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## Sri Lanka

### Technical support to the development of national health financing strategy for universal coverage and social health protection

Report of a scoping mission<sup>1</sup>, 19-22 October 2010

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## 1 About the mission

### 1.1 Context

Sri Lanka is regarded as having one of the better performing health systems especially in the developing world. Higher health care coverage than expected for its income and health expenditure, and very effective preventive service delivery have resulted in impressive reductions in morbidity and mortality rates and significantly increased life expectancy in the past several decades. However, there are challenges in sustaining and continuing such health status improvements. Access deficits are apparent in the content of services, especially in outpatient care and in the care of non-communicable diseases; the growing contribution of out-of-pocket spending to the total health expenditures, particularly for drugs and investigative services unavailable in the public facilities is a sign of the gaps in coverage. There are also geographical inequities in access; areas affected by conflict and populations residing in plantation areas, particularly the workers in tea plantations and their families, require further attention. Specific challenges lie in addressing higher and expensive health care needs of the population as a result of demographic transition (ageing), epidemiological transition (shift to greater burden of non-communicable diseases (NCD)), middle-income country transition, resulting in probable increase in health care seeking and increased expectations about quality of care.

Improvement of the national health financing system is one of the strategic objectives to improve health status and reduce inequalities when addressing the new challenges of economic, epidemiological, social and demographic transitions in Sri Lanka. With a view to developing the national health financing policy for Sri Lanka, a Steering Committee was established. The Committee, chaired by the Secretary (Health), comprises of representatives from the Treasury and National Planning, Central Bank, Finance Commission (FC), the Ministry of Health (MoH), Development Partners and academia. As directed by the Steering Committee, several research studies in the area of health financing were completed in 2009. A **consultative seminar**, supported by the World Health Organization (WHO) and the World Bank (WB), through the Providing for Health (P4H) initiative, was held in Kandy from the 29<sup>th</sup> April to the 1<sup>st</sup> May 2010 to discuss possible options for reforming of the national health financing system. This was followed by Sri Lankan participation in a **South Asia Regional High Level Forum on Health Financing**, organized by the World Bank in the Maldives from the 2<sup>nd</sup> to the 4<sup>th</sup> June, 2010. The current scoping mission is a natural follow-up from the constructive dialogue that took place between P4H partners and Sri Lankan officials.

In both consultations, concerns were expressed particularly about the increasing share of household out-of-pocket spending, which has been consistently above 40% of the total health expenditure during the last decade and is currently estimated at 51%. On the other hand, government's health expenditure has declined from 2.1% of Gross Domestic Product in 2006 to 1.5% in 2009. Recommendations of the two seminars included a critical review of the existing evidence and obtaining further evidence not only on the size and nature of the out-of-pocket spending but also on possible financing options which could help mitigate the impact of out-of-pocket spending on the poor and disadvantaged populations. Another important issue raised at the consultations was that of fiscal space constraints to meeting Sri Lanka's aspirations for a health system fit for a middle-income country, given the very high likelihood that future costs of health care would be much higher than at present (to manage NCDs, to improve quality and to meet the expectations of the citizenry). It was acknowledged that the first step to address the fiscal space constraint would be to squeeze efficiencies from the current system.

The recommendations from the workshops also highlighted the importance of considering both demand and supply side factors. However, policy changes required to address health financing should be based on further evidence, advocacy and a critical examination of the feasibility of change, including the political economy. P4H appears ideally suited to support Sri Lanka in the analytical work, pilot testing, and consultative process needed.

## 1.2 Request from MoH

In this context, MoH requested P4H in September 2010 to provide technical support for the development of a national health financing strategy to meet the challenges faced by Sri Lanka in achieving universal coverage (UC) and social health protection (SHP).<sup>2</sup> In response to that request, the first P4H (scoping) mission was conducted from the 19<sup>th</sup> to the 22<sup>nd</sup> of October 2010.

