Health Master Plan

No.

MINISTRY OF HEALTH, NUTRITION & WELFARE,
THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA (MOH)
JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

MASTER PLAN STUDY FOR STRENGTHENING HEALTH SYSTEM
IN THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

VOLUME I
SUMMARY

HEALTHY & SHINING ISLAND IN THE 21ST CENTURY

FINAL REPORT

NOVEMBER 2003
PACIFIC CONSULTANTS INTERNATIONAL

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The following foreign exchange rate is applied in the study:
US$ 1.00 = 95 Sri Lanka Rupees (as of November 2003)

Message from Vice President,
Japan International Cooperation Agency (JICA)

In response to a request from the Government of the Democratic Socialist Republic of Sri Lanka, the Government of Japan decided to provide technical cooperation for establishing of a health master plan which will be effective for the next decade for the improvement of the health system in Sri Lanka. JICA selected and dispatched the study team headed by Dr. Katsuhide Nagayama of Pacific Consultants International to Sri Lanka between March 2002 and November 2003.

I am pleased that the Health Master Plan, presented herewith by Ministry of Health, Nutrition and Welfare, was a fruit of close collaboration with the Study Team. I hope the Health Master Plan, whose ownership is assured by Ministry of Health, Nutrition and Welfare, will contribute to the promotion of the health system in Sri Lanka.

Finally, I wish to express my sincere appreciation to all the officials concerned of the Government of Sri Lanka for their enthusiastic effort exhibited in the process of formulating the Health Master Plan.

November 2003

Kazuhisa Matsuoka
Vice President
Japan International Cooperation Agency

November 2003

Mr. Kazuhisa MATSUOKA

Vice President

Japan International Cooperation Agency

Tokyo, Japan

Letter of Transmittal

Dear Sir,

We are pleased to formally submit herewith the Final Report of "The Master Plan Study for Strengthening Health System in the Democratic Socialist Republic of Sri Lanka."

This report compiles the results of the Study which was conducted from March 2002 through November 2003 by the Study Team organized by Pacific Consultants International under the contract with JICA.

The report compiles the Sri Lanka Health Master Plan covering both reform and development of the health sector in Sri Lanka. The plan consists of 1) vision, goals and objectives; 2) overall basic strategies; 3) frameworks for health sector reform and development; and 4) priority programmes.

We would like to express our sincere gratitude and appreciation to the officials of your agency and the JICA advisory Committee. We also would like to send our great appreciation to all those who extended their kind assistance and cooperation to the Study Team, in particular to the Ministry of Health, Nutrition & Welfare and provincial/district health officials concerned.

We hope that the Master Plan will be able to contribute significantly to the improvement of the health sector and development in Sri Lanka.

Very truly yours,

Katsuhide NAGAYAMA, Ph.D

Team Leader,

Master Plan Study for Strengthening Health System in the Democratic Socialist Republic of Sri Lanka

Map of Sri Lanka

EXECUTIVE SUMMARY

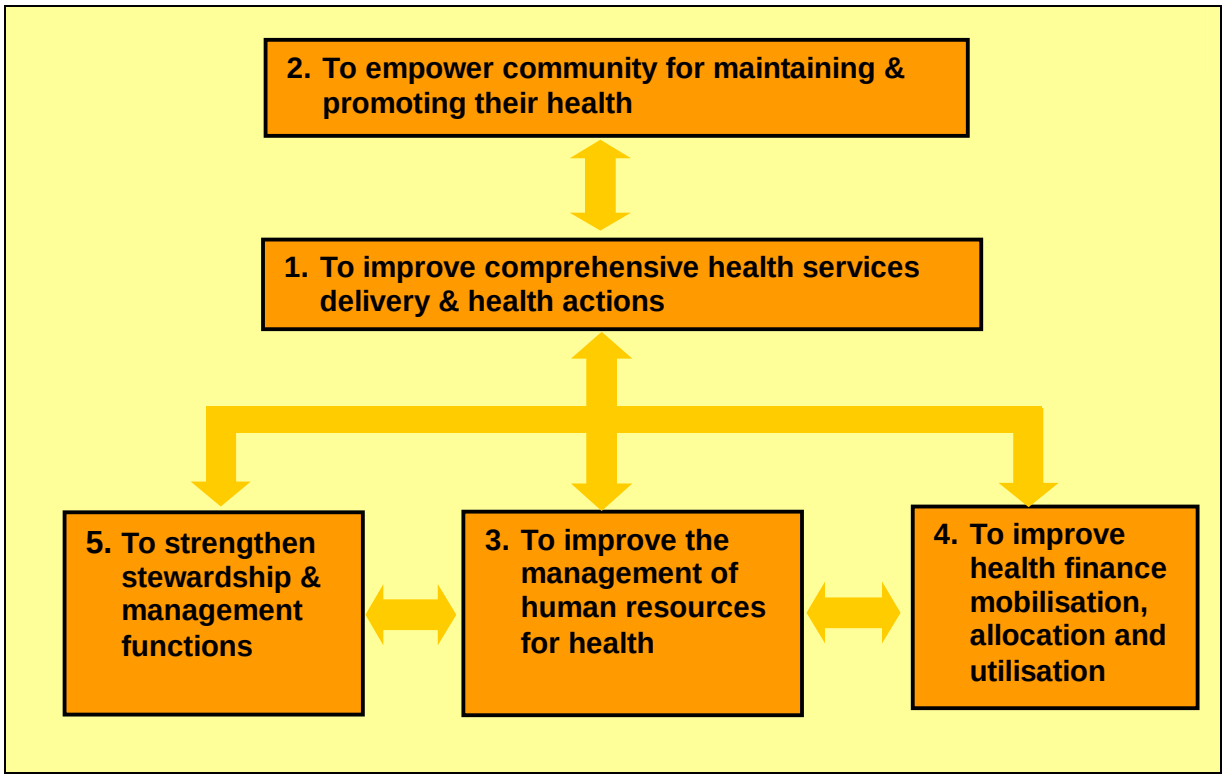
The Health Master Plan for Sri Lanka is the synthesised output of two interactive activities, complementary to each other, initiated with the assistance of two development partners, enriched by the outcomes of an extensive consultation process. The Sri Lankan Health Master Plan addresses the policy and strategic framework for an innovative health system over the next decade, targeting the year 2015.

The Health Master Plan (HMP) aims to build on the successes and experiences of the past and to address the challenges of today and tomorrow, based on a recognition that Sri Lanka has been facing with a transitional situation. These challenges include changing demographic and disease patterns, limited resources, increased demand and expectations by the public, the need for equity and the need to develop a management ethos that ensures good governance and value for money in delivering quality services.

The HMP is carefully designed to support Sri Lanka's overall economic and social goals. It aims to facilitate equity through ease of access to health services, thereby delivering high productivity to ensure that resources allocated to health result in a healthier population that is able to contribute to the economic and social well-being of the country.

In line with this context, the Government intends to foster a healthier nation that contributes to economic, social, mental and spiritual development This is to be achieved by responding to the people's needs, and working in partnership to ensure access to comprehensive, high quality, equitable, cost-effective and sustainable health services. This overarching aim of improving health status and reducing inequalities will be achieved by the five strategies, namely:

1. Ensuring delivery of comprehensive health services, which reduce the disease burden and promote health;
2. Empowering communities towards more active participation in maintaining their health;
3. Improving human resources for health development and management; and
4. Improving health financing, mobilization, allocation and utilization of resources.
5. Strengthening the stewardship and management functions of the health system;



Inter-relation among the Five Strategic Objectives

The immediate objectives that are to be achieved under each strategic objective are outlined below:

1. ***To ensure the delivery of comprehensive health services, which reduce the disease burden and promote health:***

    1) To rationalise and strengthen health network of facilities and services
    2) To reduce priority diseases/conditions through strategic interventions
    3) To enhance quality of service delivery
    4) To improve health status of vulnerable populations
    5) To increase public confidence and patient/client satisfaction in the health services
    6) To access new technologies
    7) To strengthen public - private partnerships in order to enhance efficient health service delivery
    8) To ensure adequate drugs, material and equipment for service delivery

2. ***To empower communities (including households) towards more active participation in maintaining their health:***

    1) To improve public awareness of their rights, responsibilities and options for care

2) To improve participation of civil society and Non-Governmental Organizations in promoting behavioural and lifestyle changes

3) To monitor public perception of their needs and of the health system towards serving as an input for improvement

3. To improve human resources for health development and management:

1) To expand functions and strengthen capacities of National and Provincial Ministries of Health in human resource development and management

2) To rationalise the development and management of human resources for health

3) To improve management, clinical and public health competencies of health staff

4. To improve health financing, resource allocation and utilisation:

1) To increase government financial support at all levels to strengthen the financial sustainability of the health sector

2) To improve allocative efficiency of public funds

3) To make optimal use of existing financial resources

4) To strengthen financial management

5) To improve financial equity and related equity of access

6) To identify and test alternative financing mechanisms with a view towards national implementation.

7) To optimise private sector contribution, initially establishing an information sharing mechanism to include reporting on service use and quality as well as financing.

5. To strengthen stewardship and management functions of the health system:

1) To strengthen managerial performance at national and decentralised levels

2) To enhance efficiency, effectiveness and accountability of the MoH & decentralised units

3) To strengthen and introduce, if needed, performance management systems

4) To establish a system for regulating the services of public & private providers

5) To strengthen management information system

6) To strengthen coordination and partnerships with other sectors

7) To strengthen capacity in health research and technology assessment

8) To strengthen autonomy of hospitals and unit/divisions

The HMP profiles a number of "strategic programmes" to achieve the above immediate objectives and packages of "projects to be implemented in line with the corresponding programme. In order to identify these possible interventions, programmes, a series of discussions were intensively made through Working Groups inviting stakeholders from the Ministry of Health and Provincial Ministries,

other Ministries, professional groups and other civil society organizations. This participatory approach should be continuously maintained to review and depict more detailed activity profiles for priority projects. Once the activities are identified, the inputs, verifiable indicators and means of verifications will be determined along with broad budgets for each activity.

Implementing the HMP must be an integral part of the management of the health sector and not seen as an additional piece of bureaucracy. Consequently, existing structures and regimes should be used to take the process forward rather than creating new institutions and structures.

Of particular importance will be the need to use the financing and planning systems to the best effect. Immediate steps should be taken to strengthen the Ministry of Health's contribution towards the development and negotiation of the budget with the Ministry of Finance. It will be particularly important to develop clear output measures against which investment can be measured. Similarly the planning processes should be improved at an early date to enable transparent plans to be developed and agreed.

Improved intersectoral and donor coordination is essential to ensure that a sector wide approach is adapted to the development, financing and implementation of health strategies. The building of a healthier nation is the onerous and inescapable responsibility of each and every citizen of Sri Lanka.

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1. INTRODUCTION

1.1 STATE POLICY FOR HEALTH AND THE HEALTH MASTER PLAN

Over the years, Sri Lanka has accomplished some of the Health Goals and reasonable improvements in the health status of its people. In achieving these goals, the Ministry of Health has initiated a number of programs of health development through its network of institutions. The achievement it has made is high in comparison to its Gross National Product. This is mainly due to the social policies adopted by the successive governments.

The government continues to support its long-standing policy of providing universal health services of good quality to its people, free of charge at all government institutions, and sustenance of a strong primary health care network that has been the pillar of strength for several decades. The health financing policy has been based on a universal tax-based model. However, over time, the government has allowed steady growth of the private sector in order to gradually trim its role in providing services to those who can pay in favour of and to concentrate more on the poor and the less privileged.

Thus, the policies of the government reflects the health concerns of the vulnerable populations such as in the estates, remote rural areas, and conflict-affected areas and directed at improvement of nutrition among infants, preschool children and pregnant mothers. Nowadays, due to a drastic change in a disease pattern in Sri Lanka, increase in incidence of non-communicable diseases has become a major concern, while mitigation of communicable diseases such as vector-borne diseases, immunisable diseases and STD/AIDS are still of importance in vulnerable populations.

