

HOSPITAL SERVICES IN SRI LANKA

By Dr Joel Fernando

Course organiser, community medicine section of the family practice training programme of the Post Graduate Institute of Medicine, University of Colombo and family physician, Sathosa Medical Services, Colombo 2.

In Sri Lanka the government offers free hospital services to all citizens through an elaborate network of hospitals. The private sector also runs hospital services in cities and larger towns for those who could afford to pay for their care. Hospitals in the country provide predominantly western type health care facilities. In 1989 there were 502 government hospitals having a total bed strength of 46620 providing western medical care. The government ayurveda sector had only 1876 beds in 27 institutions. (Table 1).

Origin and Growth

The present hospital system had its origin with colonial domination of the country by British in 1815. British rulers allowed the people of Sri Lanka a greater measure of self government by 1939. Pressures by the then ruling local elites resulted in a rapid expansion of health services based on the model introduced by the British. Since attaining independence in 1948 it has been the policy of successive governments to further expand and modernise the government hospital system. As a result of this policy, today there is an extensive network of government hospitals spread throughout the country. Each province has over 40 government hospitals. Beds per thousand population range from 1.8 for the eastern province to 3.6 for the western province. (Table 2).

Private hospitals played a minimal role in providing hospital services till the early eighties. Reintroduction of private practice for government doctors, liberalisation of drug imports, introduction of health insurance and medical benefit schemes, overcrowding and service provision defi-

ciencies in government hospitals resulted in a rapid growth of private hospitals in urban centres during the past decade. The absence of reliable statistics on the number of institutions, beds and inpatients treated in the private sector renders it difficult to make a quantitative assessment of the private sector contribution to hospital services in the country.

Distribution of Hospitals

Depending on size, complexity and function government hospitals may be categorised in three broad groups. Hospitals providing medical specialist services such as teaching hospitals, provincial hospitals and base hospitals form the first group. Hospitals providing medical

officer/assistant medical officer services such as district hospitals, peripheral units and rural hospitals form the second group. The third group includes special hospitals such as those for cancer, leprosy, chest diseases etc. Distribution of different types of hospitals by districts vary. Districts such as Colombo, Gampaha and Kandy are better served by hospitals offering medical specialist services. There are 483 medical specialists in the country, 327 (67%) of them serve in these 3 districts. Whereas hospitals in the districts of Moneragala, Ampara, Mannar, Vauniya and Mullaitivu had no medical specialists.

Utilization

In 1989 a total of 25,24,626 persons obtained indoor treatment in government hospitals. Utilization of government hospitals vary. Larger hospitals seem to be better utilised than smaller ones. Provincial hospitals had the highest bed occupancy rate 93% followed by base hospitals 88% and teaching hospitals 83%. Bed occupancy rates in district hospitals 65%, peripheral units 64% and rural hospitals 61% indicated lower utilization levels. Maternity homes were largely under utilized having a bed occupancy rate of only 17%. (Table 3). Reasons for under utilization of smaller hospitals and

Table 1 - Hospitals and beds, 1975, 1989

Sector	Year			
	1975		1989	
	Hospitals	Beds	Hospitals	Beds
Government Western	363	39780	502	46620
Private Western	62	1176	(Figures not available)	
Government Ayurveda	7	1000	27	1876

Table 2 - Distribution of government hospitals and beds by provinces, 1989

Province	Population	Hospitals	Beds	Beds per 1000 population
Western	4342	78	15986	3.6
Central	2173	86	6655	3.0
Southern	2177	68	4602	2.1
Northern	1281	52	3476	2.7
Eastern	1173	33	2183	1.8
North Western	1970	54	4502	2.2
North Central	1003	49	2711	2.7
Uva	1037	40	2549	2.4
Sabaragamuwa	1650	42	3956	2.3
Total	16806	502	46620	2.8

over utilization of larger hospitals have not been systematically studied. Dearth of doctors, non availability of drugs, inadequate facilities for carrying out diagnostic tests and changing expectations of patients on type of hospital care needed may account for some reasons for by passing smaller institutions in favour of larger ones.

Hospital Management

The Ministry of Health manages 27 institutions. These include hospitals in which medical and para medical staff are trained and hospitals providing special care. All other hospitals are managed by the respective Provincial Health Ministries. The country's health legislation set out in the Health Services Act provides for peoples participation in management through the appointment of regional hospital boards and hospital committees. However regional hospital boards were never setup and hospital committees have remained purely advisory organs, sometime operating without adequate technical direction and advice. With the exception of Sri Jayawardena Pura Hospital which has a board of management all other hospitals in the country are managed by medical personnel. Such persons are easily vulnerable to political manipulation and bureaucratic bungling. If todays hospitals are to adequately meet patients needs the present style of hospital management may need changes. Management by boards comprising persons competent in technical, financial and managerial skills needs to be considered as a matter of priority for hospitals providing medical specialist services.

Service provision Deficiencies

The National Health Development Plan 1990 of the Ministry of State for Health lists the major service provision deficiencies in patient care services as follows.

- (a) Lack of cleanliness of toilets
- (b) Lack of quality assurance programme
- (c) Lack of regular inservice training
- (d) Technical supervision is lacking
- (e) Natal and immediate post-natal care unsatisfactory

- (f) Patient records unsatisfactory
- (g) Irrational prescribing and excessive prescribing of drugs
- (h) Non notification of notifiable diseases
- (i) Lack of regular, planned health education programmes
- (j) The percentage of inpatients whose condition is undiagnosed is too high.

Detail action plans have been drawn up to overcome these deficiencies by moving the relevant officials into action. Administrative, bureaucratic and project based efforts to correct one and more of these deficiencies may or may not produce the desired results. Success will depend on the extent to which the root causes for these deficiencies in the hospital system are clearly understood and tackled.

