

Family Physicians without a Defined Target Population in Sri Lanka

Rasnayaka M Mudiyanse*

Department of Pediatrics Faculty of Medicine, University of Peradeniya, Sri Lanka

*Corresponding author: Mudiyanse RM, Head of the Department of Pediatrics Faculty of Medicine, University of Peradeniya, Sri Lanka, Tel: 0094812222900; E-mail: rasnayakamudiyanse@gmail.com

Received date: September 8, 2014; Accepted date: October 1, 2014; Published date: October 8, 2014

Copyright: © 2014 Mudiyanse RM. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Sri Lanka is known for its commendable healthcare indices in the region. Now the country is going through a transition of economic development after the devastation as a result of a 30-year war and the natural disaster of a tsunami in 2004. At the same time, there is a demographic and epidemiological transition. The proportion of older population is increasing with a simultaneous increase in non-communicable diseases. The country is achieving its millennium development goals through improving neonatal mortality, infant mortality maternal mortality, vaccination coverage and life expectancy, mainly because of the maternal and child health care services delivered to the public on a well-structured target population. However the target population for delivery of ambulatory care has not been strictly defined. Freedom of visiting doctors without referrals in a background of not having a target population has created many problems. Optimum utilization of expert services has been hampered due to overcrowding and maldistribution of service demand. Commercialization of healthcare has extended to inappropriate importation of drugs and opening up of pharmacies. Out-of-pocket spending for out-patient care has escalated over the years at a significant rate probably contributed to by individual investments in health promotion or NCD prevention. Lack of responsibility to a target population has undermined the doctor patient relationship that is probably contributing to some of the prevailing undesirable behavior patterns of healthcare professionals. Organizational reforms including recognizing target populations and promoting patient centered approaches in establishments and teaching and training on competencies for family physicians, starting from the undergraduate curriculum, would be a worthy investment in the future health of the nation.

Keywords: Healthcare; Non-communicable diseases; Family physicians; Maternal mortality

The Country

Sri Lanka is a 65,610 square kilometer [1] island located south of India, with 20,483 million [1] multi-ethnic and multi-religious population. The majority (74.9%) are Sinhalese, 11.2% are Sri Lankan Tamil, 4.2% are Indian Tamil, 9.2% are Muslim and 0.5% belong to other ethnic groups [1], Religions Buddhist 70.2% Hindu 12.6% and Christian 7.4% and Islam 9.7% population, make up the profile [1]. The country is progressing in spite of a 30-year war and the natural disaster tsunami in 2004. Per capita income has increased up to 3,280 US\$ [2] in 2013 from 482 US\$ in 1990 [3]. The 2013 United Nations Development Program Report has categorized the country as a country with “medium human development” and recommended as a model for developing societies in not just Asia but everywhere else [4]. Life expectancy has improved to 75.1 years in 2012 [1] from 69.5 years in 1990 [5], adult literacy ratio in 2012 is 95.6% [1] which is an increase from 92.8% in 1990 [6]. 95% of the population has access to clean water [4]. Sri Lanka is experiencing a demographic transition. Number of people above 60 years is predicted to increase from the current level of 12.1% to 24.4% by 2040, obesity, diabetes and asthma are on the rise [7].

Successful Healthcare Delivery

The country is on its way to achieving its millennium goals by year 2015., while improving Neonatal Mortality Rate from 13 per 1000 live births in 2009 up to 8 per 1000 live births in 2013 [4], Infant mortality

rate has dropped from 18 per 1000 live birth down to 8 per 1000 live births [5], maternal mortality rate is down to 3 per 10,000 live births in 2014 from 6 per 10,000 in 2009 [6]. Life expectancy 75.1 years [1], infant mortality 8 per 1000 live births, under-five-mortality 10 per 1000 [5], infant lacking immunization for DTP and measles 1%, antenatal coverage 99.4%, HIV prevalence <0.1% [5].

This success has been contributed to by the well-established primary care services delivered to target populations all over the country through 954 government institutions designated to 276 Medical Officer of Health areas with a workforce of about 50,000 people. High literacy rate and reasonable funding has been other contributors. There are 3.6 hospital beds per 1000 persons and 2,300 persons per doctor and 826 people per nurse [1,5].

