF HUMAN RIGHTS WITH RELEVANCE TO HEALTH

(1) PROGRAMME OBJECTIVE

To further health rights and thereby improve adequacy & quality of health services.

(2) PROJECTS

Project 2.2.1

Title: Establishing a System of Improving People's Access to Regularly Updated Information in All Public & Private Facilities

Project 2.2.2

Title: Development of a Health Charter, Necessary Legislation & Implementation Plans to Protect Communities, Households & Individuals

Project 2.2.3

Title: Establishment of the Ombudsman System within the Central & Provincial MoH to Promote/Protect Health Rights

Summary:

Promotion and protection of human rights related to health of individuals and the community are important aspects in an efficient health care system. Such rights should not only be promoted but also violation of them should be prevented. Human right of the providers as well as the recipients have to be taken into consideration together. There are areas of conflicts pertaining to the human rights of recipients (patient/community) and the providers (employed/workers). In the instance of violation of health related human rights, what ever the cause may be, a relief to victims is essentials and important. In such situations Ombudsman system has a major role to play and could bring about solutions to problems and relief to grieved parties. However, to establish an Ombudsman system, identification of health related human rights, problems encountered, possible solutions to problems, necessary legislation and regulation and infrastructure and manpower are the key issues. For sustainable system of promotion and protection of health related human rights the health care providers must be convinced and make them to understand and respect the rights of individuals & community. There must also be measures to deter violation of rights and a method of compensation to the victims in the instances of violations.

CHAPTER 8

STRATEGIC PROGRAMMES FOR HUMAN RESOURCES DEVELOPMENT

8 STRATEGIC PROGRAMMES FOR HUMAN RESOURCES DEVELOPMENT

This chapter discusses issues-related development of strategic programmes for human resources development in Sri Lanka. Further, it proposes strategic directions towards the human resources development in the next 10 to 12 years.

8.1 PROGRAMME JUSTIFICATION AND LINKAGES

The three programmes that are envisioned to improve human resource development are as follows:

- Programme for the Production and Strengthening of Human Resources for Health;
- Programme for the Rationalization of Human Resources for Health; and
- Programme for Improving Job Performance of Health Personnel.

Although major influences behind some of the well-discussed success stories in the health sector in Sri Lanka during the past few decades are much related to a fairly well organised infrastructure, major gaps in the human resources in the country are yet to be addressed fully. Historically, the changes that took place in the health sector of Sri Lanka has further aggravated issues related to human resources development, i.e., decentralization of the health system and establishment of provincial health setup, upgrading of hospitals, re-demarcation of public health units, alteration of job functions of some staff categories, etc.

From time to time, many human resources constraints have been identified by several persons analysing this issue. Nevertheless, the overall problem can be visualized in three dimensions:

- Production & Strengthening of Human Resources for the Health Sector;
- Rationalization of Human Resources for the Health Sector; and
- Improvement of Job Performance of Health Personnel.

(1) ISSUE OF PRODUCTION & STRENGTHENING OF HUMAN RESOURCES FOR THE HEALTH SECTOR

Production of human resources in the past has not been much planned in terms of supply and demand or need, across all categories of staff. There are 276 categories of health personnel in the public sector in Sri Lanka and 21 categories for paramedics. Non-technical production staff had not been a major concern since stream lined training process is not involved. However, training technical staff ought to be undertaken through well planned and intensive processes that need good infrastructure facilities and good quality trainers. Health personnel are allocated into various kinds of medical institutions according to cadres. In the health sector, it is quite necessary to have a good skill mix to provide better quality services with team approach. Therefore, it is essential to ensure that there are well established links between health training institutions whether medical schools, nurse's training schools or any other paramedical training institutions, which, at present, do no exist to its potential.

Continuing education is understood to be an essential element of high quality human resource stock in any health delivery system in the world. Hence, in-service training plays an important role in the development of human resources in Sri Lanka for further improvement of health performance. It has been evident that certain categories in some specialities of health staff is scarce in most parts of the country, while certain other categories are either in excess or concentrated to limited areas. Guiding correct persons to right specialities has been poorly organized at many levels. Hence, establishment of proper carrier guidance system is timely.

(2) RATIONALIZATION OF HUMAN RESOURCES FOR THE HEALTH SECTOR

Although Sri Lanka overall adopts a welfare-oriented policy in health development, there is no comprehensive policy document that illustrates the future directions of human resources development. Furthermore, it is vitally important to have a central institution that oversees all aspects of human resource development in its different dimensions. This has been further necessitated with the establishment of provincial health system that created many health institutions at the provincial level. Concerted efforts to enhance coordinated development in human resources has been a compelling requirement in the past and it is imperative that the health system be equipped with such an organization at the central level to streamline all related issues and then disseminate information accordingly. During the last two decades private sector has played a growing role in health care delivery with especial reference to outpatient care.

It is discouraging that the human resource requirement of the private sector has not been much of a concern in the public sector due to high demand scenario. However, this imbalance is not any more affordable for the country to continue tangible improvements in the health system. Therefore, it is evident that establishment of private public partnerships – resource sharing, information sharing, outsourcing – is required at central as well as at the provincial level to further optimise utilisation of human resources in health.

(3) IMPROVEMENT OF JOB PERFORMANCE OF HEALTH PERSONNEL

Health workers in this country have been under growing criticism for providing sub-standard health care in many occasions. Newspapers sometimes provide very discouraging articles on such incidents, often without looking at the working environment, capacity building and remunerations of health workers. Quality of health care services does not entirely depend on high technology, but on client-oriented service provision, which is mostly seen in the private sector. Providers' requirements, such as job satisfaction, proper job appraisal and correct incentives, should be integrated into the system in order to further improve the quality of care. Built-in requirements of working as a team with a good skill mix have not been identified enough by the concerned authorities. Some health staff categories do not have adequate opportunities to develop their competencies and qualifications to enter the ever-competitive job market with a future career ladder in sight. Highly skilled staff is necessary for sub-specialities such as advanced surgery, intensive and emergency care, and advanced laboratory services. However, facilities to provide such high levels of training and carrier development are only available to a few staff categories. It must be identified that staffs need to learn to develop accountability for their professional conduct so that a provider-friendly, quality-concerned health care services could become a reality.

8.2 PROGRAMME FOR THE PRODUCTION AND STRENGTHENING OF HUMAN RESOURCES FOR HEALTH

(1) PROGRAMME OBJECTIVE

To ensure rational deployment and utilisation of human resources optimising efficiency, effectiveness and equity in keeping with the stated health policy.

(2) PROJECTS

Project 3.2.1

Title: Formulation of an HRD Policy

Summary:

Human resources of health (HRH) are increasingly recognized as a crucial element of health systems if health services are to improve. Most of the developing countries have to accelerate development of policies and action plans to address the recruitment and distribution of skilled health care personnel, and the need for sound national policies and strategies for the training and management of human resources for health. Human resource policies that improve health systems performance are especially important in order to achieve the Millennium Development Goals. It will also minimise constraints that the health services have in delivering health interventions to the people.

Human resources for health coverage of the population are an important issue in Sri Lanka. There is a maldistribution of human resources for health in this country, especially in the provision of services for the rural poor.

The main issues on human resources for health include:

- HRH Generation
- Provision
- Retention
- Financing
- Coverage / Distribution

Generation of HRH and their employment is a very costly event to the national budget. Financing the human resources for health is a major component of all health systems with very high national budgets allocated to HRH. A challenging issue at present is how best to use the available HRH financial resources to best meet the health needs of the people of Sri Lanka.

Hence, in the formulation of an HRH policy, all the above facts have to be borne in mind so as to strike a good balance between generation, distribution and the quality of services given to the people.

Lastly, one has to keep in mind to design methods and materials to evaluate all aspects of human resources for health.

Project 3.2.2

Title: Establishment of an HRD Division at Central Level and HRD Units at Provincial Level with Clear Demarcation of Roles, Responsibilities & Authorities

Summary:

The recruitment, organization of pre-service training, deployment and provision of in-service training, which has been the sole responsibility of the Ministry, of Health is fragmented. This is evident from long delays in recruitment, shortcomings of pre-service training in terms of quality and quantity, maldistribution of Human Resources, and lack of a well-coordinated mechanism to provide in-service training to its work force.

It is proposed that Human Resource Development Units be established at the Line Ministry and Provincial Ministries to coordinate the functions related to HRD. In this project, it is proposed that the roles, responsibilities and authorities of HRD units be identified and such units established to strengthen the HRD functions. The capacity of the Provinces to do the same will be enhanced by establishment of such units as well as the Provincial Training centres. The capacity of those that are managing these centres will be enhanced to make them more efficient.

Project 3.2.3

Title: Development, Implementation & Monitoring of a Comprehensive HRD Plan Based on the Approved HRD Policy

Summary:

Project on development, implementation and monitoring of a comprehensive Human Resource Development (HRD) plan aims to ensure sufficient number of employees possessing appropriate skills, and to make knowledge available at the right place at the right time for achieving the health sector objectives and goals. HRD planning is a critical section within the sectorial planning process; therefore, it is very essential to keep a balance between sector specific plans and the HRD plan. The planning should look into the needs of the public as well as the private sector. Moreover, the demand and supply aspects should also be taken into account. On the demand side, the planners should look into the expected quantity and the quality of the employees in the organization. Similarly, planning exercises shall assess the supply side. Planning exercises will have to be conducted in order to fill the gaps both quantitatively & qualitatively.

Project 3.2.4

Title: Establishment of a Mechanism to Coordinate HRD Activities with the Private Sector with Specific Reference to Training & Continuing Education

Summary:

Private health sector provides 60% of out door care and 10- 15 % of inward care. Its provided through a wide network of institutions such as 160 private hospitals, 800 general practitioners, 400 laboratories, home care nursing services etc.

In service training of private health sector staff is not a major activity at present. There are many instances the private health sector staff not carrying out appropriate health care due to this. It is necessary to train the private sector manpower as per private medical institutions bill. The Government must be the regulator, facilitator and the information provider and guider for the private health sector.

The problem is grave that the private sector nurses looks after many people including VIP s not having the required up dated knowledge to do so. Establishment of training and continuing education program will improve the quality of care in the private sector.

Private health sector provides 60% of out door care and 10- 15 % of inward care. Its provided through a

vide network of institutions such as 160 private hospitals, 800 general practitioners, 400 laboratories, home care nursing services etc.

Trained manpower is a major problem for the private sector specially qualified nurses and paramedical staff such as pharmacists, radiographers etc. It is necessary to train the private sector manpower as per private medical institutions bill. There is a major unemployment in Sri Lanka and 1.2 Million people are exported for low paid jobs which could be avoided with private sector training of health manpower.

8.3 PROGRAMME FOR THE RATIONALIZATION OF HUMAN RESOURCES FOR HEALTH

(1) PROGRAMME OBJECTIVE

To ensure the availability of adequate numbers of technically and managerially competent health workers to serve the needs of population.

(2) PROJECTS

Project 3.1.1

Title: Strengthening of Basic Training of the Public Sector by Improving Basic Infrastructure and Supplies as well as by Providing Additional Qualified Trainers

Summary:

Strengthening of basic training project aims at providing competency-based, high-quality basic and post basic training. It envisages developing evidence-based curricula and maintaining specified standards in all stages of training. Revision of the training cadre and recruitment of additional trainers are also important component since it is the foundation of the quality training. The project will implement the following activities under the guidance and support of the Central Ministry of Health:

- Development of a master plan for training;
- Development of evidence-based curricula;
- Formulation of standards for training and maintenance of them;
- Accreditation of training institutions;
- Provision of infrastructure facilities;
- Provision of other facilities needed for training;
- Continuous development of trainers; and
- Continuous evaluation of training programmes.

Project 3.1.2

Title: Establishment of a Network between Central and Regional Training Institutions and Within the Latter Level

Summary:

This project intends to develop Provincial Training Centers (PTC) in each Province and develop a network for training and development.

Cabinet/Parliament approved body will coordinate the training and training programmes will be accredited by an accreditation body.

The project will assist in developing the infrastructure and other facilities and improve the quality of training. This development includes supporting of the already established PTCs as well as establishing

new centres in Provinces, which do not have PTCs at present.

The project will facilitate the exchange of resources, and technologies between the Provinces and PTCs and the center.

The project will also develop and implement a coordination mechanism between PTCs and with the Centre.

Project 3.1.3

Title: Establishment of Academic Degree Programs for Nurses & Selected Paramedical Categories
Summary:

Sri Lankan universities produce many graduates every year, though all these graduates are not able to find suitable employment. Therefore it may be useful to admit students to universities for academic courses which are competency based and suitable for specific occupations professions such as nursing, radiography, occupational therapy, physiotherapy, cardiography pharmacists etc. so that the Nurses and paramedical categories could be awarded degrees which will give them more recognition. There are requests from these categories for such courses.
However if degree courses are commenced as basic training courses for specific professions/occupations it is necessary for it to be policy. it should be passed out the senior members who do not than depress should not be downgraded. Hence to establish degree programme the activities need to be well planned and implemented.
Degree programme may be necessary for those who are already in service with basic training for them to be placed at a higher grade. Career structure should be developed for each category and degree programme need to be identified communicate had to be developed and how to provide clinical training need to be explored.

Project 3.1.4

Title: Strengthening of In-service Training and Continuing Education in Both Public and Private Sector
Summary:

Continuing education is necessary to ensure quality of service delivery. Health care workers need regular support and guidelines to perform their job functions. As new techniques develop, disease trends change, diseases re-emerge, new diseases emerge, demands of clients change, etc., they pave the way to justify the needs for continuing education and especially in-service education. Whether the health workers are in the government sector or private sector it is right to provide opportunities for continuing education to all of them in an organized manner.

Project 3.1.5

Title: Providing Incentives & Career Guidance to All Medical Officers Undertaking Post-graduate Studies with Special Reference to Specialities in High Priority Areas
Summary:

For any organization human resource is the most important. How ever, acquiring the appropriate human resources is one of the most difficult managerial task, many organization have to face. Organizations there fore have to engage in careful planning in order to acquire the right person when ever vacancies occur.
Reference to the health sector two important aspects in human resource development is carrier planning

& carrier management. For any person, planning & managing his/her own carrier is extremely important. Most effective & successful people are proactive to plan their carrier & manage the carriers to reach of the organizations objective & develop guiding mechanism for their employees on opportunities available within the organizational realities.

8.4 PROGRAMME FOR IMPROVING JOB PERFORMANCE OF HEALTH PERSONNEL

(1) PROGRAMME OBJECTIVE

To improve the quality of the work/output and job satisfaction of health personnel.

(2) PROJECTS

Project 3.3.1

Title: Establishment and Implementation of an Improved Supervisory System, including Improved Performance Appraisal System.

Summary:

The project envisages improving the quality of work output of all categories of health staff at national and provincial levels by establishing an improved system of supervision and performance appraisal. It is expected to critically review the existing supervisory and perform appraisal system in the health sector in order to make new proposals to improve the system. The main focal point will be DDG (P) and the MDPU of the Ministry of Health, while planning units of the provinces will act as the focal points at the provincial level.

Following are the major activities:

- Review of the job descriptions;
- Developing supervisory roles;
- Developing performance appraisal formats;
- Training of major senior categories on supervision; and
- Disseminating information on proposed system.

Project 3.3.2

Title: Development and Implementation of a Career Development Scheme for All Categories of Health Personnel

Summary:

Opportunities for career development are limited for many categories of health personnel working for the Ministry of Health. Once resuming duties as a preliminary grade officer they have to get through the efficiency bar examinations at stipulated time intervals in order to get into a higher grade, which automatically entitle the person concerned to a higher salary scale. At present this is the career development scheme available. Further existing carder vacancies are the other limiting factor for career development in the government sector.

Government sector employees once they get through the final qualifying examination continue to function without revalidation until they retire. Revalidation process should be introduced along with the EB examination for career development as well.

For certain health personnel career development is hampered or blocked due to non availability or

limitation of cadre positions in the career ladder available at present.

There is a need to critically review the career development prospects available and take positive steps to motivate and strengthen job satisfaction of health personnel.

Project 3.3.3

Title: Strengthening of Central Regulatory Controlling Bodies to Maintain Standards & Performance Auditing Activities

Summary:

The Health Ministry and the Provincial Health Ministries of Sri Lanka provide the services to meet the health needs of the people. This is done through various health institutions, which are responsible for the service provision. Providing resources, maintaining the standards and the quality of services, and monitoring and evaluation of the staff are the main responsibilities of the Ministries. At present, different institutions train the different categories of health personnel. Training of medical undergraduates is done through several medical schools that are affiliated with teaching hospitals. Postgraduate training is regulated by the Post-graduate Institute of Medicine. Paramedical staff is trained at different health institutions whereas the nurses are trained in Nurses Training Schools.