There has been a great interest over the years to understand and develop a policy process. The first action was the formulation of policy in 1992 by a Presidential Task Force, and the second was a result of review of the policy with publishing of a new policy document in 1997. There have been political changes in the last decade that has led to the two major reviews of policies, although the overall policy has remained consistent. The main goals of the government health policy can be summarised into following eight broad areas:

1) Reform the organisational structure and management to improve efficiency, effectiveness and accountability;

2) Establish mechanisms to provide need-based care, set priorities and allocate resources equitably;

3) Focus on vulnerable groups and community needs that required special attention; the elderly, disabled and mental health;

4) Improve patient care provision and quality by reorganising the health care delivery system especially at district and provincial levels;

5) Rationalise human resource development;

6) Increase life expectancy by reducing preventable deaths from both communicable and non-communicable diseases;

7) Improve “Quality of Life” through healthy lifestyles and by reduction of preventable diseases and disabilities; and

8) Facilitate health promotion through IEC activities and through media.

A major change in health policy arena was observed in 1989 as the government proceeded to change the management structures, roles and responsibilities of the Central Ministry that operated through a deconcentrated district health system before 1989.

The 13th amendment to the Constitution in 1989 saw devolution of some powers and functions to the Provincial Councils that have established their own provincial ministries and provincial health departments. The devolved functions involved administration and management of provincial hospital network and field health services.

A further change of structure and function of the central ministry was observed in 1999 when the Department of Health Services that was within the Ministry of Health was separated. But with the change of government in late 2001, these two bodies were recombined to enhance policy-making, monitoring evaluation efforts and to reduce duplication.

Recognising the emerging needs and structural weaknesses of the system, several attempts have been made to rationalise the health care system as well as to develop its human resources as spelled out in its policy statements. However, the progress of such reform has been slow. The Ministry of Health lacks full potential, authority and the capacity for policy implementation that is required for taking up a strategic change role. This Master Plan is the third attempt to address the challenges to an innovative progress of the health system improvement in Sri Lanka, over-viewing the transitional situation in terms of health service needs and financial sustainability on the medium- and long-term perspectives. The Health Master Plan (HMP) addresses measures of restructuring "the system" as well as necessary interventions for health service delivery, targeting the year 2015, and identifies priority or anchor programmes/projects whose implementation is expected to be materialised in five years, up to the year 2008.

1.2 HEALTH SECTOR AS AN ORGANIC SYSTEM

Health sector reform is now taking place in many countries throughout the world. This need for reform stems from several inter-related factors:

1) Changing perceived and professionally recognized health needs, due to demographic and epidemiological transition;

2) Political commitment to improve coverage and access to health services;

3) Rising health care costs; and

4) Insufficiency of existing structures and management methods to increase cost effectiveness of the provision of health care and assure its quality.

Reform must be undertaken in a wide range of areas, such as organisational structure, roles and relationships, resource mobilisation, the level and distribution of health care, and costs and pricing. Thus, a comprehensive overview of a country's health sector is useful to gain full understanding of the situation and the breadth of change required. To grasp how health care funding mechanisms work, it is crucial to understand the health sector as a complex organic system in which resources, organisation, financing and management all lead to the provision of health services (Figure 1.1). The numerous parts of this complex system can be classified into five core elements, with the first four leading to the fifth:

1) Organisation and service providers (health ministry, public hospitals, private providers, etc.);

2) Management (regulation, registration, planning, administration);

3) Financing (tax revenues, insurance, registration fees, out-of-pocket expenses, etc.), which sustain the fourth core element;

4) Resource inputs (trained staff, drugs, materials, facilities, knowledge); and

5) Service delivery (promotive, preventive and curative services).

Considering the long-standing vertical, compartmentalised approach in health ministries, the health sector has not been clearly recognised as an organic system needing a good management mechanism. In particular, on the clinical front, variation in quality and nature of services is pervasive, a situation which does not facilitate good functioning management mechanisms in hospitals or other health facilities. Hospital management is not a well-developed area, compared with the management guidelines used for running airports or large manufacturing entities.

A concept of modern management in the health sector needs to be explored in Sri Lanka, and this is coupled with both a generally conservative response to initiatives to improve hospital management and frequently, political inertia among the health authorities. The power of the medical profession is supportive of practical initiatives for strengthening management capacity. In recent years, there has been an increasing interest in the issue of how health sectors should be financed. The form that financing should take and the level of coverage are now major policy issues and it is essential for Sri Lanka to have a clear understanding of the implications of alternative courses of action.

The HMP provides the directions for change towards better management and improve provision services as well as lays a theoretical basis for the government to embark towards formulation of an alternative health-financing mechanism that would enable it to navigate a path through financial constraints.

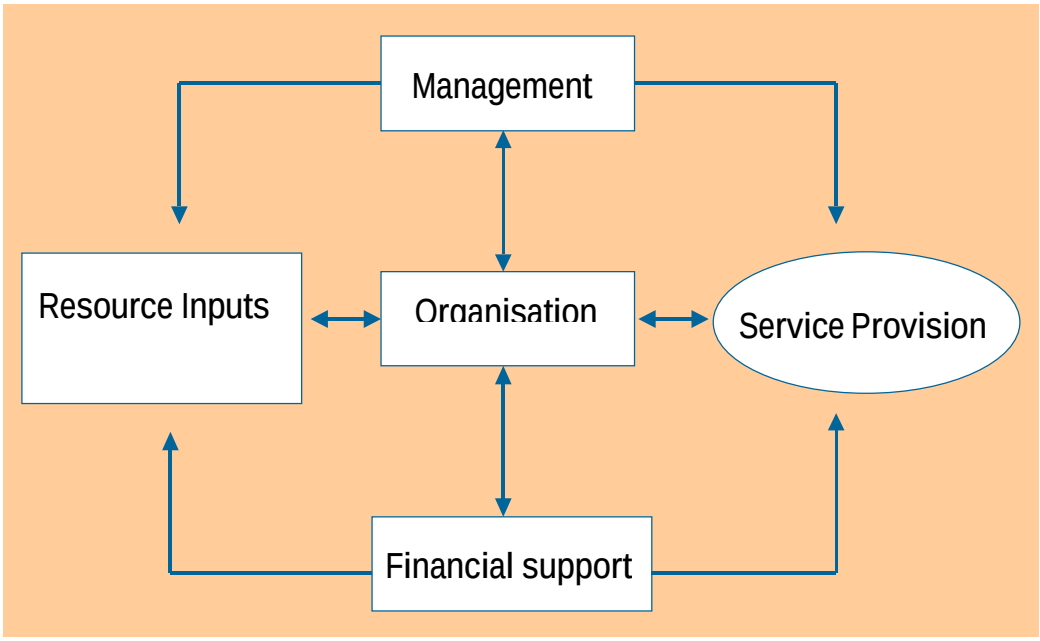


Figure 1.1 Five Elements of An Organic Health System

2. THE CURRENT SITUATION OF HEALTH SECTOR

2.1 AN OVERVIEW OF THE CURRENT HEALTH STATUS

The country's health indicators show a steady improvement over recent decades particularly in maternal and infant mortality, and life expectancy. The Maternal Mortality Ratio of 2.3/10,000 live births in 2000 is an exceptional achievement for a developing country with an income level of about US$ 800/capita. The improvement of these indicators are predominantly attributed to the Maternal and Child Care Programme implemented nationally as an integral component of the state health care system. Similarly, the Infant Mortality Rate of 16.3 per 1,000 live births has been achieved by effective and widely accessible prevention and primary health care strategies including treatment of minor infections. However, whilst post-neonatal mortality has declined significantly, prenatal and neonatal mortality efforts have been less successful. A neonatal mortality rate of 12.9/1,000 live births suggests limited progress in improving the quality of labour and delivery and in the relatively poor underlying health of mothers, which results in premature deliveries and low birth weights.

Life expectancy has risen steadily to around 75 for females and 71 for males (1997), and the fertility rate has declined to around 2.0 - below population replacement level. With the rapid ageing of the population and success in combating the major communicable diseases, the disease burden has started shifting rapidly towards non-communicable diseases including mental diseases, accidents and injuries. The leading causes of death (by percentage of total mortality for year 2000) are ischaemic heart disease (10.6%), diseases of the intestinal tract (9.3%), cerebrovascular disease (9.0%), pulmonary heart disease and diseases of the pulmonary circulation (8.6%), and neoplasms (7.5%). Over time infectious and parasitic diseases have declined in importance, while cardiovascular diseases and homicides have increased in a proportionate manner. In 1996, violence (accidents, suicides and homicides) accounted for 22% of the deaths, while cardiovascular diseases and diabetes accounted for another 24%, which indicates that the epidemiological transition is rapidly in progress.

Nutritional status has improved but remain a serious problem among the poorer and vulnerable communities and even on average is unsatisfactory. This brief analysis is based on information related to the whole country and does not address the disparities that exist between provinces. But when the Provincial or District level figures on infant and maternal mortality rates are compared there seems to be great disparities, some of which may be due to differential underreporting or to the referral of cases. In particular, information on the conflict-affected areas and the estates would show the significant variation between and within provinces.

2.2 CHALLENGES AND THEIR IMPLICATIONS

2.2.1 Health Services

The services in the state sector are characterised by a very busy and overcrowded system of National, Provincial, General and Base (large town) hospitals and a widely spread network of district hospitals and health care units operating at lower levels of utilisation and occupancy.

Sri Lanka provided around 0.2 inpatient admissions per capita in 1997. This heavy demand may be due to a number of factors including insufficient diagnostic capabilities in lower primary care and outpatient departments and patients being admitted when, with better primary care, they could have been treated on an ambulatory basis. Also, it is observed that patients bypass the lower level services keeping occupancy rates low at peripheral hospitals, in favour of larger city and provincial hos-

pitals, thereby causing overcrowding at these facilities. This is aggravated by an absence of clear admission and referral policies.

Referral and counter referrals need to be clearly formalised and monitored, and supplies and drugs have to be ordered and stocked taking the counter referral possibility into account for the most frequent diseases so that the primary level which will provide the follow up would be conversant and ready for the situation.

The fastest growing segment of private sector health care is outpatient or ambulatory care. Over 36 million outpatient visits were estimated to have taken place in 1997, an increase of 2 million over the 1990 estimate. Of the total ambulatory care market 46% is serviced by the private sector, 27% by government doctors both specialist and non-specialists, 12% by private general practitioners and 7% by traditional practitioners. Private hospitals played a minimal role in providing inpatient care till the early 1980s. Reintroduction of private practice for government doctors, liberalisation of drug imports and service provision deficiencies in government hospitals have resulted in the growth of private hospitals in urban centres.

As the size of population served varies with population density, the volume of services planned too would vary from institution to institution. But the services offered should be uniform within each level of services and will be clearly known to everyone. In principle it is accepted that health facilities with a curative role should increasingly take on secondary and tertiary prevention especially in chronic communicable and non-communicable diseases. Similarly it is accepted that primary preventive units will have to take on more primary prevention tasks especially in relation to non-communicable diseases.

Primary care and curative follow-up activities with screening of diseases and work towards patient and family-centred promotion and prevention should be in place. What is not yet clear is the scope of such preventive facilities and the number of workers required to fulfil these tasks. The prevailing paradigm is to use a campaign approach for prevention and restrict patient-centred services for secondary and tertiary care. It is questionable as to how far this paradigm can serve the emerging as well as the prevailing epidemiological challenges.

There are various branches of medicine in Sri Lanka, which contribute to the nations health. They include Ayurveda, Siddha, Unani, and Homeopathy and other systems of medicine. All of them collectively constitute an integral part of the health sector and must be included in the planning process. The development of these systems needs to be ensured by a clearer conceptual basis for coordination of health services, coupled with adequate resource allocation and the strengthening of the existing institutions.

2.2.2 Human Resources for Health

Despite the increasing numbers of specific categories of Human Resources in the health sector the past years have witnessed many problems and challenges. One of the recurrent constraints for improving the effectiveness of human resource policy and planning in the health sector is the lack of a comprehensive human resource strategy and lack of coordination among all units concerned in Ministry of Health and Ministry of Education.

The current major problems are imbalance in production of staff, geographic inequity in distribution, lack of a fit between expected job performance and training.

