

CHAPTER 4

SURVEYS ON FINANCING, RESOURCE ALLOCATION & UTILIZATION

4

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4.1

RESOURCE GENERATION AND FINANCIAL MANAGEMENT OF GOVERNMENT HOSPITALS IN SRI LANKA

(1) INTRODUCTION

The survey was conducted in 2002, and the opportunities available for health institutions to generate revenue were reviewed through three modalities.

1. The consultant team assessed the situation based on their own experience,
2. Knowledge and results of a special survey of hospital directors. Respondents in the survey were asked about the experience of their institutions in resource mobilization, and their attitudes towards the different options.
3. Existing data and prior reviews of related issues in Sri Lanka were examined.
4. Experiences in other countries were briefly reviewed.

The survey is presented under three major headings:

1. Assessment of revenue-yielding activities at government health institutions.
2. State of financial and resource controls
3. Recommendations

(2) ASSESSMENT OF REVENUE-YIELDING ACTIVITIES AT GOVERNMENT HEALTH INSTITUTIONS

Options for Revenue Generation at the Level of Government Health Institutions

Three broad mechanisms are identified, each with its own set of advantages and disadvantages, and varying potentials for generating revenue:

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

1) Charging of User Fees for All or Selected Patient Services

a. Background

Government health services have levied user fees for patient services in some form or other, since the inception of public sector medical provision in the 19th Century. In the first half of the 20th century, user fees were chargeable for all patient services but, in order to protect the

poor, they were exempt from all charges. By the 1940s, the principle of free treatment for the poor had been established, with all those earning less than Rs. 50 per month entitled to free treatment. Above this income level, user fees were chargeable in two bands, depending on the income of the individual. However, as noted by the Commission on Social Services (1947), in practice very few patients paid any charges. Other than the fact that less than 5% of the rural population at that time earned more than Rs. 50 per month, the administrative machinery did not exist in government facilities to check patients' income, so government health institutions relied on the self-reporting of income. It was and almost certainly remains the case today that the cost of establishing such administrative machinery to reliably identify richer patients without mistakenly labelling poor patients as wealthy would be greater than the gross revenues that might be generated. The Sri Lankan state appears to be no better at assessing individuals' income today than it did fifty years ago, as can be judged by the fact that less than 0.4% of the population were registered personal income taxpayers in 2001, when the level of income eligible for taxation was no higher in relation to average income than the qualifying income level for user fees was in 1948.

The system of means-tested user fees was abandoned by the UNP government in 1950, without any substantial loss in revenues for the state. A flat-rate system of user fees for all out-patients was then introduced by the Marxist finance minister of the United Front government in 1971. Although the fee was a token 25 cents and in-patients were exempt, this policy discouraged patient utilization, which fell by 30% at MOH facilities. This substantial reduction in service output was, however, associated with only a 2% gross cost recovery rate, so it is apparent that the negative impacts of the policy far outweighed the financial benefits. The political costs were also considerable, with the policy being used against the government in the subsequent general elections. In 1977, the returning UNP administration again abolished the user fee system (Rannan-Eliya and Mel, 1997), again without any significant financial cost. 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 (Table 4.1.1).

Table 4.1.1 Trends in Public Opposition to User Fees at Government Hospitals

User fee option	Number of respondents in 1996	Number of respondents in 2001	Percentage of respondents disapproving, 1996	Percentage of respondents disapproving, 2001
Fees for medicine	2,250	1892	79.8	85.7
Fees for doctor's consultation	2,247	1886	84.4	91.5
Fees for in-patient treatment	2,244	1881	87.4	90.3

Note: Survey conducted nationwide (excepting Northern and parts of Eastern provinces), by Research International on behalf of IPS.

In the absence of standard user charges (with the exception of charges for family planning commodities), the only source of patient fees is from pay-beds. Paying wards have been found in government hospitals since the end of the 19th century (Uragoda, 1987). Unlike the normal wards, admission to these beds is by choice, and requires the approval of a consultant and the hospital director. In general, these beds have been located in higher-level urban hospitals, and their total number has been declining over time. Since use of these beds is voluntary, they in theory offer a mechanism for price differentiation, with self-targeting of user fees, whilst protecting the genuinely poor (De Silva et al. 1997). Revenues from this source, however, have remained small.

b. Survey of Pay-bed Services

The survey of hospital directors included questions on revenue mobilization from pay-beds, and opinions of respondents. Out of the 33 hospitals surveyed, paying beds were only available in theory at four hospitals, and paying beds were available on a separate ward basis only in the National Hospital: the "Merchants Ward" of the National Hospital operates as a paying ward. However, at the Panadura General Hospital and the Kuliyaipitiya Base Hospital there were only a few paying beds. Kuliyaipitiya has 12 beds and Panadura has two separate rooms with 12 beds. The Gampaha Hospital has a unit with 20 beds, but they are currently non-functional due to lack of staff. These findings are representative of the situation generally, and as reported by De Silva et al. (1997).

Table 4.1.2 Revenue Mobilization from Pay-Beds in Surveyed Hospitals

Hospital	Number of pay-beds (% of total beds in hospital)	Occupancy rate of pay-beds	Income from pay-beds in 2001 in Rs Million (% of total expenditure)
National Hospital, Colombo	39 (1.4%)	*	* (89%)
Base Hospital, Kuliyaipitiya	5 (1.3%)	*	*
General Hospital, Panadura	12 (2.8%)	*	*
District Hospital, Gampaha	20 (4.2%)	0.0 (0.0%)	0.0 (0.0%)

* Hospital is unable to provide information.

Administrators Opinion on paying beds

Interviewees felt that paying beds are more desirable. Patients prefer to occupy paying beds as they like to be separated from other patients, and also because they have access to facilities such as private toilets. However, paying beds are being looked after by the same doctors who provide services to other wards. Nonetheless, respondents reported that it is the general impression among the staff that it is a place that requires “light duty”.

Interviewees felt that in both General and Base Hospitals, paying wards should be located closer to the general wards so that medical staff could give the same attention to other patients in the paying wards. Interviewees observed that the maintenance and improvement of paying units is very unsatisfactory. Interviewees reported that there are no unit costing systems in the hospitals studied, and, therefore, it was not possible to work out the cost of a bed or service using readily available information. This is to be expected, as there is no current need for hospital directors to have such information, given their responsibilities and authority.

c. Financial Contribution of Pay-beds

The study of De Silva et. al. (1997), which included a financial analysis of pay-beds at the National Hospital Sri Lanka, concluded that these pay-beds do not make any net fiscal contribution, i.e., they cost more to operate than the gross revenue realized. The results analysis concluded that the cost recovery was <94% for medical patients and <56% for surgical patients.

At the current level of prices and provision, pay-beds will not mobilize additional resources for their respective institutions, even if they were permitted to retain 100% of the revenues. Prices would need to be raised by anywhere between 20% and 100% in order for pay-beds to generate more revenues than their costs of operation, and that is assuming that costs of operation do not increase.

However, this is likely to have a negative effect on demand, since patients currently using pay-beds are not from the richest strata, but from the middle-income groups who find MoH pay-beds more affordable than private hospital pay beds. This group is likely to be more price-sensitive than the richer patients, whose first preference is private hospitals. A substantial increase in prices without any change in quality is likely to shift some patients into the non-fee-paying beds.

The experience of the Sri Jayawardanapura General Hospital (SJGH) provides an important, additional perspective. Although it charges fees from all patients in its wards, it also provides more spacious and segregated accommodation for patients who are willing to pay a higher level of charges for its own paying-beds. It provides an example of what can be achieved if hospital administrators are given operational autonomy, can retain all revenues, can directly hire personnel, can place all paying-beds close or within the major premises to ensure that all paying-patients receive adequate attention. Even with increased awareness of its services, which has led to an increase in demand and with price increases in keeping with inflation, revenues remain <45% of its annual costs. SJGH continues to receive a Treasury subsidy, which translates into the highest per unit subsidy in the public sector.

d. International Experience with Paying-beds in Government Facilities

The general experience has been that, in terms of net resource contributions, paying-beds make a negative contribution to the public sector resource position. Typically, the prices of paying-beds are administratively determined, and are set lower than the marginal costs of operation. Studies of paying-bed facilities have repeatedly found this in Sri Lanka, Hong Kong SAR, Bangladesh and Indonesia (Bossert et. al, 1997; National Economic Research Associates, 1996; Rannan-Eliya and Hannan, 1997). Although prices could, in most cases,

be raised to address this problem, the constraints appear to be a mixture of administrative inflexibility in adjusting prices, the potential loss of demand if prices are raised significantly, and lack of information on the true level of costs. It is a truism that general revenue funded hospital systems do not need cost accounting data for routine operations, and that accounting systems in these settings exist primarily to ensure that funds are spent according to the budget.

2) Donations in Money or Kind to the Institution by Households, Enterprises and Non-profit Agencies

Interviewees observed the use of several fund-raising mechanisms by public sector hospitals, leaving aside pay-beds. During the interviews, it was noted that funds were generated by hospitals, in 2001, in the following ways:

- Donations - Most likely in kind as hospitals do not accept cash donations.
 - Ex.: Hospital furniture, Goods, Consumables, Drugs, Equipment, Patients, Special Diets, Services (painting of wards and buildings)
 - 1. Individuals
 - 2. Charity Organizations
 - 3. Non-Governmental Organizations (NGO)
 - 4. Voluntary payments by patients

3) Generation of Income from Non-patient Treatment Services

a. Funds collected through hospital-affiliated organizations

Important sources of additional funds are:

1. Hospital Committees
2. Hospital Development Committee
3. Seva Vanitha
4. Welfare Societies
 - Main sources of income are from renting out the building as a hospital cafeteria.
5. Trusts for Specific Purposes, e.g.:
 - NSU Trust of the National Hospital Suba Sara Fund of the Horana Base Hospital.

b. Commercial Establishments

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

c. Leasing out space and buildings to commercial organizations

An example of this would be leasing out space to Banks. This mechanism, which maximizes returns from the Ministry of Health estate, is not systematically encouraged.

d. Foreign funds channelled through local agencies

Some hospitals have received donations of Ambulances, Specialized units, Wards and equipment through such agencies.

(3) STATE OF FINANCIAL AND RESOURCE CONTROLS

The current state of financial and managerial controls in government medical institutions were assessed using the consultants' personal experience and knowledge, and through the results of the interviews and surveys conducted.

Background

Following the Thirteenth Amendment in 1987, which devolved responsibility for health administration of non-tertiary level services to the Provincial Councils, Health Ministry institutions are administered either by the central line ministry or by the relevant provincial council. A key feature of this devolution of political power is that it has had contradictory effects on the delegation of an administrative authority in the health services. The highest level of administrative and financial delegation to individual facilities occurs in the case of the centrally-administered health institutions, whilst in the case of lower level facilities under the authority of provincial councils, devolution has paradoxically meant the increased centralization of authority at the political level of provincial governments. It is therefore important to bear in mind that political devolution is not the same as delegation of authority to individual facilities. Political pressures for devolution in Sri Lanka are from those who seek to redistribute political power within the country, and this is not driven by a concern either for depoliticization of public sector management, or for decentralization to bring authority for management down to the lowest level of operational responsibility.

Financial Control

All teaching hospitals and some general hospitals, all of which fall under the authority of the central government, function as decentralized 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 central government, and none have separately assigned budgets. The Government provides all decentralized 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 decentralized units.

Most of the hospitals do not have a formal corporate plan. However, by April 2002, these organizations would have prepared 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 on the basis of 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, it is used as a rough guidance for expenditure control only. Expenditure control is exercised through the Financial Regulations and circulars issued by the Ministry of Health.

1) Tender Procedures for Financial Control

All hospitals have to abide by the Government Tender Procedures. Heads of decentralized units have the authority to incur expenditure between Rs. 20,000/- to Rs. 2,000,000/- through the local

Tender Board, comprising 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, provided that 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 Bio-Medical Engineering Services and other technical experts.

2) Control of Petty Cash

Hospitals are allocated petty cash imprests ranging from Rs. 250 to Rs. 25,000, depending on the nature and level of the institution. Hospitals are empowered to purchase urgent supplies not exceeding Rs. 500 at a time. In order to expedite operations, in the case of Teaching hospitals, these institutions are allowed to spend Rs.1500/= per day with a value of Rs. 6000/= per month without quotations. According to government circulars, administrators are required to purchase urgent provisions from registered suppliers. However, in practice, some urgent purchases are made from the open market.

3) Cost Accounting and Cost Control

The team observed during its survey that there is no proper cost accounting and control system in hospitals.

Logistical Control

1) Medical Supplies

Institutions do not have independence in determining the control of supplies. Most hospitals estimate the demand for drugs on the basis of past consumption patterns. Larger institutions have drug review committees. Local discretionary purchases are made on prescriptions issued by consultants, depending on urgency, subject to approval by the head of institute. The team observed that most hospitals have no proper storage facilities. The major cause of wastage with regard to drugs was the expiration of drugs and over prescription.

2) Medical Equipment

In the larger institutions, annual requirements of medical equipment are assessed by a committee comprising consultants and others. This committee makes recommendations for new equipment needed and those that need to be replaced. These requirements are forwarded to the Ministry of Health. The procedure requires that the Ministry of Health appoint a technical evaluation committee (Bio-Medical Engineering Services) to prepare specifications and recommend purchases.

The team observed that, in many instances, no proper system of preventive maintenance is in place. The common practice observed is that institutions focus on carrying out repairs when

equipment breaks down rather than preventive maintenance, leading to more frequent breakdowns than necessary. Some institutions did report contracting-out maintenance to local agents. The service charges of these companies are typically very high, and many institutions cannot afford to do this given their limited cash budgets. Some respondents even informed the team that they would have been able to purchase a new item if the cost of service charges paid to contractors over two or three years had been saved.

3) Diet

The supply of food is regulated through circulars issued by the Ministry. Large hospitals generally obtain raw provisions through an open tender procedure. Small hospitals select suppliers through open tenders, who then provide raw provisions or cooked food. In both cases, the tendering process is being managed locally by the respective institutions. There are considerable concerns associated with the fact that the supply of these services is often not competitive, either at the national level owing to cartels or at the local level owing to the lack of sufficient suppliers.

A Diet Steward is responsible for the cooking and supplying of food to patients. These hospitals also provide free food to minor staff. Orders for food are made by the ward clerk. The team observed that, in some hospitals, diet orders were made even for patients who do not order or consume food from the hospital. It is estimated that there is nearly a 30% wastage factor due to this inefficiency in management.

Although the out-sourcing system has been introduced as a control measure, there are still many shortcomings in the system. There is a wide scope for improving the hospital-catering system, particularly in the better internal management of food supplies and ordering, and better management of the external contracting process.

Human Resources Development

The greatest asset of a hospital is its human resources. All medical, nursing, midwifery and paramedical grades have had basic training, ranging from a few years to five years. However, the minor staff in most hospitals have not had job-oriented training, even at the point of recruitment. However, where minor employees are promoted to be attendants, they are given three months training. A few hospitals also report having conducted in-service training programmes, with the assistance of NGOs and UN organizations.

As a result of not having adequate training, the productivity of many employees decline. Negative attitudes result in poor work ethic; some are neither punctual nor carry out their jobs efficiently. This costs the institutions additional expenditure in the form of paying salaries for half-finished work, and paying extra money for overtime and holiday pay to complete these jobs.

Utilization of Services

1) Water Supply

Water is provided through the general supply of the National Water Supply and Drainage Board. Most hospitals visited had a significantly high number of damaged taps. Almost all hospitals did not have a trained plumber for maintenance.

2) Electricity

Almost all hospitals do not have an uninterrupted supply of electricity. Some hospitals do not even have a contingency plan for unforeseen power failures. Wastage of electricity is between 10% - 30% of consumption. Most wastage occurs in employee rest rooms, toilets, passages and corridors.

3) Telephone Services

Almost all hospitals have multiple telephone lines. Usage is regulated by ministerial circulars. Wastage was around 10% to 50% of total expenditure for telephone bills.

4) Laboratory Services

All teaching hospitals have adequate space and equipment for laboratory services, but some general and base hospitals did not have pathologists. There is also a shortage of Medical Laboratory Technicians (MLTs). There is wastage of 10% - 20% of laboratory investigations. The main reason was excess requests that are made by newly appointed internal medical officers.

(4) RECOMMENDATIONS

- (a) 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 are likely to become a substantial source of revenue. They will in certain instances have a significant impact on individual facilities, but not all facilities have the resources or the opportunities to benefit equally from these opportunities. More 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.
- (b) MoH can and should support efforts to exploit these opportunities. It should provide more systematic guidance to hospital directors on 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.
- (c) There is potential for continuous savings to be made in the routine operation 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. Substantial improvements in this area will require substantial new investment in training existing and new staff, investment in support services such as IT facilities and administrative staff, and the review of existing government financial and administrative regulations.
- (d) 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 decentralization 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 decentralization. To the extent that the central ministry can do so, it should seek to develop national policies which set standards for all public sector facilities at the provincial level, in the areas of financial and management audit, human resources deployment, procurement and maintenance, and estates management.
- (e) 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 subsidize 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 lessen the ability of MoH to target its expenditures on the poor.

Options for Raising Revenues at Facilities

1. Paying Wards - Unlikely to make net positive contribution.
2. Registration Fees - Supported by wide cross-section of administrators, but opposed by a large majority of the patient population who are important voters at elections.
3. Donations - Every hospital to develop a systematic promotional campaign. One specific suggestion is to provide patients with a statement of cost on discharge and request a voluntary payment.
4. Marketing of patient services to commercial sponsors - One suggestion is to encourage hospitals to develop sponsorship agreements with commercial clients, under which they provide special or additional services to these clients in return for financial donations. Hotels and garment factories are potential clients in rural areas.
5. Improved management of Ministry of Health estate -Land and buildings can be better exploited: leasing of estate for commercial activities (advertising, rent out buildings to private firms, Hospital land for pay car parks in urban areas). Experience from several countries suggests this is

a potentially major unexploited area.

6. Advertising - Printing of advertisements by commercial organizations on stationery used in hospitals (e.g., Instruction sheets, envelopes).
7. Hiring out facilities after normal working hours - Some lab investigation facilities can be hired out to private individuals/organizations.
8. Conducting training and seminars for private sector.
9. Investment of unutilized funds – for example, hospital committee funds should be deposited in long-term deposit accounts.
10. Foster scheme for maintenance of buildings.
11. Long-term patients associations - These patients, e.g. diabetics, should be encouraged to, form associations to improve hospital services.

12. Provision of transport service - Hospitals can arrange with reputed rent-a-car/three-wheeler organizations to provide transport to patients when necessary. Hospital might levy a license fee for such contracts.
13. Charitable events - Declare a “Hospital Day” before Wesak or Christmas to collect funds for consumables required. Fairs and Raffles may also be organized.

Options for Strengthening Financial Management Control

1. Strengthening of planning and management process - A more proactive management process and culture should be encouraged. Every institution should be encouraged to develop a strategic plan or performance plan and a mechanism for implementation and monitoring actual performance against the plan. Preparation of annual budgets might be linked to this. Additional training for hospital administrators may be needed for this. Every base and general hospital should prepare a physical master plan.
2. Strengthening internal management audit - MoH needs to strengthen the internal audit department. Recent developments in the United Kingdom, where new performance review agencies are being established to promote management improvements in the NHS, may be relevant to Sri Lanka. Performance audits should be carried out every 6 months and the major areas such as patient care services, medical supplies, financial logistics and quality development programmes should be reviewed.
3. Decentralization and strengthening of management authority - Action should be taken to appoint an accountant and administrative officer for each hospital to strengthen management level facilities. Major changes in hospital management are unlikely in the absence of delegation of authority to individual hospital administrators. Though this has been the trend on a global scale, no such trend is evident in Sri Lanka.
4. Strengthening of financial audits
5. Cost control systems - Device mechanisms to provide hospital directors and staff with detailed information on the cost of delivery of services. This would increase awareness among hospital staff and lead to more efficient use of resources.
6. Improvement and streamlining of operating procedures and support services - All forms used should be reviewed and simplified, storage facilities should be improved, improve demand-based procurement of drugs, more efficient management of human resources, provision of food to staff, overtime and holiday pay and performance appraisal are some suggested methods.
7. Strengthening of management skills of health staff.
8. Increased emphasis on maintenance activities.
9. Productivity improvement and waste control methods - every hospital should implement the Japanese “5S” concept as a good housekeeping measure and work place organization practice. The following broad areas should be developed in this regard: (1) work improvement teams, (2) Waste disposal - Clinical waste management system, and (3) Quality improvement - Hospitals should prepare themselves for National Productivity and Quality awards.

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4.2

THE GROWTH AND DEVELOPMENT OF PRIVATE HEALTH INSURANCE AND ITS IMPACT ON THE GOVERNMENT HEALTH SERVICES AND HEALTH CARE

(1) INTRODUCTION

The objective of this study was to update available reports, and review the development of private health insurance (PHI) in Sri Lanka, its current status, its impact on public and private health care provision in the country, and its potential contribution to future financing. The existing literature and evidence on PHI on Sri Lanka and elsewhere are reviewed and summarized. A survey of the commercial health insurance schemes run by all the insurance firms operating in Sri Lanka was conducted with the support of the Insurance Board of Sri Lanka (IBSL). A comparative analysis of the schemes offered by private and state-owned companies was then conducted along with an assessment of their business policies and strategies. The time series data on aggregate payments and claims expenditures incurred by insurance companies were analyzed to gain an understanding of the trend in prices, costs, and patterns of use of public and private health care services by the insured population. Prevalence of market failures in the domestic insurance market, such as moral hazard, adverse selection and supplier induced demand as well as well-known problems associated with the form of indemnity insurance that is prevalent in Sri Lanka were assessed based on already available information, and on the knowledge of the IPS research team.

Private health insurance in Sri Lanka is primarily supplementary, in that its finances care is similar to that already available in the public sector but giving the insured patient the choice of private sector provision. In general, no new evidence was uncovered to indicate changes in the nature of the private health insurance market in Sri Lanka during 1998-2001. Ongoing trends are very consistent with trends that have previously been reported on in earlier studies, conducted in the mid-1990s (Rannan-Eliya and De Mel, 1997; Rannan-Eliya, 1997). In addition, a review of experiences in private health insurance markets in other countries, both in the advanced countries of Europe, and others in the Asian region, indicates that the situation and market development of private health insurance in Sri Lanka is far from unusual.

The sector is characterized by continuing and fundamental problems of adverse selection and moral hazard, which the private insurers find hard to counter. Although growth in total premiums earned by the industry has been substantial during the 1990s, growth in claims has been even faster, and the loss ratios of most insurers have deteriorated. Most insurers find private health insurance a loss-making product, but offer it mostly as a loss-leader to attract or to retain other insurance business from corporate clients. Coverage is priced beyond the reach of individual clients (primarily due to adverse selection effects), and the bulk of PHI coverage is restricted to the working age population in the work-force, who reside in the Western province, which is the segment of the population requiring the least medical care. Profound adverse selection problems prevent the industry from extending coverage to the elderly or chronically sick and pricing of products is such that they are of little value to lower-income consumers.

Although specific study is not made on the situation in Sri Lanka, international experience reviewed indicates that the current tax treatment of PHI is likely to be inequitable and very inefficient in that the government loses more tax revenues from the implicit subsidy than it gains in savings from the operation of public hospitals. It is recommended that the Sri Lanka government act, in line with international trends, to remove this subsidy. This would promote both general revenue mobilization, making more resources available for the public sector health system, as well as promote economic efficiency by reducing distortions in the labour market.

It is likely that, on current trends and on the basis of international experience, PHI coverage and expenditures will increase significantly in the medium term, but PHI is unlikely to make a significant contribution to overall health sector financing of more than 2%-3% of total financing, or provide more than 10% of the population with supplementary cover.

(2) STRUCTURE OF PRIVATE HEALTH INSURANCE MARKET IN SRI LANKA

The private health insurance (PHI) industry in Sri Lanka has experienced significant growth in the past two decades, since market liberalization in the early 1980s. Yet, in 2000, commercial health insurance contributed less than two per cent of total health care financing in the country, and covered less than two per cent of the total population (Ministry of Health and Institute of Policy Studies, 2002).

Private health insurance industry in Sri Lanka is characterized by significant insurance market failures and large transactions costs, both of which undermine the efficiency and equity of health care financing and provision. However, policy-makers' interest in this sector remains undiminished. Familiarity with the characteristics of PHI and the nature of the PHI market in Sri Lanka and other countries are essential for assessing the scope for PHI development in the country. In this review, the policy and regulatory frameworks governing PHI are outlined, and the market structure and market performance are examined and assessed. In each section, relevant theory and conceptual issues are discussed as well as reviewing empirical evidence from Sri Lanka and elsewhere.

PHI can be classified according to whether it substitutes for the statutory health care system, provides complementary coverage for services excluded or not fully covered by the state, or provides supplementary coverage for faster access and increased consumer choice (Mossialos and Thomson, 2002). PHI in Sri Lanka is largely supplementary, since the statutory health system provides universal access to all types of health care services, bar a few exceptions. The fact that the existing general revenue funded public hospital system is already performing the major insurance function has been acknowledged since the first official review of insurance options in Sri Lanka in 1947 (Commission on Social Services, 1947).

The first locally based insurance company commenced operations in Sri Lanka in 1939. About ten companies were established in the next 22 years, all of which transacted life, fire and marine business under the titles of life and general insurance. Since their inception, the provision of medical insurance was never a major line of business, or a primary concern of the insurance firms. Third-party financing to the extent that it existed was mostly provided by employer medical benefit schemes, and most of these potential clients preferred to provide these benefits on a self-insurance basis.

Lack of legislation in the insurance industry led to problems which culminated in the introduction of the Insurance Corporation Act No 2 of 1961. This then led to the nationalization of the life insurance business and resulted in the incorporation of the Insurance Corporation of Sri Lanka (ICSL). ICSL had a monopoly on the life insurance business from 1962 until 1980. The nationalization of the insurance industry retarded the development of the private health insurance prior to 1980. This monopoly ended in 1980 with the passing of the Insurance (Special Provision) Act No. 22 of 1979, which allowed for formation of another state-owned insurer - National Insurance Corporation (NIC). In 1986, the government responded to private sector demands by introducing amendments (Act No. 42-44) that allowed the private sector to compete with the two state-owned companies. Three private insurance companies, Ceylinco Insurance Co., Ltd., Union Assurance Ltd., and CTC Eagle Insurance Co., Ltd., were established in 1988.

The two state-owned companies, ICSL and NIC, were registered as limited liability companies as a first step towards privatisation (Rannan-Eliya and De Mel, 1997). In 2000, Janashakthi, one of the newly established private insurance companies bought NIC. In 2001, the industry consisted of five private and one state-owned company. In 2002, two new private firms entered the market (Asian Alliance and Hatton National Bank), although their impact remains limited. The PHI market has grown considerably in recent years leading to vigorous innovative competition between companies. This prompted the government to legislate the Regulation of Insurance Industry Act No. 43 in 2000 to provide for the

establishment of an insurance board. The purpose of the Insurance Board of Sri Lanka (IBSL) is to develop, supervise and regulate the industry.

ICSL introduced the first PHI product, a scheme for surgical and hospitalization expenses, in the late 1960s (Ministry of Health, 1994). NIC provided similar products when it commenced business in 1980. Prior to liberalization, the PHI market expanded slowly from between 15,000 - 20,000 beneficiaries covered, in 1980, to about 50,000 in 1986 (Jayasuriya, 1990). In 1980, total premiums were estimated to be Rs. 2.5 millions and total claims Rs. 1.5 million (Abel-Smith, 1980). Moreover, private health insurance was identified by the Presidential Task Force on National Health Policy (1993) as an alternative to user fees for resource mobilization in the health sector, further underlining the proclivity of policy-makers to wish to encourage the PHI development in Sri Lanka (Elo and Wijeratne, 1996).

Insurance companies market both individual and group PHI policies in Sri Lanka, with the latter generally paid for by employers on behalf of their employees. Group policies account for 80%-90% of all premium revenues. In most cases, it is provided as an employment benefit, with the employees making no contribution towards the premiums. Individual policies offer similar terms to the group policies, but the premiums tend to be higher, consistent with international experience. The patients normally pay for the treatment themselves, and then file for reimbursement either directly or through the employer, who in turn passes the claims to the insurer. Policies do not specify the providers to be used by the insured and utilization of both public and private providers to be permitted. All insurance schemes cover in-patient treatment, and most cover out-patient treatment (Rannan-Eliya and de Mel, 1997).

Problems of Moral Hazards and Adverse Selection

A key characteristic of both insurance and medical care markets is that they are subject to asymmetric information. One type of information asymmetry occurs when subscribers have more information about their own risk level and propensity to use health care than insurers. Individuals who consider themselves high risk and therefore likely to use a high volume of health services will buy policies that offer full coverage. This phenomenon, whereby higher risks selectively enrolled are adverse selection (Rothschild and Stiglitz, 1976), has the effect of increasing the expected costs of the insurer.

When the insurer raises premiums to meet higher expected costs arising from the disproportionately high enrolment of high-risks, the low-risks will drop out of the market, as the net benefit they derive from the policies will be outweighed by the costs. Adverse selection in private insurance markets then gives rise to a terminal spiral effect as all but high risks drop out, eventually making it impossible for insurers to conduct profitable business.

Another type of information asymmetry that is inherent to insurance markets occurs when the insurers cannot observe the actions of either the beneficiaries (consumer moral hazard) or the providers (provider moral hazard). Consumer moral hazard or over-consumption of care by beneficiaries are generally controlled by introducing cost sharing, benefit caps and referral systems. Provider moral hazard occurs when the provider is able to exploit the subscriber's relative insensitivity to price by raising prices or over-prescribing treatments.

Data for Sri Lanka suggest that consumer moral hazard is not yet substantial, at least in the sense of consumers using providers more frequently than they would have otherwise done.

(3) TRENDS IN PRIVATE HEALTH INSURANCE MARKET IN SRI LANKA

During the past fifteen years, there has been considerable growth in the PHI industry in Sri Lanka, as measured by indicators such as premium revenue, claims paid and number of firms operating. Table 4.2.1 summarizes the estimated trends since 1989.

Table 4.2.1 Trends in Private Health Insurance Industry 1991 - 2001

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total Premiums (Rs Million)	53	73	92	120	160	201	270	312	403	459	518
Total Claims (Rs Million)	37	43	59	75	119	169	224	260	300	457	493
Loss Ratio	70%	58%	64%	63%	75%	84%	83%	83%	74%	100%	95%
Nominal annual increase											
Premiums (%)	8%	37%	26%	30%	33%	26%	34%	16%	29%	14%	13%
Claims (%)	17%	15%	39%	27%	58%	42%	33%	16%	15%	52%	
Real annual increase											
Premiums (%)	-3%	28%	17%	21%	24%	14%	26%	7%	24%	7%	0%
Claims (%)	6%	5%	29%	18%	49%	30%	24%	8%	11%	46%	-5%
Number of firms operating	5	5	5	5	5	6	6	6	6	6	7

Source: IPS estimates from firm data.

Notes: Data are non-life schemes only. Real annual increase is calculated using Central Bank GDP deflator as inflation.

Health Service Cost

The impact of PHI expansion on health service efficiency and costs is difficult to quantify. However, it is reasonable to conclude that the overall contribution of PHI to increased health sector resource mobilization in Sri Lanka, during the 1990s, was largely negated by the problem of price inflation. Although overall financing contribution increased substantially from this source, the insured medical services market seems to have experienced price inflation running well ahead of inflation in the general economy. Thus, the contribution of PHI to the net volume of services financed would have been much less than it appears from initial inspection. It should also be noted that the average price of services paid for with insurance is higher than average in the overall private market. This may be because providers raise prices for the insured, or because insured patients seek more expensive providers than non-insured patients.

The available empirical evidence indicates that Sri Lankan doctors' fees discriminate under PHI, and this has led to significant price inflation. It is likely that the major, if not sole, beneficiaries of the expanding PHI industry in Sri Lanka have been the doctors. The insurance firms have not found this a profitable business, and the net benefits for beneficiaries have been substantially reduced by the increasing price of care.

Transaction Costs

Management and administration is generally more expensive than with public financing under PHI because of the bureaucracy needed to assess risk, set premiums, design benefit packages and review, pay or refuse claims. PHI providers also have to incur advertising, marketing and reinsurance costs.

Insurance administration is evidently cumbersome and expensive in Sri Lanka, because it is not computerized. The claims need to be checked closely for sub-limits on room rates and annual limits. Regular clerical and managerial staff with no specific training are used to administer claims and attend to underwriting (Rannan-Eliya and de Mel, 1997). Nearly 35% of premiums are spent on administration expenses. However, this does not appear unusual in international comparison.

Efficiency Implications for the Health Care System

It may be argued that the existence of a large PHI market may undermine the efficiency of the statutory health system. The impact of PHI on health care costs discussed above is not exclusive to the private health sector and may affect the public sector. Moreover, where PHI allows for faster access, this may result in individuals undergoing private consultations and then following up in the public sector, leading to an increased burden on the public sector. Alternatively, the PHI sector could cost-shift the sicker, and therefore more expensive, patients to the public sector, as in Chile and Argentina, again leading to a greater burdening of the statutory health system. There is no significant evidence of any of these trends in Sri Lanka yet, probably as a result of the small size of the PHI sector. However, it should be noted that the age groups who are likely to incur the most expensive illnesses, namely those older than 55 years, are generally not covered by PHI.

Equity Implication of PHI

International experience indicates that supplementary PHI will increase inequality in the provision of health care, since it gives rise to faster access for better quality services for those who are covered. Although the data does not yet permit a complete distributional analysis of PHI in Sri Lanka, there is evidence that the utilization of private health services, in particular in-patient services that are the target of PHI expenditures, is heavily skewed in favour of the richest urban populations (Data International, Nepal Health Economics Association and Institute of Policy Studies, 2001). Wagstaff et. al.'s (1999) analysis of vertical equity in health care funding in the OECD found PHI to be regressive in France, Ireland and Spain. Only in Germany and the Netherlands, where only the high earners are allowed to enrol in PHI, was it found to be progressive.

Tax Subsidies for PHI

In the Sri Lankan context, there is an implicit tax subsidy for PHI, since employee compensation given in the form of medical benefits or medical insurance is not taxable as income. However, there have not been any formal studies of the efficiency or equity of this subsidy. However, experience from other countries would suggest that the subsidy is both inequitable and highly ineffective as a way of reducing the government's fiscal burden.

(4) FEATURES OF PRIVATE HEALTH INSURANCE PRODUCTS IN SRI LANKA

Features of Health Insurance Portfolio

As with all classes of private insurance, insurers take a commercial attitude in providing this type of insurance. Consequently, only surgical & hospitalization expenses incurred as a result of bodily injury or sickness disabling the person in excess of three consecutive days were payable by insurance initially. Soon after private insurance companies were allowed to function in the late 1970s, Ceylinco Insurance Company came out with limited out-patient benefits as an extension to their standard in-patient scheme. Other companies followed, purely to compete with them, but provided these benefits on negotiations. Out-patient benefits have now become more or less a standard appendage to the in-patient schemes. However, where cover for out-patient expenses is purchased, such treatment has to be prescribed by a medical practitioner.

All companies are prepared to “tailor” their standard schemes to suit the particular needs of their clients. This is applicable only to groups. In adjusting these, limits per category of health care can be removed, room rates increased and maximum benefits increased.

Expenses arising from the following are generally excluded from PHI policies in Sri Lanka:

- Injury or sickness contracted outside Sri Lanka
- Injury or sickness happening in consequence of war and perils such as terrorism
- Suicide, self-inflicted injuries, sexually transmitted diseases, including AIDS and alcoholism.
- Normal childbirth or pregnancy, except where the mother’s life has been insured for 12 months and where the expenses in respect of normal childbirth become payable
- Where the insured person indulges in dangerous sports and travels in non-standard aircraft
- Pre-existing conditions and recurring ailments

In general, PHI policies will cover persons from the age of 12 months to 60 years. Depending on the importance of the group, some insurers allow children less than 12 months provided they are admitted to and registered as members of the Group policy. For those above 60 years the only meaningful scheme/package is provided by SLIC, with benefits going up to Rs.180, 000/- per year.

1) STANDARD INSURANCE PROGRAMMES OF INSURERS

Listed below are the details of the standard programmes of the various insurers. As mentioned above, the insurers allow re-designing of these schemes to suit the needs of groups.

- Sri Lanka Insurance Corporation Ltd.
 1. Agrahara Scheme for Public Servants and basic details thereon
 2. Life-Time Health Plan providing cover for individuals and families from birth to over 75
 3. New Group Scheme with higher benefits
 4. Special A & B Schemes - low cost and low benefits
- Ceylinco Insurance Co, Ltd.
 1. Ceylinco Suwa Sampatha Scheme
 2. Ceylinco Super A & B and Schemes A & B
- Union Assurance Ltd.
 1. Union Schemes A, B & C
- Eagle Insurance Co, Ltd.
 1. Eagles Proposed Scheme 1 - Scheme V
 2. Eagles Existing Scheme 1 - Scheme V
- Janashakthi General Insurance Co, Ltd.
 1. Janashakthi Schemes A - C
- Asian Alliance Insurance Co, Ltd.
 1. Asian Alliance Plans 1 - 3
 2. Asian Alliance Plans 1 & 2

2) ADMINISTRATION

Due to the manner which this class of business has been treated in the past, insurers have generally employed clerical and management/executive staff with no specific training in insurance for claims administration. They attend to underwriting and claims processing, but receive no special training.

This has resulted in the lack of statistics, which will give the management information particularly as to where the portfolio is heading. In general, firms do not have access to detailed information on the number of beneficiaries that their issued policies cover, the age and sex distribution of the beneficiary population, or the frequency and value of claims by category of beneficiary.

Management of Health Insurance Portfolio

Insurers have not attached too much importance to the health insurance portfolio in the past. None of the companies have even basic management statistics. There is no revision of standards schemes, except for new schemes introduced by them, in view of the inadequate limits per the demands of the clients. In formulating these schemes, experience is not taken into account due to a lack of statistics.

