Organisation and Financing of Public Sector Health Care Delivery in Sri Lanka: The Need for Radical Change

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Organisation and Financing of Public Sector Health Care Delivery in Sri Lanka: The Need for Radical Change

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1. Introduction

It is a truism that the approach to and the organisation of the delivery of public goods and services cannot remain immutable over time, impervious to the changes in the economic, social and political contexts within which it occurs. Continuing changes in the economic, social and political environment require that the approaches to the management, organisation and financing of the delivery system should also change if it is to remain cost-effective, quality-responsive, beneficiary-friendly and efficient. Otherwise it is more than likely that the system would be irrelevant to the actual requirements of the community, at cross purposes with the realities of the polity and increasingly a captive of the more affluent sections of the community.

Whilst the rationale for continuing change is clear, resistance to it is also equally evident. The resistance emanates both from the institutions involved in the delivery system as well as from the community which the system serves. The reasons for such resistance are several. They include the vested interests of the personnel involved in the operation of the ongoing system, the reluctance of the community to venture from long established structures and processes to hitherto untested ones, the aversion of political elites to lose ongoing instruments of personal patronage, the disinclination of both political and bureaucratic elites to cede authority -- and the power which accrues from such authority -- to others; as well as the reluctance of powerful trade unions who, with their large memberships, seek to exercise a decisive voice on the personnel issues in the system to forgo such a role.

Hence, any attempt at a process of restructuring of the organisation, management and financing of the health care delivery system must necessarily proceed deliberately and with caution on a phased basis -- open to on course correction and modification as implementation snags are encountered.

However, whilst caution is called for, the urgency of reform and restructuring is not in question. It is something which, in the case of Sri Lanka, cannot be avoided or even postponed. It has a direct bearing on issues of efficiency, cost-effectiveness, equity and the quality of service.

Any assessment of the required reforms and restructuring has to be in the context of the lacunae in and the lack of relevance of the ongoing system. However, the ongoing system itself has to be understood and evaluated in the context of its historical evolution of which it is the product.

It is the view of this study that, at any point of time, the public sector health care delivery system in Sri Lanka should satisfy three basic objectives:

- First it should provide health care of **optimal quality** -- in terms of speed of response, effectiveness of preventive measures, appropriateness of treatment regimes, standards of physical facilities etc.

- The second relates to **the cost effectiveness** of the system such that the demands which would be made both on the public budget as well as on the individual citizens who use the system would be kept within affordable limits.

- The third concerns the availability of **equity of access** to its services for all citizens, irrespective of their spatial location -- given the reality of the prevalent transport system.

These should, therefore, serve as a backdrop to any discussion on the organisation, management and financing of the system.

Previous health care system reform efforts, in the view of this study, tended to adopt an approach of reacting to specific systemic inadequacies perceived from time to time and of effecting ad hoc adjustments to the ongoing system to cope with such inadequacies. In the long run, such ad hoc reforms contribute to systemic contradictions as they do not address the fundamental issues which affect the system.

Hence, this study has opted to take a long-term, holistic view of the likely future demands on the system and of the structures, organisation and processes which are necessary to meet such demands. In adopting this approach, the study questions the structures, organisation and processes which have evolved over time and recommends the institution of radically new ones rather than tinker with what exists.

Any other approach of a routine 'reformist' character will, as past experience shows, be subverted by the vested interests within the system. What is, therefore, required is to present the citizens and policy-makers with a holistic picture of what the future structures, organisation and processes should be if they are to adequately meet the demands of the future. Only such an approach would enable the policy-makers to radically transform the system whilst dismantling the ongoing one.

This is the thrust of the discussion in this study.

It is against this backdrop that the discussion will attempt to deal with the issues related to the organisation, management and financing of the delivery of health care by the public sector.

Section 2 presents an overview of the evolution of the public sector health care delivery system, focussing particularly on the British colonial period and the post-Independence period. It attempts to bring out how, from time to time, the system adapted to the dominant administrative, economic and political concerns of the time.

Section 3 discusses the emerging reality within which the public sector health care delivery system operates and is likely to operate in the medium term.

Section 4 assesses the experience of other countries to draw relevant lessons therefrom for application in the Sri Lankan situation.

Section 5 provides an overview of the existing public health care delivery system whilst Section 6 discusses the issues which arise therefrom.

The next two sections focus on the elements of a new system for the future -- with Section 7 dealing with the systemic changes and Section 8 discussing the roles of the governance institutions at the different levels vis a vis the public sector health care delivery system.

Section 9 deals with the issues related to the management of the transition from the current to the future system.

2. Retrospect[1]

The origins of the public sector health care delivery system hark back to the ancient period of Sri Lanka's history as a nation. However, the development of the modern system, as one knows it today, is more relevantly ascribed to the period of British rule -- more specifically the period subsequent to the onset of the plantation economy.

The very early phase of the system in the British colonial period was dominated by the military. The control of both the military and the civil health care institutions was entrusted to it. The main concern of the British at the beginning of their rule was with the health of their troops. Thus, military hospitals, manned by army medical personnel, were set up in towns such as Colombo, Jaffna, Trincomalee and, later, Galle -- very likely using earlier Dutch hospitals for the purpose. The military medical service was gradually extended to other towns and areas where troops were stationed.

It was in 1817 that the first general hospital for civilians was established at Prince Street in Colombo. With the growing popularity of western allopathic medicine in Sri Lanka, the demand for health care facilities outstripped the limited resources at this hospital. The outcome was the establishment of the General Hospital at its present site in 1864.

With the creation of a separate Civil Medical Department in 1858, a new phase was born. Health care facilities were now provided to the civil population by a department free of military control. Until 1931, the Civil Medical Department came, like other government departments, under the administration of the Colonial Secretary -- who was placed immediately below the Governor.

By 1868, there were 15 civilian hospitals, beside several special institutions. In 1925, the designation of the Principal Civil Medical Officer and Inspector General of Hospitals was changed to that of Director of Medical and Sanitary Services -- in keeping with the recognition of the growing importance of public health.

The modality of providing out-patient care through a system of dispensaries was introduced around 1873. Till then the emphasis had been on establishing hospitals in large towns which, given the then spread of the transport network, served only a relatively small proportion of the population. The dispensary system established a network of out-patient facilities which served the large rural sector. The system was augmented by

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[1] This section draws heavily on material contained in Uragoda, C.G. 'A History of Medicine in Sri Lanka' (Colombo, Sri Lanka Medical Association - 1987) and Rannan-Eliya, Ravindra and Nishan de Mel: 'Resource Mobilisation for the Health Sector in Sri Lanka' (Data for Decision-Making Project, Harvard School of Public Health, Boston, Massachusetts - February 1997).

estate dispensaries[2] when it was realised that there was an unduly high death rate amongst the estate labour cohorts.[3]

It was in 1913 -- that preventive health came to be recognised as an integral part of an effective health care system. Accordingly, the Sanitary Branch was established within the department. Two outcomes were the setting up of health units with Medical Officers of Health appointed to oversee the health needs of designated spatial communities and the initiation of Special Campaigns for the control of major diseases -- such as malaria, ankylostomiasis, tuberculosis, leprosy, filaria and venereal diseases.

During the early years of British rule, the main concern of the State was with the welfare of European residents and of immigrant workers. Economic considerations influenced decisions on the provision of health facilities.[4] However, when an indigenous trade union movement emerged in the 1920s, these examples provided an impetus to union agitation for the extension of similar benefits to the rest of the population.[5] Around the same time, health care provision policies came to be further influenced by the new middle class, which had emerged with the growth of the plantation economy, and was beginning its agitation for a greater share of political power.

This congruence was crucial for a series of subsequent events of profound significance in Sri Lanka and its health sector. It led to the argument being made that universal suffrage was essential as a means to ensure a better social standard for the population as a whole. The widening of the franchise would force the government to pay attention to the social needs of the mass of the population.

Even more important in the shift to universal suffrage was the increased acceptance of the role of government in providing health care services. The existence of a universal-suffrage-based electoral system forced the political elites to recognise the day to day needs of the populace. As the system developed, the electoral competition increased

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[2] These estate dispensaries were intended mainly for primary care and were manned by medical assistants and dispensers who had only a basic knowledge of drugs. These estate dispensaries exist to the present and, in a sense, provide the backbone of the health care service system in the plantations. With time, some of the dispensaries on the large estates developed into minor hospitals with in-patient facilities.

[3] They were brought and admitted to District Hospitals for treatment when at an advanced stage of their illnesses - underlining the need to provide treatment facilities as near to their places of work as possible.

[4] For example, plantation workers on whom the economy depended at the time were given special consideration, including the provision of hospitals.

[5] Discussed in de Silva, K.M. (ed) History of Ceylon - Vol.III (Colombo, University of Ceylon - 1973).

and, in turn, led politicians to recognise the electoral benefits of channeling state services and public spending to their electorates.[6]

With the introduction of the Donoughmore Constitution in 1931, the Legislative Council came to be replaced by the State Council which exercised both legislative and executive powers. The latter were exercised through seven Executive Committees comprising Council members and chaired by a minister. The Medical Department, thus, came under the Minister of Health and the Executive Committee on Health. This change marked the beginning of a new phase that, finally, led to the evolution of the present health care service delivery system. It led to the extension of health care facilities, within a relatively short period of time, to a large sector of the population, both rural and urban, through a network of hospitals and dispensaries.

The increased use of general revenues for financing health care delivery is hampered by its limited potential due both to economic and political reasons. The revenue system in Sri Lanka had, in the main, developed to serve the direct interests of the colonial regime The demand of social expenditures on the revenue system were kept low.