The imbalance in production is caused by virtually decreasing levels of production of nurses and paramedical staff and ever increasing production of doctors. On the one hand, there are currently serious disparities in the requirements and supply of several categories of health personnel, particu-

larly nurses and paramedical personnel. These shortages cause inefficiency and ineffectiveness in the public and private delivery systems. On the other hand, the growing surplus of doctors will have serious cost and quality implications. These doctors may not be properly absorbed into the state health system, although there is an historic commitment to do so. Even if increasing numbers of doctors move into the private sector, a surplus of doctors practicing privately will cause an increase in supply-driven consumption levels in urban areas.

There is also a significant imbalance existing in the distribution of human resource for health (HRH) among districts. Specifically, the number and the rate of health personnel in the Northern Province is extremely low while districts such as Colombo, Kandy and Galle have a significantly higher concentration.

The insufficient quality and competency of health staff too has been identified as a challenge for correction. Lack of technical competency and absence of positive humane attitudes have affected the responsiveness of the services.

In terms of employment structures and human resource management, Sri Lanka still retains a system whereby certain categories of state sector staff are appointed and controlled by a Public Service Commission or similar state bodies. There are also weaknesses in the recruitment and deployment of other categories of staff. These result in distant, slow and largely unresponsive administration of staff as they strive to work in a changing environment.

The challenge is to introduce a modern system of management geared to appraise the performance of individuals and institutions against their defined roles. This will require an improvement in the working conditions of staff, a fair and transparent system for promotion, reward, discipline and training, re-certification processes and revised terms and conditions that will generate different incentives for staff who are more responsive to clients' needs. Appropriate conflict resolution procedures need to be introduced.

2.2.3 Health Financing and Resource Allocation

Sri Lanka has achieved extraordinarily good health outcomes given the level of spending on health. Total expenditure on health was Rs. 39,177M in 1999 of which 13% was capital investment. This amounts to about 3.53% of GDP or Rs. 2,068 per capita (U$29 per capita). There is heavy reliance on taxation and out-of-pocket expenditure (approximately 50%) as financing sources. Government revenue is primarily from central taxation. Private expenditure is predominantly out-of-pocket expenditure with about 10% paid by employers and individuals for private insurance, which is primarily spent on ambulatory care. Health expenditure has been increasing, albeit from a low base. Since 1990, total expenditure has been between 3-3.5% of GDP of which the Government's share was around 1.4% and 1.5%. However, in the last 4 years only 1.1% to 1.2% of GDP has been spent on health by MoH. The level of external development assistance to this sector is low compared to other developing countries, which is around 4%-6% of the total expenditure.

The predictions based on the studies done to estimate the financial burden of the health system for the next fifteen years clearly show the extent of the additional funds needed to run the health system, if there are no significant gains in efficiency.

To decrease the resource gap, there is significant pressure to make best use of the limited financial resources available and rationalise logistics and administration, in order to optimise the resource utilisation. But even so there will remain a need to mobilise more resources, particularly in health and nutrition promotion, preventive and curative primary and secondary level care

The Central Government financial allocations to Provincial Councils largely cover preventive and curative primary and secondary level health care. These financial allocations so far are not based on objective and transparent measures of people's need: only around 6% of funding is via "criteria - based'" grants (weighted favourably towards the poorer provinces).

Block grants from the Ministry of Provincial Councils constitute the largest component of funding for provinces. Provision of 'matching grants' was aimed at encouraging local revenue rising but it does not seem to have been achieved. In practice, there has been no attempt to link national policy to finance through this allocative mechanism. There is neither a contracting mechanism nor is there any evaluation of value for money. Also there is a need to ensure that equitable and fair distribution mechanisms are in place between and within provinces and that these address localised poverty pressures.

With the existing resource allocation mechanisms there is little opportunity for significant improvement in service efficiency, cost effectiveness, quality or ability to focus on the poor without a substantial change. To achieve such improvements will necessitate a review of allocations to provinces and or an increased ability for provinces to raise revenue for health, more management autonomy, improvements in finance and management systems and financing including allocations based on needs, together with more rational planning and funding of services.

2.2.4 Health Sector Management and Stewardship

Although Sri Lanka's health sector has been very successful in reducing the major public health problems that still affect other developing countries, at the turn of the 21st century, the health system faces several major problems in its organisation and management, financing and service delivery mechanism, which require review and effective responses. The prevailing ethos is one of administration, rather than management. Standards and norms are set centrally with little flexibility and authority for managers at peripheral levels to make decisions on finance, staffing and utilisation of resources and to deal with emergency and disaster situations. The issues created by the unfinished agenda of decentralisation, lack of an efficient management information system, and lack of a result-based performance appraisal mechanism pose significant challenges in management.

In addition the health information system is also beset with many challenges. Lack of an updated policy for information, insufficient coordination among managers of information, lack of easy access to existing information, uneven information management capacity, substandard quality of the existing data and sub-optimal use of information and other technology are important challenges that need to be overcome.

The need to update the health legislation, enhancing effectiveness, efficiency and accountability of the MOH through improved human and financial management, strengthening managerial performance at the provincial and sub-provincial levels with improved capacity is apparent. Capability building to handle decentralised responsibility for managing health care services, strengthening monitoring and evaluation of health service quality & delivery and enhancing evidence-based decision-making by the MOH and other institutions is important challenge for the new century.

2.2.5 Conflict- affected Areas

The devastating results of the twenty-year-old war became more overtly visible with the dawn of peace in 2002. Damaged infrastructure ranging from primary care centres to tertiary hospitals, the scarcity of human resources for health in the war-torn areas, breakdown of preventive and promotive services, lack of other supportive facilities such as medical supplies and equipment and the disorganisation of other systems such as education, sanitation, etc. that have a direct adverse influence on

health have created negative health impacts among those living in these districts. The displacement of masses of people further has created a range of physical and psychosocial problems that mandate careful attention. In addition to those districts that belong to the North and the East provinces, four borderline districts that belong to North Central, North Western, and Uva Provinces too were affected to a great extent by the prolonged conflict. The rebuilding of the health system in all of these devastated provinces remains a considerable challenge for the country.

The approach should be institutionalised and a clear strategy developed to ensure a smooth transition from emergency to development support. The requirement is for the smooth transition of the emergency aid to sustainable health management. Similarly, it is essential that international assistance be maximally utilised to support the rebuilding with a rational plan for services that can be staffed and resourced. The methodology of a sector-wide approach would be of considerable benefit in ensuring this.

2.2.6 Optimising the Private Sector Contribution

While Sri Lanka can justly be proud of a well-established public sector for health care provision, the private sector also plays a significant role in the health sector of the country. The Government tacitly encourages individuals to pay for their own health care where they are able to do so and for the private health sector to meet these needs.

However, Government has an overall responsibility to ensure that patients are protected and get value for money in both state and private sectors. As such, Government needs to consider how to regulate the private health sector and obtain data from the sector without stifling initiative and innovation. Strengthening of the capacity of the private health sector to provide quality care needs to be emphasised. Consideration also needs to be given to how best to encourage partnerships between state and private sectors to deliver quality services and contribute to the national health goals.

2.2.7 Improving Responsiveness

There is a growing consumer dissatisfaction with the services rendered by most of the state-owned health care facilities, and patients are becoming more inclined to express their dissatisfaction. The issues that are particular causes for concern include overcrowding in the larger hospitals, long waiting times, poor surroundings and the unsatisfactory attitudes of some health care workers. Issues of professional negligence are being raised strongly in the national press and recent cases have involved individuals suing the Government for compensation for negligence. There is little or no information on consumer views about the private sector. More information is required on the attitudes and perceptions of the public on the services they receive and appropriate systems will have to be developed for complaints to be heard and problems resolved.

2.2.8 Focusing on Vulnerable Groups

The challenge remains to ensure that Government funds in the health sector are targeted towards the poor and most vulnerable in society while that those who can afford to pay are encouraged to do so. Whilst Sri Lanka has been exceptionally successful by international standards in targeting state funds to poorer groups, significant gaps remain notably for the people in remote and drought-affected areas, those affected by conflict and workers in the estates sector, the elderly, the disabled, the mentally ill, working women, children of migrant workers and adolescents.

2.2.9 A Sector-Wide Approach and Intersectoral Collaboration

While the Ministry of Health, Nutrition and Welfare will take the lead in planning for the sector it needs to ensure full participation of all those involved in contributing to a healthy nation. The challenge is to involve all partners, other governmental ministries, the private sector, NGO sector, and development partners as well as civil society. This approach should ensure that contributions from donor agencies are well targeted and contribute to the Government's policy and overall strategy.

3. HEALTH SECTOR IN TRANSITION

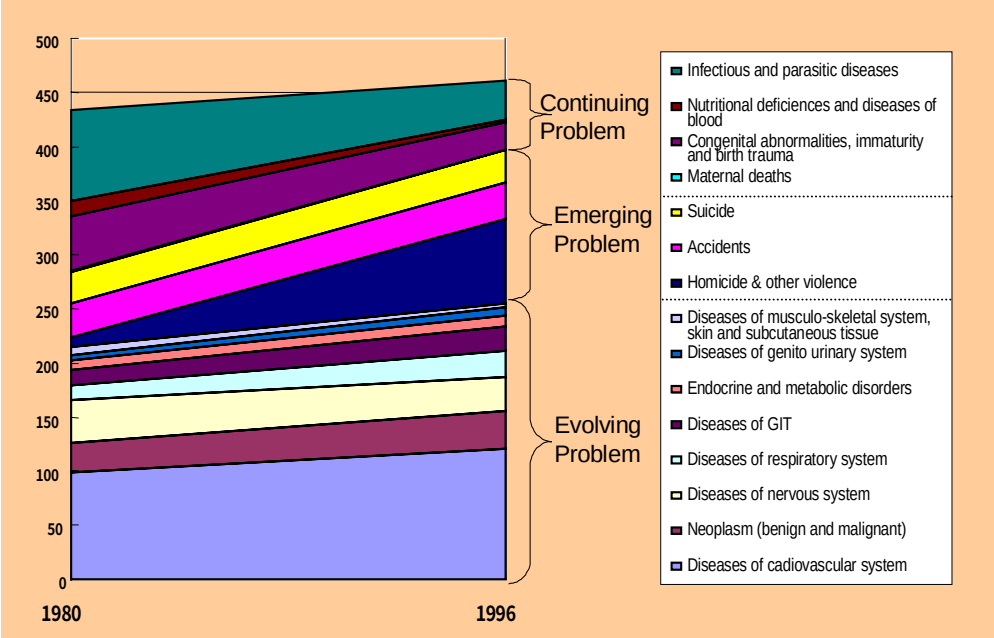
3.1 EPIDEMIOLOGICAL TRANSITION IN SRI LANKA

The Sri Lanka health sector has been a successful model of "good outcome at low costs" in the 20th century. According to the World Health Report 2002, the Sri Lankan life expectancy at birth for the entire population is 68.8, which ranks at the 7th place among 73 countries with GDP per capita below US$1,000. The success so far achieved is commendable; however, a failure would loom unless actions are taken to face the rapidly changing scenario from a health transition.

Health transition is a historical phenomenon that many developed and developing countries are now experiencing, and Sri Lanka is one such case. Most of the countries share common underlining factors, i.e., transition in epidemiologic patterns, change in patient expectation, and societal demand for efficiency of healthcare system management.

3.1.1 Three Problems on Disease Burden

Sri Lanka is regarded as being in the midst of health transition in terms of epidemiology of disease, looking into the evolution pattern of causes of deaths in Sri Lanka during a period of 20 years as shown in Figure 3.1.



Source: Govt. of Sri Lanka, Registrar General Office, Vital Statistics 1980-1996

Figure 3.1 Causes of Deaths, 1980 to 1996

Target diseases are rapidly changing, i.e., mortality due to non-communicable diseases such as Ischaemic Heart Disease, Stroke and Cancer is increasing, while communicable diseases and MCH-related conditions remain a problem and their control faces an unfinished agenda. At the same time, certain emerging diseases and conditions such as Accidents, Suicides and Homicides are show-

ing a clearly increasing trend. A large disease burden in Sri Lanka is born by a set of diseases and conditions related to lifestyle changes. These include non-communicable diseases amongst which mental disorders occupy a significant place. The characteristics of such a Sri Lanka disease burden can be explained by three groups of problems.

