

Elective report

### **Common surgical conditions seen in an urban Sri Lankan hospital and their context within Global Health**

During my time at Sri Jayawardenapura Hospital I saw a range of conditions, similar to those seen in UK hospitals, e.g. appendicitis, bowel obstruction, cellulitis, renal colic and calculi, breast masses, abscessed and cholecystitis. The difference was in the incidence of these conditions, where I saw a surprisingly large number of thyroid goitres in the surgical outpatient clinics and presenting to wards for surgery; varicose veins, which I've seldom seen presenting to surgical outpatients, but more commonly seen in primary care and referred directly to a Vascular surgeon for less invasive procedures. I also saw a relatively large number of patients presenting with renal colic and scheduled for nephrolithotomies. One compounding factor for the difference in the incidence of these conditions in UK hospitals may actually be the way the UK healthcare system is organised, rather than a true difference in incidence in the population. In the UK every condition is seen by a primary care physician, a GP, and then referred to secondary/tertiary care, a Specialist Consultant, if required. A more direct approach is acute admission to hospital and intra-hospital referral. In Sri Lanka, although a GP counterpart exists, called a Peripheral Unit or Dispensary, people seldom visit those, choosing instead to come directly to hospital to be seen. There are also few Specialists, so General Surgery is still very general, encompassing vascular, breast, endocrine, urology and gastrointestinal surgery. So any patient presenting with a problem that is not medical will be seen by a Surgeon. This may explain why there were more goitres, which would normally be seen by Endocrinologists in the first instance in the UK, and renal stones, normally seen by Medics and referred to Urologists.

However, it may also reflect a true higher incidence, as literature searches revealed that in the past there was an up to 40% prevalence of endemic goitres, which after the introduction of iodised salt decreased to 4.4% (2010 data). However, the same source states that only 68% of households use iodised salt, so the remaining households may be contributing to the high prevalence seen in the clinics (Department of Nutrition, 2011). It is difficult to find similar statistics for the UK population, but the British Thyroid Foundation states that 1 in 20 people will have a thyroid disorder in their lifetime, amounting to 0.05% of the population.

The other common presenting problem I noticed on the wards is nephrolithiasis. There are no official figures for Sri Lanka, however extrapolating from Asian populations it is estimated to be 2-5%, similar or even lower than figures from the West (Trinchieri, 2008). However noting the hot climate in this part of the world, and possible resultant dehydration it may be a bit more prevalent here.

### **The pattern of healthcare provision and structure in Sri Lanka compared to the NHS.**

Healthcare is provided free of charge in National Hospitals in Sri Lanka, serving the poorest of the population. However, as low-income families comprise the majority of the population of the country, these resources are much in demand. Those from the middle-classes upwards, who can pay for healthcare are served by private hospitals, and as they are paying for everything, their ceiling of care can thus expand. Sri Jayawardenapura is something in between these two systems, where patients pay for care, however at Government-subsidised rates of up to 30-50% less than private hospital care. This hospital is therefore better equipped than a National Hospital with better facilities, and a better ratio of healthcare provider to one patient.

It is interesting to see how provision of care changes when the money for that care comes from a different source, in this case, the patient's own pocket. In the NHS care is provided free of charge to the patient, although the taxpayer pays a part of it, therefore the onus to provide the highest standard of care, and to not miss anything lies with the NHS, and if some investigations were not done then it would be seen as malpractice and negligence. At Sri Jayawardenapura only the most necessary tests and investigations were done with careful consideration of the patient's budget and ability to pay, as the ultimate decision to comply with investigations, and sometimes even treatment, falls on the patients willingness to pay for these. So for example, a simple urine dipstick test, which in an NHS hospital is carried out on pretty much all patients that come in, especially the Elderly, is seldom done here due to cost. Similarly, when checking thyroid function, only TSH is requested in most cases, and the full barrage (free T3 and T4) are only requested in special cases, whereas in the NHS 'Thyroid Function Test' nearly always includes these parameters. On the one hand, practicing medicine on a budget makes you really evaluate your reasons behind every test to ensure you're ordering the right ones, as a result making you a better physician, and I predict this will be a valuable skill to hone in the coming years working in the NHS too, with its ever-tightening budget. However on the other hand, it feels quite restrictive, and I couldn't shake off the fear that we might miss something, or more importantly, the discomfort of knowing that money is dictating how much care we provide. Ultimately though, resources are finite even in the most developed countries, and money unfortunately will always dictate healthcare provision, and this three-tier system of having private hospitals, Government-subsidised hospitals and those that are completely Government-funded at least provides access to healthcare to even the most poor and vulnerable, while allowing those who can afford it, to pay for it themselves and relieve the burden on the National Hospitals.

## References

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