Accelerating reforms of primary health care towards universal health coverage in Sri Lanka

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Abstract

Since the late 1920s, the Sri Lankan health system has been based on a firm foundation of primary health care, and it has been recognized internationally as a highly successful low-cost model. However, rethinking the future health-care model has been essential, owing to the country having one of the fastest ageing populations in the world, coupled with a high premature mortality from noncommunicable diseases. To sustain past gains and meet new challenges, several models centred on an expanded primary health-care system have been trialled and refined in the past decade. Primary health care was identified as a key priority in the National Health Strategic Master Plan 2016–2025, and in 2018 the Cabinet approved the Policy on healthcare delivery for universal health coverage. This policy introduces the “shared care cluster” system, whereby an apex specialist institution serves the local primary care referral institutions. The catchment population is divided into populations of approximately 5000, for which one family doctor is responsible. Strengthening and retaining human resources at these primary-level curative institutions will be essential, especially in rural locations. Also critical will be initiatives to orient the population’s health-seeking behaviours. Sustained political commitment, an effective communication strategy, a tailored health workforce policy, performance monitoring and evaluation, coordination mechanisms, and changes in administrative and financial regulations are some of the future factors that will be critical to realizing the full potential of primary health care and accelerating universal health coverage in Sri Lanka.

Keywords: health-care reform, noncommunicable diseases, primary health care, Sri Lanka

Background

Sri Lanka has achieved a relatively high level of health, despite being classified by the World Bank as a lower-middle-income economy.1 In 2015, the life expectancy for women and men was 78.6 years and 72.0 years, respectively.2 The neonatal, infant and under-5 mortality rates were 6.59, 9.16 and 10.0 per 1000 live births, and the maternal mortality ratio was 32.0 per 100 000 live births, with almost all labours being attended by a skilled provider and 94.6% of all live births taking place in a government hospital.2 The country achieved many of the Millennium Development Goals at the national level and has eliminated malaria, filariasis, polio and neonatal tetanus, and controlled rubella.3 However, Sri Lanka’s achievements in health to date are threatened by increasing health demands associated with the rising burden of noncommunicable disease (NCD) and the growing population of elderly and disabled citizens. Sri Lanka has one of the fastest ageing populations in the world, coupled with a high rate of premature mortality from NCDs.4 In 2015, the World Health Organization (WHO) STEPwise approach to Surveillance (STEPS) survey of NCD risk factors estimated that 7.4% of adults either had raised blood glucose or were currently on medication for diabetes; 24.6% of men and 34.3% of women were overweight or obese; only 26.9% of men and 28.0% of women were consuming five or more servings of fruits and/or vegetables per day; 30.7% of adults had never had their blood pressure measured by a doctor or health worker; and 42% of the adults with raised blood pressure (>140/ 90 mmHg) were not on any medication.5

All citizens have access to free health care, through a system that has evolved since the late 1920s, based on a firm foundation of primary health care. The government health-care delivery system covers the entire island and comprises two streams of primary care services – preventive community health care and primary curative care. In common with other low- and middle-income countries, this system was put in place mainly to provide services for maternity care, child health and communicable diseases. The preventive stream of primary health care is organized to cover specific territories, administrative divisions or populations.

Curative primary medical care is provided via an extensive network of two types of institutions. First, primary medical care
units are relatively basic facilities staffed by medical officers that provide outpatient consultations and host field centres for immunizations, family planning and maternal care. The second type is divisional hospitals, which provide the same services as primary medical care units but with some inpatient facilities plus nursing and possibly laboratory staff. These institutions usually include healthy lifestyle centres for the screening of selected NCDs, such as hypertension and diabetes, and health education. Notably, unlike the preventive services, there are no boundaries for patients accessing curative institutions. Patients can chose freely which provider of curative care – from primary care medical unit to tertiary care facilities – they attend when sick. There is no requirement for patients to register and institutions are not responsible for a defined population or area. Patients commonly prefer to bypass primary care institutions, which often lack standard essential services, in favour of tertiary facilities. This situation means there is a lack not only of gate-keeping but also of accountability for patient care within any defined population or area.

**Business as usual is not an option**

During the past decade, it has been recognized that business as usual is not an option for Sri Lanka and that the health system needs to change to sustain its gains and progress towards universal health coverage. Specifically, the combination of an ageing population and increasing burden of NCDs required reorientation and reorganization of the otherwise historically successful health system, with development of service-delivery models focused more on disease prevention and health promotion, and on care more than treatment. This has required a paradigm shift in approach, design and service delivery.