Group 1: Continuing Problem

In the developing world, prominent diseases have been infectious and MCH-related diseases. This group of diseases and conditions poses a continuing problem and consists of diseases and conditions that had a high mortality and morbidity in the past but are under fair control now. Yet, pockets exist where mortality and morbidity from these conditions remains high. Vector-borne Diseases, such as Malaria, Dengue and Filariasis, continue to affect the population while a third of preschool children remains malnourished.

Group 2: Emerging Problem

An emerging problem that has resulted from societal changes due to rapid urbanisation, industrialisation and/or the breakdown of traditional society, is apparent. This includes traffic accidents, injuries, violence and the surge of homicides in the young age group in recent years. Sri Lanka also faces an emerging problem of HIV/AIDS.

Group 3: Evolving Problem

An evolving problem is mostly related to a result of change of lifestyles, people's behaviour and stress in daily life that are increasingly been faced by people. This is represented by an increasing propensity of non-communicable diseases such as Cancers, Heart Diseases and Mental disorders.

In Sri Lanka, where communicable diseases and MCH-related diseases have been drastically curtailed, early degenerative diseases such as Ischaemic Heart Disease and Cancer have evolved as a major problem and are more visible due to prolongation of life of its society. Thus, Sri Lanka has to bear a double burden of disease, namely, communicable and non-communicable diseases.

3.1.2 Integrated Approach Needed to Challenge the Health Transition

The challenges posed by this health transition have to be faced by a new service delivery system by making changes in its functions. The new health care delivery system should employ an integrated approach with three functional arms, namely, 1) preventive, 2) curative and 3) welfare arms. Curative services cannot alone establish an efficient and cost-effective health system that is capable of challenging the epidemiological transition.

Preventive Arm:

Policy for integration within the preventive area has to be based on tackling the risk factors from foetal stage to old age. This is so-called "***life-course approach***". The evolving and emerging diseases (Groups 2 and 3) are heavily based on people's behaviour and lifestyles. A whole set of integrated actions needs to be implemented vigorously. Alcohol, Hypertension, Tobacco, Overweight and Cholesterol are the highest risks, which create the major burden of diseases. According to a WHO study on ageing, there is a critical window for the exposure of risk factors in the early stage of life to cause degenerative diseases at later age, proven by recent epidemiological data. Hence, appropriate

preventive interventions for different age groups have to be explored to mitigate these evolving diseases.

Curative Arm:

The policy on curative care should be to reorient the services by reviewing the functions at different health care facilities, namely, primary, secondary and tertiary care facilities. These functions have to be re-defined, according to the evolving disease pattern and integrated to an emergency healthcare network, a rehabilitative community support network and a primary care network.

Welfare Arm:

Policy focus on establishment of a comprehensive health care system should also highlight the importance of welfare elements. This is particularly vital to maintain a healthy society for the aged and disabled people. Rehabilitation and social cares need to be associated with curative care services and community base programs.

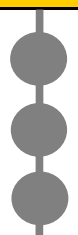
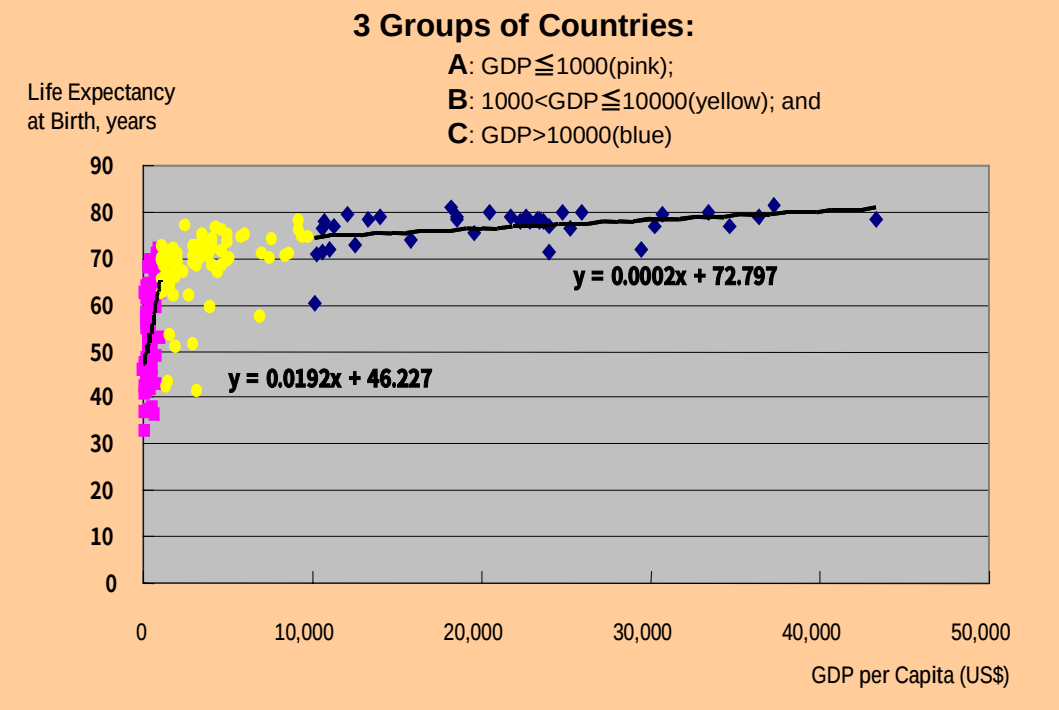
	Diseases	Risk Factors	Preventive Arm	Curative Arm	Welfare Arm
Group 1: Continuing Problem	MCH-related Infectious Others	Nutrition; Maternal State Nutrition; Environment			
Group 2: Emerging Problem	Traffic Accident Homicide & Violence Others	Multi-sectoral Social Breakdown			
Group 3: Evolving Problem	Lifestyle-related Mental Others	Individual lifestyle, diet habits Stress; Social Breakdown			
Approach to Health Policy and Strategy			New Preventive Policy, based on a "***Life-Course Approach***"	Responsive & Sustainable System Plan	Preparation of an Ageing and Welfare Society

Figure 3.2 Required Integrated Approach to A Comprehensive Health System

3.2 FINANCIAL IMPLICATIONS IN HEALTH TRANSITION

In order to design a new health system to fit to those changing demands as a result of transition, it is required also to examine a new financial strategy in line with cost-effectiveness under limited resources.

An analysis of health and development, employing a global context, shows that the increment of longevity with economic development level slows down after a very rapid increment up to GDP per capita of US$1,000 as shown in Figure 3.3.



Source: World Health Report 2000, WHO

Figure 3.3 Global Relationship between Longevity and Economic Development Level

It is partly due to the high cost of intervention in high-income countries, and partly, to the target shift to more costly non-communicable diseases such as ischaemic heart disease, stroke and cancer. As life expectancy at birth increases, health expenditure per capita increases slowly at the beginning and then rapidly at the age around 68. A formula, when applied to only countries with GDP per capita lower than US$1,000 such as Sri Lanka indicates that it requires US$31 per capita per year for health expenditure. It is almost the same amount that Sri Lanka is actually spending now. While, when a regression formula is used for countries with GDP per capita of more than $10,000, then Sri Lanka would require US$530 per capita. Thus, there exists a great difference in health expenditures between two groups categorised by the economic development level. Sri Lanka is presently moving towards a similar disease pattern as high GDP countries, although it can spend more or less US$30 per capita that enable it to cover only the traditional target. This implies that Sri Lanka, when providing sufficient health services for the changing priority diseases, will potentially have to shoulder a remarkably greater financial burden.

A Similar estimation was carried out through old age fraction over 60. For a shorter life expectancy at birth less than 68, Sri Lanka requires health expenditure 4.87% of GDP in average, while if the formula for countries whose life expectancy of over 68 is used, Sri Lanka requires 5.84% of GDP. Both figures are much more than the current real figure of 3.4%.

Besides the above macro views in the global context, the HMP examined a more detailed projection of health expenditure demands in the future. As summarised in Chapter 4 volume 2, the total health expenditures in 2015 will be Rupees 267~326 billion in a moderate economic growth scenario, compared to Rupees 50~55 billion at present, as of 2002. The projected amounts share 4.5~5.0% of GDP, compared to 3.0% at present.

A large resource gap exists in the Sri Lanka health sector and now it seems time for Sri Lanka to consider alternative financing mechanism in order to fill the gap and stop reversed of the good outcome of its health programmes.

3.3 REQUIRED POLICY FRAMEWORK AND GUIDING PRINCIPLES

In view of new strategies required to face the challenges of health transition in service delivery, a new policy framework needs to be reoriented so as to cope with three requirements, namely: 1) responding to epidemiology; 2) responding to patients' expectation; and 3) responding to efficacy of the system. These three should form major pillars of the policy framework, and each includes three principles to guide the policy formulation as described below.

Pillar 1: Responding to Epidemiology (Service and System)

In order to meet the epidemiological changes, reorientation of the health care services and their delivery system is a must. This can be derived from the following three principles:

Principle 1: Prioritisation and Characterisation of Disease
Principle 2: Exploration and Development of New Strategy
Principle 3: Linking and Integrating Services and Systems

Prioritisation and categorisation of the disease groups according to their natural history and characteristics would help in planning and managing the service delivery. The three disease groups as shown earlier imply necessary interventions.

Pillar 2: Responding to Patients' Expectation (Culture and Care)

Not only through the global awakening of patient's right and equity, but also by looking at the characteristics of the disease itself, patient participation and satisfaction bears greater importance in the success of treatment. Greater efforts are needed in educating patients as well as health service providers to make better choices. This calls for reorientation of people's cultural norm on the health care in association with the following principles:

Principle 1: Improvement of "Quality and Safety"
Principle 2: Securing of "Patient Right"
Principle 3: Enhancement of "Client Satisfaction"

Systematic feedback from clients of a service about their satisfaction should be an integral part of the information system and quality assurance programme. Provision of basic amenities, cutting down the waiting times, quick response to their needs, good communication and courteousness could improve patient satisfaction.

Pillar 3: Responding to Efficacy of the System (Mission and Management)

Reorientation of the health sector organisation, management and information systems is required to respond to efficacy of the system. In the changing situation, it must reframe the entire management system to:

Principle 1: Be Accountable
Principle 2: Be Flexible
Principle 3: Be Efficient

The newly required system is costly. Selection of cost-effective interventions by technological assessment is essential. Even in the current services, management should be reoriented toward efficiency. To become efficient, continuous analysis of demand and the effort to match supply to demand is needed. To use limited resources in changing environment, flexibility is a useful operation principle. The system has to be accountable to people who receive the care and pay for the service. Transparency and information openness should be a policy.

In line with the above, adequate capacity should be strengthened in vital areas such as policy analysis, monitoring and evaluation, health promotion and consumer education. With the devolution of powers to the Provincial ministries of health by the 1987 constitutional amendments, provincial authorities were handed over new responsibilities without preparing them for the same. This has also brought about many inefficiencies and inequities.

A sense of "health crisis" needs to be recognised by the central MoH and political decision-makers in light of the sharp transition of health care needs and further development of private services encouraged by increasing capital inflows to Sri Lanka. Moreover, under the current epidemiological change, the needs of new and more costly technologies and drugs will be significant to meet patient expectations. Patients will increasingly move to the private sector, if the difference in technological level and responsiveness continues to grow, but this tendency is constrained by rapidly rising prices for private sector services. The underlying contradictions are bound to affect people's health-seeking behaviour, thereby leading to a failure to keep the standard services as in the past.

However, on the positive side, Sri Lanka can be the leading model in the 21st century again by setting into action new long-term strategic health policy that would enhance responsiveness of the health system to emerging needs and changing burden of disease. Sri Lanka can achieve good health at low costs even for the new emerging and evolving target diseases by an innovative preventive and curative care policy. People in Sri Lanka would then enjoy a reasonable, responsible and reliable healthcare delivery system.

3.4 KEY PRINCIPLES IN INSTITUTIONAL REFORM

Health sector reform is institutionally intricate, requiring various expertises. However, the most pervasive effect of the reform should be financial restructuring, through which all core functions in the health sector are reorganised. Key concepts underlining financial reform are addressed below.