Costs of Health Care

Sri Lanka is currently spending about 70 USD per capita for health care [2,3]. Health expenditure is 3.5% of GDP [1-3]; out of which Government of Sri Lanka spends 1.7% [2] of GDP for health care, which is higher than the average (1.3%) for the region. However, the national healthcare expenditure as a percentage of GDP is lower than UK (6.8%), Canada (9.2%), Japan (8.3%), Philippines 3.6%, Thailand 3.7% or Bangladesh 3.9%. Contribution for the national healthcare expenditure from the private sector and out-of-pocket expenditure amounts to 1.8% of GDP [2,3]. Out-of-pocket spending (OOPs) for a Sri Lankan in 1990 was 5.2 billion which rose to 76.1 billion in 2009, spending Rs 70 billion more on healthcare than what they did 20 years ago [2].

However almost the entire cost of primary care is covered by public funds generated by taxes, which amounts to about 1.5% of GDP and 48% of the total health budget in the country. The rest of the health care cost 1.4% of the GDP (43.1%) [2,3] is generated by out-of-pocket expenditure and the balance is provided by employers, insurance and volunteer contributions.

The major share (86%) of the private sector expenditure (46% of total healthcare expenditure) on health is paid by the out-of-pocket spending (OOPs), which is defined as expenses for health by the private household money that is not covered by insurance or any other means [7]. OOPs amount to 1.4% of the GDP which was 76.1 billion Sri Lankan rupees in 2009. Employers, insurance and volunteer's contribution provide rest of health expenditure [8]. Effect of OOPs on poverty is inevitable. In a recent study involving 11 Asian countries, accounting OOPs in the calculation per-capita income has resulted in an additional 2.7% of the populations falling below the standard poverty line of 1 \$ per day. Almost 30% of the direct and indirect healthcare costs in Sri Lanka are borne by patients and 10% of patients declare that it difficult to bear [9]. In such situations only the provision of social and financial support could prevent the medical poverty trap. Unfortunately current practice is limited to provision of financial support and limited numbers of elderly care homes and day care centers and the necessary provision of services is non-existent [9]. Preference to use private sector healthcare services among better-off families has made them more vulnerable to catastrophic health spending than poor families; a phenomenon observed in Thailand even after the provision of universal health coverage [10].

Cost of management of minor ailments has been inflated due to free-hand health seeking behavior. People seek specialist's advice in main cities even for minor and viral infections, leading to escalation of costs incurred by the cost of travelling, higher fees for doctors and more investigations. Such healthcare seeking behaviors become inevitable due to devastating health care issues like dengue and chronic kidney disease. Dengue 'the deadly disease of tropics' has disturbed 44 456 people in 2012 and caused 180 deaths, the trend seems to continue [9]. Prevalence of Chronic Kidney Disease has increased exponentially over the years; currently the prevalence varies from 15% to 23% in some districts of the country [11].

Family Physicians, First Contact Doctors and Target Population

Family practice has been established well over 150 years ago in Sri Lanka. Most of the time family physicians in Sri Lanka had solo practices and were not affiliated to the public health care system. The first National Organization of General Practitioners was the Independent Medical Practitioners' Association (IMPA), which was founded in 1929. The College of General Practitioners of Sri Lanka was founded in 1974. World Organization of Family Doctors (WONCA) accepted Sri Lanka to its membership in 1978 [12]. However family physicians had never recognized defined target populations in Sri Lanka. Government institutions provided first contact care for people of the locality even though there was no strictly defined population and the population served by a medical officer in a recognized area was too large to develop doctor patient relationships that were expected from Family Physicians.

Economic reforms in 1977 allowed medical practitioners from the government service to practice privately outside their official working hours for a fee charged from the patient [13]. Along with these open

economic policies private sector healthcare expanded extensively. The public started seeking specialist opinion regarding a variety of health issues from private consultation centers in main cities frequently. Non-specialist medical officers also offered after-hours services to the public for a fee without any demarcation of target populations. The public had to spend more money out of their pockets. Ever expanding private sector services offered to the public were not confined to a target population. There is no referral system and recordkeeping is not a necessity. Number of private hospitals has gone up from 44 in 1990 to 112 in 2011 [1]. These institutions provided out-patient care to 419,000 in 1990 and to 6 million in 2011. Number of patients treated as inpatients in private hospitals has gone up from 65,000 in 2009 to 401,000 in 2011 [2]. In-hospital services of the private sector have been utilized mainly by the high-income groups, but the out-patient services were utilized by people of all income categories. Expansion of the private sector has opened up 3000 pharmacies and 10,000 new varieties of drugs were imported in 2011 compared to 2 200 varieties imported in 2001 [6]. This is probably linked to the prescription patterns of doctors [8]. This system allows the general public to access whatever the healthcare facilities in the country without appointments irrespective of the type of the medical problem. This freedom of access to healthcare services enjoyed by general public was not without its own problems.

