



**Progress on HRH development initiatives  
Lead by the Ministry of Healthcare &  
Nutrition, Sri Lanka during 2007/2008**

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**For**

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### **Background:**

Sri Lanka was and remains a high performer in health status terms, with better health indicators than other low income and low middle income countries. . Mortality rates are low and continue to decline at above average rates in the comparison with other comparable countries. With life expectancy projected to reach current US levels by 2020, the country faces a rapid aging process with an increasing portion of the population suffering from chronic diseases. The number of elderly is expected to increase rapidly after 2010. The country still remains free of a major HIV/AIDS epidemic and of the resurgence of old diseases such as Tuberculosis. This may be a testimony to the effectiveness of the public health and prevention programs in the existing health system.

The total mid year population (2005) is 19.6 million. The island has a land area – Sq Km 62,705. The per capita GNP was Rs 119,413 ( USD 1,188) with a GDP growth rate of 6% ( 2005)

Sri Lanka is a multi ethnic, multi religious country. The ethnic composition as per the 1981 census was Sinhalese – 74.0%, Sri Lankan Tamils – 12.6%, Indian Tamils -5.5%, Moors – 7.1%, others 0.8. The distribution of religions in the same census was Buddhist – 69.3%. Hindus – 15.5%, Muslims – 7.5%, Christians – 7.6%, others 0.1%.

Sri Lankans enjoy a long life expectancy and in 2005 for male life expectancy was 71 yrs, and for female 77yrs. In the recent years the male to female difference has been widening. The literacy rate in age 5 yrs and above in year 2003 was 90%.

### **Health system**

The Key provider of health care is through the Government health care system. Western and Ayurvedic systems are practiced. The Western system of medicine is more popular at present; however significant interest in the Ayurvedic systems is seen.

The Government health care is totally free of charge to the patient. However out of pocket spending is incurred for transport and sometimes for drugs and investigations that may not be available at the time of seeking care.

The Government health system has a wide coverage that provides accessible care through out the country. The Health system is hospital based, and preventive and promotive health care being provided through the community health care system. The health system has been decentralized since 1989 and the Ministry of Health has decentralized the management of the Health care delivery (hospitals and community care other than the teaching and specialized hospitals) to the 8 provincial health ministries. However the responsibility of training of major categories of health personnel still lies with the Central Health Ministry.

Public health programs such as maternal & child health, immunization, school health, control of malaria, leprosy, filariasis, tuberculosis, STD/AIDS etc.. are all decentralized

to the provincial level and provinces are expected to function under the policy and strategic guidance of the Central health ministry.

The curative care system has hospitals that are categorized as primary level, secondary care level and tertiary care level. Most tertiary care institutions belong to the central health ministry but all other care level hospitals are managed through the provincial system.

A major constraint in health care delivery has been the availability of funds and the allocations made to provincial councils. This is further aggravated by the lack of planning and technical competencies that exist and the deficiencies in human resources in the provincial health system.

**HRH expenditure:**

The Government spends a large proportion of the health budget on Drugs, Staff salaries and overtime and other allowances.

The table below gives the expenditure pattern ( Rs Million) on selected major items for 2005- 2007

**Table 1. Expenditure pattern ( Rs Million) on selected major items for 2005- 2007**

	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>Total Recurrent Health Expenditure</b>	<b>36,641</b>	<b>47,574</b>	<b>57,467</b>
<b>Total capital health expenditure</b>	<b>8794</b>	<b>15,895</b>	<b>17,750</b>
<b>Total health Expenditure</b>	<b>45,435</b>	<b>63,469</b>	<b>75,217</b>
<b>Drugs</b>	<b>7100</b>	<b>8400</b>	<b>10100</b>
<b>Diets</b>	<b>347</b>	<b>372</b>	<b>451</b>
<b>Salaries</b>	<b>6859</b>	<b>8147</b>	<b>12030</b>
<b>Overtime &amp; other allowances</b>	<b>4975</b>	<b>5905</b>	<b>6262</b>
<b>Hospital maintenance</b>	<b>2273</b>	<b>2319</b>	<b>2425</b>
<b>Bio-medical equipment</b>	<b>1001</b>	<b>1500</b>	<b>1500</b>
<b>Special development projects</b>	<b>3559</b>	<b>5304</b>	<b>10429</b>

It is noted that in 2007, approximately 76% of total health expenditure in the Government system was for recurrent expenses. Out of the recurrent expenses in 2007, 32% is spent on Salaries and overtime and other allowances.