Hospital services are concerned with care of sick persons who according to medical opinion need hospitalisation. The prime activity in hospitals is the interaction between care giving doctors, nurses etc. and care receiving patients. This interaction is influenced by four important interrelated factors-

1. Management of hospital staff and supplies including finance.
2. Training of hospital staff.
3. Demand for services by patients.

4. Private medical services.

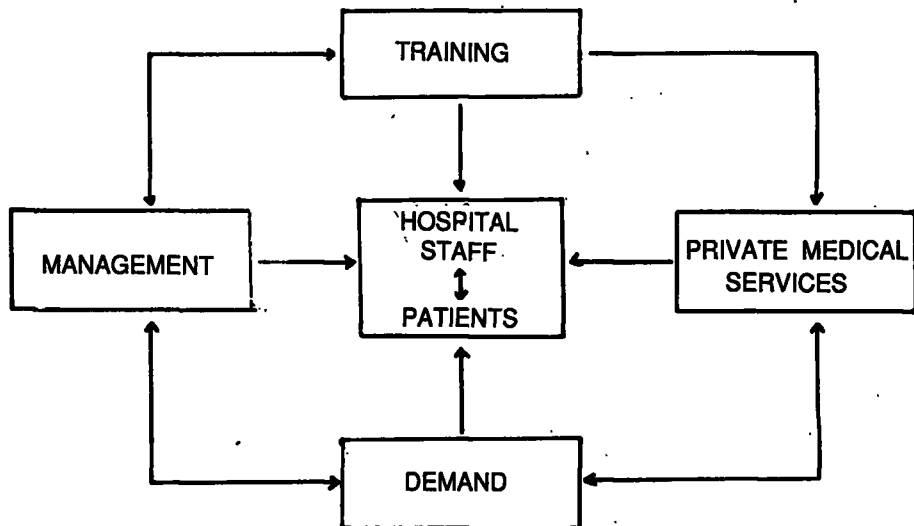
Each of these factors influence the doctor patient interaction directly as well as indirectly through influencing other factors. (Figure 1.)

Service provision deficiencies could be successfully overcome by understanding the interplay of these factors. Such an understanding must form the basis on which remedial actions are planned. For example irrational prescriber of drugs is identified as a service provision deficiency. This could be caused by defective drug supply management, training inadequacies, irrational demand by patients, availability of a wider range of drugs for prescribing and use in the private sector etc. To correct irrational prescribing it may be necessary to provide adequate opportunities for the prescribing to participate in drug supply management decision making, revise training curriculum to meet practice needs, educate patients and community on rational drug use, enforce stricter control over range of drugs available in private sector etc. This illustrates that irrational prescribing is of multicausal origin. Therefore to overcome this deficiency a more comprehensive approach involving managers, trainers, users and private medical care providers is needed.

Need for better health planning

The health policy of a nation is its strategy for controlling and optimizing the social uses of its medical knowledge and

Figure 1. Factors influencing hospital staff patient interaction.



resources. In Sri Lanka the policy strategies of the government for the health sector have to be translated into action through the National Health Development Network. This is a network of committees at ministerial, secretarial, district, division, village cluster levels and six standing committees supporting the secretarial committee. This network's activity in the health planning process needs evaluation. The work done in district, division and village cluster level committees and their impact on higher levels of decision making in the network is not known. Government policy recognises health services in the private sector as playing a supplementary role to state sector health services. Over a sixth of all doctors in the country work in the private sector. What has the network's standing committee are health manpower development done to make a realistic assessment of national manpower needs in terms of state and private sector requirements. Over half of all drugs imported to the country are recommended for use in the private sector by private doctors and government doctors engaged in part time pri-

ate practice. What has the network's standing committee on drugs done to rationalise the availability and use of drugs in the private sector? The network as it functions today seems to provide nothing more than a channel for health ministry officials and the health department's regional and institutional administrators to make their own plans and administer them. Inputs from health care workers and the users of health care do not reach the health planning and decision making process. Existing trade unions and professional associations of health care workers could be involved in the planning process at institutional, regional and national levels. The task of finding suitable user representation in planning is more difficult. Hitherto this task has been handled by governing politicians and their supporters. This has resulted in unwanted interference in hospital management, staff transfers etc. Encouraging voluntary organisations such as consumer groups, patient associations etc. to participate in the planning process at institutional level may provide better user inputs.

The future of hospital services

Hospital services in the country today are in a transition phase. The overall state monopoly over hospital services is slowly eroding. Hospitals financed from sources outside the government health budget are beginning to offer sophisticated medical services which were formerly available only within the state sector. Shortages of skilled medical, nursing and para medical manpower continue to plague the state run hospitals. The limited manpower resources are further stretched by government health workers opting to meet the needs of the growing private sector through private practice or resigning from government service. If these trends continue the choice before the patient seeking hospital services in future is between an overstrained state service that may not meet his needs adequately and a private hospital service for which he may not have the means to pay.

[Statistics used in article compiled from Annual Health Bulletin 1989, Ministry of Health.]

Table 3 - Hospital statistics by type of Institution, 1989

Type of institution	Number Institution	Number of Beds	Number treated	Average daily occupancy	Bed occupancy rate
General hospital Colombo	1	2395	117464	2108	88
Teaching hospitals	6	5790	302472	4681	81
Provincial hospitals	7	5131	297201	4769	93
Base hospitals	21	6371	441159	5580	88
District hospitals	119	11481	732019	7442	65
Peripheral units	119	5059	355815	3241	64
Rural hospitals	112	2613	121196	1596	61
Maternity hospitals	2	734	36748	451	61
Maternity homes	83	899	11818	149	17
Other hospitals	21	5839	88734	4182	71
Total	491	46312	2524626	34199	74