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Evolution of Medical Administration in Sri Lanka

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Ancient and Early History

The history of ancient Sri Lanka, which is recorded in "Mahavamsa", and some of the archeological remains in the ancient kingdoms of Sri Lanka, provide evidence that some services of a public health nature, such as drainage, sanitary facilities, and cemeteries, were provided by ancient kings of Sri Lanka. The technical ingenuity of some of these measures, practiced by the people who lived twenty centuries ago, is truly surprising." Vinaya" rules for the Buddhist monks, as well as tenets of "Ayurvedha", by their injunctions on good living, have probably contributed significantly to this health consciousness of the nation of this island paradise in the Indian ocean. (Ceylon / Sri Lanka).

Colonial Era Developments

It is true that Sri Lankans were keen on developing the health facilities since the ancient kings' period, and later, the same continued during the colonial era as Sri Lankan doctors pioneered to lead the health services of the country. This situation had been endorsed by Sir West Ridgeway (then Governor of Colonial Ceylon) in his address to Ceylon Medical College at the distribution of medals on 28th August 1903, stating as "Ceylon is proud of its medical service, and justly proud, and it has always been a great pleasure to me to be associated with it. The medical service of Ceylon is Ceylonese. essentially Ceylonese, and Ceylonese, I hope it will remain".

The British Governor, Sir Henry Ward, established the Medical Department of Ceylon in 1858, and it was mainly tuned to the control of communicable diseases. The head of the Department was named PCMO (Principal Civil Medical Officer) . His staff consisted of a medical assistant who supervised the central provinces, three superintendents of vaccination who were stationed in Colombo, Kandy, and Jaffna, respectively. 33 medical sub assistants and 100 'native 'vaccinators. The medical sub-assistants were of two grades, namely those who received their training in the Department itself and those who qualified from Calcutta Medical College.

The head of the Medical Department was always a Britisher till 1936, during which year the first Sri Lankan was appointed to the post. When the British PCMO was on lease, the first Sri Lankan to cover the post of PCMO was Dr P.D. Anthoniz, who later became the first President of Sri Lankan Medical Association.

Sir William Gregory (1872 – 1877) arranged many medical reforms, on the advice of the PCMO. The number of doctors increased, and the system of classification was changed. Although there were two Colonial Surgeons attached to the Medical Department, the new reforms were aimed at reducing the higher-class appointments and increasing the number of subordinate officers. This meant a decrease in the employment of higher-paid European doctors and a bigger intake of lower-paid Sri Lankan sub-assistant surgeons (Doctors).

In 1893, PCMO, Dr W.R. Kynsey, put forward a scheme for the unification of the Civil and the Estate branches of the Medical Department, and it was approved by the British government. With this new arrangement, Deputy Assistant Colonial Surgeons (Doctors) were attached to plantation districts as District Medical Officers. At the beginning, only those with a British qualification or a higher Indian qualification were eligible to get into this grade, but later their requisite qualification was amended to include a license from the Ceylon Medical College or an Indian Medical College.

During the Colonial period, the British were keen on developing Plantation District Hospitals as to provide the medical services required by the Indian laborers who served in Plantations owned by the British. These Indian origin laborers were originally located at Nilgiri Hills of South India (at the tri-border of Tamil Nadu, Kerala, and Karnataka States of South India). They were taken to Rameshwaram by train and then to Thalai Mannar by ship. From Thalai Mannar to up-country plantations of Sri Lanka, they had to walk due to the non-availability of transport services during those days. As a result of this long journey by foot, many of them became ill, and these Plantation District Hospitals were the places where, these sick Indians obtained

treatment. The Colonial Government approved a special Act named the Medical Wants Ordinance, the CEO of the plantation had to allocate Rs 3.25 annually per Indian Labouer for health needs, and the DMO had to send the invoice to the Superintendent of the estate requesting payments for the medical services offered at the District Hospital for the resident Indian Labourers of the Estate.

During the Second World War, the British used this island in the Indian Ocean – Ceylon as one of their best Military reserves; and Camps were established at certain places as Base Camps for their reserve of African soldiers. The hospitals created for the use of the Military–reserve were named Base Hospitals (BH).