## 1.3 Objectives of the mission

The overall objective of the visit was to assist the Government of Sri Lanka in the process of developing a national health financing strategy for universal coverage and social health protection. Specific objectives were

- To arrive at a common understanding of the expected support from P4H
- To develop a road map for joint technical support from P4H partners for the development of the country's road map for the development of the national health financing strategy

## 1.4 Methods

In order to achieve the mission objectives, the following areas were discussed and clarified:

- Stocktaking of previous works and processes concerning health financing, UC and SHP
- Expectations and technical support needs of Sri Lanka, and how the requested support relates to the broader goal of reaching universal coverage and social health protection
- How the objectives and tasks of the request are linked to the broader health sector development process

Existing documents and study reports and discussions with various stakeholders provided the basis for the mission's work. Stakeholders such as officials from the MoFP, the FC, MoH, development partners, academic researchers, non-Government Organizations (NGOs), professional associations, and independent experts were

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<sup>2</sup> P4H support is based on the understanding of SHP as a system based on prepayment and financial risk-pooling that ensures equitable access to essential health services of acceptable quality at affordable prices, and in which contributions to the system are based on ability to pay, while benefits are based on needs, and a series of measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health.

met. Discussions centred around the current health care system, health financing issues, existing mechanisms, and possible future pathway to achieve UC and SHP.

### 1.5 The Mission Team

The team had the following 11 members from the Ministry of Health, Sri Lanka, France, ILO, WHO, the World bank and the P4H Coordination Desk:

1. Dr. Michael ADELHARDT (P4H Coordination Desk)
2. Dr. Xavier CHAMBARD (GIP SPSI, France)
3. Dr. Varatharajan DURAIRAJ (WHO)
4. Dr. Sundararajan GOPALAN (The World Bank)
5. Dr. Firdosi Rustom MEHTA (WHO)
6. Dr. Kumari NAVARATHNE (The World Bank)
7. Dr. Susie PERERA (MoH)
8. Dr. Kesavan RATNASABAPATHIPILLAI (WHO)
9. Dr. Samanthi RATNAYAKE (MoH)
10. Dr. Sarath SAMARAGE (WHO)
11. Dr Xenia SCHEIL-ADLUNG (ILO)

## 2 Social health protection issues and challenges in Sri Lanka

The team noted that the Sri Lankan health system possesses a number of positive elements built over a long period of time (over 80 years).<sup>3</sup> Despite setbacks due to the tsunami and many years of conflict, effective health services continued to be provided, and most socio-economic indicators are enviably good, particularly in comparison with neighbouring countries in the region, and with developing countries more broadly. Strong economic growth – also predicted for the near future by the International Monetary Fund (IMF) – and a solid social protection system established many years ago have contributed significantly to the positive developments. The existing social security system provides for free health care and income support specifically for the elderly, disabled and the poor.<sup>4</sup> Strong and widespread health care provision by the government-financed and government-managed system, and community contribution to better health outcomes through their actions to prevent diseases and seek care when needed are other positive elements. According to one expert, whom we consulted, competition from the government inpatient care keeps the private sector price lower than what it would be under purely free market conditions. Also, the community approach in dealing with various health and health care issues is seen as an advantage in Sri Lanka.

However, new challenges have emerged because of the economic, social, epidemiological and demographic transitions. The system currently is not fully geared to meet the public expectations for a world-class health care system capable of handling the growing NCD burden, providing long-term care for the elderly and

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<sup>3</sup> Varatharajan D. *Economy and health: taking Sri Lanka towards the global best. The National Commission on Macroeconomics and Health, Ministry of Healthcare and Nutrition, Government of Sri Lanka, Colombo, 2006.*

<sup>4</sup> ILO. *Sri Lanka: A review of the social security system for the Ministry of Labour Relations and Manpower, Geneva 2008.*

reaching some of the disadvantaged and marginalized populations, all within the fiscal space constraints. Sri Lanka's past achievements cannot be easily replicated with respect to the future challenges, without newer approaches, as the nature of the problem and the types of solution are quite different, and very likely, more expensive.

Against this background, the commitment to UC, which is strongly imbedded in the socio-political framework of Sri Lanka, may motivate the development of future options to effectively deal with the new challenges while building on the strengths of the current system. Observations made by the team are based on the understanding that the country should not lose the advantages of the current system in the process of developing options to address future challenges; the observations can be summarized under the following broad policy areas:

- Equity in access
- Effectiveness of health care
- Efficiency in provision/purchasing of care
- Enhancement of fiscal space

The report also has observations regarding the following five process areas, as a way of addressing the above four policy areas:

1. Strategic approach to and a road map for the development of policy options for Universal Social Health Protection clearly specifying contributions of national stakeholders and development partners
2. Timely implementation of the strategy and the road map
3. Monitoring, evaluation and correction, if any, based on evaluation
4. Inter-sectoral stakeholder process
5. Formation of a support network

Issues identified and listed here are not exhaustive because it was not the primary purpose of the mission to provide an elaborate analysis of all issues concerning social health protection in the country. Rather, these issues form the focus of this report, having emerged from the mission's review and discussions.