3.4.1 Reform of Tax-based Financing Model

In terms of the public financing of health care, there are two main approaches used: 1) tax based, and entitlement depending on citizenship and or residence status, and (2) social insurance based on the payment of a premium for the entitled. Health care financing in Sri Lanka is of the first type, tax based.

Tax revenues have often been used in countries such as the U.K., New Zealand, and Denmark, where the government operates the health services. The government directly owns, operates, and manages the facilities. This approach provides the greatest amount of integration between financing, payment and organization of delivery.

In the Scandinavian countries and the U.K., the structure of the welfare state and financing mechanisms were developed out of the statutory allocation of government budgets. A typical example was the early British National Health Service. However, this model has already been greatly reformed in the U.K., New Zealand and Denmark.

3.4.2 Purchase-Provider Split

Tax revenue has often been used in countries mentioned above, where the government operates some health services, and need to raise revenue to support those services. It is generally argued that tax-based funding systems lack direct links between financing mechanisms and expenditure, resulting in no incentive to minimise costs. These systems also are generally characterised by sloppy accounting and weak, delayed reporting of financial performance.

Countries with state financed systems have initiated a fundamental reform measure known as the **purchase-provider split**. These governments separate public purchasing (payment for the services) from public providers (supply of services). This is a central policy component for "managed competition", which aims at improving efficiency and maintaining cost control through cash limits. This split creates a situation closer to the **third-party-payer mechanism in social insurance**, where the service provider is always obliged to make a claim to the insurer for disbursement based on its service record. This mechanism is typically used as the institutional basis for a more accountable system.

Interestingly, under the traditional system, where financing, payment and the organisation of service delivery are under the same authority but without explicit links, the provider (hospital) has little real organisational incentive to develop a functional system of medical information. The purchaser-provider split creates that incentive, as the payment organisation requires detailed information to justify the reimbursement of provider entities.

3.4.3 Hospital-based Management

The term **"hospital-based management"** can be rephrased as a **"system of autonomous hospitals"**. However, **"autonomy"** is a slippery word, and its usage can vary. In Sri Lanka, hospital autonomy may be equated with the Sri Jawardenapura General Hospital (SJGH). However, SJGH is not the only possible type of autonomous set-up. The levels of hospital autonomy can have a wide range.

Some variations of autonomous management have been found. Since the 1980s, there have been many cases where public sector hospital management has been reformed. Successful examples are found in Thailand, Indonesia and the U.K., adopting one common approach of moving away from centralised bureaucratic control toward increasing reliance on hospital-based management and financing.

3.5 FUTURE DEMAND FOR HEALTH FACILITIES

The fact of "over crowded higher level health facilities and underutilization of lower health facilities" is recognised as one of crucial problems in Sri Lanka, in terms of efficient resource allocation and mobilisation. The so-called bypassing issue is related greatly to absence of the adequacy of locations, quality and quantity of health facilities as well as absence of well-defined functions attached to

different levels of facilities. The GIS analysis revealed that a sufficient number of lower health facilities are located with neither a functional service catchment areas system nor a hierarchical operation system.

As for the number of hospital beds provided, compared with other South Asian countries, Sri Lanka is running ahead in availability of hospital beds. This, however, does not mean that the number of beds matches with the level of doctor-population rate or the share level of health expenditure to GDP. A future demand of hospital beds will very much depend on the rationalisation of the network and the OPDs and the ability to lower the number of hospitalisations.

The projection analysis indicates that on an assumption that the nation's health conditions be improved and OPD be better able to deal with diagnostic tests, one could expect a lowered rate of annual hospital admission (**154 per 1,000 population**) with 5.5 days duration and an average of 80% occupancy, the necessary number of hospital beds in 2015 is estimated at about 60,000, which is equivalent to the present number, 59,635. This means that no additional beds are needed. This rate of annual hospital admission 154/1,000 population, is assessed to be achievable, given the implementation of the HMP.

3.6 FUTURE HEALTH EXPENDITURES

The diseases burden, as overviewed in the preceding chapters, is drastically changing, which requires increasing financial resources imposed on both the government and household sectors. It is a crucial aspect whether or not the **health expenditures** will be affordable for the national economy in the future. The HMP examined these aspects as follows:

3.6.1 Macro Approach

Health finance at the national level comes mainly from government expenditures and private payments for care. These two sources of financing represented about 90% of the total financial support for the health sector in 1999. A third financing strategy, social health insurance, represents an alternative approach, which is expected to expand during the next fifteen years. However, it is difficult to project how it may evolve, as it currently does not exist in the country. Therefore, it is assumed the third finance be under government expenditures because it would essentially fill the gap in tax support.

Given the various assumptions regarding a) the rate of GDP growth, b) the MoH share of GDP and c) the household health expenditure elasticity with respect to total household expenditure, total health expenditures will grow to varying levels.

The total health expenditures are estimated at around Rs.50 to 55 billion in 2002, and will climb to between a low of Rs.169 billion to a high of Rs.464 billion in 2015. The increase is a low of three-fold to a high of nine-fold. These estimates show that, as a share of total GDP, this level of expenditures will grow from around 3% in 2000 to between 3.6% and 6.7% respectively of GDP in 2015.

Table 3.1 Total Health Expenditure Projections (macro approach) for Sri Lanka by 2015

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

Source: MoH-JICA Study Team

3.6.2 Implications on Health Finance in the Future

This estimate implies that the share devoted to health will grow from the current level of about 3.0% of GDP. Most of the evidence presented in this analysis suggests that this share will grow from **4% to 5%** of GDP. Both the macro and micro approaches tend to suggest this basic finding. As such, if the trends continue and the assumptions hold, then Sri Lanka will be able to provide the level of expenditures equal to or even greater than international standards. Given this, the essential health services could be financed.

Even if a high population growth is considered, both approaches however did not account for ageing of the population and epidemiological transition. They have not factored in the higher cost of providing health services for non-communicable diseases that often require long-term if not life-long interventions. As such, the results of the analyses using either approach may be an underestimation of the total health expenditures.

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

4. AIMS, PRINCIPLES AND TRUSTS FOR STRATEGY

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

4.1 VISION

The government aims to foster a healthier nation that contributes to its economic, social, mental and spiritual well-being. It will achieve this by responding to the people's needs and working in partnership to ensure access to comprehensive, high quality, equitable, cost-effective and sustainable health services.

4.2 UNDERLYING PRINCIPLES

The vision reflects the fact that:

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

2) The role of Government is not just to deliver services but to develop partnerships, between Government departments and external agencies which contribute to improving health. These include:
   - Communities in the design, management and use of services;
   - The private sector and Non-Governmental Organizations that play a key role in the delivery and financing of the health care; and
   - Developmental partners (donors and other international agencies).

3) The Government would ensure that health services are:
   - Accessible and affordable to the state and the public;
   - Free of charge for state services at the point of delivery;
   - Comprehensive and serve the whole population;
   - Are of an acceptable quality both in the state and private sectors;
   - Responsive to emerging and changing health needs;
   - Accountable to users and the population at large;
   - Evidence-based; and
   - Sustainable.

4.3 STRATEGIC OBJECTIVES

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

1. To improve health service delivery and health actions
2. To strengthen health actions of communities, households and individuals
3. To improve management of human resources for health
4. To strengthen stewardship and management functions of the health system
5. To improve health finance mobilisation, allocation and utilisation

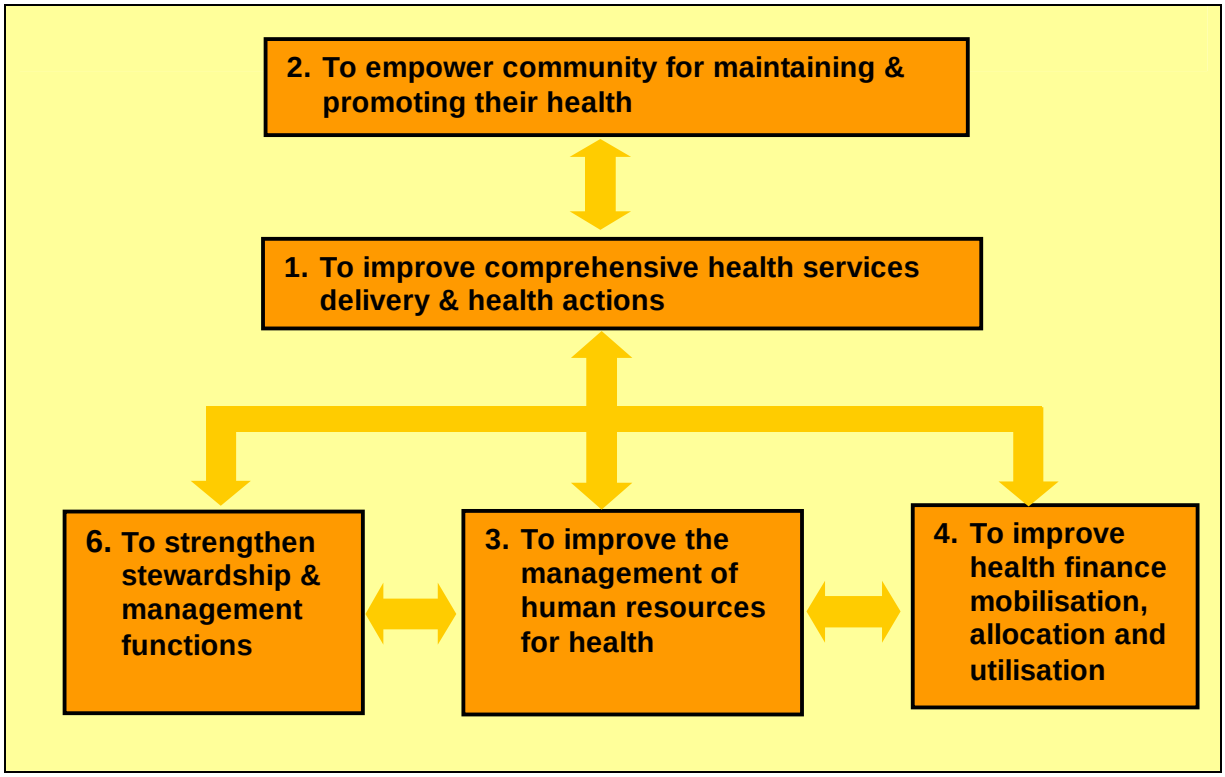


Figure 4.1 Inter-relationship among the Five Strategic Objectives

To ensure the five strategic objectives, the following immediate objectives are planned.

1. To ensure the delivery of comprehensive health services, which reduce the disease burden and promote health:

1) To rationalize and strengthen health network of facilities and services
2) To reduce priority diseases/conditions through strategic interventions
3) To enhance quality of service delivery
4) To improve health status of vulnerable populations
5) To increase public confidence and patient/client satisfaction in the health services
6) To access new technologies

7) To strengthen public-private partnerships in order to enhance efficient health service delivery

8) To ensure adequate drugs, material and equipment for service delivery

2. To empower communities (including households) towards more active participation in maintaining their health:

1) To improve public awareness of their rights, responsibilities and options for care

2) To improve participation of civil society and Non-Governmental Organizations in promoting behavioural and lifestyle changes

3) To monitor public perception of their needs and of the health system towards serving as an input for improvement

3. To improve human resources for health development and management:

1) To expand functions and strengthen capacities of National and Provincial Ministries of Health in human resource development and management

2) To rationalise the development and management of human resources for health

3) To improve management, clinical and public health competencies of health staff

4. To improve health financing, resource allocation and utilisation:

1) To increase government financial support at all levels to strengthen the financial sustainability of the health sector

2) To improve allocative efficiency of public funds

3) To make optimal use of existing financial resources

4) To strengthen financial management

5) To improve financial equity and related equity of access

6) To identify and test alternative financing mechanisms with a view towards national implementation.

7) To optimise private sector contribution, initially establishing an information sharing mechanism to include reporting on service use and quality as well as financing.