After categories received the basic training and recruited, there is no proper system adopted to monitor or to evaluate their performance capacities. There is no suitable system also to ensure the continuous in-service training to these personnel. Upgrading of the staff knowledge to meet the advancements in technology has not been planned properly. There is no proper regulating system or mechanism for capacity building of the health personnel.

The Ministry of Health, the Provincial Ministries of Health, SLMC, Professional Bodies, e.g. College of Surgeon and College of Obstetricians, UGC and other training institutions engage in above activities. They act in an ad hoc manner that is not satisfactory at all. The lack of resources, improper planning, and not having a definite policy to adhere have caused the quality of service to deteriorate to a considerable extent.

With the implementation of this project:

Existing central regulatory controlling bodies will be strengthened and improved.

SLMC, MoH, PHA, and Professional Bodies will be integrated to ensure improved intersectoral cooperation and coordination.

Capacity of management of above bodies would be enhanced to enforce the standards and performances.

A new committee will be formed to look into the health management problems.

Ethical issues and other constraints arising during the service performance will be addressed through a National Arbitration Committee.

Actions will be taken to improve the bilateral relationship between these bodies and the Trade Unions of the health sector.

Capacity of MoH will be enhanced in regulating the standards of health performance.

Project 3.3.4

Title: Regular Review of Activities & Output of Training Institutions at Central and Provincial Levels to Strengthen the Management Capacity of these Institutions

CHAPTER 9

STRATEGIC PROGRAMMES FOR FINANCING, RESOURCE ALLOCATION & UTILISATION

9 STRATEGIC PROGRAMMES FOR FINANCING, RESOURCE ALLOCATION & UTILISATION

This chapter discusses issues related to the development of Health Financing in Sri Lanka. Further, it proposes strategic directions towards the development of comprehensive health services delivery in the next 10 to 12 years.

9.1 PROGRAMME LINKAGES AND JUSTIFICATION

The two programmes designed to strengthen health financing towards becoming sufficient and self-sustainable are as follows:

- Programme for Development of Health Finance Policy for Equity, Efficiency & Sustainability; and
- Programme for Strengthening of the Health Financial Management System.

The main function of the health system is to provide health services to the population. Since its independence, Sri Lanka has been globally known for the strong performance of its health sector in achieving very high health status indicators. The health care system operated by the government has been gradually deteriorating as financial support has been eroding. While the demand for health services is increasing due to demographic and epidemiological changes, resources are limited due to stagnation of national economy. It is important to address this issue at this time and find some suitable solution for the country.

There are two main issues recognized in the area of health financing, resource allocation & utilisation.

(1) LACK OF FINANCE POLICY FOR EQUITY, EFFICIENCY & SUSTAINABILITY

There is no comprehensive financing policy to provide a framework for public /private sectors that can serve as a guide for the politicians, administrators, health planners in decision making in this country. "*The programme for the Development of Health Finance Policy for Equity, Efficiency and Sustainability*" will answer this issue.

Research studies, policy analyses and pilot testing some of the recommended models are needed in order to come up with an adequate finance policy in this country in the next 10 to 12 years. Based on the financing policy, which can show the direction of health financing in this country, a blueprint of health financing mechanism needs to be drawn. For the " blueprint" to be operational, it will require considerable discussion about all of its components, including the financial flows from payers of all types to providers of all types, both public and private, as well as the regulatory functions of government, and the institutional modalities which will enable the "blueprint" to be implemented.

(2) ISSUE OF WEAK HEALTH FINANCIAL MANAGEMENT SYSTEM

The second main issue in the area of health finance in this country is weak health financial management system in the health sector. After various studies/surveys, it is suggested to design a development and implementation plan to reorient procedures and formats towards performance-based planning and budgeting in the health sector of this country. *The Programme for Strengthening of The health Financial Management System* aims to strengthen a mechanism of accountability assessment and to strengthen the accountability of the health system in this country. The program also aims to strengthen and reorganize the office of Deputy Director-General of Finance and Deputy Director-General of Planning for health service delivery & intersectoral health issues within the context of health economic reality and with full accountability. This may be facilitated to improve macroeconomic performances along with goals for health status improvement.

9.2 PROGRAMME FOR THE DEVELOPMENT OF HEALTH FINANCE POLICY FOR EQUITY, EFFICIENCY AND SUSTAINABILITY

(1) PROGRAMME OBJECTIVE

To improve the equilibrium among equity, efficiency and sustainability of health finance.

(2) PROJECTS

Project 4.1.1

Title: Development of a Health Finance Policy for National, Provincial & District Levels

Summary:

The project of Support for Development of a Health Finance Policy for National Level will look into feasibility and desirability of a social health insurance model in Sri Lanka, taking into account practical requirements and risks of any implementation. A t the same time the project will invest in developing the national human resources required to assist GOSL in making such strategic choices. The project is composed of three components as follows.

- To develop evidence base to assess feasibility of social health insurance financing option
- To develop understanding of public opinion concerning health financing choices, and issues related to social health insurance design
- To develop human resources to support assessment and development of national health financing strategies, and to implement potential action plans

Project 4.1.2

Title: Development & Implementation of a Plan to Reorient Procedures & Formats Towards Performance-based Planning & Budgeting

Summary:

The demand for health services is growing at a rate faster than available resources: Allocative efficiency and efficient utilisation against the growing demand for health services. And the system of performance-based planning and budgeting are important factors that enable the MoH to face the health demand. Following procedures should be taken by MoH, provincial MoH (including office of PD, DPD) to implement the performance-based planning and budgeting system.

- Developing agreed upon performance indicators;
- Prioritising programmes;
- Establishing targets;
- Establishing a proper planning and monitoring unit; and
- Ensuring continuous monitoring system being implemented.

9.3 PROGRAMME FOR STRENGTHENING OF THE HEALTH FINANCIAL MANAGEMENT SYSTEM

(1) PROGRAMME OBJECTIVE

To improve transparency & accountability of the health system.

(2) PROJECTS

Project 4.2.1

Title: Strengthening & Reorganizing the DDG Finance Office and DDG Planning for Health Service Delivery & Intersectoral Health Issues within the Context of Health Economic Reality and with Full Accountability

Summary:

The resources required to maintain the health services in the country depends on the general Treasury. Both DDG (Finance) and DDG (Planning) are expected to plan and utilize the limited resources in a more efficient and effective manner in order to provide maximum benefit to the nation. To achieve these objectives the MOH must work in collaboration with the provincial setup. The finance division and the planning division of the MOH in collaboration with provincial officials are acting as central agents between the health institutions and the Treasury.

The responsibility of preparation and monitoring of the total estimates are held by Chief Accountant/ DDG (finance) while DDG (Planning) is assisting in providing annual capital estimates. In order to achieve the strategic objectives the following activities must be embarked on:

- To make use of planning and activity based budgeting system that gives more meaningful expenditure estimates rather than the incremental budgeting system.
- To improve the government financial support.
- To improve allocative efficiency of public funds.
- To identify alternative financing mechanisms and ensuring financial sustainability.
- To improve monitoring and evaluation of performance in the MOH and PCs.
- Implementation of corrective measures to achieve these goals.

Project 4.2.2

Title: Strengthening & Reorganising the Financial System & Capacity of the PDHS Office

Summary:

In the process of strengthening and reorganising the Financial System and Capacity of the PDHS office, not only the Department of Health but all parties involved in the different stages in mobilising funds, from the Chief Secretary to the lowest level manager, who is the implementing agent, plays an important role.

In mobilising resources, adherence to a set of guidelines considering the national policy and

expectations according to the local needs may help in an equitable distribution of available resources among the identified sectors.

Capacity building of all health managers, including financial managers, in the establishment of a comprehensive financial information system, development of an internal auditing procedure and an efficient system of monitoring and outcome evaluation is imperative for effective utilization of resources.

CHAPTER 10

STRATEGIC PROGRAMMES FOR STEWARDSHIP & MANAGEMENT OF THE HEALTH SECTOR

10 STRATEGIC PROGRAMMES FOR STEWARDSHIP & MANAGEMENT OF THE HEALTH SECTOR

This chapter discusses issues related to the development of stewardship and management of the health sector in Sri Lanka. Further, it proposes strategic directions towards the development of stewardship and management functions of the health sector in the next 10 to 12 years.

10.1 PROGRAMME JUSTIFICATION AND LINKAGES

The six programmes that are envisioned to strengthen the central and provincial MoH in the performance of their stewardship and management responsibilities are as follows:

- Effective Policy Development Programme;
- Management Development Programme;
- Health Regulatory Mechanism Programme;
- Strengthening of Health Information System Programme;
- Health Research Programme; and
- Intersectoral Programme.

The stewardship and management function of the health sector of this country has several issues: unclear role/functions and responsibilities of MoH at different levels, weak regulatory mechanism and enforcement, insufficient health information system, insufficient research capacity and weak intersectoral coordination and program implementation.

(1) CLARIFYING THE ROLE, FUNCTIONS, RESPONSIBILITIES OF DIFFERENT LEVELS OF HEALTH MINISTRIES

The major issues in the health sector management in the country are confusion and conflicts over roles, responsibilities and lines of accountability between central and other levels of MoH caused by the devolution of the health sector. The role/functions and responsibilities of the central MoH are still dominant in the tertiary hospital administration, and recruitment and deployment of medical doctors.

Stewardship function and management capacity within the state sector need to be strengthened to start proper sector's structural changes which will make the sector more responsive to the emerging and re-emerging challenges in the country. This requires a major shift in the management and organizational structures of all parts of the system. With provinces assuming more responsibilities for operating state services, the role and functions of the provincial Ministry of Health too will be subjected to change. Central Government health sector functions should move towards providing guidance, setting standards, ensuring quality, exercising regulatory functions, and monitoring & evaluation. Better performance and value for money is mandating significant restructuring of the Ministry of Health and a major change in management programme.

" ***Effective Policy Development Programme***", "***Management Development Programme***", "***Health Regulatory Mechanism Programme***", and "***Strengthening of Health Information Programme***" aim to clarify the role/functions and responsibilities of different levels of Health Ministries.

(2) WEAK EFFICIENCY, EFFECTIVENESS AND ACCOUNTABILITY OF THE MINISTRY OF HEALTH

The efficient and effective decentralized management in the Line Ministry and the provincial ministries could be achieved by development capacity of provinces to plan and manage services and by providing technical support, training and funds. Budgets will be linked to targets and technical performance agreed between central and provincial government. Strengthened technical capacity at provincial level will increase the pressure on Provincial Councils to allocate the designated share of budgets to health. Capabilities at field level needs to be strengthened to improve front line services and referral system, and information services too needs be developed.

The health sector needs well-trained managers who have the authority and ability to manage the changes proposed and to ensure that their staff and institutions are involved. The immediate priority is to focus on in-service training of those individuals currently acting as managers at national, provincial, district and divisional levels. "***Management Development Programme***" will assess the management development needs and establish a comprehensive management training program to strengthen the management capacity of health officials at different levels.

All managers and institutions including field health units must be held accountable for the state resources used and the outputs achieved. A system of individual and institutional performance management will be introduced to facilitate their performances. Individual performance management will be based on defining clear roles, responsibilities, and agreed performance targets and lines of accountability. "***Management Development Programme***" will aim to strengthen the institutional performance as well as individual performance and accountability.

(3) WEAK REGULATORY MECHANISM OF HEALTH MINISTRY

Sri Lanka's health system is rich with a wide array of legislation and regulation that have been developed over a hundred years before and after its independence. However, close examination shows that some of the health legislation & regulation are not timely, feasible, nor comprehensive. Some existing legislation is 100 years old and it clearly provides ample justification why this needs to be addressed.

The Ministry of Health is not presently geared to take up the challenge. It appears that other than the Legal Officer's branch, which carries out the routine legal procedures, there is no other focal point to focus on these legislative and regulative mechanisms. These shortcomings are not confined to the Line Ministry only. The decentralization process, although allowed the provinces to be most strengthened with the development of provincial statutes, have failed to be so due to varying technical capabilities across Provincial Councils. "***Health Regulatory Mechanism Programme***" aims to institutionalise mechanisms to introduce periodic reviewing & carrying out necessary amendments, introducing new legislation, and to harmonize the existing legislation and regulation related to health at and between national and provincial levels together with building institutional capacity in regulatory function.

(4) INSUFFICIENT HEALTH INFORMATION SYSTEM

The measure of efficiency of a service basically relies on a well-designed Health Management Information System. Without appropriate information, it is not possible for health care workers and managers to deliver, or measure, the significant improvements in productivity and quality of the health services or the system. "***Strengthening of Health Information System Programme***" aims to develop the information policy and strengthen the capacity among managers and users of information. Clinical and Management Information Systems will be reviewed and will be improved to ensure that managers have appropriate information to make evidence-based decisions and deliver value for money.

(5) WEAK CAPACITY IN HEALTH RESEARCH AND TECHNOLOGY ASSESSMENT

The role of health sector research should be emphasized more in the area of active promotion of evidence-based decision making at all levels. The main areas in urgent need of research are: Health Delivery System, Health Promotion, NCD, Nutrition, Indigenous Medicine and Health Economy. The country has eminent academics and good research potential capacity. However, capacity of health and health-related research institutions and researchers needs to be improved. "***The Health Research Program***" aims to establish a mechanism for research sustainability by creating suitable career structures – infrastructure for research to meet the increasing demand. Competency will be discussed and planned as a national agenda.

(6) WEAK COORDINATION AND PARTNERSHIPS WITH OTHER SECTORS

Improving the health status of the people will not occur by simply improving health service delivery. Health is influenced by many other factors and there is a definite need to have good coordination among health-related sectors. For example, improving school health, reducing road accidents, and carrying out preventable disease control programme need to involve all partners including civil societies. "***The Intersectoral Programme*** "will aim to strengthen the existing Health Development Network at National, Provincial & Local levels to involve all the stakeholders in the intersectoral issues. It is hoped that the Ministry of Health will develop clear fora and channels for thematic ongoing coordination, such as Human Resource Development, Nutrition Improvement, and Non-Communicable Disease Control.

10.2 EFFECTIVE POLICY DEVELOPMENT PROGRAMME

(1) PROGRAMME OBJECTIVE

To establish effective mechanisms for policy development within existing units.

(2) PROJECTS

Project 5.1.1

Title: Capacity-Building of National & Provincial MoH Officials in Effective Policy Development Processes

Summary:

In order to increase sustainability of policy reforms, much greater emphasis should be placed on strengthening national capacity for policy development and policy analysis.

To enable this there should be a critical mass of health policy experts at national and provincial levels. This will be achieved by implementing the following activities:

- Defining necessary competencies for national and provincial MoH officials;
- Designing and conducting education / training programmes;
- Keeping the MoH officials well informed about current health policy issues;
- Setting performance standards; and
- Evaluating performance.

Project 5.1.2

Title: Establishing a Mechanism for Advocating Commitment of National & Provincial Political Leaderships towards Ownership of Health Programmes

Summary:

The expectations and aspirations of people are rapidly changing. One of the prerequisites to develop a health service responsive to public needs is a committed political leadership with the sense of ownership of the health programmes. This is essential for the successful implementation of the health programmes at national and provincial levels.

There should be an involvement of political leadership in the planning, implementation, monitoring and evaluation stages of the health programmes. Those in the health sector should be in a position to provide sufficient evidence to convince the political leadership about the necessity of implementing health programmes.

10.3 MANAGEMENT DEVELOPMENT PROGRAMME

(1) PROGRAMME OBJECTIVE

To achieve effective, efficient and accountable health care delivery through improved management at all levels.

(2) PROJECTS

Project 5.2.1

Title: Establishing an Improved Management System/s and Building the Capacities of Management Teams

Summary:

Investments in management staff, skills and systems will be critical in the Management Development Programme in order to achieve effective, efficient and accountable health care delivery through improved management at all levels. This would include improved planning, budgeting and management processes with a results/output oriented approach. In order to establish an improved management system/s and building the capacities of management teams, this project will firstly, identify the Management development needs at national, provincial, district and divisional levels. Based on these needs a plan for improved management systems at national, provincial, district and divisional levels will be developed.

In most countries of the region such as India, Bangladesh, Thailand, and Pakistan, there are institutions for inservice training of health manpower in planning and management. Such a mechanism ensures institutionalization of training, resulting in cumulative, sustained impact of training interventions in health services planning and management. It is important to set up such a centre or a unit for health management development in Sri Lanka.

The skills of managers and their key staff at national, provincial, district and divisional levels will be enhanced through management training locally and abroad.

Improved management systems will be established at national, provincial, district and divisional levels using participatory approaches envisaged in the national productivity policy.

The health system management at the national, provincial, district and divisional levels will be monitored closely, and achievements will be recognized at the Annual Productivity Awards Ceremony.