Health insurance is written under the Miscellaneous Accident or General Accident Department of each of the companies operating in Sri Lanka. Most insurers treat health insurance as a form of business that is necessary for attracting other type of business, particularly from corporate clients. It is an account that

is written to accommodate the clientele and obtain their other insurance purchases, which are more profitable. Health insurance is thus a loss leader for the typical company.

(5) ASSESSMENT OF THE PUBLIC SERVANTS' MEDICAL INSURANCE SCHEME

Public Servants' Medical Insurance Scheme In Sri Lanka - "Agrahara"

The Sri Lanka Insurance Corporation initiated Agrahara, in January 1997 following a request made by the government. Sources indicate that the decision to provide this benefit to civil servants was not formally approved by the Ministry of Finance, and that the decision was made at higher political levels. This indemnity insurance scheme covers all public servants (estimated to be 600,000-800,000) and their dependants (estimated to be 1.3 million) for accidents and illness. Accidents covered are limited to those arising out of motorecycling, riots and civil commotion. Also included in the coverage are the costs of childbirth, spectacles, specific medical tests and travel. The policy, while covering the cost of a private hospital room, also provides an allowance for those opting to receive free treatment in a state hospital (Hsiao et al. 2000). This allowance has remained unchanged since the policy was introduced in 1997. Benefits covered by the Agrahara scheme are shown in Table 4.2.2. The cost of this non-profit scheme is borne by the Ministry of Public Administration.

Table 4.2.2 Benefit Limits in Agrahara Scheme

	Benefits	Rupees
1	Hospital & Nursing Home maintenance charges	16,000
2	Hospital Medical operation expense including the use of the operating theatre	6,500
3	Surgeons & Anaesthetists fees	12,000
4	Consultants & Specialist fees	7,500
5	Specialist services including deep therapy treatment, X-rays, radiological & radium examination & treatment	
6	Expenses incurred for travelling within Sri Lanka to obtain above benefits	2,000
7	Normal child birth (limited to maximum)	3,000
8	Spectacles - (excluding sun glasses)	
	Once in 5 years	2,000
	Changing of lenses once in 2 years	2,000
9	Out-Patients benefits	2,000
10	Government Hospital allowance (per day)	
	Executive officers	300
	Others	250
	Limit per event	40,000
	Limit per year	50,000

By the end of 1997, 14,600 claims had been made and only 80% of the necessary funds had been allocated to reimburse those claims. However, claims were still being made in 1998 for expenditures incurred in 1997, as public sector employees became increasingly aware of the benefits available to them. Between 1998 and 2001, as claims expenditures rose without commensurate increases in premium incomes, Agraphara became a loss-making scheme.

(6) ASSESSMENT OF INSURANCE MARKET FAILURES

Assessment of Moral Hazards

Moral hazard effects can occur because of induced behaviour on the part of the patient or the medical provider. Hospitals or physicians can either raise their pricing levels for insured patients, provide additional services in excess of the requirements of the patient, or collude with the patient in charging for additional services that are not actually provided. Some of this is legitimate, as one of the functions of insurance is to reduce the price-sensitivity of patients, and providers may legitimately price-discriminate in these cases. However, a major element of it results from the weakening of normative constraints that may control what doctors may charge or provide. Moral hazard effects on the part of the patient would include utilizing more care than is needed. It would not be legitimate though, to include the effect of insurance on patients which reduce their price sensitivity of demand and thus leads them to use more expensive providers than they would have otherwise done.

According to interviews with insurance company representatives and other industry sources, moral hazard effects are a substantial problem in the Sri Lankan PHI market. The general industry view is that the effect of moral hazard on the health insurance portfolio is not less than 30%, although it is difficult which proportions of this are due to consumer moral hazard and which is due to provider moral hazard. All insurers privately report that it is commonplace for many providers to charge excessive prices when they know the patient is insured (both hospitals and doctors), and that it is common place for some doctors to provide additional, unnecessary services. The problem appears to be worse with out-patient and specialist services.

Assessment of Adverse Selection

Adverse selection effects are substantial in the Sri Lankan PHI market. The observation that the Sri Lankan PHI market is already concentrated and offers cover mostly to working-age adults in formal sector employment working in the Western Province, and those individual policies are essentially not available for pre-existing illness. The elderly, and several major categories of illness, is the direct evidence that adverse selection effects are substantial.

(7) RELATIONSHIP BETWEEN PRIVATE HEALTH INSURERS AND HEALTH CARE PROVIDERS

Prevalence of Insured Patients

Under the prevailing system, hospitals do not routinely identify insured patients at the time of registration. So all the hospitals interviewed indicated that they lacked accurate statistics of the number of insured patients, and several indicated that in many cases the hospital was ignorant of the insurance status of an individual patient. The overall rate of insured varied significantly across individual hospitals. In general, for private hospitals and nursing homes, it ranged from 10%-25%. For government hospitals the percentage of patients with PHI was much lower, but the majority of paying patients at one government hospital were reported to be civil servants with government insurance.

Providers Attitude Towards Insured Patients and Administrative Costs

Hospitals generally report no strong attitudes to insured patients. To some extent, the attitude of some might be characterized as indifference. Many of the hospitals do not have records of how many patients are insured, and cannot distinguish such patients from the non-insured ones. Interviewees reported in general that insurance does not impose significant additional administrative burdens on them, which reflects the fact that, under the current schemes, the burden of claiming reimbursement falls on the beneficiary. One nursing home did report that it preferred insured patients as their documentation was easier. Most hospitals do not operate separate billing systems for insured patients, and do not price services differently. There was little overt evidence of systematic efforts to price-discriminate by the hospitals. However, doctors were reported to be more likely to adjust prices, and some individual physicians reported that they preferred insured patients because they could recommend more tests and investigations. Respondents also indicated that they did not think that insured patients had different attitudes or demands to the non-insured ones.

Special Agreements between Providers and Insurers

Currently, private hospitals (and public hospitals) lack formal arrangements with insurers. The practice is that patients are billed directly by the hospital, and the patient will then later seek reimbursement from the insurer. Some hospitals indicated that they did not like the idea of developing closer relationships, but others indicated that they were interested in doing so. However, the major motivation in developing such relationships is they would bring about an increase in patients to their specific facility. Lesser motivations were that this might help reduce the paperwork involved in managing insured patients.

In the past few months, it is reported that one new private hospital in Colombo has negotiated special arrangements with some insurers, which involve agreed price tariffs. However, it is too early to assess these agreements.

(8) FEASIBILITY OF LOW-COST/LOW-BENEFIT SCHEMES

Low-cost/low-benefit schemes can be considered to already be in existence, if one classifies as such schemes those that offer benefits limited at Rs. 10,000. However, such schemes are quite inadequate when considering the actual costs of treatment in the private sector, which for the average admission costs at least Rs. 10,000 or more. In the context of escalating medical expenses, the insurers report that demand is not there for such low-cost, low-price schemes. This is consistent with economic theory,

since the value to the consumer of insurance increases with the size of the risk insured against. Actual experience of insurers is that the substantial demand from clients is for more comprehensive policies, which offer better benefits. However, given the very high loss ratios, most insurers cannot provide such packages without raising prices. So, in general, market trends are towards higher-cost, higher-benefit policies.

Nevertheless, it was reported by industry sources that it is possible to design low cost/low benefit schemes, if this is only to settle the hospital bills, which arise from non-serious illness and ailments, and preferably at state sector hospitals only. Dropping out-patient benefits would also reduce prices, as most insurers essentially treat this as indemnity insurance, with premiums set at 80% - 90% of the limit of the out-patient benefit.

In general, there is no evidence to indicate that the Sri Lankan PHI market is any different to that in other countries, where PHI rarely covers the low-income population, because of adverse selection effects or lack of consumer demand at low-incomes. In addition, the lower-income population who might be potential clients for such products already have access to, and use, free government services. It is not at all clear that there is significant demand from this group to spend available discretionary cash to buy better hotel-quality medical care, which is the main function of PHI. Given that a significant proportion of the poorer population suffers from malnutrition, it is unclear what public policy benefits would be gained from encouraging them to spend their money on buying medical services in addition to those provided free to them by the government. The rationale for such schemes is thus both questionable from a market-perspective, and also from the perspective of wider social policy.

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4.3

UNIT COST OF TREATMENT FOR TEN SELECTED DISEASES AT PUBLIC MEDICAL INSTITUTIONS IN SRI LANKA

(1) INTRODUCTION

This report presents the findings of a study undertaken with the objective of estimating the unit cost of treatment for ten selected diseases at public medical institutions. These ten diseases include three communicable diseases, namely, Malaria, Tuberculosis and Diarrhoea and six non-communicable diseases, , Bronchial Asthma, Mental illness, Diabetes Mellitus, Hypertension, Ischaemic heart disease, Dental caries and Upper respiratory tract infection. Except malaria, none of these diseases has been subjected to a unit cost analysis with respect to the public medical institutions in Sri Lanka. In selecting these ten diseases, the recent trends of the mobility and mortality patterns of the public health sector were taken into consideration.

Table 4.3.1 Recent Trends of the Incidence of Ten Selected Diseases

Disease	Remarks
Malaria	For several decades, until recently, malaria was the leading communicable disease in the country. Although the number of cases hospitalised dropped from 800/100,000 in 1990 to 262/100,000 in 1995, it moved up to 304/100,000 in 2000.
Tuberculosis	Admission rate of tuberculosis cases in 2000 was 60/100,000 compared with 54/100,000 in 1995. Although the death rate of tuberculosis was decreasing during past two decades, it is considered to be a re-emerging disease.
Diarrhoea	Intestinal infectious diseases are the 6 th leading cause of hospitalisation in 2000, accounting for 4.1% of the total morbidity in the country. Although the mortality rate due to diarrhoeal diseases has decreased dramatically, morbidity rate has not decreased at a similar pace. Admissions to public hospitals due to diarrhoeal diseases have been fluctuating between 676 and 961 cases per 100,000 during the past 20 years. In 2000, this rate was 747.
Upper respiratory tract infections	Diseases of the respiratory system were the second leading cause of hospitalisation in 2000. The diseases of the upper respiratory tract were among the ten leading causes of hospitalisation in seven districts in 2000. Under this study, a brief survey was conducted among the OPD patients at the Colombo South Teaching Hospital and it indicates that 43% of the OPD patients had sought treatment for upper respiratory tract infections.
Asthma	Admissions due to asthma have increased from 555 per 100,000 population, in 1990, to 895, in 2000. Similarly deaths per 100,000 have increased from 15.1, in 1990, to 18.6, in 2000.
Mental illness	In 1995, 43,096 patients with mental disorders were treated at public medical institutions and this number had increased by 10%, in 2000, to 47,824. There were 94 deaths, in 1995, and 128, in 2000.
Diabetes Mellitus	There was a sharp increase in the number of diabetic cases during recent times: the number of reported cases has increased from 66/100,000, in 1980, to 205/100,000, in 2000.
Hypertension	Hypertension was the eleventh leading cause of morbidity in 2000. Its share of the total admissions had a twofold increase during the past decade and it moved up to 2.4% in 2000.
Ischaemic heart disease	Ischaemic heart disease was the leading cause of hospital deaths in 2000 with a mortality rate of 19/100,000. Its hospitalisation rate has moved up from 163/100,000, in 1990, to 313/100,000, in 2000.

Disease	Remarks
Dental caries	During the recent past there was a sharp increase in attendance at dental clinics of the public medical institutions. The total number of dental visits increased from 1,085,721, in 1990, to 1,840,825, in 2000, by 41%.

Source: MoH

(2) METHODS

On the basis of the specific characteristics of the disease concerned and the availability of necessary data, the most appropriate method of costing was applied to each disease (Drummond et. al., 1997). However, the level at which the cost estimates was made was also common for all the diseases, i.e., operational cost. Thus, cost of immovable capital assets such as buildings and land were not taken into consideration. The respective consultant/s of each disease were interviewed to design the cost estimation framework of each disease. The details of the costing framework of each disease are presented below under the section titled 'results'. For all diseases except diarrhoea, cost estimations were made for outpatient care. For diarrhoea, the paediatric ward of the Colombo South Teaching Hospital, in which a section is reserved for diarrhoea patients, was taken into consideration. Data on clinical procedures were collected mainly from the respective clinics/wards at the Sri Lanka National Hospital or the Colombo South Teaching Hospital. Furthermore, necessary data was collected from the Anti-Malaria Campaign and the clinic conducted at the Medical Research Institute (MRI) for tuberculosis patients. Through these sources, data on the manpower involved in each clinical procedure, remunerations including additional payments such as overtime, type and number of patients treated and investigations conducted, type and quantity of inputs used for investigations, equipment used for investigations and treatment, type and quantity of drugs dispensed etc., were collected for the respective period taken into account for the cost estimation of each disease. Prices of most of the equipment and drugs were collected from the Medical Supplies Division (MSD) of the Ministry of Health. For certain equipment, prices were collected from their registered suppliers. Since the administrative cost of the MSD stands at about 10%, this percentage was added to the price of each drug and the equipment provided by the MSD. Given the time constraints, and as an approximation, 10% was added to the total cost to cover up administrative cost and overheads. Cost of the capital inputs, which were taken into account for cost estimates, were estimated by discounting their replacement value at the annual rate of 6% for the lifetime. The respective medical staff as well as the paramedical staff of each clinic were interviewed, particularly, to gather information for apportioning the time utilization of different staff categories across different but interrelated activities.

(3) RESULTS

Malaria

A typical malaria clinic at a secondary level hospital was taken as the model for the estimation of the cost of treatment for malaria.

Table 4.3.2 Cost of Treatment: Malaria

Type of cost	Amount
1. Cost per blood film examined¹	19.80
2. Cost per case detected:	
a) If SPR ² = 6.45 (current rate)	307.01
b) If SPR = 11.7 (2000)	169.25
3. Cost per case treated:	
a) For a pv case	38.17
b) For a pf case with resistance to Chloroquine ³	123.31
4. Cost per case detected and treated:	
a) If SPR = 6.45 (current rate)	345.17
b) If SPR = 11.7 (2000)	207.41

Note:

1. On the assumption a microscopist examines the expected 65 blood films per day.
2. SPR - Slide Positive Rate
3. Cost for treatment with Pyremethamine-Sulfadoxine.

Tuberculosis

The cost of treatment for tuberculosis was estimated on the basis of the performance of the clinic at the MRI in 2001. Out of the 64,727 patients treated at this clinic, 20.04% sought treatment for tuberculosis. The patients had been subjected to several investigations such as X-ray, UFR, ESR, WBC/DC, AFB, Sputum culture and Mantoux test. For simplicity, the average cost figures of chest X-ray, UFR, SER and WBC/DC were taken from the estimates made for some other diseases in this study. The average cost figures of AFB and Mantoux tests were estimated using data collected from the clinic. However, due to the complexity of the procedure of sputum culture and time constraint, an approximate value was assumed for its unit cost. The cost of sputum culture was assumed to be half of the price of private sector.

Table 4.3.3 Cost of Treatment: Tuberculosis

Item	Rs.	%
Manpower	172	39
Drugs	174	40
Investigations	52	12
Overheads	40	9
Cost per patient	438	100

Note: The substantially low average cost for investigations was largely due to the undertaking of a relatively very small number (110) of Sputum cultures (the most expensive investigation) and the confinement of other investigations for a relatively small proportion of patients.

Diarrhoea

Diarrhoea was the only disease for which unit cost was estimated for inpatient care.

Table 4.3.4 Cost of Treatment: Diarrhoea

Item	Cost per patient	Cost per patient day	%
Manpower	815	503	84
Drugs & Supplies	46	28	5
Investigations	23	14	2
Overheads	88	55	9
Total	972	600	100

Note: A substantially high proportion of unit cost was attributed to manpower (84%). This was mainly due to the extremely low value of drugs (i.e., Jeewani - a ORS solution) given to patients who normally stay at hospitals for relatively short periods (about 1 1/2 days).

Upper Respiratory Tract Infection

A brief survey was conducted amongst OPD patients at Colombo South Teaching Hospital and it was found that almost 43% of those patients had sought treatment for upper respiratory tract infections. Thus, the total input of the health manpower of the OPD was apportioned on the basis of this patient attendance pattern, and in estimating the cost of treatment for the patients with upper respiratory tract infections. Cost of drugs was directly estimated on the basis of the types of drugs prescribed for three different age groups, namely, children below 1 1/2 years, children above 1 1/2 years and adults.

Table 4.3.5 Cost of Treatment: Upper Respiratory Tract Infection

Item	Children < 1 1/2 yrs.		Children > 1 1/2 yrs.		Adults	
	Rs.	%	Rs.	%	Rs.	%
Manpower	44	61	44	74	44	70
Drugs	22	30	10	16	13	21
Overheads	7	9	5	9	6	9
Cost per patient	73	100	60	100	64	100

Note: The proportion of the manpower input is relatively high in all three categories.

Bronchial Asthma

Treatment for Bronchial Asthma was looked at in two ways. Firstly, a cost estimation was made for nebulizing asthma patients on the basis of OPD. Secondly, cost of treatment for a patient who attends the asthma clinic was estimated. Whilst some of patients who attend the asthma clinic are directed to the nebulizing unit, some others are directed to obtain chest x-ray in addition to nebulizing. Thus three types of cost were estimated as normal treatment, normal treatment with nebulizing and normal treatment with nebulizing and x-ray. Since only about 1% of patients could be considered as severe cases, the cost estimates were confined to the treatment procedure for mild and moderate cases.

Table 4.3.6 Cost of Treatment: Asthma

Item	Normal Treatment ¹	With Nebulizing ²	With Nebulizing ³ and X-ray
Manpower	9	9	9

Drugs	2	148	148
Nebulizing	-	51	51
Chest X-ray	-	-	92
Overheads	1	21	30
Cost per patient	12	229	330

Note:

1. Indicates mildness of illness and prescription of Salbutamol only.
2. Indicates treatment for moderate patients, which involves Salbutamol, Nebulization and provision of Beclamethazone Rota caps.
3. Indicates patients who appear for annual CXR in addition to 2.

Mental Illness

In estimating the cost of treatment for psychiatric patients, no emphasis was given to different types of the illness. These cost estimates indicate the average cost of treatment for a patient who attends the psychiatric clinic, irrespective of the type of mental disorder. These estimates are based on the total attendance during the year 2001, and the other inputs such as drugs dispensed and medical investigations conducted during the same period. The investigations were Thyroid Function test, EEG, BU, UFR, LFT, FBC, ESR, ECG, CT Scanning, Chest X-ray and Skull X-ray. However, neither a chest x-ray nor a skull x-ray was performed during the study period at Colombo South Teaching Hospital for psychiatric patients. Meanwhile, a few patients were referred to the Sri Lanka National Hospital for CT scanning and Thyroid Function tests.

Table 4.3.7 Cost of Treatment: Mental Illness

Item	Rs.	%
Manpower	256	64
Drugs	98	24
Investigations	11	3
Overheads	36	9
Cost per patient	401	100

* Manpower accounted for 64% of total cost.

Diabetes Mellitus

The estimation of the cost of treatment for diabetes mellitus was undertaken in four steps. Firstly, the cost of blood drawing at the OPD was estimated, which was Rs. 22 per sample. Secondly, the cost per lab investigations for FBS, PPBS, UFR and ECG were estimated. Thirdly, the cost of treatment per patient at the diabetes clinic was estimated. Lastly, the cost of an annual check-up at the eye clinic was estimated. With this basic information on cost of treatment, patients were categorized into three groups for cost estimates, which will be taken up below. For each category, for the purpose of illustration, cost estimates were made for four combinations of drugs prescribed. These cost estimates could be subjected to any other possible combinations of drugs in the form of a sensitivity analysis. The four drug combinations are I) Tolbutamide & Glibenclamide, II) Tolbutamide & Metformin, III) Glibenclamide & Metformin and IV) Insulin. The results are presented in Table 4.3.8.

Table 4.3.8 Cost of Treatment: Diabetes Mellitus

Type of patient/Item	Type of drugs prescribed							
	I		II		III		IV	
	Cost	%	Cost	%	Cost	%	Cost	%
1. 1 st visit with all tests								

Investigations	156	73	156	67	156	79	156	17
Drugs	45	21	61	27	27	14	726	81
Manpower & overheads	14	6	14	6	14	7	14	2
Total	215	100	231	100	197	100	896	100
2. For a year for non-complicated cases								
Investigations	437	38	437	33	437	47	437	5
Drugs	539	47	736	55	325	35	8,717	94
Manpower & overheads	166	15	166	12	166	18	166	2
Total	1,142	100	1,339	100	928	100	9,320	100
3. For a year for patients with cardiac symptoms								
Investigations	467	40	467	34	467	49	467	5
Drugs	539	46	736	54	325	34	8,717	93
Manpower & overheads	166	14	166	12	166	17	166	2
Total	1,172	100	1,369	100	958	100	9,350	100

Note:

- Investigation for 1st category included FBS, UFR, PPBS, ECG and Eye Check Up.
- Cost estimates for 2nd category, for period of one year, with assumption that patient makes a visit each month and is subjected to FBS and UFR on each visit and an eye check once a year.
- Cost estimate for 3rd category, made on assumption that in addition to monthly FBS and UFR and annual Eye check the patient also had an ECG.

Hypertension

Cost of treatment for hypertension was estimated for patients above 35 years old. Patients were categorized into four groups and cost estimates were made for the treatment protocol for a period of one month. The four estimates are a) cost of treatment for a patient for the first visit with no other complications, b) cost of treatment for a patient with diabetes, c) cost of treatment for an elderly patient with no complications and d) cost of treatment for a patient who is difficult to be controlled.

Table 4.3.9 Cost of Treatment: Hypertension

1. Cost of treatment for a patient with no other complications (Primary Hypertension) for a period of one month						
Item	1 st Visit	2nd Visit	3rd Visit	4th visit	Total	%
Manpower	14	-	-	-	14	6
Investigations	193	-	-	-	193	82
Drugs	6	-	-	-	6	3
Overheads	21	-	-	-	21	9
Total cost	234	-	-	-	234	100
2. Cost of treatment for a patient with diabetes for a period of one month						
	1st visit	2nd visit	3 rd visit	4th visit	Total	%
Manpower	14	14	-	-	27	10
Investigations	193	22	-	-	215	77
Drugs	5	5	-	-	10	4
Overheads	21	4	-	-	25	9
Total cost	233	45	-	-	277	100
3. Cost of treatment for an elderly patient with no complications for a period of one month						
	1st visit	2nd visit	3 rd visit	4th visit	Total	%
Manpower	14	-	-	-	14	6
Investigations	193	-	-	-	193	84
Drugs	1	-	-	-	1	0.4
Overheads	21	-	-	-	21	9
Total cost	228	-	-	-	228	100
4. Cost of treatment for a patient who is difficult to be controlled						
	1st visit	2nd visit	3 rd visit	4th visit	Total	%
Manpower	14	14	14	14	55	15
Investigations	193	-	78	-	271	72
Drugs	5	5	5	5	19	5
Overheads	21	2	10	2	34	9
Total cost	232	20	107	20	379	100

Note:

- For Category 1 Pt, the investigations were X-ray, FBS, ECG, UFR, Blood Urea, and Serum Electrolytes.
- For Category 2 Pt, the difference in the cost estimate was due to types of drugs prescribed and two attendances at clinics during a period of one month.
- For Category 3 Pt, the difference in cost was only due to the type of drugs prescribed.
- For Category 4 Pt, the high cost was due to weekly visits and the conducting of three investigations at the third visit (namely, ECG, Blood Urea and Serum Electrolytes).

Chronic Stable Angina

In estimating the cost of ischaemic heart disease, the cost estimates were confined to chronic stable angina. Uncomplicated myocardial infection and complicated myocardial infection were not taken into consideration, due to time and resource constraints and the complexity of the treatment protocols of these two types of the disease. Patients were categorized into three groups. The first group consists of patients who make the first visit with symptoms and for them the cost estimates were made on the assumption that they are subjected to ECG and FBS. The second estimate was made for the patients who appear for Stress ECG annually, ECG every three months and FBS every six months, in addition to

attending the clinic every month. The more complicated patients in the third category are subjected to stress ECG annually and echocardiogram once in six months.

Table 4.3.10 Cost of Treatment: Chronic Stable Angina

Item	Rs.	%
Average cost 1: Per month with only ECG and FBS		
Manpower	71	22
Investigations:	61	18
Drugs	199	60
Total	332	100
Average cost 2: Per year with Stress ECG annually		
Manpower	857	22
Investigations:	707	18
Drugs	2,390	60
Total	3,953	100
Average cost 3: Per year with Stress ECG annually and echocardiogram in every 6 months		
Manpower	857	20
Investigations:	1,073	25
Drugs	2,390	55
Total	4,320	100

Dental Caries

These cost estimates were based on the average monthly performance of the dental clinic during the year of 2001. The activities of the clinic were categorized into three broad groups namely, extraction, temporary filling and permanent filling. The third group was sub-categorized as back, front and side fillings. An assumption was made to simplify the cost estimation procedure: the input of the manpower is the same for each activity. Thus the cost differences are mainly due to the differences in the utilization of medical supplies and equipment for each activity. The sum of these inputs varies between Rs. 11 (for a temporary filling) and Rs. 58 (for a permanent side filling). As percentages, it varies between 13% and 43% respectively. When looking at the cost per case, a temporary filling accounts for the lowest unit cost of Rs. 84 followed by a permanent back filling of Rs. 86. As the next expensive activity, a front permanent filling accounts for a unit cost of Rs. 93, followed by an extraction and side filling of Rs. 108, and Rs. 136 respectively.

Table 4.3.11 Cost of Treatment: Dental Caries

Item/Activity	Extraction	Temporary Filling	Permanent filling			
			Back	Front	Side	Average
Cost in Rupees:						
Manpower	65	65	65	65	65	65
Medical supplies & equipment	33	11	13	20	58	30
Overheads	10	8	8	9	13	10
Total	108	84	86	93	136	105
Cost in %:						
Manpower	60	77	76	70	48	62
Medical Supplies & equipment	30	13	15	21	43	29
Overheads	9	9	9	9	9	9
Total	100	100	100	100	100	100

(4) CONCLUDING REMARKS

Estimation of the cost of treatment for any disease is indeed a very complicated process, particularly with the absence of a performance-based (e.g., clinic, ward-based) accounting system for the public hospital sector in Sri Lanka. Therefore, the cost estimation procedure has to be based on several assumptions and, given the time and resource constraints, all attempts were made to make a realistic set of assumptions. As a result of these limitations, on the one hand, for certain diseases such as ischaemic heart disease, some varieties of the disease with complications had to be left out by confining the cost estimates for one simple form of the disease. On the other hand, for diseases such as mental illness, the average cost estimates had to be made for all the patients without making different cost estimates for different types of the disease. With the exception of diarrhoea, it was not possible to make cost estimates for any other type of inpatient care, and once again due to the requirement of relatively the high time and resources for making such estimates. However, on the basis of the results of this costing exercise, it is possible to make a comparison across the selected diseases with respect to the level and composition of their unit costs. Therefore, with the perspective of introducing a performance-based monitoring and evaluation system for the public hospital sector, this study urges the policy makers to take necessary steps to extend this exercise for the formulation of a unit cost system, in the form of the very well established diagnostically related groups (DGR) system, encompassing all aspects of the hospital sector in Sri Lanka.

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4.4

HOUSEHOLD COST OF LONG-TERM ILLNESS : DIABETES, HEART AILMENTS AND MENTAL ILLNESS

(1) INTRODUCTION

Household cost of illness is increasingly becoming an area of importance for policy makers as well as researchers. However, only a very few studies of this nature have so far been undertaken, particularly in less developed countries. Most of these studies have focused on communicable diseases such as malaria (Attanayake, Fox-Rushby and Mills 2000; Asenso-Okyere & Dzator 1997, Mills 1994). The focus of the studies on other diseases has been largely directed towards direct cost rather than indirect cost. In this endeavour, however, de Silva (2001) has made an attempt to examine the economic impact of mental illness on the household in the Sri Lankan context. This study has paid more attention to valuing the losses attributable to the changes in employment status due to illness. Russell (2001) has made an attempt to examine the affordability of the cost of long-term illness, as well as coping mechanisms in an urban setting in Sri Lanka.

(2) GENERAL OBJECTIVE

The general objective is to assess the cost of long-term illness, of a few selected diseases, on the household.

Specific Objectives

The specific objectives of the study are to:

1. Estimate the cost of long-term illness on the household.
2. Assess the affordability of long-term illness on the household through addressing coping mechanisms.

(3) CONCEPTUAL FRAMEWORK

Household cost of illness basically consists of direct and indirect cost, and psychic cost is considered to be a concomitant part of the latter. Drummond et al (1997) has devised the framework for the estimation procedure of household cost, with due recognition given to each type of cost. Thus, costs involved in receiving care such as cost of travel, cost of treatment, and complementary cost such as nutritional and supplementary/special food could be considered as the direct cost of the household. Indirect cost, except psychic cost, is directly linked with the loss of earnings of the patient and household members; the latter due to spending their time looking after the patient. Measurement, as well as valuing the cost of time loss, is directly related with the corresponding output losses and such losses can best be handled at individual level. Goldschmidt-Clermont (1987) has termed this approach as an output-related method and was adopted by Attanayake, Fox-Rushby & Mills (2000) in estimating the indirect cost of malaria. This study examines the costing scenario at the household level, within a broad framework, incorporating both direct and indirect cost.

(4) METHODS

Selection of Disease

The study focuses on three diseases namely, ischaemic heart disease, diabetes mellitus and mental illness. According to recent data from the Ministry of Health (MoH 2000), ischaemic heart disease was the leading cause of hospital deaths, in 2000, with a mortality rate of 19/100,000. Its hospitalisation rate has moved up from 163/100,000, in 1990, to 313/100,000, in 2000. Similarly, there was a remarkable increase in the number of diabetic cases, in that the number of reported cases increased from 66/100,000, in 1980, to 205/100,000, in 2000. Meanwhile, mental illness is becoming a more and more intolerable burden for households, as well as for public providers, with a sharp increase of its prevalence rate, irrespective of the contributions made by some non-governmental organizations to handle those affected by the disease. In 1995, 43,096 patients with mental disorders were treated at public medical institutions and this number increased by 10% to 47,824, in 2000.

Study Location

Given the time constraint, it was intended to interview 50 patients for each disease from five locations: Colombo, Kandy, Matara, Badulla and Anuradhapura. These five locations provide a combination of the characteristics of rural, urban and estate sector. As the first step for conducting interviews, patients were selected at random from those who attended the respective clinics in the National (NH), Provincial (PH), Teaching or Base (BH) hospital in the five study locations. After the identification of patients at the clinic, appointments were made with each of them and home visits were made. Although the interviews conducted at home were very productive, it was found to be a highly time consuming and expensive procedure, particularly in the locations outside Colombo. With only one Research Assistant for the study, on certain days only two patients could be interviewed. This led to interviewing a few patients, who were from very distant locations, at the hospital itself. Thirty patients were supposed to be interviewed in each location and the distribution of the sample across five locations is given in Table 4.4.1.

Table 4.4.1 Sample by Location

Hospital in which the interviews were initiated	Mental illness	Heart Ailments	Diabetes
Colombo NH	7	12	8
Matara BH	10	10	10
Kandy TH	10	7	10
Anuradhapura PH	11	8	9
Badulla PH	10	10	10
Total	48	47	47

Table 4.4.2 Sources of Treatment by Type of Disease

Disease	Source/s of treatment				Total
	Public out-patient care	Public out-patient & in-patient care	Private care	Public & private care	
1. Mental illness	42	3		3	48
2. Heart ailments	31	7	7	2	47
3. Diabetes	33		12	2	47
Total	106 (75%)	10 (7%)	19 (13%)	7 (5%)	142 (100%)

Study Instrument

A questionnaire was designed as the tool for the interviews, which consisted of 6 sections namely, a) background information of household members, b) health seeking behaviour, c) direct cost of treatment, d) indirect cost of treatment, e) coping mechanisms and f) income. Whilst the first four sections and the last one focused on the first specific objective of the study, the fifth along with relevant aspects of the other sections dealt with the second specific objective. The interviews were not strictly confined to the questionnaire and the respondents were allowed to express their views freely, particularly about indirect cost. This qualitative data was screened, and prepared for the estimation procedure of indirect cost, which was largely done at individual level. The recall period was taken as one month and all cost estimates in this study are made for a period of one month.

(5) 4. RESULTS

Socio-Economic Background of Patients

Table 4.4.3 Age by Type of Illness

Age	Mental illness		Heart ailments		Diabetes	
	No	%	No	%	No	%
<18	3	6	2	4	0	0
18-25	6	13	0	0	0	0
25-40	21	44	2	4	1	2
40-50	13	27	8	17	13	28
50-60	2	4	16	34	13	28
60-70	2	4	12	26	14	30
70<	1	2	7	15	6	13
Total	48	100	47	100	47	100
Below 40	30	63	4	8	1	2
Above 40	18	38	43	91	46	98
Average		36		56		58

Table 4.4.4 Sex and Marital Status by Type of Disease

Sex/ Marital status	Mental illness		Heart ailments		Diabetes	
	No	%	No	%	No	%
Sex						
a. Male	23	48	31	66	19	40
b. Female	25	52	16	34	29	60
Total	48	100	47	100	47	100
Marital status						
a. Single	23	48	2	4	2	4
b. Married	23	48	36	77	37	79
c. Divorced	2	4	9	19	8	17
Total	48	100	47	100	47	100

Table 4.4.5 Educational Attainment by Type of Illness

Educational attainment	Mental illness		Heart ailments		Diabetes	
	No	%	No	%	No	%
a. Illiterate	2	4	1	2	1	2
b. Up to Year 6	12	25	13	28	10	21
c. Up to O/L	26	54	28	60	27	57
d. A/L or above	8	17	5	11	9	19
Total	48	100	47	100	47	100

Table 4.4.6 Employment Status by Type of Illness

Employment status	Mental illness		Heart ailments		Diabetes	
	No	%	No	%	No	%
Non-income generating:						
Retired	2	4.2	7	14.9	7	14.9
Housekeeping	7	14.6	9	19.1	18	38.3
Elderly	2	4.2	6	12.8	4	8.5
Student	2	4.2	2	4.3	0	0.0
Unemployed/Disabled	26	54.2	3	6.4	4	8.5
Sub Total 1	39	81.3	27	57.4	23	48.9
Income generating:						
Professionals	0	0.0	0	0.0	1	4.3
Business	2	4.2	8	17.0	5	10.6
Skilled labourer	0	0.0	0	0.0	1	2.1
Unskilled labourer	4	8.3	1	2.1	3	6.4
Manual labourer	0	0.0	3	6.4	1	2.1
Farming	3	6.3	3	6.4	0	0.0
Fishing	0	0.0	1	2.1	0	0.0
Clerical and related work	0	0.0	2	4.3	0	2.1
Teaching	0	0.0	1	2.1	1	2.1
Armed forces/Police	0	0.0	1	2.1	2	4.3
Sub Total 2	9	18.7	20	42.6	14	51.1
Total	48	100.0	47	100.0	47	100.0

Table 4.4.7 Monthly Household Income by Type of Illness

Income	Mental illness		Heart ailments		Diabetes	
	No	%	No	%	No	%
<2000	5	10	4	9	2	4
2001-4000	10	21	11	23	4	9
4001-6000	10	21	6	13	6	13
<6,000	25	52	21	45	12	26
6001-8000	8	17	6	13	9	19
8001-10000	5	10	5	11	5	11
10001-15000	5	10	5	11	13	28
15001-20000	2	4	4	9	4	9
20001-30000	2	4	3	6	3	6
30001-40000	1	2	2	4	0	0
40000<	0	0	1	2	1	2
Total	48	100	47	100	47	100
Average		7,677		11,126		10,144

Household Cost

1) MENTAL ILLNESS

Table 4.4.8 Household Cost of Mental Illness

Type of cost	Public out-patient care (N=42) (1)	Public out-patient & in-patient care (N=3) (2)	Total public care (N=45) (1+2) (3)	Public & Private care (N=3) (4)	Total (N=48) (5)
1. Total direct cost	668 (19%)	7,642 (68%)	1,133 (28%)	1,837 (25%)	1,177 (28%)
2. Indirect cost					
a. For the patient	2,070 (59%)	3,167 (28%)	2,143 (53%)	3,333 (45%)	2,218 (52%)
b. For household members	754 (22%)	500 (4%)	737 (18%)	2,300 (31%)	834 (20%)
Total indirect cost	2,824 (81%)	3,667 (32%)	2,880 (72%)	5,633 (75%)	3,052 (72%)
Total cost	3,492 (100%)	11,308 (100%)	4,013 (100%)	7,471 (100%)	4,229 (100%)

Note:

- On average a household with a psychiatric patient spent Rs. 1,177 as a direct cost with 70% (Rs. 829) going for ritual treatment and Rs. 3,052 as indirect cost.
- Of the total direct cost of treatment, 6% (Rs. 76) was for travelling, 8% (Rs. 97) for vitamins and nutritional and special foods and 12% (Rs. 140) for direct medical expenses: Fees/drugs/investigations see Table 4.4.9.
- Of the total indirect cost, 73% was attributable to the patient.
- Loss of employment opportunity was the main component of indirect cost, accounting for, on average, 47% of the total indirect cost (see Table 4.4.10).