**International comparisons:**

Sri Lanka's per capita income in 2008 is USD 1600 (source - Central Bank, Sri Lanka )  
The per capita expenditure on health is USD 31 ( 2003)

When compared with other countries that have achieved similar life expectancy and % population above 60yrs Sri Lanka has been able to do this with lesser expenditure on health care.

**Table 2. International comparison of health outcomes and expenditures**

Country	Life expectancy at birth Yrs ( 2004 )	Population aged 64+ ( 2004)	Total expenditure on health 2003 ( per capita USD)
<b>Bangladesh</b>	<b>62</b>	<b>6</b>	<b>14</b>
<b>India</b>	<b>62</b>	<b>8</b>	<b>27</b>
<b>Sri Lanka</b>	<b>71</b>	<b>11</b>	<b>31</b>
<b>China</b>	<b>72</b>	<b>11</b>	<b>61</b>
<b>Turkey</b>	<b>71</b>	<b>8</b>	<b>257</b>
<b>Mexico</b>	<b>74</b>	<b>8</b>	<b>372</b>
<b>Korea</b>	<b>77</b>	<b>13</b>	<b>705</b>
<b>Slovenia</b>	<b>77</b>	<b>20</b>	<b>1218</b>
<b>USA</b>	<b>78</b>	<b>16</b>	<b>5711</b>

**Source World Health Organization 2006**

**Countries are ranked in order of increasing GDP per capita**

Sri Lanka's Health sector performance as reflected through selected health indicators (maternal and infant mortality, life expectancy) are far ahead of the averages for countries at comparable levels of income.

These health indices however do not reflect non communicable diseases which have posed a significant health burden affecting all demographic strata and is seen to affect out of pocket health care expenditure. NCDs contribute to 65% of all cause mortality. This is a high rate where the WHO – SEARO region rate is 50% and WHO – EURO regions rate is 85%. (page 68, Sri Lanka: Addressing the needs of an aging population – The WB , Human development division South Asian region, 2008) The cost of addressing non communicable diseases is high in a situation where there is already significant prevalence (Diabetes mellitus 14.2% men and 13.5% women ( Wijewardene et al. 2005) . Early diagnosis and long term treatment to prevent adverse outcomes is vital. The management of adverse clinical outcomes of these NCDs becomes costly and hence more emphasis needs to be placed on earlier diagnosis and treatment (secondary prevention) . Recent analysis of Sri Lanka's mortality data ( Institute of Policy studies, Sri Lanka) shows that the age adjusted mortality rates are 20-30% higher in Sri Lanka than in the developed countries. This clearly indicates that Sri Lanka has much to do to improve health services in management of NCDs. Whilst health promotion programs must be delivered to prevent risk, the already high prevalence of the chronic diseases must be addressed through proper clinical management programs.

The problem of escalating chronic NCDs necessitates that we reassess the competencies of health personnel in delivery of appropriate care. Presently the primary level emphasis has been on Maternal and child health and communicable diseases.

