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*Editorial*

# Strengthening Primary Care in Sri Lanka: Lessons from Recent Health System Strains

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Primary care is widely recognised as the foundation of resilient and equitable health systems. Sri Lanka's publicly funded healthcare model has long been celebrated for its achievements in maternal and child health, infectious disease control, and community-based prevention. However, pressures in recent years, including the flooding, COVID-19 pandemic, recurrent outbreaks of dengue and influenza, shortages of essential medicines, demographic transitions, and macroeconomic instability, have exposed significant vulnerabilities within the primary care system. These stresses underscore the need for a renewed strategic focus on strengthening primary care as a national priority.

Sri Lanka now faces a dual burden of disease characterised by rising noncommunicable diseases (NCDs) alongside persistent infectious threats. NCDs account for more than 80% of total deaths, reflecting late diagnosis, limited preventive engagement, and fragmented long-term management at the community level [1]. Simultaneously, outbreaks of dengue, influenza, and leptospirosis continue to recur annually, placing repeated stress on hospital-based services [2]. With an ageing population and increasing multimorbidity, Sri Lanka requires a primary care system capable of both proactive chronic disease management and rapid public health response.

Despite this need, many citizens bypass primary medical care institutions (PMCIs) and seek treatment directly at secondary or tertiary hospitals. This behaviour is partly driven by limitations in diagnostic capacity, inconsistencies in medication availability, and perceptions of higher-quality care in hospital settings [3]. The result has been chronic overcrowding in outpatient departments, reduced efficiency of specialist services, and diversion of resources away from complex care.

A major structural limitation is the insufficient development of continuity-based, person-centred primary care. PMCIs often function as facilities for episodic treatment rather than for ongoing management, preventive care, and coordinated follow-up. For chronic diseases, this reduces opportunities for regular review, education, and lifestyle counselling that are the core functions of effective primary care [4].

The absence of interoperable electronic health records further undermines continuity. Fragmented medical information leads to repeated investigations, weak referral feedback, and loss of longitudinal data. Strengthening referral pathways with reliable two-way communication between PMCIs and hospitals remains essential for integrated care delivery.

Human resources remain a determinant of system effectiveness. Many primary care facilities experience shortages of medical officers, nurses, and allied health workers, particularly in rural regions [5]. Recent migration of health professionals has intensified staffing gaps and threatens long-term system stability.

Developing a competent and motivated primary care workforce requires targeted investments in training and professional pathways. Family medicine, in particular, must be strengthened through expansion of postgraduate programmes, structured career progression, and incentives for rural service. International evidence demonstrates that strong primary care relies heavily on well-trained generalists supported by multidisciplinary teams [6].

The economic crisis underscored vulnerabilities in the procurement and distribution of essential medicines. PMCIs were among the most affected, disrupting NCD management and basic acute care. Ensuring supply chain resilience through diversified procurement mechanisms, adequate buffer stocks, and improved logistics systems is critical [7].

Enhancing diagnostic capacity at primary level is equally important. Dependence on hospital-based laboratory services delays care and contributes to hospital overcrowding. Expanding point-of-care testing and upgrading selected PMCIs into diagnostic hubs

could significantly improve access, early detection, and system efficiency.

Digital health presents an opportunity to strengthen integration and continuity of care. Electronic health records, e-prescriptions, appointment systems, and teleconsultation platforms have shown promise in improving coordination, reducing duplication, and enhancing follow-up for chronic diseases [8]. For Sri Lanka, digital initiatives must be phased, interoperable, and inclusive, ensuring that underserved communities are not further marginalised. Robust governance frameworks are essential to safeguard privacy and data security. The DIGIPATHS project aims to improve care for people living with multiple chronic conditions by developing and implementing Digitally Integrated Care Pathways that incorporate electronic health records, a clinical decision support tool, automated feedback mechanisms, and a patient-facing application to support integrated, continuous care. This collaborative initiative is led by the University of Birmingham in partnership with the University of Jaffna, the University of Edinburgh, the University of Leicester, and Sri Lankan institutions including the University of Kelaniya, University of Colombo, Sabaragamuwa University of Sri Lanka, and the Ministry of Health.

Technical reforms alone cannot strengthen primary care without parallel efforts to rebuild public trust. Health-seeking behaviour is strongly influenced by perceptions of quality, timeliness, and respectfulness of care. Enhancing patient experience, including reduced waiting times, consistent service availability, and better communication, will be essential in increasing utilisation of PMCIs.

Community health workers, particularly public health midwives and public health inspectors, remain critical connectors between households and formal health services. Greater integration of these cadres into primary care pathways could enhance preventive outreach, early detection, and follow-up.

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