Shortly after the Second World War, the entire Medical Department was staffed by Sri Lankans, but the existing District Hospitals were mainly providing health services to the British planters and their resident Indian laborers in the estates. The medical services provided for the local village population were extremely insufficient. To address this gap in medical services, the Colonial Government of Ceylon introduced the Visiting Dispensary service in remote rural regions of the catchment area of each plantation District Hospital.

A doctor from Kandy, who had to attend such a Visiting Dispensary service, wrote to "The Lancet" on 30th September 1877, giving a graphic description of the travails of a District Medical Officer of His day. "The roads, as a rule, are very bad, and severe upon both horse and rider, over most of these, anything but a walking pace is impossible. Owing to the size of the districts (twenty five to thirty in diameter) the district surgeon (doctor) is compelled to remain away from home two or three nights at each week, and is fortunate indeed if he gets a bed to sleep on; but in most instances will have to be content with a sofa, and exposure all night to the attacks of mosquitoes."

As such, the Visiting Dispensary service was not capable of providing emergency services in these remote rural regions. The Colonial Government later established Maternity Homes (MH), the Central Dispensaries (CD), and in certain places the amalgamated model, which was designated as the Central Dispensary & Maternity Home (CD & MH).

In addition to providing the aforementioned system of curative services, the Colonial Government made a significant change in 1926 by initiating an organized form of Preventive Health service. The establishment of the Health Unit system in 1926 was a major advancement in the field of Preventive health services in Sri Lanka. Till then, assistant sanitary officers were responsible for large districts. Their work was centralized to the urban areas, while the rural sector was largely neglected. The first Health Unit in Sri Lanka, or for that matter in Asia, was established in Kalutara in July 1926. Health Units in Sri Lanka undertook the usual duties of a public health department in a tropical country, including health education, general sanitation, collection of vital statistics, study and control of preventable diseases, vaccination, maternal and child health, and school medical inspections. The second Health Unit was set up in "Weudawili Hathpattu" in Northwestern Province in November 1927. and the third in Matara in May 1928. At present, the name of these Health Units has been changed as the Office of the Medical Officer of Health (MOH), and such MOH divisions have been established in each of the administrative divisions (Divisional Secretary areas) of the country.

Post-Independence Reforms

After the Independence (1948), the successive Sri Lankan Governments identified the deficiencies of Curative Services at locations distant to existing Base Hospitals (BH) and District Hospitals (DH) and therefore developed an intermediate model of hospitals named as Peripheral Units (PU) for these distant locations (Peripheral Hospitals). At the same time, most of the existing Maternity Homes (MH) and the existing Central Dispensaries & Maternity Hospitals (CD & MH) were developed into Rural Hospitals (RH), considering the three A principle (Accessibility, Availability, and Attentiveness).

According to the Recategorization of Hospitals, the aforementioned BH are now classified into two categories according to the number of service provision units (BH–A and BH–B). The DHH, PUU, and RHH are given a new name as Divisional Hospitals and classified according to Bed Strength as DH–A, DH, B, and DH–C. However the DH , PU , RH system and the modern version of medical administration of it ; namely the Divisional Hospital system (with the upgraded CD as Primary Medical Care Units – PMCU) remain as the Primary Level Curative Care institutions of the country . It is also noted that ; in addition to BH of Colonial era , certain large DH had been upgraded to the state of BH

during the post-independent area . Such medical administrative reforms were implemented to provide a better coverage by specialty clinical services throughout the country (Secondary Level Curative Care Institutions)

Legal and Administrative Frameworks

The most important decision taken by the first Sri Lankan Government after Independence was to invite the Director General of Health Services of Australia to design a suitable Health Administrative System for Sri Lanka. This was the first attempt in the history of Sri Lanka to analyze the available service components to design better health futures. This report has been named as the 'Cumpston Report 'as it was prepared by the late Dr. J.H.L. Cumpston (C.M.G, M.D., D.P.H), the Director General of Health Services of the Government of Australia in February 1950 (printed by the order of the Government at the Government Press).

The Legal framework of the Health System of Sri Lanka is based on this report. The following are the major recommendations of the Cumpston report.

1. Establishment of a separate department titled as Department of Health.
2. The ultimate highest authority of the Department of Health should be a medical man, designated as the Director of Health Services (DHS).
3. The Department of Health should consist of three divisions: Medical Services, Preventive Services, and Laboratory Services.

