

Public Hospital Governance in Asia-Pacific

Sri Lanka Case Study

Comparative Country Case Study Group Meeting

11 December, 2013

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Case Study Team

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Country profile



- Democracy
- Population: 20.3 M (2012 census)
- Lower-middle income (WB)
- GDP at current market prices (2012 US\$ billion): 59.4
- GDP per capita (2012 current US\$): 2,923
- HDI: 0.715 (high human development)
- Female literacy (2010): 90%

Country profile – health indicators

	1960	2007
Infant mortality (per 1000 live births)	57.0	8.5
Neo-natal mortality (per 1000 live births)	34.2	5.9
Maternal mortality (per 100,000 live births)	302	14

	1963	2007
Life expectancy at birth female (years)	61.4	76.4
Life expectancy at birth male (years)	61.9	71.7

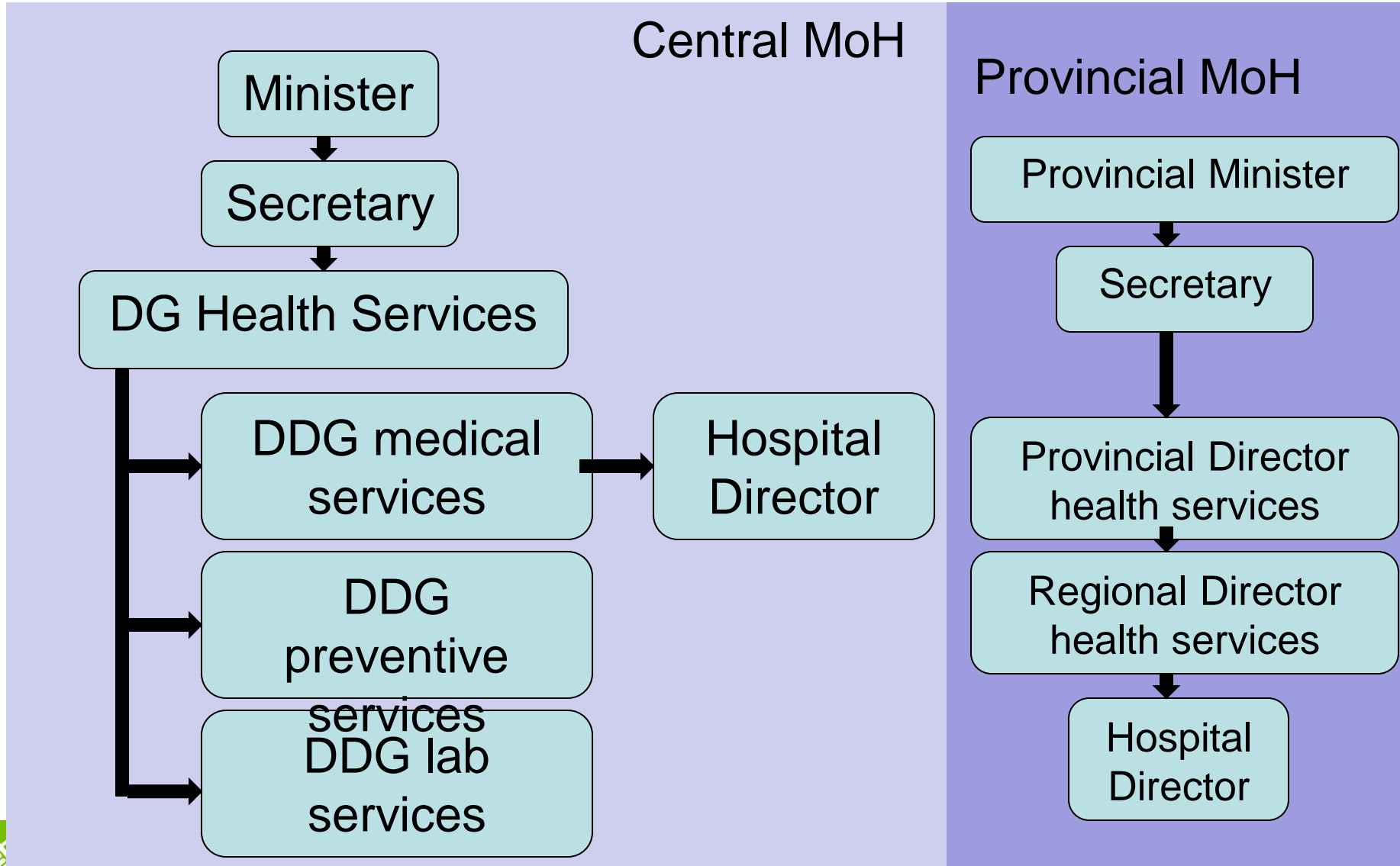
Total fertility rate (per woman)		2.3
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Source: Sri Lanka Annual Health Bulletin