Project 5.2.2

Title: Strengthening the Management Development & Planning Unit and the Planning Units at the Provincial and District Levels in Areas of Policy Analysis, Project & Plan Formulation, Monitoring & Evaluation, and Finance

Summary:

The MoH and Provincial health ministries' primary function is to act as steward over the health care system, i.e., provide direction and support to partners, and to monitor and evaluate the impact of services delivered to the public. The Management Development & Planning Unit (MDPU) at national level and the provincial planning units have to support the above function by ensuring planned

development of health services.

However, at present, the broad range of responsibility of MDPU is carried out by a very limited staff. The present organization and allocation of staff is inconsistent with the expected role of the MDPU. There is a need to reorganise the unit and strengthen the capacities of its staff with a view to covering its mandate in the areas of policy analysis, planning, health information and health financing. Similar reorganisation and strengthening of capacities at provincial and district levels have to take place, with a view to establishing a strong network to support health planning throughout the country.

The planning units at present have limited capacity to undertake their functions listed below:

- To determine the health needs of people of Sri Lanka;
- To undertake planning and assist other units at National and Provincial levels in planning in most efficient manner;
- To undertake policy analysis as required to assist senior management of MoH in setting priorities for allocation of resources;
- To prepare plans for human resources and for capital expenditure;
- To make accurate, timely data/information available for decision makers and for other users;
- To direct and coordinate organisational development activities; and
- To monitor & evaluate health development plans and programs.

The project aims to strengthen MDPU, planning units both at national and provincial levels, to fulfil these functions.

Project 5.2.3

Title: Developing Systems & Capacities for Monitoring, Evaluation & Audit as well as Introducing System/s to Recognise Good Performance of Institutions, Individuals and Communities at National, Provincial, District, & Divisional Levels

Summary:

Monitoring and evaluation of performance of health institutions, individuals and communities at different levels, and proper follow-up actions are key elements of an effective and efficient health care delivery system. To accomplish this, it is necessary to identify weaknesses and strengths of the existing system, and take most essential steps to restructure the methods used in this process. It will be necessary to recognise differences in the system in monitoring and evaluation at different levels, and at different health care institutions: national to divisional levels, preventive and curative sectors. Developing capacity of the responsible officers, strengthening infrastructure facilities, establishing information system, and building follow-up actions are usual aspects of a scaling–up evaluation and monitoring of health care programmes. In order to achieve these targets, the following major activities are proposed:

- Capacity building at all levels;
- Developing infrastructure;
- Reviewing existing system;
- Strengthening information system; and
- Developing follow-up actions.

10.4 HEALTH REGULATORY MECHANISM PROGRAMME

(1) PROGRAMME OBJECTIVE

To ensure enforcement of regulations in order to strengthen safety and quality of health services.

(2) PROJECTS

Project 5.3.1

Title: Institutionalising Mechanisms to Introduce New as well as Reviewing, Harmonizing and Amending (if Required) Existing Legislation/Regulations Related to Health at and between National & Provincial Levels

Summary:

One of the key determinants for proper functioning of an effective health system is availability & implementation of a timely health legislation & regulation mechanism. Such health legislation & regulation is widely prevalent in Sri Lanka. However close examination shows that some of these are not timely, feasible, nor comprehensive. In fact some existing legislation nearly 100 years old.

The changing global scenarios, introduction of new international treaties etc. too need consideration in adjusting the changing health legislation mechanism. It appears that other than the legal officer's branch, which is responsible for the routine legal procedures within the Ministry there is no other focal point to look into matters pertaining to the legislative and regulatory mechanisms of the Health Ministry.

The decentralization process although allowed the provinces to be most strengthened with the development of provincial statutes, it evident that except for about two provinces other provinces were unable to develop provincial specific statues. The variation of capacities among provinces and political commitment are two important factors for this deficiency.

This programme is designed to institutionalize mechanisms, to introduce periodic reviewing & carrying out necessary amendments, and new legislation, and to harmonize the existing legislation and regulation related to health at and between national and provincial levels. Further, sharing of technical know-how for development of provincial health statues and sharing of best practices could be made available to other provinces which will enable them to develop their own provincial specific statues.

Project 5.3.2

Title: Strengthening of Enforcement of Legislation & Other Regulations at National & Provincial Levels

Summary:

Implementation of Health legislation is vital for the safeguarding of community and Health Care Workers within a health system. In spite of availability of a wide range of Health Legislation and Regulation the implementation of such still remain at an unacceptable level.

This project is aimed to ensure enforcement of legislation and regulation at National and Provincial levels in order to strengthen the safe delivery of health care services.

It is proposed that some of the major deficiencies experienced today will be addressed by this project. The areas identified are; making public aware of health legislation in order to increase the public demand for implementation; making health legislation readily available for relevant front-line users to make them accessible for Health Legislation; develop capacity among relevant categories of HCW to build their confidence in interpreting and implementing health Legislation and Regulation; and to establish a mechanism to monitor and evaluate the implementation of health legislation.

10.5 STRENGTHENING OF HEALTH INFORMATION SYSTEM PROGRAMME

(1) PROGRAMME OBJECTIVE

To improve efficiency and quality of health care delivery through use of reliable, complete and timely information.

(2) PROJECTS

Project 5.4.1

Title: Development of Policy, Implementing Guidelines and Plans for Health Information System for Public & Private Sectors

Summary:

Without information, where will management and stewardship of the health sector be? Without information, how will the implementation of the Health Master Plan be monitored and evaluated? Without a policy on health information, what will happen to information and information systems?

The objective of the project is to generate quality and useful information for better stewardship and management of the health sector in general and for efficient implementation of the Health Master Plan in particular.

To achieve the objective, a Health Information Policy and its Implementation Guidelines will be formulated that will clearly specify the process in defining the minimum data sets, mechanisms to foster the use of information and the fundamental principles in generating quality information. Consensus among stakeholders will be built. Also, existing relevant national level and ministry policies on information, communication and health information will be analysed.

A study to review options for developing the institutional capacities of the central and provincial MoH in managing health information systems will be conducted.

Beyond policy formulation, the project will facilitate coordination within and outside of the MoH. It will support the transformation of existing information systems to conform to the approved Policy and Guidelines. It will assist the development of new subsystems particularly the implementation of the Health Master Plan as well as those for better management of drugs and other medical supplies, medical equipment, logistics, and vehicle. More importantly, it will promote the use of information among priority users within and outside of the Ministry of Health.

Project 5.4.2

Title: Promoting the Use of Information for Policy-making, Planning, Management, and Provision of Health Services

Summary:

Improving the use, generation, processing, analysis, and exchange of information is fundamental to strengthening the health system in Sri Lanka. With decentralization, the provinces acquired broader responsibilities in policy-formulation, planning and management for the health sector.

The goal of the project is to improve the total quality of health care delivery in two provinces during the

initial implementation and all other provinces during the nationwide implementation. Its objective is to implement a new provincial Health Information System (HIS) that is responsive to the information needs of priority users.

The provinces with health statistics that are below the national average will be given preference in the selection for the initial implementation phase. The new provincial HIS will be built on existing systems, procedures and resources. It will reflect the lessons gained in previous and ongoing pilot-testing of systems for human resources, hospital management, financial management, surveillance of notifiable diseases, and primary health facilities. It will introduce information subsystem for better management of logistics, medical equipment, drugs, and other medical supplies. It will strengthen institutional and individual capacities of users, producers and managers of information through sustainable mechanisms. It will support the requirements for additional hardware, software, human resources, and finance. As a pilot, it will emphasise documentation not only of project milestones but also of capacity-enhancement activities. Above all, it will try out options in propagating the culture of Evidence-Based Medicine (EBM) and Evidence-Based Decision-making.

10.6 HEALTH RESEARCH PROGRAMME

(1) PROGRAMME OBJECTIVE

To assist evidence-based decision-making.

(2) PROJECT

Project 5.5.1

Title: Enhancement of Capacities in Health Research & Research Management at Central & Provincial MoH

Summary:

The Health Research Programme aims to provide evidence-based results for the Ministry of Health and Provincial Ministries of Health with regard to planning, implementation, monitoring and evaluation of health services programmes for the people of Sri Lanka. This programme should include both the basic (Biomedical) and health systems research. The research most needed for the line ministry and provincial ministries of health is the Health Systems Research which will provide evidence-based results for better management of health services for the needs and expectations of the people of Sri Lanka. Evidence-based results received from Health Systems Research should be the key approach for health planning. Research provides the direction and pathway for better utilisation and management of health resources. With people of this country now enjoying long life as their life expectancy has increased and with the emergence of non-communicable diseases to the forefront, management of resources for health becomes the most important subject in the health services in the years to come. Together with unconquered infectious diseases, and known infectious diseases emerging in other ways, and with the emergence of new infectious diseases, mankind is facing large threats for survival along with the vast spectrum of non-communicable diseases. Certainly the list of health problems and the threats to survival will increase in the years to come. The answers to existing and forthcoming problems have to be resolved in the most cost effective way. Research is the only scientific pathway, which can provide answers to health problems. Hence, the Ministry of Health and Provincial Ministries of Health together have to join hands with international, bilateral and non-governmental agencies to develop and implement a sound Health Research Programme in Sri Lanka. This programme should encompass:

- Establishment of a National Health Research Centre/Unit;
- Establishment of linkages of this center/unit, with all other research centers nationally as well as internationally (where relevant); and
- Dissemination of results for policy makers to utilise the results, to improve health services.

10.7 INTERSECTORAL PROGRAMME

(1) PROGRAMME OBJECTIVE

To optimise contributions of other sectors to health.

(2) PROJECTS

Project 5.6.1

Title: Strengthening the Existing Health Development Network at National, Provincial & Local Levels

Summary:

Health services are mainly administered through the central & provincial ministries. Still, the significant improvements in health indices are not only due to the effectiveness of the national health services, but also due to the contributions made by other sectors such as related Other Government Ministries, Private Sector, Non-governmental Organizations, International and U.N. Agencies, and Community-based Organizations. Continuous socio-economic development itself has contributed to the betterment of the health status of the community. Various sectors including the health sector have contributed for socio-economic development. Intersectoral action for health is now considered as a major process in developing health care programmes. Meaningful cooperation between all related public sectors, NGOs, International agencies, and community is essential in achieving the health goals. At present, the health ministry has taken an initiative to develop formal intersectoral coordinating mechanisms in the form of a National Health Committee, a Health Advisory Council, a National Health Development Committee, etc. In recognising the close links between health and other development areas, the multisectoral involvement in health development will be a useful approach.

Project 5.6.2

Title: Public-Private Partnership Development at National & Provincial Levels

Summary:

Private health sector is a major component in Sri Lankan health care shearing 60% of OPD care and 10-15% of inward care. At present private health sector is not included in National statistics. The successive Governments POLICY was to give priority for private sector.

There is a new private medical institutions bill finalized by the ministry and legal draftsman. It is proposed to manage the private sector by an executive council

It is a necessary to consider the existence of legal frameworks in a master plan and take appropriate steps to make the Act work. If we were to achieve Government concerns for health such as Efficiency, effectiveness, Quality, stability Equity, Sustainability and affordability we should develop the partnership rather than being in different compartments.

At present there is not much coordination between public and private sectors except for shearing some resources.

CHAPTER 11

STRATEGIC PROGRAMMES FOR INDIGENOUS SYSTEMS OF MEDICINE

11 STRATEGIC PROGRAMMES FOR INDIGENOUS SYSTEMS OF MEDICINE

This chapter discusses issues related to the development of Indigenous Systems of Medicine (ISM) in Sri Lanka. Further, it proposes strategic directions towards the development of comprehensive health services delivery in the next 10 to 12 years.

11.1 PROGRAMME JUSTIFICATION AND LINKAGES

The five programmes that are envisioned to strengthen the Indigenous Systems of Medicine are listed as follows:

- Strengthening Stewardship and Management Functions;
- Strengthening Service Delivery;
- Strengthening Integration of ISM and Allopathic Sectors;
- Human Resource Development; and
- Strengthening of Research Capacity.

The justifications of programs/projects are described against the challenges, which ISM has been facing.

(1) LACK OF ISM HEALTH SERVICE MODEL

In the absence of an articulated theoretical model for health services that could compete or complement the modern medical model, Indigenous medical services are under pressure to imitate the Western system, although in Ayurveda, there is a holistic model for health truly taking into account that, health is not the absence of disease, but the physical, mental, social and spiritual well-being. Attempts to expand and develop indigenous medicine in the public sector seem to have made little progress as they copy the administrative and practice patterns of the allopathic system leading to duplication of services and a lack of fit between the philosophy underlying users expectations, the nature of interventions and the actual delivery of services.

“Strengthening Stewardship and Management Functions Program”, “Strengthening Service Delivery”, & “Human Resource Development Program” aim to establish a health service model for ISM in this country.

(2) ISSUE OF “AYURVEDIZATION”

Paramparika Practices are constantly being viewed and even translated to Ayurveda by the personnel trained in classical Ayurveda. This may be harmful to the transitional knowledge and practices, which may have developed on other foundations. This process could destroy the specialist knowledge claimed by certain practitioners who have inherited such knowledge through generations of family lines.

"Strengthening Stewardship and Management Functions Program" and "Strengthening Service Delivery" will preserve the knowledge of *Paramparika*.

(3) ISSUE OF "COMMUNICATION IMPASSE"

There is hardly any communication on what Allopathic and Ayurvedic systems can offer jointly to a given health problem of an individual or of the community. A complementary approach can be more useful for health promotion and care delivery. Countries like India and Japan are living examples of indigenous medicine surviving and flourishing in close dialogue with Western Medicine.

"Program for Strengthening Integration of ISM and Allopathic Sectors" aims to integrate/link two systems at the service delivery level.

(4) SCIENTIFIC SCRUTINY

The holistic philosophy of Ayurveda is being challenged to be proven scientifically through research although the basic principles of Ayurveda itself have not yet been fully understood. Although the underlying philosophy of Ayurveda is not empirical methodology, its disease categorisations and intervention methods are now under scientific scrutiny. Nonetheless, experimentation on diseases in isolation is not the realistic way to test the concepts of Ayurveda.

"Strengthening Research Capacity Program" will give strength to ISM and will strengthen the health service of the ISM.

(5) ISSUE OF COMMERCIAL EXPLOITATION

Given the present day interests in natural products and traditional medical knowledge, there is ample room for legitimate as well as unethical exploitation of the indigenous medicine sector by the industry, by practitioners of other systems of medicine and by agencies and individuals within the sector itself. The existence of a large number of medical "texts" giving thousands of recipes treasured by traditional practitioners' families regarding herbs and other natural products of medicinal value opens up avenues for unethical exploitation.

"Strengthening Stewardship and Management Functions Program" and "Strengthening Service Delivery" aim to solve this issue of commercial exploitation.

(6) LACK OF OVERALL STRATEGY OF ISM AND INSTITUTIONAL CONSTRAINTS

The overall issue existing in ISM, which is leading the issues explained above, is based on mainly its institutional constraints, such as lack of overall strategy to steer indigenous medicine into the mainstream of general health system, and weak performance of the Ministry. The functions of the Ministry such as policy formulation, planning, monitoring & evaluation, and regulating services not

only in the public but also in the private sector need to be strengthened; re-organization needs to be taken into consideration also in order to strengthen the role and responsibility of ISM to the people.

“Strengthening Stewardship and Management Functions Program” aims to empower institutional capacity on ISM.

11.2 STRENGTHENING STEWARDSHIP AND MANAGEMENT FUNCTIONS

(1) PROGRAMME OBJECTIVE

To strengthen the stewardship functions and management functions of MIM in order to reinforce the capacity of MIM to delivery better health services.

(2) PROJECTS

Project 6.1.1

Title: Restructuring of the Ministry of Indigenous Medicine (MIM)

Summary:

Restructuring of MIM Project aims to restructure and reinforce the capacity of MIM in order to deliver better health services to the public through ISM. Following outputs will be realized:

- National ISM Policy functional.
- Establishment of a Task Force to initiate activities.
- Establishment of the Planning, Monitoring & Evaluation Unit.
- Establishment of the Project Management Unit.
- Restructuring of Department of Ayurveda.
- Strengthening of management of provincial hospitals.
- Establishment of the Ayurvedic Drugs, Cosmetics and Devices Authority.
- Establishment of a Health Promotion Bureau for ISM.
- Development of a MIS in MIM.
- Restructuring the National Institute of Traditional Medicine (NITM).
- Provision of necessary legislations for the ISM in Sri Lanka.
- Formulation of legislations for restructuring the BMARI.
- Assisting the implementation of new legislations for IPR on traditional knowledge.