The introduction of universal suffrage in 1931 changed this picture by

- Providing a counter-force to the interests of the upper income groups, including the plantation owners, in a low level of taxation;[7] and by
- Creating a mechanism whereby the health care needs of the majority of the population could be translated into political pressure on the elites.

The malaria epidemic which began to affect the country in the 1920s also had a considerable influence on the progressive evolution of the health care delivery system. An organised campaign for the control of malaria on a country-wide scale was launched in 1921. It functioned through a chain of centres located in some of the high incidence areas with an increasing array of locally appropriate control measures being progressively adopted.

The severity of the epidemic triggered several interesting developments.

- The economic impact of the epidemic, in terms of its effect on productivity of the plantations, was felt by the planters. As a result, the Ceylon Estates' Proprietary

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[6] For a fuller discussion see Moore, Mick: The State and Peasant Politics in Sri Lanka (Cambridge, C.U.P - 1985) and Jayantha, Dilesh: Electoral Allegiance in Sri Lanka (Cambridge, C.U.P. - 1992).

[7] For example, direct taxes on individual and corporate incomes was introduced in 1932.

Association Malaria Control Scheme was started in 1926. Later the activities of the scheme[8] came to be enlarged to include other health problems.

- To meet the heavy demand for curative facilities posed by the epidemic, approved private organisations were provided with grants to open temporary facilities -- thus presaging the harnessing of the capacities of NGOs in the delivery of health care services.

- The Sri Lankan public, at all social and income levels, became accustomed to seeking allopathic treatment as a matter of course -- thus expanding future demand for allopathic curative services throughout the country.

By 1934-35 the malaria epidemic had been compounded by famine[9] providing opportunities for several left wing political groups to respond by organizing relief efforts in the hard hit districts. This, in turn, was seen as a political threat by establishment politicians who countered by supporting increased provision of relief programmes and medical services to the rural population.[10] It became clear that private initiative was totally inadequate to meet the demand for services created by the epidemic.

This recognition of the inadequacy of private financing and provision to meet the demand for health care services, combined with the need to maintain electoral support, enhanced the readiness of politicians to invest in expanding public sector health care services.

Individual members of the legislature became accustomed to making demands for peripheral health care facilities in their constituencies. The nature of executive governance under the Donoughmore Constitution magnified the impact. This led to a major expansion of the public sector delivery system financed by increased mobilisation of general revenues. By its very nature, it was very much an unplanned and demand driven expansion.

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8 With its name changed, in 1949, to 'The Planters Association Estate Health Scheme'.

9 During its peak in 1935, more than 5 million cases were recorded at government dispensaries when the country's population was only 5.6 million. The technology of the time had little to offer in terms of malaria control or treatment.

10 See Sandaratne, N: Public Expenditure in Health: A Case Study of Accountability in Sri Lanka (I.P.S. - mimeo).

By the time the British left in 1948, an independent department with responsibility for health care services had been in existence for ninety years. The achievements during this period were noteworthy. When the department was created in 1858, there were only three civil hospitals, a leprosy hospital, a mental hospital, a small pox hospital and two prison hospitals. By 1946 the number of hospitals had risen to 183, inclusive of specialised hospitals and 45 rural hospitals serving an in-patient cohort of 502,012. By the same year, there were 240 central dispensaries, 176 branch dispensaries and 453 visiting stations[11] which catered to a total of 7,498,552 out-patient visits. In this manner, health care services, within the context of the technology which was then available, were brought almost to the door step of many villages.

In the first ten years after Independence there was no change in government policy. Public spending on health care service provision expanded both in absolute terms and as a percentage of national income. Through this approach, an ideology of free health care service provision took root in the political culture.

This expansion was, ultimately, based on the transfer of resources from the plantation sector of the economy to the social sectors through the mechanism of export duties and corporate taxes. The haphazard expansion of such social sector commitments triggered major economic imbalances. The plantation sector could not increase production at a rate fast enough to meet the combined effects of accelerating population growth and expanded welfare services.[12] By the time the impact of rapid population growth began to be felt as a result of the earlier success in reducing mortality rates, it was felt to be politically suicidal to reduce the levels of public commitment -- given the range of social welfare handouts to the provision of which the governments had already become committed.[13] Politicians opted to take the road of drawing down of the country's foreign reserves and, then, of imposing foreign exchange controls and of attempting to control government spending -- particularly on capital investment.

During the period 1960-1970, despite substantial reductions in the share of national income spent by the government in social welfare measures such as education and food subsidies, there was little change in spending on health care services. 1971, however, saw a substantial cut in public spending on health care and the re-introduction of user

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11 This classification of dispensaries was adopted in 1922. The visiting station constituted the lowest rung of the health care service ladder, where an apothecary visited a remote station on a set day

12 See Snodgrass, Donald R: Ceylon: An Export Economy in Transition (1966)

13 See, Alailima, P: Social Welfare Policy in Sri Lanka (1991).

charges for the first time since 1951. The latter had a major impact on utilisation of out-patient services which fell to levels of the mid-1950s.

This reduction in government expenditure saw no attempt to increase reliance on private sector financing. In fact, private practice by government medical personnel was banned and substantial controls were imposed on the private sector pharmaceutical import and retail trade.

A change of government saw the abolition of user charges in 1977. This, in a measure, restored the level of utilisation of out-patient services. This restoration of the use of out-patient services, together with the increased awareness of the potential of western allopathic treatment, had its own impact on the demand for in-patient care -- in terms both of volume and of spatial spread.

However, the increase in the provision of public resources for the financing of health care services did not adequately keep pace with the growth in demand. These remained static as a percentage of GNP. The expenditure for 1980 was 1.3 per cent of the GNP. The comparable figure for 1985 remained at 1.3 per cent. In 1990 it inched up to 1.6 per cent and in 1995 to 1.7 per cent. When placed in the context of the rising cost of human resources and material inputs, it becomes apparent that the expansion of the public sector health care provision could not adequately keep pace with the demand.

The continuing under-provision of resources occurred concurrently with expanding public demand for services as well as the emergence of newer treatment regimes and technology which called for ever increasing investments. The result has been both a deterioration in the delivery of services and an inability to improve the quality of health care through the introduction of modern technological advances.

3. Contextual Changes in Public Sector Health Care Delivery

As the preceding discussion brings out, the public sector health care delivery system was, in its origin, a response to the economic, social, political and administrative context of the time. In a sense, though not necessarily deliberate in intent, subsequent changes and modifications to the system were also influenced by changes in the same contextual frame.

If a public health care system is to remain relevant to the evolving demands of the society which it seeks to serve, it must, necessarily, anticipate the changes in the economic, social and political environment. Hence, any process of reform of the system should take as its context the changes in the operational environment which have occurred and are likely to do so in the medium term future.

This Section will, therefore, focus on the nature and content of such changes.

Several major changes in the economy, the society and the polity can be considered as having a direct nexus with the organisation of the delivery of health care services.

The first is the growth of the economy. Even given the varying rates of growth over different periods, there has been a rise, over the decades, in the Gross National Product per capita. The data available points to a quadrupling of GNP per capita from U.S. dollars 171 in 1970 to U.S. dollars 673 in 1996. Equally relevant is the progressively widening spatial spread of economic activities -- leading to rises in disposable incomes, even though to varying degrees, in almost all areas of the country. The spatial spread of formal, organised economic activity also has an impact on the type of expectations that consumers have from curative services providers -- particularly in terms of their own time-investment.

The second is the rapidly rising expectations of the citizenry in terms of quality of treatment, the level of facilities, speed of delivery of care and the like which are, in turn, triggered by a continuously increasing awareness of the comparative developments internationally. The increasing awareness is the outcome of the widely spread rise in literacy and education, increased mobility as well as greater access to the print and electronic media.

Demographic changes constitute a third. These include both the spatial relocations of people consequent on shifts in the availability of employment opportunities as well as the changes in the size of age cohorts. For example, the rapid ageing of the population[14] will constitute a major challenge to the organisation and financing of health care services to the elderly.

A fourth change in the environment of health care delivery flows from the improvements to the country's transport facilities. This will provide the citizens with flexibility of access

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[14] It is estimated that by the year 2020, the elderly will constitute 17.7 percent of Sri Lanka's population.

to alternative providers of curative services, both public and private, within the total health care system -- thus expanding their range of options.

Changes in Sri Lanka's political and administrative system in terms of the devolution of authority and responsibility for delivery of public goods and services constitute a fifth set of contextual changes. These changes also include the increasing aspirations of the local government institutions for managing the delivery of public goods and services such as the primary levels of health care and the increasing possibilities and opportunities to enable them to enhance their capacity to deliver such responsibilities. These developments point to the need for a restructuring of the organisation and management of the components of the public sector health care delivery system.

A sixth contextual change would be the recent expansion of the network of Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs).[15] The growth is not only in terms of numbers and spatial coverage but also in terms of their levels of capability -- with the increasing professionalism of their cadres. Their potential to be active participants in the delivery of different categories of health care services, preventive as well as curative, should affect the future approach to the organisation, management and financing of the delivery systems.

The rapid expansion of the private supply of curative health care services constitutes a seventh new dimension. It has been computed that about 50 per cent of those seeking out-patient services and almost 5 percent of those seeking indoor services opt for private providers. Whilst privately provided inpatient facilities tend to be concentrated in the urban centres, especially in the greater Colombo area, outpatient services have tended to move wider spatially in response to demand. A not insignificant segment of the private sector supply is provided through out-of-duty-hour work by health professionals who are already on the government pay roll -- an issue which needs to be addressed in any restructuring of the public sector health care delivery system.

