Delivering UHC to the people of Sri Lanka

Sri Lanka's publicly financed, high-performing healthcare system is widely acclaimed. In this article, Pavithra Wanniarachchi, Sri Lanka's Minister of Health and Indigenous Medical Services, describes the main challenges and opportunities in delivering healthcare for all in a middle income country, and imparts lessons for other Commonwealth nations striving to achieve universal health coverage.

Pavithra Wanniarachchi,
Minister of Health and Indigenous Medical Services,
Woman and Child Affairs and Social Security, Sri Lanka

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Sri Lanka embarked on a universal health coverage (UHC) delivery process almost seven decades ago, through a comprehensive, free-at-the-point-of-delivery healthcare system. It covered promotive, preventive, curative rehabilitation care, almost fully supported by the government. As a result, Sri Lanka stands out in the region as a middle income country with relatively high social and health indicators – life expectancy of 74.9 years, an average literacy rate of 93.3 per cent, maternal mortality of 33.7 per 1,000 live births (2015), a neonatal mortality rate of six per 1,000 live births and an infant mortality rate of 8.6 per 1,000 live births (2015) – all of which are showing a downward trend.

A British crown colony for over a century, in 1931, Sri Lanka inherited a legacy of strong government institutions and self-rule, based on universal adult franchise, as well as a system of governance committed to delivering free healthcare services to all its citizens.

Our country's expenditure on health, which stood at 1.8 per cent of GDP in 2017, is gradually moving towards a target of 4 per cent. In spite of the present, relatively modest level of health expenditure, as a country with a low cost, high impact model of healthcare, Sri Lanka has achieved its many health goals through well synchronised, regularly upgraded primary, secondary and tertiary health care facilities, with a special focus on strengthening primary care in the plantation sector. In order to reverse the trend of seeking initial treatment at secondary/tertiary facilities and bypassing primary services, the government is now in the process of adopting a family medical model with an empanelled population.

Each year, the national health sector – which operates alongside a vibrant private sector – serves seven million inpatients, accounting for nearly 95 per cent of the national total, and over 35 million outpatients, or 45 per cent of the national total. The health sector has over 19,500 medical officers, over 32,000 nursing staff and nearly 30,000 paramedical and support staff. Overall, staffing per bed is 1:4, indicating efficient use of available staff.

Immunisation – a cost-effective intervention

Sri Lanka's robust National Immunisation Programme works well within the primary health care delivery system and is a key, cost-effective component of the successful delivery of UHC. The programme uses effective, safe and quality vaccines and has almost 100 per cent coverage. Immunisation began during the British era, with vaccination against smallpox in 1886, and has since helped the country to successfully control

several communicable diseases. The Expanded Programme on Immunisation, established in 1978 with a special focus on childhood TB, tetanus, whooping cough, diphtheria, polio and neonatal tetanus, has continued to make excellent progress over the years. The most recent addition to the programme is a vaccine for the Human Papilloma Virus that causes cervical cancer.

Meanwhile, we have also initiated a programme of inbound health assessments to detect conditions of public health importance, with a special focus on TB, HIV, Malaria and Filariasis, adopting an inclusive approach to assessing and treating those who are planning to reside in the country for a long period of time.

We do not want to leave anyone behind!

To face the challenges of international public health emergencies such as coronavirus, Sri Lanka has put in place a special programme in collaboration with the World Health Organization. In parallel, training programmes are being conducted to build the capacity of the health staff to face possible chemical, biological, radiological and nuclear threats.

Meanwhile, the conduct of National Health Research Symposia in 2017 and 2019 and the publication of 'Research Governance Strategy' and the 'Code of Conduct for Research' has contributed towards the expansion of health research, fortifying the research culture among health professionals while enhancing the evidence based decision making process.

The challenge of demographic change and noncommunicable diseases

Like many countries in the region, Sri Lanka is facing demographic transition, with an ageing population alongside a shift of disease pattern from primarily communicable diseases to noncommunicable diseases (NCDs). NCDs now account for 65 per cent of all hospital deaths, from conditions such as heart disease, stroke, diabetes and chronic respiratory diseases.

To mitigate this situation, Sri Lanka has implemented both individual and population-based strategies to address awareness-raising, NCD prevention, treatment and rehabilitation, as well as palliative care. These include introducing screening at 930 healthy lifestyle centres and 840 well-women centres at all levels of healthcare institutions island-wide, providing everyone with access to screening within a radius of 3km. Those identified as having a higher risk for particular diseases through primary care screening are referred, without charge, to secondary or tertiary care hospitals with expanded test facilities, or to a curative care centre for further management or healthy lifestyle counselling, as appropriate. All citizens aged over 35 are encouraged to enrol at a primary care centre. Steps are also being taken to establish a new nursing cadre to provide domiciliary care to NCD, cancer and mental health patients.