As summarized in Box 1, initiatives have taken place since 2008 to inform and move towards a change of service delivery, including testing of different models of care. Evaluations of these interventions highlighted the need to have a broader and more comprehensive health-system reform, focusing on the primary care level. The impetus for reform came because of sustained

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### Box 1. A timeline of events of primary health-care initiatives in Sri Lanka

**2005**
- Sri Lanka Disease Specific Accounts Project, led by the Institute for Health Policy, allowed analysis of health spending in the public and private sectors, by disease and demographic group.6

**2008–2009**
- Revisiting the profile of primary health care in the *Health Master Plan 2007–2016*, i.e. rationalising primary health-care delivery structure.
- Rapid assessment of government curative facilities in the plantation sector was undertaken to study primary health-care facilities for vulnerable populations, i.e. the estate/plantation community. In parallel, the Ministry of Health was implementing measures to improve health access to the plantation community by taking over estate hospitals.
- A study was carried out in Galle District on health-seeking behaviour and the level of bypassing primary health care.
- A series of stakeholder consultations was carried out and secondary data were used in finalization of 10 advocacy posters on the need for a new model of primary care. The posters were used to communicate with health and non-health professionals, including senior officials of the health ministry, national planning officials and politicians. They were also used in postgraduate training in medical administration and community medicine.
- An analysis of the existing health service structure and policies was carried out by the policy analysis and development unit. This led to the understanding that major changes to the existing organization of health delivery were needed, as the system was not geared to providing continuity of care or to preventing or managing lifestyle-related diseases. The policy analysis unit suggested system changes, and a decision was taken to conduct pilot studies to test possible conceptual models.

**2010**
- Proposed system changes were discussed at the first national scientific and policy forum for strengthening primary care.
- *The National Policy and Strategic Framework for Prevention and Control of Non-communicable Diseases* was finalized, which also highlighted the strategy on health delivery organization change.8
- The World Bank Human Development Network paper: *Prevention and control of selected chronic NCDs in Sri Lanka: policy options and action* was published.9
- Several ongoing systems-strengthening pilots were discussed at the policy forum in the context of strengthening primary health care:
  - WHO *Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings* (WHO-PEN);10
  - NCD Prevention Project (NPP), piloted by the Japan International Cooperation Agency (JICA) (NPP-JICA);10
  - the community-based health-promotion component of the National Initiative to Reinforce and Organize General Diabetes Care in Sri Lanka (NIROGI Lanka) of the Sri Lanka Medical Association.10
- An initiative for a change in primary health-care infrastructure was reviewed by the planning unit at the health centre in Samadhigama village in Hambantota, which was a post-tsunami construction. The review included a study of designing the internal layout for a primary care centre, analysing the health-seeking behaviour of the people using the facility, and planning and costing the range of further services needed.
2011
● The Ministry of Health identified 16 essential drugs to be made available for management of NCDs at the primary health-care level; the decision was communicated by official circulars.
● Budget was allocated to address NCDs through a primary care approach.

2012
● Guidelines for strengthening primary health care were developed for pilots.
● The personal health record was developed and introduced for the pilot.

2013
● Piloting of the initial system was carried out in three districts: Polonnaruwa, Nuwaraeliya and Hambantota. The piloting included empanelment of the local populations to the hospitals, first iteration of the personal health record, the family doctor/general practice concept of care, and streamlined referral pathways.

2014
● The concept of a “shared care cluster” system was put forward to the government.
● A common competency framework for doctors was developed, with the involvement of all medical faculties.
● The personal health record system was revised, based on the results from the pilot districts.

2015
● A survey was carried out by the policy analysis and development unit to identify requirements to improve residential facilities for health-care workers. Provision of quarters and accommodation has been used by the health authorities as a strategy for greater retention of health-care workers in rural settings, as well as improvement in the quality of care provided at these facilities (i.e. residential quarters have made possible the provision of 24*7 emergency care and inpatient admissions).
● Tools for supervision of and within primary curative care institutions were developed. The tools developed were compatible for the hospital to undertake supervision from within (by the hospital administration or professionals) and from outside (from regional/district supervision and administration teams).

2016
● Budget debate was conducted, with announcement of a “family doctor for all” and shared cluster system.
● Draft policy was presented to senior officials.
● Indicators for monitoring performance were developed.
● Primary care was identified as a priority in the National Health Strategic Master Plan 2016–2025.11

2017
● A draft policy was presented at the National Health Development Committee, followed by discussions with professional colleges on the reform; the draft policy was uploaded on the ministry website for comments.
● A roadmap was developed and used for advocacy of the draft policy.
● Project negotiations were conducted with the Asian Development Bank and the World Bank for loans in the health sector.
● Mapping of clusters and specialists’ locations was carried out.