4. Lessons of Experience

The Sri Lankan contextual backdrop that has been discussed helps in assessing the relevance and effectiveness of the ongoing public sector health care delivery system. However, the lessons to be drawn from the comparative experience of other countries can also be useful in evaluating the options available in restructuring its organisation,

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[15] The number of Non Governmental Organizations, of varying sizes, is currently estimated to be 30,000.

management and financing. This Section focuses on aspects of this experience. The issues of concern include the following:

- the task assignment amongst and the inter-relationships between components of the management structure of the public sector health care delivery system;

- approaches adopted for the constitution of management organisations for the different categories of service providers -- curative as well as preventive;

- approaches to the financing of health care including modalities, if any, of cost recovery from beneficiaries and the systems of provision of financial resources to service providers; and

- the organisation of human resource development of health care professionals.

4.1 The Management Structure

The Scandinavian countries provide several useful pointers to the organisation and management of public sector health care services. A feature shared by these countries is their overwhelming dependence on public provision for the health care needs of the individual and the community. Private sector provision plays, at best, a marginal role in the supply of health care.

In Denmark, the function of health care provision is shared by three levels of governance The Government at the Centre is responsible for policy and legislation. Counties are responsible for planning and management of most of health care services whilst the Municipalities are responsible for the management of certain specific services. Individual and public health care are, thus, decentralised and are planned and managed by the Counties and Municipalities within the ambit of central legislation and general guide-lines.

Public sector curative service delivery in Denmark, as also in Finland and Sweden, is based on a referral system -- the only hospital service a patient can turn to without referral being the emergency service.

Health care delivery in Finland is mainly a function of municipalities and the stress within the system is on primary health care -- combining both curative and preventive services. There are 215 health centre districts in Finland for primary health care, providing the initial contact for the whole population, with referral for specialized treatment only if necessary. These centres provide not only general medical care but also dental care, ward treatment, rehabilitation, laboratory services etc.

In Sweden, the responsibility for health care services vests in the County Councils. At this level the provision is divided into primary care which covers all individual health care and all treatment that can be provided outside a hospital and into secondary care which is concentrated in hospitals -- with most specialised treatment being referred to tertiary level regional hospitals.[16]

In all these three Scandinavian countries, emphasis is on the enhancement of the effectiveness of primary care, both curative and preventive, based on a system of catchment areas wherein the characteristics of the population are known and resource planning becomes more realistic.

The post-1993 reforms in New Zealand provide for a series of Regional Health Authorities (RHAs) who act as receivers of funds from the Ministry of Health and, in turn, contract for services, both curative and preventive, with a series of providers. These include Crown Health Enterprises (CHEs) which operate as self managed enterprises and deliver curative services; Community Trusts; Private providers mainly of primary care (and sometimes even of specialist care); and voluntary agencies. The contracts, in both directions, are well structured and specify expected outcomes, outputs and budgets, and performance indicators as well as provide for reporting requirements.

The United Kingdom has introduced several major changes[17] in regard to the specifics of organisation and management of its health care delivery system since the National Health Service (NHS) was introduced in 1948. These changes, from time to time, were introduced after deliberate enquiry[18] into the continuing relevance of the ongoing systems of organisation and management. Whilst they seek to respond to the periodic changes in demands from the system, they also reflect the political and social ideologies of the different governments in office at the time the changes were introduced.

At the head of the NHS organisation is a 14-member Policy Board[19] which combines those with special knowledge of the NHS and persons with experience in the

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16 The Swedish Health Act provides for six health care regions within which the several County Councils are required to collaborate.

17 For example, in 1974, in 1982 and in 1990.

18 For example, the Guillebaud Committee (1956); the Cranbrook Committee (1959); the Poritt Committee (1962); the Gillie Committee (1963); the Salmon Committee (1966); Bonham-Carter Committee (1969); the Royal Commission on the NHS (1979); 'Patients First' (1979); the Griffiths Inquiry into NHS Management (1983); the two White papers 'Working for Patients' and 'Caring for People' (1989).

19 The 14 members include 3 ministers, 2 chairmen of Regional Health Authorities, the Permanent Secretary, the Chief Executive and the Chief Medical Officer both of whom are appointed in their personal capacity, as well as a leading clinician from the NHS and 4 persons drawn from industry.

management of other industries and organisations. The Board deals not with management issues but with matters of advice on the overall pattern and balance of policies for the NHS and with the assessment of the effectiveness of the implementation and the impact of such policies.

Accountable to the Policy Board is the NHS Management Executive which is headed by the Chief Executive and includes NHS managers and career civil servants as well as one or two others who are inducted for their special knowledge and experience. It is the responsibility of the Management Executive to ensure good management within the NHS and to monitor the performance of the health authorities in relation to national policies and to public demand.

The organisation of the NHS is based on a set of regions with each having a Regional Health Authority (RHA)[20] responsible for the allocation of the health resources of each region in accordance with the policies which are determined both nationally and regionally as well as for providing major supporting services. These responsibilities entail functions of service planning, information management, staff development, legal affairs and public relations.

Within each region are a series of District Health Authorities (DHAs)[21] covering an average population of 300,000. Their focus has, since the reforms of 1990, moved away from being in charge of the operational aspects of health care delivery (which are now the responsibility of Self Governing Trusts). They now include responsibility for the purchase of health care services for the population of the district, ensuring that such care was comprehensive and that disease prevention and health promotion were effectively in place and the monitoring of the performance of care providers.

Within the district, the DHAs and the SGTs (with their own Boards of Management) have a separate but equal relationship in their negotiations. In addition are a series of General Practices, comprising a group of doctors, catering to an average of 2,000 patients. These act as a filter to screen out those patients whose health status does not need the more expensive services of the hospitals. The larger of these General Practices, with a patient cohort of more than 9,000, are encouraged to assume the role of Budget Holders providing them with more discretion in obtaining care for their patients.

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20 The membership of the RHAs comprises a Chairman and 5 executive members and 5 non-executive members.

21 The DHAs have a membership comprising a chairman with 5 executive members and an equal number of non-executive members selected for their business acumen.

4.2 Approaches to Financing

The sources of funding in the U.K. are threefold. The main source remains the central government tax revenues. National Insurance Contributions, which are paid by employers and employees within the P.A.Y.E. system, constitute a second. The third source of direct payments by patients[22] remains a minor source.

The allocation of central government revenue in the U.K. involves an intricate set of negotiations between the Treasury and the Department of Health. The latter passes on the resources received from the Treasury to RHAs and DHAs according to previously agreed budgets -- with the budgets of the DHAs being computed from the size of their resident populations. The SGTs raise their resources mainly through the supply of contracted services to the DHAs.

In Sweden and Canada local and regional health taxes have been resorted to, with the former utilising this source for 75 per cent of the total finances. Dedicated taxes, in the form of an extra tax on tobacco, were tried in New Zealand but did not last long.

A large proportion of the health care in the Netherlands is provided through private sources which are, however, controlled through a system of regulatory legislation.[23] Private fees account for around 25 per cent of the total budget, with the Sickness Fund Insurance Scheme and the Special Sickness Expenses provisions accounting for much of the balance and direct state funding providing a small share.

Compulsory health insurance, which is administered through government approved schemes, covers most of the population in Japan, Australia and parts of Western Europe.

In The United Kingdom, the U.S.A. and in France voluntary health insurance schemes operate.

In Germany, 90 per cent of the population are covered by insurance. Of these, 57 per cent are compulsorily covered whilst 13 per cent are voluntarily insured and 30 per cent are retired but insured.

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22 Direct payments are for such services as sight tests and dental examinations and for private beds in hospitals as well as for doctors' prescriptions for certain categories of patients.

23 For example, the Hospital Facilities Acts of 1972 and 1979 and Health Charges Act of 1984.

Whilst direct payment schemes exist across the spectrum, they remain marginal in the context of the total outlays on public sector health care provision.

4.3 Human Resource Development

The U.K. provides an interesting pattern of human resource development which has developed over a long period of time.

Medical schools attached to universities provide the education and training of doctors at the undergraduate level whilst Postgraduate education is regulated by a series of Central Councils.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is mandated to establish and improve the standards of training and professional conduct of the nursing profession, to determine the rules for their registration and to maintain a single professional register and to protect the public from unsafe practices. It is supplemented by 4 National Boards which, within the framework of the policies and rules of the UKCC, are required to arrange for others such as schools of nursing, polytechnics, universities and technical colleges to provide training courses leading to registration as well as post-registration courses.

Continuing management education has been recognised as a major instrument of capacity building in the NHS. The National Health Service Training Authority (NHSTA) is, thus, made responsible for developing, standard setting, organising, and evaluating training strategies for the NHS staff.

5. An Overview of the Current Situation

The developments in comparative situations that have been discussed above provide a context for understanding the current situation with regard to the system as it has evolved in Sri Lanka. It is, first of all, necessary to map the ongoing system before seeking to assess it. This is what this Section seeks to do. The following Section attempts to assess the issues which arise from it.

The public sector health care delivery system does not operate in a vacuum. It operates in the milieu of a mixed system -- with the private sector active in the delivery of curative services and the NGO sector involved in the delivery of preventive services. The discussion in this Section will therefore include a portrayal of the roles of both these sectors in the provision of health care services.

The availability of different levels of curative facilities in the country in relation to population distribution is analysed in the table provided in the Annex I.[24] Two basic factors emerge from this analysis:

- that specialised institutions tend to be concentrated in the Western Province and most particularly in the metropolitan district of Colombo; and

- that there is a significant degree of variation in the per capita availability of access to tertiary care institutions between the Provinces -- especially between the Western, Southern and Central provinces on the one hand and the other provinces on the other.