Country profile – health services

- Total expenditure on health as % of GDP (2011): 3.4%
- Public/private expenditure on health as % of total expenditure on health (2011)
 - Public 45%
 - Private 55%
- Inpatient care
 - Public sector – 95% of inpatient care
 - Expenditure – 76% of total expenditure for inpatient care
- Per capita expenditure on health (2011): US\$ 97

Public Hospitals – Organization (1)

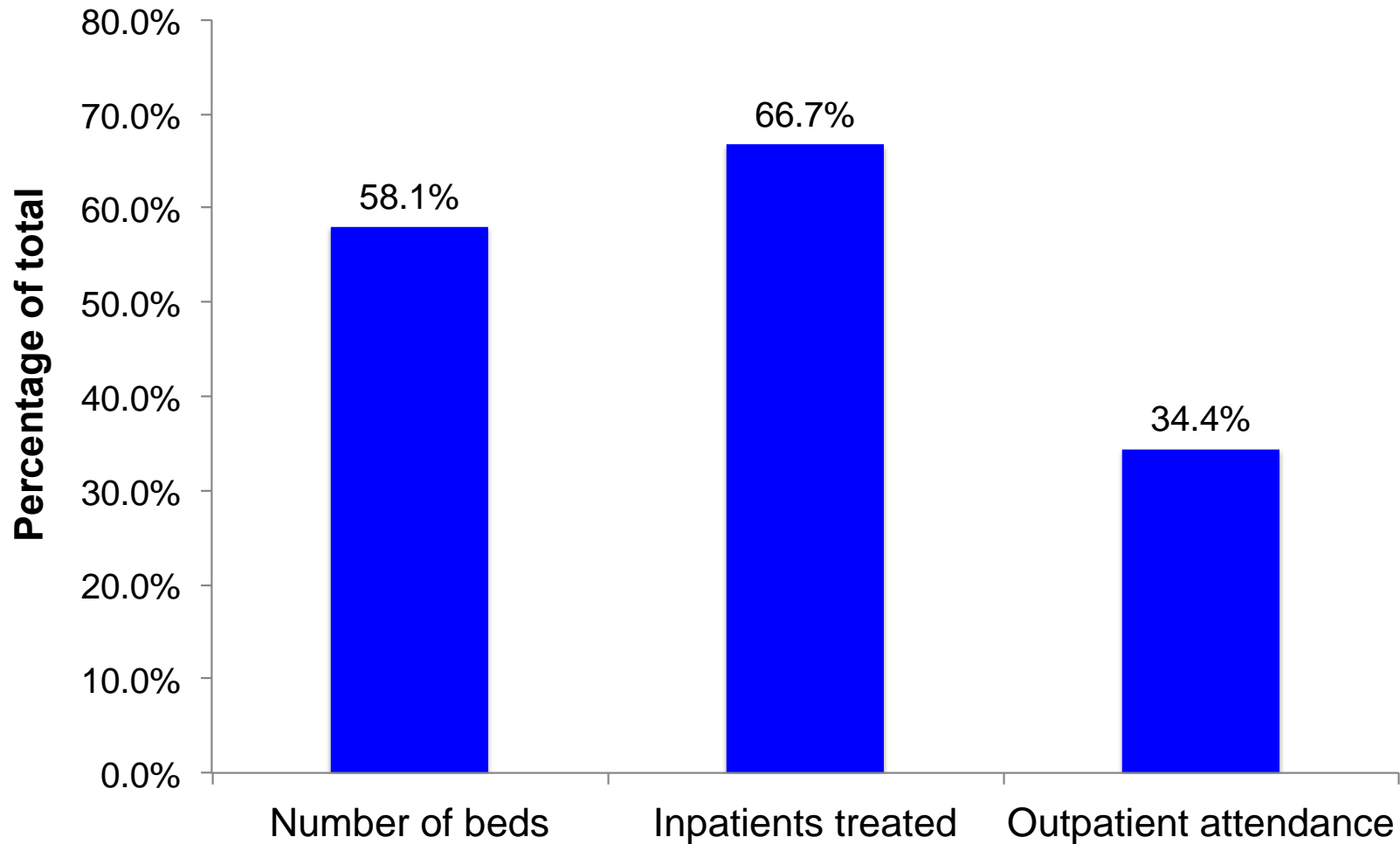


Public Hospitals – Organization (2)

- Extensive network
 - Within 5 km of person's residence

Type of hospital	Level of care	Direct supervision	Number of hospitals
Teaching/Provincial	Tertiary	Central MoH	24
District general	Secondary	Central and Provincial MoH	18
Base (Type A, B)	Secondary	Mostly Provincial MoH	78
Divisional (Type A, B, C)	Primary	Provincial MoH	493
Primary care units	Primary	Provincial MoH	474
Special hospitals		Central MoH	5
Board managed			2
Total			1094

Bed capacity, inpatients treated, and outpatient attendance at Teaching/Provincial, District General, and Base Hospitals (% of total)



Objectives

1. Identify major reforms that had an impact on the governance of public health facilities
1. Describe public hospital performance (tertiary and secondary)
1. Describe hospital governance
2. Identify and understand the underlying reasons for the observed level of performance