5. To strengthen stewardship and management functions of the health system:

1) To strengthen managerial performance at national and decentralised levels

2) To enhance efficiency, effectiveness and accountability of the MoH & decentralised units

3) To strengthen and introduce, if needed, performance management systems

4) To establish a system for regulating the services of public & private providers

5) To strengthen management information system

6) To strengthen coordination and partnerships with other sectors

7) To strengthen capacity in health research and technology assessment

8) To strengthen autonomy of hospitals and unit/divisions

4.4 DEVELOPMENT OF NATIONAL HEALTH OBJECTIVES & TARGETS

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

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

5. STRATEGIC OBJECTIVES

5.1 COMPREHENSIVE SERVICE DELIVERY

Delivery of comprehensive health services, which forms the keystone of health development, covers many facets out of which the important ones are outlined below.

5.1.1 Rationalised Health Network

A detailed National Health Service plan for medium term, up to 2010, will be prepared relating services to population needs for primary, secondary and tertiary health care. This will specify the optimum configuration of services for a given level of total annual health expenditure, show the implications for the state sector of assumptions about growth in private sector services, and identify priorities for capital investment. It will take into account, demography and epidemiology, current and future treatment methodologies, including a gradual shift to ambulatory care for diagnostic and surgical procedures and the potential of new technology, e.g., laser and laparoscopic surgery etc., to reduce inpatient stays.

The national health services plan will be used to guide the allocation of recurrent and capital financing to provinces. Mechanisms will be put in place to ensure that this process is transparent and equitable. Donor investments will fit into this plan.

In conformity to the detailed national health services plan, a facility master plan will be developed based on identified requirements at provincial, district and divisional levels and for tertiary and teaching hospital facilities. It will be based on demographic, epidemiological data and projections and on the technological advances in medical practices, rather than on historic patterns of provision. The planning systems will be reviewed and made more open, transparent and participatory, based on locally assessed requirements. Facilities will be re-classified according to agreed criteria and to reflect the types of service to be provided. The recurrent implications of any capital development programme will be considered as part of the master plan and integrated into the expenditure framework. Donor support needs to fit within the overall master plan.

In addition, appropriate referral strategy including admission and discharge policies will be introduced to ensure that patients receive treatment at the most appropriate level. This will include home-based care when and where appropriate. The supportive services too will be developed in a parallel manner.

5.1.2 Reduced Priority Diseases/Conditions through Strategic Interventions

Sri Lanka will have to continue to deal with existing communicable diseases while developing programmes for prevention and management of injuries, non-communicable diseases and new threats such as HIV/AIDS. Cost-effective treatment protocols will be developed for selected diseases such as cardiovascular disease, diabetes, arthritis and renal disease and introduced into all relevant education, training and continual professional development activities. An example of this is the diagnosis, control and maintenance of diabetes through community level interventions with the objectives of minimising hospitalisation and maximising quality of life. Pilot programmes will be established to introduce easy-to-use ambulatory technologies in the Sri Lankan context.

5.1.3 Enhanced Quality of Service Delivery

A quality assurance strategy will be developed to facilitate the delivery of high quality services central to the ethos of the health sector. Although backed by regulation it will have as its basis self-regulation. The Ministry of Health will lead in developing quality assurance in a systematic manner that enhances team spirit and is patient- and consumer-focused. This approach will include clinical accountability and the development of peer group review and clinical audit as well as other methods of monitoring patient satisfaction and the quality of service delivery. The need for regulation to include re-certification of doctors, nurses and other health care workers at regular intervals will be discussed with the appropriate professional bodies.

Clear protocols and accreditation processes will be introduced to upgrade and sustain standards in both the state and private sector. To ensure sustainability, professional organisations, medical faculties and service providers will be involved in the developmental process. The role of the Sri Lankan Medical Council in encouraging quality improvements with wide public representation will be reviewed. The quality assurance strategy will ensure regulation and implementation of public health care programmes like food safety, environmental health and occupational health.

5.1.4 Improved Health Status of Vulnerable Populations

State health services will give particular attention to the poor and vulnerable groups by:

- Expanding preventive and other state health care programmes, with greater emphasis on health promotion; special efforts will be made to influence the young. Increased efforts will be made to prevent and treat nutritional problems.
- Expanding access to curative health care services through the selective upgrading of facilities in order to make these services more accessible to the rural poor.

Health care services will be expanded to meet the needs of specific groups such as the adolescent, elderly, families of migrant workers, victims of war and conflict and to promote specific areas of health care such as occupational health, mental health and estate health services. Training will be expanded in the area of mental health and geriatric medicine to meet emerging health care requirements.

5.1.5 Increased Public Confidence and Patient/Client Satisfaction in the Health Services

Survey data are necessary on a regular basis to ascertain patients' and the public's views on the responsiveness of the health system. These surveys will ascertain the consumers' perceptions of the services provided, their level of satisfaction with the services and their views on the sorts of services they would wish to receive. Undertaking these surveys will send a clear message that their views are valued and will facilitate their increased participation in the planning and management of services in future. Findings of these surveys, which will be publicly available, could also be used to inform the policy-makers on what changes are needed to develop a responsive and people centred service.

5.1.6 Access to New Technologies

New technologies and innovations will be evaluated and where they clearly demonstrate their value and impact, introduced into the state sector. In particular, the use of minimally invasive treatments and interventions including day care surgery will be encouraged as these have clearly demonstrated that they are beneficial to quality of treatment of patients and result in significant productivity gains.

Policies will be developed to share investment in this area between the state and private sector where it is cost-effective.

5.1.7 Strengthened Public-Private Partnerships to Enhance Efficient Health Service Delivery

The private sector will be encouraged to develop with a view to providing a good quality health service especially for those that can afford.

Careful cost effectiveness studies will be carried out comparing acquisition and use of technology with purchasing of services from the private health sector for state sector patients, thus encouraging private-public partnership. The state sector will be encouraged to pilot such partnerships.

5.1.8 Ensure Adequate Drugs, Materials and Equipment in Place

The challenges in medical supplies and equipment management are many and interrelated. The essential drug lists for each level of medical institutions need to be reviewed. The purchasing and distribution systems of drugs as well as the storage capacities at provincial, district and divisional levels will be improved minimising the wastage and pilferage. The quality of medicines in the public sector will be tested routinely to ensure the uninterrupted distribution of potent medicines at the points of service delivery. Similarly, the purchasing, distribution, maintenance and repairing systems will be strengthened, for equipment along with the supply of other logistics.

5.2 COMMUNITY AND HOUSEHOLD ACTIONS FOR HEALTH

The role of the individuals, households and the community in health development should not be underestimated at any point. In order to obtain the maximum cooperation, it is important that the people are made knowledgeable for their rights and responsibilities, and are provided with inputs that are necessary for positive behavioural changes and also to provide adequate opportunities for maximum involvement in health activities.

5.2.1 Improved Public Awareness of their Rights, Responsibilities and Options for Care

The community, patients and Human and Patient Rights Groups need strengthening in order to make the public and patients aware of their rights and responsibilities. Efforts to build and strengthen these groups will be promoted with a view to maximising the responsiveness of the health system to meet the legitimate expectations of the people of the country. The public will be made to realise of their responsibilities with a view to maximise their involvement to maintain a high degree of responsiveness of the services.

5.2.2 Improved Participation of Civil Society and Non-Governmental Organizations in Promoting Behavioural and Lifestyle Changes

The determinants for behavioural and lifestyle changes are multi-factorial. They are multi-faceted and are densely interwoven to the social fabric that has been enriched by ideas, norms, values and beliefs of people. The effort needed to achieve a positive behavioural change in selected population risk groups needs to be equally shared by civil, non-governmental and other governmental organizations as well. In selected areas the programme will work with relevant government departments aiming to achieve healthy public policies and interventions in all sectors. Similarly, the community

groups and other non-governmental organisations too will be encouraged to participate in these activities.

The Ministry of Health will lead in planning and sponsoring a major national behaviour change communication programme and set off activities aimed at healthy lifestyle changes in target population groups. It will be carried out through intersectoral and multi-sectoral collaboration with relevant department and agencies. The objective will be to reduce preventable risk factors and the main stakeholder is the population themselves. The Ministry of Health with collaboration with other partners will identify the target groups and the needed lifestyle changes based on evidence of epidemiology, treatment cost and effectiveness factors. These will include how to optimise health, productivity and educational performance and ageing through nutrition, exercise, relaxation and sleep, through avoidance of tobacco, alcohol intake, substance abuse, unsafe sex, and observance of road safety including seatbelt use. Commercial sector behavioural change advertising and lobbying companies will be contracted to design, pre-test and implement and manage these programmes.

5.2.3 Enhanced Monitoring of Public Perception of Needs and of the Health System

The responsiveness of the health system towards the legitimate expectations of the health needs of the community is vital as an input in the designing of a health system. The basis for being responsive lies primarily on the identification of public perception of their needs. It is proposed that mechanisms will be developed to monitor such perceptions in order to make it an input for the improvement of health sector.

5.3 IMPROVED MANAGEMENT OF HUMAN RESOURCES FOR HEALTH

Significant changes in employment structures are unlikely in the short term. However there will be opportunities for incremental organisational changes and to introduce new incentives for staff. Also there is a desire for more managerial autonomy at all levels in order to raise job satisfaction and service efficiencies. A human resource strategy will be developed to ensure that the right people are available with the right skills in the right locations at the right time.

5.3.1 Strengthened Capacities of National and Provincial Ministries of Health in Human Resources Development and Management

In the present context, the basic and post basic training of Human Resources for Health (HRH) is the responsibility of the Central Government. However the responsibility of in-service training remains with both Central and the Provincial Governments. The shortcoming of the supply of certain categories of HRH, and the lack of adequate in-service training and career development opportunities for all categories have been clearly highlighted over the past few decades. The capacity of the Central and the Provincial Governments to coordinate and to cooperate in Human Resource Development will be enhanced.

Projections of HRH needs and supply will be made for the next 20 years based on the service needs, demand, actual type of services, workloads and the economic feasibility.

5.3.2 Rationalised Development and Management of Human Resources for Health

There is a significant imbalance existing in the current distribution of HRH. Specifically, the number and the rate of health personnel in the Northern Province are extremely low while Colombo, Kandy and Galle districts have higher concentrations. Other provinces too experience shortages of

HRH. The factors that lead to this imbalance will be identified and corrected while transitional measures may be needed as HRH imbalances last for decades if no strong measures are taken. The capacity at the central and provincial levels to overcome the imbalance of HRH will be improved. The institutions will be strengthened in order to utilise the available HRH optimally.

The MoH role and responsibilities in human resource planning and development will be expanded for not only recruitment, training and staff allocation of paramedical health staff but also for policy/planning, development and management, collecting human resource related information, and coordination among human resource related institutions/units/ministries. Training on managerial skills for managers of health service providers will be provided under Ministry coordination. Comprehensive human resource development plans and policies will encompass not only public health /allopathic sector but also private health sector and non-allopathic sectors as well and will cover all categories of human resource recruitment, training and deployment, and other aspects of human resource development. It would be important to have a unified unit or a mechanism to unify the currently compartmentalised human resource functions existing inside and outside of MoH.

5.3.3 Improved Management, Clinical and Public Health Competencies of Health Staff

Another important dimension in health human resource development is the issue of quality. The two main aspects of quality are technical competency and human attitudes. Building positive human attitudes and appropriate knowledge and skills in provision of services of defined quality have been emphasised for decades but still need lot of attention. For improvement of technical competency, in-service training and continuing education with career development need to be institutionalised. Once adequate opportunities are made available for re-training, re-registration too could be considered as a means for improving technical quality. The minimum standards for certain categories trained by the Private Health Sector establishments for internal use too should be ensured as the MoH has a responsibility to look into this aspect of quality assurance from the patient protection point of view.

Building of positive attitudes among health service providers will be given top priority. In-house training, supervision and performance appraisal will be established in each institution with a view to building positive attitudes among health care workers.

5.4 IMPROVED FINANCING, RESOURCE ALLOCATION AND UTILISATION

The need of additional financial resources for the development and the maintenance of the health system should be given high priority. This could be achieved by additional allocation of financial resources as well as by facilitating the optimal use of existing resources. Further the mechanisms to achieve the above while improving the financial equity of health care too will be strengthened.

