

Policy on Healthcare Delivery for Universal Health Coverage

1. Policy Background

- 1.1 Providing health care free at the point of delivery, with equitable coverage and of good quality has been the development mandate for health services over the past several decades in Sri Lanka. Significant achievements are evident due to expansion of preventive and curative services in a government lead health delivery system. Higher life expectancy, good health outcomes such as reduction in maternal mortality, child mortality, control of communicable diseases, elimination of malaria, poliomyelitis, Filariasis and control of vaccine preventable diseases are noteworthy. Sri Lanka is known for its effective health service delivery at reasonable cost when compared with countries with comparable health outcomes where their investment on health in terms of percentage GDP is relatively higher. In 2016 the Sri Lankan Government contribution for health was 1.6% of the GDP.
- 1.2 During the past two decades, despite low investment, Sri Lanka was able to expand its infrastructure for specialized health care services. The policies on re-categorization of health care institutions of 2005 and the development of one hospital in each district to the level of a District General Hospital brought about the expansion that was much needed. The recategorization policy was effective at a time when specialized services were not available with equitable access and there was a need to drive an expansion of these services.
- 1.3 The policy also had an effect on attracting patients to seek health care at the specialist hospitals (Base hospitals and above) whilst bypassing primary level institutions that are closer to home. Health financing through Line capital budget, especially in a decentralized setting has supported the policy of expanding specialized facilities leaving primary level facilities relatively neglected and making them less attractive to public.
- 1.4 The changing health burden from communicable disease to non-communicable disease now requires a different type of health service delivery model, to give more attention to continuity of care due to chronicity of the high prevalent conditions such as Diabetes, Hypertension, Ischaemic Heart disease, Stroke, chronic kidney disease, mental health problems. They also require prevention strategies that should be family centered and personalized. Management of these health conditions require universal coverage of a range

of services to be available at primary level, supported with appropriate referral for specialized care.

1.5 This reform is intended to support the implementation of the policy for management of chronic non communicable diseases through organization of existing health services and will support other health care policies addressing general health care needs of the population also targeting specific needs of elderly and more vulnerable communities that need to be reached and would vary across the country. A harmonization of primary first contact care with specialized care is expected through rationalization of the Health care delivery system, with affordability and wide access to people. The Policy also recognizes the strengths within the system which can be used for better health outcomes and efficiency through reorganization.

2. Policy Goal

To ensure Universal health coverage¹ to all citizens, relevant to the disease burden experienced in the country through a well integrated², comprehensive and efficient health service

3. Policy Objectives

3.1. Responding to evolving needs with quality years to life are added, resulting in reduction in elderly people living with disabilities.

3.2. Reduced catastrophic health spending in lower - middle income groups

3.3. Improved overall satisfaction of people on health experience.

¹ Universal health Coverage (UHC) is defined by the World Health Organization as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. UHC is considered the overarching strategy for achievement of health related SDGs.

² Integration means coordination of health services across continuum of care to a defined population

4. Policy priority areas

The policy prioritizes

- 4.1. Provision of quality first contact care through primary care strengthening and a family centred approach,
- 4.2. Continuity of care through appropriate referral and back referral,
- 4.3. Development of a supportive and equitably distributed network of specialized care services to facilitate coordinated care
- 4.4. Citizen engagement and empowering the community for rational health seeking behavior
- 4.5 Protection from financial risk
- 4.6 Monitoring and adapting: Disease surveillance, priority setting, innovation/ learning

5. Key Strategic areas for policy implementation (Strategic directions)

- 5.1. Reorganization of health care delivery by establishing an appropriate PHC model for Sri Lanka (Recommended model where PHC system is set into a network of clusters referred to as "shared care clusters" - refer to annexure I)
- 5.2. Strengthening Human resource at Primary level curative institutions which will include; creating a health workforce that is fit for purpose and are accountable for health care delivery in defined areas, e.g. A family doctor for all 1: 5000 -refer to annexure II, home based care - community nurse, community psychiatric nurse, lifestyle guidance staff etc.
- 5.3. Providing access to all essential medicines, laboratory tests, at primary care level and other levels of care as appropriate
- 5.4. Providing basic emergency care at primary care level
- 5.5. Creating an environment within the primary care hospitals which will improve its utilization by the people and also retain healthcare personnel, especially in rural areas.