The Act of Parliament No. 12 of 1952, "The Health Services Act," was prepared to the aforementioned recommendations of the Cumpston report. Vide section 2. (1) The Department of Health has been established; and vide section 3. (1) the Head of the Department is appointed from the medical profession with the designation of Director General of Health Services (DGHS). Section 3.(1) further describes the legal framework of the Department of Health , and it is as follows (a) A person to be or act as the Director of Health (DHS) ; (b) A person to be or act as the Deputy Director (Medical Services) ; (c) A person to be or act as the Deputy Director (Preventive Services) ; (d) A person to be or act as the Deputy Director (Laboratory Services)

However , as at present, the Department of Health has been absorbed into the Ministry of Health, but it is not possible to trace any such Amendment to the Act of Parliament No. 12 of 1952 – The Health Services Act.

Modern Developments in Medical Administration

Other than the aforementioned Legal procedures, a Health Policy had not been formulated for the next forty years (40 years from 1952 to 1992). However, the Ministry of Health has expanded its internal organization over the decades to undertake the ever-increasing workload efficiently. The Medical Services Division (of Cumpston Report) has been divided among Deputy Director General (Medical Services) I and II, with Directorates of Tertiary Care Services, Medical Services, and Primary Care Services. For Dental Services, a Deputy Director General and a Directorate of Dental Services have been established. The Laboratory Services Division (of the Cumpston Report) is manned by a Deputy Director General with a Directorate of Laboratory Services. The Preventive Service Division of Cumpston's report has the most ramifications at present. Deputy Director General (Public Health Services) I; for Surveillance Services with Units such as Epidemiology Unit, Quarantine, Malaria, Leprosy, Filariasis, Dengue, STD & HIV, Tuberculosis, Rabies, etc. Deputy Director General (Public Health Services) II, for Preventive Programmes with Units such as Family Health Bureau, Health Promotion Bureau, Directorates of the Health of Youth, Elderly, Disabled, etc. A separate division for Management Development & Planning has been created (MDPU) with a Deputy Director General (Planning) and Directorates of Planning, International Health, etc. To facilitate the development of the health workforce, a separate division has been created as Education Training & Research (ETR) with a Deputy Director General (ET& R) and Directorates of Training, Research, etc. All the aforementioned posts are manned by Medical Administrators with postgraduate qualifications. The Medical Services Minute has stipulated the relevant Post Graduate qualifications required for the respective posts.

In the 1980's the Department of Health introduced a new Health Administrative system identified as the DHO system. In response to the WHO – Alma-Ata – Health for All policy, and with funds from the WB – IDA project, certain District Hospitals were developed as Divisional Health Centre (DHC) and the DMO was designated as the Divisional Health Officer. Certain satellite small hospitals

(PUU & RHH) were developed into Sub Divisional Health Centres (SDHC). The DHO had to function as the administrative head of DHC and satellite SDHC of the demarcated area (It is necessary to note that Preventive Services of the demarcated area, including the staff and functions of the MOH, came under the purview of the DHO). But due to a lack of experienced staff, this Health System ceased to function after a few years.

Considering the Evolution of Medical Administration in Sri Lanka, one of the major steps taken is the establishment of a General Hospital (GH) in each district in the country (Tertiary Level Curative Care Institutions). These General Hospitals consisted of several clinical disciplines and functioned as the apex hospital or the key referral centre for the smaller hospitals of the district. But depending on the geographical location of these GH, and the availability of public transport to and from GH, the patients of the surrounding districts, too obtained treatment from these GH irrespective of their permanent residence in adjoining districts (as any patient in the country is free to obtain treatment at free of charge from any hospital of the country) With the establishment of Provincial Councils under the 13th Amendment of the Constitution, the GH of main city of the Province was designated as the Provincial General Hospital (PGH) and the GH of other districts of the Province ware designated as the District General Hospitals (DGH). As new Medical Faculties were created at certain locations, the relevant PGHs were developed with Professorial Clinical Units and designated as Teaching Hospitals (TH). All these hospitals (Including Special Hospitals for Women, Children, Dental Services, Mental Health, Eye Care, etc) are manned by Medical Administrators viz, Hospital Directors and Deputy Directors.