**Present Health cadre**

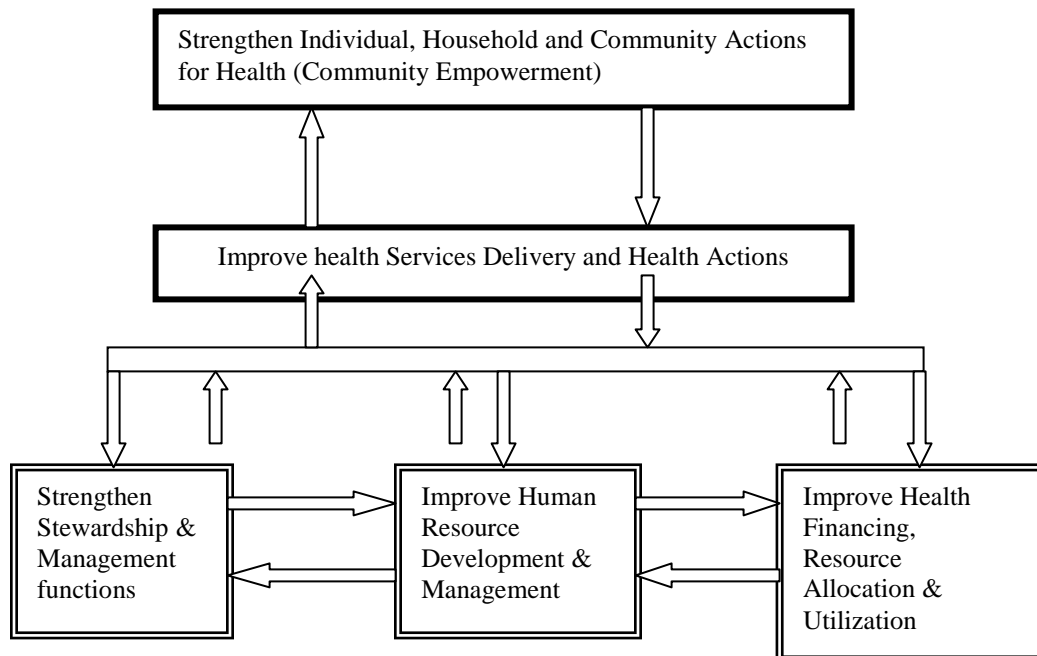
The Government health system has 296 categories of staff. As of end June 2007, 57,459 health personnel are deployed in the Line Ministry institutions and 48,839 in the Provincial Health Institutions, which indicates a total of 106,298 in the Government health workforce.

With the 13th amendment to the Governments Constitution the Health system which was a de concentrated system where there was more Central control from the Ministry of Health became a decentralized system from year 1989 onwards. However training of HR and their recruitment and deployment is largely a central function. Minor staff categories are recruited by the Provincial Health Authorities.

**Key issues in HRH development-**

Several issues are identified ranging from HRH planning, HRH management, training, lack of personnel policies, lack of job description, lack of HR performance management systems. The need for updating of existing staffing norms has been identified.

The Health Master plan, which is the Health Policy document for Sri Lanka outlines the Strategic Framework for Health Development. The interrelationship and contributory nature of the following elements are clear in the Framework given below:



The Framework identifies the pivotal role of HRH in the ultimate efforts to improve health service delivery where

1. HRH need to improve- quantity , quality, efficiency, motivation,
2. HR stewardship and management needs to improve
3. Financing for HRH  
needs to be improved.

Thus the key determining factor in improving health care delivery is in having adequate , well trained, quality workforce equitably distributed throughout the country.

These key HRH issues have lead to several development initiatives by the Ministry of Healthcare & Nutrition.

### **Recent initiatives and progress**

**A. HRIS** – The need for a Human Resource Information System was a long felt need. As of now all data of staff deployed in the Institutions coming under the Central Ministry of health have been computerized and of those deployed under the Provincial Health Authorities are near completion. The system is a web based system and data management staff has been trained to update this system.