5.6. Equitable distribution of specialized care - All clusters to have a minimum level of specialty care - annexure III. All sub specialties distributed equitably to provide optimum physical access for identified services³

5.7. Strengthening cluster performance through management strengthening

5.8. Acknowledging cluster performance through performance incentives

5.9. State recognition and regulation of Private Providers (Private General Practitioners), who can be purchased to provide health care free at the point of delivery to identified/ opted persons.

5.10. Changes in the demand through citizen engagement and improving health empowerment and health seeking behaviors

5.11. Further strengthening of the community health services through improving HRH availability, skill mix and functional linkages of staff with closest primary care hospital

5.12 Robust changes in the Health Information system is envisaged to support implementation and would be relevant to Patient care management and ensuring continuity of care through PHR and unique persons health identification number , resource and supply chain management, Human resource management information system, institutional and cluster performance management system, use of international classification of diseases in primary care coding (ICDPC) to report out patient morbidity, strengthen cause of death data by ensuring correct coding and use of verbal autopsy.

5.13 Effective engagement of the private sector and the involvement of the private General Practitioners in first contact care, ensuring provision of healthcare free at the point of delivery. Explore and implement methods to reduce out of pocket payment that will reduce financial risk.

³ Purpose - to distribute other specialties/ sub specialties in a rational, affordable and equitable way making it physically accessible without being confined only to one or two provinces. In doing so only some hospitals would have finer specialties of care as it is not rational to have these in all larger tertiary hospitals. This will define the development potential for each and every institution in the country, as per the plan available in the ministry of Health.

6. Expected Outcomes of the Policy

- 6.1. Coverage of essential health services improved
- 6.2. Health facilities at primary, secondary and tertiary care level are equitably distributed
- 6.3. A first contact care Family Doctor for every 5000 population
- 6.4. Skill mix of Human resources for Health is improved to address the current requirements for health care
- 6.5. Access to essential medicines and laboratory facilities are improved
- 6.6. Access to emergency care is improved
- 6.7. Efficiency in health service delivery is improved
- 6.8. Male participation in health screening programs is increased
- 6.9. Overall participation in health screening programs are improved
- 6.10. Increased knowledge on health and healthcare among the population
- 6.11 Staffing of Community health services is improved to support continuity of care
- 6.12 All adults will have a personal health record and a personal health identification number (PHN). Systems to support shared clinical exchange are in place (shared Electronic Health Record)

7. Implementation Measures

- 7.1 This policy will replace the one on re-categorization of health care institutions and create delivery system that will support equitable health care, complemented by the Primary health care reform.
- 7.2 The policy will complement and build further on gains accomplished through existing community health services.

7.3 The essential services package will define how curative and community health services would contribute to preventive, promotive, curative, rehabilitative and palliative services at different levels of care.

7.4 Mapping of clusters will be done using Geographical information system technology based on ground realities.

7.5 Each cluster will be considered as a sub district unit of performance for curative care to align with DS area as much as possible. The administration system will be strengthened to enhance performance monitoring and supervision giving due consideration to public responsiveness. Health administrators will be appointed to improve cluster performance and clinical and patient experience outcomes.

7.6 All institutions, depending on the level of function will have operational guidelines, where the use and adherence will be monitored

7.7 A re orientation of Health work force would be required to change attitude and skills to perform in the reorganized system. This would need reforms in basic undergraduate and other health personnel training programs.

7.8 Considering that the reform addresses universal health coverage, the policy is to ensure that the reorganization would include and provide access to all vulnerable communities. (E.g. the shared care cluster would include all primary care hospitals in Plantation sector, it would ensure that migrant workers and their families have access to primary health care and vulnerable urban populations too would be reached)

7.9 Citizen engagement and community participatory mechanisms will be fostered to ensure that developments are client and community centred.

7.10 The National Health systems performance framework would capture the progress of implementation of this policy through the identified indicators of effectiveness, efficiency and equity.

Annexure I - Shared Care Cluster

1. 'Shared Care Cluster': a unit where a specialist care institute functioning as the apex hospital providing general specialties of care will be considered together with its surrounding primary care curative institutions (divisional and primary medical care units) to form a cluster.

2. All BH, DGH, PH will have their draining primary care hospitals (DH and PMCU) and will each form a 'shared care cluster'.

3. Each primary level institution will have its own draining community area and population. The total areas of all the surrounding primary care institutions will be the catchment population for the apex or specialist hospital (BH, GH, TH). In the future a separate primary care unit can be set up to cater to the primary care needs of the immediate population around this apex hospital.