The National Health Policy of 1992 had identified many policy issues about Sri Lankan Health Sector, but the main focus was to decentralize the Health system from District Level to Divisional Level by introducing a new Health Administration system at Divisional Level (Divisional Director of Health Services – DDHS) which is in par with 13th Amendment to the Constitution of Sri Lanka (1987) which introduced the devolution of power to the Provincial Council System. However, the DDHs system failed, and the main reason for failure was the non-availability of experienced medical administrative staff at most of the newly created DDHS areas (At most of the places the MOH office was changed as the DDHS office, the MOH became the DDHS after a short training, but the DMOO of the hospitals of the DDHS area were much senior to the newly designated DDHS, and the change in administration from RDHS at District level, down to the DDHS at Divisional Level led to much confusion confrontation and communication issues. It is interesting to compare the rise and fall of the DHO system and the DDHS system.

As experienced from the issues of the DHO system and DDHS system, the Ministry of Health decided to create a postgraduate course of study for medical officers to obtain academic qualifications in Medical Administration. The curriculum of this post graduate course of study had been designed in par with international standards of Health Administration and to award PG degrees of M.Sc. and M.D after successful completion of the stipulated curriculum (which included a period of overseas study of one year for M.D. trainees in Internationally accredited Hospitals and Health Systems) Accordingly the Post Graduate Institute of Medicine of the University of Colombo, commenced the programme with first batch of M.Sc. students (selected after a screening test) in 1996

As a result of the 13th Amendment of the Constitution of Sri Lanka, the centralized Medical Administration was devolved to a certain extent to the provinces by creating a post of Provincial Director of Health Services (PDHS) for each of the Provinces in Sri Lanka. According to the duties and responsibilities stipulated for the PDHS, he/she has to report to the Central Government (DGHS and DDGs of the National Health Ministry) and also to the respective Provincial Council (Secretary of the Provincial Health Ministry). To accommodate the existing Medical Administration in the Districts, which has the designation as Regional Directorate of Health Services (RDHS), was renamed as Deputy Provincial Directorate of Health Services (DPDHS). But sometimes later, it was renamed again as the RDHS (and in certain places, the designation of District Directorate of Health Service is also used).

Another milestone of Medical Administration in Sri Lanka is the creation of a Deputy Director General Post as the head of institution with the upgrading of Colombo General Hospital as the National Hospital of Sri Lanka (NHSL) Later the General Hospital – Kandy and General Hospital – Karapitiya (Galle) have been upgraded as National Hospital – Kandy and National Hospital – Galle and requisite qualification for the respective heads

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The Government in 1994 appointed a committee to revise the National Health Policy of 1992 and formulate a new National Health Policy. Accordingly, the new National Health Policy was prepared and approved in 1996. Both of the National Health Policies (1992 and 1996) were instrumental in Re-structuring of Health System & Medical Administration by creating new Directorates at the National Ministry of Health, such as Organization Development, Policy Analysis & Development, Health Information, Health Quality and Safety, Disaster Preparedness & Response, Health Research, Private Health Sector Development, Estate & Urban Health, Mental Health, Non Communicable Diseases, Environment & Occupational Health, etc.)

However, the Medical Services and Laboratory Services (designed by the Cumpston report) remain without much expansion. (when compared to the present expansion of the Planning and Preventive Divisions of the Ministry of Health Sri Lanka) The National Health Policy 2016 – 2025 has proposed major reforms to the health system in the document titled "National Health Strategic Master Plan 2016 – 2025 Volume V – Section on REFORMS.

For the first time in Sri Lanka, the National Health Policy 2016 – 2025 with linked National Health Strategic Master Plans 2016 – 2025 Vol I (Preventive Services), Vol II (Curative Services), Vol. II (Rehabilitative Services) and Vol. IV 9 Health Administration and Reforms) have been approved by the Cabinet of Ministers of the Government of Sri Lanka on 18th July 2017 (Reference No. Cabinet Decision 17/17/1366718/084) One of the reforms proposed by the aforementioned National Health Policy 2016 – 2025 and the Master Plan linked is the creation of a NCD Bureau under a Deputy Director General (NCD) which has become a reality now. The present-day Medical Administrators have to implement the REFORMs approved to create a better Health System.

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