Methods (1)

- Literature review
 - Gvt commissioned reports
 - National policies, health plans
 - Gvt circulars
 - Others – peer-reviewed and non peer-reviewed publications, reports (IHP reports and others)
 - Publications from Medical Statistics Unit, Sri Lanka

Methods (2)

- Existing databases (Institute for Health Policy)
 - Sri Lanka National Health Accounts
 - Public Hospital Inpatient Discharge Survey 2005
 - Private Hospital Survey
 - World Bank Quality of Care Study

Methods (3)

- Focus group discussions
 - Hospital Directors (MoH)
- In-depth interviews at different levels of administration
 - Hospital Directors (MoH and Provincial MoH)
 - Regional Directors
 - Retired administrators (former secretary, DGHS, hospital administrators)

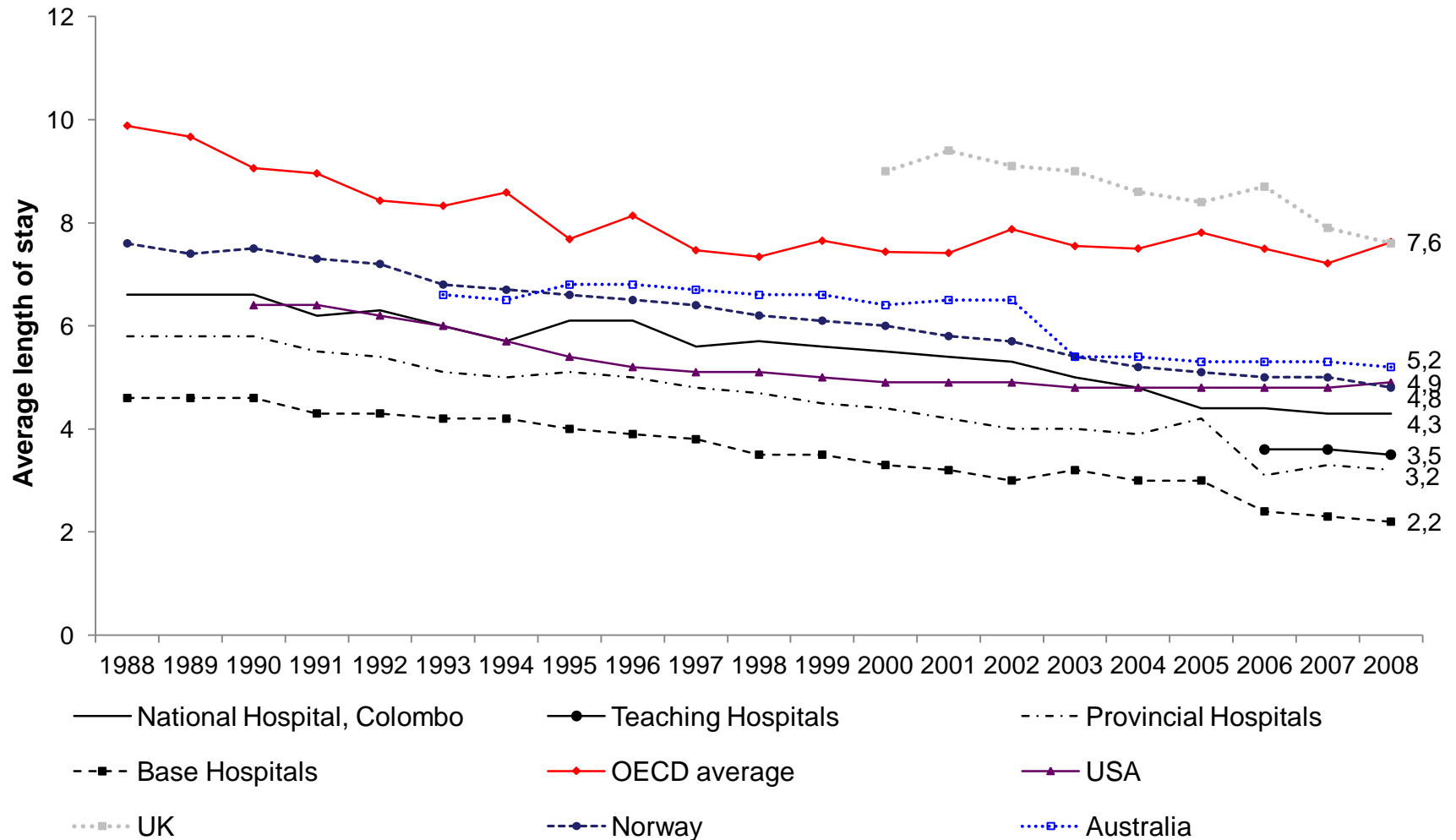
Reforms

Reforms on public hospitals

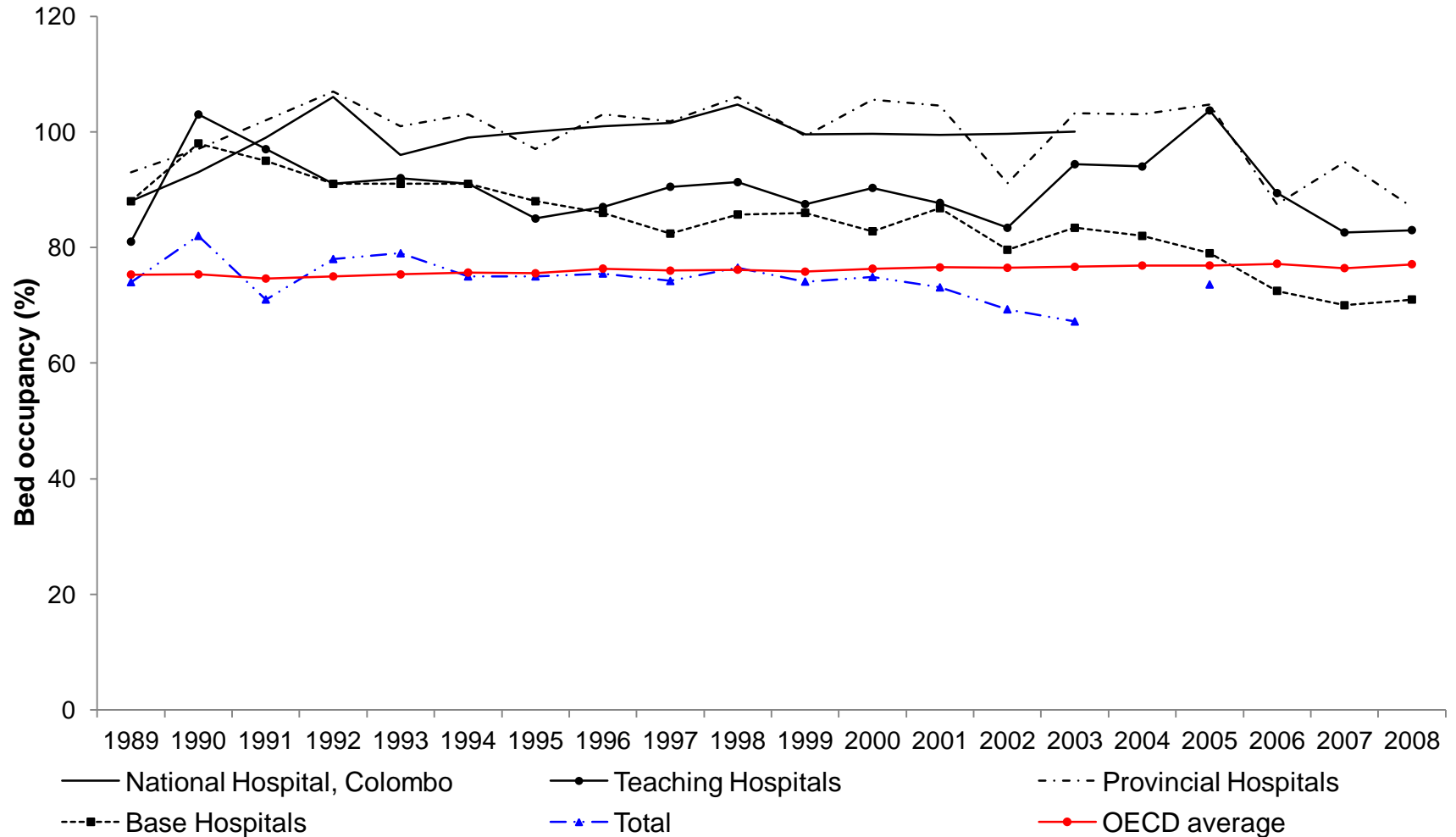
- Cumpston 1950, Hance 1956
 - Decentralisation
 - Standardization of hospitals
- 1987 Devolution of power to Provinces
 - Establishment of Provincial Ministries of Health
- 1993 Establishment of College of medical administrators
- 1997 Presidential task force
 - Upgrade hospital to district general hospital