Table 4.4.9 Direct Average Cost of Seeking Treatment for Mental Illness

Type of cost	Public out-patient care (N=42) (1)	Public out-patient & in-patient care (N=3) (2)	Total public care (N=45) (1+2) (3)	Public & private care (N=3) (4)	Total (N=48) (5)
1. INFORMAL TREATMENT					
1.1 Ritual treatment	471	6,667	884	0	829
1.2 Self-treatment	7	3	7	17	7
Sub total 1	478	6,670	891	17	836
2. FORMAL TREATMENT					
2.1 Travel cost:					
- Patient	23	31	24	113	29
- Accompanying person/s	12	31	13	74	17
- Visiting in-patients	0	481	32	0	30
2.2 Vitamins, nutritional & special food:					
- Prescribed by doctor	9	45	11	0	11
- Self-determined	80	0	75	253	86
2.3 Treatment cost (fees, investigations, drugs)	61	0	57	1,380	140
2.4 Other unspecified	5	383	31	0	29
Sub total 2	190	972	242	1821	341
3. Total treatment cost *	634	7,098	1,064	1,650	1,101
4. Total travel cost**	35	544	69	187	76
TOTAL COST	668	7,642	1,133	1,837	1,177

Table 4.4.10 Indirect Cost of Mental Illness

Type of cost	Public out-patient care (N=42) (1)	Public out-patient & in-patient care (N=3) (2)	Total public care (N=45) (1+2) (3)	Public & private care (N=3) (4)	Total (N=48) (5)
1. Hiring labour	178	500	199	0	187
2. Loss of earnings to the patient:					
2.1 Due to losing employment	1,474	2,167	1,520	0	1,425
2.2 Due to poor attendance at work	596	1,000	623	3,333	793
3. Loss of earnings of Household members due to poor attendance at work	524	0	489	467	488
4. Other unspecified costs to the household	52	0	48	1,833	160
5. Total indirect cost:					
- to the patient	2,070	3,167	2,143	3,333	2,218
- to household members	754	500	737	2,300	834
TOTAL	2,824	3,667	2,880	5,633	3,052

2) HEART AILMENT

Table 4.4.11 Household Cost of Heart Ailments

Type of cost	Public out-patient care (N=31) (1)	Public out-patient & in-patient care (N=7) (2)	Total public care (N=38) (1+2) (3)	Private care (N=7) (4)	Private & public care (N=2) (5)	TOTAL (N=47) (6)
1. Total direct cost	1,082 (39%)	2,015 (41%)	1,254 (39%)	2,546 (51%)	3,502 (45%)	1,542 (42%)
2. Indirect cost						
a. For the patient	1,227 (44%)	1,971 (40%)	1,364 (43%)	2,429 (49%)	3,750 (49%)	1,624 (45%)
b. For household members	465 (17%)	971 (20%)	558 (18%)	0 (0%)	475 (6%)	471 (13%)
Total indirect cost	1,692 (61%)	2,943 (59%)	1,922 (61%)	2,429 (49%)	4,225 (55%)	2,096 (58%)
Total cost	2,774 (100%)	4,958 (100%)	3,176 (100%)	4,975 (100%)	7,727 (100%)	3,638 (100%)

Note:

- On average a household with a patient with heart ailment spent Rs. 1,542 as a direct cost of treatment and Rs. 2,096 as an indirect cost.
- Of the total direct costs, 8% (Rs. 122) was for ritual treatment, 12% for travelling, 12% for vitamins and nutritional supplements. A patient spent 65% (Rs. 1,007) of direct medical cost for fees, drugs, and investigations (see Table 4.4.12).
- Of the total indirect cost, 78% was attributed to the patient.
- Poor attendance at work, by patients, was the major component of indirect cost, accounting for 52% of indirect cost (see Table 4.4.13).

Table 4.4.12 Direct Average Cost of Seeking Care for Heart Ailments

Type of cost	Public out-patient care (N=31) (1)	Public out-patient & in-patient care (N=7) (2)	Total public care (N=38) (1+2) (3)	Private care (N=7) (4)	Private & public care (N=2) (5)	TOTAL (N=47) (6)
1. INFORMAL TREATMENT						
1.1 Ritual treatment	185	0	151	0	0	122
1.2 Self-treatment	9	5	8	11	13	9
Sub total 1	194	5	159	11	13	131
2. FORMAL TREATMENT						
2.1 Travel cost:						
- Patient	112	179	124	101	123	121
- Accompanying person/s	5	127	28	7	0	23
- Visiting in-patients	0	226	42	0	0	34
2.2 Vitamins, nutritional & special food:						
- Prescribed by doctor	17	26	19	0	0	15
- Self-determined	166	321	194	61	140	172
2.3 Treatment cost (fees, investigations, drugs)	588	870	640	2,366	3,227	1,007
2.4 Other unspecified	0	261	48	0	0	39
Sub total 2	888	2,010	1,095	2,535	3,490	1,411
3. Total treatment cost*	966	1,482	1,061	2,439	3,379	1,365
4. Total travel cost**	117	533	193	108	123	178
TOTAL COST-	1,082	2,015	1,254	2,546	3,502	1,542

* 1 + 2.2+2.3+2.4 and ** 2.1

Table 4.4.13 Indirect Cost of Heart Ailments

Type of cost	Public out-patient Care (N=31) (1)	Public out-patient & in-patient care (N=7) (2)	Total public care (N=38) (1+2) (3)	Private care (N=7) (4)	Private & public care (N=2) (5)	TOTAL (N=47) (6)
1. Hiring labour	218	157	207	0	275	179
2. Loss of earnings to the patient:						
2.1 Due to losing employment	387	714	447	1,143	0	532
2.2 Due to poor attendance at work	840	1,257	917	1,286	3,750	1,093
3. Loss of earnings of household members due to poor attendance at work	226	814	334	0	200	279
4. Other unspecified costs to the household	21	0	17	0	0	14
5. Total indirect cost:						
- To the patient	1,227	1,971	1,364	2,429	3,750	1,624
- To the household members	465	971	558	0	475	471
TOTAL	1,692	2,943	1,922	2,429	4,225	2,096

3) DIABETES MELLITUS

Table 4.4.14 Household Cost of Diabetes

Type of cost	Public outpatient care (N=33) (1)	Private care (N=12) (2)	Public & private care (N=2) (3)	Total (N=47) (4)
1. Total direct cost	767 (30%)	1,251 (59%)	948 (100%)	899 (38%)
2. Indirect cost				
a. For the patient	1,570 (62%)	667 (32%)	0 (0%)	1,272 (54%)
b. For household members	206 (8%)	192 (9%)	0 (0%)	194 (8%)
Total indirect cost	1,776 (70%)	858 (41%)	0 (0%)	1,466 (62%)
Total cost	2,543 (100%)	2,110 (100%)	948 (100%)	2,365 (100%)

Note:

- On average, a household with a diabetic patient spent Rs. 899 as a direct cost of treatment and Rs. 1,466 as an indirect cost of treatment.
- Of the total direct cost, only 0.3%(Rs. 3) was spent on ritual treatment. Rs. 45 (5%) was spent on self-treatment, and Rs. 772 (86%) was spent on vitamins, nutritional and special foods. 5.5% (Rs. 50) was spent on travelling and only 1.9% (Rs. 50) on fees, drugs and investigations.
- Of the total indirect cost, 87% was attributable to the patient (see Table 4.4.15).
- Poor attendance at work by patient is a major component of indirect cost accounting for 77% of indirect cost (see Table 4.4.16).

Table 4.4.15 Direct Average Cost of Seeking Care for Diabetes

Type of cost	Public out-patient care (N=33) (1)	Private care (N=12) (2)	Public & private care (N=2) (3)	Total (N=47) (4)
1. INFORMAL TREATMENT				
1.1 Ritual treatment	3	3	0	3
1.2 Self-treatment	57	19	0	45
Sub total 1	60	21	0	48
2. FORMAL TREATMENT				
2.1 Travel cost:				
- Patient	31	72	37	42
- Accompanying person/s	6	15	18	8
2.2 Vitamins, nutritional & special food:				
- Prescribed by doctor	259	234	303	254
- Self-determined	412	826	425	518
2.3 Treatment cost (fees, investigations, drugs etc.)				
2.4 Other unspecified	0	20	145	11
Sub total 2	707	1,230	948	851
3. Total treatment cost*	731	1,165	893	848
4. Total travel cost**	37	87	55	50
TOTAL COST	767	1,251	948	899

* 1 + 2.2+2.3+2.4 and ** 2.1

Table 4.4.16 Indirect Cost of Diabetes

Type of cost	Public out-patient care (N=33) (1)	Private care (N=12) (2)	Public & private care (N=2) (3)	Total (N=47) (4)
1. Hiring labour	105	0	0	73
2. Loss of earnings to the patient:				
2.1 Due to losing employment	197	0	0	138
2.2 Due to poor attendance at work	1,373	667	0	1,134
3. Loss of earnings of household members due to poor attendance at work	89	192	0	112
4. Other unspecified costs to the Household	12	0	0	9
5. Total indirect cost:				
- to the patient	1,570	667	0	1,272
- to the household members	206	192	0	194
TOTAL	1,776	858	0	1,466

(6) A BRIEF COMPARISON

Although the proportion of treatment cost, as a part of direct cost, is almost the same (i.e., around 90%) for the three diseases, the monetary values are substantially different from each other (Table 4.4.17). Whilst heart patients have reported the highest cost of Rs. 1,365, diabetes has the lowest value of Rs. 848. Similarly, although the main element of indirect cost, loss of earnings, stands at around 90% for all three diseases, its values demonstrate substantial variations. Mental illness has the highest value of Rs. 2,705, followed by heart ailments and diabetes with Rs. 1,903 and Rs. 1,384 respectively.

Mentally ill patients and their household members have borne the largest share of the total cost as indirect cost (72%) followed by diabetic patients (62%) and heart patients (58%). These losses and other costs related to treatment, indicate that amongst the three diseases, mental illness imposed the biggest burden of Rs. 4,229 per patient during the recall period of one month. Although heart patients also appear to bear a relatively high cost (Rs. 3,638), it is 14% less than mental illness. The average cost of diabetic patients is the lowest (Rs. 2,365), which is 44% less than mental illness. Finally, whilst the loss of expected earnings to the patient and the household members has resulted in depriving 41% of the expected income of households with mentally ill patients, this loss stands at 28% and 21%, respectively, for households with diabetic and heart patients.

Table 4.4.17 Summary: Direct and Indirect Cost

Type of cost	Mental illness		Heart ailments		Diabetes	
	Rs.	%	Rs.	%	Rs.	%
Direct cost						
a. For treatment	1,101	(94)	1,365	(88)	848	(94)
b. For travelling	76	(6)	178	(12)	50	(6)
Direct cost per patient	1,177	(28)	1,542	(42)	899	(38)
Indirect cost						
a. Loss of earnings	2,705	(89)	1,903	(91)	1,384	(94)
b. Other losses	347	(11)	193	(9)	82	(6)
Indirect cost per patient	3,052	(72)	2,096	(58)	1,466	(62)
Total cost per patient	4,229	(100)	3,638	(100)	2,365	(100)
Loss of earning as a						
% from expected income		41		21		28

(7) COPING MECHANISM

With the highest direct cost of Rs. 1,542, which is 14% of the household income, almost 40% of the households with heart patients were not in a position to cope with the cost of treatment (Table 4.4.18). For psychiatric patients this percentage is 38%. However, with a substantially low average direct cost along with a relatively high income, only 21% of the households with diabetic patients were unable to bear the treatment cost. The inability to bear the cost of the disease has led 31% of the households with mentally ill patients and 29% of the households with heart patients to borrow from relatives/friends and/or withdraw their savings. Although this percentage is just 10% for diabetic patients, they reported the highest amount of average borrowings (Rs. 609) followed by households with mentally ill patients (Rs. 584) and heart patients (Rs. 361). With the lowest average income, households with psychiatric patients are reported as having the highest percentage of borrowings and withdrawals from the household income (8%), followed by diabetic (6%) and heart (3%) patients.

Table 4.4.18 Coping Mechanisms by Type of Disease

Item	Mental illness (N=48)	Heart ailments (N=47)	Diabetes (N=47)
1. No of households for which the cost of illness was intolerable	18 38%	19 40%	10 21%
2. Number of households:			
a. No borrowing	4 8%	6 13%	7 15%
b. Used personal savings	2 4%	1 2%	2 4%
c. Borrowed from relatives	11 23%	11 23%	2 4%
d. Borrowed from friends	2 4%	2 4%	1 2%
3. Total income	368,506	522,922	476,782
4. Total direct cost	56,506	72,413	42,233
5. Average direct cost	1,177	1,541	899
6. Average income of a household	7,677	11,126	10,144
7. Direct cost as a % of income	15	14	9
8. Total borrowings and withdrawals of savings	28,050	16,950	28,600
9. Average borrowings and withdrawals	584	361	609
10. Borrowings and withdrawals as % of direct cost	50	23	68
11. Borrowings and withdrawals as % of income	8	3	6

(8) CONCLUDING REMARKS

Estimation of household cost, particularly indirect cost, is an area in which only a few studies have been undertaken, even in developed countries. The three diseases looked at in this study, diabetes, heart ailments and mental illness, are emerging as leading causes of morbidity and mortality throughout the world. However, as this study clearly indicates, a considerably large proportion of the total cost of each of these diseases is borne by the households. For instance, in the case of diabetes, although the provider's cost for a period of one month stands at around Rs. 900 (Attanayake 2002), the household cost for such a patient was recorded as a substantially high value of Rs. 2,365, indicating the provider's share is only about one-third of the total cost. In a comparison with the same study, this proportion stands well below 10% for mental illness and heart ailments. These findings, firstly, raise the issue of affordability for the patient and the household in seeking care for these illnesses. Secondly, these findings bring out the extent to which the burden of each of these diseases has not been addressed in planning and implementing public sector health services. This indicates a limitation of the predominantly supply-side approach of the public sector for the provision of health services. No provisions have so far been made by the state sector to ease the burden borne by households with respect to these diseases. In other words, the social cost of these diseases has so far not been given any prominence in the agendas of policy forums. Therefore, policy makers are urged to develop a social network, with the assistance of NGOs and other social organizations, to build up safety nets for patients who cannot afford the costs, and with a view to minimizing the social cost of these diseases. This would be a drastic move away from the traditional supply-side approach towards a social approach, in the form of a public-private mix in easing households of the social cost of these diseases.

* * * * *

This section was prepared by Dr. Nimal Attanayake, Health Economic Study Programme, Department of Economics, University of Colombo.

CHAPTER 5

SURVEYS ON STEWARDSHIP & MANAGEMENT OF THE HEALTH SECTOR

5

SURVEYS ON STEWARDSHIP & MANAGEMENT OF THE HEALTH SECTOR

5.1

HEALTH SECTOR REFORMS OF SRI LANKA - PROCESSES AND OUTCOMES

(1) INTRODUCTION

The health systems of countries are faced with pressing issues. As a means to overcome these challenges, all over the world, health systems have been subjected to numerous reforms. Sri Lanka is not an exception.

This study was carried out to examine the health sector reform activities that have taken place in Sri Lanka over the past two decades and to determine the opinions and knowledge of key stakeholders on these reforms. Seventy-four key informants were interviewed, with the majority being senior medical administrators from the state health sector, semi-government and private organizations, universities, professional organizations and some patient groups, using self-administered questionnaires.

The groups identified the elements and the need for reform but were not of the view that Sri Lanka has undergone much reform. They identified reform only in a few areas such as decentralization and organization of the Ministry. A lack of definite plans for country reform was highlighted and the reluctance of the Ministry of Health to press reforms was stressed.

The need for participatory planning for reforms emerged, while the role of different stakeholders in the health reform process was highlighted. The role of the Ministry of Health and organizations in identifying, planning, implementing, coordinating, monitoring and evaluating reform was stressed.

The importance of strengthening stakeholders, to prepare them for the challenges of reforms, was emphasized during this study.

(2) OBJECTIVES

General Objective

The study aims to study the health sector reform process and outcome in the allopathic sector in Sri Lanka and to identify the views of key stakeholders regarding the need for, and their commitment to, for health sector reforms (HSR).

Specific Objectives

Specifically, the study intends:

- To document major milestones of HSR in Sri Lanka;

- To identify the major components of the health sector reform process and outcomes;
- To assess the strengths and weaknesses of major HSR that has taken place;
- To describe the experiences and reflections on HSR components from healthcare officials, associations of professional and other community groups;
- To determine the knowledge of stakeholders regarding HSR;
- To estimate the degree to which HSR components are perceived by policy makers or key stakeholders; and
- To identify strategies to strengthen the monitoring and evaluation mechanism for HSR.

(3) METHODOLOGY

The descriptive study was carried out to describe the experience and reflections of officials of the Ministry of Health, Nutrition & Welfare and other key informants for Harland to determine which components of health sector reform have been already tried in Sri Lanka, and to learn lessons from past experience with a view of facilitating future reforms.

Study Setting

The study was carried out among higher officials in the Ministry of Health, Nutrition & Welfare who were holding administrative or other senior administrative positions, among a sample of those who are currently retired but have held similar posts in the Ministry of Health within the past 20 years and among selected representatives of Universities, Professional Organizations, Private and Non-Governmental Organizations.

Sample Size

The survey was carried out among 100 key informants: Fifty (50) senior officials who are currently working in the Ministry of Health, Nutrition & Welfare and other institutions under the Ministry including the offices of Provincial and Deputy Provincial Directors of health, holding Medical administrative or other senior positions; and 20 individuals who are currently retired but who have held similar posts over the past 20 years, were selected to participate in this survey to determine the government's point of view on the HSR process. In addition, from Universities, Professional Organizations, Private and Non-Governmental Organizations and selected consumer organizations, 30 more respondents were questioned to identify their views on HSR from a non-Health Ministry perspective.

Data Collection Methods

A self-administered questionnaire was used to collect data from key informants. The respondents were encountered face to face, the importance of the study was explained, the self-administered questionnaire was distributed and the respondents were requested to fill the same and make it available for collection within 3 days. For those not willing or able to answer the questionnaire within 3 days, the completed questionnaire was collected at their convenience. The respondents were constantly reminded and encouraged to respond, and those who returned the completed questionnaire were rewarded with a token of appreciation.

In addition, a comprehensive literature review was carried out to document the major milestones of HSR in Sri Lanka.

Data Collection Instrument

A structured questionnaire comprising open and closed-ended questions was developed for data collection. The questionnaire consisted of 2 portions. The first portion was designed to collect selected background information on the respondent, which were used to assess the credibility of the respondent against the response. The second portion of the questionnaire was a mixture of open and closed ended questions, out of which some were pre-coded.

(4) RESULTS AND DISCUSSION

Outcome of Key Informant Survey

The survey, as mentioned previously, was carried out among 100 key informants across a wide range of fields. The response rate was 74%. The most common reason provided by the non-respondents was that “the questionnaire was too hard”, that they are “unaware of what was exactly meant by health system reforms” or “too busy to answer” and, finally, the “questionnaire was too lengthy”.

1) Profile of Key Informants

Table 5.1.1 Affiliations of Respondents

CATEGORY	NUMBER INCLUDED IN THE SURVEY	NUMBER RESPONDING	PERCENTAGE RESPONDING
Ministry of Health (Line Ministry)	40	36	90
Provincial Health Ministries	10	8	80
Other Ministries	5	3	60
University/Academic Institutions	10	8	80
Private Sector Institutions	5	3	60
NGOs	5	2	40
Consumer/Patient Groups	5	3	60
Expert Advisory Panels	5	3	60
International Organizations	5	2	40
Professional Associations	5	3	60
Research Organizations	5	1	20
Retirees in Government Sector	3	2	66
TOTAL	100	74	74.

2) The findings

The findings suggest that Health System Reform (HSR) can be defined as “Sustained purposeful change in order to achieve the maximum efficiency, effectiveness, quality and equity of the health system”. It is important to note that 3 (4.1%) key informants explicitly showed their dislike to the term “Reforms” and suggested alternative terminology such as “Change”, “Modernization” or “Re-organization”. This indicates that a certain degree of resistance could be anticipated in using the term “Reforms”, although it may directly linked to its concept.

3) Important Elements of Health System Reforms in a Country

Table 5.1.2 Important Elements in HSR in a Country

ELEMENTS	FREQUENCY	%
Improving efficiency	70	94.6
Improving equity	63	85.1
Increasing responsiveness to local needs	63	85.1
Improving effectiveness	60	81.1
Development of human resources for health	58	78.4
Responding to changing socio-economic dimensions	49	66.2
Enhancing Private-Public Mix	47	63.5
Decentralization (transfer of authority to smaller institutions) and/or reorganization of provincial ministries	44	59.5
Alternative approaches for financing health	44	59.5
Reorganization of Ministry of Health	43	58.1
Reducing cost for the health system	35	47.3

Note: Multiple answers were provided.

4) Important Elements of HSR in Sri Lanka

Table 5.1.3 Important Elements of HSR in Sri Lanka

ELEMENTS	FREQUENCY	%
Decentralization (transfer of authority to smaller institutions) and/or reorganization of Provincial Ministries	44	59.5
Reorganization of the Ministry of Health	33	44.6
Development of Human resources for Health	32	43.2
Increasing responsiveness to local needs	27	36.5
Improving equity	23	31.1
Improving efficiency	21	28.4
Improving effectiveness	20	27.0
Reducing cost	20	27.0
Public private mix	15	20.3
Alternative approaches for financing Health	16	21.6

Note: Multiple answers were provided.

5) Areas in which Sri Lanka Should Undergo Reforms

Table 5.1.4 Areas in which Sri Lanka Should Undergo Reforms

AREA	FREQUENCY	%
Reorganization Of the Ministry Of Health	21	28.4
Decentralization (transfer of authority to smaller institutions) and/or reorganization of Provincial Ministries	21	28.4
Increasing responsiveness to local needs	37	50.0
Improving efficiency	44	59.5
Improving effectiveness	36	48.6
Improving equity	40	54.1
Reducing cost for the health system	34	45.9
Development of human resources for health	23	31.1
Responding to changes in socio-cultural dimensions	22	29.7
Alternative approaches for financing for health	35	47.3
Enhancing Private-Public Mix	24	32.4

Note: Multiple answers were provided.

6) Factors Important in Health Sector Reform in Sri Lanka

Table 5.1.5 Factors Important in Health Sector Reforms in Sri Lanka

FACTORS	FREQUENCY	%
Financial resources constraints	12	16.2
Increasing health demand	9	12.2
Policy considerations	6	8.1
Political pressure	5	6.8
Pressure from trade unions and other organizations	5	6.8
Donor perception and interest	3	4.1
Equity issues	2	2.7

Note: Multiple answers were provided.

7) Factors that Have Forced the MoH to Embark Upon Health Sectors Reforms

Table 5.1.6 Factors that have Forced the MoH to Embark on Reforms

FACTORS	FREQUENCY	%
Increasing health demands	52	70.3
Financial constraints	47	63.5
Pressure from donors	47	63.5
Political reasons	44	59.5
Equity issues	33	44.6
Public pressure	22	29.7
Overall reform of the government	14	18.9

8) Important End Points of Health System Reforms

Table 5.1.7 First Most Important End Points

PRIORITY	END POINT	FREQUENCY	%
1	Improving the performance of the health care delivery system through system empowerment	24	32.4
2	Establishing a sustainable system which will be in place with the changes in other sectors	22	29.7
3	Establishing a systematic process which will enable regular evaluation	20	27.0

9) Organizations that Should Take the Leadership in Carrying Out the Reform

Table 5.1.8 Organizations that Should Take Leadership in Reforms

ORGANIZATION	FREQUENCY	%
Ministry of Health	44	59.5
Ministry of Health with the support of Provincial Health Ministries	5	6.8
Political Leadership	3	4.1
Nominees of the President/Prime Minister	2	2.7
Government	15	20.3
No response	5	6.8
Total	74	100.0

10) Organizations that Play an Active Role in Health Sector Reforms

Table 5.1.9 Organizations that Play an Active Role in HSR

ORGANIZATIONS	FREQUENCY	%
Private organizations	27	36.5
Non-Governmental Organizations	22	29.7
Consumer Groups	13	17.6
Ministry of Finance Planning, Policy Planning	24	32.4
Trade Unions	3	4.1
Ministry of Health	9	4.1
Medical, Paramedical Organizations	1	1.4
Provincial Health Ministries	8	10.8
Professional Organizations	4	5.4
Universities	2	2.7

Multiple answers were provided

11) Key Stakeholders of Policy Development for Health Sector Reforms.

ORGANIZATION	FREQUENCY	%
Health Ministry	69	93.2
Provincial Governments	61	82.4
Professional Associations	60	81.1
Private Health Sector	59	79.7
Health-related Ministries	59	79.7
Community Groups	54	73.0
Municipalities and Local Govt.	45	60.8
Trade Unions	42	56.8
Health industries, e.g. Pharmaceuticals	37	50.0
Non-Governmental Organizations	37	50.0
UN Agencies	30	40.5
Legislative groups	29	39.2
International NGO'S	26	35.1
Mass Media	21	28.4
Bilateral Donors	20	27.0
Religious Bodies	12	16.2
Development Banks	9	12.2

Note: Multiple answers were provided.

12) Responsible Organization

Of the key informants, 65 (87.8%) were of the view that the Ministry of Health is primarily responsible for the planning and implementation of health sector reforms. Only 2 (2.7%) respondents stated that the Ministry of Policy Planning, Presidential Task Force, should bear the primary responsibility of implementing the reforms, while 5 (6.8%) respondents in general mentioned "Government" as the responsible organization.

13) Participatory modalities that could be deployed in the development and implementation of the policies pertaining to HSR

MODALITY	FREQUENCY	%
Discussions	69	93.2
Meetings	55	74.3
Reviews and analysis by research organizations	55	74.3
Advocacy	46	62.2
Internal Departmental reviews	45	60.8
Use of Mass Media	43	58.1
Lobbying	31	41.9
Political Campaigns	11	14.9
Demonstrations	9	12.2
Referenda	5	6.8

Note: Multiple answers were provided.

14) International Assistance

A total of 61 (82.4%) respondents stated that international assistance would be beneficial for the development of HSR in Sri Lanka, while 13 (17.6%) responded negatively. When requested to specify the type of international assistance that is required, 41 (55.4%) and 20 (27.0%) respondents named financial assistance and technical assistance respectively.

Recommendations

All stakeholders, especially those from the Ministry of Health, should be made aware of the Health Sector Reforms (HSR) in general as a means to overcome the challenges faced by the health sector. They should be provided with opportunities to develop insight on reforms that take place within and outside the region.

The officials of the Ministry of Health should be empowered to critically review the needed reforms in the health sector. Representatives from the private Health Sector, and also other sectors, should be invited to participate during these activities.

All stakeholders that are responsible for reforms should be brought in to identify and plan reforms during the planning stage. The Ministry of Health may take the leadership in the process.

Based on and backed by the evidence, the reforms necessary to face the emerging challenges should be identified. The Ministry of Health should proactively collaborate with other sectors in doing so.

The reforms should be planned meticulously, with a participatory approach with all stakeholders. The policy framework for planning should be explicitly stated.

Assistance from all stakeholders should be obtained for the implementation of reforms. A mechanism should be developed for the efficient monitoring and evaluation of the reforms.

* * * * *

This section was prepared by Dr Shanthi Dalpatadu (former Deputy Director of Planning) and Dr Thushara Fernando (Director of Planning), MoH.

5.2

PRIVATE CO-OPERATION AND
COLLABORATION IN HEALTH SYSTEMS OF
SRI LANKA

(1) INTRODUCTION

Sri Lanka, despite its status as a developing country, has an efficient health care delivery system. Vital health indicators such as Maternal Mortality Rate, Infant Mortality Rate, Birth and Death Rates, and Life Expectation at Birth, have steadily improved, despite the low per capita health cost enabling comparison with even a few developed countries.

The health system of Sri Lanka consists of an allopathic system and other native, Ayurvedic, Unani and Siddha systems, which have evolved over thousands of years. However, the Allopathic system which was established two to three hundred years ago, is deeply rooted among urban and rural areas, the rich and the poor, the educated and the uneducated, irrespective of any socio-economic barriers.

In Sri Lanka, both Public and Private Sectors are responsible for the provision of health care. Statistics reveal that the Public Sector provides health care for more than 95% of the population. It has been estimated that the state Sector provides 95% of the inpatient care and a little less than 50% of the outpatient care. The Ministry of Health, Nutrition & Welfare services and the Provincial Health Ministries encompass the entire range of preventive, curative and rehabilitative health care provision.

The Private Health Sector provides mainly curative care, which is estimated to be around 50% of the outpatient care and about 5% of the inpatient care, and is largely concentrated in the urban and suburban areas. The one-day general practice morbidity survey in Sri Lanka (1998) has estimated that general practitioners in Sri Lanka provide medical care for at least 26.5% of primary care consultations every year.

A recent study conducted on general practitioners in Sri Lanka reveals finer details about the numbers and services provided by general practitioners, providing outpatient care from Private clinics, on a fee-for-service basis. This is further supplemented by the Private practice of the Government-employed medical practitioners, who may work from home, clinics or Private hospitals. However, the inpatient care by the Private Sector is restricted to a small number of hospitals and nursing homes, in urban and suburban areas. These are being staffed by full-time Private practitioners and/or by medical officers who are working in the Government Sector.

The existing health policy clearly reflects the Government's will in promoting the Private Health Sector. Over the years, more and more financial and other privileges and benefits have been provided to the Private Sector with the intention of facilitating investment on health. The results are evident with a marked development of the Private Health Sector over the past ten years.

With the rapid development of the Private Sector, the Sri Lankan health system has been challenged in a few but yet important issues. There have been many questions that have been raised in many forums for discussion but these still remain unanswered.

They are:

- Should the Government get actively involved in collaboration with the Private Sector? What are the views of the Government health officials and the Private Sector representatives in this regard?
- In such collaboration, what support does the Private Sector expect from the Government/Government Health Sector?
- Similarly, what does the Government expect from the Private Sector in order to maximize the efforts for provision of better health care?
- Can the two parties arrive at a consensus and identify areas in which both parties are willing to provide for each other, for the benefit of Consumers?

Another aspect that should be studied in order to enhance the Private-Public collaboration is to carefully review what elements are being presently shared by the Government and the Private Health Sectors.

- What is the disparity between the ideal and the reality?
- Can this disparity be minimized? And how?

The third aspect is to determine what action has been proposed by the Government Health Sector to coordinate and to regulate the Private Health Sector.

- Does the bill address the issues that will be identified by the above questions?

A fourth, and one of the most important aspects, is to explore the opinions of Consumers in this regard.

- Do Consumers expect the Government health system to cooperate and collaborate with the Private health system effectively?
- What is Consumer's opinion on the Government's action to regulate the Private Sector?

These are the questions that need careful answering, in order to strengthen the Public-Private collaboration and coordination. To date, no systematic attempt has been made to determine a set of answers for the above questions. This study is designed with a view to obtaining answers for the research questions mentioned above and to determine what action can be proposed to maximize the Private-Public Health Sector collaboration and coordination.

(2) OBJECTIVES

General Objective

To study the existing coordination/regulatory mechanism between MoH and Private Health Service (PHS) and the factors that need consideration for strengthening it.

Specific Objectives

1. To identify the elements of mutual assistance required by the Private and Public Health Sectors for effective collaboration;
2. To determine the level of existing mutual assistance between the Private and the Public Health Sectors;
3. To explore the views of patient and Consumer groups, for an ideal Public-Private collaboration and regulation mechanisms;
4. To describe the contents of the Private Medical Institution (Regulation) Act, with respect to the identified elements of Public-Private Collaboration; and
5. To identify the components of the Private Medical Institution (Regulation) Act which are already in place and those that need implementation.

(3) METHODOLOGY

A descriptive study design was used to determine the elements of an ideal coordinating/collaborating mechanism between the MoH and the Private Health Service (PHS) and to assess whether there is such a mechanism in existence.

This descriptive field study was designed to study the existing coordination/collaboration mechanism between the MoH and the Private Health Service (PHS) and to identify the factors that need consideration for the development of such coordination and collaboration.

Study Setting and Sample Size

The study was carried out in three different settings. A sample of 90 officials from the Ministry of Health, Nutrition and Welfare, Universities, and other professional organizations, who were holding positions directly in relation to the health system development in Sri Lanka, were selected for the study, out of which 59 responded.

Secondly, a sample was drawn from those who are working directly and indirectly for Private medical organizations including Private hospitals, general practices, medical laboratories, insurance companies, and home nursing care organizations. A sample of 70 was selected using a snowballing technique, out of which 41 responded.

In addition, 50 Consumers of medical care from Consumer organizations, patient/human rights groups and Community groups were selected for interview.

Data Collection Methods and Instrument

Structured interviews were carried out using self-administered questionnaires. The respondents were encountered face-to-face and briefed on the value of the study, the questionnaire was distributed and the respondents were requested to fill the questionnaire and make it available for collection within one week. The respondents were reminded and encouraged to respond, and were rewarded with a token of appreciation on returning the questionnaire to the study team.

The Consumer and the Community groups were selected using a snowballing technique and the questionnaire was introduced by trained interviewers.

Two structured questionnaires were developed for data collection. The respondents from the MoH, the Private Health Sector and other sectors were interviewed with a common questionnaire while the consumer/Community groups were interviewed using a second questionnaire. The questionnaire consisted of a mixture of open and close-ended questions, of which some were pre-coded.

(4) RESULTS

Structured interviews were carried out using self-administered questionnaires. The respondents were encountered face-to-face and briefed on the value of the study, the questionnaire distributed and the respondents were requested to fill the questionnaire and make it available for collection within one week. The respondents were reminded and encouraged to respond, and were rewarded with a token of appreciation on returning the questionnaire to the study team. The Consumer and the Community groups were selected using a snowballing technique and the questionnaire was introduced by trained interviewers.

Table 5.2.1 Details of Respondents and Response Rates

Category	# Selected	# Responded	Response Rate %
1 Ministry of Health, Nutrition & Welfare	60	40	66.6
2 Private Health Sector	70	41	58.6
3 Other Sectors	30	19	63.3
4 Community/Consumer groups	50	50	100.0
Total	210	150	71.4

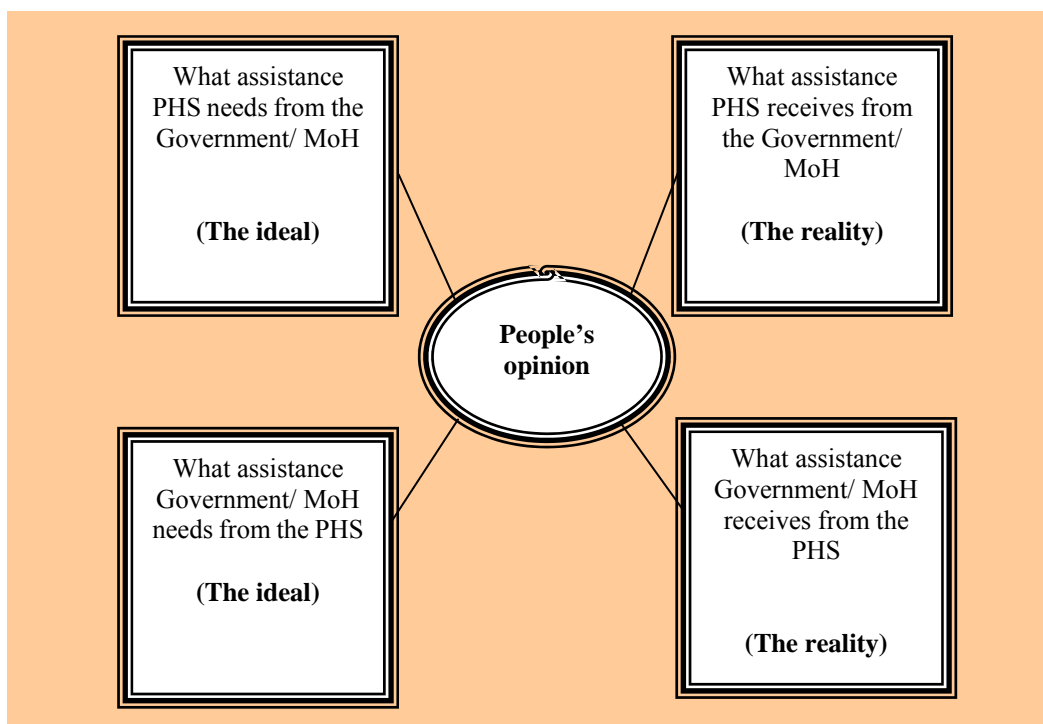


Figure 5.2.1 The Research Context

(5) CONCLUSIONS

The opinion survey was carried out among a diverse group of key Informants selected from the Ministry of Health, Nutrition & Welfare (MoH), the Private Health Sector (PHS), and from other sectors such as Universities, the Ministry of Education, the Ministry of Finance etc. Those whom were selected as respondents were holding senior positions in their work settings, and could be considered as credible and responsible enough to respond to this questionnaire.

A sample from Consumer groups and Community groups were also interviewed during this survey. The perceptions of these groups were sought on selected issues, with a view to understanding their views on the need for coordination/collaboration between the two Sectors on these issues.

The response rate varied from 58.6% to 100.0% for different categories. The average response rate was 72.1%, which was high.

The study clearly showed the willingness and the positive mindset of respondents for active participation, cooperation and collaboration in activities between the MoH and the PHS.

All respondents were of the view that the Government/MoH should assist the PHS by extending financial assistance, sharing information, sharing Human Resources and Human Resource Development, cooperating in transfers, referrals etc., and by assisting in improving quality in service delivery. Similarly, except for financial assistance, all groups were of the unanimous view that the PHS, too, can assist the MoH in the same fields described above.

The views of the Consumer group were similar in these areas. They also stressed the areas for partnership building, with special emphasis on Human Resources Development, information sharing and enhancing cooperation in terms of transfers and referrals etc. among state and private groups.

Provision of financial assistance to the PHS was considered favorably, mostly by respondents of the PHS, compared to those of the MoH. The Consumer group also held a strong view that the Government should provide financial assistance to the Private Health Sector. Describing the modes of financial assistance, the respondents recommended the removal of duty on medical equipment and drugs, expansion of health insurance coverage/universal health insurance, removal of commercial tariffs etc., could be adopted as measures that could assist the development of the PHS. It was clearly shown that the assistance provided by the Government/MoH in these areas is minimal in the present context.

All respondents, irrespective of their category and affiliation, were of view that sharing information was vital as an element of Public-Private Corporation. The willingness to participate shown by the PHS, in the information collection process and information sharing mechanisms, was stressed. The respondents from the MoH also identified information as an area where the PHS can assist the MoH. Both groups were of the view that the extent of information provided to each sector is minimal.