The current system of resource allocation, at both the provincial and the central level, is based on historical antecedents rather than on actual service outputs or on changing epidemiological profiles. What is regarded as `recurrent expenditure' is normally allocated on the basis of expenditures of previous years. Allocations for capital investment (including maintenance of infrastructure) are, more often than not, a matter of last-minute-disaster-avoidance rather than an anticipatory provision for meeting emerging needs.

The prevalent structures and processes for the management of institutions providing curative care are characterised by a high degree of centralisation in regard to decision making. Whether the facilities in question are considered to be within 'central' or 'provincial' purview, all decisions ultimately end up in the Ministry of Health at the Centre The individual institutions lack management autonomy concerning key management instruments such as personnel management, procurement of supplies and the flexible utilisation of financial resources.

Individual institutions have little or no voice with regard to their personnel. The cadres are, generally, set historically and imposed from super-ordinate hierarchical levels -- whether at the Centre or at the Province. All groups of personnel[25] are recruited to all-Island pools. The specific allocation and movement of personnel follows historically set rules and procedures of transfer etc, which have evolved from those of colonial times, rather than the specific needs or task flows of particular institutions. Sri Lanka follows

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[24] This analysis provides only broad indicators as to the spatial spread of facilities. Further mapping within each province and at sub-provincial levels co-related with transport networks, is required to assess the real ground situation as regards disparities in access encountered by citizens in different areas of the country. What is likely to be suggested by such a mapping would be the need to strengthen existing curative facilities whilst improving transport and communication infrastructure, rather than further multiplying the network of curative institutions. Such a mapping exercise has, as at the time of writing, been decided upon by the Southern Provincial Council.

[25] For example, doctors, assistant medical practitioners, nurses, public health personnel, para-medical grades.

what appears to be a unique custom of periodically transferring its health care personnel regardless of specific institutional needs.[26] Disciplinary matters almost always end up in the central ministry, thus weakening the disciplinary nexus which must exist within individual service delivery facilities if they are to function effectively.

A similar culture of centralisation exists as regards the procurement and management of supplies and materials as well. For example, not only is the procurement of drugs decided upon centrally but they are also physically collected centrally and apportioned thereafter to the different service providers -- a process which contributes to delays in receipt by the latter, uneven availability, losses and pilferage in bulk storage, transit and handling etc.[27]

Centralisation is also the underlying basis of the management arrangements for public sector preventive health care services and programmes. They suffer from the same lack of autonomy as regards personnel management, procurement of supplies and deployment of financial resources as discussed in the case of curative facilities.

The preventive programmes have a further negative feature. When these programmes are formulated and launched, they are not set time bound targets for the achievement of their programme objectives. The result is that, more often than not, they continue to linger on as part of the public sector institutional scene for decades with continuing loss of momentum and with progressively diminishing returns on investment.

Most ancillary and supportive programmes which have a direct co-relation with the improvement of the health status of the community -- such as nutrition programmes, environmental sanitation programmes, water supply projects, measures aimed at prevention of occupational hazards etc. -- are the responsibility of organisations that fall outside what is traditionally regarded as the health sector. In the absence of effective institutional arrangements for inter-ministerial and inter-departmental co-ordination, the links between these measures, which are, in effect, preventive health care interventions, and the rapidly changing demands of health status objectives tend to be tenuous.

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[26] These transfers are usually based on rules hallowed by tradition related to such matters as periods of service in different stations and movements from 'good' to 'bad' stations and vice versa. Of course, personal relationships also play a significant role in influencing the actual transfers.

[27] Considering that drugs typically need to be stored and transported below preset temperatures, one would suspect that the current stocking and distribution process also creates problems of deterioration and wastage.

As briefly discussed in Section 3, the private sector has come to play an increasing role in the provision of western as well as ayurvedic curative care. This, as pointed out earlier, is especially the case in regard to outpatient services.[28]

The trend has been towards an increasing shift to private providers in the case of outpatient services and this has a bearing on the future planning of public sector provision of services. An increased emphasis may be required on the public sector provision of indoor services whilst the expansion of outdoor services is de-emphasised.

The provision of preventive services has, albeit slowly, begun to involve the participation of the NGO community. This has, to a considerable extent, been the outcome of the recognition by Community Based Organisations (CBOs) of the importance of preventive health interventions both as entry points as well as critical elements in their programmes of community upliftment and development and their resultant readiness to participate in the state-initiated activities in this sector. However, there is considerable distance to be traversed in achieving a full partnership in a joint government and NGO effort at a more cost-effective, client-friendly programme of preventive health care interventions.

6. Issues Arising from the Current Situation

The ongoing system of health care delivery in the public sector raises several issues that need to be addressed and that have a bearing on future reform of its organisation, management and financing. For purposes of discussion, these issues will be placed in four groups:

- issues that are related to the effectiveness of service delivery institutions and programmes;
- issues that concern system direction at the national and sub-national levels;

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[28] This is, in a measure, reflected in statistics in regard to outpatient visits to public sector institutions. From a total of 28.85 million per annum in 1960, the figure has risen only to a total of 35.27 million in 1994 - a rise of 22.25 per cent as compared with a population increase of 74.4 per cent during the same period. The rate per thousand of population which was 2,915.5 in 1960 had declined to 1974.6 by 1994. Whilst the improvements in morbidity figures due to higher income levels and better nutrition as well as the reduction of the volume of repeat visits due to better treatment regimes and drugs could partly account for the drop in outpatient visits, it is not possible to ignore the effect of the utilisation of private sector provision in this reduction.

The situation as regards inpatient services has, however, increased both in absolute numbers as well as pro rated to 1000 of population. The former has increased 130 per cent from 1.39 million to 3.20 million and the latter from 140.7 to 179.3.

- issues that affect the system's interface with its clientele and the general public; and

- issues that relate to private sector provision of health care services.

6.1 Institution and Programme Related Issues

These issues relate to management effectiveness; the mobilisation and management of financial resources; human resource management; materials and supply management. Each will be briefly discussed in the paragraphs which follow. Related to these are issues concerned with the capacity of the delivery institutions to mobilise community support as well as their accountability to the community. These would be dealt with under the third set of issues.

The current management structures of the public sector health care delivery system has lines of command, both formal and informal, running from the individual provider institutions to the bureaucracy at the Ministry of Health of the central government -- with even routine management decisions tending to arrive at the Ministry. This situation is made more complex by the predilection of the Ministry to be accommodative of the interventions of party political cadres in regard to minutiae of management of health care service delivery facilities.

The Thirteenth Amendment to the Constitution, in 1987, vested the major role in the operational overview and overall management of the public sector health care delivery institutions in the respective provinces -- both curative and preventive -- on the Provincial Councils. However, even ten years after the event, the precise roles of the Centre and of the Provincial Councils in regard to management functions and authority have not been agreed upon and remain in confrontational dispute. The resistance evinced by the authorities at the centre to this exercise in devolution and the resultant tug-of-war between the two levels has only served to worsen the situation as regards management, through the overlapping of responsibilities, of control and of oversight.

The result is a multiplicity of lines and layers of management. This has led to procedural delays, contradictory management decisions, weak human resources management, inefficient utilisation of material and financial resources etc. -- all contributing to ineffective management at the level of service delivery facilities. The service delivery institutions, themselves, are in bewildered confusion and their personnel have not been slow to exploit this confusion to their own advantage.

Another critical defect which flows from the current situation is the continuing mismatch between resource demands of the task responsibilities of the individual service delivery institutions and the timely availability of human, material and financial resources to them. The highly centralised process of resource allocation, which tends to follow a practice of basing itself on historical antecedents, finds itself unable to respond readily to shifts in service demands, variations in client preferences, spatial and age cohort based changes in morbidity patterns etc. This is made more complex by the current constraints on government budget resources. The historical inequities in the allocation of resources continue and any rationalisation of the equitable availability of services becomes well nigh impossible.

> **With little or no control over financial, human and material resource allocation, the individual service delivery facilities find themselves unable to effectively plan resource management. The result is that the quantum and quality of service delivery suffers -- contributing to increased public dissatisfaction.**

6.2 Macro and Sub-national Level Issues

Into this category fall issues of budgeting; resource mobilisation and allocation; expenditure control; accountability and transparency; and relationships between the centre, the provinces and the local government institutions within the devolutionary political structure.

A major issue as regards budgeting lies in the appropriateness of the approach to the annual provision of financial resources for health care services. This, as described earlier, tends to be based on historical antecedents rather than actual current needs. Procedures followed do not permit assessment of the changing service demands in different spatial areas so that they could be aggregated and costed to serve as the basis for resource mobilisation and allocation. There is therefore a continuing mismatch between overall resource needs and resource provision via the annual government budget.

As a result, resource provision for the health care sector lacks a logical basis. It tends to be based on the ebbs and flows of the annual interchange between the Health Ministry at the centre and the Treasury. The Ministry of Health lacks the information and data on assessed service needs to back its requests for resources and, thus, has no option but to accept ad hoc Treasury diktats which emanate from its pre-occupation with concerns of

overall budget management. Neither the process nor its outcomes in regard to the country's health budget are predictable -- making any form of forward planning well nigh impossible.

The distribution of the annual resources obtained amongst the different service delivery points also follows historical precedents rather than assessed current needs.

Given this process of resource allocation, it is not surprising that resource management remains ineffective. There is no way in which expenditure can be tested against service delivery outputs or in which the validity of unit costs of service delivery could be assessed.

In the absence of pre-set expenditure norms and unit costs of service delivery, accountability for the utilisation of allocated funds becomes almost non-existent. There is no transparency in regard to resource utilisation (in terms of outputs produced) as far as the general public or the immediate community is concerned. The public, in the absence of information concerning expenditure norms, have no way of assessing the cost effectiveness of the service outputs provided for them.