Hospital Performance

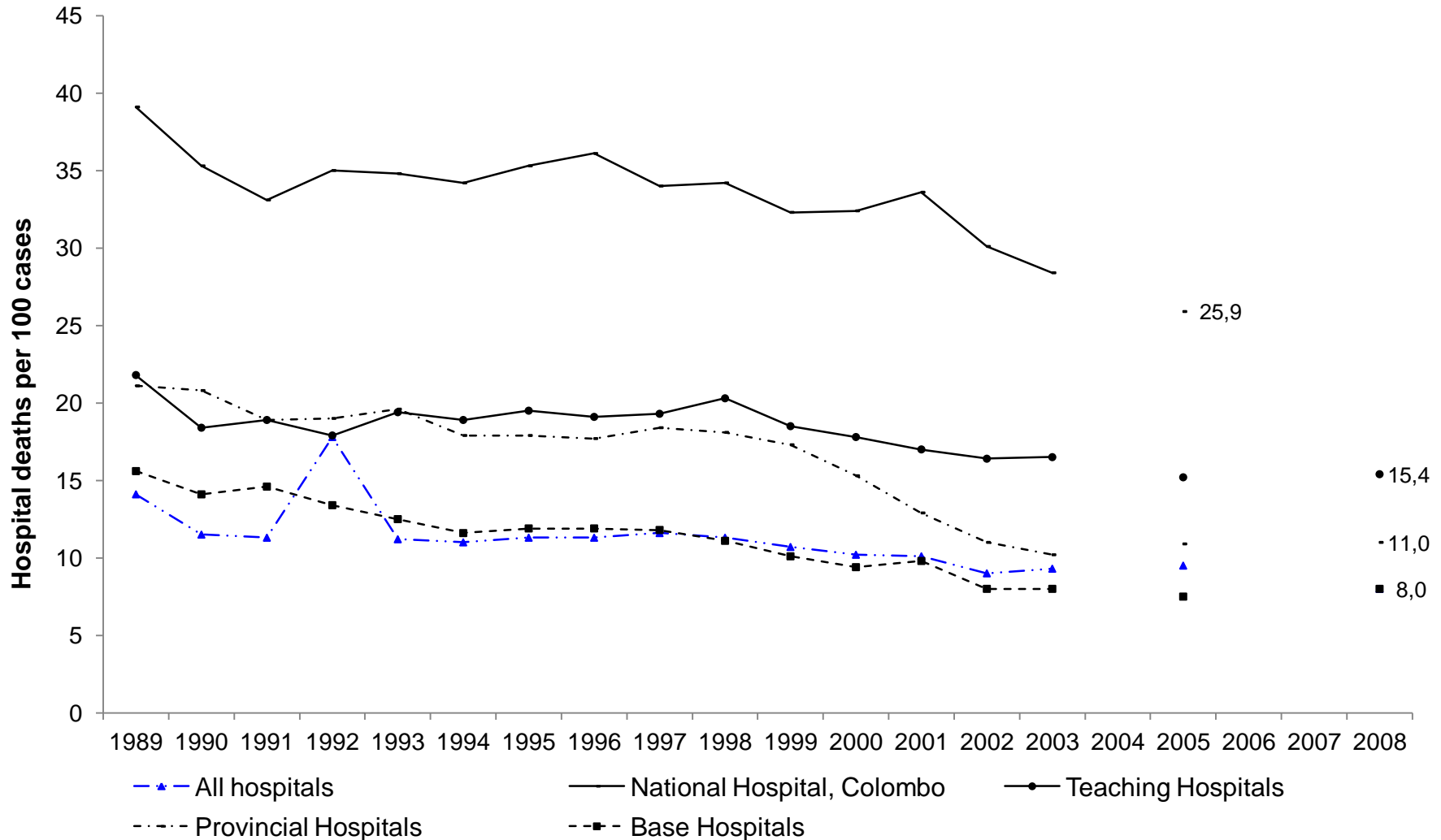
Length of Stay



Bed occupancy

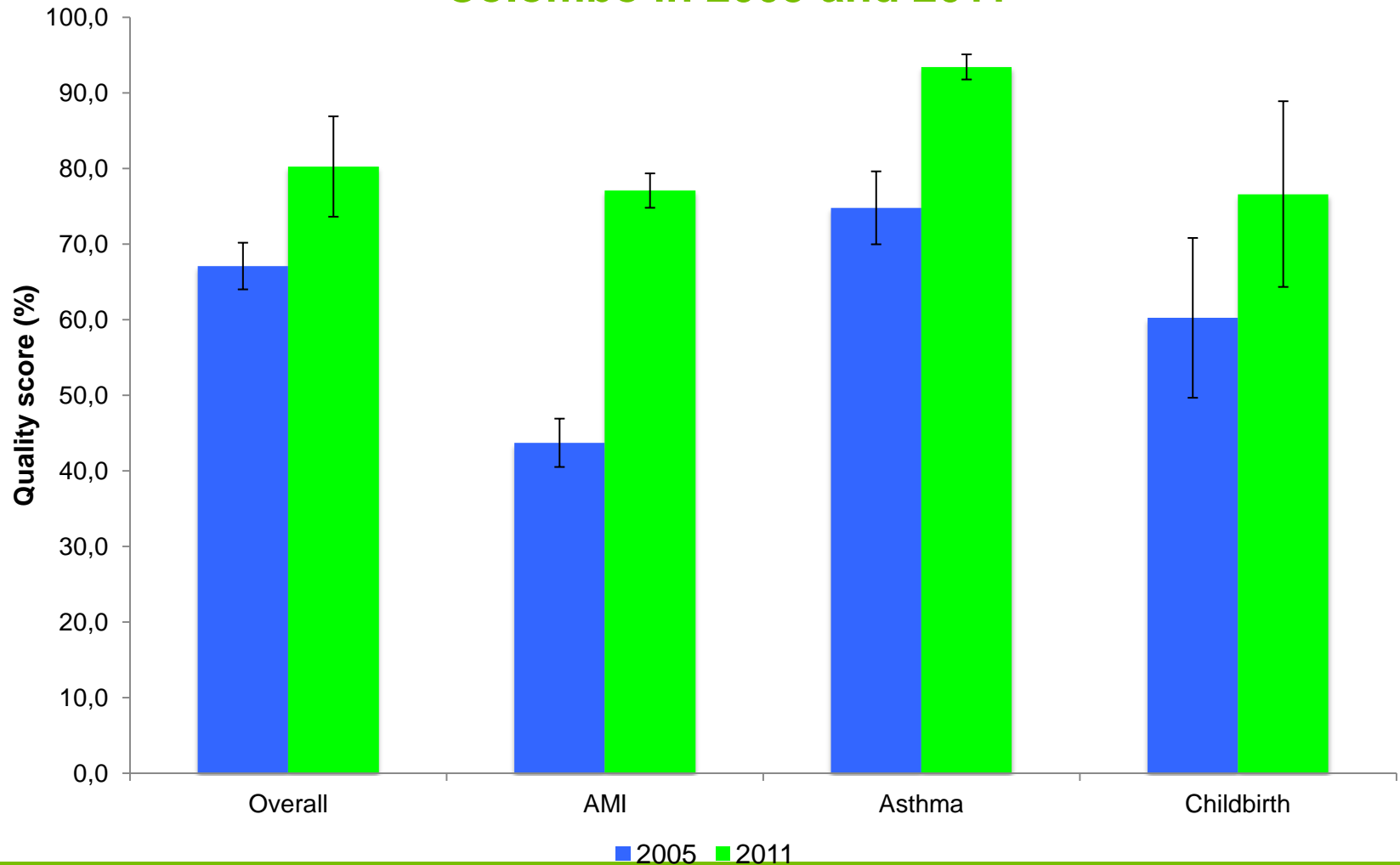


Hospital deaths