### **B. HRH Situation Analysis for Strategic plan preparation**

The need to carry out a comprehensive Situation Analysis was identified in 2006 with a view to reviewing HRH policies for the development of a Strategic Plan for 2009-2019

The following key actions are already accomplished:

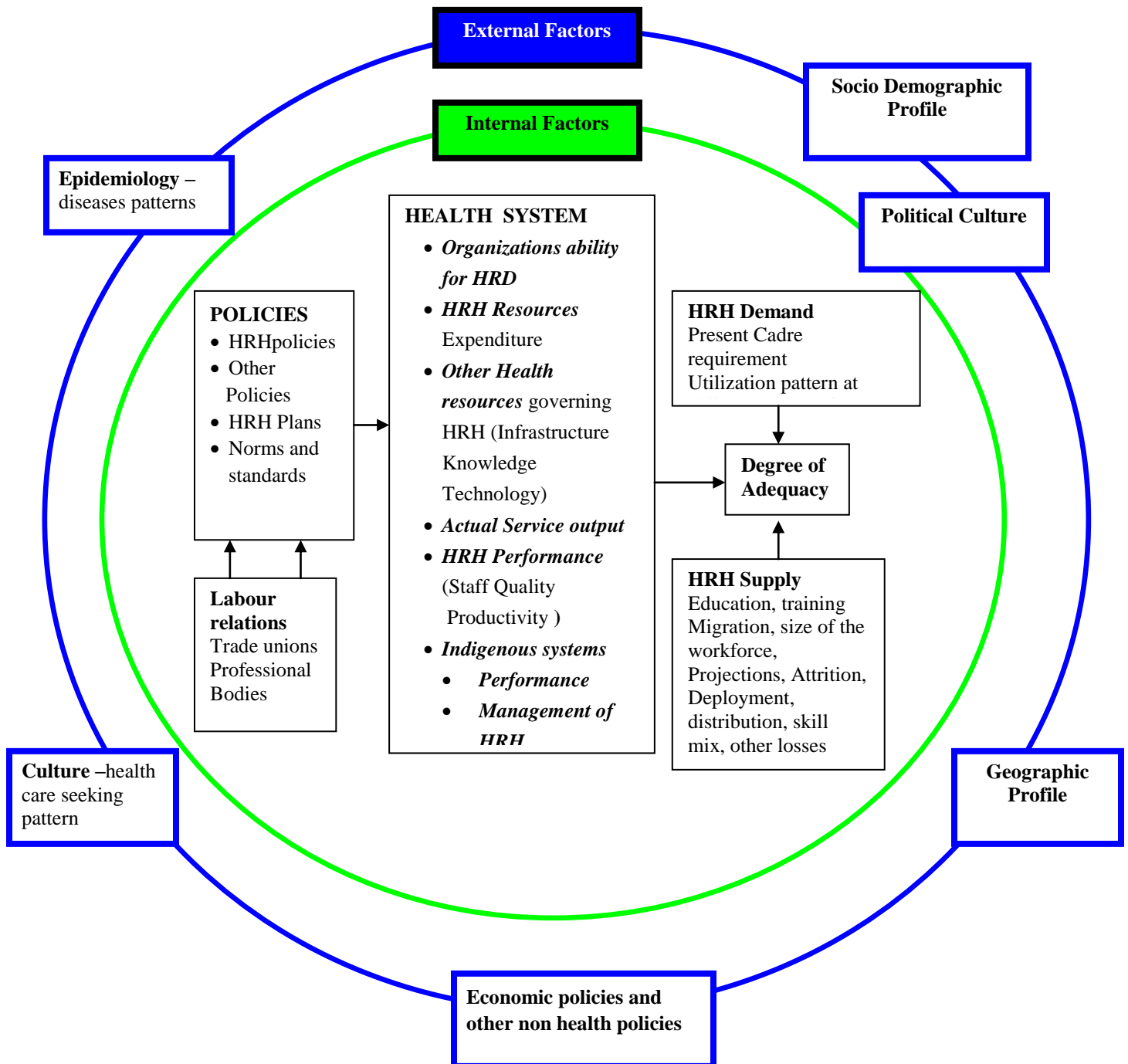
- Appointment of a Working group – completed
- Developing a Conceptual framework to identify areas of information required for situation analysis - completed – refer diagram below.
- Setting up of a Task Force – appointed
- Work plan developed and work in progress accordingly
- Identification of data and means of collection – Data requirements were identified based on the Conceptual framework. Different methods of data collection were used. Eg. Use of secondary data, special surveys, key informant interviews, review of documents, stakeholder meetings etc.