## **2.1 Equity in access**

Over time, some gaps in the social protection system have become evident, as outlined in recent ILO studies.<sup>5</sup> High unemployment rates, particularly of the youth, a high share of the informal sector in the labour market (more than 60% of the total workforce), pockets of poverty that often disproportionately affect the women and the elderly living in rural areas, and impacts of one of the most rapidly ageing population need to be addressed if the government's aspiration for Sri Lanka to become a middle income country with a per capita income of US\$ 4,000 by 2015 is to be achieved, in an inclusive and equitable manner.

One of the key policy areas that would require a better understanding and clarity is the geographical disparity expressed in infrastructure gaps (e.g. in the post-conflict areas, tea plantations, and certain remote rural areas) and health workforce as well

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<sup>5</sup> ILO. *Sri Lanka: A review of the social security system for the Ministry of Labour Relations and Manpower*, Geneva 2008.

as poverty incidence in rural areas leading to issues in access to health care. In addition, there are gaps in what is being delivered in already existing government health care institutions (e.g., non-availability of medicines & laboratory tests, for some diseases at all levels of care). Due to this and other factors, lower-level government facilities in rural areas are under-utilized (measured by bed-occupancy rates) meaning people either remain without treatment due to high access costs<sup>6</sup> or opt out to seek care from private for-profit providers thus incurring out-of-pocket spending (OOPS). However, the real size and dynamics of the OOPS for health care are not fully understood in Sri Lanka. More importantly, how resources for OOPS are being mobilized and their potential impoverishing effect on households require further research. Also, the current estimate of OOPS does not capture the volume of services not consumed by the poorest, due to lack of affordability. Therefore, it is evident that some sections of the population, especially the rural and poor people, lack full access to a complete package of essential health care of acceptable quality; health care needs of some of them may have been partially met. Other than the rich-poor and urban-rural disparities in health care access, there are other types of inequities as well. For instance, there are certain vulnerable groups (e.g. estate population) that fall behind others in health care access.

Our discussions with experts led to the suggestion to examine the increasing (imperfect) *commercialization* of health care (taking advantage of the gaps in the public sector services and the growing expectations of a highly educated consumer, with an increased purchasing power). This is one of the reasons for increasing OOPs. While the government policy guarantees free health care to all at the point of delivery, gaps in free care provision due to deficits in infrastructure, the health work force and quality of services, hiked health care needs due to higher expectations and awareness push people towards the private health care market, which is currently unregulated. Now, more than before, health care has a price in Sri Lanka and the increasing number of private hospitals surfacing in different provinces indicates such a trend. There are reports of deprivation due to expensive management of chronic diseases. This trend suggests that there may be additional forms of out-of-pocket spending in the future, if adequate prepaid financing mechanisms are not developed (at present, there is very little by way of health insurance in Sri Lanka). Even newly evolving financing mechanisms, if not guided well, may add to the (imperfect) market route and impose additional access costs and financial burden.

Since any Sri Lankan can freely access any public health care facility in the country, a better understanding is needed of the extent to which such inequities impose greater access barriers and financial burden on those who reside outside the catchment areas of well-functioning health care institutions in terms of UC. They may particularly affect outpatient care provision thus forcing people to seek outpatient care from institutions at a higher level<sup>7</sup> than necessary or from the private sector, or wait till the illness is more serious, warranting inpatient care. Both are likely to impose additional financial burden on both demand and supply sides.

The role of tax-subsidized uncoordinated mandatory insurance schemes for civil servants, armed forces, central bank employees for attaining universal coverage also

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<sup>6</sup> These are costs incurred by people outside a health facility (e.g. transport cost or cost of medicines or diagnostics purchased from outside the government facility).