Reference has already been made to a major weakness in the operation of the current system -- namely, its lack of consonance with the devolved polity which was introduced by the Thirteenth Amendment to the Constitution. The Ministry of Health at the Centre, both at the political and at the bureaucratic level, has been unable to wean itself from the old traditions of central control. This trend has been reinforced by the continuous pressures exerted on policy-makers by large and powerful trade unions in the health care sector whose members have, over the years, found centralised management to be to their group advantage. There has, thus, been a reluctance to devolve financial and management responsibility and authority effectively to the provincial administrations.

The result of this dissonance between the objectives of the devolutionary polity and the continued attempts at maintaining centralised control has been a duplication of functions between the provinces and the centre, confusions and inefficiencies in the exercise of supervision and control and the consequential wastage of resources.

6.3 Interface with the Clients and the Community

Issues in this area include equity of access to the available services; the networking of multi-level facilities to provide such equity; the institution-community nexus; and the cost of accessing services.

The discussions in Section 5 and statistics provided in the Annex (concerning the spatial spread of the different levels of curative health care delivery facilities in relation to the pattern of distribution of population and the availability of transport facilities) point to the continued existence of considerable spatial inequities in the availability of tertiary and secondary care with an overwhelming concentration of such facilities in the administrative district of Colombo.

No serious effort has been made, over the years, to network the different levels of facilities within spatial areas and to provide for the progressive filtering of service seekers within them through a referral system. The latter, based on institutional networks, has obviously to be undergirded by the upgrading of primary level institutions in terms of personnel, technology and supplies so that the clientele has confidence in them and would not be induced to bypass them[29] and seek direct access to secondary and tertiary level institutions. The reality of the overcrowding of the latter is mute testimony to the failure to effect any such changes.

Even though curative services are provided free at point of delivery, there is an inevitable regressive cost to health care seekers in terms of access costs depending on their own spatial location -- with those in the more remote areas (which are not served by facilities of adequate quality) incurring the highest costs of access. These access costs place heavy burdens on the lower income groups of service seekers in attempting to access secondary, and more particularly tertiary, levels of services.

The centralised management structure of the system, coupled with the system of routine transfer of health care professionals, also acts as a barrier to the development of a symbiotic relationship between its constituent service delivery institutions and the immediate communities which they are designed to serve. They tend to be looked upon as alien implants by the local community. The latter does not readily recognize any sense of obligatory responsibility on its part to provide support to what is viewed as

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[29] It has been estimated that only 41 per cent of those seeking treatment for illness use the nearest provider whilst 59 per cent bypass them and go to providers further on. See Samarasinghe, Daya D. and John S. Akin: Report of the Health Strategy and Financing Study' (Unpublished - Ministry of Health, Colombo - 1995).

something that 'belongs' to the Ministry of Health at the centre and not to the local community.

6.4 Issues Related to Private Sector Provision of Health Care

As has already been discussed, the private sector has, over the years, come to be a major supplier of curative health care services, particularly of outpatient services, with increasing sections of the population depending on them. Several reasons have triggered this trend, including the following:

- the relative convenience, in terms of time utilisation, in accessing private providers, which is a point of high significance for those employed in the formal sector;

- the perception by patients of a higher degree of individual attention and quality of care in private sector service delivery as contrasted with that of the state sector; and
- the rise in disposable income among increasing groups in the economy.

The recent rapid growth of the private sector supply raises several issues which need to be addressed by the state as part of its own agenda of reform of the organisation, management and financing of the public sector system.

- The private sector supply is characterised by a high level of dependence on the part time services of almost all categories of public sector health care professionals.

- The heavy involvement of public sector health care professionals in the private sector has contributed to conflicts of interest. Complaints are made of those who are so engaged paying lesser attention to their responsibilities in the public sector institutions, misusing public facilities for the benefit of private patients, performing private services within mandatory public sector working hours etc.

- A major contributory reason for the current ongoing situation is the low supply of health care professionals[30] as measured against the demand posed by the community as a whole. Hitherto the supply has been mainly measured against the demand of the public sector -- which has also been kept artificially low by budgetary constraints.

- A critical issue which needs to be addressed therefore is the need to increase the total supply of health care professionals and to provide the outputs from the

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[30] This applies to almost all categories of health care professionals including Consultants, Family Physicians, Nurses, Pharmacists, Para Medical Professionals etc.

educational and training systems with the necessary financial assistance to practice their professions in the community.

6.5 The Future Direction

Several issues which need, in the future, to be addressed through a reform of the management, organisation and financing of the public sector health care system emerge from the foregoing discussion. These include:

- Separation of the tasks of policy and strategy formulation and of management of service delivery.

- Ensuring a consonance between both the policy management structures as well as the service delivery management structures on the one hand and the devolutionary polity on the other.

- The direction of future investment of public funds towards ensuring a more equitable spatial spread of secondary and tertiary level institutions as well as upgrading primary level institutions.

- Removal of the multiple layers of oversight and control of service delivery facilities, providing them with optimum management autonomy.

- Undergirding the system of public sector curative services delivery structure by a referral system.

- Establishing a direct co-relation between the requirements of services provided by individual institutions and the resources available to them as well as between the resource allocation to the health budget as a whole and the changing demands on the public sector service delivery system.

- Ensuring a closer nexus between the service delivery institutions and the immediate communities which they serve.

- Providing for an increase in the supply of health care professionals and a phasing out of the part time involvement of public sector health care professionals in private provision of services.

The discussion in Section 7 will attempt to integrate these issues in the design of an improved system of management, organisation and financing.

7. Towards an Improved Organisational and Financing System

A major contributory cause of the current confusion in the public sector health care delivery system is its attempt to address two, not necessarily related, concerns. The first is the efficient and effective provision of acceptable levels of health care services -- which is obviously the primary task of a public sector health care delivery system. The second is providing a safety net for low income segments of the community through their access to public sector health care services.

Both concerns carry equal weight as elements of public policy and a government's desire to pursue them equally vigorously is not a matter for surprise. However, the attempt to combine them within the public sector health care service delivery system has not yielded optimum results in respect of either.[31] Both concerns would be better served if they were individually addressed relative to their own unique compulsions.

> **The designing of the future system should, therefore, be based on a de-linking of the two concerns and their being specifically addressed separately.**

Hence, the future public sector health care delivery system should be so designed as to focus more directly and exclusively on the task of delivery of curative and preventive health care services. The second objective of ensuring a safety net in regard to access should become the responsibility of public agencies concerned with social security.

An effective reform of the organisation of the state institutional structure of the health sector will only be realistic if it is based on an assessment of the future role of the government in relation to the sector. An attempt must be made to set out this role in the changing contextual environment discussed in Section 3 and to dis-aggregate the tasks that arise amongst the institutional components within the structure.

The emerging role of the state, in the new context that has been discussed, comprises three sub-roles.

- Providing policy guidance for the sector. This should be extended to all task performers within the sector, and should aim at ensuring that the sectoral objectives and goals that are set from time to time are achieved.

- Facilitating effective and efficient functioning of the different providers of health care services -- both public and private.

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[31] Given the realities of political compulsions, the latter has, often, taken precedence over the former in terms of policy decisions, of investment decisions and of resource allocation decisions.

- Regulation -- more especially for the protection of the interests of the service seekers vis a vis the service providers.

Viewed against this background, the functions of the state in regard to health care delivery would basically comprise three elements.

i. The first would be policy management in regard to the health sector. This would include the analysis of policy options, decision making on policies, the formulation of strategies which should be implemented to attain the policy objectives, the setting of standards related to the delivery of health care -- both preventive and curative -- as well as the continuous monitoring and evaluation of the implementation of such policies, strategies and standards.

ii. The second is the facilitation of the efficient functioning of the service providers within the health care delivery system, both in the public and private sector, at its several levels of operation.[32]

iii. The third is the exercise of regulatory oversight of the standards of the delivery of services, whether such delivery be by public or private providers.

How effectively these functions are discharged will depend to a great extent on the manner in which their performance is structured. At present, there is a co-mingling of all these functions within the Ministry of Health at the centre. This has been an impediment to the effective performance of all three. The general approach has tended to be one of ad hoc attempts to cope with recurrent crises.

The absence of a structured approach to the institutional support for the three functions has adversely affected the quality of policies, it has contributed to the inefficient delivery of services due to ineffective facilitation and it has prevented the emergence of an effective regulatory process.

Hence, in any future restructuring of the performance of the roles of the state in regard to health care there should be a clearly demarcated allocation of responsibility for the three sets of functions. An appropriate approach is suggested below.

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[32] These would include the primary, secondary and tertiary levels of curative services as well as preventive services.

- The tasks of formulation, of implementation monitoring and of evaluation of policies and strategies[33] should become the future focal function of the Ministry of Health.[34]

- A National Health Commission responsible for providing the Ministry of Health with policy advice on a continuing basis,[35] should be institutionalised in order to provide for continuity and professionalism in the policy management process.[36]

- The setting of standards for the delivery of health care services should also be a responsibility of the Ministry of Health. This activity should, however, be organised separately within the Ministry -- distinct from the policy management activity discussed above.

- Facilitating an efficient and effective delivery of services by public sector institutions and programmes should become the responsibility of a Department of Health Services (DoHS).[37] The functions that fall within this role would include bulk procurement of drugs and other supplies, technical assistance on procurement of equipment,[38] guidance on the recruitment of personnel, the undertaking of health research, health education, direction of special campaigns etc.

- The task of regulatory oversight encompasses both the public sector and the private sector delivery of services. Hence, it should not be placed under the proposed Department of Health Services but be the responsibility of the Ministry of Health which also has the responsibility for the setting of the performance standards. Appropriate institutional arrangements, linked to the Ministry of Health, should be created for this task.