Data collection on the Hospital survey is complete and data is being analyzed.

*(An island wide Hospital survey was conducted where 135 hospitals in 20 districts were sampled. The purpose was to compare service utilization with the HRH and other resource availability. The survey is intended to fill in selected data gaps that were identified when the data collection plan was made. Therefore institutional level data was required to relate to:*

- a. Human resource availability/ requirements*
- b. Service availability and their utilization*

**Diagram 1: The Conceptual Framework, Sri Lanka – for identifying information requirement for HRH situation analysis**



*The current situation is to be described as per the following parameters:*

*I Trend in overall hospital utilization by in patients 2003-2007- ( inpatient days, bed occupancy rates, average length of stay)*

*II. Trend in overall hospital utilization by outpatients- general OPD and special clinics*

*III Trend in utilization of surgical facilities*

*III Currently available wards/ units ( in patients)*

*IV. Currently available Out patient units ( special clinics)*

*V Current availability of HRH selected categories*

*VI. Retrospective data on pattern of transfer of patients made out of the institute.*

*VII Retrospective data on absenteeism rates for two days for selected staff categories*

*VIII Retrospective /prospective assessment on the catchment population from inpatient records*

*IX. Day assessment of gender and place of residence of patients attending OPD*

*X Availability of basic facilities in the OPD- checklist ( Yes/No )*

- Outline of the Situation Analysis report has been drafted
- The writing of the Situation Analysis Report is in progress
- Further need to conduct selected interviews have been realized during the phase of data analysis and writing

Upon completion of the Report, the Ministry of Health will through a series of stakeholder meetings present the findings of the Situation Analysis Report.

The next step will be to critically look at the strategic direction of the HRH plan ( policy assumptions , economic feasibility assumptions, policy decisions/ changes that are required in order to prepare the Strategic Plan.

### **C. Capacity building for HRH Strategic Planning**

Three Medical officers from the Ministry of Health participated at the AAH training workshop on Regional Guidelines for Country Strategic Planning of HRH held this year. They are currently engaged in the ongoing HRH Strategic planning activities.

The Deputy Director General (Planning) from the Ministry of Health also participated as a Temporary Advisor at the Expert Group Meeting for Finalizing Regional Guidelines for Health Workforce (HWF) Strategic Planning and HWF Database, 28-29 August 2008 in Katmandu, Nepal this year.

### **D. Reviewing HRH needs in revitalizing primary level health care**

In keeping with the Health master plan the MoH has initiated policy dialogues with several National Program Directorates and Provincial Health Authorities who are the implementers, to identify how primary health care level can be better suited to address the changing demographic and epidemiological pattern Sri Lanka. These are mainly to address chronic non communicable diseases, mental health, care of the Elderly and emergency care. On going discussions suggest that there will be some changes to

existing job functions of Public health staff and better utilization is expected from primary level curative care institutions. Thus a training needs assessment is to follow that will identify gaps in existing training curricula or suggest other capacity building inputs for all primary level staff ( curative and preventive programs)

#### **E. Ongoing discussion to centralize HRD functions with a coordinating and HRD policy unit**

The Health Ministry Organization for carrying out HRD functions have been studied and the Ministry of Health has identified that responsibility for HRD functions are currently scattered and that there is lack of coordination amongst these areas. The need to set up a central coordinating unit that will look at the strategic issues of HRD is realized.

#### **Following actions are envisaged in the future**

1. Restructuring at MoH to have a separate HRD coordinating unit and a developing a Plan of Action for Human Resource Development/management at the Central level
2. Review of existing HRH policies following discussions on the HRH Situation Analysis Report to be submitted before end 2008.
3. Preparation of HRH Strategic Plan
4. Policy decisions on HRH at Primary care level
5. Review of HRH training needs  
(eg. Develop knowledge and clinical skills for the management of chronic NCDs at primary care level,  
Management / leadership program for health managers, clinical leaders etc )