Impact of Lack of Defined Target Population and Referral System in the Country

Expansion of the private sector has widened the inequities and adversely influences the healthcare seeking behavior of the general public [14]. Patients visiting specialists are likely to lose the relationship with medical officers in their locality. When patients start changing doctors frequently, they will end up in "doctor shopping", without proper planning or regular follow up. As there is no proper record keeping repetition of investigations become inevitable. The lack of professional guidance has resulted in irrational spending and escalation of out-of-pocket expenditure with an inevitable impact on their economic status hampering even some important aspects of their own health. As people seek for specialist advice more and more, people gather around popular specialists and popular healthcare centers resulting in over-crowding and long waiting time in some places while some of the other private centers as well as public centers were empty. Scheduled visits were not a routine practice. Patient has the liberty to visit any doctor on their schedule. Such unscheduled visits to doctors are bound to cause confusion and disorganization of services [15]. Specialists' time was consumed by attending to minor ailments and time available for them was curtailed due to over-crowding. This situation would have undoubtedly led to deterioration in the quality of performance. Ultimate result is direct or indirect commercialization of the entire health service. Multitudes of health care facilities became available. Competitive nature of private practice was not without conflicts between colleagues; situation being made worse by the lack of a target population. Patients under-valuing locally available services not only spend excess of money by lending and selling their belonging but also have higher chances of delaying to get even the available services. Such a system is conducive for errors in diagnosis as the patients take the initial decision regarding the specialist to consult.

Irrational healthcare seeking behavior and escalation of out-of-pocket expenditure is likely to end up in catastrophic consequence on health in a country with an impending explosion of non-communicable diseases and an ageing population in the country. In

the current practice NCD prevention activities seem to be concentrated in the secondary and tertiary care centers of the government sector and in the private sector located in main cities catering for the affluent society [7]. However in a society in the phase of transitions to affluence, NCD prevention strategies should be universal and affordable to everybody. The society should be motivated and guided to invest on health promotion that would be otherwise surpassed by the escalating out-of-pocket expenditure on regular ambulatory care.

What could be Done?

Organizational reforms including recognizing target populations and promoting patient centered approaches in establishments and teaching and training competencies for family physicians starting from undergraduate curriculum would be a worthy investment in the future health of a nation.

Change in the organizational structure is mandatory. Problems of the healthcare delivery have been recognized mostly as inadequacy of funding, facilities and regulations [8]. Place for private public partnership in delivery of health has been highlighted [13]. However the value of patient centered care, identifying target populations, promoting doctor patient relationships and the need for teaching and training competencies for family physicians has not got deserved attention [16]. Competencies in communication, advocacy, collaborations, managerial skills and professionalism that trained in family medicine could be utilized optimally to ameliorate many issues highlighted earlier. Teaching and training should focus on developing better attitudes and building relationship. A background of serving for a target population is essential to achieve this.

Patient centeredness is the key. Doctor centered approaches promoted in 1950s adopted methods of Western science and data gathering style of communication was paternalistic and patients' psychosocial needs were marginalized. Recognition of the value of patient's engagements, perceptions and partnership in successful health care delivery has led to the birth of the concept of patient centered care that has demonstrated multitudes of benefits all over the world [16]. Successful primary health care programmes in Sri Lanka were 'program centered' on target populations but not necessarily patient centered. The public with high literacy ratio exposed to expanding avenues to access medical knowledge demand more and more partnerships rather than being passive followers of doctor's advice. This situation along with an increasing population of elderly people with multiple healthcare problems demands more time from doctors. However working environment distracts the doctor from patient centeredness [16]. Doctors are occupied with clearing the crowd and time is diverted to administrative or managerial issues, entering data into computers and attending meetings [16] People flocking around the consultation table are prohibitive of personalized discussion.

The available workforce could be utilized optimally. At present 17 000 doctors are available to deliver ambulatory care to the public in the public sector [3]. They are ready to extend their working hours by 2-6 hours beyond routine duty hours. This could be utilized optimally. Family physicians in the private sector and first contact doctors in the government institutions should be allocated a defined target population and promote practice of competencies in family medicine. Such an approach would create more realistic private public

partnerships while preserving doctor patient relationships that are conducive for well-coordinated healthcare delivery.