<sup>7</sup> Of course, there is no institution in Sri Lanka which is purely “inpatient”. Higher level institutions also offer outpatient care.

needs to be studied, since they exclude the majority of the population. Moreover, many of those 'insured' are not claiming benefits either due to lack of awareness or due to complex procedures attached with the insurance. Additionally, the premiums for the main public sector insurance scheme called *Agrahara*, are a flat amount irrespective of the employee's salary level, thus making it a regressive "tax". In short, existing limited health insurance in Sri Lanka works favourably only to a small section of the population. A large proportion of the population seek uninsured care from private health care providers, when faced with gaps in the tax-funded public services.

From a social health protection point of view, there is a need for better monitoring of public expenditure, out-of-pocket payments and other private spending in order to better match supply and demand and address the financial barriers to access health services e.g. of vulnerable people. This could be developed on the basis of national health accounts as well as integrated social protection expenditure and performance reviews.<sup>8</sup> Further, equity issues due to legislation should be addressed, e.g. disparities in maternity leave benefits between the public and the private sector may pose a barrier to meet international obligations.<sup>9</sup> Moreover, the impact of certain additional health financing mechanisms such as the private health insurance and community-based financing in providing social health protection on effective delivery of services is not known. In particular the role of regulation, which guides the activities of private health insurers in the country, needs to be clarified.

## 2.2 Effectiveness of care

Effectiveness relates to both quantity and quality of health care services provided. In Sri Lanka, quantity, range and quality of services provided by both public and private sector facilities are not well-defined and details are incomplete (while quantities are available for the public sector and can be estimated for the private sector, quality is essentially unknown in the absence of systematic measurement). For instance, services targeting non-communicable diseases and injuries are in short supply both in public and private facilities in rural areas. Since health care supply does not match the needs in rural areas, rural people may directly access public and private facilities in urban areas. Some inpatient care wards of urban facilities are overcrowded to an extent that more than one patient occupies a bed (in contrast to lower level facilities where bed-occupancy rates are often below 50%). As a result, both rural and urban populations are deprived of good quality health care due to under-provision and overcrowding. Means and options to reduce this double adverse effect on the quality and effectiveness of care as well as the cost and access, need to be identified.

Treatment effectiveness of outpatient care provision in both government and private facilities is unknown. While significant health care spending, particularly from the households, goes towards outpatient care, there is no morbidity or mortality reporting with respect to outpatient care – even in the public sector, where inpatient records are fairly well-kept. Moreover, what is provided under outpatient care is unclear, especially in the private sector, as there is no regulatory mechanism to monitor the content or quality of services by private providers. Budget allocation for preventive and promotive health services is low (5.5% of total health budget)<sup>10</sup> which is likely to

<sup>8</sup> Methodologies of social protection expenditure and performance reviews including social health protection are available on <http://www.ilo.org/public/english/protection/secsoc/areas/stat/spers.htm>

<sup>9</sup> Arising out of the ratification of the ILO Convention No 103 on Maternity Protection

<sup>10</sup> It was 11% in the 1990s (Varatharajan, 2006)

have a deleterious effect on the quality of these services, especially when they seek to prevent the more expensive NCDs.

While there has been a recent push for total quality management and the successful introduction of the Japanese 5S system to improve quality, the focus has been mainly on cleanliness, orderly organization of supplies, more helpful staff, and such issues of health facility improvement. It is now time to focus more on improving clinical care quality, while expanding the successful 5S efforts. Although 93 clinical care guidelines have been prepared (under the Health Sector Development Project supported by the World Bank), their practical utilization has been very limited; also, a system of updating and expanding them is yet to be developed. A quality secretariat has been set up under MOH, but is yet to be fully functional. There is a serious need to instil the quality consciousness in the organizational culture of public and private health care facilities in Sri Lanka.

Perhaps the single-most important issue that needs to be addressed in order to improve quality and effectiveness would be the lack of a robust system of measuring quality, and the insufficient utilization of data from the existing health information system to analyze and interpret them critically for evidence-based management at various levels. A simple system of monitoring patient care outcomes in all health facilities could be introduced, and weekly clinical audit meetings held to discuss adverse outcomes as well as clinically interesting cases, as a way of improving quality, while imparting training to the younger care providers.