Process Quality

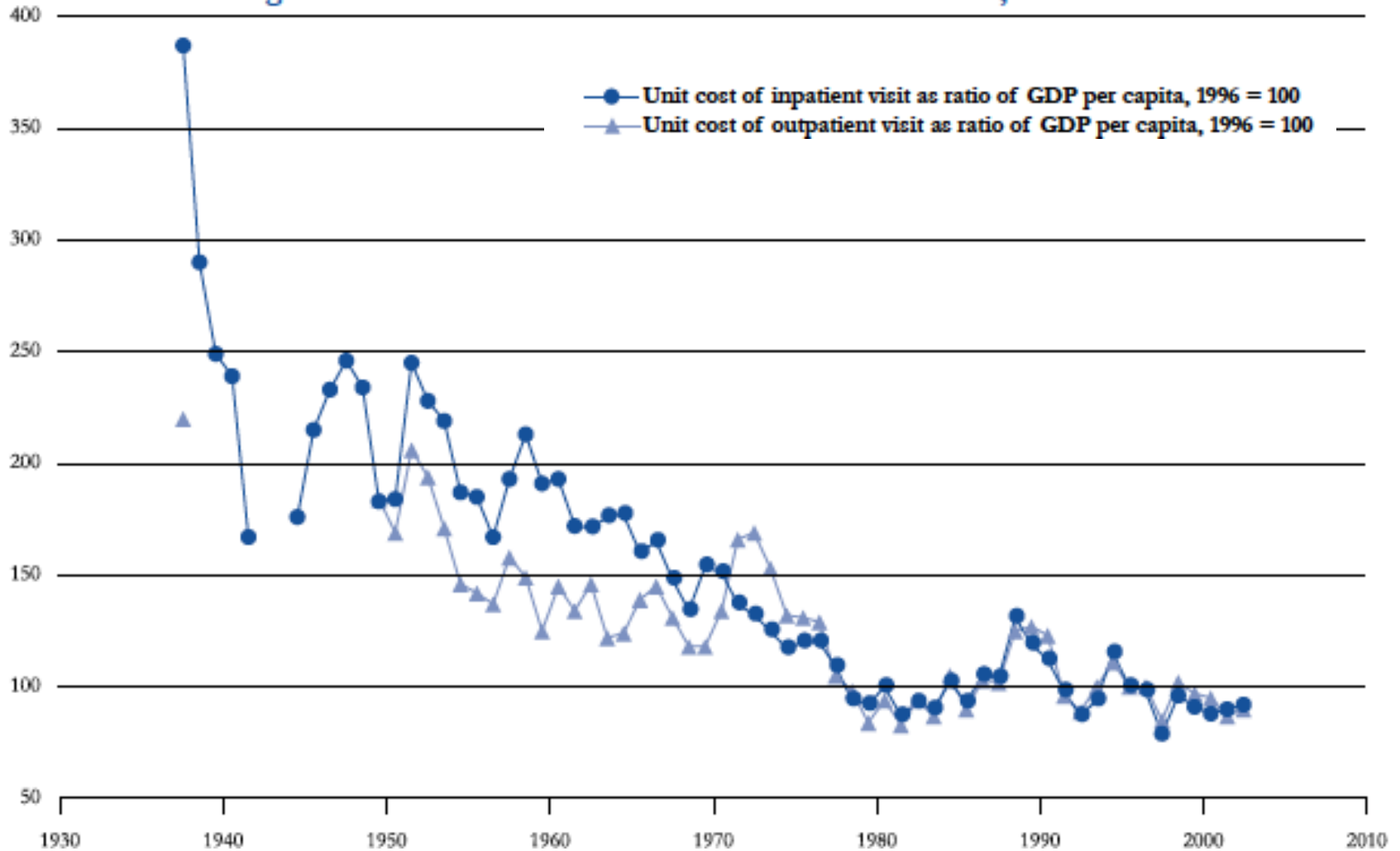
Comparison of quality of care in teaching and base hospitals in Colombo in 2005 and 2011