2018
● A Cabinet memorandum was produced, with approval of the Policy on healthcare delivery for universal health coverage.12
● A nationally representative rapid outpatient morbidity survey was undertaken across five provinces and across all levels of care, including outpatient facilities in teaching hospitals – the highest level of primary care at the tertiary level – to primary medical care units – the lowest level primary care. This also included data from the private sector, including private hospitals and general practitioners. The results informed the development of the essential services package (ESP).
● A draft ESP was developed – the first Sri Lanka comprehensive ESP,13 integrating in a single package the existing explicit, well-known package of preventive services with a newly defined set of curative interventions to be delivered by primary medical care institutions, and part of the secondary level of hospital care.

high-level advocacy, health leadership and propitious timing. Advocacy and communication were instrumental – results of the initiatives were captured in posters and briefs that were widely disseminated to stakeholders. The resulting model of reformed primary-care-led health services was underpinned by the following key elements:

● a clear policy on universal health coverage, covering both primary health care and specialized care;
● a defined essential service package, together with a service-delivery model;
● the provision of human resources for primary health care to cater for a designated population, including identification of cadres, rescaling and retooling of human resources, equitable cadre placements, and retention of human resources in primary health care;
● strengthening of the health-care infrastructure and allied facilities and capital equipment, such as for delivery of
Towards people-centred, integrated and equitable primary health care

The National Health Strategic Master Plan 2016–2025 noted: “Our vision is to develop ... strong primary-led patient care services in the country where every citizen has access to a family doctor” and “Our mission is to achieve as far as possible universal health coverage for all citizens of Sri Lanka with doctors trained in the family practice approach working in state and private sector providing accessible cost-effective quality primary care services to all citizens of Sri Lanka.”

The plan underscored the pivotal roles of the “family doctor” and the “shared care cluster”, allowing these key elements of the reformed primary health-care structure to gain traction. In the shared care cluster system, the cluster comprises an apex institute, providing specialist investigations and treatment, together with the geographically surrounding primary care curative divisional and primary medical care units. The cluster provides a continuum of care between primary and specialist services. Thus, both the responsibility for the care of an individual patient and the resources required are shared between the different levels of care, to optimize the availability and utilization of services.

In 2018, the Cabinet approved the Policy on healthcare delivery for universal health coverage. The strategic directions in the policy for universal health coverage include the reorganization of health-care delivery to a nationwide network of shared care clusters; strengthening human resources at primary-level curative institutions, including provision of one family doctor per 5000 population, and allied health-care workforce cadres, including public health nurses; providing access to all essential medicines and laboratory tests; providing basic emergency care; and creating an environment in primary care hospitals that is conducive to improving their utilization by patients and retention of health-care personnel, especially in rural areas.

Each shared care cluster will be responsible for delivering the newly defined essential service package (ESP). Developed in 2018, this is the first comprehensive ESP in Sri Lanka, integrating into a single package the existing explicit, well-established suite of preventive services with a newly defined set of curative interventions to be delivered by the primary medical care institutions, and part of the secondary level of hospital care. In explicitly defining the primary care services that must be delivered to the whole population, the ESP informs the changes required in the various elements of the health system.

Phased implementation of these health-system reforms by the government is now actively under way, with a national steering committee set up in 2018 to monitor the progress in implementation and provide overall oversight and guidance. Examples through which development partners, including the Asian Development Bank, World Bank and WHO, are providing support appear below.

WHO is providing catalytic technical support on the health system work, such as for a health information system mapping and assessment, which will form the basis for developing the architecture of the health information system enterprise to monitor universal health coverage.

The Asian Development Bank will support nine clusters in nine districts, mostly located in underresourced or rural areas.

The World Bank is providing budget support to the whole country, in line with the goal of achieving a more people-centred and comprehensive model of primary health care service provision.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has recognized that a strong, resilient health system is needed to end HIV, tuberculosis and malaria, and has invested in technical catalytic activity for primary health care with WHO, for example a cross-programmatic efficiency analysis and development of the ESP service-delivery model; policy dialogue and provincial consultations on reorganization of primary health care; and health information system mapping.

In Sri Lanka, what began as a search for primary care changes to address the burden of NCDs has evolved into a holistic model of primary health care that is people centred, integrated and equitable. Critical factors to realize the full potential of strengthening primary health care to accelerate achievement of universal health coverage in Sri Lanka are sustained political commitment, an effective communication strategy, a tailored health workforce policy, performance monitoring and evaluation, a coordination mechanism, and changes in administrative and financial regulations.

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