The assistance that the MoH can provide to the PHS in Human Resource Development was highly valued by all respondent categories, including the Consumer/Community groups. This shows the eagerness of all stakeholders to provide and receive a range of quality services through a network of well-trained health care workers. It was revealed that the PHS, too, can play an active role in the development of Health Human Resources, especially basic training, and the value of joint in-service training was also highlighted. Lack of opportunity for the PHS to get engaged in activities, in relation to Human Resource Development, was emphasized.

The assistance MoH can provide in areas such as transfers/referrals, sharing resources for investigation, formalizing Government staff for working in Private settings and enhancing collaboration between the PHS and MoH institutions and Universities was highlighted. The majority of the Consumer/Community groups viewed transfers and referrals between the institutions of the two Sectors very favorably. However, in the present context, it seems that such regular coordinating mechanisms are not available.

The need for quality control, as a means of strengthening Public-Private cooperation and collaboration, was viewed very highly by all respondents. Almost all respondents representing the PHS, MoH and other sectors clearly stated that standards for quality control should be developed along with Private Health Sector participation. The concept of joint accreditation was stated as a means to improve quality of care. The Consumer/Community groups also viewed this as a very important area.

Opinions on the existing role of the MoH, in providing assistance as stated above, were expressed. It was clearly shown that the MoH presently does not have a formal mechanism to assist the PHS in these areas. A lack of initiative by the MoH to adopt a participatory approach in this regard was emphasized.

It was the view of the MoH staff that the Government is providing assistance to the PHS by providing training in the area of human resources. The assistance extended by the MoH in cooperation was also viewed as unsatisfactory by the respondents. Almost all respondents from the two groups were of the view that, in the present context, there is no formal transfer or referral scheme between the Government and the Private medical institutions.

Through the responses of all categories, there was an indication that the MoH does not have a policy to maximize the cooperation and collaboration with the Private Health Sector. Lack of mechanisms to do so in the current context was clearly reflected in this study.

The Consumer and the Community groups stated the importance of the MoH in regulating the PHS. The respondents emphasized the value of such mechanisms and were of view that such mechanisms should be developed by participatory approaches with the PHS and Consumer groups.

(6) RECOMMENDATIONS

- A policy should be developed to maximize the cooperation and collaboration of certain activities between the Ministry of Health, Nutrition & Welfare and the Private Health Sector.
- As an initial measure, a core group within the MoH should be identified to study the areas of cooperation and collaboration with the PHS. Members from various disciplines should be mobilized as the members of the core group who, in turn, should propose a mechanism to enhance the collaborative process.
- A committee comprising representatives from the MoH, the Private Health Sector, and other sectors should be formulated to study the existing drawbacks and obstacles for such collaboration and to propose mechanisms to establish the collaborative process. This group may be strengthened with a few Consumer/Community representatives, in order to bring in proposals from the Consumers of Health Care.
- Some studies on the cost efficiency of certain services and investigations in the Government Hospital setting and in Private Health Sector institutions should be carried out. Any decisions on the out-sourcing of services should be carefully considered, based on the results of these studies.
- The Private Health Sector has a definite role to play in the information sharing process, sharing Human Resource Development and in joint quality control mechanisms. The maximum participation of the PHS in these areas should be encouraged.
- The Government/MoH should assist Private Health Sector development by extending some assistance to the PHS, such as certain types of financial assistance, free accessibility to relevant information, sharing technical knowledge on Human Resource Development and assistance in developing quality control programmes.

* * * * *

This section was prepared by Dr Thushara Fernando (Director of Planning), MoH.

5.3

DECENTRALIZATION OF HEALTH SECTOR IN SRI LANKA

(1) INTRODUCTION

With the establishment of Provincial Councils, consequent to the passage of the 13th amendment to the Constitution, health administration, along with the rest of the peripheral administration in the country, was almost entirely decentralised.

The establishment of the Provincial Councils (PCs) in 1988, intended to be a solution to the North and East conflict, was introduced throughout the country. It was perceived as constituting a radical departure from the centralized form of governance Sri Lanka had practiced since emerging from colonial rule. The “Provincial Councils System” that has been functioning for over a decade has passed through several rounds of elections and constitutes a legal and administrative reality for managing public affairs and human development in the country.

The PC that was constituted for the North East was dissolved in 1991 but the system continued to operate in the rest of the country, and this study is about the experience of the devolution of power in those provinces in relation to the services provided in the Health Sector.

There has been much criticism of the “system” and its functioning, not the least its justification as a form of governance in the local context, costs of maintenance, and benefits accruing to people. Serious concern has been expressed regarding its effect on the long-term territorial integrity of the country, its impact upon the economy and, not the least, its efficacy in bringing about a “genuine” devolution of power needed to address the fundamental issue that it was meant to resolve. By contrast, the “provincial administrators” seem to have viewed the system as yet another set of legal and administrative institutions concerned with the conduct of public affairs at the provincial level. They are of the view that Provincial Councils have failed to become effective institutions of devolved governance due to “legal and administrative” problems.

This report is a detailed study of the existing decentralised system, with a view to understanding its strengths and weaknesses and identifying areas for improvement.

With special focus on the health sector, an analysis of Sri Lanka’s experience with Provincial Councils and its impact on the Health Delivery System was carried out.

Accordingly, the study does not examine the political concerns of devolution in Sri Lanka nor does it attempt a financial analysis to identify the advantages and disadvantages of decentralisation.

All of the provinces, namely, Western, Central, Southern, North/East, North Western, North Central, Sabaragamuwa and Uva were covered for this study.

The study was carried out using a critical analysis of the actual operation of this system in order to study the impact of this form of governance on the delivery of Health Services to the community; an analysis of all the statutes enacted by all the Provincial Councils and, through interviews with key officials in the PC as well as in the Health Ministry in the Provincial and Central government, to analyse the efficiency and effectiveness of the decentralised system.

Special recommendations have been given, based on the findings which included a survey of senior officials in the health sector. It is important to note that though the decentralization process through the 13th Amendment took place due to political pressure, and not with the main objective of delegating powers to local level to provide an effective and efficient service, the study clearly shows that the Provincial Councils did not take advantage of the powers given them through the Provincial list and also the Concurrent list.

(2) OBJECTIVES

General Objective

The general objective is to study the existing decentralised system with a view to understanding its strengths and weaknesses and identify areas for improvement.

Specific Objectives

- a. To describe the evolving structure of the health sector since the 1980s as officially set out in legislation or policy documents;
- b. To describe the actual roles/responsibilities of these different levels in practice and how these have evolved since 1988;
- c. To examine the degree of management autonomy that hospital managers currently hold, and how this autonomy might be increased gradually;
- d. To review the current basis of resource allocation for decentralized units (procedures and criteria used) and to examine how resource allocation procedures and criteria can be changed to promote equity between provinces and more efficient resource use;
- e. To identify, through policy analysis, the main factors that explain the nature and degree of decentralization in Sri Lanka since 1988 (explaining patterns identified in objectives 1-4), and which are likely to constrain decentralization in the future; and
- f. To provide policy recommendations and guidelines on how to improve the decentralized system, in terms of defining the appropriate responsibilities and powers for different levels, and the most appropriate lines of accountability.

(3) METHODOLOGY

- A literature review of the relevant legislation, statutes and executive decisions in setting up the decentralised system of governance was carried out.
- This is followed by an analysis of the actual operation of this system in order to study the impact of this form of governance on the delivery of health services to the community.
- Interviews with government officials involved in resource allocation to Provincial Councils. (A **key informant survey** was carried out to identify and clarify roles, responsibilities and functions of Provincial and Deputy Provincial Directors within the decentralized health system for carrying out selected functions of finance, human resource development and service provision).
- The study was conducted among selected higher officials in the Ministry of Health (Line Ministry) and Provincial Ministries of Health. In the Provincial setting the study was confined to 3 categories - Provincial Director of Health Services (PDHS), Deputy Provincial Director of Health Services (DPDHS) and Divisional Directors of Health Services (DDHS). From the Ministry of Health, selected officials holding senior administrative posts were selected. **Forty (40) key informants were selected**, among them 10 senior officials from the Line Ministry, 8 Provincial Directors, 12 Deputy Provincial Directors and 10 Senior Divisional Directors of Health Service.
- A **self-administered, structured, open-ended questionnaire** was developed and field tested and, using this as a guideline, key officials in the PC as well as in the Health Ministry were interviewed, in addition to studying available secondary data to analyse the efficiency and effectiveness of the decentralised system. The questionnaires were handed over to respondents personally by two research assistants. The respondents were requested to post the completed questionnaire within 1

week. In all, 26 officials responded to the questionnaire. The provinces covered were Western, Central, Southern, North/East, North Western, North Central, Sabaragamuwa and Uva.

Table 5.3.1 Details of Respondents

Category	Selected		Response Rate	
	#	%	#	%
1 Line Ministry Officials	10	25	5	12.5
2 Provincial Directors	8	20	5	12.5
3 Deputy Provincial Directors of Health Services	12	30	10	25.0
4 Divisional Directors of Health Services	10	25	6	15.0
Total	40	100	26	65.0

(4) LIMITATIONS OF THE STUDY

- The establishment of the PCs was intended to be a solution to the North-East conflict. However, it was introduced throughout the whole country. The PC that was constituted for the North and East was dissolved in 1991 but the system continued to operate in the rest of the country, and this study is about the experience of devolution of power in those provinces in relation to the services provided in the Health Sector.
- The study does not examine the political concerns of devolution in Sri Lanka.
- The study does not attempt a financial analysis.

(5) THE PROCESS OF DECENTRALIZATION AND THE EVOLVING STRUCTURE OF THE HEALTH SECTOR IN SRI LANKA

Defining Decentralization

Decentralisation has been defined differently, making for much ambiguity in the usage of the concept. The core of the concept is the transfer of state power and authority to perform specified services to organizations located closer to the public to be served. Whereas such transfers are usually territorial, they can also be functional. Transfer of authority to perform can be within formal political structures (devolution), public administrative and parastatal structures (deconcentration), or to a non-state agency (privatization).

According to a United Nations definition, “Decentralization is a PROCESS that helps to improve the quality of GOVERNANCE in a state by ensuring that decision-making is made closer to those who are affected by those decisions.”

It is the basis of sub-national government. It is an institutional arrangement on the part of the government in order to become responsive to citizen’s needs and preferences. It involves reallocation of powers, on the one hand, between different tiers of government and, on the other, between the government, the private sector and community organizations.

Strategies of decentralisation have been applied in several context of local governance, yielding various results. The traditional emphasis on the role of local governments has been augmented by decentralisation programmes designed for economic and political processes and all types of administrative processes.

Ministry of Health Organization Chart - 1986

In 1986, there was a change in the Health Administration. A new Ministry was created, “Ministry of Women’s Affairs and Teaching Hospitals”. With this change in the Health Administration, the Colombo Group of Teaching hospitals and the Teaching hospitals Galle, Kandy and Jaffna came under the Administration of the new Ministry. In 1989, these two Ministries were again amalgamated.

In 1983, there was a change in the designation of the staff of the Ministry of Health and the Decentralised Units. The “Director Health Services” was designated “Director-General Health Services.” This was one of the recommendations made by Dr. Cumpston in 1950 but it was not implemented at that time. The Deputy Directors were designated “Deputy Directors - General Health Services” and the Assistant Directors were designated “Directors.” The Superintendents of Health Services were designated “Regional Directors of Health Services”.

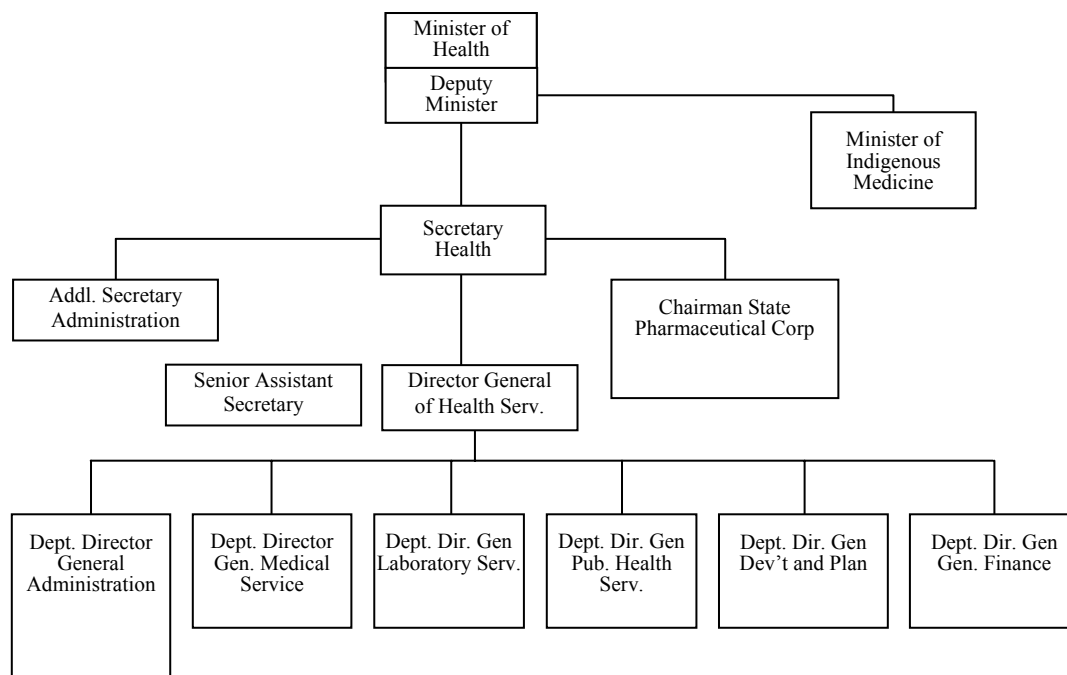


Figure 5.3.1 Ministry of Health Organization Chart - 1986

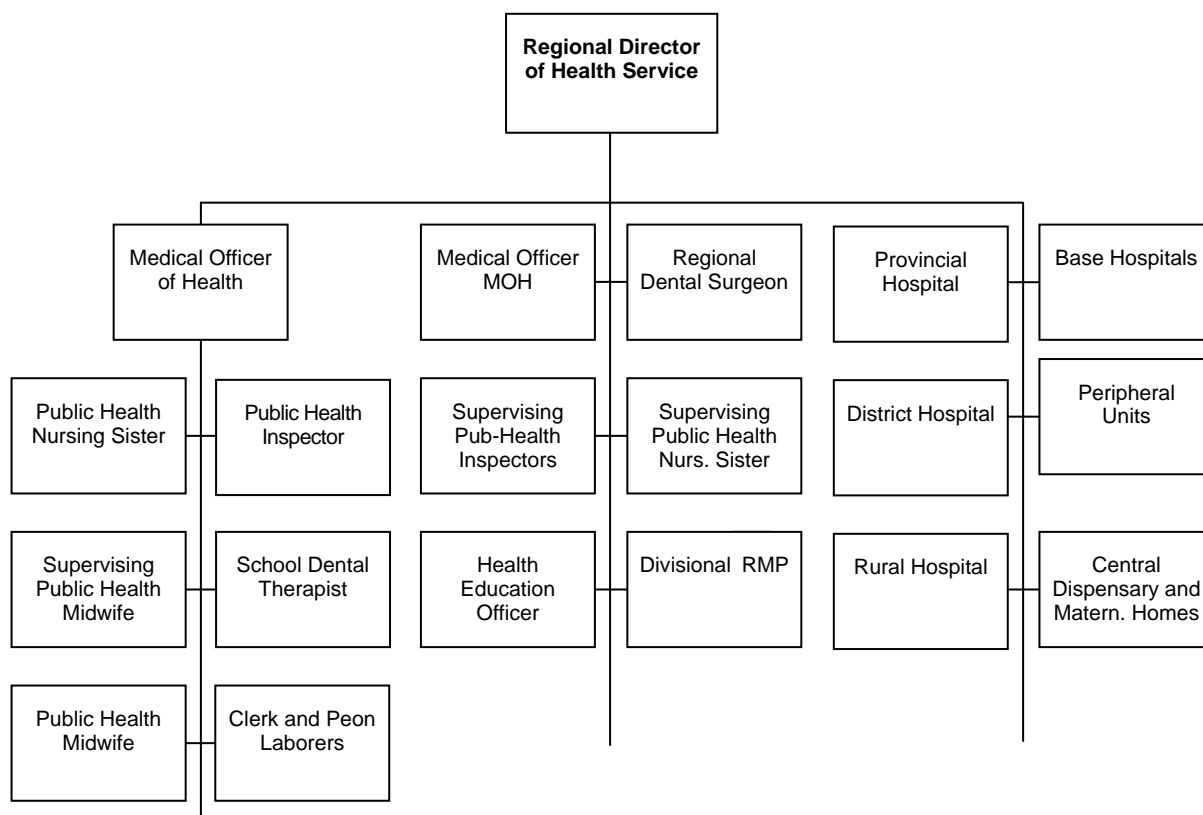


Figure 5.3.2 Regional Health Service

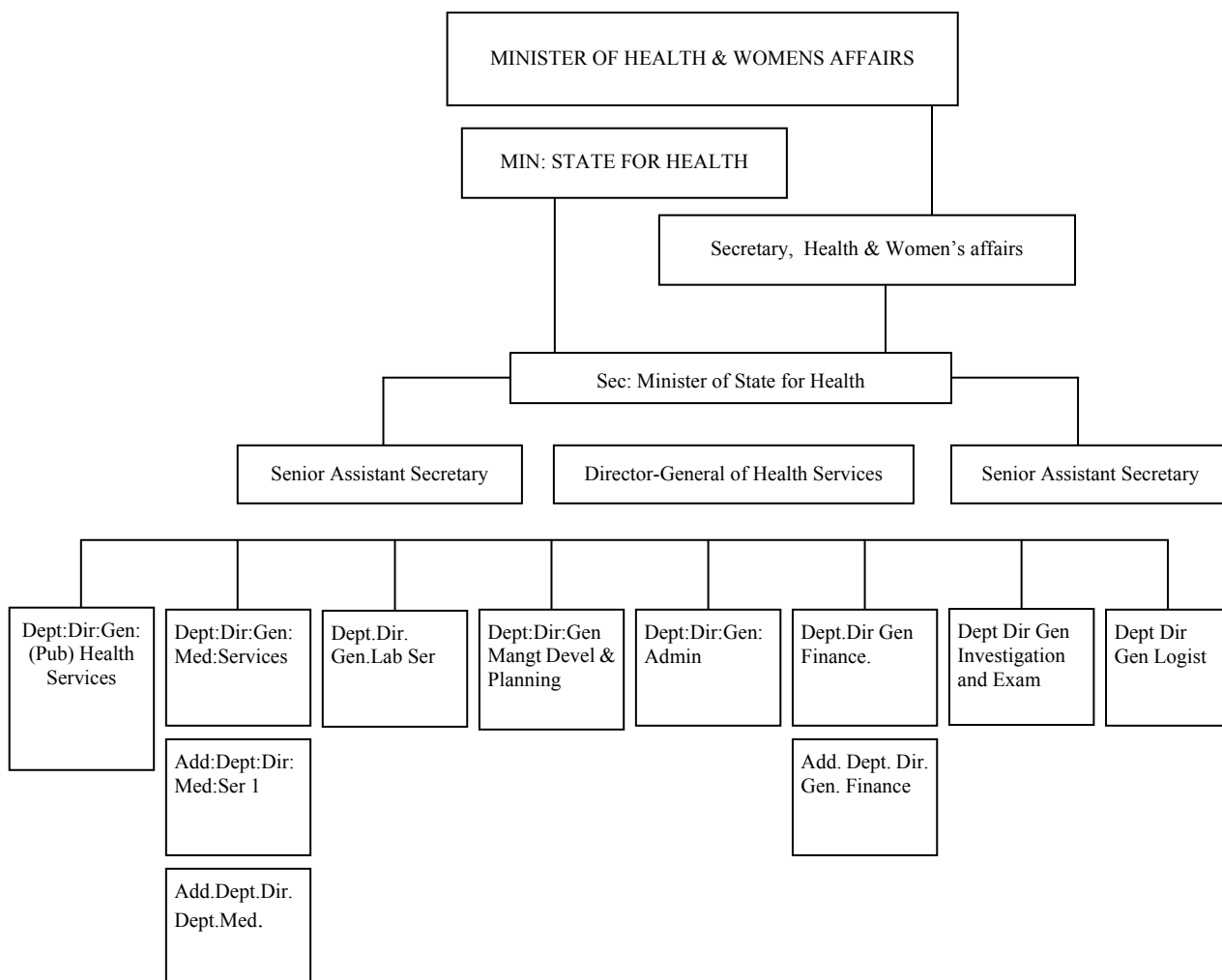


Figure 5.3.3 The Organization Chart of the Ministry of Health and Women’s Affairs after the Devolution of Powers to the Provincial Councils

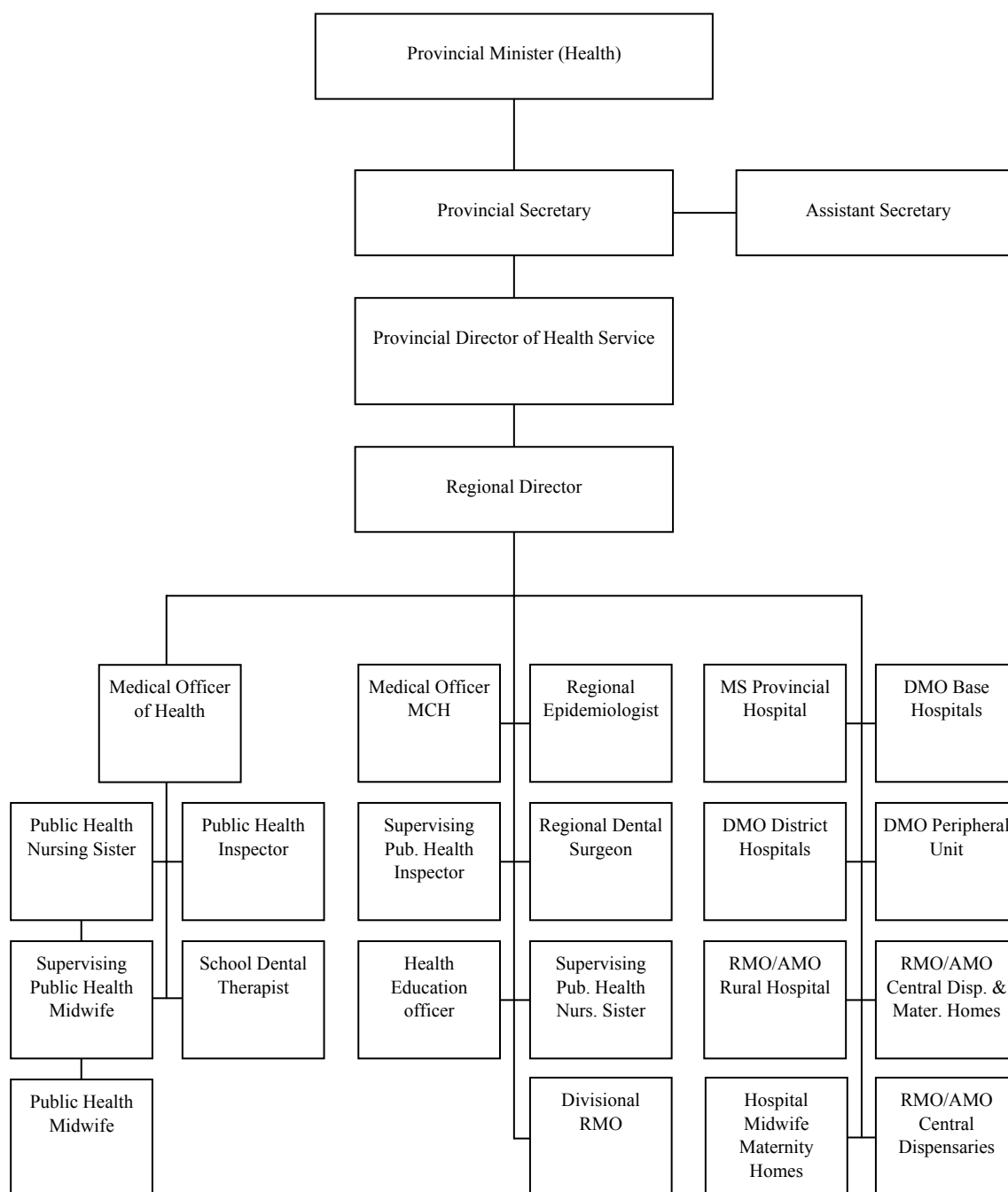


Figure 5.3.4 Organisation of Health Services Under Provincial Councils after the Devolution

(6) ESTABLISHMENT OF PROVINCIAL COUNCILS

With the establishment of Provincial Councils in Sri Lanka, in 1988, consequent to the passage of the 13th Amendment to the Constitution of the Democratic Socialist Republic of Sri Lanka, certified on 14th Nov 1987, and the Provincial Councils Act No 42 of 1987, the Health Administration, along with the rest of the peripheral administration in the country, was entirely decentralised or rather devolved.

Under the 13th Amendment, the Central Government retains exclusive responsibility only for national (health) policy - vide List 11 (the Reserved List) and by implication under List 1 (Provincial Council List) for teaching hospitals and hospitals established for special purposes.

List 111 (Concurrent List) provides for the Central Government to share responsibility with the Provincial Councils for such health administration activities as schools for training of auxiliary medical personnel; supervision of private medical care; population control and family planning. The rest of the entire health care system is devolved to the Provincial Councils, under List 1 (the Provincial Council List).

The establishment of the Provincial Councils (PCs), in 1988, was perceived as constituting a radical departure from the centralized form of governance Sri Lanka had practiced since emerging from colonial rule. The “Provincial Councils System” has been functioning for over a decade and passed through several rounds of elections. It constitutes a legal and administrative reality for managing public affairs and human development in the country. The PCs have also passed through changes of government at the centre, also involving change of the political party in power. Accordingly, they have been exposed to many vicissitudes in relations with the government at the centre. The system was introduced in the face of much criticism, as well as opposition marked by violence with major political parties boycotting the first elections. However, having gone through several rounds of elections, the Provincial Councils System (PCS) has come to be accepted by all political parties, at least tacitly by those who opposed the system by contesting for representation in the PCs.

The assignment of responsibilities between the center and the provinces is defined by legislative, executive, fiscal and administrative arrangements. They define the scope and extent of the assignment of responsibilities to provinces and what has been retained by the centre.

In the Provinces

1) Statute Making Powers in Respect of the Province

A PC may make statutes applicable to the province in respect of subjects under the Provincial Councils List in terms of Article 154G (9). Accordingly, when a PC passes a statute on a subject where there is already a law, which in its long title is described as inconsistent with that law, the statute makes it inoperative within the province so long as the statute is in force. The governor of the province must give his assent to statutes passed by a PC. Statute making powers of a PC are subject to certain conditions and limitations.

- In respect of concurrent subjects after such consultation with Parliament: and,
- Where there is a law already passed, subject to Parliament’s power to decide to the contrary by a resolution.
- In respect of Provincial Council Subjects to the extent specified.
- Within the framework of national policy.

In this context, it is important to note Parliament’s power to pass laws in respect of subjects under the Provincial and Concurrent Lists.

- In respect of Provincial Subjects, after such a Bill has been referred to every PC by the President and where such Councils agree the Bill is passed by a simple majority and where one or more Councils do not agree by a two-thirds majority.
- Where one or more Councils request, by resolution, to make laws on any matter set out in the Provincial List.
- In respect of subjects in the Concurrent List after such consultation with all the PCs.

2) Provincial Policy Formulation and Implementation

Executive powers in respect of subjects where PCs may make statute are vested in the Governor of the Province. Executive powers may be exercised in the following ways.

- Directly by the Governor.
- Through the Ministers of the Board of Ministers.
- Officers subordinate to him.

When there is a Board of Ministers the Governor exercises executive powers with the aid and advice of the Board of Ministers. Accordingly, de-facto responsibility for policy formulation and implementation rests with the members of the Board of Ministers who are collectively responsible and answerable to the Provincial Council. Accordingly, the Board of Ministers headed by the Chief Minister as constituting the executive branch of the provincial system, is responsible for provincial policy and implementation.

The President appoints a Chief Secretary, with the concurrence of the Chief Minister for each province under the Provincial Councils Act, 42 of 1987. Whereas the law does not specify the powers and duties of the Chief Secretary, the role and responsibility in relation to provincial financial management is set out in the Financial Rules formulated by the Governor. Accordingly, the Chief Secretary functions as the Chief Accounting Officer in respect of the financial operations of the provincial administration. This role responsibility makes the Chief Secretary the head of provincial administration.

3) Resources Mobilization and Expenditure Management

The 13th Amendment assigns, to PCs, the revenue from twenty sources set out in the Provincial List. The Amendment also provides for the allocation from the Annual Budget such funds as are adequate for the purpose of meeting the needs of the Provinces. In this regard the Government is expected to make such allocation on the recommendation of and in consultation with the Finance Commission. A provincial council is a competent spending authority.

4) Staffing and Personnel Management

The Provincial Councils Act 42 of 1987 provides for a Provincial Public Service (PPS). The appointment, transfer, dismissal and disciplinary control of the officers of the PPS are vested in the Governor of the Province. The Governor may delegate his powers to a Provincial Public Service Commission (PPSC) for that province. The Governor of the province appoints the PPSC. The PPSC functions as an independent body, and any attempt to influence its decisions is made an offence punishable by the High Court. The establishment of a provincial public service and an independent PPSC seeks to secure functional autonomy of a PC in respect of staffing and personnel management.

5) The Service Delivery System

The assignment of expenditure responsibilities to PCs for the provision of public goods and services calls for institutional and organizational arrangements to take care of their delivery to people. The law does not specify any institutional or organizational arrangements for service delivery. It is important to note that PCs took over, from central government line ministries and departments, the service delivery operations in respect of the Provincial List activities. These activities organized as Provincial Departments or Provincial Authorities (established under Statutes passed by PCs) constitute the core of the provincial service delivery system.

The provincial service delivery system is coordinated spatially at the divisional level by the Divisional Secretary (DS), except for Health and Education that have tended to remain outside the DS's purview. While the Provinces have tended to work through the DS, LAs have remained outside the mainstream of the provincial delivery system. The service delivery system should be envisaged in a broader sense than a narrow concept of a network of service outlets. It refers to the whole set of institutional and organizational arrangements that have a role and function in the provision of public goods and services to people.

6) Governance Capacity and Capability

Devolution must lead to empowering the periphery for local development action. Then, in turn, institutional strengthening at the local level is essential to creating a demand for devolution at the periphery. A necessary corollary of the transfer of responsibilities is the transfer of expertise to perform those functions. The responsibilities that have been transferred on devolution to PCs are not only operational. Devolution to PCs brings out a provincial policy, planning and budgeting responsibility. Legislative and executive competence to act creates a provincial governance role and responsibility that calls for a provincial governance capacity and capability, that is qualitatively different from an aggregation of a set of discrete departmental operations that existed prior to devolution to PCs. Therefore, the capacity and capability to take action in responding to needs and preferences of people in their jurisdictions is a necessary element of the system of devolved governance in the province.

7) At the Center

1. National policy formulation
2. Designing inter-governmental transfers
3. Establishing and managing centre-province relations
4. Cadre and staffing
5. The administration of "home affairs"

(7) PROVINCIAL COUNCIL LIST - LIST I (NINTH SCHEDULE)

According to the Ninth Schedule of the Amendment, Provincial Ministries of Health were to have the following roles:

Health

1. The establishment and maintenance of public hospitals, rural hospitals, maternity homes, dispensaries (other than teaching hospitals and hospitals established for special purposes);
2. Public health services, health, education, nutrition, family health, maternal and child care, food and food sanitation, environmental health;
3. Formulation and implementation of Health Development Plan, and the Annual Health Plan for the Province;
4. The provision of facilities for all the institutions referred to in 1 above, within the Province, excluding the procurement of drugs;
5. Awarding of Scholarships for Post-Graduate Education within Sri Lanka to personnel attached to the Institutions specified in 1 above.

Indigenous Medicine - Ayurvedic, Siddha and Unani

1. Establishment of Ayurvedic dispensaries and hospitals, grants to such dispensaries and hospitals;
2. Establishment and maintenance of herbaria.

(8) INSTITUTIONS MANAGED BY THE CENTRE

In addition to the hospitals mentioned above, there are a number of institutions which will continue to be managed by the Ministry of Health. These institutions are:

1. Cancer Control
2. Mental Health
3. Anti-Tuberculosis Campaign
4. Anti-Leprosy Campaign
5. Anti-V.D. Campaign
6. Anti-Malaria Campaign
7. Anti-Filariasis Campaign
8. Central V.D. Clinic, Colombo
9. Judicial Medical Officer, Colombo, Galle, Kandy, Jaffna, Colombo South, Peradeniya
10. Port Health Officer, Colombo
11. Port Health Officer, Galle
12. Port Health Officer, Talaimannar
13. Quarantine Officer, Deans Road
14. Family Health Bureau
15. Health Education Bureau
16. Public Health Veterinary Office
17. Office of the School Medical Officer, Colombo
18. Medical Statistician
19. Food Quality Control Laboratory
20. Medical Research Institute
21. National Blood Transfusion Service
22. Epidemiological Unit
23. State Medical Supplies
24. Bio-Medical Engineering Services
25. Directorate of Medical Technology and Supplies

(9) TRAINING INSTITUTIONS MANAGED BY CENTRE

1. National Institute of Health Sciences and all health institutions in the project area of NIHS
2. Post Basic School of Nursing, Colombo
3. 10 Nurses Training Schools
4. Dental Therapists Training School, Maharagama
5. School of Radiography
6. School of Medical Laboratory Technology
7. School of Physiotherapy

(10) FUTURE DECENTRALIZATION

Following the establishment of the Provincial Councils and the devolution of power to the councils, the Government, in 1992, decided to further decentralise powers to the periphery.

The administrative functions of the government were transferred from the district to the sub-district, i.e., to the divisional level (decentralization).

For this purpose, the Government established smaller administration units at the level of the Divisional Assistant Government Agent. This unit was designated as the Divisional Secretariat, and the Divisional Assistant Government Agent was designated as the Divisional Secretary. Most of the functions carried out by the Government Agent at the Kachcheries were delegated to the Divisional Secretaries in charge of the Divisional Secretariats.

The objective of these changes in the administration was to bring the administration closer to the people at the level of the Pradeshiya Sabha.

To conform to these changes in Public Administration, the Health Administration had to be restructured. Health Administration units were formed corresponding to the Divisional Secretariats. The administration and management of provincial health services were assigned to the Medical Officers in charge of these Health Administration Units, which were designated "Divisional Directors of Health Services", DDHS.

Each DDHS area has a population of about 60,000 to 80,000. A DDHS area will have one or more Divisional Health Centres (DHC). The DHC will provide comprehensive health care-curative and preventive services. All DDHS in a district were made accountable to the Deputy Provincial Director of Health Services (DPDHS), who is the chief authoritative officer at the district level.

The person responsible for all activities of the Province is the Provincial Director of Health Services.

Therefore, the decentralization process in the Health sector has been devolution of power to Provincial Councils (to PDHS) and decentralization of administration within the provinces to DDHS.

Table 5.3.2 Different Levels of Decentralization

Level	Health Services	Public Administration	Elected by
National	Ministry of Health, Nutrition and Welfare	Ministry of Home Affairs, Provincial Councils and Local Govt.	Parliament
Provincial	Provincial Ministry of Health, Pro. Sec. Health, Pro. Dir. Health	Chief Secretary	Provincial Council
District	DPDHS (RDHS)	(GA) District Secretary	District M.P.
Divisional	DDHS	Divisional Secretary	Municipal Council Urban Council Pradeshiya Sabha
Sub-Divisional	AMP, RMP		
Village	PHM	Grama Niladhari	Gramodaya Mandapaya

Functions at Divisional Level

The Divisional Health Organization (DHO) headed by the Divisional Director of Health Services will ensure the Provision of Comprehensive, Promotive, Preventive, Curative and Rehabilitative Primary Level health care to all the people in the division. It will include, amongst others, the following services:

1. Collection, analysis and interpretation of Basic Vital and Health Data;
2. Basic Epidemiological Investigation with focus on micro-epidemiological work;
3. Essential Maternal Health Services;
4. Family Planning Services;
5. Essential Child Health services (Infant/Preschool);
6. School Health Services;
7. Immunization against vaccine preventable diseases;
8. Essential Environmental Health Services;
9. Prevention and control of communicable diseases such as Rabies, Malaria, Sexually transmitted diseases, Leprosy, Filariasis, Tuberculosis, HIV/AIDS, Japanese encephalitis, Dengue Haemorrhagic fever etc.;
10. Prevention and control of non-communicable diseases;
11. Nutrition;
12. Health and Nutrition Education; and
13. Primary Level Medical Care services including early diagnosis and prompt referral.

Health Administration Operates at Three Different Levels

- At the bottom level - the Local Authorities, functioning with technical collaboration with the peripheral (village and divisional) layers of the provincial health administration.
- Next level - the provincial health Administration itself, with a Provincial Director and Regional Directors. Bulk of the health services and institutions fall into this category.
- The Apex - with a Director-General of Health Services, responsible for health care and institutions at that level, including teaching and specialised hospitals.

1) Local Government

At the time of independence, in 1948, the system of Local authorities in operation were Municipal Councils, Town councils and village Committees.

In 1981, Town Councils and Village councils were abolished and a system of district development Councils (DDC) was established under the provision of District Development Councils Act No.35 of 1980.

After realizing that the performance of the DDCs were not up to expectations, a new local authority called “ Pradeshya Sabha” was introduced in 1987 under the provision of Pradeshya Sabha Act No.15 of 1987 and DDCs were abolished.

At present, there are three types of Las, which number 309 in total.

The breakdown is follows:

Municipal Councils	14
Urban Councils	37
Pradeshiya Sabhas	238

In post-devolution Sri Lanka, the primary, if not the sole, concern hitherto has been a centre-province relation leaving out the local as a sub-system of provincial interests. The Thirteenth Amendment, while establishing Provincial Councils for every province, guaranteed the status of Local Authorities.