Project 6.1.2

Title: Setting up of an Ayurveda Pharmacopoeia Commission

Summary:

Setting up of an Ayurveda Pharmacopoeia Commission Project aims to revise and update the Ayurveda Pharmacopoeia and publish a formulary to be official references to guide the manufacture, quality control and formulation of products of specified standards. Following activities are to be implemented by the MIM to realise the outputs:

- Appointment of members to the commission.

- Provision of resources for setting up an office.
- Preparation of TOR.
- Appointment of subcommittees.
- Preparation of monographs.
- Review of monographs on plants and products.
- Preparation of a formulary.
- Preparation of the Pharmacopoeia for printing.
- Continuation of updating with the preparation of addenda.

Project 6.1.3

Title: Planned Development of the Private Sector Partnership in ISM Project

Summary:

Planned Development of Private Sector Partnership in ISM Project aims to enable the private sector participation and contribution for ISM healthcare service in a responsive and effective way. This can be accomplished by establishing a system for assisting and regulating the services of private health care providers. To realise the outputs of the project, following key activities are to be carried out :

- Preparation of a directory of private sector / non-formal local health care providers and institutes.
- Development and implementation of standards and guidelines to monitor private sector involvement.
- Promotion of investments of private sector in different ventures.
- Develop strategies for HRD taking into consideration private sector needs.
- Provision of practice support to enhance quality of service.
- Identification of areas for reciprocal relationship with private sector.
- Liaison with state agencies to promote private sector enterprises internationally.
- Development of a strategy for encouragement and reorganization of marketability of ISM related services.

11.3 STRENGTHENING OF SERVICE DELIVERY

(1) PROGRAMME OBJECTIVE

To Strengthen the ISM service delivery system and pharmaceutical industry to deliver better health service in this country.

(2) PROJECTS

Project 6.2.1

Title: Development of ISM Pharmaceutical Industry

Summary:

Ayurvedic drugs available in the market for public use are not subjected to quality control due to the absence of specifications and the necessary legislation. The production processes used are traditional and could be improved to be more cost effective to produce products of consistent standards by introducing modern technologies where appropriate. The Ayurvedic Drugs, Cosmetics & Devices Act is awaiting legal enactment will provide the legal basis for quality control. There is a serious lack of raw material for manufacture of Ayurvedic drugs and cultivation of medicinal plants on large scale has to be undertaken Most of the raw material needed are imported and not quality controlled. The project aims to develop the Industry to make available good quality Ayurveda Pharmaceuticals to meet national & international demands in conformity with acceptable standards. It is expected to conduct activities to achieve the following outputs:

- Research on use of Modern appropriate technology for drugs production conducted
- Quality specifications for commonly used products established
- Modern technologies where appropriate for traditional production processes and quality specifications introduced to Industry
- Investments by the ayurvedic pharmaceutical industry promoted and encouraged
- Systematic cultivation of commonly used medicinal plants promoted.
- Market opportunities for export of products negotiated
- Ayurvedic Drugs, Cosmetics & Devices Authority (ADCDA) regulations implemented

Project 6.2.2

Title: Development of Specification & Technology for ISM

Summary:

Development of ISM Pharmaceuticals Project aims to make available ISM products and analytical services to meet national and international demands conforming to acceptable standards. To accomplish this objective national quality assurance laboratory and the BMARI has to be well-equipped, supplied with necessary materials and provided with trained staff. In order to assist the quality control of ISM pharmaceuticals specifications have to be developed. Work relating to the development of new dosage forms / products is to be undertaken followed by pilot scale production. To assist the cultivation of medicinal plants agronomic packages on selected plants species will be developed.

Project 6.2.3

Title: Facility Development Project

Summary:

The facility development project aims to establish the basic infra structure facilities, in order to give high quality health care delivery service to the people. In this context the task is to restructure/ rehabilitate and add facilities and facilities network to be more be responsive to people's needs and adequate for proposed programmes Health Network in the Indigenous Medical sector needs to be established and strategies for meaningful integration with mainstream health sector Development of Infra structure facilities of three existing Teaching hospitals are to be worked out. Referral linkages to peripheral hospitals and dispensaries and to secondary and tertiary allopathic hospitals are envisaged. Equipment needs for diagnosis and investigation services, for treatment, facilities for the production of good quality medicines at hospitals, improvement of kitchens, and facilities for proper disposal of waste products have to be provided.

The project would achieve following outputs by above activities:

- Infrastructure facilities of three teaching hospitals funded and developed
- Infrastructure facilities of one provincial hospital for each province funded and developed
- Infrastructure facilities of one district hospital/ central dispensary for each district funded and developed
- One central Ayurvedic dispensary for a population of 20,000 people in the A G A division established
- A model National Ayurvedic Hospital Complex (NAHC) Established with specialised units. (Yoga, Panchakarma, massage and rehabilitation) for in and out patients
- ISM Primary Health Care Units (PHCU) established according to the needs incorporating 2 or 3 AGA Divisions.
- Drug Processing and Manufacturing Unit (DPMU) established in each province for supplying quality ISM medicine
- Infrastructure for storing facilities provided for all ISM / HSPI
- Cultivation plots for selected medicinal plants developed and maintained

Project 6.2.4

Title: Strengthen the Service Sector of Indigenous Systems of Medicine

Summary:

Development of the Service Sector of Indigenous Systems of Medicine Project aims to enhance the quality of ISM health care services to ensure their responsiveness to the public needs and thereby increase public confidence and patient / client satisfaction There is need to make available ISM services and medicines commonly used at affordable cost. At three levels and improve the services to provide the best ISM practices. In this regard activities will be undertaken to achieve the following outputs:

- Health institutions reorganized into three service levels with standards of minimum services to be provided.
- Utilization of existing service facilities enhanced.

- Mechanism for referral and counter- referral system established.
- Strategies introduced to develop and integrate preventive & curative services of both allopathic and indigenous systems to be patient-cantered using health team approach.
- ISM Integrated into the proposed HIS.
- Quality of services enhanced through adoption of best ISM practices.
- Rational prescribing, dispensing and use of medicine continually promoted in the public and private sectors.
- Responsiveness to clientele of ISM increased.
- Confidence of the public, dispensers and prescribers on the quality of medicine sales outlets generated and sustained.
- Client satisfaction assured.
- The role of ISM within the proposed National health charter identified and incorporated.
- Mediatory mechanism established for conflict resolution at ISM institutions.
- Community accountability through participatory involvement initiated.

Project 6.2.5

Title: Non-formal "*Paramparika*" Knowledge Base Project

Summary:

It is well known that a medical knowledge base and traditional practices outside the Ayurveda exist in Sri Lanka. The documented segment of this knowledge is found embedded in the numerous ola leaf manuscripts, which are not well preserved. Such knowledge should be preserved and harnessed to the benefit of the public. Therefore this Non-formal Knowledge base project aims to obtain optimum inputs from non-formal (*Paramparika)* healthcare providers by establishing a mechanism for harnessing their special skills and knowledge relating to ISM. To accomplish this following activities are to be carried out:

- Inventorization of available traditional knowledge and skills of *Paramparika* practitioners.
- Surveying practitioners for current utilization by patients and therapeutic effectiveness.
- Development of a strategy for application of traditional knowledge and skills.
- Accreditation of genuine traditional practitioners (TP) by Rescheduling the registration procedure.
- Use of the services of identified best practices into clinical practice.
- Implementation of Guru Kula education system for apprenticeship.
- Collection of possible palm-leaf medical manuscripts available in the country.
- Preparation of a descriptive catalogue on inventorized medical manuscripts.
- Establishment of a national database on traditional resources available.
- Collection of ethnomedical and ethnobotanical knowledge.

11.4 STRENGTHENING INTEGRATION OF ISM AND ALLOPATHIC SECTORS

(1) PROGRAMME OBJECTIVE

To strengthen the integration of ISM and allopathic sectors in order to achieve more effective and efficient health services to the people in the country.

(2) PROJECTS

Project 6.3.1

Title: Development of Home-based and Community-based Services

Summary:

Development of Home-based and community based services Project aims to establish and run an ISM Long Term Home Based Care programme for identified problems in the communities and evolve community participation for such a programme. To realize the outputs of this project the following activities are to be carried out:

- Further conceptual development and planning of projected delivery. methodology for long-term care management for selected services.
- Provision of training for those involved in providing services.
- Incorporation of traditional knowledge of local healers available in the village.
- Establishment and mobilization of stewardship groups at village level.
- Establishment of a mechanism to coordinate and supervise the home-based services at CD level Primary Health Care Units (PMCUs).
- Broad base services of CDs to include field and extension services related to home-based long-term care management.

Project 6.3.2

Title: ISM Health Promotion Program
Summary:

ISM Health Promotion Project aims to incorporate traditional health promotive practices into mainstreamed health system. To provide an effective ISM health promotion service to the community for improving their quality of life in terms of positive health-seeking behaviour and avoid health risks of NCDs Following outputs are to be realized by the activities that are to be carried out by Central Ministry of Indigenous Medicine (MIM) with the assistance of Department of Ayurveda and Provincial Departments of Ayurveda:

- National policy on ISM health promotion services formulated.
- Approved plan for implementing ISM health promotion services.
- Experimental Health Promotion Units at primary level established .

- Trainers for health promotion trained.
- Healthy lifestyle including dietary regime (*Swastha vritha*) based on Ayurveda / traditional norms promoted.
- Special programmes for mental well-being through ISM introduced.
- Partnerships with civil society and NGOs in health promotion and prevention with regard to needed groups established.
- Elements of ISM health promotion introduced into Ayurvedic curricula and CPD programmes.
- IEC measures taken for promotion of health and changing lifestyle.
- Field surveys on health promotion and its impact conducted.

Project 6.3.3

Title: Systematisation of ISM Rehabilitation Services

Summary:

Systematisation of ISM Rehabilitation Care Services Project aims to expand and Strengthen Rehabilitation services for identified conditions by establishing Rehabilitation Service Units at all the provincial hospitals and teaching hospitals. For this following activities are proposed to be carried out:

- Identification of types of rehabilitation services manageable by ISM.
- Development of protocols.
- Development of human resources to provide standard and uniform services according to protocols.
- Identification and provision of physical resources and medicines.
- Access expertise in relevant areas in the private and public sectors.
- Undertaking close monitoring of each patient for physical and psychological progress.
- Annual impact assessment (IA) of the overall performance of rehabilitative Care Services (RCS).

11.5 HUMAN RESOURCE DEVELOPMENT

(1) PROGRAMME OBJECTIVE

To strengthen the human resource development capacity of ISM in order to make the health service delivery more responsible to the health needs of the people in the country.

(2) PROJECTS

Project 6.4.1

Title: Human Resources Development in ISM

Summary:

Human resources are one of the core assets of IM sector and the success of the health care delivery depends largely on the management of the Human resources. The present status of the development of Human Resources in the Indigenous system of medicine has to be strengthened for a meaningful development of The IM sector. This project aims at first identifying the present status of HRD at various levels in the ISM sector, followed by the assessment of needs in personnel and in training and in the preparation of an action plan to solve the problems. The action plan envisages provision of training/postgraduate training for all health providers in public sector and selected providers in private. Continuing Training is required in for different categories of personnel in the ISM sector in order to improve service delivery significantly and improve job satisfaction. It is also proposed to introduce performance appraisals and schemes for motivations at different levels among the service sector personnel.

11.6 STRENGTHENING RESEARCH CAPACITY

(1) PROGRAMME OBJECTIVE

To strengthen the research capacity of the ISM in order to make the ISM sector more scientifically evidence bas and will strengthen the health service of the ISM.

(2) PROJECTS

Project 6.5.1

Title: Strengthening of Research & Development in ISM

Summary:

Research activities carried out in the fields of Ayurveda & Traditional medicine in Sri Lanka, have to be properly planned and strengthened. To achieve this goal existing National research institute (BMARI) is to be restructured and strengthened. Strengthening of Research & Development in ISM aims to provide all facilities and personnel to strength ISM research and development. In order to expand research activities that are relevant to make development decisions and selection of priorities, Epidemiological, Sociological, Agronomical research units are to be established. Library and the database are to be strengthened with necessary inputs for data storage and retrieval. Research programmes will be developed and prioritized in the areas of Clinical, Literary, Drugs, Agronomical, Epidemiological, and Social research. A unit for the dissemination of information on research findings is to be established. The research activities would be multidisciplinary and the BMARI will establish research linkages with universities, state research institutes, foreign institutions and the industry and introduce mechanisms for coordination at national and international level. Procedure will be introduced for screening of all research projects for ethical concerns.

CHAPTER 12

TRANSITIONAL STRATEGY FOR NORTH & EAST PROVINCE

12 TRANSITIONAL STRATEGY FOR NORTH & EAST PROVINCE

The chapter discusses transitional strategy for the expected outcomes in the recovery of the health system in the North-East Province. Further, it proposes strategic directions towards the development of comprehensive health services delivery in the next 10 to 12 years.

(1) STRATEGY FOR MEDIUM TERM HEALTH SECTOR DEVELOPMENT NORTH - EAST PROVINCE

The achievement of equitable, sustainable and satisfactory health outcomes depends on coherent and well-targeted health strategies and health programmes. The proposed health strategy aims at improving the health outcomes by addressing the health determinants as well as initiating the essential health actions.

Priority has been accorded to the rehabilitation of the affected services and meeting the medium-term health development needs to ensure the provision of essential services and the sustainability of the health system. The immediate health needs, which are being addressed by the World Bank financed North East Emergency Reconstruction Programme based on WHO's health system assessment in the North and East and the proposal for its recovery , have been taken into reckoning in the formulation of these strategies.

The conflict has increased the "women headed" households and will be identified as a vulnerable group in the health projects. In addition mainstreaming gender considerations in all the health programmes/strategies is envisaged as one of the cross cutting issues.

(2) THE KEY OUTCOMES OF THE PROPOSED STRATEGY

The key outcomes of the proposed strategy are aimed at achieving the following:

- Improved health status of conflict affected, poor and vulnerable population groups through effective targeting of priority health issues;
- Enhanced performance of basic preventive and curative health services in meeting current and new challenges for health of the people;
- Development of models for health services deliveries that are sustainable, efficient and effective.
- District health system rebuilt and recovered to modern standards of health care.

To achieve these outcomes the priority strategies that have been identified and are as listed below.

1) Supporting the delivery of people-responsive primary, secondary and tertiary health care services by developing the physical infrastructure in the conflict affected areas.
2) Development of the Human Resources in the conflict affected areas to enable the facilities to be operational for quality care.
3) Reducing the disease burden, disability and deaths from preventable conditions through strategic interventions.
4) Strengthening the extension of the Reproductive Health Initiatives undertaken in the rest of the country with particular emphasis on Emergency Obstetric Care (EmOC) to conflict affected areas.
5) Strengthen the child and adolescent health programmes and support implementation of the Early Childhood Care and Development (ECCD) programme for children.

6) Establishing a comprehensive Mental Health Program in the conflict affected areas where there is pervasive psychological trauma.
7) Strengthening of the Health Management System and to establish an efficient surveillance and management information system to provide technical and logistic support for rational planning and decision-making.
8) Establishment of quality water and sanitation facilities along with waste management mechanisms in hospitals for a safe environment.
9) Improving the malnutrition status and taking measures to improve food safety and food security.
10) Improvement of laboratory, diagnostic and blood transfusion services to acceptable standards.
11) Strengthening the District Health System with special emphasis on decentralized planning, monitoring and evaluation and provision of basic health care, in addition to establishment of a referral system to enable rationalized delivery of secondary and tertiary health care services.
12) Maximize the rehabilitation process of the increasing number of disabled including reconstructive procedures to enable them to participate in rebuilding of the nation.
13) Promotion of the healthy life style of the community by empowering them to acquire adjustments through Behaviour Change Communication activities for enhanced quality of life.
14) Development of an emergency/disaster preparedness and response program in order to strengthen the response to any unexpected emergency, disaster or accident as a pilot project to be extended nation wide later on.
15) Strengthening the provision of essential medicines and biologicals and their logistical management.

The strategy aims at building and strengthening the health services in the North East Province so as to be able to deal with the challenges that have arisen as a result of the past conflict.

12.1 PROGRAMME JUSTIFICATION AND LINKAGES

The Transitional Strategy program is composed of the following projects:

- Health of People in Conflict-Affected Areas and Displaced Populations; and
- Development & Implementation of New Strategies (including incentives) for Development of Human Resources in Priority Regions such as North East Provinces and Other Needy Areas.

A comprehensive approach is required when addressing the issue of improving the health of populations affected by conflict. Currently health care delivery and the health status of the people affected can be seen as the outcome of the conflict situation that prevailed over the past two decades, which had disrupted the general health services in the areas. The health service delivery system was in disarray to a larger extent in this region and to a lesser extent in the Eastern Region. Other areas bordering these two regions have also been affected.

