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Understanding the Sri Lankan Patient Psyche and Health Pluralism — A Strategic Imperative for Health System Leaders

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Abstract

The Sri Lankan government healthcare system is currently facing a "double burden" of disease and a demographic shift that threatens to overwhelm its capacity. While the system is technically robust, it faces mounting pressure from complex patient health-seeking behaviours that often appear irrational to the biomedical administrator. This perspective article argues that medical administrators and policymakers must look beyond the formal allopathic health system to understand the deep-rooted sociocultural factors—or the "patient psyche"—that govern decision-making. We synthesize recent evidence, including the 2025 "Ecology of Healthcare" study in Gampaha, through the lens of Arthur Kleinman's framework of health pluralism. Evidence suggests that while symptom prevalence in the community is high (93%), only a minority (45%) seek professional care, with a distinct preference for private services for outpatient interactions despite the availability of free state care. This reveals a patient who acts as a savvy consumer, balancing free allopathic care with traditional systems and a willingness to pay for a "humane" experience. We conclude by offering strategic imperatives for health leaders: to humanize the patient experience, to engage openly with medical pluralism for safety, and to invest in "digital listening" to build a people-centric health system that survives the challenges of the next decade.

Key Words: *health pluralism, health-seeking behaviour, patient experience, Sri Lanka, health administration*

Introduction

The Sri Lankan health system has long been the envy of the developing world. Built on a foundation of universal free access, it has achieved indicators in maternal and child mortality that rival high-income nations. Yet, for the modern medical administrator sitting in a Provincial Directorate or a hospital boardroom, these historical accolades offer little comfort against the daily reality of the present. Our Out-Patient Departments (OPDs) are not just busy; they are besieged. The increasing burden of NCDs suggests that demand for outpatient care will continue to rise, further straining an already congested system [1].

However, the "crowded OPD" is only one visible symptom of a much more complex ecosystem. We often observe behaviours that seem puzzling from a purely logistical standpoint. Why do patients bypass a functional Primary Medical Care Unit (PMCU) to wait six hours at a Tertiary Hospital for a simple fever? Why do low-income earners, who can barely afford daily essentials, bypass the free government dispensary next door to pay 1500 rupees at a private GP practice? And perhaps most critically, why do our patients nod compliantly when we prescribe antihypertensives, only to go home and secretly supplement them with herbal decoctions (*kasaya*) suggested by a neighbour?

These behaviours are not "irrational." They are the logical outcomes of a decision-making process deeply embedded in Sri Lanka's unique sociocultural fabric [2]. For too long, health administration in Sri Lanka has been "facility-centric"—focused on beds, drugs, and cadres. We have largely ignored the "person-centric" reality: the complex psychological and cultural journey the patient takes before they ever step foot in our institutions.

This perspective article synthesizes recent evidence on health-seeking behaviour to argue that a profound understanding of **health pluralism** is no longer an academic exercise for sociologists. It is a core competency for modern health administration. By applying Arthur Kleinman's explanatory models [3] to recent local data, we can chart a roadmap for a health service that is not only clinically efficient but culturally resonant.

A System in Transition: The Mismatch

Before dissecting the patient's psyche, we must contextualize the arena in which they seek care. Sri Lanka is grappling with a difficult "double burden." On one hand, the tide of non-communicable diseases (NCDs)—diabetes, hypertension, ischaemic heart disease—has become the primary driver of morbidity and mortality [4]. On the other hand, the threat of infectious diseases like dengue requires unwavering vigilance.

Simultaneously, our successes in Maternal and Child Health (MCH) have birthed a new challenge: a rapidly ageing population. We have reached a fundamental architectural mismatch. The Sri Lankan health system was designed for the 20th century—to treat acute infections and deliver babies. It is an episodic care model. However, the

21st-century patient suffers from chronic conditions requiring lifelong management, lifestyle modification, and sustained engagement.

Continuing to operate this outdated framework is financially unsustainable. We are trying to manage 2025's problems with 1980's tools. The imperative for today's health leader is to ask: *How do we adapt?* The answer lies not just in new buildings, but in a new philosophy that understands where our patients actually are.

The Three Sectors of Health: A Sri Lankan Lens

To comprehend the patient's journey, we must accept a humbling truth: the hospital is often the last stop, not the first. Kleinman's model postulates that healthcare in any society is a composite of three overlapping sectors: the **Popular**, the **Folk**, and the **Professional** [3].