While national policies would be the domain of the Ministry of Health at the centre and the core facilitative services to provider institutions would be a function of the Department of Health Services, the monitoring of the service provider institutions, the allocation of resources to such institutions as well as the implementation of the national policies within

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[33] Policies and strategies should encompass such areas as the continuously changing roles of the public and private sectors in the delivery of curative services, the roles of health authorities, local government institutions and NGOs in the delivery of preventive services, modalities for provision of financial resources for service delivery, education and training of health care professionals, the role of other agencies of government in regard to associated areas such as occupational health, environment, sanitation, water supply, nutrition etc.

[34] In the context of rationalisation of government functions, the portfolio of health should exclusively cover the health sector - including ayurvedic health care.

[35] The National Health Commission should comprise of health policy professionals as its members. In its policy analysis activities it should provide for the participation of the Provincial Governments. In order to enhance its position within the policy management process, it should be made mandatory for the Ministry of Health to publicly explain any instance of rejection of the proffered advice with reasons therefor being assigned.

[36] The absence of continuity and of professionalism has been a major gap in public policy management in Sri Lanka in regard to all sectors. This is more fully discussed in: Wanasinghe, Shelton and Harshitha Gunaratna - 'Enhancing the Effectiveness of Public Policy Management: The Challenge for Sri Lanka' (Institute of Policy Studies - October 1996).

[37] As competencies begin to be developed at the Provincial (Regional) level and bulk purchasing ceases to be a critical factor in price determination, the role of the DoHS could progressively shrink.

[38] Including the determination of specifications, calling for and evaluation of tenders, effecting maintenance arrangements etc.

each Province/Region would be the responsibility of the Provincial (Regional) Governments.[39] This requires that appropriate institutional arrangements be available at this level to perform the related tasks. What will be critically important will be to ensure the continuity of policies and the professionalism of management.

This need is best met by the institution of a Provincial Health Authority in each Province/Region. This would comprise the Provincial Minister responsible for the health sector, the Provincial Director of Health Services, the Chairpersons of the Boards of Management of service delivery institutions and three members of the public appointed by the Provincial Minister from amongst a panel recommended by the Provincial Director.

While the facilitation of the effective functioning of public sector curative service providers as well as of preventive and promotional programmes would be the function of the proposed Department of Health Services and of the proposed Provincial Health Authorities, the actual management of these facilities[40] and programmes should be organised on the basis of autonomy at the institution level.[41] This would imply that

- there would be an autonomous Board of Management for each tertiary level hospital,[42] for each institutional cluster comprising a District Hospital and its feeder facilities[43] and for each discrete preventive/promotional programme;

- such Boards of Management (of not more than 5 persons) would be constituted by the Provincial/Regional governments[44] and would be composed of professional members. They would be non-executive Boards and would appoint a full time Chief Executive Officer to direct the management;

- Boards of Management would be responsible for the management of the financial, personnel and material resources of the institutions/programmes in their charge; and

- their accounts and performance reports would be published annually, available to the public and defended at public meetings of the Provincial/Regional Councils.

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[39] The term Province/Region is used in this discussion as the current (June 1997) proposals for constitutional reform envisage a system of Regional Councils at the sub-national level.

[40] Including facilities providing allopathic care as well as ayurvedic care.

[41] One of the advantages which would flow from management autonomy at the institution level would be the discretion to organise the supply of services for each institution in a manner that would fit into the conditions in its operational environment. One such possibility is the out-sourcing of a range of supplies such as janitorial services, security services, ambulance services, pharmacies etc.

[42] This would include Provincial Hospitals, Base Hospitals, Specialised Hospitals (e.g. Cancer Institute, The Colombo Eye Hospital) and Teaching Hospitals.

[43] These would currently include Central and Visiting Dispensaries, Rural Hospitals, Maternity Hospitals.

[44] In the case of the proposed Capital Territory, this would be the function of the Capital Territory Administration.

7.1 Personnel Resources and Their Management

A major supportive activity for the efficient functioning of the health care services delivery system is the availability of skilled technical personnel to staff the delivery facilities -- both public sector and private sector. Hitherto, the emphasis has been on such cadres for the public sector, which was the dominant sector, being produced by the Ministry of Health itself which was the sole employer.

Two major changes have since come about.

- The first is that the private sector has emerged as a major provider of curative services and the NGO community is increasing its role in the delivery of preventive services.

- The second is that, even within the public sector, the Ministry of Health will cease to be the sole employer. In the new scenario, with autonomous Boards of Management and with Provincial responsibility for the delivery of services, there will be several employers.

The ongoing arrangements as regards the education and training of health care professionals has meant that private sector providers lack the necessary personnel or have to resort to poaching from the public sector for their supply of part time personnel -- an ad hoc arrangement that prevents the private sector service providers achieving sustainable viability.

It is, therefore, necessary to adopt a changed approach to the task of human resource development in the health care sector.

The projection of total human resource requirements for the country's health sector and setting of standards of qualifications[45] should be an integral element of the policy management function of the Ministry of Health. These projections would provide the demand signals to the training and education supply system. The actual training and education activities should, thereafter, be the task of tertiary level institutions -- both public and private -- in the education and training sector.

An important element of the restructuring process of the public sector health care system would relate to personnel management. The uniquely Sri Lankan practice of recruiting all health care personnel to Island-wide pools and periodically transferring them amongst public sector institutions and programmes has been a major impediment both to

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[45] In most of the professions in the health care field, the qualifications would, in the contemporary context of technology advancement, need to be at Degree or Higher National Diploma levels.

management effectiveness and to institution building. This practice has, thus, to be replaced.

- Whilst regulating the qualifications for each type and level of position in the health care services would be a concern for the Ministry of Health, the actual appointments would be a matter for each Board of Management.

- Health care professionals would be free to apply for any vacant position advertised by any Board of Management, subject to the qualifications laid down in such advertisements.

- The Boards of Management would constitute selection panels to conduct the recruitment. These selection panels should include a nominee of the relevant Provincial Ministry of Health.

- Whilst specific appointments and the assignment of remuneration packages and conditions of employment for specific positions should be the responsibility of the Boards of Management, the broad salary ranges of the different categories of health care personnel would need to be set from time to time by the Department of Health Services at the centre.[46] Otherwise confusion could arise.

It is expected that the approach to the question of superannuation benefits of public sector personnel will be rationally resolved without delay as part of the ongoing programme of administrative reform, through the establishment of a contributory pension scheme. This would be a facilitation measure as far as the reform of the personnel management activity in the health care sector is concerned. It would enable health care personnel in the public sector to carry their pension entitlement with them as they, on their own volition, move amongst different public sector providers.

7.2 Financial Resources and Their Management

How effectively such a structure of autonomously managed curative and preventive service institutions functions would, to á large extent, depend on the modalities through which their financial resources are mobilised, deployed and managed.

Current practices in regard to resource allocation have evolved over the decades:

- these follow a basis of incremental increases on historical outlays in assessing financial resource needs of service delivery institutions;

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[46] In doing so, the Department of Health Services would, of course, act in consultation with the Ministry of Finance.

- they enforce rigid restraints through both rules and traditions on the flexible deployment of the available resources in response to changing service delivery compulsions; and

- they impose a multiplicity of time consuming hierarchical approvals in incurring of actual expenditures by the service delivery institutions.

Over the years, as the network of service delivery institutions has expanded, control procedures have become more and more cumbersome and dilatory. Through the addition of extra layers of bureaucracy, they have increased the total resource requirements of the health sector and diverted resources which could otherwise have been spent on improving service delivery.

In regard to the mobilisation of resources, the current procedures

- do not provide adequate predictability as regards the flow of resources and make the planning of inputs of human and material resources for service delivery well nigh impossible; and

- fail to match resource provisions with the constantly changing needs of service delivery due to the failure to link resource supplies with the service delivery outputs of the institutions.

In regard to the deployment and management of the resources which become available to the service delivery institutions, these procedures

- deny institutions the capacity to allocate resources to previously unperceived, yet urgent, needs as they arise;

- prevent them from changing objectives of expenditure to suit emerging service delivery needs;

- lock the institutions into continued expenditures on personnel and material resources which have become redundant; and

- delay the process of service delivery through the imposition of dilatory procedures into the incurring of expenditures on inputs.

The thrust of the preceding discussion in regard to the management of the delivery of services has been that each delivery organisation, whether of curative services or of preventive services, be vested with autonomous authority and be held accountable for the delivery of entrusted services. This would need to be undergirded by a modality of

resource allocation in which the available resources would match the costs of efficient service delivery.

The actual modalities would, of course, vary as between the delivery of curative services and of preventive services and as between recurrent costs and investment funds.

The optimal modality as regards curative services would be to re-imburse the providers with the costs of delivery.

Given the information and data which is currently available, it is now possible[47] to establish unit costs for the range of curative services, both out-patient as well as in-patient, which would be provided by different levels of service providers -- primary, secondary and tertiary.

Such unit costs should include all inputs which are required to provide the relevant services -- e.g. personnel costs, drugs and other treatments, investigative tests, depreciation of buildings and equipment, administrative overheads etc. The costs would thus be true reflections of all that goes to produce the services and the resources would always be available for the routine maintenance and replacement of facilities and equipment.

Unit costs should, as far as possible, reflect the actual outlays incurred by specific providers depending on their location, local cost structures etc.[48] It may, thus, be necessary to establish a range of costs for different services so that equity as regards quality of services can be ensured for citizens in all parts of the country.