The main problem is a general lack of human resource in professional and skilled staff categories. The situation has been further aggravated by the deficiencies in management of health services due to lack of trained staff in management and at technical supervisory levels, lack of support staff and proper epidemiological surveillance and data management systems.

There is a clear difference and deterioration of health status and resource accessibility indicators between conflict-affected areas and others in the island. A restoration programme needs to be planned with the aim of bridging this gap and at least restoring health care services in conflict-affected areas to a level on par with the rest of the country.

The Health of People in Conflict-Affected Areas and Displaced Populations Project aims at delivering the restoration programme in a more coordinated and efficient method and showing the priority services to be re-installed and the priority areas to be given attention.

The Project for Development & Implementation of New Strategies (including incentives) for Development of Human Resources in Priority Regions such as North-East Provinces and Other Needy Areas is almost a pre-requisite project to be implemented in order to make the first project, *The Health of People in Conflict-Affected Areas and Displaced Populations Project*, be implemented successfully. Therefore, the two projects need to run in parallel.

12.2 HEALTH IN NORTH – EAST AND BOARDER PROVINCES

(1) PROGRAMME OBJECTIVE

To improve the accessibility of health services such as preventive, curative, promotive and rehabilitative services in the region to a level comparable with the rest of the country within a five-year period.

(2) PROJECTS

Project 1.5.8.a

Title: Strengthening Health Services for People in Conflict-Affected Areas and Displaced Populations

Summary:

The project for "Health of people in Conflict-Affected areas" aims at improving the accessibility to health services to a level comparable with the rest of the country within a five-year period. As such the key issue is the acceleration of the restoration process with more emphasis on establishing effective management structures and procedures and thereby the efficient management of resources.

The project spans across many of the ongoing health programmes in the country; primary health care, secondary and tertiary care, emergency health services, Blood bank services, management of health services, transport facilities, laboratory facilities, Safe water and waste management systems in hospitals, Management information systems and making available the required Human resource for service delivery.

It can be assumed that after successful completion of the project activities during the specified period that the normal health care delivery programmes will continue to be implemented. Implementation of these activities after the 5-year period will be defined through other relevant project profiles.

The project also emphasizes on the need for an effective mechanism to address policy issues at the central and provincial level in order to facilitate the implementation process.

While a comprehensive needs assessment has already being carried out at District level for the north & east province, a similar assessment will be required in other districts bordering these areas that have been affected as a result of the conflict situation.

Project 1.5.8.b

Title: Development of Human Resources for Health, North-East Province

Summary:

This project aims at making health services more accessible to people in conflict-affected areas through improving availability of human resource in health.

Planning of Human resource for health services in such situations should be given special emphasis as regular human resource development strategies usually do not suffice in bringing the desired effect in that they are not responsive to the urgency of the demand and hence timely action cannot be taken.

The project profile is described in two sections;

1. Developing a mechanism within the Health Sector that can respond to such situations
2. Developing a HRD plan for the transition period, with the incorporation of short-term policy changes and new strategies to address the urgency in conflict-affected areas with special reference to North & East.

PART III :

STRATEGIC FRAMEWORK AND PROGRAMMES

CHAPTER 13

IMPLEMENTATION OF THE HEALTH MASTER PLAN

13 IMPLEMENTATION OF THE HEALTH MASTER PLAN

13.1 INTRODUCTION

There are three major aspects to the implementation of the Health Master Plan.

The first aspect is the collective national commitment to pursue the. This will demand involvement of the political leaders and civil society leaders the implementation of the HMP in the health sector, in other sectors of the day-to-day life of the nation and, finally, in people's lifestyle at work and at play, so that health will be promoted by individuals, families and the community at large.

The second aspect is the preparation of the health sector and especially the public sector to provide stewardship and management of the implementation and where necessary strengthen human resources capacity for service delivery as well as put in place the necessary supplies, equipment and their logistic system.

The third aspect is that the Health Master Plan (HMP) and the implementation activities need to maintain continuity of purpose and flexibility of means. It should be faithful to the vision, mission, goal and strategic objectives but should respond to different contexts and local preferences by adapting service delivery and support programmes and their intermediate objectives, being guided by the feedback from people, and the results of monitoring/supervision and evaluation.

The following sections explain the details of the principles of implementation of the HMP.

13.2 PRINCIPLES OF IMPLEMENTATION

The Sri Lankan Ministry of Health has a good reputation of successfully implementing health programmes throughout the country. The Expanded Programme of Immunization (EPI), the Polio Eradication programme, the Leprosy Eradication programme, the Control of Diarrhoeal Diseases (CDD) and the Acute Respiratory Infection control programme are some of the recent examples of such projects. The Sri Lanka EPI has been rated as the world's best.

The principles factors in these successful disease control and management programmes were the motivation and commitment of health staff, the commitment and cooperation of religious, political and community leadership and the collaboration and motivation of the public.

These principles should be applied in the implementation of all HMP programmes and projects; this chapter also spells out other principles that are important to HMP implementation.

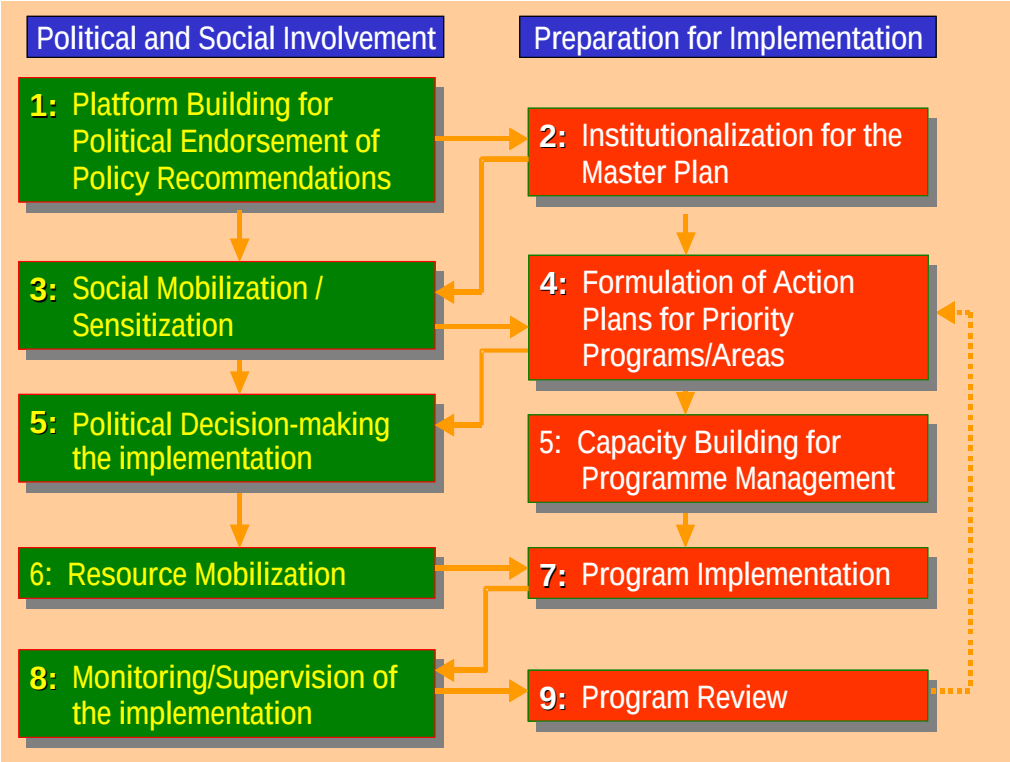


Figure 13.2.1 Principles of Implementation

(1) PLATFORM BUILDING FOR POLITICAL COMMITMENT & ENDORSEMENT OF POLICY RECOMMENDATIONS

The Health Master Plan should be marketed among all the political parties in the Parliament, Provincial, Municipal, Urban Councils and Pradeshiya Sabas. Commitment should be sought from all the political leaders representing those institutions to the strategic framework. It is hoped that as the plan is non-partisan and serves all the people, it will be possible to obtain such a general non-partisan commitment. This is *sine qua non* for the long-term effort.

It will also be very important that MoH stimulate dialogue with each of the ministries listed in Table 13.4.1. All these ministries can make direct contributions to people's health and assuring their

understanding and ongoing collaboration is vital to create a socio-cultural and economic environment where people are enable to promote health and feel society protects and nurtures them. Personal and family life style can fully promote health in such an environment.

Some proposed programmes/projects might require changes or expansion of health policies. There should be careful sequencing of these activities and come up with a new and appropriate set of "Policy Base" for implementation of the Health Master Plan.

(2) INSTITUTIONALISATION OF THE MASTER PLAN

For the Master plan to be meaningful, the current and subsequent Governments of Democratic Socialist Republic of Sri Lanka should accept the Health Master Plan as a National Health Plan and be committed to its implementation for the next 12 years at least.

The Health Master Plan will be submitted to the Cabinet to be approved by the current government and to the select parliamentary committee to be discussed by all political parties and will be institutionalised as a national health plan before the implementation starts.

(3) SOCIAL CONSENSUS BUILDING AND OWNERSHIP

A wide publicity should be given to Vision, Mission, Goal, Objectives and Strategies of HMP during the parliamentary debate and again after its finalisation. All the stakeholders including trade unions should have a chance to clarify points, make suggestions on how to implement etc. Benefit to individual persons, to communities, to implementers and the impact on economy of the country should be highlighted positively during the HMP consensus building process. Once the Health Master Plan is accepted by Parliament, the stakeholders should continue to be informed and given a chance to make inputs. The HMP should be for the health of the people and should be owned by the people.

The final accepted Health Master Plan document should be printed and distributed among all the health institutions, other relevant institutions and among all the stakeholders.

(4) FORMULATION OF ACTION PLANS FOR PRIORITY PROJECTS/AREAS

Formulation of action plans for priority programmes/areas should be carried out in consultation with all the stakeholders of the particular geographical/ administrative division. In the formulation of action plans, prioritisation of activities should be carried out by the local implementers in consultation with stakeholders. Some criteria should be identified to prioritise activities. One universally valid one is that activities that have direct impact on felt local needs should be implemented as soon as possible in order to encourage and involve local implementers and beneficiaries fully and create rapport on which the implementation of the whole plan depends.

(5) CAPACITY BUILDING FOR PROGRAMME MANAGEMENT

Prior to and during the implementation of programmes/projects, capacity building for programme management should be taking place for the project implementers and focal points. Organizational structure of project management needs to be established and project monitoring mechanism need to be put in place based on the existing organizational structure and the purposes of monitoring. The information system needs to be linked to the monitoring system and financing mechanism as well, so that the accountability of the health system would be strengthened. Many of project managers and financing managers need to be trained in order to make the system workable. The necessary training

should be done before and at the very beginning of implementation period and should be carefully evaluated and followed up with supportive supervision and further training where needed.

In the service delivery technical guidelines and technical capacities may need to be formulated/reviewed and strengthened such as in nutrition, non-communicable disease prevention, first aid and ICU care in surgical, obstetrical and medical emergencies.

(6) RESOURCE MOBILIZATION

The government treasury should agree to allocate adequate resources in a planned and timely manner to implement HMP activities. Foreign Donors should also act within the Master Plan programmes/projects and decide what to fund to meet also the mandate of their organizations and how to fund in a timely and continuous manner.

A sector-wide approach (SWAP) may be one option to facilitate the integrated implementation. However, it would be no harm to further study before taking the next step forward, learning from other countries' experiences in terms of merits and demerits, or expected positive and negative impacts on the total health management system during the course of the SWAP implementation.

(7) PROGRAMME IMPLEMENTATION

Implementation should be organized and coordinated in a way to allow individuals or teams to take initiatives on their own within the common framework. Such initiatives should be encouraged, commended and promoted by giving rewards. Implementation strategies may be varying from institution to institution, district to district or province to province. Therefore, frequent dialogue between implementers should be carried out along with planners. Successful implementation models should be promoted where applicable among other implementers.

The HMP is only a guideline for implementation of activities and it has to be frequently improved, updated and revised based on dialogues with various groups.

The MDPU should be strengthened and enabled to initiate and carry out dialogues between various groups to monitor implementation, and make necessary changes. This unit should be able to clarify health policies, provide guidance and directions to HMP implementers when necessary.

(8) MONITORING/EVALUATION OF THE IMPLEMENTATION

The HMP monitoring should be incorporated in the routine daily duties of respective project managers. Implementing agencies should have direct access to resources within the planned budgets, so that programme focal points should actively monitor the implementation of several projects and should be co-responsible for their good development.

A Ministerial HMP Management Unit should be established to monitor and assist implementation of HMP at national level and a Provincial Management Unit for each province should be established to monitor the provincial implementation. Quarterly HMP implementation progress review meetings should be conducted and the progress should be monitored at district, provincial and national levels. Line Ministry should assist provincial ministries in the progress monitoring activities.

Inter-Ministerial HMP coordinating committee at national level should be established to obtain the required support from other ministries and to monitor the progress of HMP implementation by other

sectors. Inter-Ministerial HMP coordinating committee should review the progress once in every six months.

Regular and continuing dialogue should be carried out with all the stakeholders including religious leaders, community leaders and the public while implementing the HMP and should as far as possible, involve evidence from critical incidents and monitoring, and appropriate changes should be made to the implementation and/or HMP according to the outcomes of such dialogues.

(9) PROGRAMME REVIEW

There should be adequate discussion with the religious leaders, community leaders and the public before, during and after implementation of HMP activities and their views should be taken into consideration. The HMP should be reviewed and revised according to the outcomes of such discussions.

A mechanism should be established to share inter-district and inter-provincial HMP implementation experience, knowledge, good practices and success stories. There should be a mechanism to publish those success stories and experience.

13.3 PLATFORM BUILDING FOR POLITICAL COMMITMENT AND ENDORSEMENT OF POLICY RECOMMENDATIONS

(1) PLATFORM BUILDING FOR POLITICAL

Given the socio-economic background prevalent in Sri Lanka over the last 20 years, it is not surprising to note that long-term health policies have not been a "priority" in the Sri Lankan political arena. The outside world applauded the successes in control of infectious diseases, in lowering infant and maternal mortality. There was civil unrest and economic changes that preoccupied the national psyche. Thus, politicians primarily addressed local short-term health issues. This attitude caused and might continue to cause severe disruptions to the medium and long-term health considerations. It is good to bear in mind that the emphasis of the master plan falls in to the medium and long-term segment of health action, even though important short-term activities like emergency networks are included too.

Sri Lanka, being a working democracy will have to have all policy options proposed and worked out by experts, debated by stakeholders and cleared by politicians. Thus, politicians automatically become key stakeholders in health policy implementation, and in some cases, in policy formulation and revisions. In Sri Lanka as in any democracy, politicians need to be involved and/or kept informed of key policy and technical developments. All major political parties in the country should make sure that their health representatives be involved/informed of these developments taking place in the health sector. In this way, one ensures that health policies reflect the will of the people and that key and important policies have continuity even if the political landscape might change.

(2) ENDORSEMENT OF POLICY RECOMMENDATIONS AS BASIS FOR IMPLEMENTATION OF THE HEALTH MASTER PLAN

Some proposed plans require some changes or expansion of health policies. There should be extensive discussions to come up with a new and appropriate "Health Policy Base" for implementation of the health master plan.

The details of the recommended policy base for the implementation of the HMP are described in Chapter 14.

13.4 SOCIAL MOBILISATION/SENSITISATION

(1) INTERSECTORAL MOBILISATION FOR HEALTH

During the development of the strategic framework and the proposed programmes, a wide-ranging attempt was made to involve all stakeholders directly related to the Health offices at central, provincial and district level, as well as relevant health NGOs. However, there is need to widen the circle of consultations in the last phase of the development of the HMP. Broadened range of stakeholders in the health sector need to be consulted in order to raise awareness of the HMP among them and get a consensus on the Strategic Framework for the next 12 years, the desirable policies, and programmes.

First, various Ministries which oversee activities that are health related need to be consulted, since health and disease are produced within the socio-economic cultural environment mediated also by individual risk or health seeking behaviour.

The most obvious ministries and their concerned activities are shown in Table 13.4.1.