4. People accessing primary care at the primary level institution will be registered and issued with a *personal health record*. Management protocol and flow sheets in *personal health record* are to be used for referral and back referrals (based on referral criteria)

5. Patients who are too complicated for management at primary level and who require medications only available at the specialist institutions would access care at the apex hospitals.

6. Patient load will be distributed equitably at primary level, which will reduce patient load for clinics at specialist hospitals.

7. Patients will have easier access through primary care, to the appropriate specialist when required and the objective would be to refer in a timely way, to clarify management plans and to avoid any adverse outcomes.

8. Key requisites for shared care to function would be the availability of essential drugs and laboratory facilities. A monitoring system to ensure availability of medicines in primary care institutions is vital.

9. To make access to laboratory tests at primary care, two systems can be adopted

a. system of collecting specimens and tests performed at apex institution of the cluster through automated facilities

b. Availability of services of a mobile laboratory on an appointed day is preferred in some districts

10. Specialists in apex hospital of the cluster would be responsible for updating knowledge and skills of primary care doctors as per the need and support can be extended through outreach clinical visits on demand.

11. *Shared care implies that*

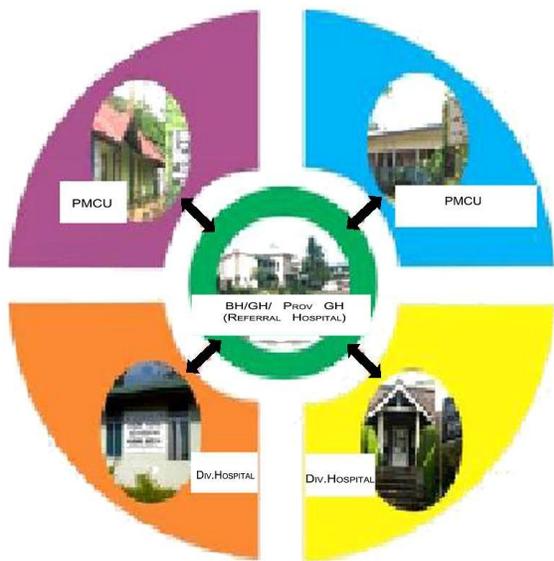
a. An individual's health care will be shared and form a continuum between primary care and specialized services

b. Resources within the cluster to be shared so that there is optimum availability and utilization

12. Key objectives of shared care cluster system

a. to provide universal access to continuing care making the best use of the existing system with optimum use of resources

b. to bring about a system of accountability for care as a shared care cluster will have its defined catchment area.



Annexure II - A family doctor for all

The Family Doctor would function within the shared care cluster at primary level curative institutions (Divisional hospital / PMCU/ Estate hospital).

Depending on the population in the catchment area there would be one family doctor for every 5000 population.

GN divisions can be grouped to populations of 5000 for which one Family Doctor would be responsible.

This reform calls for transformation in undergraduate teaching to ensure that doctors are competent to deliver in first contact care, providing more personalized and family centred care and they are accountable for health of the population in catchment area assigned.

Policies for retention of staff in rural / difficult areas would need strengthening.

Guidelines to practice family medicine within a government led system should be established in collaboration with the professional bodies of general practice.

Deployment of Medical officers with Diploma in Family Medicine to primary care hospitals (DHs and PMCUs) is advantageous and every effort should be made to deploy them suitably.

An in service training program to train all medical officers in primary care reorienting on practice of Family medicine is needed.

A program for continuous professional development is needed and should be mandatory to private practice when providing primary care.

Family Medicine specialists (with MD Family Medicine qualification) should be appointed to build capacities to promulgate the practice of Family doctor within the cluster system. They can be appointed to a larger Divisional Hospital within a cluster and can train other Medical officers in primary care to practice Family Medicine in the transitional phase where there will not be adequate doctors who have the optimum skill level.

Annexure III - Minimum level of specialty care for each cluster

Basic requirements for specialty care will be available universally i.e. in all specialized institutions

All base hospitals will have similar facilities and only the size will differ as per the catchment population

The classification of type A, B Base hospitals will not apply as all will have similar facilities in a phased out manner. Following is the list of specialties and technical services that should be available in all.

- General Surgery
- General Medicine
- General Paediatrics
- Gynaecology and Obstetrics
- Dental Surgery
- Anaesthesia

- Radiology
- Microbiology
- Histopathology
- ENT
- Ophthalmology
- Dermatology
- Venereology
- Psychology
- Psychiatry
- Forensic Medicine
- OMF
- Blood Bank
- A&E
- Stroke unit
- Planning Unit
- Quality Unit