Source: 2005 data from Public Hospital Inpatient Discharge Survey, 2005; and 2011 data from World Bank quality of care study, 2012

Cost efficiency (1)

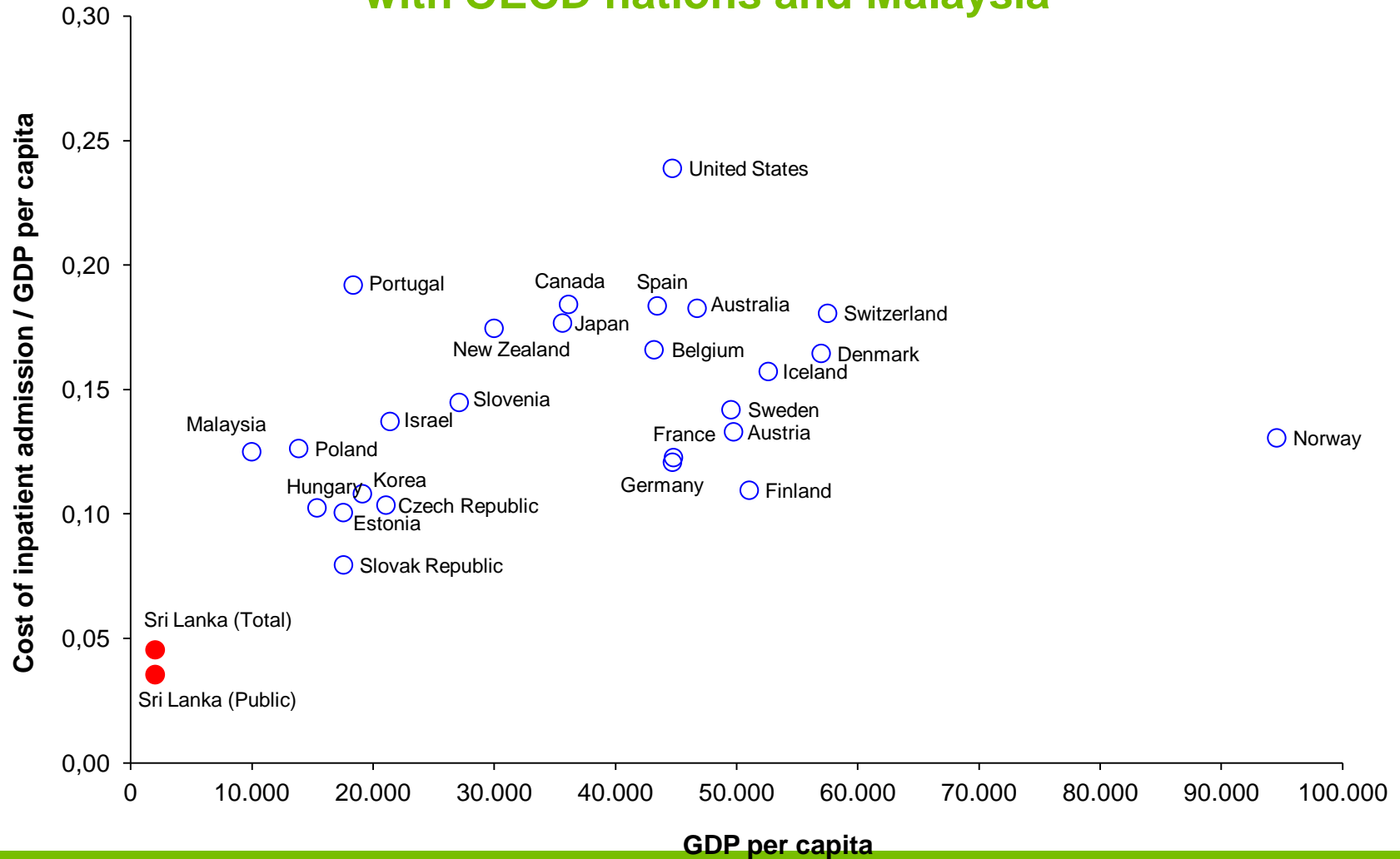
Figure 3.2: Estimated trends in unit cost of MOH services, 1935-2005