Table 13.4.1 Health-related Ministries and their Concerned Activities

Name of the Ministries	Concerned Activities
Ministry of Health, Welfare and Nutrition	All.
Ministry of Indigenous Medicine and Disaster Relief	All.
Ministry of Finance and Planning	Budget, financial management and accounting, TQC?
Ministry of Policy Development and Implementation	Food and Nutrition policy, Policies necessary for HMP? Policies for Intersectoral Health-related activities, TQC?
Ministry of Education	School Health, detection of chronic illness, child abuse, Health Education of Children, Life skills, Health promoting school (school canteens, sanitation, hand washing, exercise), HRD for nursing and paramedicals.
Ministry of Labour	Standards for work environment, ergonomics, occupational health, preventive screening , accident prevention, environmental pollution prevention.
Ministry of Transport	Vehicle control, drivers license, road design , traffic rules.
Ministry of Agriculture	Implementation of agricultural extension for improved access to vegetables, fruits and protein, improved rural marketing of such produce, improved market responsive cultivation of herbs for IM.
Ministry of Interior	Family violence, conflict management, first aid at accidents and injuries and burns.
Ministry of Defense	Riot control, conflict management, first aid at accidents and injuries and burns, agreement on best practice for traumatology and surgical emergencies (MoD has its own hospital and traumatology unit), collaboration in disaster preparedness and HRD.
Ministry of Mass Communication	Health journalists to popularize HMP and major health education messages.
Ministry of Higher Education	HRD for allopathic and indigenous doctors, potentially for leadership in nursing and paramedicals as well as hospital administrators.
Ministry of Women Affairs	Family planning, family law, abortion, family violence, sexual abuse, prostitution.

The intersectoral activities will be the responsibility of the secretary in collaboration with the focal point and implementing agencies most closely related to a particular theme. Most discussions and collaboration will need to be done theme by theme.

Other stakeholders listed below should be consulted during the finalization of the HMP in order to raise awareness of the HMP and also to ensure their mandates are also reflected into the HMP. These stakeholders are:

- Private Sector Health Institutions;
- Providers and Support Staff in Allopathic/Indigenous Medicine;
  - Professional Bodies
  - Trade Unions
  - Health teams by facility
- Political parties- eventual health platform;
- District and Divisional Health and Development Committees;
- Provincial Councils & Local Government Bodies;
- UN Organizations;
  - WHO, UNICEF, UNFPA, UNHCR, WB-IDA, etc.
- Regional and Bilateral Bodies;
  - ADB, NORAD, JICA, JBIC, etc.
- Health Related Non-Governmental Organizations;
  - Reference: Directory of Health Related NGOs Sri Lanka. World Health Organization, Colombo, Sri Lanka, January 2003
- Research Institutions Including Universities SL;
  - Central Bank of Sri Lanka, Institute of Policy Studies, Institute of Fundamental Studies, Ceylon Institute of Scientific and Industrial Research, Sri Lanka Standards Institute, Department of Census and Statistics, Registrar Generals Office, Medical Research Institute, Government Analyst, Agrarian Research Institute, Water Board
- Service related Non-Government Organizations;
- State and Private Social Security Schemes; and
- Religious Bodies

(2) PUBLIC RELATIONS

Publicity activities shall be strengthened. A wide publicity should be given to Vision, Mission, Goal, Objectives and Strategies of HMP through newspapers and other medias. Participation of consumers, communities and other stakeholders in the design of implementation strategies is inevitable, especially involvement in the management decisions such as scheduling of OPD visits, special clinics and, waiting time are so important to greatly minimise inconvenience, hardships or delays in care. A clear response to consumers' opinion is obligatory to render the health system more responsive to the people's perceived needs.

MoH shall publish a directory of secondary and tertiary care with clear indication of services available, cost and last years performance. All facilities will post in a readily visible place essential information on services and costs.

MoH shall expedite its effort to strengthen the mechanisms of organizing consultation meetings and consensus building among consumers, communities and other stakeholders on specific themes and activities.

13.5 FORMULATION OF ACTION PLANS FOR PRIORITY PROJECTS/AREAS

Prioritisation of projects should precede the formulation of action plans.

Not all projects can or should be implemented immediately. There are not only financial but also human resources constraints in the development of supportive mechanisms that may delay service project implementation. Other aspect of prioritisation is that some projects are strategically important to be implemented prior to others, for example, such projects for policy formulation or laying out the plans. As a strategy for the development of the implementation plan, prioritisation and sequencing of projects/activities are as described below..

Why should we prioritize?

1) Public good needs to be optimized by a judicious choice of delivery methods and guidelines for care that optimizes cost/effectiveness[1] and equity[2].

2) Public funds are limited and if no priorities are made and made public in full transparency the rule becomes biased at best and special preference as well as potential corrupt practices is indirectly favored.

3) A plan that has strategic approach to attain the short-term, mid-term, and long-term objectives should identify the strategically important projects for achieving these objectives within the limited resources.

4) It is important to focus on the national interests and mandates through a set of priority projects in order to coordinate better the foreign input together with the national input.

5) The plan should identify prerequisite projects whose outcome would be an input to other projects.

Prioritization is not a one-time process and priority setting needs to be flexible enough to adjust to changes in the epidemiology and local context over time. The public debate on it will continue as many diverse interests and views emerge, so that the plan would need adjustments along the way.

Why should we sequence?

1) Not all projects are equally urgent and not all, even very crucial projects, can be started in year one as the prerequisite conditions may not be in place as yet (adequate human resources and finances both for investment and running costs, equipment and supplies availability).

2) Techniques of network analysis help in sequencing. One such approach is Programme Evaluation and Review Technique (PERT). This is a prerequisite of an efficient rolling plan as it rationalizes implementation and helps in review of programmes.

[1] For a critique and reflection on the ethics of using cost/effectiveness in isolation see Dan W. Brock “Health Resource Allocation for Vulnerable Populations” in Ethical Dimensions of health Policy eds M.Danis et al Oxford University Press 2002
[2] Dan Brock “The trade off between equity and choice : Ensuring fair procedures” In Hidden assets :values and Decision Making in NHS London UK The Kings Fund, 2002

3) Supportive and or capacity building projects like improvement of lab services derive their content and their timing from the variety of service improvement projects. Detailed collaborative planning and implementation of these supportive projects should come **very early in the sequences**.

4) Early service projects should either be very urgent or promise early visible results within existing or easily mobilisable resources that create momentum for plan implementation.[3]

5) Resource constraints in terms of human resources take some time to solve and clear sequences can help to **keep momentum** rather than just wait.[4]

In modern times, spending of public moneys for health as well as using private insurance, [5] is under intense scrutiny not just for honesty, but also for explicit or implicit priorities. There is strong demand that organizations and governments be held accountable for reasonableness of priorities defined as relevance, transparency, responsiveness[6], cost/effectiveness and equity.

"Decision makers in health care struggle with how to set such priorities in health care, especially choice of technologies. There is no widely accepted model."[7]

(1) PRIORITISATION OF PROJECTS/ACTIVITIES

The projects to be considered for earliest start in this country would have one or more of following characteristics:

- Support policy formulation and implementation;
- Core system projects that are prerequisite to several service projects such as capacity development and, facility development for particular services;
- Service projects that help improve equity in input and outcome;
- Service projects that build partnerships and intersectoral collaboration; and
- Service projects that are feasible within existing resources or can be mobilized easily.

(2) STEPS IN PRIORITISATION

There are many ways to prioritise projects/activities. In Sri Lanka HMP, prioritisation was approached in two different ways.

Proposed Process 1: Prioritise projects by setting up stage-wise criteria to choose priority projects. The process is described as follows:

[3] This criterion is particularly important given the lack of implementation of most past long term plans in Sri Lanka

[5] Daniels N., Sabin J. Limits to Health care: Fair procedures, democratic deliberation and the legitamicy problem for insurers Philosophy and Public Affairs 1997, 26: 303-350

[6] J.L.Gibson et al Priority setting for new technologies in medicine: a transdisciplinary study University of Toronto BMC Health services research 2002 2: 14

[7] ibid

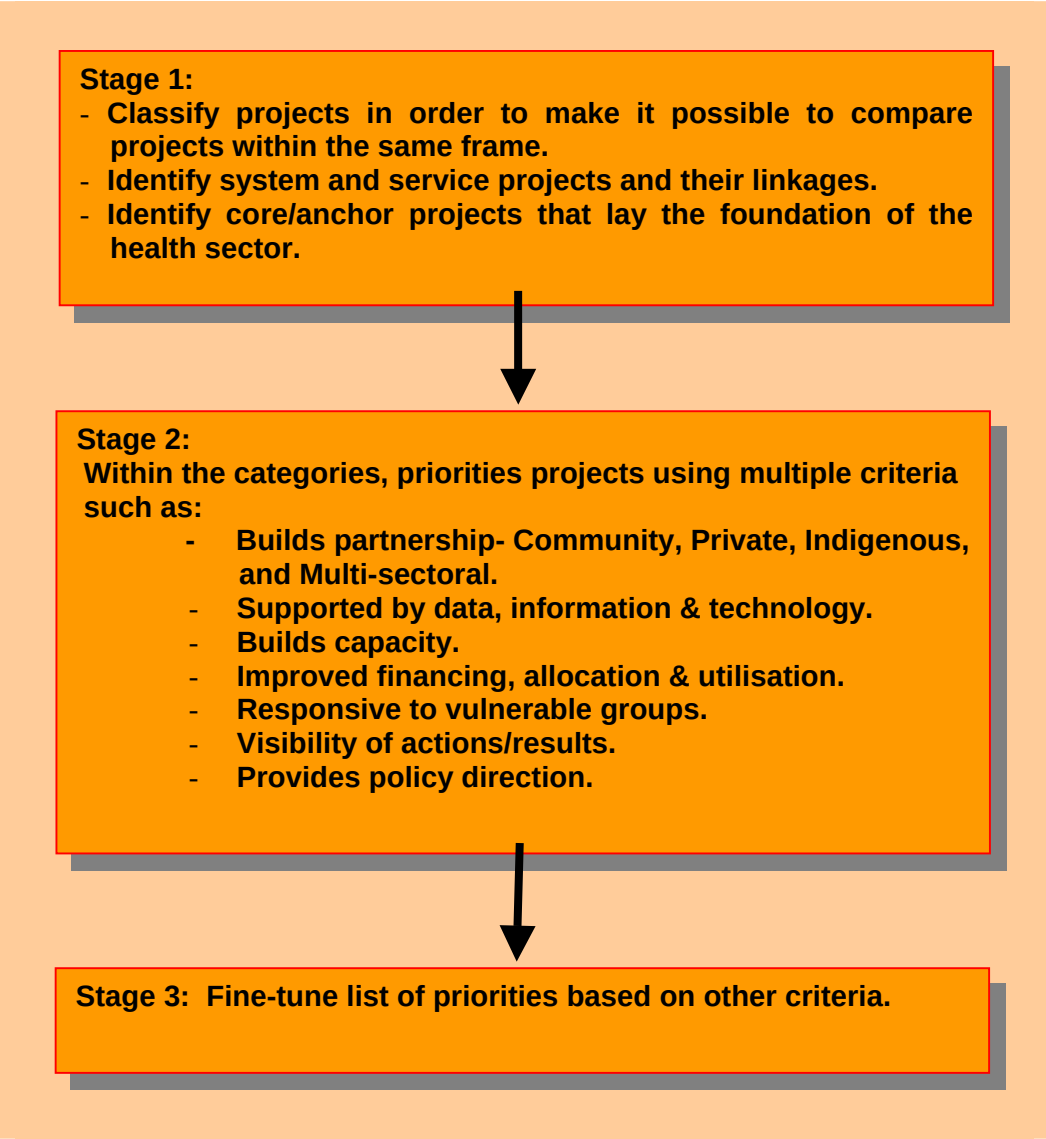


Figure 13.5.1 Stages for Prioritization

(3) PRIORITY PROJECTS

Priority Projects identified in the first five years are as follows:

- Functional Rationalization by Developing a New Health Services Delivery Plan.
- Facility Development According to the Rationalized Health Service Delivery Plan.
- Strengthening of Services for Mother & Child.
- Strengthening Support Services: Medical Supplies including drugs, Medical Equipment, and Laboratory Services.
- Total Quality Control/Management of Hospital Services.
- Total Quality Control/Management of Promotive & Preventive Services.
- Integrated Prevention of NCD.
- Respiratory Diseases Control.
- STD/AIDS Control.

- Vector-Borne Diseases Control.
- Food- and Water-Borne Diseases Control.
- National Nutrition Programme.
- Programme for improved community involvement for health development.
- Formulation of HRD Policy.
- Development of Health Financing Policy for National, Provincial & District Levels.
- Establishing an Improved Management System/s and Building the Capacities of Management Teams.
- Strengthening the Existing Health Development Network at National, Provincial & Local Levels.
- Public- Private Partnership Development at National & Provincial Levels.

Strategic Linkages of Priority Projects

The linkage are drawn, first by classifying the projects into two categories namely 1)system projects such as formulation of policies; reform of health system and 2) health service projects such as NCDs. HMP projects provide a pathway to impact on the chosen priorities. For this to be effective, it is also required to understand the linkages among the projects Figure 3 shows linkages of projects with the system and services as well as with policies and projects improving efficiency, equity and quality. It is expected that the MoH and other stakeholders will link the priorities accordingly.

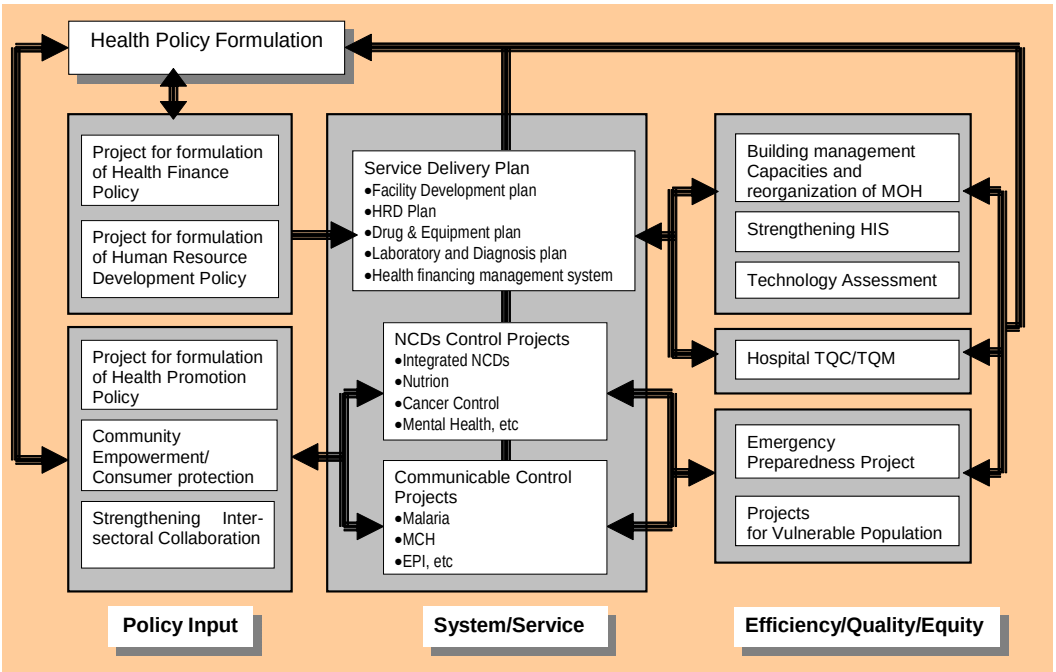


Figure 13.5.2 Linkage of Priority Projects

(4) FORMULATION OF ACTION PLANS FOR PRIORITY PROJECTS/AREAS

Once priority projects are identified, the individual implementation/action plan can be drawn by implementers. Time frame of activities should be included in the plan, so that sequence of activities is clearly shown to anyone. Sequencing of activities is very important to show the steps of implementation to all implementers who are involved in a project. This right sequencing of activities will determine the

effective implementation and success of a project. Formulation of these action plans should be carried out in consultation with all the stakeholders of the particular geographical/ administrative division and should be sequenced in PERT[8] (Plan Evaluation Review Technique).

The latte approach helps in developing a network plan of elements of a project with a list of activities and tasks to be performed to accomplish the project objectives. Each activity ends with one event which is a start of the next activity. Once the elements of the project are determined, they are arranged in sequence, preferred for their accomplishment. In preparing a network plan, administrative activities should also be included.

[8] Martin E. Modell, "A Professional's Guide to Systems Analysis",, (2nd. McGraw Hill 1996)

13.6 RESOURCE MOBILIZATION AND COORDINATION

(1) COORDINATING MECHANISM

Well-coordinated resource mobilization would be another important factor to determine the successful implementation of the Master Plan. The objective of the resource coordination is threefold:

- Intra-ministerial coordination among different departments of MoH;
- Inter-ministerial coordination with socio-economic development- related ministries; and
- International donor coordination to mobilize external aid funds effectively.

The most effective level of coordination are district and provincial levels through a better inter-sectoral planning, community involvement, and as well as private sector involvement.

As the Master Plan is sector wide and comprehensive in nature, an identified programme n the Master Plan may rest on a variety of different resources allocation. Strong emphasis, therefore, needs to be placed on deliberate design and programming of the project implementation.