1. The Popular Sector: The "Hidden" Giant

This is the lay, non-professional domain consisting of the individual, the family, and the community. It is the largest and most influential sector, yet it appears in almost no Ministry of Health annual reports. In Sri Lanka, the "popular sector" is where the diagnosis is actually made. When a child develops a fever, it is the grandmother who decides if it is "heatiness" (*ushna*) requiring a cooling food, or "illness" requiring a doctor. Today, this sector has been supercharged by technology. The "village well" has been replaced by the WhatsApp group. A patient entering our OPD today has likely already consulted "Dr. Google" or seen a Facebook post about the side effects of statins. This digital layer provides unprecedented access to information (and misinformation), empowering patients but creating friction with providers who are used to unquestioned authority.

2. The Folk Sector: The Enduring Role of Tradition

This sector comprises traditional healers, religious rituals, and spiritual interventions. In many Western nations, this is a fringe alternative. In Sri Lanka, it is a parallel mainstream [5]. Concepts of *Deshiya Chikithsa* and Ayurveda are woven into the national consciousness. It is not uncommon for a patient to view a stroke not just as a blood clot (biological) but as a karmic or energetic imbalance. These healers offer something the biomedical consultant often does not: a culturally resonant explanation for *why* the illness happened, and a remedy that feels "natural."

3. The Professional Sector: The Official Silo

This is our domain—the allopathic system and professionalized Ayurveda. It is governed by scientific theory, hierarchy, and legality. A critical disconnect arises when we, as administrators, view this sector as the *only* legitimate source of care [6]. We tend to view the other two sectors as obstacles to be overcome ("ignorant patients" or "quacks"), rather than powerful forces to be engaged with.

What the Data Tells Us: The Savvy Consumer

This theoretical framework is not just abstract philosophy; it is supported by hard data. The recent "Ecology of Healthcare" study by Withana et al. (2025) in the Gampaha district provides a granular snapshot of the modern Sri Lankan patient [1]. The findings are a wake-up call for administrators.

The "Iceberg" of Illness

The study revealed an extremely high sensitization to illness. Over 93% of the population reported at least one symptom over a one-month period. However, of this vast number, only 45.1% sought treatment from a healthcare institution [1]. The majority (54.9%) managed their condition entirely within the **Popular Sector**—through self-treatment, home remedies, or advice from family. This single statistic is vital. It proves that the "Popular Sector" is the primary filter of our health system. If this filter fails—if people stop self-managing minor ailments—our hospitals will collapse within days.

The Vote for "Experience"

For those who did seek professional walk-in care, the data shows a clear preference: 55.7% chose the private sector, compared to 35.7% for the free public sector [1]. Why would a patient in an economic crisis pay for something they can get for free? The literature suggests the decision is not about clinical quality. Studies consistently show that public and private sectors in Sri Lanka perform similarly on technical clinical quality [7]. The difference lies in the **non-clinical experience**. Patients in the private sector receive longer consultations, more explanations, and higher interpersonal satisfaction [8]. They are paying for dignity. They are paying to be listened to. In the public sector, the "price" is free, but the "cost" is often long wait times and a perceived lack of empathy from overworked staff.

The Inpatient Reversal

However, the data reveals a fascinating reversal when the illness becomes serious. Over 91% of hospital admissions were to public hospitals [1]. This reveals a highly pragmatic, savvy patient psyche. They prefer the private sector for the convenience and comfort of minor outpatient care,

but they implicitly trust the state sector for serious, high-tech, inpatient treatment. They know the state has the best specialists and equipment. They just don't like the "front door" experience.

Strategic Imperatives for the Modern Administrator

Understanding this psyche changes the job description of the medical administrator. We can no longer be mere logisticians of medicine; we must be designers of care systems.

1. Compete on Experience, Not Just Price

The exodus of outpatient care to the private sector is a market signal we cannot ignore. It is a critique of our service delivery model. While we cannot easily reduce patient numbers, we can innovate the **process**. Administrators must champion low-cost, high-impact interventions.

- *Queue Management***:** Why must patients stand in physical lines for hours? Digital token systems or simple tiered seating can reduce the physical strain of waiting
- *Frontline Soft Skills***:** The security guard and the admission clerk are the "face" of the hospital. Investing in their training—teaching them to de-escalate anxiety with empathy rather than authority—can do more for patient satisfaction than buying a new MRI machine.
- *Dignity by Design***:** Simple changes, like ensuring privacy screens are actually used and that doctors introduce themselves, re-establish the human connection that patients crave.