Source: Rannan-Eliya (2008)

Cost efficiency (2)

Comparison of relative unit costs of inpatient medical care in Sri Lanka with OECD nations and Malaysia



Hospital Governance

Governance (1)

Function	Hospital Director	Provincial MoH	MoH
Staff recruitment	No authority	All staff except medical officers	Full authority
Staff allocation to hospitals	No authority	To hospitals under Provincial MoH	Full authority
Staff deployment within hospital	All staff except designated staff	Can give staff designations except to medical officers	Identified categories of nursing staff and designated medical officers
Staff increments	Authority to approve	All staff except medical officers	Full authority
Promotion	No authority	All staff except medical officers	Full authority
In-service training	Full authority	Full authority	Full authority

Governance (2)

Function	Hospital Director	Provincial MoH	MoH
Disciplinary action	Informal inquiry	Formal inquiry except medical officers	Full authority – formal investigation
Hospital budget setting	No authority	Full authority	Full authority
Hospital budget spending	Full authority	N/A	N/A
Raise revenue	No authority	Full authority	Full authority
Receive monetary donations	Set up hospital foundation to retain donations	Full authority	Full authority
Expand range of services offered	No authority	Full authority	Full authority

Governance (3)

Function	Hospital Director	Provincial MoH	MoH
Implement programmes to improve quality of patient care	Full authority	N/A	N/A
Maintenance of infrastructure	Full authority within allocated budget	Full authority	Full authority
Construction of new buildings	No authority	Full authority	Full authority
Procurement of drugs	No authority	No authority	Bulk purchase
Drug allocation to hospital	N/A	Full authority to allocate to hospitals under Provincial MoH	Full authority to allocate to hospitals under MoH
Local purchase of drugs	Within allocated budget	N/A	N/A

Interview findings (1)

- Continuous performance review in line with national health goals
 - Quarterly: indoor morbidity and mortality
 - Monthly: hospital management committee meetings
 - Bimonthly:
 - Meeting of all hospital directors under MoH
 - National Health Development Committee meeting
 - Reviews are considered as encouragement as opposed to being ‘punitive scrutiny’

Interview findings (2)

- ‘Collaborative hierarchy’
 - Small network of individuals that begin ties at medical school
 - Knowledge transfer
 - Clear career path – largely based on seniority
 - Positions are largely unthreatened
- Challenging work environment
 - Successes are rewarding
 - Sense of pride and achievement

Interview findings (3)

- Doctors as administrators
 - ‘Technocratic’ administration
 - The majority of positions in the central and provincial department of health services to hospital directors
 - Respect among politicians
 - Less politicization
 - Ease of communication with superiors: “they get it”
 - Reinforced with hierarchy

Interview findings (3 contd.)

- Doctors as administrators
 - Previous experience with non-medical administrators was unsuccessful (1980s)
 - Comprehensive process for qualification
 - MBBS degree
 - Post-graduate qualification (2007 only medical administration or community medicine)
 - 8 years experience in public health service

Interview findings (4)

- Formal training in medical administration
 - 1993: College of Medical Administrators
 - Post-graduate Institute of Medicine offered MSc and MD in Medical Administration
 - At present 60% had a post-grad qualification in medical administration
 - Opinion: very helpful to perform better as hospital director
 - Upgraded the status of director among the consultants

Interview findings (5)

- Service to public (individual motivators)
 - Sense of obligation and responsibility to provide good healthcare to the public
 - Public sector utilization is predominantly by the poorer segments of the population
 - Sense of pride and achievement with good performance
 - Sense of ownership of hospital

Interview findings (6)

- Process of socialisation
 - Medical school to seniors in public administration motivate and stir a sense of obligation to serve the public
 - Sense or ownership of the healthcare system and gains
 - Continued involvement of retired administrators
 - Expert advice
 - Teaching
- Devolution of power to provinces
 - More flexibility to implement changes without approval from MoH
 - Setting up of preliminary care units
 - 5S program

Conclusions (1)

- No major reforms since the 1950s
- Favourable outcomes at low cost
- Flexibility provided through devolution of power to provinces
- Political support – equity, access, efficiency, outcomes
- Guided by national policies, plans, and goals
 - Organization and delivery of services continuously assessed by gvt

Conclusions (2)

- Sense of ownership of the healthcare system
- Hospital directors have limited authority in budget, staff recruitment and discipline, drug purchasing
- However, within given resources hospital administrators have flexibility to take action to improve efficiency, and quality of services delivered
- Several instances where individual initiatives have been adopted system-wide
 - Such results can be strong individual motivators

THANK YOU