5.4.1 Increased Government Financial Support at All Levels to Strengthen the Financial Sustainability of the Health Sector

The demographic, epidemiologic, technical and social transitions were responsible for the changes of the health system, which were experienced over decades. The end result of all these changes was the escalating cost for health care delivery services by the government as well as by the people as out-of-pocket expenses.

With further improvements it is obvious that the government would have to increase the financial support at all levels to make the system sustainable. The Macro Economic Commission was established in 2002 with a view to identify principles and policies to maximise the government's financial support. It is proposed that further action would be identified and implemented to increase

governmental financial contribution at all levels in order to strengthen the financial sustainability of the health services.

5.4.2 Improved Allocative Efficiency of Public Funds

An increased share to state health interventions: There are concerns that real expenditure on key state health interventions is declining over the past few years. Though the primary responsibility for the delivery of such services rests with the provinces, it will be important to consider what incentives and mechanisms can be put in place to encourage the provinces to strengthen their efforts in this area. The Ministry of Health will take the leadership to set standards and performance indicators along with the provinces and other stakeholders and to assess the cost requirements to achieve these goals. Guidance will be provided on how provincial resources are to be allocated to ensure that they are consistent with national objectives and that equity is enhanced throughout individual provinces. Earmarked grants may be provided to support this process.

A focus on addressing the gaps in provision in the conflict-affected areas and the estates sector: Access to health services and health outcomes are clearly much worse in the conflict-affected areas and in the estate sector. Reducing such inequalities will require well-planned, concerted action. A sustainable investment strategy will be developed based on realistic staff and resource availability.

Removing unwarranted subsidies: The current preferential tax treatment for private health insurance is unwarranted. It involves a net subsidy to the most affluent and should be withdrawn. The revenue foregone through this policy is at least five times greater than the net savings to the government in terms of reduced utilisation and expenditures at state hospitals, or the amount of resources released for spending on other patients. This was described in an analysis of PHI in Sri Lanka: Findings and Policy Implications. Institute of Policy Studies, 1997. Government could spend this money better elsewhere. The case for subsidising the development of private facilities is also questionable and needs to be closely reviewed

Contracting Out where it offers value for money: There is already extensive contracting out of non-clinical services. Government will review the case for contracting out both clinical and non-clinical services where this offers value for money.

Maintaining the share of state subsidies to low income groups: Government will continue to support the low-income groups through:

- Ensuring resources are equitably allocated on a geographical basis between and within provinces;
- Focusing resources as far as possible on health promotion and disease prevention;
- Focusing services toward vulnerable groups; and
- Removing subsidies that primarily benefit the better off – e.g., tax deductibility on private insurance contributions and favourable treatment related to the development of private infrastructure

5.4.3 Optimal Use of Existing Financial Resources

Detailed work will be undertaken to estimate the costs of running a rationalised health service in Sri Lanka. This will form the basis of a prioritised financing plan that can be implemented as resources allow. This will be periodically reviewed and revised.

In view of the current economic climate and the need to address other priority issues, such as the rehabilitation of the conflict-affected areas, the scope for additional resources for health is extremely

limited. However, Government is committed under the PRSP to raising state allocations for health to 8%-10% of total public expenditure from current levels of around 5% to 6% and this will be confirmed within an agreed Medium-Term Expenditure Framework. Such increases will only be forthcoming if the Ministry of Health can clearly demonstrate that the additional funds contribute to improving health.

The Ministry of Health would comply by developing and monitoring a series of performance indicators that will be used to evaluate current structures and interventions and guide future investment.

5.4.4 Strengthened Financial Management

The Strategies for strengthened financial management include capacity, authority, monitoring & supervision and use of available resources. Financial resources will be used more effectively and efficiently. Allocated resources need to arrive at cost-centres in a timely manner. Finance posts need to be filled by those with the necessary skills, and better financial management information is needed. Currently, a lot of information is generated but little use is made of it for management and strategic planning purposes. Information will be collected systematically and initiatives such as national health accounts institutionalised. The entire budgeting process will be made more transparent.

5.4.5 Improved Health Financial Equity and Related Equity of Access

Financing equity is high in Sri Lanka as the tax system is progressive. In general, the poor receive a large share of the tax subsidies and utilise health care services relative to the more affluent. The more affluent increasingly seek care in the private sector, for both inpatient and OPD care. However, financial burden on health care including the catastrophic expenditure of certain segments of the population, namely, those from urban slums, displaced, estate workers, and the rural poor, need careful consideration. Efforts would be made to improve the financial equity of health care and the related equity of access to health care services.

5.4.6 Identification and Testing Alternative Financing Mechanisms with A National View

Tax-based funding has served Sri Lanka well in the past. However, it has not generated sufficient resources to allow services to be modernised in line with the expectations of the population and it has not provided a service that is responsive to changing health needs. Also the limited finances create few incentives for improved performance.

Other approaches that may contribute to the revenue base, and which will warrant review include, either alone or in combination; health insurance (social, community or private), fee for services including co-payments, and earmarked taxation.

Social health insurance offers the potential to address some of these problems. However, the feasibility of developing social health insurance as the primary financing mechanism is constrained by the relatively low level of formal employment and its management cost. The high level of informal employment would make it difficult to collect premiums and the additional costs involved would have to be financed – either by Government, by employers or by the people. Preliminary studies are being undertaken to estimate the levels of contribution that can be expected. A programme of work will be developed to assess the feasibility of social health insurance and will draw heavily on international experience. Any decision on the primary financing source will need to consider the extent to which the shortcomings in the current tax-based system can be addressed.

User charges can be inequitable and inefficient means of raising revenue for basic health services. State health services will be provided free of charge at the point of service delivery. However, at facility level, managers would be free to explore alternative ways of raising revenue that do not compromise equity. This could include amenity beds, selling services at full cost to the private sector and raising donations.

A more proactive and rational approach needs to be taken to donations. The current approach is rather ad hoc and there may be much untapped potential. In maximising such contributions it will be important to ensure that they contribute to national development goals and are rationally distributed. Guidelines will be produced.

Government will also review the case for additional taxation on products that harm health such as alcohol and tobacco and also on vehicle insurance. Whilst this might reduce the demand for such products it may reduce overall tax revenues. The case for earmarking such revenues for health will also be considered.

5.4.7 Optimising Private Sector Contribution

Private insurance offers little scope for contributing to national health objectives as it is a private good and is currently only affordable to the more affluent segment of the population. The private health insurance market in Sri Lanka is in its infancy and is beset with major problems. Government has a responsibility for ensuring consumers are protected and therefore needs to consider which forms of regulation are appropriate and to develop a regulatory framework before powerful vested interests have had a chance to fully establish themselves. Other areas for consideration might include the need to: define minimum benefit packages, develop approaches which ensure transparency and comparability, agree on treatment protocols, ensure guaranteed renewal, reduce companies' ability to deny coverage on the basis of pre-existing conditions, establish conflict resolution mechanisms and promote and develop quality assurance procedures. A form of managed care may offer more than traditional health insurance to consumers seeking an alternative to the state sector and providing more of a family medicine/general practice package as well as secondary care.

5.5 STRENGTHENED STEWARDSHIP AND MANAGEMENT FUNCTIONS

The term "Health Sector Management" is essentially similar to the term "Stewardship", which the WHO defines as "being ultimately responsible for the careful management of people's health". Careful review of the management of the health sector at various levels shows some areas need to be strengthened immediately. These areas and issues are outlined below.

5.5.1 Strengthened Managerial Performance at National and Decentralised Levels

The major issues in the health sector management in the country are confusion and conflicts over roles, responsibilities and lines of accountability between central and provincial levels of the MoH caused by devolution. The role/functions of the central MoH is still dominant in the tertiary hospital administration and recruitment and deployment of medical doctors. Provinces still have little control over recurrent expenditure, human resource deployment and disciplines.

Management capacity within the state sector will be strengthened to introduce changes and make the sector more responsive to the emerging and re-emerging challenges. This requires a major shift in the management and organisational structures of all parts of the system. With provinces assuming more responsibilities for operating state services, the role and functions of the Ministry of Health too will be subjected to change. Central Government health sector functions will move towards provid-

ing guidance, setting standards, ensuring quality, exercising regulatory functions, and monitoring needs, allocations, performance and value for money mandating significant restructuring of the Ministry of Health and a major change management programme.

5.5.2 Enhanced Efficiency, Effectiveness and Accountability of the MoH and Decentralised Units

The efficient and effective decentralized management in the Line Ministry and the provinces could be achieved by developing capacity of provinces to plan and manage services and by providing technical support, training and funds. Budgets will be linked to targets and technical performance agreed between central and provincial governments. Strengthened technical capacity at provincial level will increase the pressure on Provincial Councils to allocate the designated share of budgets to health. Capabilities at field level will be supported to improve front line services and referral and information services too will be developed.

The health sector needs well-trained managers who have the authority and ability to manage the changes proposed and to ensure their staff and institutions are involved. The immediate priority is to focus on in-service training of those individuals currently acting as managers at national, provincial, district and divisional level. Management development needs will be assessed and a comprehensive management training and development programme established which is open to all professionals. Consideration will be given to setting up an Institute for Health Management and distance-learning programmes on health management will be implemented. Universities will be encouraged to develop post-graduate degrees in health management.

5.5.3 Strengthened Performance Management Systems

All managers and institutions including field health units must be held accountable for the state resources used and the outputs achieved. A system of individual and institutional performance management will be introduced to facilitate their performances. Individual performance management will be based on defining clear roles, responsibilities, agreed performance targets and lines of accountability. It is proposed that the promotion and incentives be linked to individual performance. Institutional performance management will be based on agreed plans for each institution and annual reports produced to account for the use of resources and results achieved. Guidelines on planning will be drawn up and strategic and operational plans will be developed and distributed for every major institution. The Ministry of Health will hold formal annual review meetings with each province to review achievements, identify challenges and agree on an action programme for the following year.

5.5.4 Established System for Regulating the Services of Public and Private Providers

The role of the MoH and the Provincial Directors in the private health sector in terms of quality assurance, setting up of a regulatory framework, sharing information systems and resources, outsourcing clinical services and manpower training is almost non-existing in the country. The MoH and Provincial Directors have been neglecting their role in regulating the private sector to date, and the precise situation of the country is unknown. The MoH has been dependent on the self-regulatory mechanism of the private sectors up to date. However, from the consumer protection point of view, this aspect is one of the most crucial issues in the assurance of quality services. The private sector should be encouraged to raise and maintain standards. Legislation, now in draft, should be finalised, enacted and implemented to regulate private sector standards and the import of expensive technologies. Similar regulation mechanisms should be established for the state and private sectors so that quality is improved in the whole sector.

5.5.5 Strengthened Management Information System

The measurement of the effectiveness and the efficiency of a service basically rely on a well-designed management information system. Without appropriate information it is not possible for health care workers and managers to deliver, or measure, the significant improvements in productivity and quality of the health services or the system. The information policy will be developed and the capacity among managers and users of information will be strengthened. Clinical and management information systems will be reviewed and improved to ensure that managers have appropriate information to make evidence-based decisions and deliver value for money. Benefit-incidence analysis will be carried out on a regular basis to ensure equity and access. Institutional data will be linked to community, clinical and epidemiological information.

5.5.6 Strengthened Coordination and Partnerships with Other Sectors

Improving the health status of the people will not occur by simply improving health service delivery. Health is influenced by many other factors and there is a definite need to have good coordination among health-related sectors. For example, improvement of school health, reducing road accidents, and preventable disease control programme need to involve all partners including civil societies. It would be important to establish a sub-committee for health at the District and Divisional Development Councils to coordinate between stakeholders. It is hoped that the Ministry will develop clear channels for programmatic ongoing coordination on such issues as Human Resources Development, Nutrition and Non-Communicable Diseases, among other things.

5.5.7 Strengthened Capacity in Health Research and Technology Assessment

The role of health sector research should be emphasised more in the area of active promotion of evidence-based decision making at all levels. The main areas in urgent need of research are: health delivery system, health promotion, NCD, nutrition, indigenous medicine and health economy.

The country has eminent academics and good research potential capacity. However, capacity of health and health-related research institutions and researchers should be improved. A national research agenda will be drawn up every year reflecting the health sector needs. Building of a national research institute to lead the development of appropriate evidence for decision-making will be emphasised but available research capacity in universities and other institutes will be tapped.