The assignment of the responsibility for the supervision of the administration of local authorities to PCs does not, and cannot, in any way detract the role and function of Local Authorities, and indeed the significance of “local” interests in the governance concerns of the nation or the provinces.

The powers and responsibilities of local authorities (Municipal Councils, Urban Councils and Pradeshiya Sabhas) constitute an integral sphere of devolution and a partner in devolved governance, making for a tripartite governance relationship.

Accordingly, the Thirteenth Amendment in effect establishes two arenas of devolved governance, i.e., the provincial and local.

Therefore, a third element that comes into health administration, as in the case of several other areas of public administration, is the considerable amount of health work assigned to Local Authorities (Municipal Councils, Urban Councils and Pradeshiya Sabhas) by statute. They include such public health matters as the following:

- Promotion of Public Health
- Drainage
- Conservancy on scavenging
- Unsanitary buildings
- Latrines
- Nuisances

It is not unusual to find some Local Authorities, especially the Municipalities, also providing curative care through their dispensaries and clinics, both of the Western and Ayurvedic systems.

Since under the 13th Amendment to the constitution, *Provincial Councils can enlarge, but not curtail, the powers entrusted to Local Authorities*, these health activities also gain constitutional validity and remain as part of the health administration of the country.

It would seem that, in effect, Local Authorities find themselves stranded in a scheme of devolution where they must relate to the province on matters of administration and the centre in respect of matters of national policy.

2) Analysis and Findings

a. Involvement in the Preparation of Health Budget in the Area

Table 5.3.3 Involvement in Preparation Health Budget in the Area

Involvement	PDDHS		DPDDHS		DDDHS	
	#	%	#	%	#	%
1 Yes	5	100	1	10	1	16.7
2 No	0	0	9	90	5	83.3
Total	5	100	10	100	6	100.0

- Results clearly show that Provincial Directors are involved in budget preparation.

b. Authority to Allocate Expenditure Depending on the Need

Table 5.3.4 Authority to Allocate Expenditure on Need

Authority	PDDHS		DPDDHS		DDDHS	
	#	%	#	%	#	%
1 Yes	1	10	0	0	0	0
2 No	4	40	10	100	6	100
Total	5	100	10	100	6	100

- Except for one province the PDDHS has no authority to allocate expenditure depending on needs.

3) Level of Dependence on Central Finances

Table 5.3.5 Level of Dependence on Central Finances

Level of dependence	PDDHS		DPDDHS	
	#	%	#	%
1 Total	4	80	10	100
2 Partial	1	20	0	0
3 Totally independent	0	00	0	0
Total	5	100	10	100

- All provinces except one said that they were totally dependent on central finances.
- The province that stated that it was partially dependent said that 85% of its finances came from Central financial sources. The other 15% came from such sources as international and national non-governmental organizations.

4) Possibility of Becoming Financially Independent within Next Three Years

Table 5.3.6 Possibility of Financial Independence within Three Years

Financial independence	PDDHS		DPDDHS	
	#	%	#	%
1 Yes	0	0	0	0
2 No	5	100	10	100
Total	5	100	10	100

The unanimous view was that provinces would not be able to achieve total financial independence within three years.

5) Constraints for Provinces to Become Self-sustainable

- The existing health policy does not allow the collecting of user fees
- Non-availability of health statutes in the provinces
- Lack of autonomy in the provincial settings
- Provincial income generation is not adequate for financing the health system in the province
- Provincial environment is not conducive and attractive for investors
- Lack of vision among political leaders
- Unavailability to directly obtain foreign financial assistance
- Local and international brain drain

6) Suggestions to Overcome the Drawbacks

Table 5.3.7 Suggestions to Overcome Drawbacks

Suggestion	PDDHS		DPDDHS	
	#	%	#	%
Constitutional reforms	2	40	5	50
Administrative reforms	3	60	5	50
Clearing of grey areas in the constitution (remove the concurrent subjects)	4	80	8	80
Strong support from the Line Ministry	4	80	7	70
More autonomy for requirement	3	60	4	40
More authority at PDHS level	3	60	2	20
Adequate resource allocation	5	100	7	70
Strengthen capacity at the provincial level	3	60	3	30
More authority at district level	2	40	6	60
Closure of Provincial Directors Office	0	0	3	30

7) Power to Recruit Required Workers

Table 5.3.8 Power to Recruit Required Workers

Authority for recruitment	PDDHS		DPDDHS		DDDHS	
	#	%	#	%	#	%
1 Yes	2	20	0	0	0	0
2 No	3	30	10	100	6	100
Total	5	100	10	100	6	100

- Two Provincial directors stated they have the power for recruitment but specifically stated it was only for Minor Staff. The rest answered “No” but added that they too can recruit Minor Staff.
- It is important to note that Provincial directors do not have authority to recruit any other categories: Medical, Paramedical, or Clerical except Minor Staff.

8) Responsible Personnel for Special Programmes
(Malaria Control, HIV/AIDS and Dengue Control)

The responses provided by the PDDHS and DPDDHS are given below.

Table 5.3.9 Responsibility for Special Programmes

Programme	Policy Making	Planning	Implementation	Supervision	Evaluation
Malaria Control Programme	LM	PD/DPD	DPD	PD/DPD	LM/PD/DPD
HIV/AIDS Control Programme	LM	PD/DPD	DPD	PD/DPD	LM/PD/DPD
Dengue Control Programme	LM	PD/DPD	DPD	PD/DPD	LM/PD/DPD

Lm - Line Ministry: **PD**- Provincial Director: **DPD**- Deputy Provincial Director

- It is clear that policy development in the present context is done by the Line Ministry, while planning is considered as the joint responsibility of PDHS and DPDDHS. Implementation was the responsibility of the Deputy Provincial directors and Supervision responsibility was shared by PDHS and DPDDHS. The group agreed that the Line Ministry also has a role to play in evaluating these programmes along with PDHS and DPDDHS.

9) Accountability

Table 5.3.10 Accountability

Accountability	PDDHS		DPDDHS	
	#	%	#	%
1 Governor /Chief Provincial Secretary /Provincial Health Secretary	5	100	5	50
2 Secretary Health LM/DGHS	3	60	3	30
3 Provincial Director			10	100

The striking feature in these responses were that three Provincial directors and a few DPDDHS claimed their accountability was to the Director-General of Health Services (DGHS) and the Secretary of Health of the Line Ministry (i.e., Accountability was to the Centre and not the Province).

10) Passing of Health Statutes in the Provinces

Only two Provincial directors stated that their provinces have passed health statutes. Two more Provincial directors stated that, although health statutes have been formulated, their provinces are still to pass them.

11) Well-defined Duties

Except for one PDHS and one DPDHS, all other PDHS and DPDHS stated that they do not have a duty list. Three DDHS stated they have duty lists while the rest said “No”.

12) Empowerment to Perform Duties

Except for one Provincial Director, the others (PDHS, DPDHS, DDHS) stated that they are not adequately empowered to perform their duties. However, two of the officials from the Line Ministry were of the view that the Provincial Directors are empowered to carry out their duties.

Conclusion

In Sri Lanka, the devolution of powers has taken place within the framework of a unitary state. Due to this, the Parliament of the Central Government is still supreme with regard to the exercise of the sovereign power of the state. In this context, the Provincial Councils virtually become subordinate to the Parliament, although their powers and functions have been demarcated and set out by the constitution. Thus, the Provincial Councils have not been created on the basis of true federal principles, which involve not only the division of administrative powers but also the political powers between the centre and the regional units. In the case of Provincial Councils, only the administrative powers have been divided but not the political power. As a result, the Provincial Councils are not sovereign and they do not have powers independent of the supremacy of the Parliament. It should be noted here that all matters relating to the origin of the Provincial Councils, such as the decision to establish them, the demarcation of their powers and functions and the form of organisation, were unilaterally decided and defined by the Central Government.

At present, there is much criticism of the decentralised system and the way it works. Some of the reasons are:

- costs of maintenance,
- the benefits accruing to people.
- serious concern expressed regarding its effect on the long-term territorial integrity of the country,
- impact upon the economy,
- its efficacy in bringing about the “genuine” devolution of power needed to address the fundamental issue that it was meant to resolve, and
- “legal and administrative” problems.

In order to ensure sustainable development, consensus is growing that governments need to create new relationships with global, regional, and local institutions, and with non-state-owned enterprises and citizens organizations. This calls for creative partnership between multiple actors, including business groups, state and local bureaucracies, NGOs and CBOs.

Conclusion from Survey

- The PDHS are involved in the preparation of the health budget, while in general the DPDHS were of the view that they were not involved directly.
- The PDHS do not have the authority to shift resources from one budget allocation to another. Similarly, the PDHS stated that they do not have the authority to allocate expenditure depending on the need.
- Today's provincial health system is totally dependent on central government for financing. Even in the future, there is no hope that the province could be self-supporting. Difficulties of provinces in generating own revenue has been identified as the main cause for this inability.
- The provinces have no responsibility for the basic training of technical categories of health workers. However, they do have a responsibility for the in-service training of all categories. The provinces have limited authority to transfer health workers within the district. Furthermore, the Provincial Directors do not have adequate authority in disciplinary matters. The authority in the same fields among DPDHS is very minimal.
- The responsibility of service delivery lies with the districts and the divisions. However, the responsibility for policy development lies more with the central ministry. The responsibilities for planning, monitoring and evaluation are shared by the Line Ministry, Provincial Ministries and the District Health Offices.
- All respondents are of the view that the effectiveness and the efficiency of the provincial health system is still below standard.
- The important drawbacks for these deficiencies are issues related to human resources, lack of authority and autonomy, inadequate infrastructure facilities, financial constraints, lack of support from the centre and political influences.
- The respondents from the provincial settings were of the view that the practice of the Line Ministry to take over institutions under its care is incorrect.
- All respondents were of the view that the present resource allocation mechanism is unsatisfactory and the basis for resource allocation for the provincial health systems should be changed.
- The need for further decentralization of the powers to the district level was implied.
- The PDHS and the DPDHS do not have a specified list of duties.

(11) RECOMMENDATIONS

Overcome Legal Constraints

In order to overcome this situation, the Provincial Councils should be provided with legal experts to write statutes and, in a similar manner, the Local authorities should be provided with the expertise to formulate by-laws.

Provincial Policy Formulation

The making of statutes must be preceded by the formulation of provincial policy in respect of the subjects where executive action is contemplated. However, in order to carry out this function effectively, the “grey area” in this subject area must be made clear. An inadequate definition of the Subjects devolved has been one of the deficiencies highlighted.

Financial Allocations

The annual allocations should be given based on work output, efficiency indicators of the institutions. Institutions should earn the allocations. For the implementation of the recommendations, departments should undertake unit work studies such as cost per bed day in various disciplines, cost per intervention, cost per laboratory test etc. Computer programmes could be developed for the allocation of funds based on performance.

Generating Funds

At present, the generation of funds by Provincial Councils is very poor. According to the present policy, all funds generated at the institutional level go to the consolidated funds. This does not give any incentive for the institutions to generate funds. A policy decision has to be taken to retain the funds, generated at the institutional level, with the institution itself. A 75% share of the funds are to be utilized for the development/improvement of the efficiency of the institution, and the balance to be credited to the national/provincial health funds, to be used for national/provincial health development activities.

Capacity Building

The Provincial councils should have control over their cadre. It becomes difficult to maintain discipline by the superiors when the subordinates know that action cannot be taken against them without the involvement of other key actors. Regular in-service training programmes have to be developed for all categories to improve their skills and improve quality of care. Organize a tripartite (with the Ministry of Health, public sector organizations and donor agencies such as JICA, ADB, World Bank) institution for training of mid level technical categories such as Radiographers, Physiotherapists, and MLTs for public and private health sector. This institution should be supervised by the Ministry of Health for training, curriculum development and conducting the examinations. It can be a fee levying institution. If the Health sector is to be strengthened in the provinces, there is a need for local administrators to learn new skills in policy analysis and planning, resource management, management of science and information, technology and other strategic areas of development.

The Constitution

A legal team should be appointed to look into the aspect of providing more flexibility to the Provincial councils by overcoming the present identified obstacles, while retaining the unitary status of the country.

Information Capacity Building for Provincial Councils

Local communities which cannot take advantage of the information revolution and surf this great wave of technological changes become “information-isolated islands” and may be crushed by it. In that case, they are likely to be even more marginalised and economically stagnant in the future than they are today. Hence, the information revolution offers provincial councils and local governments a dramatic opportunity to leapfrog into the future, breaking out of decades of stagnation or decline.

Demonstration Projects

Rather than having awareness programmes through seminars and workshops, it is more beneficial to have a few demonstration projects where an actual problem is identified and the consultants work through until the results are achieved.

(12) RECOMMENDATIONS COMING OUT OF THE SURVEY

- All Provincial Directors and Deputy Provincial Directors should be made aware of their roles, responsibilities and functions and this must be routinely carried out, particularly those who are newly appointed to these posts
- The duties that are specified in the Provincial Council List and the concurrent list must be carefully reviewed by a team composed of all stakeholders and steps must be taken to minimize confusion.
- The responsibility of the province in human resource development should be carefully reviewed. The feasibility of provinces to carry out basic training programmes should be explored. The provinces and districts should be strengthened to carry out in-service training for health workers of the province/district.
- The responsibilities in policy development, planning, monitoring and evaluation should be carried out on a shared basis by Line Ministry, Provincial Ministries and the District Health Offices.
- The policy of taking over secondary and tertiary care institutions under the Line Ministry should be carefully reviewed.
- The present resource allocation mechanism, and the basis for it, should be reviewed.
- The Line Ministry should assist the provincial health systems to carry out their duties efficiently and effectively, and should at all times assist the provinces and their health administrators.

* * * * *

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5.4

HEALTH LEGISLATION - OPINIONS OF FRONT LINE HEALTH CARE WORKERS AND COMMUNITY GROUPS

(1) INTRODUCTION

Law is described as the body of principles recognized and applied by the state in the 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 Parliament, 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 a 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. It also provides governments with a regulatory framework for implementation.

The term Medical Law is used throughout the world to indicate the areas of law that governs the practice of medicine, but according to the WHO digest of Health Legislation, there is no exact definition of this branch of law. Health Legislation expresses and formulates health policies. The terms of Medical Law and Health Law are often used side by side as if synonymous but, according to Van Olsten, it seems to be evident that the term “Health Law” has a wider meaning than the term “Medical Law”

As health issues are getting more and more complex day by day owing to emerging new diseases and new therapies, a closer link or cooperation is needed between law and medicine.

(2) OBJECTIVES

General Objective

The general objective of the study is to collect the existing important legislation pertaining to health in order to develop a synopsis, and to determine the opinions of front line health care workers and community members on different facets of health/medical legislation.

Specific Objectives

- 1) To describe the process of the formulation of legislation pertaining to health in a national and provincial context;
- 2) To review the current national and sub-national policies and practices in the conceptualization, formulation and enactment of bills, acts, regulations, laws, by-laws etc in Sri Lanka;
- 3) To make a compilation of selective legislation and amendments that relate to health;
- 4) To identify the legislation on the subject areas given above and write a synopsis; and
- 5) To carry out a survey to assess the opinion of selected categories of health care providers and recipients on the coverage and adequacy of current legislation pertaining to health and to identify areas for further strengthening.

(3) METHODOLOGY

Study Setting

The two studies were carried out among target groups of two settings. The first study included 50 frontline health care workers, from 8 districts, employed by the Ministry of Health, Nutrition and Welfare while the second study was carried out among 50 community members of different strata who were selected from 6 districts.

Sample Size

A convenient sample was selected in the two studies. However, measures were taken to select the respondents from different districts. The study on health care workers was carried out among all categories that are using medical/health legislation in their official work regularly.

Data Collection Methods

- 1) **A self-administrated questionnaire** was used to collect data from those that were considered to be front line health care workers. Fifty (50) selected frontline health workers from 8 districts (Kalutara, Ratnapura, Galle, Ampara, Kegalle, Puttalam, Moneragala and Mannar) were sent questionnaires. The respondents were sent the questionnaire along with a covering letter explaining the purpose of the study, and a reminder was sent two weeks later. The respondents were reminded and encouraged to respond. The self-administered questionnaires were hand-delivered and posted to the selected respondents and were collected within a month.
 - 2) **A field survey** was carried out among 50 informants selected from various strata of the community from six districts, namely, Colombo, Kalutara, Ratnapura, Galle, Kurunagala and Moneragala.
 - 3) **A Focus Group Discussion (FGD)** was held at the National Institute of Health Sciences, Kalutara for two groups. The two groups were:
 - FGD for Primary health care workers and Trainers of primary health care workers (Staff members of the NIHS)
 - FGD for Community Leaders (From the Districts where the field survey was conducted)
- (4) RESULTS OF THE SURVEY CARRIED OUT AMONG FRONT LINE HEALTH WORKERS.

Details of Respondents

A field survey was carried out among 50 informants selected among those that work as front line health care workers and who are expected to use medical/health legislation as part of their official work. These respondents were from eight districts that were selected, namely, Kalutara, Ratnapura, Galle, Ampara, Kurunagala, Puttalam, Monaragala and Mannar.

The different areas of commonly used legislation were The Food Act, Nuisance Ordinance, Bread Ordinance, Wells and Pits Ordinance, Cosmetics Devices and Drug Ordinance, Environmental Act, Cosmetic Devices and Drug Act and The Factories Ordinance.

Table 5.4.1 Details of Respondents

CATEGORY	SELECTED	RESPONDED
PHII/SPHII	40 (44.4%)	27 (54%)
Food and Drug Inspectors	8 (8.9%)	3 (6%)
DDDHS/MOOH	42 (46.7%)	20 (40%)
TOTAL	90 (100%)	50 (100%)

Sources of Supply of Legislation**Table 5.4.2 Sources of Supply of Legislation**

SOURCE	NUMBER	%
Provided Officially	45	90
Obtained from Co-worker/friend	42	84
Purchased by self	11	22

Causes of Non-Availability of Legislation**Table 5.4.3 Causes for Non-Availability of Legislation**

REASON	NUMBER	%
1. Ministry does not have a formal distribution system	26	52
2. Legislation not available for sale	31	64
3. Lack of knowledge on new amendments	13	26
4. Unable to get them duplicated in official setting	5	10

Note: Multiple answers were provided.

Reasons for Not Being Satisfied with Implementation of Legislation**Table 5.4.4 Reasons for Not Being Satisfied with Implementation of Legislation**

REASON	NUMBER	%
1. Delays in implementing litigation	21	42
2. Lack of proper legal backing from the Government	19	38
3. Unavailability of an official/supervisor at district level to provide technical support.	12	24
4. Legislation not being foolproof	11	22
5. No training on legislation applications	4	8
6. Lack of legislative power in the MoH	4	8
7. No participatory approach in bringing in new legislative amendments	6	12
8. Corruption within the system	6	12

Note: Multiple responses provided.

Areas of Legislation that Need Change**Table 5.4.5 Areas of Legislation that Need Change**

AREAS OF CHANGE	NUMBER	%
1. Food Act	14	28
2. Nuisance Ordinance	7	14
3. Environmental Act	13	26
4. Factories Ordinance	4	8
5. Cosmetics Devices and Drugs Ordinance	9	18

Areas that Need New Legislation**Table 5.4.6 Areas that Need New Legislation**

Are of New Legislation	Reason for Proposing	Number	%
1. Genetically Modified Food	Lack of Legislation	3	6
2. Abortion Laws	Lack of Legislation	1	2
3. Amendments to Mental Health Act	Too old	1	2
4. Litigation for malpractices	Lack of Legislation	1	2

Conclusions

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

Recommendations

- A system should be designed to enhance the dissemination of all relevant health legislation: both new and old (but still valid), along with relevant amendments to all users.
- All amendments to legislation should be brought to the notice of all front line users regularly and without delay.
- Adequate in-service training opportunities should be made available regularly for users of legislation.
- Important pieces of legislation should be periodically reviewed, and the necessary amendments should be made.

(5) RESULTS OF THE FIELD SURVEY CARRIED OUT IN THE COMMUNITY

The field survey was carried out among 50 informants from various strata of the community in the following 6 districts. Colombo, Kalutara, Ratnapura, Galle, Kurunagala and Moneragala.

Details of Respondents**Table 5.4.7 Details of Respondents**

Category	Number	%
1. State Groups	5	10
2. Teachers	5	10
3. Private Sector Groups	5	10
4. Priests	5	10
5. Restaurant owners/managers	5	10
6. Housewives	5	10
7. Pensioners	5	10
8. Lawyers	5	10
9. Grama Sewaka	5	10
10. Members of Pradeshiya Sabhas, Municipal and Provincial Councils	5	10
TOTAL	50	100

Important Areas of Health/Medical Legislation Specified by Respondents**Table 5.4.8 Important Areas of Health/Medical Legislation**

Area of legislation	Number	%
1. Food and Drugs act	7	14
2. Nuisance Ordinance	5	10
3. Control of Communicable Diseases	5	10
4. Environmental Act	3	6
5. Penal Code	1	2

Note: Multiple responses were provided.

New Areas of Legislation

New Area	Number	%
1. Legislation to regularize the private sector	13	26
2. Legislation on compulsory medical insurance	11	22
3. Clear laws on litigation on medical malpractice	6	12
4. Abortion should be legalized	5	10
5. Prohibit private practice by government doctors	4	8
6. Legislation to eliminate quacks	3	6
7. Euthanasia should be legalized	1	2
8. SLS standards to be introduced for all food items	1	2

Reasons for Dissatisfaction with Implementation**Table 5.4.9 Reasons for Dissatisfaction**

Reason	Number	%
1. Laws outdated – need amendments	14	28
2. No pressure from public	6	12
3. Incompetence of Health Care Workers (HCW)	6	12
4. Inadequate contact and interaction between HCW and community	5	10
5. Health Manager not effective	5	10
6. Corruption among Health Care Workers	4	8
7. Too many “loopholes”	4	8
8. Political interference	3	6

Necessity to Bring in New Legislation**Table 5.4.10 Necessity for New Legislation**

Necessity	Number	%
1. Very Necessary	33	66
2. Somewhat necessary	16	32
3. Not necessary	0	0
4. Unable to comment	2	4

Modes of Dissemination of Information**Table 5.4.11 Modes of Dissemination of Information**

Mode	Number	%
1. Newspaper	50	100
2. Tabloid	50	100
3. Radio	44	88
4. Television	50	100
5. Website	14	28
6. Brochures and booklets	37	74
7. Organized small groups	6	12

Conclusion on the Field Study

- The knowledge of community groups regarding health/medical legislation is not satisfactory.
- Their opinion on the implementation of such legislation is poor.
- The respondents were hungry for knowledge. However, their interests were different from the health workers. They showed an interest in certain areas such as medical ethics, litigation, medical negligence etc.
- People still prefer traditional modes of dissemination of medical legislation among the community.
- People want the legislation to be changed/amended in certain areas.
- Respondents strongly prefer to participate in activities in relation to the development of legislation.

Recommendations Coming Out of the Field Study

- Important pieces of legislation should be periodically reviewed, and the necessary amendments made.
- The community groups/members should also be allowed to participate actively when legislation is being developed.
- A system should be designed to enhance the dissemination of all relevant health legislation: both new and old, along with relevant amendments.
- Efforts should be made to maximize the implementation of health/medical legislation.
- Traditional modes should not be discontinued in disseminating health/medical legislation among the community.

(6) FOCUS GROUP DISCUSSIONS (FGD)

Focus group discussion where held for two groups of participants:

- Primary health care workers and trainers of primary health care workers (NIHS staff)
- Community leaders from areas of the field study

FGD for Primary Health Care Workers and Trainers of Primary Health Care Workers

Staff members of NIHS, Kalutara, participated and the discussion was led by a Community Health worker. The reporter was an assistant director of planning.

Highlight of the FGD of NIHS Staff

- The following were identified as officers who regularly use public health laws during their day-to-day activities - Medical Officers of Health, (MOH) Public Health Inspectors, Food and Drug Inspectors, Veterinary Surgeons, Port Health Officers, Judicial Medical Officers and Medical Officers/Airports.
- It was clearly seen that even Medical Officers of Health do not have some legal enactments but Public Health Inspectors had gone out of their way to collect the relevant documents.
- Facilities and the mechanism available to publish the information regarding health/medical laws are minimal, according to the respondents.

- When the present laws are changed, special programmes for MOH and Supervising PHIs are held to bring this to their notice during supervisory visits and during monthly conferences. However, the community is not made aware of these changes on a methodical basis.
- It was strongly felt that there should be coordination of work between the Health Ministry and the notice publication unit.
- They also highlighted the fact that many authorities hold responsibility for legislative powers and there is no proper coordination, e.g., Labour Ministry, Environmental Authority and Irrigation Department etc.
- It was pointed out that, rather than abolishing laws, it is more important to review laws regularly.
- New laws should be stipulated to protect the environment, and new laws to cover pre-schools and their administration, according to the participants.

Highlights of FGD for Community Leaders

- Some participants were of the view that health/medical legislation is a set of legal enactments which facilitate a healthy lifestyle while some others were of the view that it is a set of obligations that people must do willingly or unwillingly for the welfare of society, to achieve the objectives of the Health Ministry.
- On the issue of what amendments should be made to render health legislation more effective, much discussion was generated. The following are the salient points: The laws should not be a threat to society. Existing health legislation is adequate but people are not aware of the laws. They were of the opinion that community participation is very important in drafting or making amendments to laws.
- Another suggestion was to have new legislation and regulations for homes for the elderly and also legislation for the welfare and protection of children of migrant workers who are outside of Sri Lanka.
- They highlighted the fact that no law directly addresses domestic violence at present.
- There should be strict laws to ensure that prescriptions carry pharmaceutical names and not brand names of drugs. There should be laws to prevent the issue of drugs by pharmacies without prescriptions. Also laws governing nursing homes should be introduced.
- Laws related to garbage disposal should be introduced and violators punished.
- Laws to protect the rights of patients should be introduced, as patients in hospitals are helpless when the doctors go on strike.
- Consumer protection laws should be strictly enforced.
- All children to have an immunization card at school.
- Food authorities, with legal powers, to be established.
- The public should be given the opportunity to be knowledgeable on health legislation via seminars or mass media.

* * * * *

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CHAPTER 6

SURVEYS ON INDIGENOUS SYSTEM OF MEDICINE

6

SURVEYS ON INDIGENOUS SYSTEM OF MEDICINE

6.1

INDIGENOUS SYSTEM OF MEDICINE IN SRI LANKA

(1) INTRODUCTION

The term indigenous medicine does not necessarily refer to the practice of medicine indigenous to Sri Lanka. Both official statutes and the perceptions of the hierarchy of practitioners of indigenous medicine refer to a variety of medical practices of foreign origin together with an array of truly local traditions as 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 of Sri Lanka. Its influence has been epochal, commencing probably in the pre-Christian era and facilitated through cultural interactions between the two countries that runs through the entire history of Sri Lanka up to the present times. Such influence is evident in the medical texts of the great tradition, written throughout the history of Sri Lanka and, in present times, with the governmental formalization of Ayurveda since 1958, when the practitioners were sent to Indian institutions for training.

What are commonly referred to indigenous medicine are, therefore, practices of Ayurveda, Traditional Practices (*paramparika*) Siddha, Unani and Homeopathy. With the inclusions of Unani and Homeopathy and with the conviviality shown towards acupuncture of Chinese origin by the indigenous medical practitioners of Sri Lanka, opportunities seem to have been left open to incorporate any indigenous system, of whatever origin, as an indigenous medicine of Sri Lanka.

In the meantime, there are attempts to ethnicize Siddha with the Tamils of the North, Unani to Muslims of the East and Paramparika Ayurveda Practices to the Sinhalese of the South. However, ethnographic information is grossly lacking to support such claims.

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

(2) INSTITUTIONS AND HUMAN RESOURCES

The following tables have been generated from the information provided.

Table 6.1.1 Number of Physicians Registered under the Ayurvedic Medical Council, Sri Lanka

	As of 31st Dec. 2000	As of 31st Dec. 2001
Traditional (General)	4,855	4,707
Graduates		
BAMS	349	395
BSMS	189	209
BUMS	89	97
Diploma Holders	3,607	3,602
Diploma in Ayurveda Shastri	486	526
Total (1)	9,575	9,639
Special Traditional Physicians	(6,646)	(6,491)
Snake Bites	2,869	2,832
Fractures & dislocations	1,420	1,415
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
Total (2)	6,646	6,491
Total 1 + 2	16,221	16,130

Table 6.1.2 District Level Distribution of Curative Institutions and Human Resources of Selected Cadres

Districts	Government Large Hospitals >101 beds	Government Small Hospitals <100 beds	Government Dispensaries	Government Doctors ?	Government Nurses ?	Government Pharmacists
Colombo	02	03	03	16	06	03
Gampaha		02	07	18		03
Kalutara		02	05	13	02	01
Kandy		07				
Matale						
Nuwara Eliya						
Galle	01	02		18	01	01
Matara		03		20	01	
Hambantota	01	02				
Kurunegala	01	01		48	13	04
Puttalam		01		09		
Anuradhapura	01	05		23	03	
Polonnaruwa				14		01
Badulla		01	12	21	08	02
Monaragala		02	04	09		
Ratnapura	01	03		19	08	03
Kegalle		05		27	03	02
Jaffna	01					
Kilinochchi						
Mannar						
Vavuniya						
Mullative						
Batticaloa						
Ampara						
Trincomalee						

Note: Compiled by NDK/2003-02-12 and based on information provided by the Commissioner of Ayurveda.

Table 6.1.3 District Level Distribution of Traditional Practitioners and Traditional Practitioner Specialists

District	Practitioners	Practitioner Specialists
Colombo	1,194	595
Gampaha	1,356	711
Kalutara	634	330
Kandy	625	475
Matale	254	268
Nuwara Eliya	92	97
Galle	619	350
Matara	662	453
Hambantota	185	235
Kurunegala	1,210	820
Puttalam	128	228
Anuradhapura	232	307
Polonnaruwa	83	116
Badulla	159	225
Monaragala	67	202
Ratnapura	421	399
Kegalle	448	434
Jaffna	1,002	146
Kilinochchi	28	00
Mannar	29	07
Vavuniya	20	10
Mullative	16	02
Batticaloa	147	62
Ampara	139	77
Trincomalee	75	21
Totals at 31.12.2002	9,825	6,570

Note: Compiled by NDK/2003-02-12 and based on information provided by the Commissioner of Ayurveda.

Table 6.1.4 Comparison of Total Numbers by Practitioner Type: Private Sector

PRACTITIONER TYPE	PRACTITIONERS	SPECIALISTS
Ayurveda	8,295 (?9,825)	6,345 (?6,570)
Siddha	1,246	204
Unani	265	40
Homeopathy	n.a	n.a
Acupuncturists	n.a.	n.a
Totals (incomplete)	9,806	6,589

Note: Compiled by NDK/2003-02-12 and based on information provided by the Commissioner of Ayurveda. (These figures do not tally with figures of the previous table.)

(3) UTILIZATION OF SERVICES

Number of Patients

Information on the utilization of services among the various categories of practitioners, namely, the Siddha, Unani, Homeopathy, Ayurveda and *Paramparika*, are not available. Information or even indicators as to utilization in the private sector are lacking. Similarly, client perceptions regarding the sector, although scarce, have been elicited in several community medical and sociological studies on

health seeking behavior (to be accessed). This deficiency of information has led to much confusion regarding the claims of the practitioners of the indigenous medicine sector, particularly in relation to its *complementarity*, *competitiveness* and to being an *alternative* to biomedicine and its therapeutic outcomes.

Year 1999	Line Ministry	Provincial Government	Local Government
Institutions	03	46+121=167	230
Outpatients	176,139 (Avg:4892/M/Ins)	2,111,239 (Avg: 1053/M /Ins)	1,784,221 (Avg: 646/m/Ins)
Inpatients	3,236	25,621	
Totals for the year			
OUT Patients:	4,071,599		
IN Patients	28,857		

(Source: Department of Ayurveda)

Note: Data is for the government sector only

Biomedical Services

The percentage of biomedical services is 10 % of outpatients and 0.75% of inpatients.

No information is available on the socioeconomic background of these help seekers or about the ailments for which they sought interventions. A review of available literature on health seeking behavior has to be undertaken.

Similarly, a review of literature available in the biomedical sector on health seeking behavior may provide further information on the utilization of indigenous medicine services in Sri Lanka. Available hospital-based data could also shed more light on this aspect.

(4) CHALLENGES

The indigenous medicine sector has many challenges. Some of these, that are ideological in nature, are listed here. The problems that are operational are discussed in detail elsewhere in this report.

Scientific Scrutiny:

Although the underlying philosophy of Ayurveda is not empirical methodology, its disease categorizations 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.

Ayurvedization :

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

Biomedicalization:

This process may be taking place in the training and research centers where biomedical knowledge is being used extensively. Although this may fulfill the expectations of students and some academics who aspire to an image of a doctor of allopathics, there may be negative effects in terms of the practice and the overall outlook of the indigenous medical services. On the other hand, the process of biomedicalization may also help the IM practitioners to be reflective and develop agendas for good practice.

Model for Health:

In the absence 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, namely, the western system. The attempts to expand and develop indigenous medicine seem to have had little impact as they copy the administrative and practice patterns of the allopathic system, leading to duplication of services. This has left the indigenous medicine sector with a lesser bargaining power for revenue and recognition.

Commercial Exploitation:

Given present day interests in bio-diversification and traditional medical knowledge, there is ample room for exploitation of the indigenous medicine sector by the industry and practitioners of other systems of medicine and also from agencies and individuals within. The existence of a large number of medical "texts" giving thousands of recipes, and the specialist knowledge among traditional practitioners regarding herbs and other natural products of medicinal importance, may add to this burden.

"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.

(5) STRENGTHS

The "indigenous medicine" has many strengths and they are as follows:

1. A philosophy that supports particular lifestyles by promoting the health of persons of various age groups and communities and stressing the food, dietary habits, morality, social interactions and interactions with the environment. This transcends the health of the individual and the physicality associated with it;
2. Approximately 16, 000 practitioners are spread out in rural and remote areas;
3. Access to large numbers of medicinal recipes for various types of ailments commonly found among Sri Lankans;
4. Access to a knowledge based on herbs and other medicinal products available in and unique to Sri Lanka;
5. Availability of intervention methods (e.g., massage and *panchakarma*) that would promote health in those people needing long-term care;
6. Ability to incorporate yoga and meditation to promote healthy living and stress relief;
7. Availability of approximately 6,500 specialists who claim success in using techniques and in

- treating special disorders;
8. Political commitment to advance the practice;
 9. Public acceptance that it is natural medicine with little or no harmful effects;
 10. Existence of a large number of practitioners who have self-sustained practices (private sector); and
 11. Developing pharmaceutical industry that produces for export and caters to the private sector needs.