(2) DOMESTIC RESOURCE INTEGRATION

First of all, for the successful implementation of the HMP, the Treasury of the government should agree to allocate resources in a planned manner to implement the HMP activities. Available domestic resources are, however, not only national funds but also other supporting financial capacities such as Community Based Health Insurance Schemes, which are growing in this country. In addition, human resources existing in the private sectors and service NGOs are enormous resource existing in this country. Research capacities also exist in this country. All these existing domestic resources need to be recognized by the Health Ministry and be apped in an effective and optimal way.

Utilization of private sector resources in this country is inevitable for the successful implementation of the HMP, especially resources in the associative and religious bodies, the NGOs and professional bodies.

Tapping such voluntary and private resources demands great transparency in plans, execution and reporting of results. The building up of positive rapport between the MoH staff and the different private institutions will call for fundamental reorientation.

(3) EXTERNAL RESOURCE COORDINATION

External resource coordination is becoming very important to implement the HMP. Periodical meetings with Development Partners have to be organized for information exchange and effective resources mobilization.

A sector-wide approach (SWAP) may be one option to facilitate the integrated implementation. It is suggested to further study the approach before taking the next step forward. If there is one lesson that can be learned from other countries, it is that “flexibility” may be the key in designing and operating the programmes to be programmatic and in tune with the attributes of Sri Lanka. An alternative approach or a Sri Lanka model might need to be pursued. The important thing is the MoH should always determine the destination and the way, while occupying the drivers seat to establish a well-coordinated mechanism and stay the course guided by the national strategic framework.

13.7 MONITORING /SUPERVISION AND EVALUATION OF THE IMPLEMENTATION

The Master Plan is hoped to be fully used as the policy guidelines for the health system improvement with the long-term perspective, and with action plans for immediate activities to move urgent problems and difficulties.

The Master Plan, however, should not be static but dynamic, needing to be periodically reviewed and modified every two to five years, based on a periodical evaluation of projects/programmes carried out and of outcomes achieved.

The Master Plan should keep its technically rational position with little or no ad hoc distortions introduced by donors or other parties. This will demand monitoring, supervision and evaluation to be focussed, readily accessible to all concerned and produced in a timely fashion for clear feedback.

This chapter uses the following definitions:

(1) MONITORING

Monitoring is all forms **of observation over time** (sight, hearing tactile, chemical = smelling, tasting, mechanical or instrumental etc.) either from a temporarily non acting or actively provoking observer, who, depending on the nature of his observation, becomes alarmed or interested and **acts on the situation** to change it or change his position in it to improve chances or lessen danger. During the reaction, the monitoring goes even more intensive.

A performance plan (activities with clear sequencing and timeline) at each level with clear specification of inputs, hoped for outputs and outcome is the first requirement for meaningful monitoring.

Even the best of performance plans in health can be only a wish list as long as the **inputs** do not start being put at the disposal of the right person or team, quantitatively correct in a timely fashion (finances, physical infrastructure, personnel, supplies and equipment, technical guidelines). Once the inputs are in place, **the organization of the access** to their use (who can request, release goods or assign people) and **the processes** of their use (adequacy of procedures, scientific validity of actions, technically sound and, equitably and fairness), will determine whether **outputs** (managerial efficiency, effective coverage) are actually happening of expected volume and nature. Finally, when outputs are as planned one can start hoping for **outcomes and wider impact**.

At each of these stages of implementation, monitoring needs to be happening by the appropriate persons with agreed upon indicators and criteria at a specified frequency. Decision makers need to be alerted if the implementation is deviating and needs their attention and intervention to come back on track.

(2) SUPERVISION

Supervision gains importance whenever the quality of the process is as important or more so than the quantitaty of the final product, and strengthening the competence of the workers maybe needed. It is of tremendous importance in increasing clinical competence of nurses and paramedicals and junior physicians.

Supervision uses monitoring data collected by the workers and analyzed by them or the supervisor, supplemented by direct observation, participant observation**,** key informants and sometimes discussion groups of clients or workers to **assess the quality of the process.** Where needed it may **investigate**

likely **causal factors for patient dissatisfaction** conversely low utilization of services, or instead for **lack of quality** of the services (such as growth monitoring with little or no counselling).

Supervision and monitoring are complementary to each other, feedback to providers and support staff from monitoring,most of the time needs to pass through supervisors, who need to discuss and help to plan corrective action.

(3) EVALUATION

Evaluation takes a longer-term perspective of at least 12 months, or it could take more two to three years. It evaluates outputs and wherever possible outcomes. It speaks to efficiency, effectiveness and equity and can look at other indicators of success. Evaluation may influence management but in general, it is mostly used for improved planning.

Monitoring and evaluation is central to steward and implement the HMP. A comprehensive monitoring/supervision and evaluation system needs therefore, to be created soon by the Planning Department of MoH. The Planning Department needs to be strengthened to assume those vital functions and responsibility. The specific plans and arrangements for the creation of the overall system need to be formulated as early as possible.

(4) HOW CAN WE SET UP MONITORING SYSTEM AND EVALUATION SYSTEM?

Monitoring would ask a small core number of indicators selected from the existing HIS system to be followed at all different levels of aggregation on a monthly basis or every three month. However, peripheral levels and specific programmes may need or wish to follow more indicators. The questions to be asked in order to set up a monitoring system are:

- By whom and how should these indicators be chosen?
- Who should interpret and who can take action respectively at divisional, district and provincal level?
- How would feedback get to the peripheral workers?
- How would feedback and follow up action be documented?

It would probably be best to conduct evaluation once or twice a year. For Midterm Evaluation of the HMP, there should be every mandatory to identification of areas where the overall planned sequence needs to be adapted or the Project Profiles or Project Implementation Plans need to be amended.

In the HMP, many projects are in support programmes or stewardship aiming at improved processes for which output will change in a matter of time and the evaluations in the first 3 three years should definitely take into account at what stage each project is. It should judge whether operational plans and guidelines were done, are meaningful and faithful to the strategic framework, are widely understood by those concerned, whether they are being implemented at what scale, with what changes in process and eventually output. Such midterm evaluation needs to look carefully into pilot efforts that may direct the future implementation and at some selected outcome indicators of projects given the performance on output.

However, the questions are:

- Should this be a responsibility of HIS in Ministry?
- Should a university or a consultants group be contracted to do this?

- Is there another way to perform evaluations?

(5) ALL INFORMATION COSTS TO COLLECT

It will cost to collect any type of information, and the original proposed lists of indicators would be mostly like too generous. The questions need to be asked are:

- Who should study their use and cost?
- When can a major revision be made of the lists?
-

(6) HOW SHOULD WE USE THE RESULTS OF MONITORING AND EVALUATION?

A well-done monitoring contributes to the management and the efficiency and equity of services, while evaluation tends to make major contributions to improved planning and can help to improve technical quality.

The questions need to be answered are: What mechanism would assure the use of the results? Should statistics or a contractor do the analyses? Do individual ministry departments want to do their own analysis? How will the results be shared and become public? How will the results be shared at the primary level health institutions such as peripheral units?

(7) ORGANIZATIONAL STRUCTURE

A separate directorate or a Ministerial Taskforce/Management Unit should be identified/established to coordinate the planning and implementation of the whole monitoring process, starting by working out the monitoring of primary health care, including preventive, promotive and curative aspects, at the MOH, and district level, followed by the programme/project monitoring. Provincial Task Force/Management Unti for each province should be established to monitor the provincial implementation. Quarterly HMP implementation progress review meetings should be conducted and the progress should be monitored at district, provincial and national levels.

Inter-Ministerial HMP coordinating committee at national level should be established to obtain the required support from other ministries and to monitor the progress of HMP implementation by other sectors. Inter-Ministerial HMP coordinating committee should review the progress once every six months.

(8) MONITORING FORMS/ MODULES HAVE TO BE DEVELOPED

Monitoring is needed in service delivery, in financing, in logistics. The principles and steps are the same but the indicators, the frequency and the networks involved will be very different. The steps of monitoring mechanism are:

1) Selection of Indicators, definition of sources of information;
2) Development of Monitoring Forms;
3) Development schedule and Models for Analysing Indicators or numerator analysis and judging critical levels and changes;

4) Identification of Decision-makers and Description of Actions that can be taken [feedback loop] and which supervisors should be involved;

5) Capacity-Reinforcement on Monitoring and Feedback; and

6) Network of stakeholders to be kept informed and who can help interpret results; urgently a mechanism has to be developed for monitoring of financial performance. Coordination meetings with funding agencies / treasury etc.

13.8 CAPACITY BUILDING FOR PROGRAMME MANAGEMENT

Prior to the implementation of programmes/projects, capacity building for programme management should take place for the project implementers and focal points. Organizational structure of project management needs to be established and project monitoring mechanism need to be put in place based on the existing organizational structure and the purposes of monitoring. The information system needs to be linked to the monitoring system and financing mechanism as well, so that the accountability of the health system would be strengthened. Many of project managers and financing managers need to be trained in management of a project including monitoring in order to make the system workable. This capacity building trainings should be aimed before or at the very beginning of implementation period. Capacity building needs for the health sector have to be assessed first. The following questions need to be asked to formulate the capacity building trainings:

- Who should be the trainees?
- What should be the scope of the training?
- Human Resource and Institutional Capacity Development for Programme Management:
- Planning of Programmes/Projects.
- Programme/Project Management.
- Facility Management.
- District Management.
- Accounting and Financing Capacity Enhancement:
- Bookkeeping/Accounting and Financing related to Projects/Programmes.

Training and skill development are the core in capacity building, but training by itself will not have an effect unless it is accompanied by strengthening institutional capabilities. The trained staffs needs to be given required resources, supervised, and motivated. The implementation capabilities focus on organizational actions, managing assets, monitoring and use of feedback, incentives, and teamwork, while planning capabilities focus on analytical skills and interdisciplinary collaboration. Both these capabilities are interdependent and have to be in place for effective HMP implementation.

Finally, close linkages have to be created with policy institute such as IPS and universities where capacities have been created or available outside of the system. Capacity building should be seen as an investment, the results of which take time to emerge.

CHAPTER 14

POLICY RECOMMENDATIONS AS BASIS FOR IMPLEMENTATION OF THE HEALTH MASTER PLAN

14 POLICY RECOMMENDATIONS AS BASIS FOR IMPLEMENTATION OF THE HEALTH MASTER PLAN

The Health Master Plan aims to strengthen health system that strives for excellence to improve the health outcomes of the people in Sri Lanka. There is, however, a perceived demand for the government health policies to be put in place in order to the HMP to effectively implement. The Ministry of Health will implement the HMP through its management processes by first clarifying the policy and direction. Therefore, in this chapter, these Policy Recommendations as basis for implementation of the HMP are spelled out for endorsement by relevant policy decision makers. Health policies should give emphasis on challenging the inequalities in health and tackling the determinants in ill health, and this emphasis is as reflected in the Mission of the health sector of this country.

14.1 POLICIES ON REORGANIZATION OF HEALTH CARE DELIVERY SYSTEM BOTH STRUCTURALLY AND FUNCTIONALLY

(1) APPROPRIATE LEVELS OF CARE IN A REORGANISED HEALTH SERVICE DELIVERY PLAN

In order to rationalize the services, there is a call to **formulate policies on appropriate levels of care in a reorganised Health Service Delivery Plan with a functional referral system**. The District Health System based on Primary Health Care requires new policy directions to cater to the new needs of the population and further strengthened to provide integrated care.

Whilst in earlier years there was merit in expanding the number of health care units to maximize access, this is no longer the case. The changing pattern of ill health and the technologies available to deal with it **require larger health care units with a certain nucleus of qualified staff and supporting functions**.

Under-utilised services are potentially unwanted services and the demand behaviour of consumers already recognises this. Such institutions have to be put to better use, for example, some under utilised maternity homes could be converted into geriatric homes **and day care centres. The rapidly aging population calls for new policies on care for the aged and social welfare**.

Policy for Preventive Care: Life-Course Approach

Policies for preventive health care of evolving diseases such as life-style related diseases (NCDs) have to be integrated upon a life-course approach. According to the WHR 2002, major risk factors that create the burden of disease are quite different in low-mortality developing countries from high-mortality developing countries and resemble more that of developed countries. Figure 14.1.1 shows major burden of disease and risk factors in developing countries such as Sri Lanka with low child and low adult mortality.

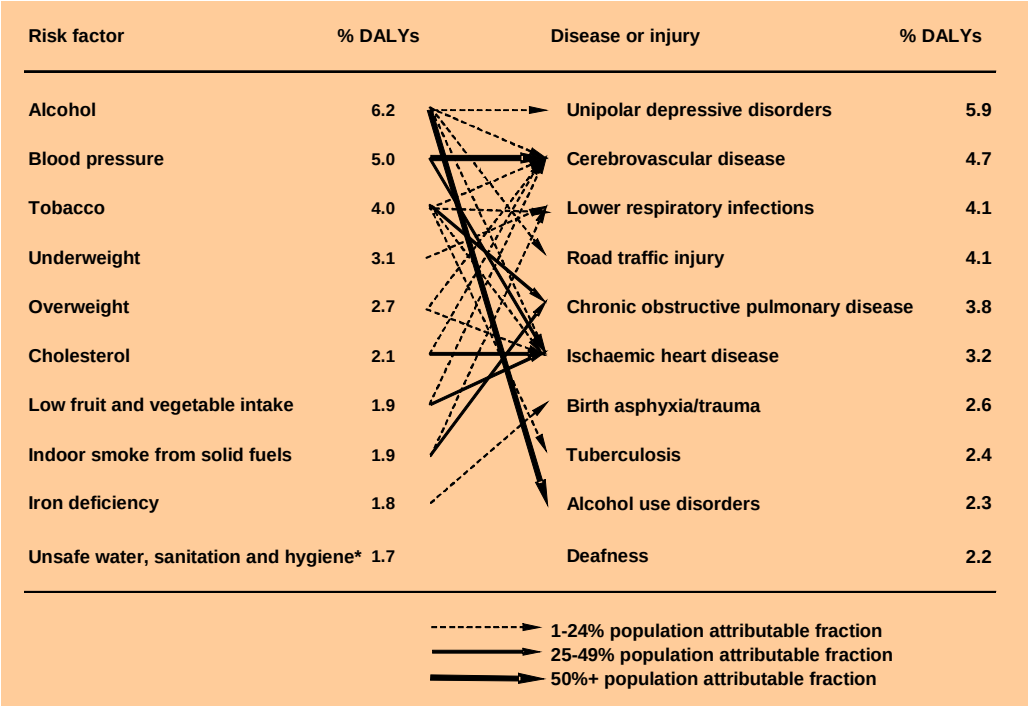


Figure 14.1.1 Major burden of disease -- 10 selected risk factors and 10 leading diseases and injuries, 2000 (AMR-B, EMR-B, SEAR-B, WPR-B)

Source : World Health Report 2002, WHO

Note : *Unsafe water, sanitation, and hygiene disease burden is from diarrhoeal diseases NB. The selected risk factors cause diseases in addition to those relationships illustrated, and additional risk factors are also important in the aetiology of the diseases illustrated.

Alcohol, Hypertension, Tobacco, Overweight and Cholesterol are the highest risks, which create the major burden of diseases. According to another WHO study on ageing, there is a critical window for the exposure of risk factors in the early stage of life to cause degenerative diseases at later age, proven by recent epidemiological data. **A policy on life-course approach that requires design and implementation of appropriate preventive interventions throughout the life of individual has to be in place.**

Policy for Curative Care: integrated approaches

Policy for curative care at different health care facilities, such as primary, secondary and tertiary, have to be redefined according to the evolving and emerging disease pattern and integrated into an emergency health care network, and rehabilitative community support network and a primary care network.

(2) SERVICE DELIVERY INCLUDING REFERRAL AND ADMISSION

Over crowding in the larger hospitals while other health care institutions operate at lower level of occupancy, long waiting times, unsatisfactory staff attitudes and quality of care require **a rationalization of services with the introduction of appropriate referral and admission policies**.

Hospitals also need to change in response to changing health care needs and emerging technologies. The nature of ill health is also changing and demands new service delivery priorities to be established. Some conditions are chronic and require lifelong treatment. **This implies policy changes in the service**

delivery priorities including training, the use of new diagnostic kits in primary care, and patient monitoring and maintenance at community level.

(3) QUALITY ASSURANCE

With increasing number of private care health institutions and reported inefficiencies in quality of service provided by both the public and private sectors, **a policy for a strong quality assurance program is called for including peer review and clinical auditing.**

(4) PALLIATIVE/REHABILITATION SERVICES

With the shift of the disease burden towards non-communicable diseases, chronic diseases will continue to show a rising incidence. **Policies towards strengthening home care and palliative care** have to be in place to face this challenge. There are conditions under mental and disabled health that can be successfully managed through community-based rehabilitation programs. **Policy to use and integrate Ayurvedic Services** in managing palliative and rehabilitative care has to be considered.