Nutrition labelling for sugar-based drinks using a traffic light system has been introduced to address excessive sugar and calorie intake among school children. A similar system will follow for sugar content in snacks and salt in prepared foods, in line with the National Salt Reduction Strategy (2018–2022).

To tackle malnutrition and undernutrition among vulnerable groups, the manufacturers of Thriposha nutritional food supplement supplies nearly three million soya/maize/milk powder packs per month, through a mixed marketing scheme using indigenous ingredients. The product is issued free of charge to around 1.3 million pregnant mothers and malnourished children through primary health care providers. The range of available products is expanding, with the private sector also supplying the market with parallel products.

Addressing the socioeconomic and health burden of tobacco and alcohol

In a bid to mitigate the serious social and health implications of smoking and excessive alcohol consumption, the National Authority on Tobacco and Alcohol (NATA) has taken decisive steps, including signing the Framework Convention of Tobacco Control (FCTC). Sri Lanka is the first country to do so in the South-East Asian Region, and this is in spite of the attractive tax income potential to the government from increased sales of tobacco.

Regardless of strong opposition from the tobacco industry, the government has also banned smoking in public places, required that 80 per cent of cigarette packs are pictorial health warnings, hiked the tobacco taxation from 70 to 90 per cent, introduced new steps towards plain packaging and an eventual move away from tobacco cultivation, as well as mobilising

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a strong social movement against tobacco and tobacco products through awareness creation, while banning the sale of cigarettes within a 100m radius of schools.

Financial risk protection

The healthcare delivery model in Sri Lanka has many provisions to reduce out-of-pocket expenses for target populations and make curative services more affordable to the public. As a developing nation, the capacity of households to bear costly medical expenses and interventions is limited, and so several financial risk protection measures were taken to sustain and further expand a universal healthcare process in the country.

One of the major interventions has been the introduction of Maximum Retail Prices (MRP) for 48 of the most commonly used medicines, in consultation with pharmaceutical manufacturers and distributors, 16 of which are important for addressing NCDs. A further 28 were subsequently added to the list, resulting in price reductions in the range of 30 to 300 per cent. The government also promoted the issuance of generic prescriptions, to enable patients to make informed decisions about purchasing medication. The steps taken to expand local manufacturing of pharmaceuticals is also designed to introduce competitively priced medication to the market.

Under the free healthcare system, the government provides intraocular lenses used in cataract surgery, hearing aids, cardiac stents and certain other medical devices free of charge to patients seeking treatment at government hospitals. Laboratory facilities in these hospitals have been upgraded to enable patients to have the majority of their investigations performed in one place, to ensure reliability of reporting and reduce the financial burden on these individuals. If any investigation is not available inhouse, they can be conducted elsewhere using government funds.

E-health – improving service efficiency

The launch of the e-Health information system, which assigned a Personal Health Number to all, was another initiative designed to improve health service availability, accessibility and capacity, and deliver quality people-centred integrated care. The scheme enables health information to be transferred electronically to care providers, enabling more efficient long-term management of chronic NCDs, while also encouraging information-sharing through telehealth applications, when a second opinion is needed.

The service helps to reduce associated travel and ancillary costs and avoid unnecessary travel, as well as contributing towards streamlining the procurement and supply of medicines and medical supplies and efficient resource allocation through drug management systems, while minimising wastage and drug shortages.

The challenges ahead

However, all is not rosy in our drive towards UHC, as we still have some critical challenges to overcome. To address the lack of human resources in the medical and paramedical categories, we need not only the mechanisms to increase supply and recruitment, but also to revisit staff quality and tasks in the context of aggressive primary care reforms. In a system that has been performing well for maternal and child health in the past, it will be quite a challenge.

To change the mindset of those choosing to seek initial treatment at secondary/tertiary units and bypass the closest primary care hospital, we hope to adopt a family medical model with an empanelled population. With a current doctor-patient ratio of 1:1000, this requires a significant growth in the number of trained and skilled healthcare professionals.

The interventions that bring us closer to free medical supplies and enhanced services, though costly, will have positive socioeconomic and health returns in the long term, while ensuring sustainability of the move towards UHC. ■