2. Operationalize Pluralism for Safety

Ignoring the "Folk Sector" is dangerous. We know patients use traditional remedies alongside western drugs. A patient on Warfarin may be taking a herbal decoction that increases bleeding risk, but they will never tell their consultant because they fear being scolded. We must move from a policy of "don't ask, don't tell" to one of open dialogue. Administrators should train clinicians to ask a simple, non-judgmental question: *"What other remedies or supplements are you using for this condition?"* The goal is not to endorse unproven therapies, but to ensure patient safety. By acknowledging the patient's pluralistic reality, we build trust. When a doctor says, *"I understand you want to take the herbal medicine, but please stop it for three days while we give this antibiotic so they don't react,"* the patient is likely to comply. If the doctor simply says *"Stop all that rubbish,"* the patient will likely stop the antibiotic instead.

3. Rebrand Primary Care: The HLC Opportunity

The data shows that 54% of people self-manage symptoms [1]. This indicates a readiness to use accessible, local care. Yet, our Primary Medical Care Units (PMCUs) and Healthy Lifestyle Centres (HLCs) are often bypassed. We need to reposition the HLCs. Currently, they are viewed as "screening centres" for the sick. They should be rebranded as "Wellness Hubs" for the community—the first trusted point of contact. This requires a shift in hours (opening evenings/weekends for working populations) and a shift in attitude. If primary care can capture the "minor ailments" currently clogging tertiary OPDs, the system efficiency gains would be immense [9].

4. Listen to the "Digital Popular Sector"

Finally, health leaders must enter the 21st century of surveillance. The "Popular Sector" is now online. Administrators should invest in "Digital Listening." This does not require expensive software; it requires a designated officer to monitor public social media chatter, local community groups, and search trends. Are people in the district complaining about a rude staff member? Is there a rumour spreading that the local hospital has run out of insulin? Is there a surge in posts about "fever remedies"? This real-time intelligence allows administrators to be proactive—to issue clarifications, to restock drugs before a panic starts, and to address service gaps before they become newspaper headlines.

The Implementation Gap: A Note on Reality

It is easy to write about "empathy" and "patient-centricity" in a journal; it is much harder to implement it in a peripheral unit with understaffed cadres and limited budgets. Staff burnout is the single biggest barrier to this vision. Asking a medical officer who has worked a 24-hour shift to "smile more" is not leadership; it is disconnect. Therefore, the shift towards a people-centric system must start with staff-centricity. Administrators must ensure that the basic needs of their teams—rest, safety, and recognition—are met. A cared-for staff member is the only one capable of caring for a patient. The "patient experience" and the "employee experience" are mirror images.

Conclusion

The Sri Lankan patient is not a passive recipient of state benevolence. They are active, discerning navigators of a vibrant and complex healthcare marketplace. Their journey is shaped by the wisdom of their grandmothers, the discussions in their WhatsApp groups, and a pragmatic assessment of a dual-track professional system.

To continue providing "good health at low cost" in the face of the NCD tsunami, medical administrators must evolve. We must become sociologists as much as managers. We must realize that our competition is not the private hospital

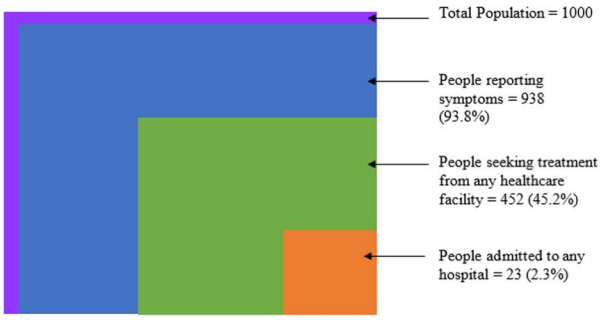

Figure 1: From: Ecology of healthcare in an urban and rural area of Gampaha district of Sri Lanka: a community-based prospective study on symptom prevalence and healthcare utilization

down the road, but the misinformation on a smartphone and the silence of a patient who does not trust us enough to tell the truth.

By understanding the deep-seated psyche of the people we serve, we can build a public healthcare system that is not only clinically excellent but profoundly human. That is the only way to turn the "crowded OPD" from a crisis into a community.

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