Other issues of effectiveness include: the absence of emergency treatment units in all lower level facilities (where they do exist, most do not function 24 hours a day), the need to retool the health workforce gearing them to be able to provide NCD care (as part of their pre-service training), the absence of systematic long-term care provision, incomplete treatment due to the shortage of certain essential drugs in the public system (especially for NCD treatment), the lack of an accreditation system for the private hospitals and the weak adherence to the clinical quality guidelines recently developed.

### **2.3 Efficiency in provision and purchasing of care**

The Sri Lankan health system is slowly transforming into a pluralistic system. The attainment and maintenance of universal coverage could be challenged by the absence of clear planning, strategic guidance and regulation, which may introduce a number of imperfections and inefficiencies. A more comprehensive understanding of system losses and inefficiencies born out of mismanagement and unskilled operations, waste of resources e.g., due to irrational prescription practices, use of expensive medicines ('technology effect'), inadequate inventory management, unnecessary admissions, bypassing of lower level facilities, lack of effective referral system (as MOH officials acknowledge, and justify in terms of the patients' freedom of choice to use whichever services they wish to), under-utilization of available health infrastructure, mal-distribution of resources – human, financial, and material, lack of coherent planning while locating new health facilities and when expanding or upgrading existing health facilities, etc. would be required for evidence-based and strategic decision making. In addition, one needs to further examine planning issues e.g. related to costing and procurement of supplies and equipment, as well as coordination of various authorities involved in policy making impacting, for example, on maintenance and availability of medicines at the provincial level. Gaps may also exist in human resources in different categories of staff, e.g. shortage of certain types of specialists, lack of coordination among MOH units and disparities in human



resource availability between provincially and centrally managed hospitals, etc. Policy decisions about referrals and admissions could be important in reducing unnecessary inpatient care; for instance, the policy of compulsorily admitting all patients visiting health facilities after 4 pm is a clear candidate for review.

There is a need to address the issue of insufficient monitoring of expenditure in terms of meeting population needs, changing health priorities, administrative performance, etc. and its strategic role in achieving UC. While hospitals in rural areas are perceived to be of poor quality offering inadequate range, quantity and quality of services leading to underutilization, provincial and national level hospitals are perceived to be good and therefore overburdened. This may result in a less seriously ill patient receiving care at a higher level facility even while the resulting overcrowding delays or denies care to a more seriously ill patient.

A closer look at the *Agrahara Scheme* (the Government-managed and subsidized health insurance scheme for civil servants and their families) may provide better insights regarding some efficiency and sustainability concerns raised, and its role in attaining universal coverage; for instance, no actuarial assessment has been carried out for the scheme so far. The premium collected from the payroll of all civil servants is a flat amount of roughly 1 USD per month per employee, regardless of his/her income level. As of September 2010, the scheme has covered 659,170 government employees and their families thereby covering a total population of about 2.64 million.<sup>11</sup> The benefit package covered this scheme needs to be reviewed in the context of the fact that public sector services are entirely free of charge. In 2007, 81,999 claims were processed; out of these, 39,947 were for eyeglasses<sup>12</sup> and out of the rest, a significant amount of money is being spent on claims emerging from care outside the country. At present, it is not clear what proportion of employees or their families who are hospitalized at any given point of time actually benefit from this insurance. Although only a small proportion of the enrolled is actually covered for their financial risks in real terms, 2010 estimates indicate that claims exceed contributions by about 27%, raising sustainability concerns.

On the other hand, the scope, efficiency and sustainability of the limited number of private and community based insurance schemes and their level of financial risk and population coverage need to be studied further. All insurance schemes including the *Agrahara Scheme* aim at covering the care obtained from private facilities, i.e., care that is not obtained from the public sector either due to unavailability or perceived quality differentials; outpatient care, except the provision of spectacles, is not covered. Given that the public sector is providing free inpatient care to over 90% of the population, these insurance schemes focus on part of the remaining 10% (out-of-pocket payments accounting for part of this as well). Since outpatient care is inadequately covered by both free care and insurance, management of chronic diseases demands more OOPs because most of the NCD treatments occur in outpatient care setting both in the public and private sectors. Such a large share of OOPs could impact on efficiency, especially in an unregulated private health care market, because patients who pay out of their pockets at the point of delivery lack the bargaining power of insurance firms who could control the unnecessary use of expensive procedures and negotiate better bulk prices for their clients.