The mechanism of research sustainability will be achieved by creating suitable career structures, remuneration of researchers, and the importance of building up suitable infrastructure for research to meet the increasing demand and competency will be discussed and planned as a national agenda.

5.5.8 Strengthened Autonomy of Hospitals and Units/Divisions

The numerous shortcomings that are prevailing in medical institutions are attributed to a large extent to the malfunctioning of the existing management system. This provides the mandate to examine the traditional hospital management system that has been in existence from the inception of the modern health system. Since 1970 it has been proposed over and over again that some of the large hospitals should be given autonomy in order to make the management more and effective efficient. Hospital autonomy could be of various levels and need careful designing. It is proposed that further work be encouraged with the view of providing a suitable background to pilot hospital autonomy.

6. RECOMMENDED PROGRAMMES AND PROJECTS

In line with the defined strategic and immediate objectives as mentioned in the preceding section, programmes and projects to be undertaken towards the target year 2015 were identified.

6.1 STRATEGIC PROGRAMMES AND PROJECTS

In the HMP formulation process, a concept of "***Strategic Programmes***" was introduced, being defined as a composite of projects, interventions and/or activities necessary to achieve the corresponding strategic objectives, integrating a variety of resources and functions. In other words, the HMP may be materialised through the implementation of the strategic programmes. A total of 22 programmes are depicted for the five strategies. Since a strategic programme needs to be integrated through functional linkages with each other, a collective effort by relevant responsible parties and project owners is required to be implemented under a deliberate implementation scheme.

6.2 PRIORITISATION UNDER RATIONALES OF PROGRAMME SEQUENCE

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

Four elements are thought to be key criteria, namely: 1) **Needs/Demands**, represented by urgency, effectiveness and beneficiaries; 2) **Social and Economic Effectiveness** implying the cost-benefit performance; 3) **Readiness** of the implementation, meaning that the intervention in question would be free from critical technical and institutional constraints, or be accorded within the constitutional framework; and 4) **Resource Availability** in terms of funding and human resources.

In order to keep a rational order of the implementation process, the above evaluation approach needs to be reviewed from a planning rationale of programme sequence, taking into account inter-sectoral linkages of each intervention in a phasing process and linkages between systems and services. Those enhancing on-going programmes/projects are given a priority. Based on the above considerations, a priority package of interventions, including concrete projects, was identified as **anchor projects** whose achievement shall be materialised in the short-term, or five years.

6.3 LISTING OF PROGRAMMES AND PROJECTS

Table 6.1 presents recommended strategic programmes, and projects to be undertaken for the corresponding strategy. This list indicates "focal point" which stands for the coordinating body and/or chiefly responsible body for the implementation, and "anchor project", meaning that the project is expected to urgently implement in the short-term.

Table 6.1 Recommended Programmes/Projects

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

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

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

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

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

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

Acronyms:

Secretary	Secretary of Health Service, MoH
DG	Director General of Health Service, MoH
DDG/BES	Deputy Director General of Biomedical Engineering Services, MoH

DDG/ET&R	Deputy Director General of Education Training & Research Branch, MoH
DDG/F	Deputy Director General of Finance Branch, MoH
DDG/LS	Deputy Director General of Laboratory Services, MoH
DDG/MS	Deputy Director General of Medical Services Branch, MoH
DDG/P	Deputy Director General of Management Development & Planning Unit, MoH
DDG/PHS	Deputy Director General of Public Health Services, MoH
D/HEB	Director of Health Education Bureau, MoH
D/MCH	Director of Maternal and Child Health, MoH
D/N Med Ser	Director of Nursing (Medical Service), MoH
MIM	Ministry of Indigenous Medicine and Disaster Relief

7. POLICIES AND MEASURES FOR THE IMPLEMENTATION

7.1 FORMATION OF AN IMPLEMENTATION MECHANISM

There are three major aspects for the implementation of the health master plan. The first aspect is the development of a collective national commitment to pursue the health vision addressed by the Health Master Plan (HMP). This will demand involvement of political leaders and civil society leaders into the implementation of the HMP in other sectors of the day-to-day life of the nation as well as people so that people can promote the health of themselves, their families and the community at large.

The second is the stewardship and management of the implementation of the HMP with necessary strengthened human resource capacity for the service delivery. This places special emphasis on innovative changes in necessary supplies, equipment and their logistic systems.

The third is that the HMP implementation activities need to maintain continuity and coherence of the policy, keeping flexibility of the measures. It should be faithful to the vision, mission, goal and strategic objectives by adapting service delivery and support programs and their intermediate objectives being guided by the feedback from people's needs and their satisfaction. This calls for an urgent action to establish a functional monitoring system to supervise and evaluate performance and outputs of the health services. In order to assure the above, the following measures should be put into action.

7.1.1 Platform Building for Political Commitment & Endorsement

The Health Master Plan should be marketed among all the political parties in the Parliament, Provincial, Municipal, Urban Councils and Pradesheeya Sabhas. Commitment should be sought from all the political leaders representing those institutions to the strategic framework. It is the hope that as the plan is non-partisan and serves all the people it will be possible to obtain such a general non-partisan commitment. This is a condition *sine qua non* for the long-term effort that will be needed.

It will also be very important that MoH stimulate dialogue with each of the ministries listed in Table 7.1. All these ministries can make direct contributions to people's health and assuring their understanding and ongoing collaboration is vital to create a socio-cultural and economic environment where people are enabled to promote health and to feel society protects and nurtures them. Personal and family lifestyle can fully promote health in such an environment.

7.1.2 Institutionalisation of the Health Master Plan

The HMP, which is a firm basis for health of the nation to assure people's benefits, is required to be a long-term national health plan being committed to its implementation for the next decade. The Plan will be submitted to the Cabinet to be approved by the current government and to the select parliamentary committee to be discussed by all political parties and will be institutionalised as a national health plan before the implementation starts.

7.1.3 Social Consensus Building and Ownership

A wide publicity should be given to the Vision, Mission, Goal, Objectives and Strategies addressed in the HMP during the parliamentary debate and again after its finalisation. All the stakeholders, including trade unions, should have a chance to clarify strategies, programmes/projects, and make suggestions on how to implement them. Benefits to the national economy as well as individual persons and communities should be highlighted positively during the HMP consensus building process.

7.1.4 Formulation of Action Plans for Priority Projects

Formulation of action plans for priority programmes/projects should be carried out in consultation with all stakeholders of the particular geographical/administrative division. In the formulation of action plans, prioritisation of activities needs to be reviewed, taking into account the local reality and needs in consultation with stakeholders. Encouragement of local beneficiaries' participation in the project implementation process is a key to create rapport on which the successful implementation of the whole plan depends.

7.1.5 Capacity Building for Program Management

Capacity building for the program management in the health administration needs to be facilitated, establishing an organisational structure for program management with an appropriate monitoring mechanism. To this end, an information system needs to be linked to the monitoring system and financing mechanism as well, so that the accountability of the health system would be strengthened. The necessary training should be done before and at the beginning of implementation period and should be carefully evaluated and followed up with supportive supervision and further training where needed.

7.1.6 Financial Resource Mobilisation

The government of treasury should agree to allocate adequate resources in a deliberate manner to assure the implementing activities of the HMP. Foreign donors should also collectively act as supporting partners to materialise the Master Plan programmes/projects, in particular, to make the transitional health reform successful and to enhance the human resource capacity for this purpose.

A Sector-wide Approach (SWAP) may be one option to facilitate the integrated implementation. This approach needs to be well studied before taking the next step forward, learning from other countries' experiences in terms of merits and demerits, or expected positive and negative impacts on the total health management system during the course of the SWAP implementation.

7.1.7 Monitoring of Program Implementation

The implementation should be well organised and coordinated in such a way that it allows individuals or parties to take initiatives on their own within the common framework. Such initiatives are encouraged, commended and promoted by giving rewards. Throughout these efforts, some successful implementation models should be created to be applicable for other implementers. The HMP is a guideline for implementation of activities and it has to be monitored, updated and revised based on periodical assessment of the local reality. In this regard, MDPU should be strengthened to clarify health policies, undertake systematic policy analysis and provide guidance and directions to HMP implementers when necessary.

7.1.8 Organisational Arrangement for Programs Review and Monitoring

A Ministerial Taskforce should be established to monitor and assist the implementation of the HMP at the national level and a Provincial Task Force for each province should be established to monitor the provincial implementation. Quarterly HMP implementation progress review meetings be conducted at district, provincial and national levels. The line ministry should assist provincial ministries in the progress monitoring activities.

An Inter-ministerial Coordinating Committee should be also established at the national level to obtain required support from and coordination with other relevant ministries/authorities to seek for more effective performance. The committee reviews the progress once every six months.

Table 7.1 Health-related Ministries and Activities to be Coordinated

Name of the Ministries	Concerned Activities
Ministry of Indigenous Medicine and Disaster Relief	Health promotion, in particular, preventive health care services
Ministry of Finance and Planning	Budget, financial management and accounting, TQC?
Ministry of Policy Development and Implementation	Food and Nutrition policy, Policies necessary for HMP? Policies for Intersectoral Health related activities, TQC?
Ministry of Education	School Health, detection of chronic illness, child abuse, Health Education of Children, Life skills, Healthy living style in school (school canteens, sanitation, hand washing, exercise), HRD for nursing and paramedicals.
Ministry of Labour	Standards for work environment, ergonomics, occupational health, preventive screening, accident prevention, prevention of environmental pollution.
Ministry of Transport	Vehicle control, drivers license, road design, traffic rules.
Ministry of Agriculture	Implementation of Agri extension for improved access to vegetables, fruits and protein, improved rural marketing of such produce, improved market responsive cultivation of herbs for IM.
Ministry of Interior	Family violence, conflict management, first aid at accidents and injuries and burns.
Ministry of Defense	Riot control, conflict management, first aid at accidents and injuries and burns, agreement on best practice for traumatology and surgical emergencies (MoD has its own hospital and traumatology unit), collaboration in disaster preparedness and HRD.
Ministry of Mass Communication	Health journalists to popularise HMP and major health education messages.
Ministry of Higher Education	HRD for allopathic and indigenous doctors, potentially for leadership in nursing and paramedicals as well as hospital administrators.
Ministry of Women Affairs	Abortion, family planning, family law, family violence, sexual abuse, prostitution.

7.2 THE WAY FORWARD

This HMP for a healthier nation is not an end by itself, rather, it is the beginning. As mentioned earlier, there will be wide consultations on the draft strategy, then the strategies embodied by the HMP will be widely communicated to the general public, health workers, professional bodies, unions of health care workers and other stakeholders for comments. Once finalised this document will be submitted to the Cabinet of Ministers of the Government of Sri Lanka for approval and subsequently submitted for parliamentary approval.

The health sector is changing rapidly and the strategy needs to evolve over time to reflect this continually changing environment. Mechanisms will be put in place to ensure that the planning systems and management of the health sector reflects and takes forward the strategy.

In order to identify possible interventions, projects and programmes to realize the HMP, a series of discussions were intensively made through Working Groups inviting stakeholders from the Ministry of Health and Provincial Ministries, other Ministries, professional groups and other civil society organisations. This participatory approach should be continuously maintained to review and depict more detailed activity profiles for priority projects. Once the activities are identified, the inputs, verifiable indicators and means of verifications will be determined along with broad budgets for each activity.

Implementing the HMP must be an integral part of the management of the health sector and not seen as an additional piece of bureaucracy. Consequently, existing structures and regimes should be used to take the process forward rather than creating new institutions and structures.

Of particular importance will be the need to use the financing and planning systems to the best effect. Immediate steps should be taken to strengthen the Ministry of Health's contribution towards the development and negotiation of the budget with the Ministry of Finance. It will be particularly important to develop clear output measures against which investment can be measured. Similarly, the planning processes should be improved at an early date to enable transparent plans to be developed and agreed.

Improved intersectoral and donor coordination is essential to ensure that a sector-wide approach is adapted to the development, financing and implementation of health strategies. The building of a healthier nation is the onerous and inescapable responsibility of each and every citizen of Sri Lanka.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