(6) WEAKNESSES AND PROBLEMS

Through the focal group discussion with invited stakeholders in the indigenous medicine field, the problems that were highlighted are shown in the following tables:

SETTING: Pharmaceuticals, Natural Resource Based Industry, Research

NO.	Problem
01	Lack of accepted (verifiable) standards for raw materials and finished pharmaceutical products in terms of composition, hygiene, and stability of the active ingredients
02	Non-availability of expert knowledge in the authentication of raw materials
03	Non-availability of quality control mechanisms and safety standards for all IM products (Industrial and practitioner-based preparations)
04	Increasing costs of raw materials and finished products
05	Non-availability of clear guidelines for patenting of products, recipes and endemic floral and faunal products
06	Insufficient medical evidence for the use of metals, poisons (<i>visa</i>) or poisonous substances and narcotics in practice
07	Non-availability of an overall research agenda relating to fundamentals of IM, its practice, industry and utilization of services
09	Non-existence of mechanisms to publicize IM research findings nationally and internationally
10	Lack of mechanisms to monitor standards
11	Lack of mechanisms for self-regulation and audit
12	Lack of promotion of market-oriented cultivation of medicinal plants

SETTING: Education & Human Resource Development

NO.	Problem
01	Non-availability of information on needs for human resource development planning
02	Lack of a performance appraisal system
03	Non-identification of training programmes for outsourcing
04	Lack of an institutional development plan for the NITM
05	Lack of proper admission guidelines for university training institutes
06	Lack of guiding principles regarding the structure of an administrative and service delivery institutions system
07	Insufficient provision of quality paramedical personnel training programmes
08	Insufficient availability of qualified trainers to run university and non-university courses
09	Lack of a continuous professional development programmes for various cadres of physicians both in public and private sectors
10	Poor knowledge of English among Ayurvedic physicians (also poor knowledge of Sanskrit and Hindi essential for postgraduate work)
11	Lack of clear objectives for postgraduate training programmes
12	Insufficient IT knowledge/ non-availability of IT knowledge for training, implementation, and monitoring and evaluation.
13	Non-availability of quality training programmes for nurses, physiotherapists, yoga-meditation teachers, and nutrition facilitators
14	Non-availability of coordinated community programmes on self-care and home gardening

SETTING: Policy Formulation and Financing

NO.	Problem
01	Delays in having the Ayurveda Act amended
02	Lack of an overall strategy to have indigenous medicine incorporated into the general health system
03	Insufficient information on user expectations of indigenous medicine
04	Non-availability of sufficient information on the human resource needs of indigenous medicine systems
05	Non-availability of epidemiological and other relevant information necessary for planning
06	Lack of needs-based financing mechanisms for an integrated medical service development
07	Insufficient inter-sectoral coordination among institutions within the sector and outside relevant agencies in implementing their respective functions
08	Non-availability of a clear policy on the role of the private sector
09	Insufficient political commitment to promote IM as a complimentary/alternative health service

SETTING: Service Delivery

NO.	Problem
01	Lack of consensus on the competency levels of various practitioners (government and non- government)
02	Non-availability of an IM model for the provision of services (e.g., Family Practitioners, Experts in Promoting Health, Health Activist!)
03	Conflicting ideologies relating to service delivery among different medical systems (e.g., <i>rathe kalke</i> and exclusive breastfeeding of the new born)
04	Lack of assessment of the IM health needs of the people
05	Insufficient utilization of traditional knowledge (Deshiya Knowledge) by the practitioners
06	Inadequate mechanisms to promote good and ethical practice among various cadres
07	Non-availability of a system to utilize the services of the Desheeya practitioners within the health system
08	Use of non-Ayurvedic drugs and procedures by some practitioners
09	Inadequate availability of Ayurvedic drugs/raw materials for dispensing at practices
10	Lack of a systematic promotion of Ayurvedic pharmacies as "mixed drugstores"
11	Non-availability of new IM knowledge to enhance effective practice
12	Lack of IM qualified paramedical staff for both private and public sectors
13	Lack of proper human resource planning
14	Lack of a referral system within the system and among systems

NO.	Problem
15	Non-uniformity in interventional protocols
16	Lack of proper record keeping systems in institutions and practices
17	Non-availability of quality IM pharmaceutical preparations at treatment centers
18	Lack of re-certification of practitioners
19	Lack of an accreditation system for all IM-related public and private institutions
20	Lack of drug monitoring for side effects, adverse effects and toxicity

SETTING: Linkages to Universities, National and International Institutions and Other Systems of Medicine including Biomedicine

NO	Problem
01	Lack of a clear policy regarding the relationship between the Department of Health and Department of IM within the Ministry of Health
02	Conflict with the SLMC regarding professional association with biomedical practitioners
03	Lack of an UGC institutional policy regarding the Ayurveda Institutions located at University Systems
04	Lack of formalized collaboration with institutions abroad for the purposes of postgraduate education and research
05	Ineffective utilization of WHO funding from the country budget for IM services
06	Lack of clarity regarding the roles of Unani, Siddha and Desheeya systems within the IM sector
07	Non-availability of formal linkages with India, Nepal, Pakistan and centres such as Harvard University

SETTING: Traditional Practice and Informal Knowledge Base

NO	Problem	Contributing factors
01	Decreasing numbers of traditional practices and specializations limiting the transmission of knowledge across generations	<ul style="list-style-type: none"> ⇒ No proper registration procedure for TPs ⇒ No proper mechanism to transcend TK to next generation ⇒ Less number of full time practitioners due to low income ⇒ Existing curricula and institutions for TP trainings are not TK oriented ⇒ No CPD is operated ⇒ Existing registration process does not have criteria for authenticating genuine TPs ⇒ Existing legislations / statutory mechanism are not adequate to eliminate malpractices ⇒ Uninformed, over-enthusiasm on TK is misused by quasi or pseudo TPs, through the media ⇒ No follow up process to review the quality of service provided by TPs
02	Insufficient participation of traditional practitioners in research	<ul style="list-style-type: none"> ⇒ Existing research process / methodology / parameters do not accommodate TK as it is ⇒ Most of the TPs do not tolerate well the conventional approach of Ayurvedic researches ⇒ Traditional norms have restricted accessibility to TK best practices ⇒ Existing curricula do not have clarity / intelligibility on TK ⇒ Postgraduate studies do not accommodate the TK element in their special areas of research ⇒ Obsolete and narrow minded professional attitudes at formal academic level ⇒ Academic staff do not accommodate TK-oriented subject matters
03	Diminishing utilization of traditional practices	<ul style="list-style-type: none"> ⇒ Low acceptability due to quackery ⇒ No recognition in public and private sector for TPs' recommendations on medical certifications ⇒ Cost-effectiveness / affordability is not optimal ⇒ No mechanism for bottom-up health policy planning ⇒ TK elements are not mainstreamed ⇒ No referral system is operated or existing referral system does not admit TPs' opinions in terms of professional or scientific paradigm ⇒ Operated system is monopolized by Allopathic medicine ⇒ Official health education is discouraging public from utilizing TK ⇒ TK practices for health needs are not admitted in current health care process ⇒ TPs are considered to be either underprivileged, non-professional or

NO	Problem	Contributing factors
		<p>unscientific primitive healers in the society</p> <p>No official declaration to define pluralistic health care service available in the country</p>
04	Exploitation of familial recipes and practice methods for commercial and other gains by practitioners of other systems of medicine	<p>⇒ Legislation yet to be enacted</p> <p>⇒ No mechanism for fact finding or review has been enabled with regards to international conventions / agreements like GATT / TRIPS / CBD</p> <p>⇒ Accessibility is traditionally restricted</p> <p>⇒ Low socioeconomic status of TPs</p> <p>⇒ No benefit sharing system available</p> <p>⇒ No register / database maintained</p> <p>⇒ Less documentation on unrecorded knowledge</p> <p>⇒ No focal point at national level to commit</p> <p>No MIS available</p>
05	Non-availability of medicinal substances to foster the traditional practice	<p>⇒ Insufficient knowledge gathered on the traditional uses of medicinal plants and other raw materials</p> <p>⇒ Inadequate information on requirements of raw materials specific to traditional practices</p> <p>Lack of network or mechanism to exchange such information</p>
06	Lack of an organized system to preserve and disseminate traditional medical knowledge	<p>⇒ Knowledge system is not nurtured</p> <p>⇒ Best practices are not disseminated</p> <p>⇒ No exchange / interrelationship/ linkages between TK systems</p> <p>⇒ No proper validation has been exercised so far</p> <p>⇒ No inputs from international agencies such as UNESCO / WHO / UNDP for TK</p> <p>⇒ No remedy for socioeconomic degradation of TPs</p> <p>⇒ Values and norms do not prevail in terms of ethics in practice</p> <p>⇒ No participation in planning at provincial level</p> <p>⇒ No policy / strategy</p> <p>⇒ No plans</p> <p>⇒ No commitments</p> <p>Lack of money/ resources</p>

(7) OPPORTUNITIES

The following opportunities exist at present:

1. There is a worldwide interest in indigenous medicine relating to what it can offer to health delivery systems as a complement and/or an alternative.
2. Current challenges faced by the biomedical system in dealing with issues such as the burden of non-communicable diseases
3. Lack of a coherent approach for solving nutritional problems and in deficiencies in the current system regarding conceptualizing health promotion has created a lacuna that can be filled by IM.
4. Conducive atmosphere in the Ministry of Health for IM
5. Worldwide interest in bio-diversity
6. Emerging national and multinational herb-based industry

(8) PROPOSALS FOR FURTHER ACTION

1. A group of selected individuals, with medical and administrative backgrounds, to be formed to meet with Ministry of Health officials on a regular basis regarding the *identification of areas* for complementary and alternative services of health, to be implemented within the overall health care delivery system (list of some proposals and strategies annexed);
2. Expedite the *process of amended Ayurveda act* presented in Parliament;

3. Ministry to arrange a meeting to *disseminate* scientifically proven information to practitioners and policy makers of the biomedical system;
4. Ministry to facilitate a programme of *joint research* (based on health needs) among practitioners of IM and biomedicine and with relevant funding agencies such as the World Bank, WHO, NSF and Universities;
5. Ministry to facilitate *problems analysis* meetings for those identified in the lists, provided in the report, in order to identify more accurately (after review of the factors listed in the tables) the contributory factors for developing strategies to overcome them and to develop action plans for the different sections and levels of the IM sector;
6. Ministry to launch a *data generation* exercise and sustain it over the subsequent years to generate data for management and policy making purposes (a proposed list is attached; more work is necessary regarding data to be gathered from curative institutions);
7. Ministry to maintain a website with information on services, research, pharmacopoeias, rules and regulations, new programmes, funding etc.

* * * * *

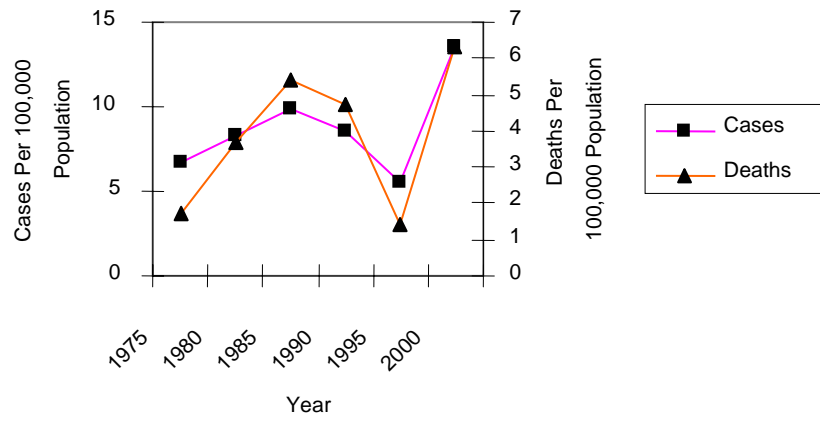
This section was prepared by Dr. Nimal. D. Kasturiaratchi, Director Medical Education Unit, Faculty of Medicine, University of Peradeniya.

CHAPTER 7

EPIDEMIOLOGICAL TRANSITION BASED ON HEALTH BULLETIN 2000 & REGISTRAR GENERAL 1980-96

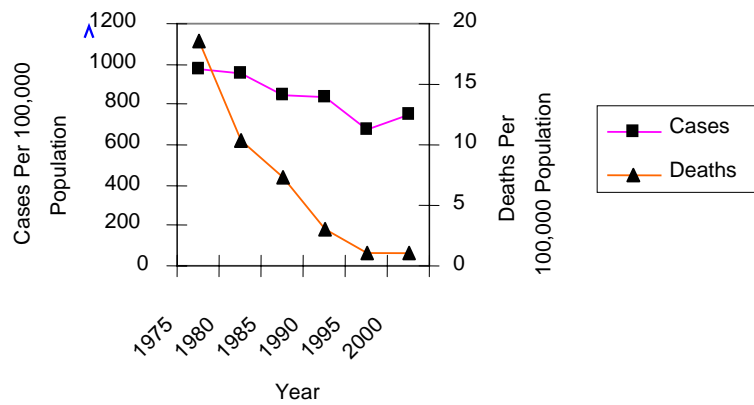
Septicaemia

Source: Annual Health Bulletin 2000



Intestinal Infectious Diseases

Source: Annual Health Bulletin 2000

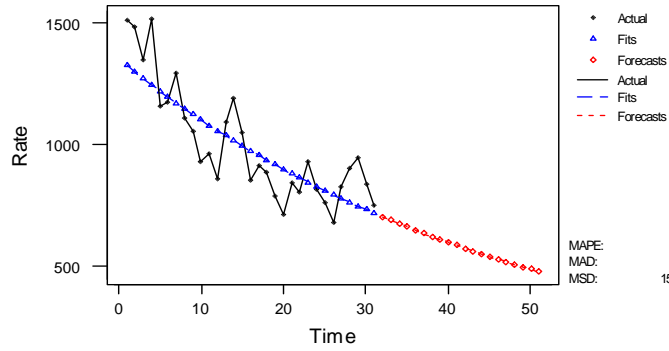


Diarrhoeal Diseases Trend Analysis

Trend Analysis for Rate

Growth Curve Model

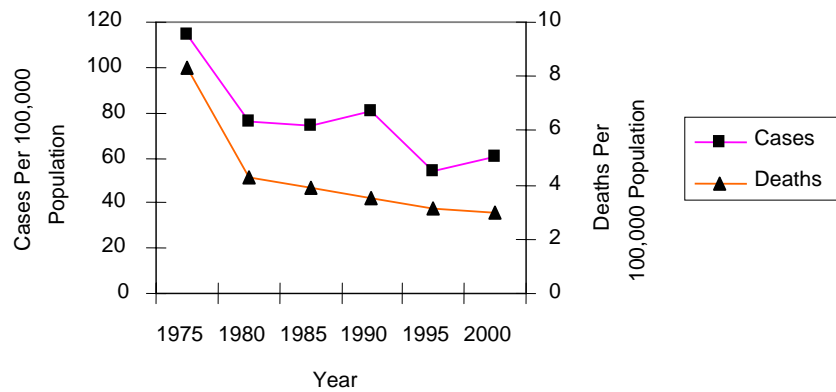
$$Y_t = 1349.56 \cdot (0.979670^{*t})$$



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	699
2005	644
2010	581
2015	525
2020	473

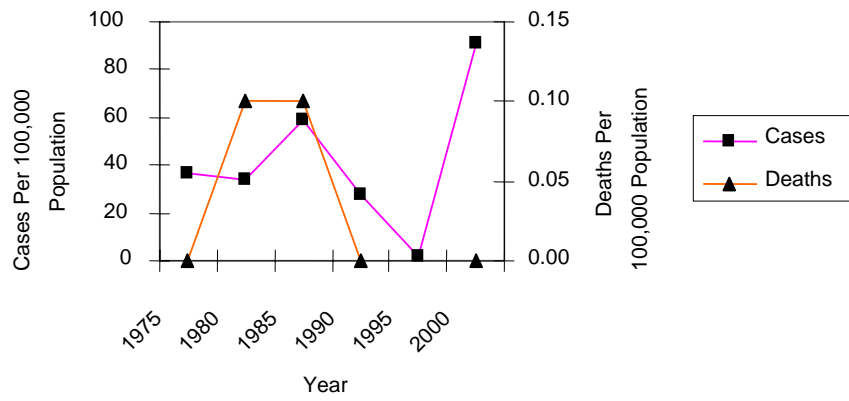
Tuberculosis

Source: Annual Health Bulletin 2000



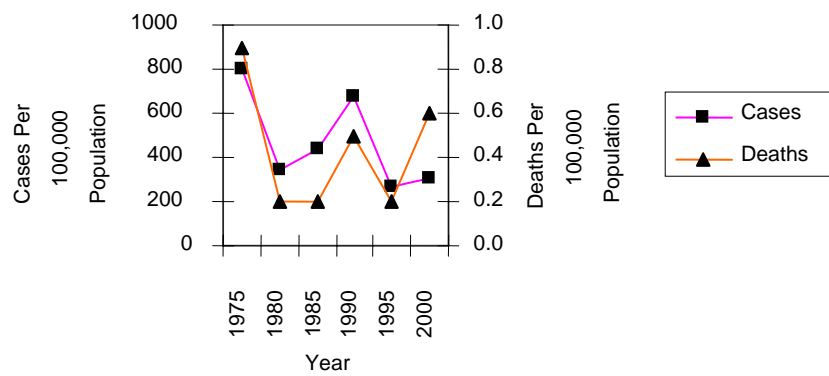
Measles

Source: Annual Health Bulletin 2000



Malaria

Source: Annual Health Bulletin 2000

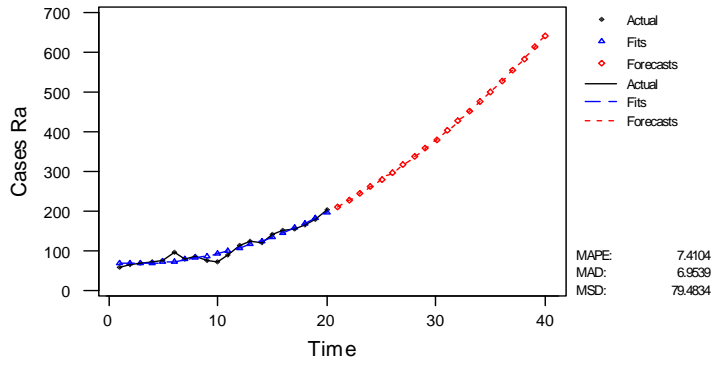


Diabetes Mellitus National Trend Analysis

Trend Analysis for Cases Ra

Quadratic Trend Model

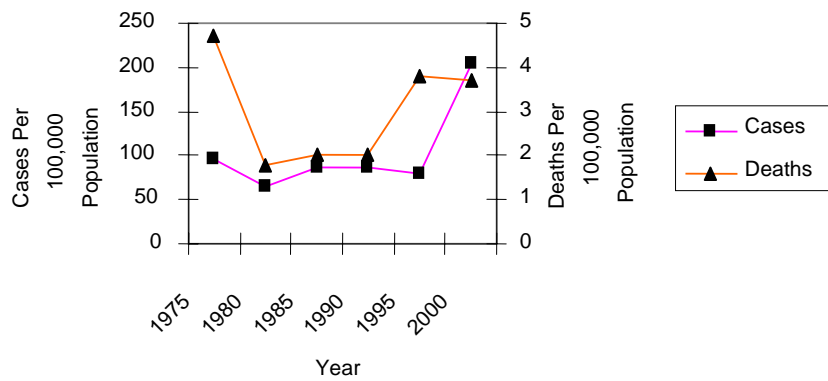
$$Y_t = 68.8545 - 1.5066t + 0.396173t^{**2}$$



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	212
2005	279
2010	380
2015	501
2020	642

Diabetes Mellitus

Source: Annual Health Bulletin 2000

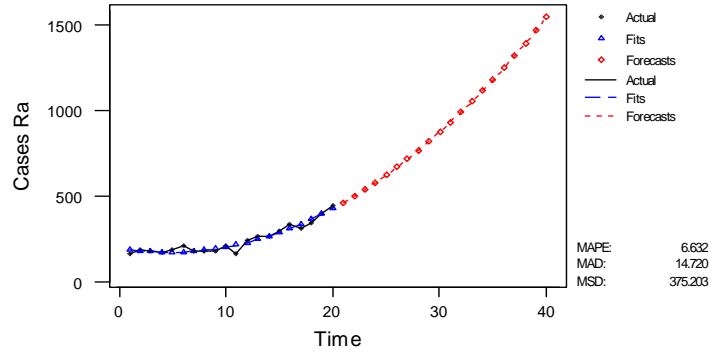


Hypertensive Diseases National Trend Analysis

Trend Analysis for Cases Ra

Quadratic Trend Model

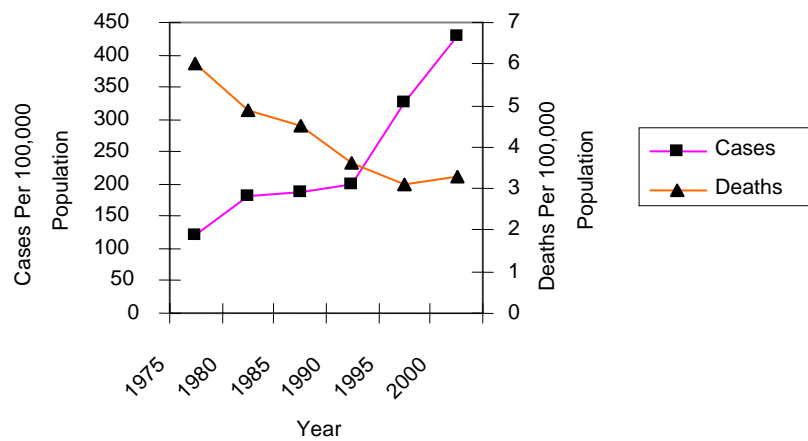
$$Y_t = 199.014 - 10.7568t + 1.11144t^2$$



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	625
2005	876
2010	1184
2015	1184
2020	1547

Hypertensive Diseases

Source: Annual Health Bulletin 2000

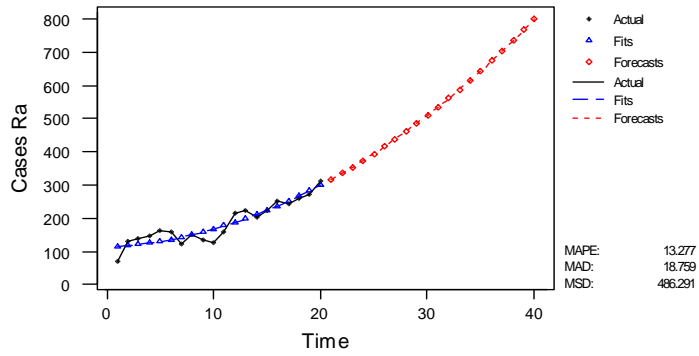


Ischaemic Heart Disease National Trend Analysis

Trend Analysis for Cases Ra

Quadratic Trend Model

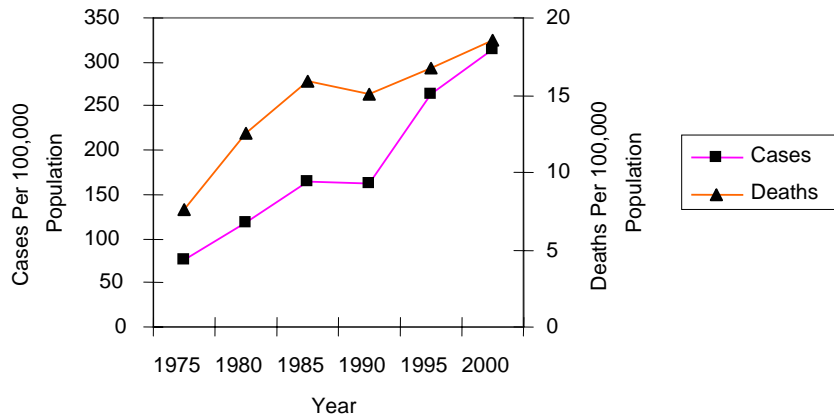
$$Y_t = 112.782 + 1.43382t + 0.393796t^2$$



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	317
2005	395
2010	510
2015	645
2020	800

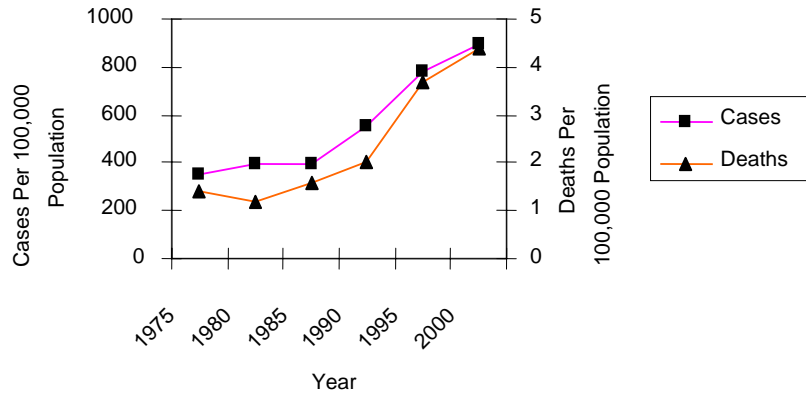
Ischaemic Heart Disease

Source: Annual Health Bulletin 2000



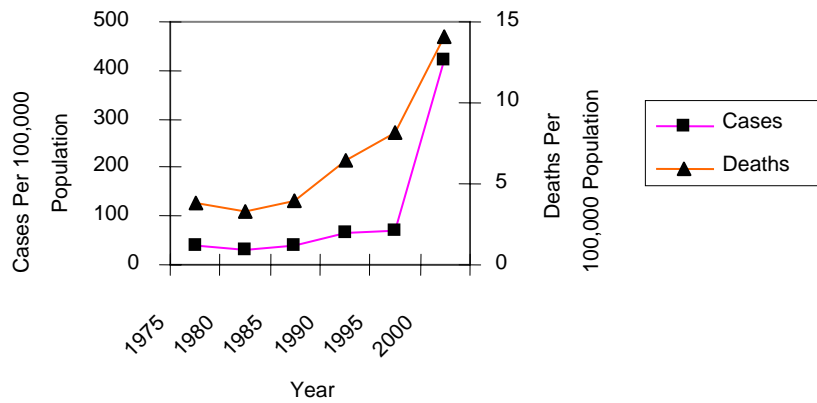
Asthma

Source: Annual Health Bulletin 2000

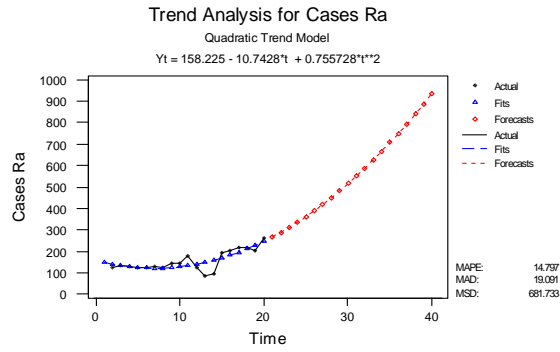


Diseases of the Liver

Source: Annual Health Bulletin 2000

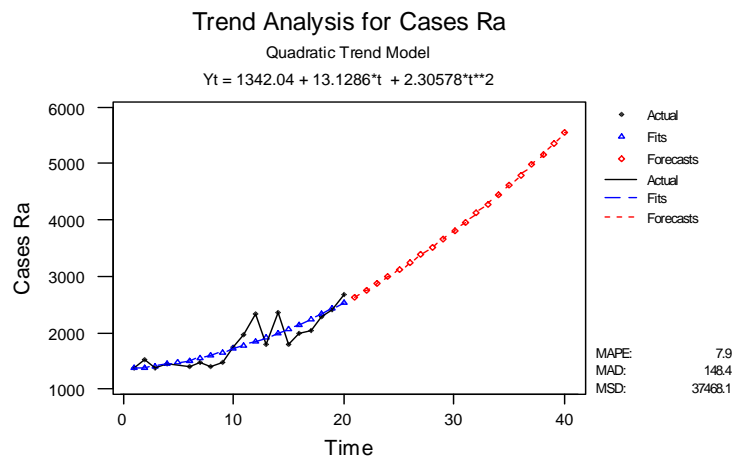


Neoplasms National Trend Analysis



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	266
2005	362
2010	516
2015	708
2020	938

Traumatic injuries National Trend Analysis



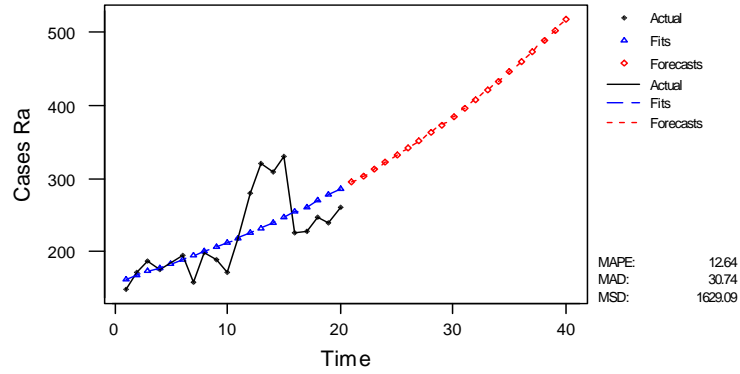
Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	2635
2005	3111
2010	3811
2015	4626
2020	5556

Poisoning National Trend Analysis

Trend Analysis for Cases Ra

Growth Curve Model

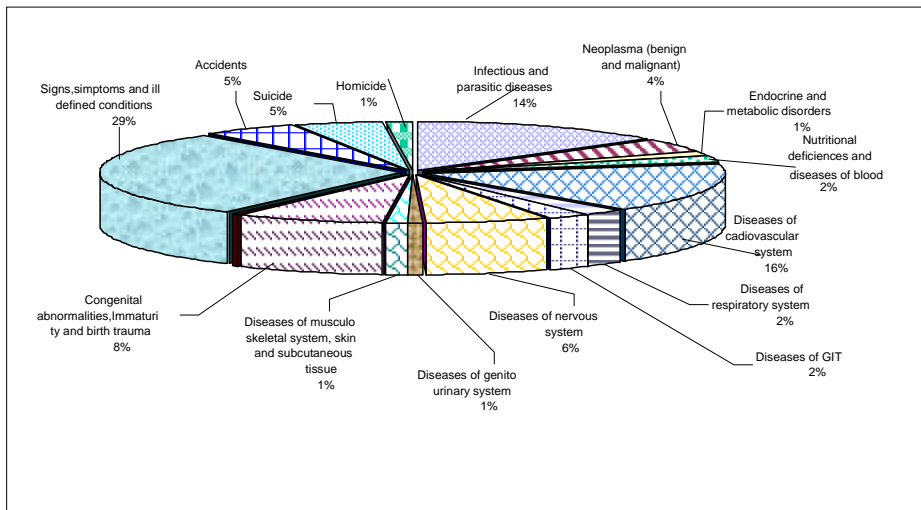
$$Y_t = 157.267 * (1.03028^{**t})$$



Year	Projected incidence/prevalence (as a rate per 100 000 population)
2001	294
2005	332
2010	385
2015	447
2020	519

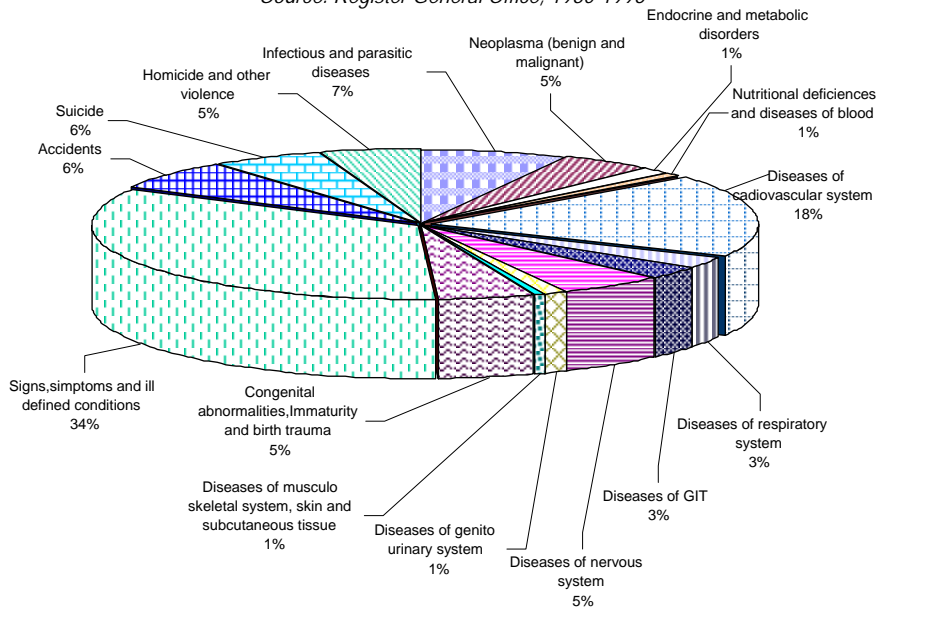
Causes of deaths 1980

Source: Register General Office, 1980-1996



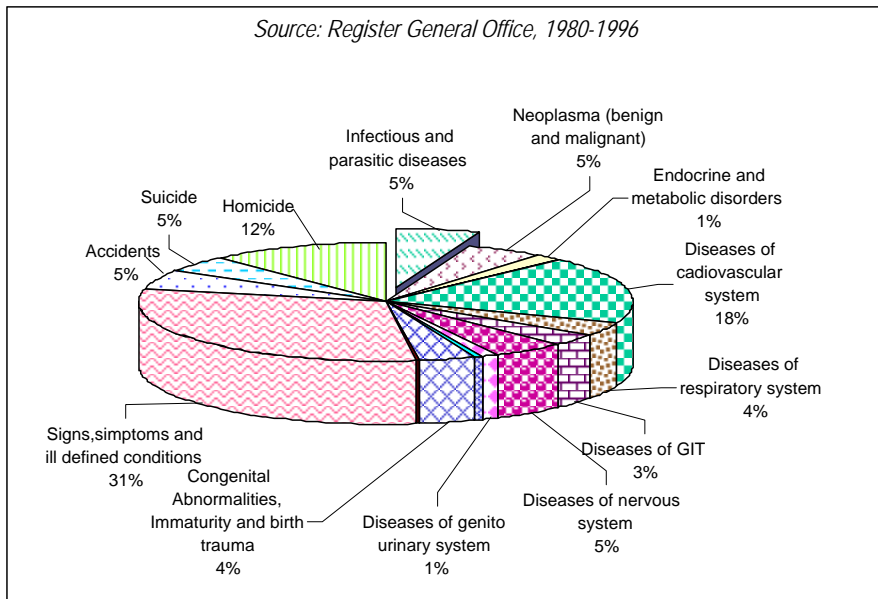
Causes of deaths 1991

Source: Register General Office, 1980-1996



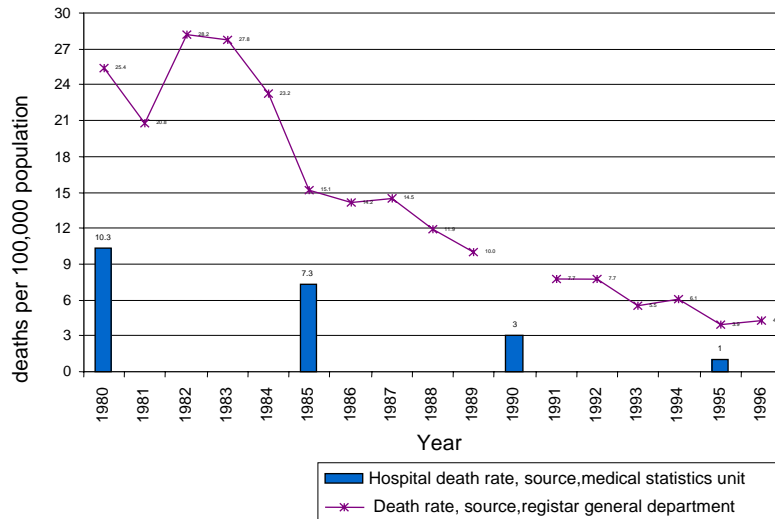
Causes of deaths 1996

Source: Register General Office, 1980-1996



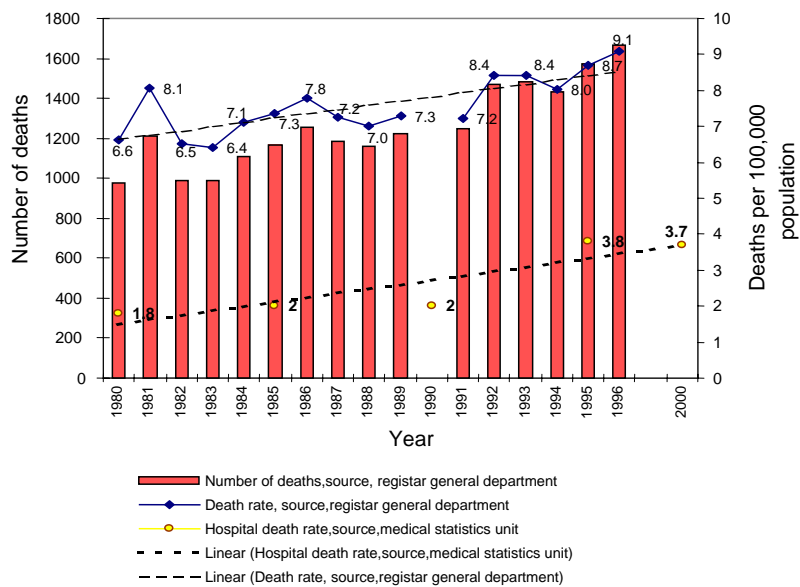
Deaths due to intestinal infectious diseases

Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000



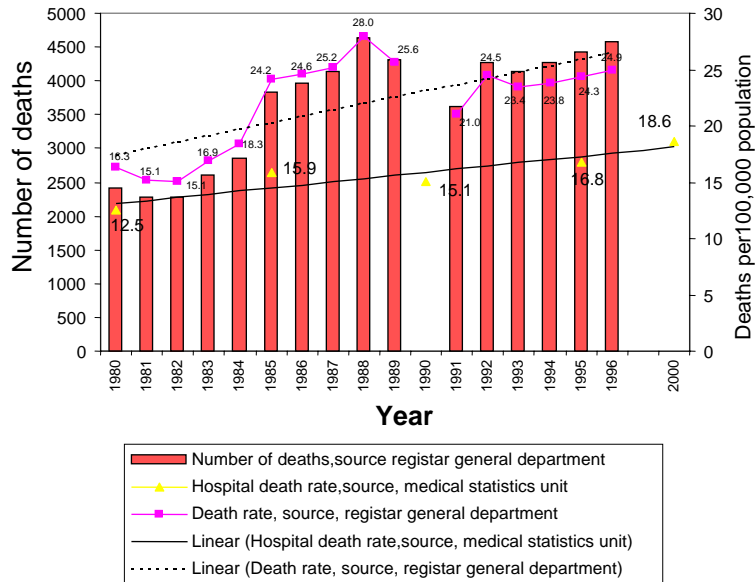
Deaths due to diabetes mellitus

Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000



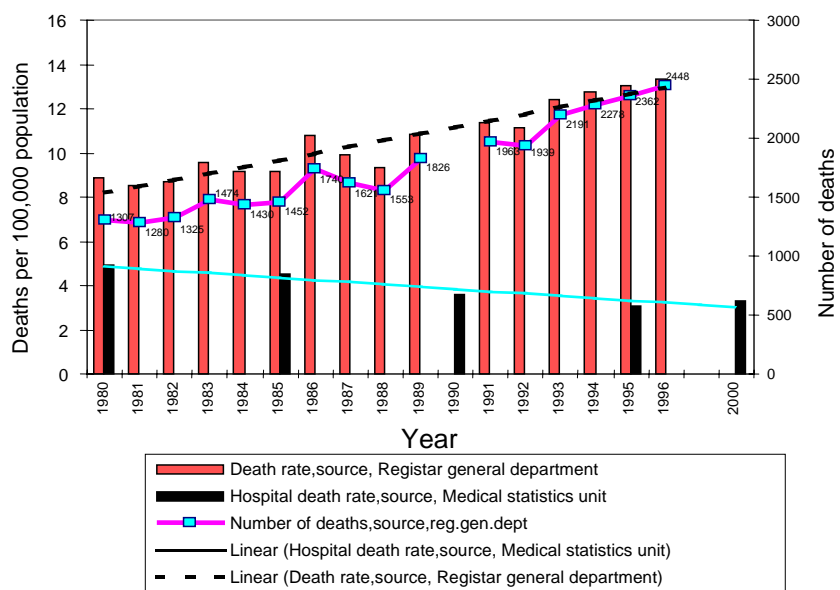
Deaths due to ischaemic heart disease

Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000



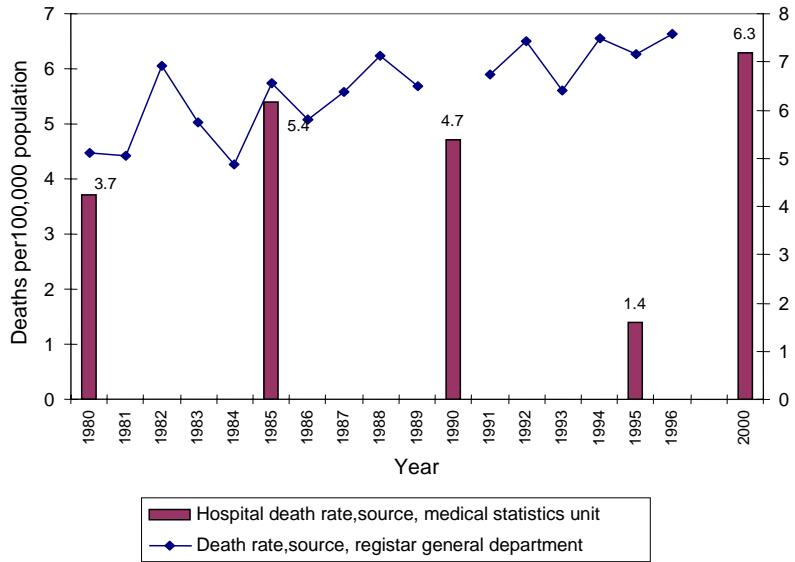
Deaths due to hypertension

Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000



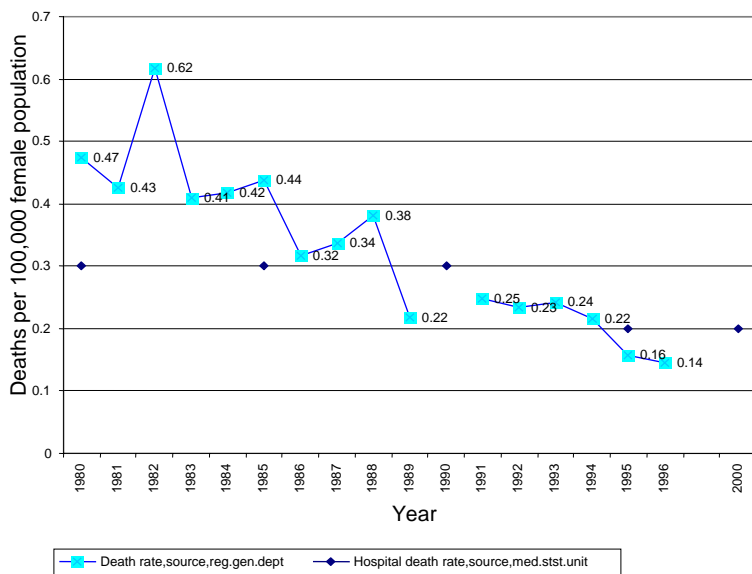
Deaths due to septicaemia

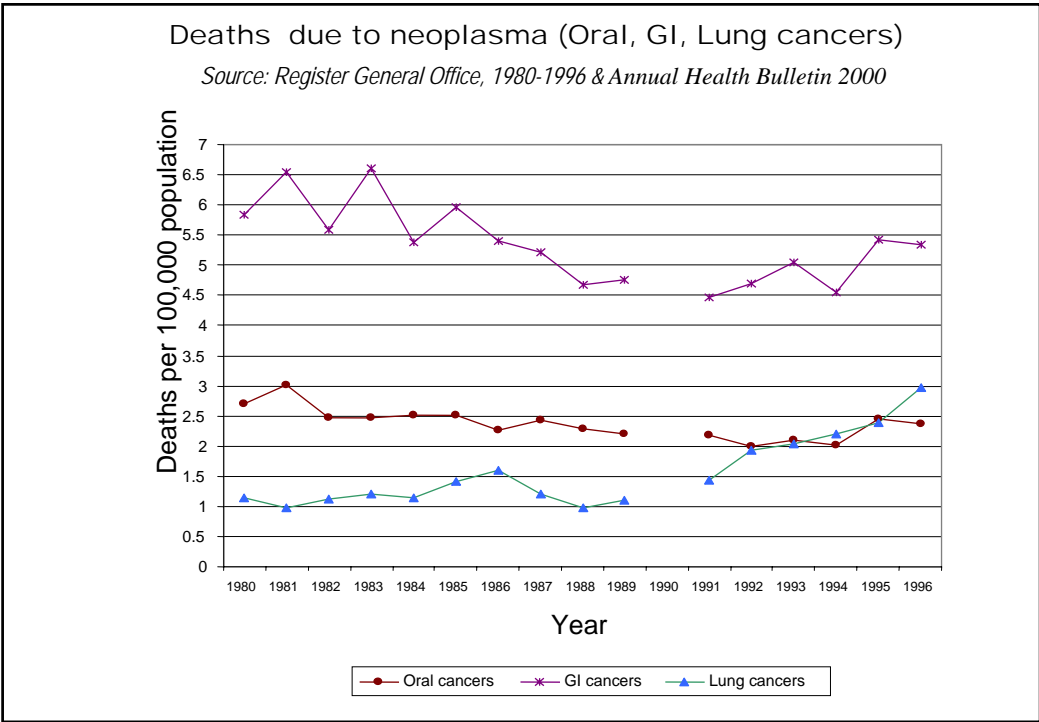
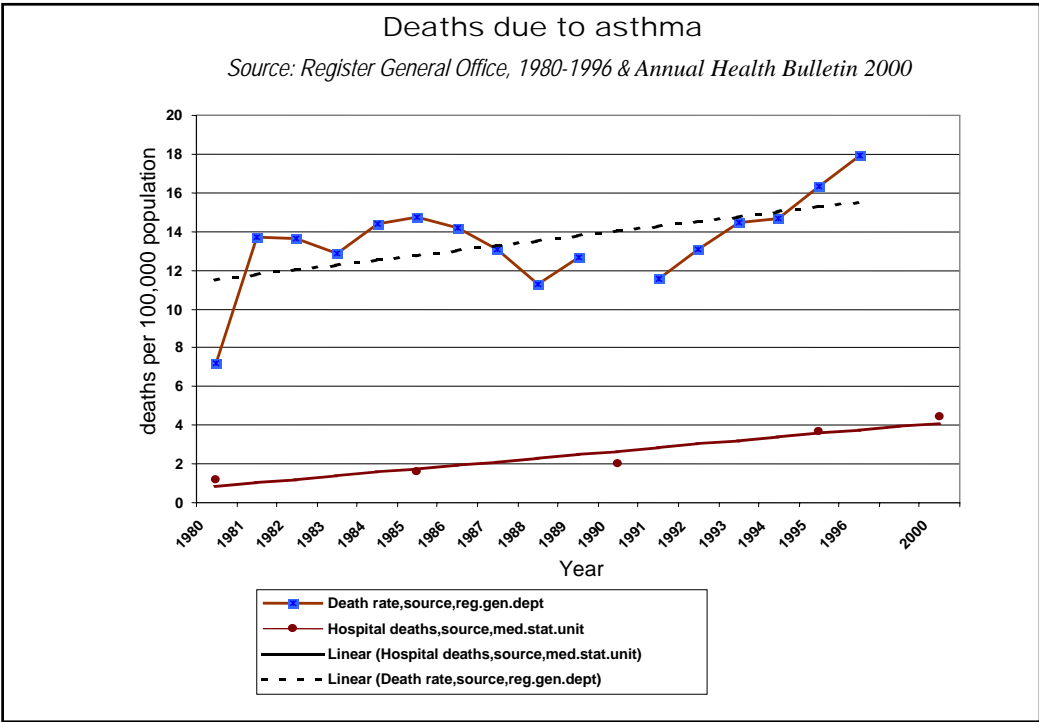
Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000

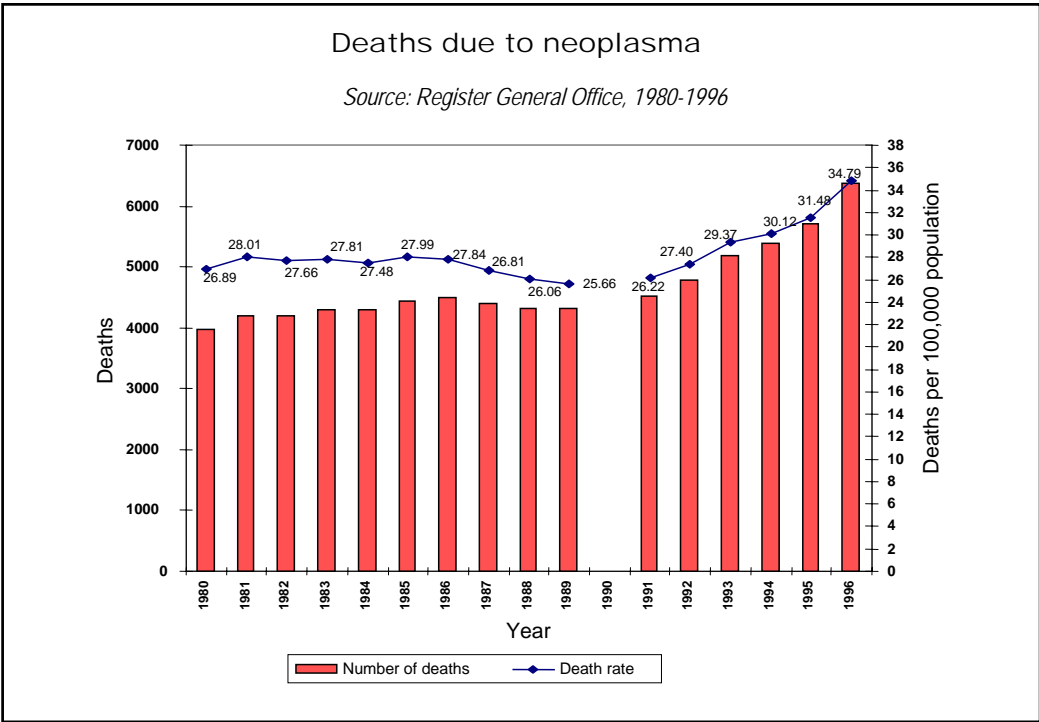
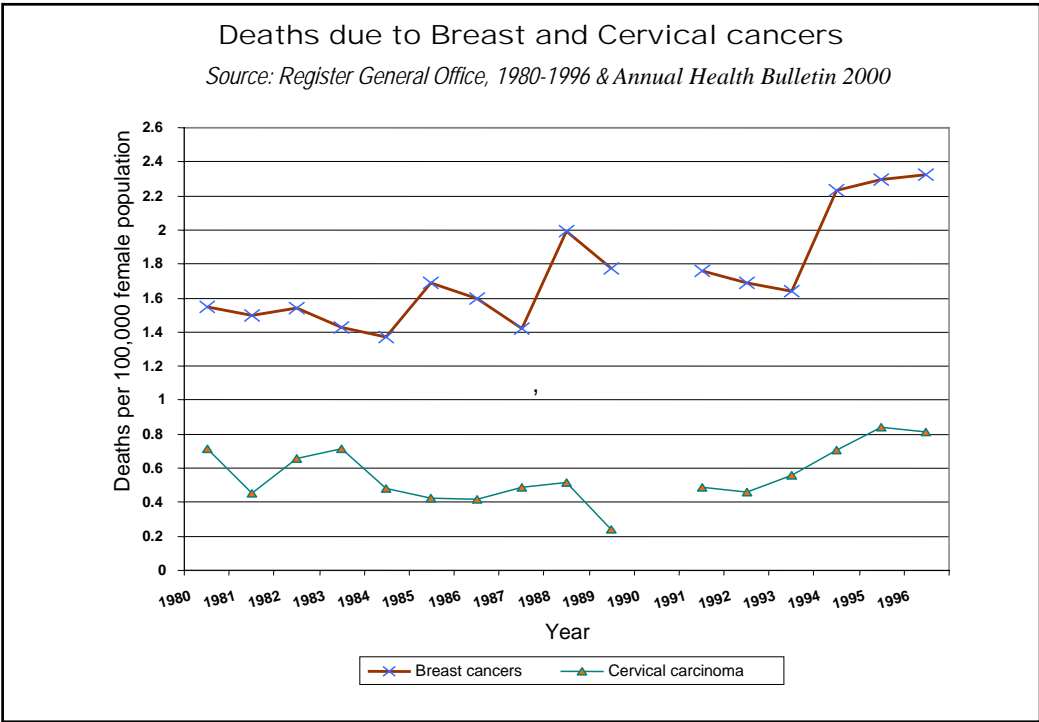


Deaths due to abortion

Source: Register General Office, 1980-1996 & Annual Health Bulletin 2000

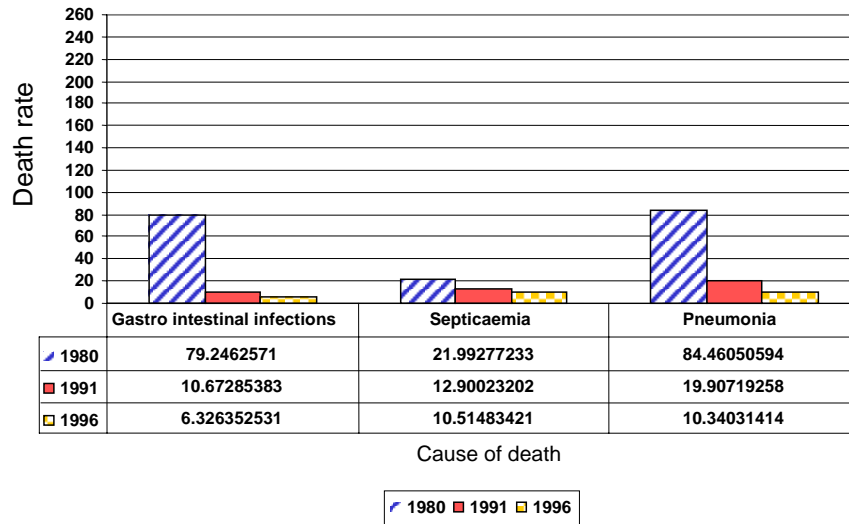






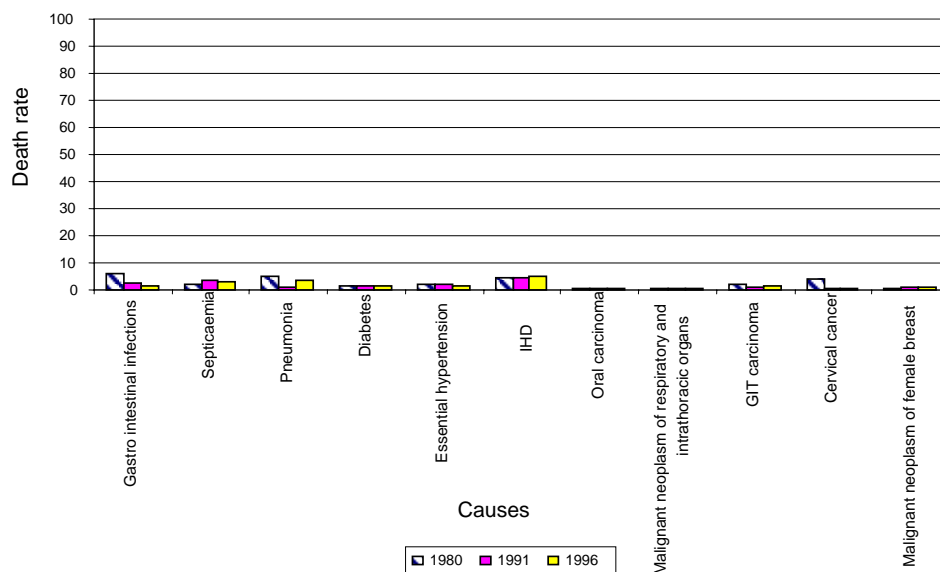
Death rate <5 years in 80, 91 and 96 for 3 common causes

Source: Register General Office, 1980-1996



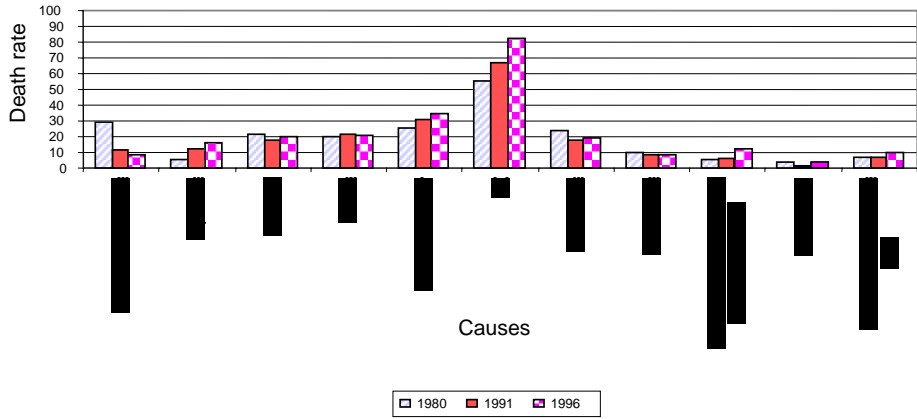
Death rates for age group 15 to 45 in 80,91 and 96 for selected causes

Source: Register General Office, 1980-1996



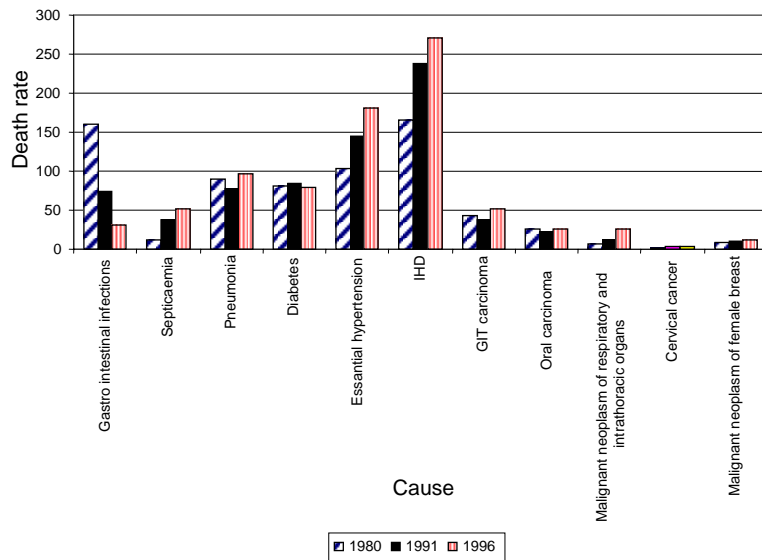
Death rate for age group 45 to 65 in 80,91 and 96 for selected causes

Source: Register General Office, 1980-1996

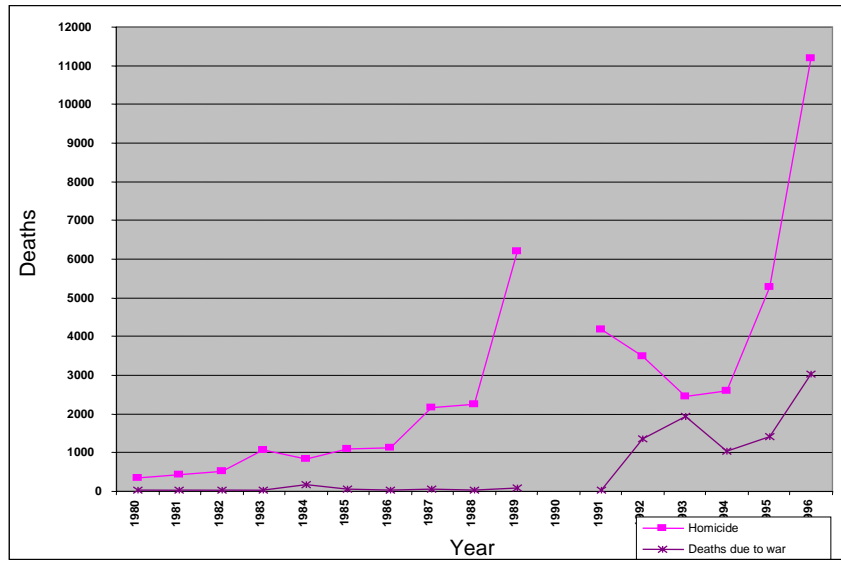


Death rate for age >65 in 80,91 and 96 for selected causes

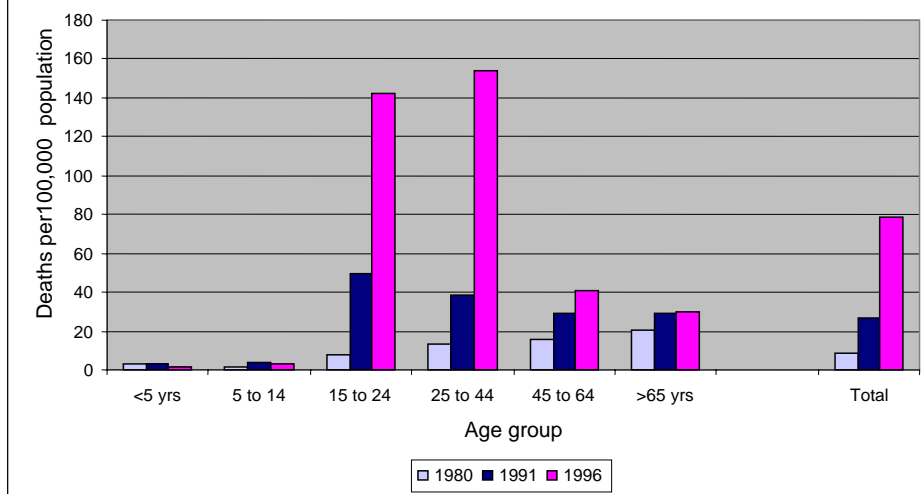
Source: Register General Office, 1980-1996

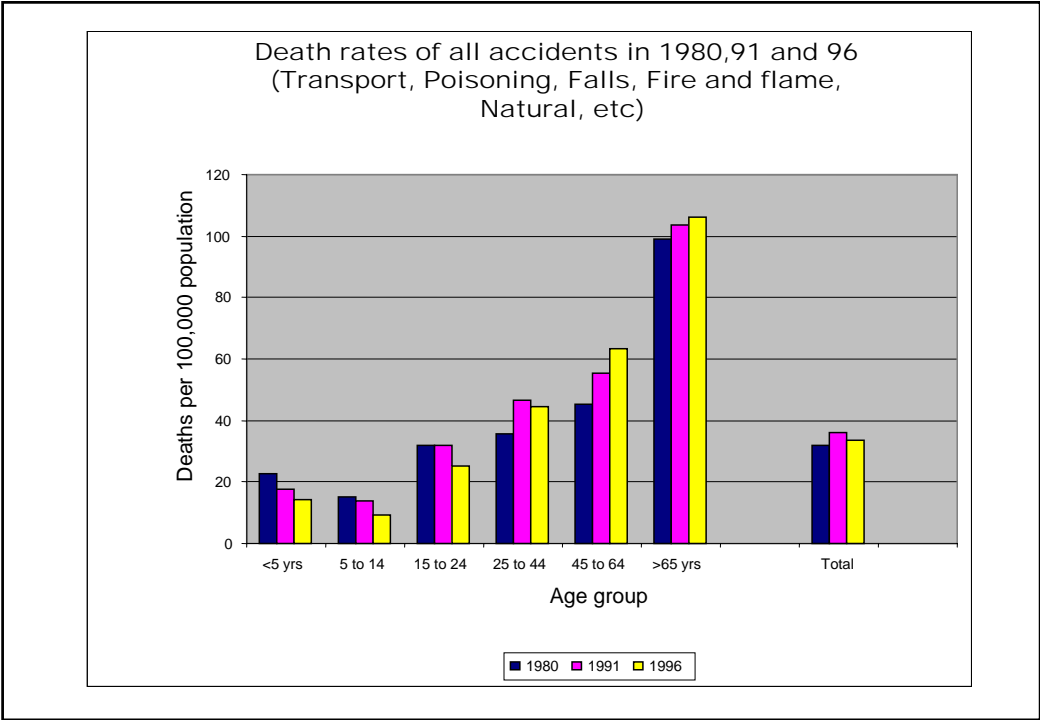
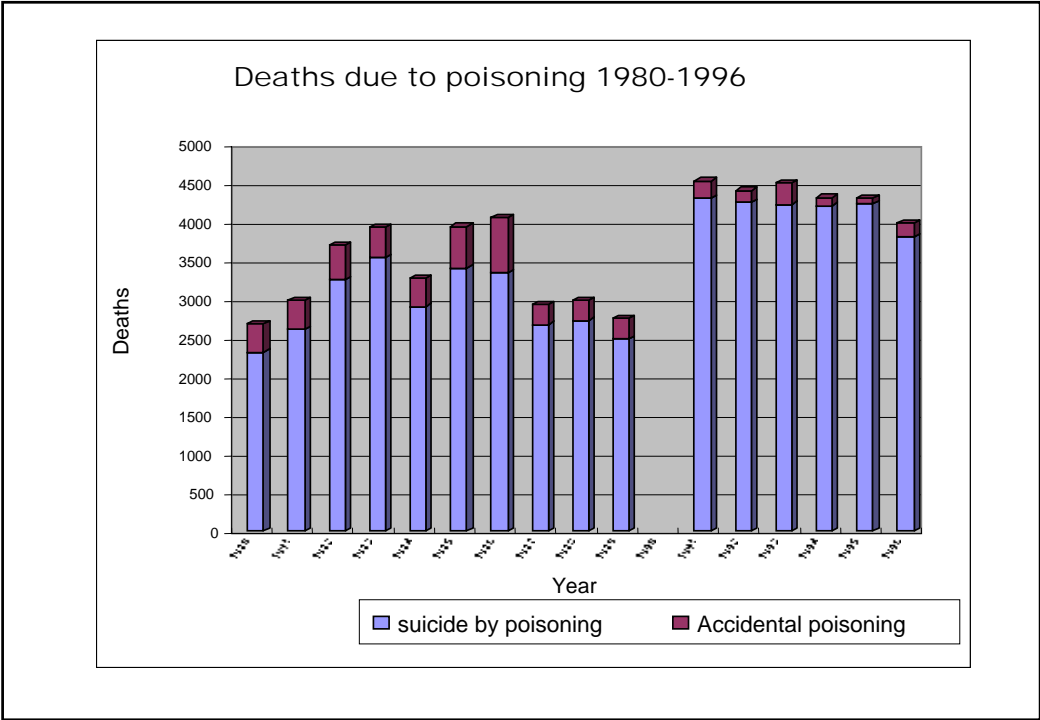


Homicide and deaths due to war 1980-96

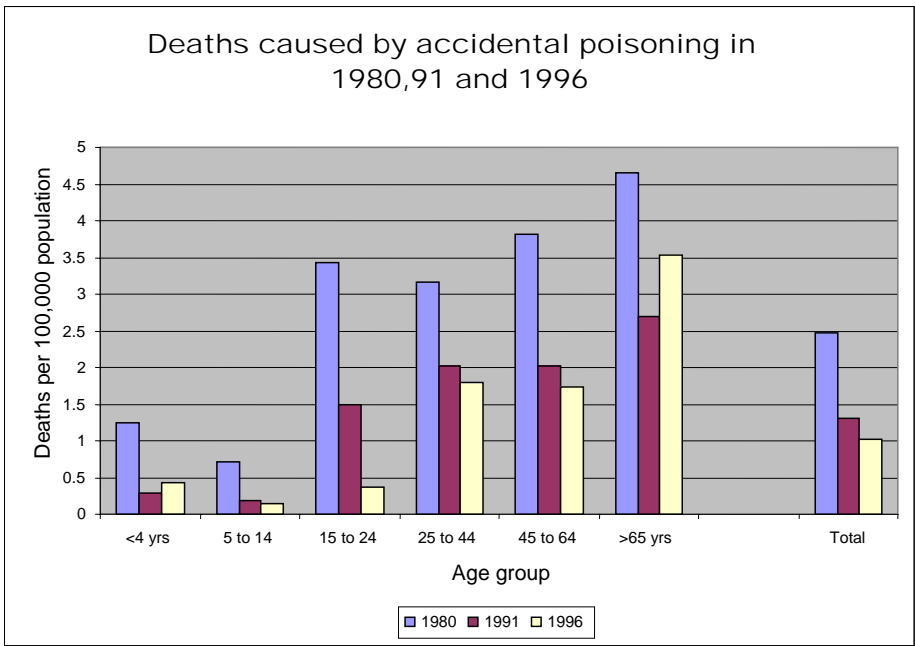


Age specific death rate for homicide and other violence (1980,91 and 96)

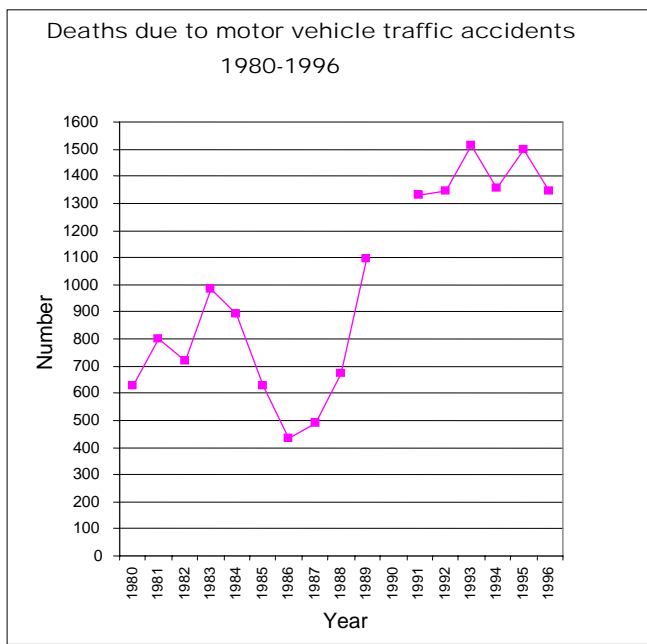


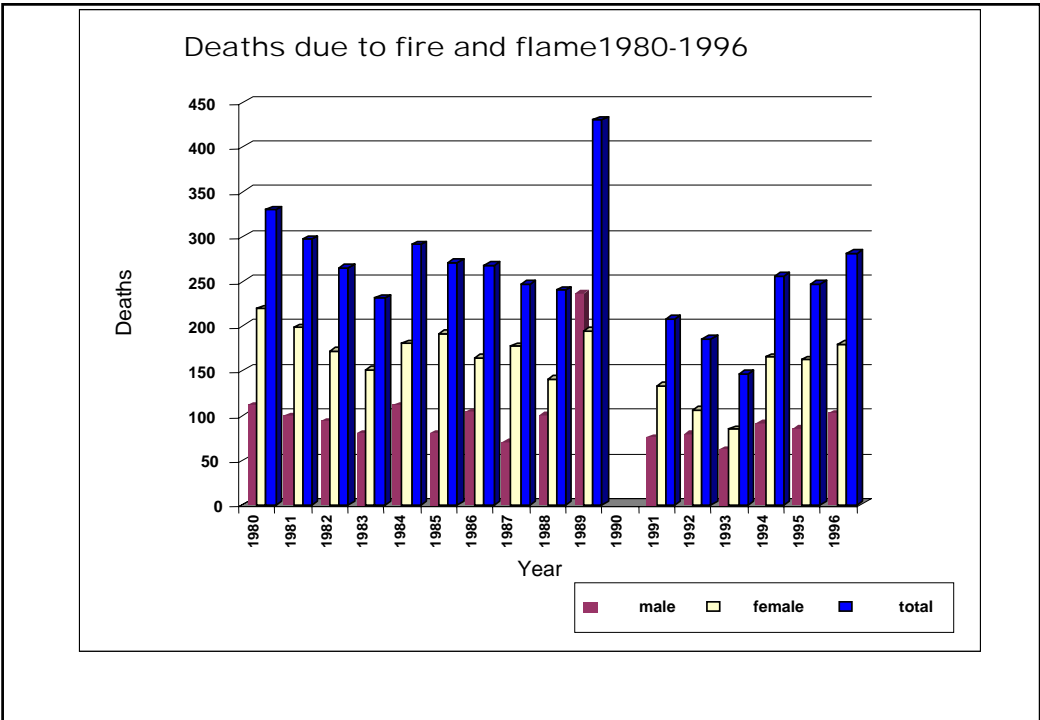
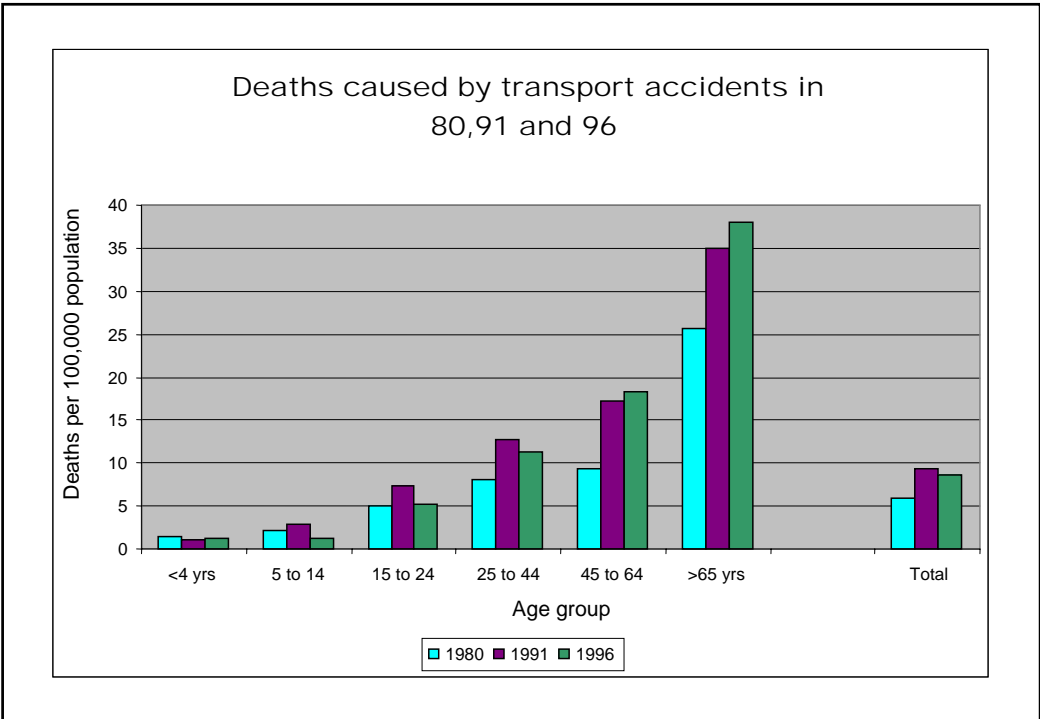


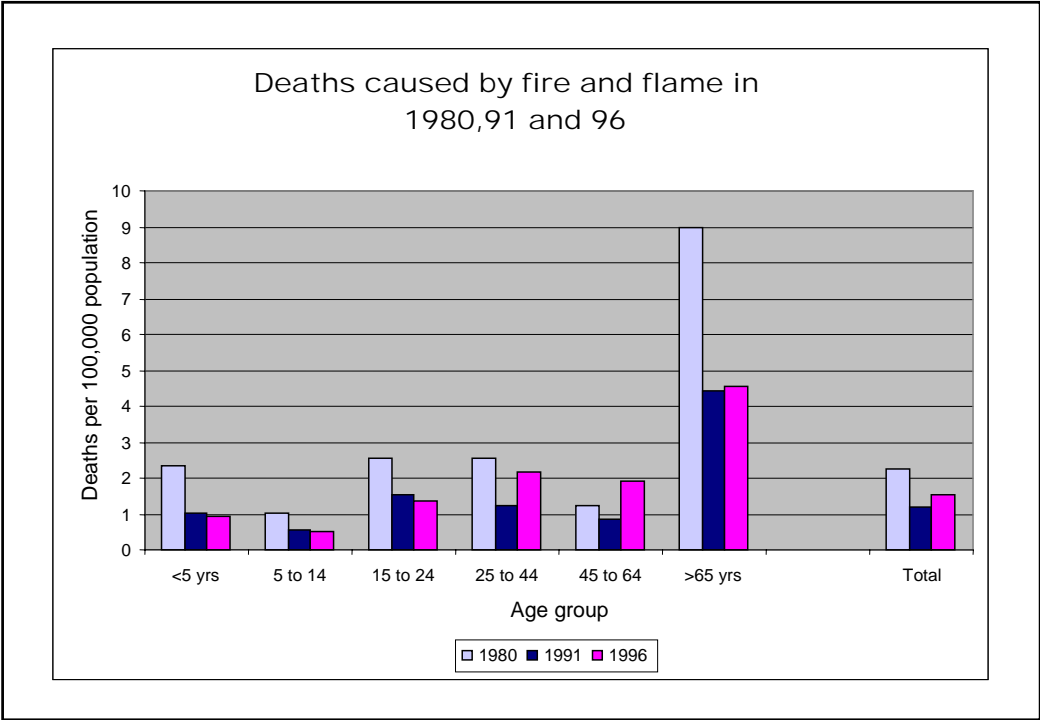
Deaths caused by accidental poisoning in 1980,91 and 1996