Sri Lanka has had a tradition of providing curative services free of charge to all citizens irrespective of their levels of income. This practice has hardly ever been questioned in the first half century since Independence. The main reason for this has been a sense of political insecurity on the part of all competing political parties that doing so would provide a convenient handle that rival parties could use in electoral contests.[49]

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[47] The initial exercises in setting unit costs would, no doubt, make heavy demands on time and skills. They would also be imperfect. Nevertheless, a start has to be made - sooner rather than later. Once commenced and appropriately monitored, the procedures would, over time, achieve reasonable accuracy and reliability.

[48] Personnel costs would, for example, constitute a significant element in such costs - with professional cadres having to be provided with location incentives in order to attract them to difficult locations, whilst at the other end of the staff profile costs could be lower in rural as against urban areas. Patient transport costs could, similarly, vary - with heavier costs in poorer transport conditions.

[49] This, in fact, has happened as was observed in the 1977 General Elections - as stated in Rannan Eliya, Ravindra and Nishan de Mel: op cit.

However, several changes in the contextual environment of public sector health care provision make a reappraisal of this long cherished policy stance necessary.

- Sri Lanka faces severe constraints as regards the government budget and, within it, the availability of resources for meeting the health needs of the community.

- Expenditure on preventive services would further limit the funding available for curative services.

- Reduction of available resources requires that their use be prioritised. A key issue to be faced in this is whose needs will be met by the expenditure of the available limited public funds.

- The rise in levels of income as a result of the growth of the economy is a major factor which needs to be taken into account in considering the above issue. Unlike the early post-Independence years, the pool of citizens who can budget for the costs of their curative health care is increasing in size.[50]

- There is a concurrent expansion, albeit slow, of private health insurance -- with employers in the formal sector increasingly recognizing the provision of health care insurance as a significant element in employee remuneration.

The approach to this issue has, logically, to be on the basis that curative health care is a personal responsibility. The role of the state, in this context, would be that of providing affordable curative services; of regulating that all such services -- whether by public or private providers -- meet pre-set standards of quality; and ensuring equity such that no citizen, by reason of income status, lacks access to public sector health care.

The above proposal implies that in order to ensure the effective targeting of public resources, citizens above a pre-set family income level be required to re-imburse the costs of the public sector curative services they use. The quantum of such reimbursement should vary depending on the actual family income levels of the beneficiaries. This would make the process more equitable.

Such a programme of cost recovery would require the institution of an effective system of comprehensive means testing. It is correct that such a system has not been in vogue in Sri Lanka[51] and that it will take considerable time and effort to develop one. But this is no

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50 An indicator of this trend is the increasing percentage of those who opt for private sector supply of out-patient care.

51 One instance in which such a system has been attempted has been in regard to poverty alleviation programmes - both the Janasaviya and the Samurdhi Programmes.

excuse for not starting to develop an effective system.[52] Effective tools for doing so are increasingly available and rational use of public funds requires that methodologies for targeting of such resources be developed.[53]

However, over and above such recurrent unit costs, there would be the need of resources for investing in upgrading and expanding facilities and services. Such resources would need to be allocated from the investment budgets of the respective provinces (or of the Capital Territory). This makes the task of investment resource allocation a complex one for the Provincial Health Authorities. The provincial investment budget, however, should be looked upon as but one of the sources of investment funding. Given the autonomy of management envisaged in this discussion for individual institutions or clusters of them, mobilisation of community resources should be looked upon as a major possibility.

7.3 Preventive Health Care Services

The delivery of preventive health care services will, in the foreseeable future, remain a responsibility of the public sector. Its organisation will, therefore, be a matter of priority concern in any attempt at the rationalisation of the delivery of health care.

Activities which fall under the umbrella of preventive health care services could, for purposes of organisation and management, be grouped in two categories.

- The first are those activities which are specifically directed at the individual. Examples would include maternity and child health, family planning, immunisation activities etc.

- The second are activities which are, in the main, directed at the community as a whole. Examples would include campaigns against diseases such as malaria, dengue fever, tuberculosis, AIDS, as well as environmental sanitation programmes, nutrition programmes etc.

Activities in the first group lend themselves to integration in the organisational arrangements for the delivery of primary care services. Thus, both curative and preventive services would, normally, radiate from the Primary Health Centres established, on the basis of population and transport factors, in each spatial area. This would contribute to greater effectiveness in preventive as well as curative service delivery.

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52 The process would be facilitated by the gradual expansion of wage employment in the formal sector.

53 An effective means testing system would not only be of use for cost recovery in regard to curative health care. It would also assist in rationalising the public sector education system and the social security system.

Activities in the second group, however, require specific organisational arrangements. Whilst these would differ from case to case, certain guidelines would be helpful in the interests of cost effectiveness:

- The planning of programmes and campaigns would, necessarily, remain at a national level with financial resources provided nationally and the national co-ordination points serving as management centres.

- Each such programme and campaign should have a preset date for closure which is announced at the time of planning. This would require them to be monitored and reviewed at pre-determined intervals so that lags in implementation can be rectified. This would alter the tasks at programme headquarters to those of planning, monitoring and provision of expert assistance.

- To the extent possible, it would be cost effective to use the structure of Primary Health Centres for the actual delivery of services to the community -- through a system of contractual agency arrangements.

- Such contractual arrangements would also be appropriate with local government institutions and with NGOs which could be appropriate instruments for programme delivery.

8. The Roles of the Governance Institutions

The public sector health care delivery system does not operate in a vacuum. It functions in a set of symbiotic relationships with the network of institutions which together constitutes the system of governance in the country. These symbiotic relationships

- set the policy framework for the operation of the health care delivery system and modify it as necessary;

- lay down the quality standards for the operation of the system and monitor their observance;

- provide resources to meet the needs of the constituent institutions and programmes of the system;

- facilitate the co-ordination of the operations of the constituent institutions and programmes -- both horizontally and vertically;

- enable the functioning of provider institutions through the provision of facilitation and supportive services and inputs;

- institutionalise the participation of the community in the identification of service needs, the planning and operation of responses, and the monitoring of their performance.

The symbiotic relationships described above imply the performance of four different roles by the institutions in the polity. They are those of guidance, facilitation, enabling and accountability enforcement.

In assigning these roles to the different institutions within the polity two considerations need to be kept in view. The first is the reality of the devolutionary character of the polity which is reflected in Sri Lanka's Constitution.[54] The second is the importance of avoiding cost ineffective and inefficient overlapping of functions.

The assignment of the roles already identified above would, in the ensuing discussion, be appraised in the context of these two considerations.

8.1 The Guidance Role

The guidance for the organising, management and financing of the delivery of curative as well as preventive services would flow from two sources.

The first would be national policies on health which would be formulated at the centre. These would include priority setting for health interventions, setting of quality standards for service delivery, setting of quality norms for different categories of health care personnel, issues related to health care costs and targeting of state subsidies to low income groups, laying down of norms of service provision for the different levels of provider institutions, matters related to the referral system for curative care seekers, organisation of preventive programmes, inputs into policies in other sectors[55] etc.

The second would be the area specific operational strategies. These would, normally, be drawn from and interpretative of the national policies as discussed above and would be formulated, with advice from the relevant Provincial Health Authority, by the Provincial Ministries of Health. They would relate to such matters as the location of provider institutions and their grading and networking, other investment decisions, personnel policies and practices including emoluments, resource mobilisation etc.

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[54] It needs to be kept in mind that the constitutional changes which are currently (September 1997) under discussion envisage an even greater degree of political devolution.

[55] For example environment policies, educational programmes and policies, habitat and water supply and sewerage programmes, nutrition polices and programmes, policies related to work place standards etc.

Thus, the formulation and review of nationwide policies and of province or region focussed operational strategies would be a key continuing function at the centre and at the provinces. At both levels, the institutional arrangements for this task should provide for the active participation of those who would implement them.

The degree of continuity of policies and operational strategies, across political regimes, would, to a large extent, determine their level of effectiveness and implementability. At the same time, they need to respond to changes in their operational environment if they are to retain their relevance.

Given these determinants, the institutional arrangements[56] for policy formulation at the centre would require:

- that the Ministry of Health at the centre would, in the future, focus its attention on policy management -- including the formulation of policies and the monitoring of their implementation -- rather than on facilitation and on system maintenance, and that the quality of its staffing would reflect this role;

- the setting up of a National Health Commission, comprising technical expertise and Provincial participation, which would provide the advisory inputs[57] into the national policy management process; and

- the establishment of a Provincial Health Authority in each Province which, at that level and vis a vis the Provincial Ministry of Health play the same role, in relation to the formulation of operational strategies, as the National Health Commission does vis a vis the central Ministry of Health.

8.2 The Facilitation and Enabling Role

The provider institutions and programmes would, for their efficient functioning, require a wide range of facilitative and enabling services. These services, for reasons of cost effectiveness and of technical efficiency, would need to be organised as 'global' services Considerations of viability, in most cases, would mean that such organisation be for the country as a whole.

For this purpose, it is appropriate to establish a Department of Health Services at the centre. It would operate within the ambit of the central Ministry of Health and adhere to the parameters of the national health policy framework. The DoHS would not, in any

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[56] These have already been referred to in Section 6.

[57] The non-acceptance, by the Ministry of Health, of policy advice tendered by the National Health Commission should always be informed to the public, giving reasons for such non-acceptance.

sense, control the provider institutions and programmes. Nor would it be a direct supplier of services to the provider institutions and programmes. It would, instead, play the role of facilitator and enabler -- through a process of programming, organising and ensuring of the availability of supply of resources required by the providers

The DoHS, for example, would in the case of:

- human resources, project the requirements and make appropriate arrangements with educational and training institutions for their availability in the required time schedule;

- the bulk purchase of drugs and other consumable supplies, invite and finalise bids and link the different provider institutions and programmes with the selected suppliers so that they could obtain their supplies direct from the approved sources;

- equipment etc, provide technical specifications and call for and appraise bids or assist the provider institutions and programmes to do so as appropriate;

- research needs, establish appropriate institutions[58] and programmes to undertake such research and to disseminate results;

- public health education and information, establish appropriate institutions and programmes to conduct such activities.