(5) TECHNOLOGY ASSESSMENT

Newly required system for tackling evolving and emerging diseases is costly. It is a fact that outcomes of the new technological inputs are not always satisfactory but, once new technologies become available, they will be demanded by consumers and providers will be keen to supply them. Thus, **a policy on technology assessment has to be in place for selection of appropriate cost-effective interventions**.

(6) IMPROVING THE HEALTH OF VULNERABLE POPULATION

Although, there is an exceptional achievement in reduction of Maternal Mortality and Infant Mortality Rates in this country, efforts to reduce perinatal and neonatal mortality have been less successful. This suggests a need to improve the quality of labour and delivery services and the relatively poor underlying health of certain categories of mothers, which results in premature deliveries and low birth weights. Further disaggregated data could identify pockets of high incidence of underweight babies, maternal and infant mortality in relation to vulnerable population. The challenge remains to ensure that Government funds in the health sector are targeted towards the poor and most vulnerable. Significant gaps remain in funding and in development of programs for the vulnerable groups. **Policies that spell out the direction to tackle the identified problems would help to formulate effective targeted interventions for the vulnerable groups.**

Maternal anaemia at 35% and childhood malnutrition which is as high as 29% (weight for age) in under fives calls for **an inter-sectoral program to combat malnutrition supported by policies on food supplementation and poverty reduction measures.**

(7) HEALTH PROMOTION

Emerging challenges such as growing disease burden caused from tobacco, alcohol consumption, road accidents, suicides and violence, and poisoning can be addressed through behavioural change adopted by population. An adequate mechanism has to be in place for this massive exercise. The health

education programs presently run by the Health Education Bureau are not sufficient to achieve this objective because of organisational and staff constraints. There is a need for policy change in this field.

It is proposed that **Health Education Bureau to be strengthened and renamed Health Promotion Bureau**. **It should be run under the direction and guidance of a Board** with specific responsibility for development and **implementation of an island-wide Behaviour Change and Communication program** including conduct and coordination of research in this field. It should also develop and implement Health Promotion Programs on a settings approach in coordination with other programs and other health related sectors. Health education on various other areas including rational use of technology, public health law and its enforcement falls as yet another responsibility of this Bureau.

Policies with regard to School Health Services need to be reviewed with a view to redesigning its services in line with the health promoting school concept and towards empowering school children for healthy action.

(8) INVOLVING FAMILY PHYSICIANS IN THE DELIVERY OF PHC

A policy on a new strategy for creating new opportunities for those graduating from medical colleges to take up to primary care general practice is required. Such policy is necessary to serve those areas where supplies of health providers are relatively low. Policy of developing a Family Physician cadre to be responsible for a well-demarcated populations should be considered. **Policy of offering special incentives to GPs including continuing education** would help in creating responsible primary care physician cadre to respond to the immediate health needs of the people.

(9) REVIEWING AND REVISING HEALTH ACT MINUTE AND RELEVANT HEALTH RELATED ACTS AND LEGISLATIONS

Health acts and health-related acts and legislations are required to be reviewed as these have been set on the requirement of the health services many years ago. With changing condition of the health sector, **policy decision has to be taken to review and to redraft acts and legislations to fit into the new needs and demands.**

14.2 POLICIES ON HUMAN RESOURCE DEVELOPMENT

(1) RATIONALIZATION OF HUMAN RESOURCE DEVELOPMENT

Human resource in the health sector requires significant modernization. In addition to the shortages of certain cadres of staff such as paramedics and nurses, the growing surplus of doctors will have serious cost and quality implications. There are also major shortages in some regions, particularly in the North and East of the country and in remote rural areas.

One of the main constraints on improving the effectiveness of human resources policy and planning in the health sector is the lack of a comprehensive human resource strategy.

Development of a human resource strategy and formulation and implementation of a Human Resources Plan needs to be undertaken and required policies for Rationalization of Human Resource Development should be put in place. This includes reviewing and revising policies regarding recruitment, deployment and utilization.

(2) IMPROVING MANAGEMENT OF HUMAN RESOURCES

Repeated trade union actions show the dissatisfaction of staff regarding management of human resources. The need to consult trade unions and professional bodies in the decision-making process seems to be more important now than in the past.

Elevation of staff morale will require an improvement in the working conditions of staff, a fair and transparent system for **recruitment, transfers** promotion, reward, discipline and training, re-certification processes and revised terms and conditions that will generate different incentives for staff who are more responsive to clients needs. Appropriate complaints and resolution procedures need to be introduced. **Following policy, options are to be considered**:

- Establish HR Arbitration Panel.
- Appraisal-based training and re-certification of health professionals.
- Re-registration, revalidation and re-certification of nursing, medical and paramedical staff.
- Establish professional councils for nurses and paramedics. Professional Codes of Conduct to be reviewed updated or established and monitored by councils.
- Establish a result-oriented, performance-based monitoring and reward systems.

14.3 POLICIES ON STEWARDSHIP AND MANAGEMENT

(1) REORGANIZATION OF MINISTRY OF HEALTH ACCORDING TO ITS ROLES AND FUNCTIONS

Future **ministry** of health will not resemble the ones of today. **Their skills and capacities should be as required to undertake the following functions**:

- Advocacy, consensus-building,
- Negotiation and mediation,
- Formulating and advocating health policies,
- Influencing the policies and monitoring the health effects of the activities of other sectors,
- Providing technical guidance to all participants in health systems and services,
- Monitoring health status trends and health systems performance,
- Collaboration in national health systems research, and
- Regulation and enforcement of agreed national standards.
- **Securing adequate and sustainable financing and fair resource allocation.**

In order to carry out these functions, there is a need for **policy towards reorganizing of the Ministry of Health on the following lines:**

1) As policy, planning and monitoring functions form the core of the responsibility of MoH, there is a need to expand the MDPU and elevate its position. **MDPU functions need to be redefined.**
2) Plan and establish a Human Resource Policy, Planning and Development (HRPPD) Unit under **a DDG.**
3) Planning Units to be established and strengthened at provincial and **district** level**s** with networking arrangement.
4) Organizational review of MoH to be conducted to develop clear organizational structure, to assign responsibilities, to set up clear mechanisms for measuring performance and to identify capacity building needs.
5) Establishment of Management Boards in all major hospitals and groups of smaller hospitals with a responsibility to hold managers accountable for funds and performance. Operational and strategic plans to be developed by all major institutions.
6) Blood Transfusion Services, Bio-Medical Engineering Services and the National Drug Quality Assurance Laboratory**, National Institute of Health Sciences (NIHS) and Medical Research Institute** to be given autonomous status with clear workload and quality targets.
7) Development of norms and standards for acquisition and management of drugs and medical supplies, physical facilities, laboratory services and biomedical equipment.
8) Functionalise a Logistics MIS system to regularly monitor the availability of equipment /drugs.

9) Establishment of an Institute for Health Management **linked to NIHS** and **a Continuing Professional Development (CPD) programme.**

10) Establishment a laboratory and diagnostic services regulatory authority.

11) Monitor quality of care and standards in both government and private sectors.

(2) STRENGTHENING MANAGEMENT FUNCTIONS

Delegation of Authority

There is confusion of roles and processes between the centre and the provinces. Provincial Ministries of Health should be given more powers and authority to run all institutions in the province with guidance from the centre. At present, there are neither managerial nor financial systems nor trained staff to ensure proper management. Policies need to be adopted to support development of Provincial and District Health System allowing sufficient authority to enable them to manage financial and human resource, and allowing flexibility to local action. MoH should develop broad guidelines that specify the roles and responsibilities of centre, the provinces and districts in consultation with provincial administration. **Ministry of Health should also engage in monitoring and supervision of programmes and in the exercise of allocating resources to the provinces and monitor its utilization.**

Standards and norms that are set centrally have little or no flexibility and authority for individuals to manage the delivery of services locally taking into account population distribution and terrain. Managers are unable to take decisions on finance, staffing and utilisation of resources and have little flexibility to deal with emergency and disaster situations. Thus, there is little incentive for managers to strive for productivity. **This requires greater delegation, clear accountability, flexibility and freedom for managers to manage, development and implementation of the concepts of good governance are also needed.**

Development of Information System

The development of management and financial information systems will encourage and reward the achievement of results and help to focus on outputs rather than inputs.

Even in the current situation, management should be reoriented toward efficiency. To become efficient, continuous analysis of demand and the effort to match supply to demand are needed.

To be accountable, flexible and efficient, good management information system is essential to link consumed resources to service output. Intra-hospital and nationwide standardized information system to measure outcome and cost for defined service package have to be developed. Regular analysis of information to review system performance and for policy making has to be undertaken.

Research and Training

The development of operational research to analyse and find solutions to systems problems that includes Problem Oriented Action Research needs to become an integral part of health management at all levels.

A policy to establish a Research Unit/Organisation/Institution to facilitate the conduct of research in support of evidence based policy making has to be considered. A rational policy on all pre-service education including demand and supply, selection procedures, and review of curricula and training policies has to be determined.

(3) COMMUNITY EMPOWERMENT

Policies have to be developed to put in place the commitment of national governments to support community involvement in health and to promote self-reliance. Not only the global awakening of patient right and equity, but also characteristics of the disease itself, calls for patient participation and satisfaction that is important factors for the success of treatment.

There is also growing consumer dissatisfaction with the state sector. The issues that are particular causes for concern include overcrowding in the larger hospitals, long waiting times and the unsatisfactory attitudes of some state sector staff. Issues of professional negligence are beginning to be raised. There is little or no information on consumer view about the private sector, as well as the public sector. More information is required on the attitudes and perceptions of the public to the information and services they receive and appropriate systems developed for complaints to be heard and problems resolved. **There should be a mechanism to obtain regular feed back from consumers.**

A policy on establishment of an Ombudsmen System and formulation and implementation of a Patients Charter of Rights has to be considered. The system has to be accountable to people who receive the care and pay for the service. Thus, transparency and information openness should be another policy.

(4) BUILDING PARTNERSHIPS

The responsibility for adhering to the Mission and achieving the Vision of the HMP, rest**s** not only with the Ministry of Health but also with all its health partners. Therefore, **new policies for collective efforts and for enhancing partnerships with the relevant health care providers including private sector and indigenous sector have to be formulated and implemented. Private sector would play an important role in this respect. There should be better coordination with private sector in sharing information, outsourcing, training of staff, quality assurance and regulation.**

14.4 POLICY FOR HEALTH FINANCING

The Sri Lanka system for delivering health care of good quality, continues to follow the principle that it is free at the point of use based on the needs and not on the ability to pay. Present resource gap for public health provision in Sri Lanka is threatening continuous adherence to this principle. It finds it difficult to meet the total demand solely by tax funds collected by the government at present.

(1) FINANCING THE RESOURCE GAP FOR PUBLIC HEALTH SERVICE PROVISION

Since independence, Sri Lanka has made significant investments in the health of its people. To achieve this national objective, the GOSL has allocated over the years about 1.8% of GDP each year. However, since the mid-1970s, it has gradually reduced health's share of GDP. During the last decade, the share of GDP allocated to health has eroded further, falling to a new low, over the last four years to an average less than 1.3%.

Several years of below average expenditures can lead to efficiency gains. However, when the pattern of reduced expenditures extends over a period of nearly 25 years, with the few odd exceptions, then significant changes occur in the package of care provided. The impact on service quality resulting from continually reduced expenditures becomes greater than what might be expected in a random fluctuation in financial support.

Public financial support of health care in Sri Lanka needs to increase over the next half decade. It is particularly important to spell out the policy to increase the recurrent expenditure from around 1.2% in 2002 to at least 2.0 % of GDP within the next five-year to prevent further erosion of the quality of public sector services, especially for primary care and preventive services.

(2) RESOURCE ALLOCATION

There are two major issues to raise regarding public resource allocation within the health sector. The first issue is the significant change, which has emerged since the early 1990s, regarding pubic expenditures on preventive and promotive health services. The second issue is the share of OPD visits, and IPD stays and days of care have grown over the last nearly 23 years at secondary and tertiary public facilities, and service use at primary level facilities have dropped concomitantly.

Preventive and Curative Resource Allocation

During the early years after independence, Sri Lanka typically allocated between 25% to 30% of its total health expenditure to preventive and promotive programs and services. Such noteworthy programs included MCH Care and services, Malaria Control, EPI, Environmental Sanitation, and many other initiatives. Some of these initiatives obtained a large amount of financial support from the international community.

These preventive programs have been very successful in improving the health status of Sri Lanka way above its GDP per capita would expect, such that people in Sri Lanka often live to between 70 and 75 years. However, today, in 2003, preventive and promotive programs spending as reflected in the budget estimate has been reduced to barely 5% of public spending on health. This trend has been particularly noticeable during the 1990s and has bottomed out at this low level over the last four years, when there has been particular pressure on health spending in general.

Today, Sri Lanka has two challenges. First, it must sustain the gains of the past. Second, , it must make new progress preventing the rapid escalation of Chronic Diseases such as Heart Disease, Cancer and Diabetes, and Accidents. To make headway on these problems, the MoH will require significant investments in promoting life-style changes, as well as continuing to implement the successful past prevention programs. Without these investments, the health status and life expectancy of the people of Sri Lanka will likely fall, as the age specific mortality data, found in the Annual Health Bulletin, 2000, already suggests, has been happening throughout the latter half of the 1990s.

Allocation to preventive and promotive activities and services should be significantly increased in order to achieve continuing improvement of the impressive health status gains that have been achieved since independence.

Tertiary ,Secondary Care vs. Primary Health Care

The share of OPD visits, and IP stays and days of care have grown over the last nearly 23 years (1979 to 2001) at secondary and tertiary public facilities, and service use at primary level facilities have dropped concomitantly.

Health expenditure share trends would also confirm this trend in service use between primary, secondary, and tertiary facilities. In 1991, primary care level facilities obtained between 30% and 35 % of total recurrent patient care expenditures, whereas secondary and tertiary level facilities used 65% to 70%. Today those shares have likely evolved to about one -quarter to primary level facilities and three quarters to secondary and tertiary level care. (Unit Cost Analysis of Public and Private Health Facilities in Sri Lanka in 1992. IPS HPP Occasional Paper No.06. IPS Health Policy Programme).

To alter the long established pattern of people going to the largest and most complex service delivery center will require investments in improving the package of care currently offered to patients at primary level facilities. But this can be achieved with a two-pronged approach. **The first, investment would be designed to increase the capacity of provincial and district levels in terms of human resource, planning and management skills and management systems.**

The second investment would be the allocation of considerably more recurrent funds to primary facilities for the purpose of improving service quality, maintaining of required equipment, and providing a full basic package of primary care services to those seeking care. A policy of creating large health care units with a set of qualified staff and supporting functions would help to respond to people's expectations as well as improve the health service quality. It is also recommended that a study on the role, use and options for financing private general practitioners be considered.

(3) HEALTH FACILITY-BASED MANAGEMENT

Today at all levels, the Government gives little latitude to hospital directors to make decisions about:

a) Personnel and compensation packages,

b) Procurement of supplies or other consumables,

c) Changing line item expenditures from initial budgeted amounts,

d) How to finance projected budget deficits from other possible sources of revenue, including through possible reimbursement from emerging health insurance programs and donations, and

e) How to respond to public interest in improving the quality of services provided at the facility, by means of technological improvements, personnel training, or other service amenities.

The country must learn from past and present experiences of running autonomous hospitals. It is suggested to pilot a new approach towards the devolution of greater financial and personnel

autonomy to the management of individual facilities. This needs to happen at both nationally owned facilities as well as provincially owned facilities.

(4) ALTERNATIVE FINANCING MECHANISMS

The free medical service policy is in line with the ethos and constitution of Sri Lanka; therefore, this policy should be maintained as far as possible. In reality, however, half of the health expenditures already come from out-of-pocket money of patient households. Thus, the coverage by tax money is already limited. This indicates the necessity of capturing the large share of health expenditure in the unorganised sector in the form of out-of-pocket payment, as a base for mobilizing more resources to the health sector.

Future financial demands for health expenditures are anticipated to increase at a considerable rate, due to a combination of epidemiological and demographic changes, which require expansion of preventive services and increasingly expensive curative care. It is a fact that the financial situation in the national health budget will get tighter year-by-year.

In order to bridge the gap between the present health expenditure and expected health expenditure, new health financing policy needs to be considered that would form a feasible financing mechanism in the future. Studies have to be carried out on alternative financing mechanism and feasible ones need to be piloted in selected districts.

The development of social heath insurance system should also be considered as an additional funding mechanism while safeguarding positive feature of the current tax-based health financing system.

(5) BLUE-PRINT FOR IMPROVED HEALTH FINANCING

It is recommended **to use the master plan as a starting point for the development of a consensus blue-print** to formulate a financing scheme that supports progressive improvements in the health sector.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