Teaching and training has a major role to play. Inculcating patient centred attitudes, empathy, communication skills and collaborative skills are immediate essentials for all these doctors as most of them have been trained previously on a traditional subject based curriculum. Most of the family medicines competencies are integrated with attitudes. They are nevertheless trainable. Continuous professional development programmes targeted to all professionals that have been initiated by professional bodies need strengthening and streamlining to achieve the best out of it.

Teaching and training should be initiated from the beginning of the undergraduate curriculum. As almost all the doctors are accepting the management of first contact patients, they should be abreast with family medicine competencies. The undergraduate curriculum should cater to this need irrespective of student's preferences on specialization. The necessity should not be surpassed by introduction of postgraduate courses in family medicine. So far only 85 out of over 10,000 doctors who are involved in family medicine have undergone post graduate training [12]. Teaching Family medicine concepts without real Family Physicians creates an artificial situation. However some of the medical faculties in the country have created Family Medicine Units for the purpose of teaching and claim are made that they are quite successful. Prevailing system diverts the student towards specialization other than family medicine, marginalizing the need to learn important competencies for a first contact doctor. There is a trend to select ultra specialization by students for their carriers because of convenience or the financially lucrative nature of the job. The government has an unofficial obligation to provide them with jobs in main cities even if the peripheries are devoid of the full complement of basic specialists, partly due to influences on the system either by trade unions or other influential people such as politicians.

The public has a role to play. Patient centeredness does not confine to health professionals. Our patients are not patient centered as much as we could expect from their educational back ground. Most of the problems are entrenched in the healthcare seeking behavior of the public for which doctor patient relationship matters more than anything else. Such relationships could be established by defining target populations and patient education. Knowledgeable society is the strength of a healthy nation.

Conclusion

Recognition of target populations and reorganizing the ambulatory services and establishing universal NCD preventive activities should further enhance and preserve achievements in health indices in the country. Establishing proper family medicine system in the country could mitigate many issues in the delivery of healthcare including escalating out of pocket expenditure and its consequences. Delivery of healthcare needs personalized attention and collaborative planning while paying attention to holistic care and patient empowerment. All the universities should invest on enhancing their undergraduate Family Medicine Curricula rather than promoting specialization. The need for teaching family medicine competencies in undergraduate curricula cannot be replaced by postgraduate courses in family medicine.

References

1. Economic and Social Statistics of Sri Lanka 2014 central Bank of Sri Lanka.
2. Sri Lanka Health Accounts, National Health Expenditure-1990-2008.
3. Sri Lanka National Health Accounts 2005- 2009.
4. <http://hdr.undp.org/en/countries/profiles>
5. <http://www.unicef.org/infobycountry/>
6. <http://www.unescap.org/stat/data/statind/pdf>
7. Bandara S (2011) Talking economics. The blog of the Institute of Policy Studies of Sri Lanka (IPS) Sri Lanka apex socio-economics policy think-tank.
8. Dayarathna GD (2012) Talking economics. The blog of the Institute of Policy Studies of Sri Lanka (IPS) Sri Lanka apex socio-economics policy think-tank.
9. Jayasingha S (2010) Illness and social protection: an agenda for action in Sri Lanka. Sri Lanka Journal of Social Sciences 33.
10. Somkotra T, Lagrada LP (2009) Which households are at risk of catastrophic health spending: experience in Thailand after universal coverage. Health Aff (Millwood) 28: w467-478.
11. Jayatilake N, Mendis S, Maheepala P, Mehta FR (2013) Chronic kidney disease of uncertain aetiology: prevalence and causative factors in a developing country and On behalf of the CKDu National Research Project Team. BMC Nephrology 14: 180.
12. Ramanyaka RPJC (2013) Historical Evolution and Present Status of Family Medicine in Sri Lanka. Journal of Family Medicine and Primary Care 2: 131- 34.
13. Dayarathna GD (2013) Talking economics. The blog of the Institute of Policy Studies of Sri Lanka (IPS) Sri Lanka apex socio-economics policy think-tank.
14. Thresia CU (2013) Rising private sector and falling 'good health at low cost': health challenges in China, Sri Lanka, and Indian state of Kerala. See comment in PubMed Commons below Int J Health Serv 43: 31-48.
15. O'Cathain A, Knowles E, Munro J, Nicholl J (2007) Exploring the effect of changes to service provision on the use of unscheduled care in England: population surveys. BMC Health Serv Res 7: 61.
16. Charlton R (2014) Effective health delivery. J Gen Practice 2: 4.

This article was originally published in a special issue, entitled: "**Effective Health Service Delivery to the Target Population**", Edited by Jongwha Chang