Given the above task profile, the DoHS itself need not be a large organisation. It should be seen as a small group of professionals in different disciplines working mainly through specific institutions and programmes to meet the needs of providers.

Given the fact that, according to the scenario envisaged in the foregoing discussions, the provider institutions and programmes will have their own autonomous management structures, the task at the provincial level would be restricted to one of intermediation between the suppliers of facilitative services at the national level and the providers within each province. With the task of formulating operational strategies at the Provincial level being mainly the role of the Provincial Health Authority, the function of intermediation could be handled by the provincial Directorate of Health which would be quite small in size.

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[58] For example, the Medical Research Institute (M.R.I.).

8.3 The Accountability Enforcement Role

Public sector health care providers should be held accountable for the effective utilisation of resources which are made available to them as well as the quality of their service provision. Being primarily users of public funds and providers of services to a defined community, their accountability would be to two constituencies -- the general public who provide them with their resources and the immediate community which is served by them. In both categories, accountability should be enforced through the relevant public representative institutions.

In regard to the effective use of resources, the accountability would, primarily, be exercised at the level of the province. The reports of the Auditor General and of the Inspectorate of the Provincial Ministry of Health would be reviewed and discussed in the Provincial Council.[59] Similar discussions should take place in the national parliament also.[60]

An appropriate instrument for the enforcement of accountability to the local communities would be local government institutions. This purpose would be best served by instituting a practice of periodic meetings of representatives of the local government institutions[61] at which both the aspects of the effective use of resources and of the quality of service provision could be monitored on the basis of audit and inspection reports and at which public representations are discussed. Such a forum could also assist in establishing enabling trans-sectoral linkages which would facilitate the functioning of the provider units.

9. Managing the Transition

It is clear from the foregoing discussion that what is projected as a desirable organisation and management structure for Sri Lanka's health sector and a feasible modality for the financing of the delivery of curative services is a radical contrast to what obtains at present in regard to both. Hence the management of the proposed transition has to be approached with due care so that there is no breakdown of the system.

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[59] The proposals on constitutional reform which are presently (September 1997) being discussed provide for the introduction of a system of Executive Committees which could provide a valuable forum for the exercise of this accountability oversight. Of course, the Council, in full sessions, would also review the discussions in Executive Committee, thus reinforcing the review process.

[60] The Public Accounts Committee of the Parliament would be the appropriate forum for this review.

[61] The most appropriate would be the Chairmen of the Pradeshiya Sabhas and of the Urban Councils and the Mayors of Municipal Councils. The monitoring meetings could be held either quarterly or half-yearly as necessary.

The planning and implementation of the transition has to recognise the inevitable resistance to the new order which is likely to arise from several sources.

- One would be groups in the bureaucracy and the political system with vested interests in the continuance of the current regime -- particularly those with powers of oversight and control over the service provider institutions.

- A second would be the public who have got accustomed to the system and to manipulating it, particularly in terms of by-passing the need for a referral process.

- A third would be groups who are inflexibly fixed in viewing the universal provision of free curative health care services as a pillar of a `socialist society' which should not, at whatever cost, be tampered with. It would be seen as the thin end of a destructive wedge being driven into the assumed `socialist fabric' of Sri Lankan society.

- An important group from whom resistance could be expected would be the large trade unions of different categories of health care professionals. These trade unions derive their strength from their large memberships which, coupled with the essential nature of the services provided by them to the community, provide them with a high bargaining power vis a vis the monolithic employer. This bargaining power has been consistently used to improve their emoluments and perquisites and other conditions of employment. They would, as is to be expected, look askance at reforms, particularly those which introduce a multiple number of employing agencies and affect their existing ability at obtaining routine transfers.

A possibility which has to be realistically expected would be the formation of coalitions of these different interest groups to oppose selected reform measures which would make the task of implementing an integrated reform agenda difficult. The result could be a failure to obtain optimum results from the reform measures which are implemented, thus bringing the whole reform effort into disrepute.[62]

To counter this resistance, the implementation strategy should provide for a programme to create awareness in the public, the bureaucracy and the political decision makers on the goals of the reform agenda as well as its elements. Such a programme should seek to explain the rationale of the different proposals as well as the specific results expected to be achieved by each and from the agenda as a whole. The awareness programme could use such instruments as the media (electronic as well as print), discussion groups and seminars, group targeted explanatory literature etc.

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[62] An interesting example of such a situation is that of the reform agenda which was recommended by the Administrative Reforms Committee of 1987-88. This experience is more fully discussed in Wanasinghe, Shelton : 'Activating the Administrative Reform Process in Sri Lanka' - IPS - July 1994.

The objective of such an awareness programme should not only be the removal of mis-perceptions and resistance but also the growth of a pro-reform constituency amongst the public, bureaucracy and the political decision makers. It is only such a constituency which could adequately underpin a sustainable reform process.

Reform of the country's health care delivery system is not a short-term exercise which could be conveniently telescoped into the term of office of a particular government. Given that it will be a continuous and evolving process, it will, necessarily, run through the terms of successive governments. It is, therefore, important to view it as a `national activity' which should receive the endorsement, support and agreement of both the government of the day as well as of the opposition. If not, the classical Sri Lankan political syndrome of one government's initiatives being dismantled by the succeeding one which would seek to develop its own, will cripple the entire reform effort.

It is necessary to recognise that the reforms advanced in the foregoing discussion constitute an integrated agenda. The elements are interdependent. Hence, it is essential that the agenda be objectively implemented as a whole. An ad hoc implementation of subjectively selected elements would only result in chaos, waste of financial resources, loss of efficiency, low personnel morale, and public dissatisfaction with its political fallouts.

This makes it important to

- grant a priori approval for the integrated reform agenda at the highest levels of the government with such approval being backed by a multi-party consensus;

- set out an approved co-ordinated time frame for action milestones in respect of all elements in the reform agenda as an integral part thereof;

- monitor the implementation of the elements in the plan in terms of adherence to time schedules, of inter-element co-ordination and of impact on the efficiency and effectiveness of delivery of health care.

These tasks would be the responsibility of a focal point which would co-ordinate the implementation of the reform agenda. Given that the reforms would impinge on the entire public sector institutional system for delivery of health care -- from the Ministry of Health at the Centre to the provider units in the remotest areas -- implementation of the reform agenda would need the collaboration of agencies which deal with such areas as public finance, environment management, public administration, social security etc.

These considerations require that the focal point for the task be located in the Office of the Head of Government.

Given the political and administrative culture of Sri Lanka, this would be the only approach to ensuring an appropriately co-ordinated direction of the implementation of the reform agenda. It would provide the required leadership to the process, facilitate the necessary co-ordination as well as enable the meaningful monitoring of its progress and its impact.

What is more important is the location of the focal point rather than its size. Given the reality that all of the actual implementation activities will be carried out by other agencies of government, the focal point should remain small in size -- led by a senior professional.[63]

10. Conclusion

What is suggested as a reform agenda in this discussion is, obviously, a radical one. However, as the discussion seeks to bring out, it is also unavoidable. The linear path followed for half a century, which was one of evolution from the organisation, management and financing system of the colonial period, disregarding changes in the contextual environment has, if anything, led the sector into a blind alley.

The sector now faces a completely different contextual environment from that which was faced in 1947. This makes the ongoing organisational, management and financing system not only irrelevant, but an impediment to developing an effective public sector instrument to meet the health care needs of the community.

Hence, reform is inevitable if public needs are to be effectively and efficiently met and public dissatisfaction is to be avoided. This far outweighs the short-term negative political fallouts which would be imagined from affected vested interest groups.

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[63] The ongoing effort at administrative reform, the leadership of which is centred around an Administrative Reform Unit and an Administrative Reform Advisory Board located in the Presidential Secretariat provides a useful precedent.

Annexe

Distribution of Curative Facilities in Relation to Population by Districts

District	Population '000	Tertiary Facilities			Secondary Facilities	Primary Facilities		
		Teaching Hospitals	Provincial Hospitals	Base Hospitals	District Hospitals	Peripheral Units	Rural Hospitals	Central Dispensaries
Colombo	2120	3		1	4	6	1	21
Gampaha	1790	1		3	5	4	3	31
Kalutara	989		1	1	6	5	6	5
Kandy	1286	2		2	11	9	24	18
Matale	445			2	3	4	6	14
Nuwara Eliya	707			1	13	2	1	19
Galle	1007	2			9	8	5	15
Matara	796		1		5	3	8	12
Hambantota	547			1	4	7	5	10
Jaffna	869	1		1	3	3	2	13
Mannar	136			1	2	1	1	6
Vavuniya	115			1		1	1	4
Mullativu	95				1	1		2
Kilinochchi	106				1	2		5
Trincomalee	320			1	3	2	1	11
Batticaloa	428	1			6		1	6
Ampara	496			2	7	5		27
Kurunegala	1452		1	2	13	15	4	44
Puttalam	632			2	3	5	6	16
Anuradhapura	712		1		4	7	22	21
Polonnaruwa	348			1	2	4	4	9
Badulla	789		1		12	5	7	16
Moneragala	385			1	9	1	4	9
Ratnapura	969		1		11	9	4	14
Kegalle	798			1	8	1	5	19

Source: Ministry of Health, Annual Health Bulletin-1995

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