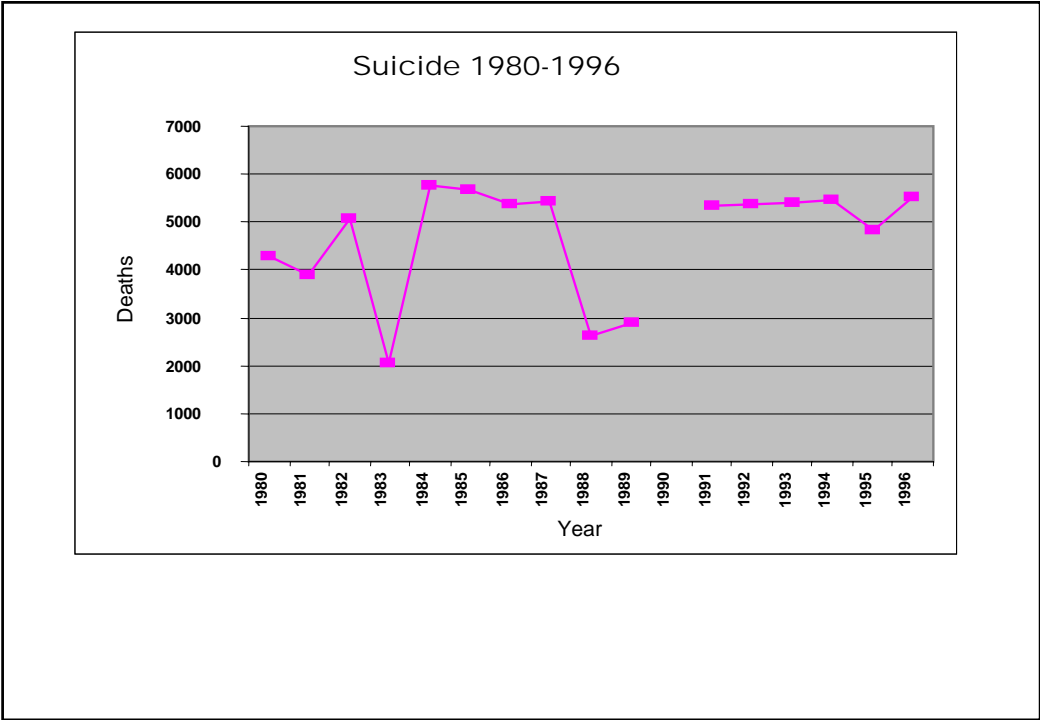
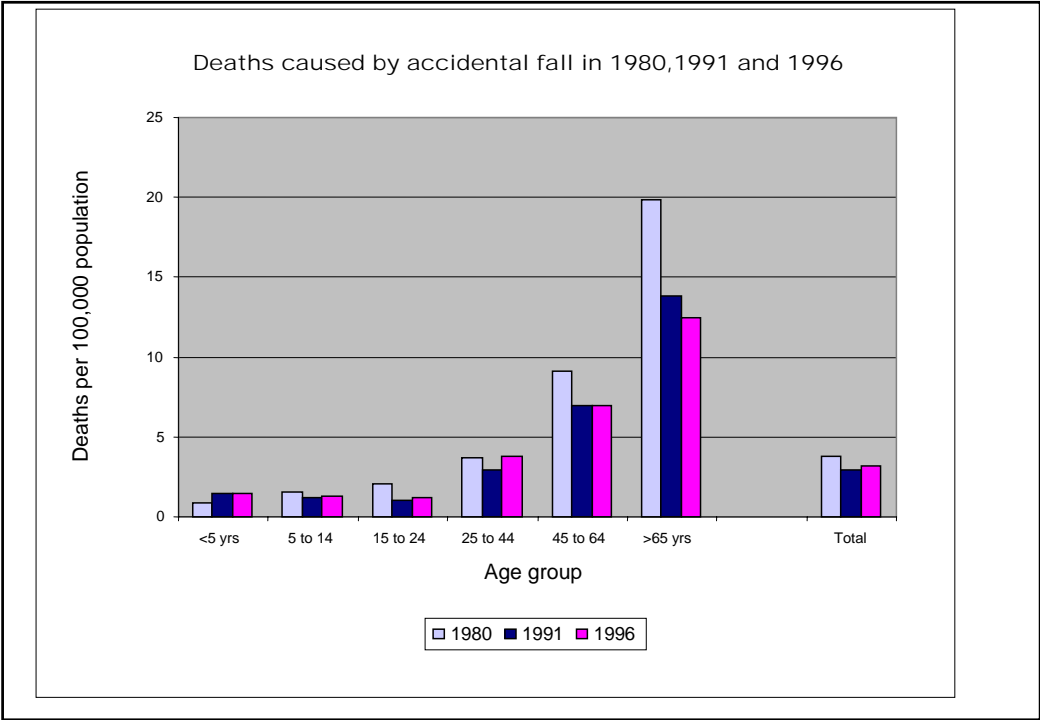


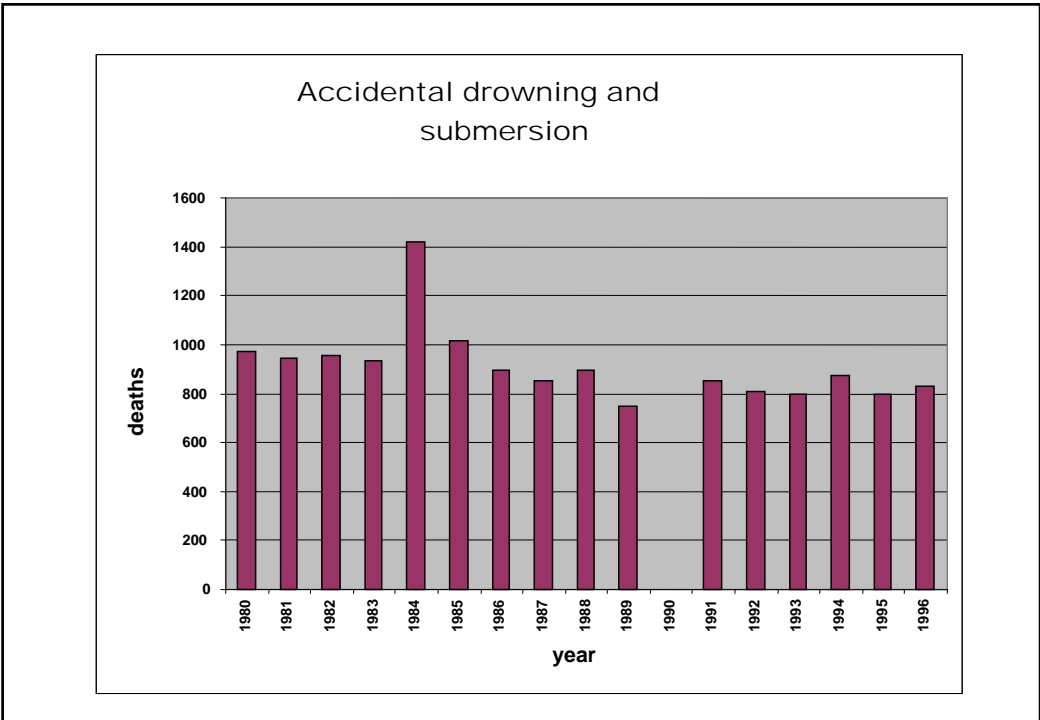
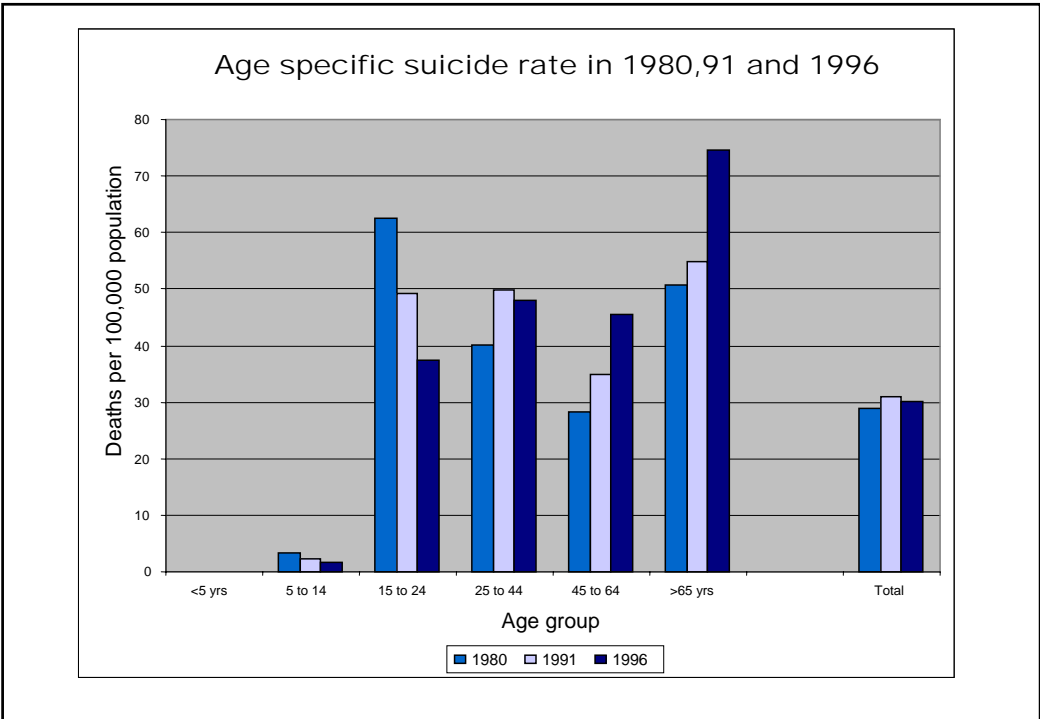
Deaths due to motor vehicle traffic accidents 1980-1996

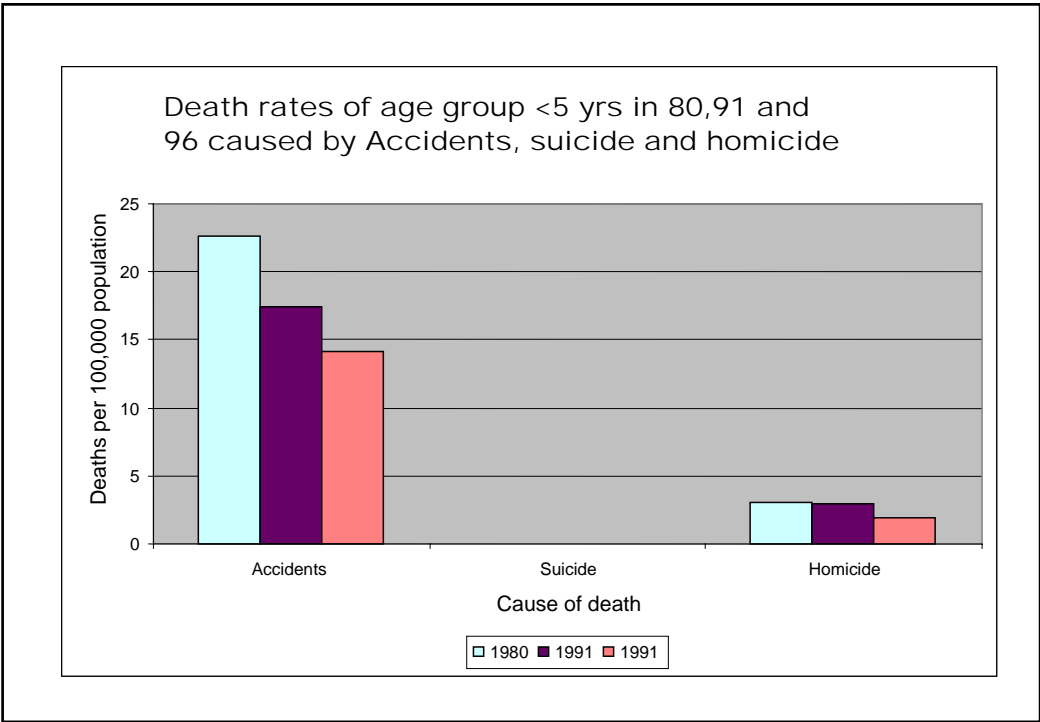
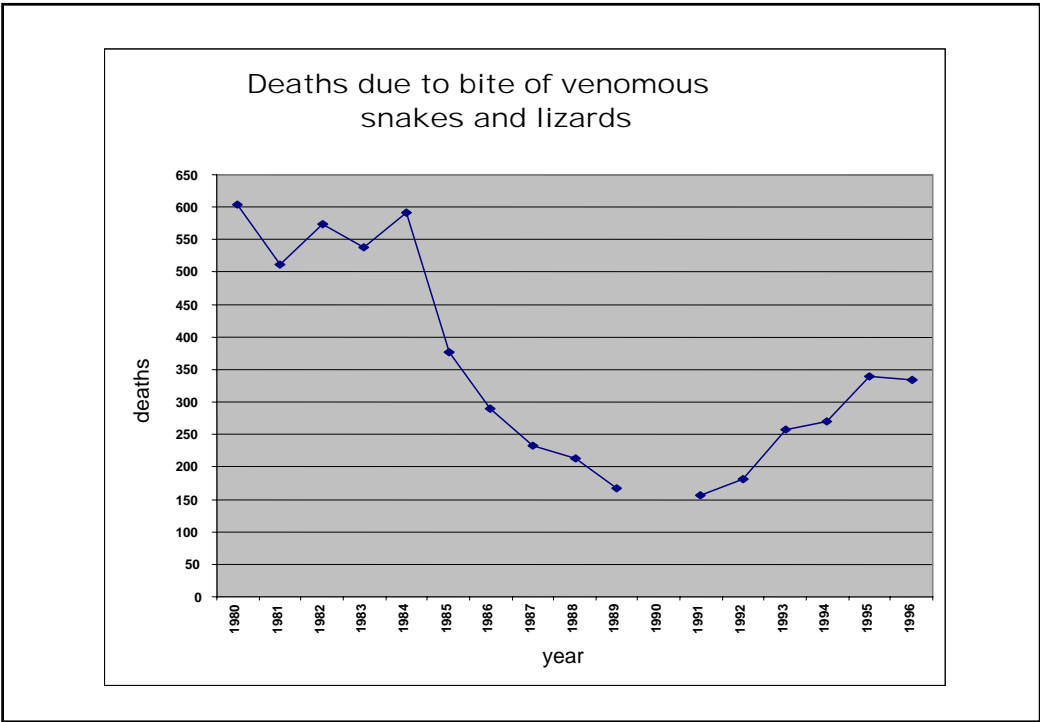


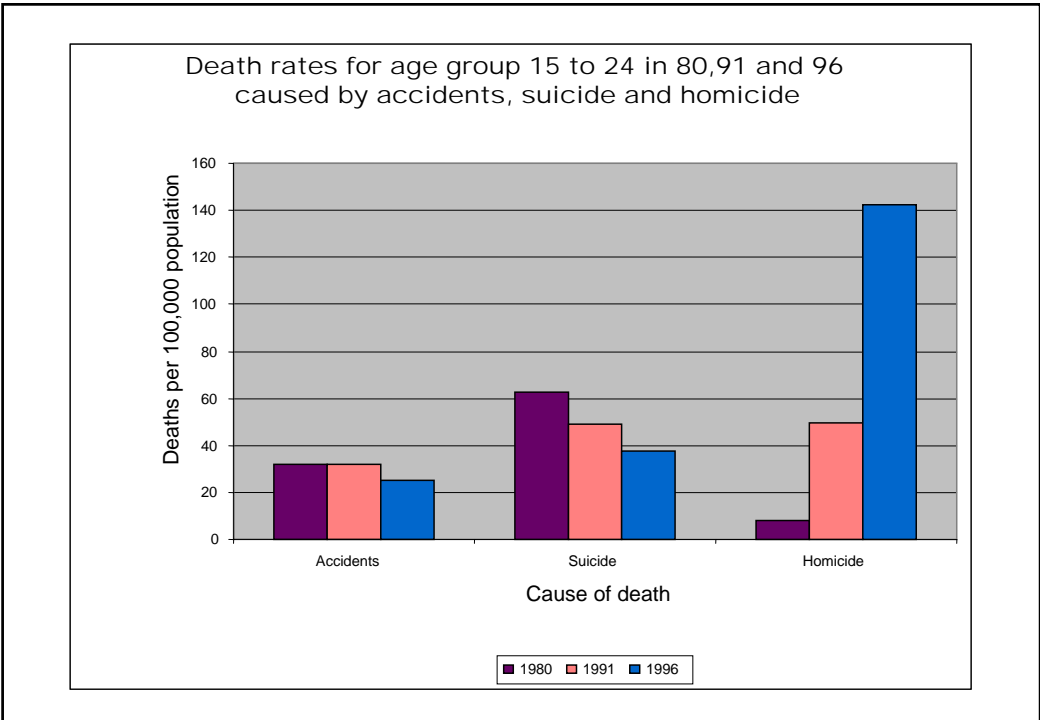
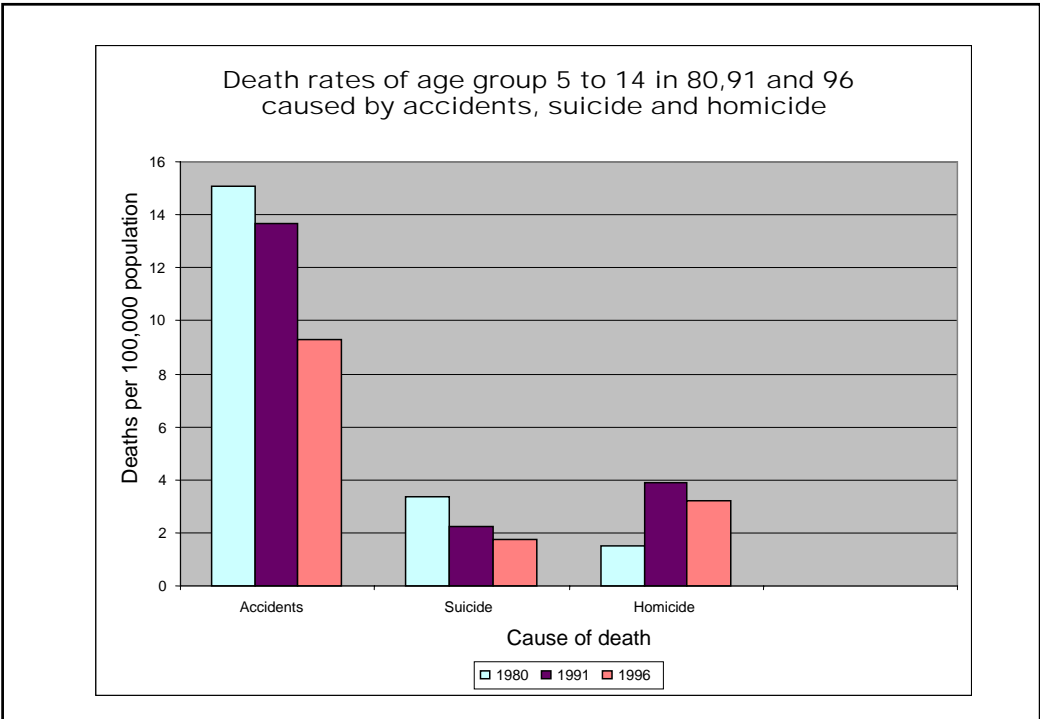




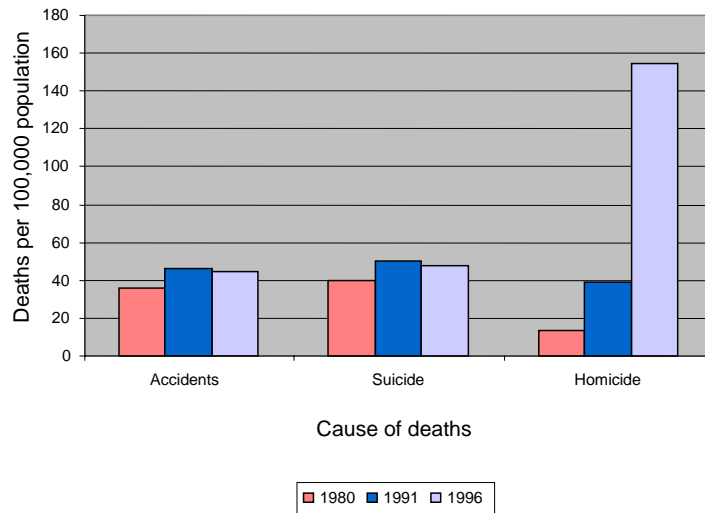




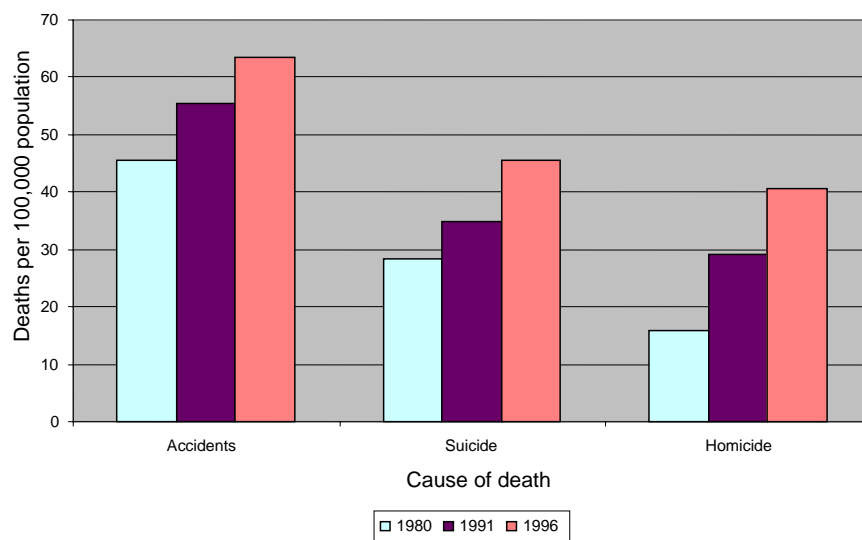


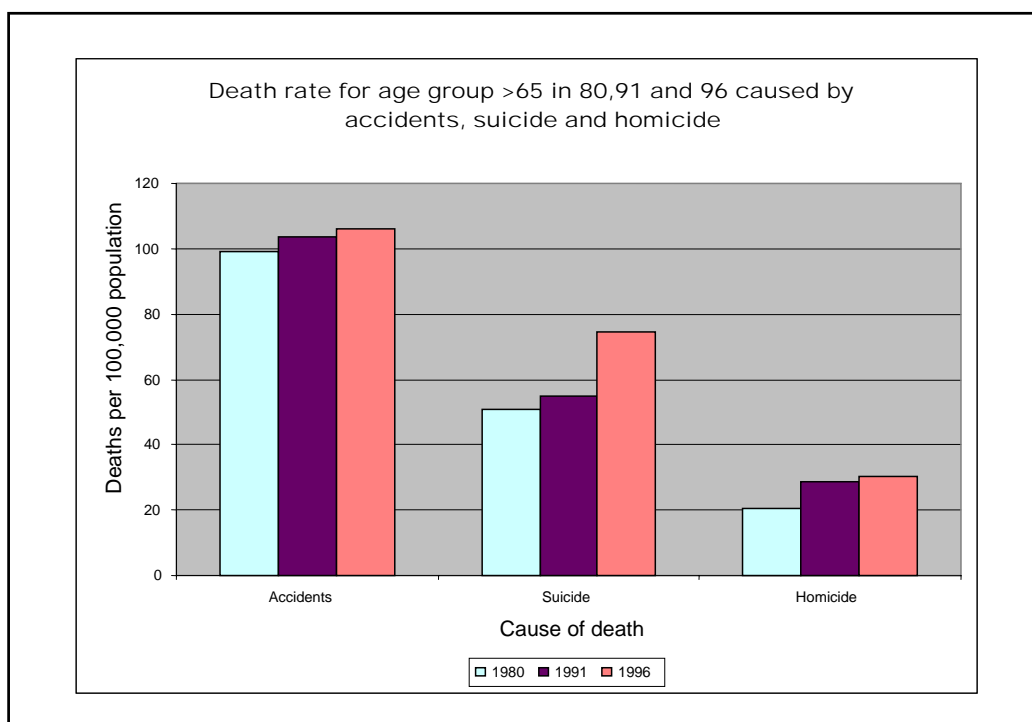


Death rates of age group 25 to 44 in 80,91 and 96 caused by accidents, suicide and homicide



Death rates for age group 45 to 64 in 80, 91 and 96 caused by accidents, suicide and homicide





Prevalence of illness by type of illness and sector

	Urban 2500	Rural 7980	Estate 1164	Total 11644
Acute illness				
No. of patients	162	535	51	748
Prevalence	6.5	6.7	4.4	6.4
As % of patients in the sector	37.5%	40.2%	26.6%	38.2%
No. of day sick	822	2144	161	3127
Average no of days sick	5.1	4.0	3.2	4.2
Chronic illness				
No. of patients	266	791	133	1190
Prevalence	10.6	9.9	11.4	10.2
As % of patients in the sector	61.6%	59.4%	69.3%	60.8%
Total Patients *	432	1332	192	1956
Prevalence of any illness	17.3	16.7	16.5	16.8
As % of the total no of patients	22.1%	68.1%	9.8%	100%

* Including 18 Patients with both acute and chronic illnesses

Ten leading diseases by sector

Disease	Percentage of patients							
	Urban		Rural		Estate		Total	
	%	Rank	%	Rank	%	Rank	%	Rank
Influenza	17.8	1	19.8	1	7.1	5	18.0	1
Hypertension	15.6	3	12.5	3	15.9	2	13.6	2
Arthritis	5.8	5	12.7	2	8.8	4	10.8	3
Asthma	8.5	4	8.6	4	18.2	1	9.5	4
Diabetes	17.2	2	6.5	5			8.4	5
Heart Failure	5.6	6	6.1	6	11.8	3	6.5	6
Viral Fever	5.3	7	5.2	7			4.7	7
Accidents	4.0	8	4.9	8	5.3	6	4.7	7
Mental Illness	2.1	9	3.8	9			3.2	9
Acute Respiratory tract infection			2.6	10	3.5	8	2.4	10
Stroke					2.9	10		
Cancer	1.9	10						
Cataracts					4.7	7		
Food Poisoning					3.5	8		

ANNEXES

A. STEERING COMMITTEE

B. COUNTERPART TEAM

C. JICA STUDY TEAM

ANNEX

A STEERING COMMITTEE

Members List of Steering Committee for Health Master Plan Study

Name	Organization
Dr. Reggie Perera	Secretary
Dr. H.A.P Kahandaliyanage	DG
Dr. K.C.S. Dalpatadu	Ex. DDG(Planning)
Dr. H. S. B. Tennakoon	Acting DDG(Planning) / DDG (MS II)
Dr. Dula De Silva	DDG (PHS I)
Dr. Manil Fernando	DDG (PHS II)
Dr. Stanly De Silva	DDG (ET & R)
Dr. U. Ajith Mendis	DDG (Laboratory Service)
Dr. Terence De Silva	DDG (MS I)
Mr. I. K. Chandrasena	DDG (Finance)
Dr. N.U.K.M. Jayathilaka	DDG (Dental Service)
Mr. Liyanage	DDG (BES)
Mr. W.A.Premasiri	DDG (Administration)
Dr. Thushara Fernando	D/Planning
Mr. B. Abeygunewardhana	D/Human Resources Dev. Div., Dep. of National Resources
Mrs. Asoka Fernando	D/Japan Div., Dep. of External Resources
Mrs. Ranjini Nanayakkara	Additional DG, World Bank Div., Dep. of External Resources
Mrs. Kumarashinghe	D/Budget Div. Dep. of External Resources
Representative	Independent medical Practitioners Association
Representative	Nursing Homes' Association
Dr. H.U.R. Indrasiri	PDHS – Western Province
Dr. Ananda Gunsekera	PDHS – Central Province
Dr. S.W.Pathinayake	PDHS – Southern Province
Representative	Embassy of Japan
Representative	JICA Sri Lanka Office
Representative	WHO
Representative	World Bank
Representative	Asian Development Bank
Representative	Japan Bank for International Cooperation

B.1

COUNTERPART TEAM (NATIONAL ADVISORY COUNCIL)

Members List of National Advisory Council

Name	
Dr. Ranjith Atapattu	Dr. Palitha Abeykoon
Ms. Siva Obeysekera	Dr. Tissa Cooray
Ms. Renuka Herath	Dr. Ranjan L. de Sylva
Ms. Sunethra Ranasinghe	Dr. Godfrey Goonatilake
Mr. L. Panambalana	Dr. Ms. Priennie Ranatunga
Dr. Joe Fernando	Dr. Upali Pilapitiya
Dr. Cristie Silva	Dr. R.C.A. Johnpulle
Dr. George Fernando	Dr. N.W. Vidyasagara

B.2

COUNTERPART TEAM (WORKING GROUPS)

Health System Management Group

Name	Organization
Dr. K.C.S. Dalpatadu	Ex. DDG(Planning)
Dr. H. S. B. Tennakoon	Acting DDG(Planning) / DDG (MS II)
Dr. S.M. Samarage	D/OD
Dr. Thushara Fernando	D/Planning
Dr. D.A.B. Dangalla	D/PDHS
Dr. Dula De Silva	DDG (PHS I)
Dr. Lokky Wai	WHO
Ms. Rukmal Abeywickrama	Assistant Director, Dept. of National Planning
Dr. Shelton Wanasinghe	IPS
Dr. Susantha de Silva	WHO Consultant
Dr. Palitha Abeykoon	WHO Consultant
Dr. Patricia Alailima	DG/National Planning
Dr. Joel Fernando	Rep. Independent Private Practitioner
Dr. H.U.R. Indrasiri	Provincial Director of Health Services/WP

Health Service Delivery Group

Name	Organization
Dr. Terrance De Silva	DDG(MS)I, Chairman
Dr. H.M Fernando	DDG(PHS) II
Dr. N.U.K.M. Jayathilake	DDG(OH)
Dr. Ajith Mendis	DDG(LS)
Dr. H.A.Ariyadasa	DDG(L&B)
Dr. Piyasena Samarakoon	D/MS
Dr.S.M.Samarage	D/OD, Coordinator
Dr. L.Somathunge	D/NCD
Dr. Deepthi Perera	D/YEDD
Dr. Jayasundara Bandara	D/LS
Dr. C.K.Shanmugarajah	D/PHC
Dr. Amal de Silva	D/PHSD
Dr. Neil Fernando	D/Mental Health
Dr. Dammika Guranathne	D/Nutrition

Mrs. S. Perera	D/N(PHS)
Mr. Daya Kumara	D/N(PHS)
Dr. Shyama Nanayakkara	MO/MDPU, Secretary

Health Supply Management Group

Name	Organization
Dr. U. Ajith Mendis	DDG (LS)
Dr. B.S.F.Samaranayake	D/MSD
Dr. Amal de Silva	D/PHSD
Mr. Liyanage	D/BME
Mr. K.M.S.B. Redogama	Chairman/SPMC
Ms. Sunetra Ranasinghe	Chairperson/SPC
DR. W.G.Gunawardena	D/Teaching Hospital Colombo South
Mr. A.A Priyadarshana	Director/National Drug Quality Assurance Laboratory
Mr. Kingsley Fernando	Divisional Pharmacist Gampaha

Human Resource Management Group

Name	Organization
Dr. Stanley De Silva	DDG(ET&R)
Dr.(Mrs) S. D. De Silva	Director (NIHS)
Mr. W.A. Premasiri	DDG(Administration)
Dr. H. S. B. Tennakoon	Acting DDG(Planning) / DDG (MS II)
Dr. Ajith Fonseka	Director/International Health
Dr.(Mrs) H. De Silva	Director(Training)
Mrs M. Thilaka Amarasinghe	Director/Nursing, (Education)
Dr. G.S. Senanayake	Director(Information)
Dr. B.V.S.H. Beneragama	D/PDHS-Kalutara

Health Financing Group

Name	Organization
Mr. I.K. Chandrasena	DDG(Finance)
Mr. P.A.P. Pathiratne	D/Finance(Planning)
Mr. A. H. Sudasinghe	PDHS, Sabaragamuwa
Dr. D.N. Edirisinghe	PDHS, Sabaragamuwa
Mr. S.M.H. Fernando	D/Expenditure I Finance
Mr. M.L.A. Chandradasa Liyanaarachchi	Research Office, Finance Commission
Dr. Amala De Silva	Senior Lecturer, Univ. of Colombo
Dr. S.M. Panagoda	D/PDHS(Colombo)
Mr. B.N.Pathiratne	National Budget Div., Ministry of Finance

HIS / GIS Group

Name	Organization
Dr. T. A. Kulatilake – Leader	Epidemiologist
Dr. G. Sunil Senanayake – Coordinator	Director/Health Information
Dr. Mrs. Vineetha Karunaratne (representative)	Director/Maternal and Child Health
Dr. P. G. Maheepala	Director/Tertiary Care Services
Dr. Jayasundara Bandara	Director/Laboratory Services
Dr. Mrs. Lakshmi Somatunga	Director/Non-communicable Diseases
Dr. Sunil Settinayaka	Director/Anti-Leprosy Control
Dr. W.M.T.B. Wijekoon	PDHS/North-central Province

Indigenous Medicine Group

Name	Organization
Group 1: Pharmaceuticals, NRB Industry, Research Institutes	
Dr. Nimal Samarasundara	Chairman, Sri Lanka Ayurvedic Drugs Corporation
Dr. M. M. Chandrasena	Registrar, Ayurvedic Medical Council
Prof. Ajith Abesekara	Director, Ayurveda Research Institute
Dr. Chandralatha Samarasekara	Senior lecture, NITM
Prof. Bahwani	Medical Officer
Dr. W.A Tissera	Lecture , W.Ayurvedic Institute Yakkala
Mr. K.G.M. Bandara	Director, NITM
Group 2: Education & Human Resource Development	
Mr. R. H. M. Piyasena	Director, Institute of Indigenous Medicine Rajagiriya
Dr. Sarath Ranasighe	Additional Director, Institute of Indigenous Medicine
Mr. K. G. M. Bandara	Director, National Institute of Traditional Medicine, Nawinna
Dr. M. M. Chandrasena	Registrar, Ayurvedic Medical Council
Pro. S. Bahwani	Medical Officer
Dr. W. A. Tissera	Lecture , Ayurvedic Institute Yakkala
Group 3: Policy Formulation and Financing	
Mr. M. L. Perera	Senior Assistant Secretary (IM)
Mr. Asoka Malimage	Commissioner of Ayurveda
Dr. Danister Perera	Medical Officer, Sri Lanka Conservation & Sustainable Use of Medicinal Plant Project
Dr. Ranjith Mahindapala	Programme Officer, IUCN
Dr. (Mrs) Somaratne	Medical officer, Ayurvedic Teaching Hospital, Borella
Dr. Najeeb	Lecturer, Institute of Indigenous Medicine Rajagiriya
Dr. C. Weerasekara	Homeopathic Practitioner
Group 4: Service Delivery	
Dr. D. W. J. Senaratne	Director, Ayurvedic Teaching Hospital, Borella.
Dr. Lakshmi Senaratne	Senior Scientists Ayurvedic Research Institute
Dr. Gamini Bandara	Provincial Commissioner of Ayurveda (Uva)
Dr. MSPC Vidyasekara	Senior Lecturer, Institute of Indigenous Medicine
Dr. Nimal Jayathilaka	Assistant Commissioner (Technical) Ayurvedic Research Institute
Dr. Ratnapala	Ayurvedic Physician
Dr. Mrs. Somaratne	Ayurvedic Teaching Hospital, Borella.
Dr. A Moulana	Medical Officer
Group 5: Linkages to Universities Research Institutes & Allopathic System	
Prof. S.Bahwani	Medical Officer
Dr. J. Jayatissa	Lecture, Kalaniya University
Mr. R.H. M. Piyasena	Director, Institute of Indigenous Medicine
Prof. Ajith Abesekara	Director, Ayurvedic Research Institute
Dr. Samaratunge	Lecture, Institute of Indigenous Medicine
Dr. Withanage	Lecture, Institute of Indigenous Medicine
Dr. D M R Dissanayake	Consultant, Wickramarachchi Ayurvedic Institute
Group 6: Traditional Practitioners and Informal knowledge Base	
Dr. Danister Perera	Medical Officer, Sri Lanka Conservation & sustainable Use of Medicinal Plant Project.
Mr. Cyril Pallegedara	Director, Sri Lanka Conservation & sustainable Use of Medicinal Plant Project
Dr. A. H. M. Tissera	Lecturer , Ayurvedic Institute Yakkala
Dr. J. Mendis	Ayurvedic Physicians
Dr. Alawaththegama	Ayurvedic Physician, Abaya Osu, Balapitiya
Dr. R. J. S. Sayakkara	Ayurvedic Physician
Dr. L. P. A. Karunathilake	Lecturer, Institute of Indigenous Medicine

Future Demand Scenario Group

Name	Organization
Dr. A.T.P.L Abeykoon	WHO
Dr. Nimal Attanayake	University of Colombo
Dr. T.A Kulatilake	Epidemiology Unit
Dr. Ananda Amarasinghe	Epidemiology Unit
Dr. Thushara Fernando	Ministry of Health
Dr. S. Senanayake	Ministry of Health
Dr. S. Wickremasekara	Epidemiology Unit
Dr. R. Premaratne	Ministry of Health
Dr. M. R. N Abeyasinghe	Epidemiology Unit
Dr. R. Wickremasinghe	University of Colombo

B.3**COUNTERPART TEAM
(PROJECT PROFILE REVIEW PANEL)**

Name	
<p><u>1 Service Delivery</u> Prof. Rohini Senaviratne Dr. Saroj Jayasinghe Dr. Joel Fernando Dr. Malinga Fernando Prof. Dulitha Fenand Dr. Daya Samarashinghe</p> <p><u>2. Community Empowerment</u> Mr. Sunil Silva Dr. Ranjith Atapattu Dr. Vinya Ariyaratna</p>	<p><u>3. HRD</u> Dr. Saroj Jayasinghe Dr. Tissa Cooray Dr. Palitha Abeykoon</p> <p><u>4. Health Finance</u> Dr. Amala de Silva Dr. Nimal Attanayake IPS</p> <p><u>5. Stewardship</u> Dr. Tissa Cooray Dr. Thurushinghe Mr. L. Panambalana</p>

C JICA STUDY TEAM

Name	Assignment
Dr. Katsuhide NAGAYAMA	Team Leader
Ms. Akiko OKITSU	Deputy Team Leader/ Health Policy and Planning
Dr. Steven RUSSELL	Health Sector Reform
Mr. Gerald MOORE	Health Financing and Insurance System/ Drug Management System
Dr. David W. DUNLOP	Health Financing and Insurance System
Prof. Yasuo UCHIDA	Health Financing and Insurance System / Hospital Management
Dr. Cecile De SWEEMER	Health Service Delivery System/ Monitoring and Evaluation System
Mr. Kazumi AKITA	Health Facilities/ Medical Equipment and Commodities
Ms. Yuko SASA	Health Facilities
Mr. Masaya SEKIGUCHI	Human Resource Development/ Training System
Ms. Izumi MURAKAMI	Preventive Medicine/ Health Promotion
Mr. Yoshinori TAKAHASHI	Health Information and Geographical Information System
Dr. Francisco P. FLORES	Health Information System
Ms. Tomoko TAMURA	Social and Gender Analysis/ Medical Anthropology
Mr. Shingo SATO	Financial Evaluation/ Administrative Coordinator