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<sup>11</sup> Assuming an average family size of 4

<sup>12</sup> National Insurance Trust Fund. Annual report 2007

Another way in which unregulated private provision could add to inefficiencies is through the snowballing effect on public expectations, resulting in pressures on the public system to emulate the high technology care available in the private sector.

All these inefficiencies discussed in this section may deprive the system of resources required to provide essential health care at all levels of health care institutions, and skew the utilization further towards the higher level facilities. More importantly, MOFP has clearly indicated that until inefficiencies are addressed in full earnest, additional fiscal allocation is unlikely. Therefore, a major risk to be avoided is a vicious cycle of inefficiencies reducing fiscal space, resulting in further reduction in quality and content at lower level facilities, leading to further inefficiencies, and so on.

## 2.4 Enhancement of fiscal space

Expansion of fiscal space in Sri Lanka has to be viewed from three perspectives. First is the set of reasons why future health expenditures are going to be higher. There is a growing concern regarding the widespread prevalence of NCDs including injuries. The health system needs to be geared up to face this challenge before it gets out of hand. NCDs are expensive to treat and demand an increasingly higher share of resources. Many of them are chronic in nature with continuous resource requirements. The system also needs to take into account the increasing demand for good quality care due to rising expectations. This also makes the care expensive. In the context of attaining and maintaining UC, the health system configuration may require structural adjustments taking into account current developments concerning disease profile of the population, modern diagnostic and treatment technologies, other technological advances including telemedicine, growth of the private sector which needs effective regulation, requirements under international treaties and conventions and the advent of new institutional mechanisms such as insurance, microfinance and community-based mechanisms. All these call for higher allocation to health, both short and long term, particularly with Sri Lanka transitioning into a middle income country. However, this year's budget indicates the opposite because health's ranking in budget allocation has slipped down from the 4<sup>th</sup> highest allocation (after Defence, Finance & Planning and Public Administration & Home Affairs) in 2008 to the 6<sup>th</sup> in 2011 (after Defence, Highways & Roads, Public Administration & Home Affairs, Finance & Planning, and Economic Development) and though the health budget in Rupee terms is slightly higher than the previous years,<sup>13</sup> it has fallen as a percentage of the total allocation (from 6.3% in 2008 to 5.8% in 2011). As a percentage of GDP, it fell from 1.3% in 2008 to 1.0% in 2011.<sup>14</sup>

Second is a consideration of how realistic it would be to expect the Government's revenue base to cover the above-described increase in costs. The overall fiscal space is limited (about 15% of GDP) and there are competing demands for it from several sectors. The Government has been running a fiscal deficit for over a decade. Moreover, the government is a major employer in Sri Lanka and therefore, the salary bill is high, leaving little wriggle room for budgetary reallocation. A significant portion of the budget goes for debt servicing. All these limit the scope for expanding the fiscal space for health unless the economy grows faster as expected and/or the government finds ways to improve revenue generation, through new forms of taxation and/or more effective enforcement of the tax code, especially from the

<sup>13</sup> It was 57.8 billion in 2008, 58.6 billion in 2009, 53.1 billion in 2010 and 62.3 billion in 2011

<sup>14</sup> These figures, however, reflect only central government allocations

informal sector, and exploring other avenues of revenue generation specifically for social health protection. On the positive side, there could be savings from reduced defence spending in view of the recent conclusion to the 30-year long civil conflict, and from other sectors where certain current government investments may be phased out. Another possibility to expand the fiscal space for health may be for other Ministries step in to reduce the demand for MoH resources, e.g., by addressing challenges posed by population ageing and lifestyle.

Third and perhaps most imminent would be to improve the way in which current health allocation is spent, in addition to advocating for higher allocations. Efficiency gains may be possible within the health sector through better coordination and management of facilities, and through policy decisions (e.g., regarding referral systems or after-hours admissions). Appropriate guidelines on what cases need inpatient care, their inclusion in medical curricula and subsequent mechanisms to ensure adherence to these guidelines could help reduce unwarranted admissions. The size of current system losses and potential gains with policy actions need to be carefully studied.

All these issues require further examination, clarification and discussions about their possible policy implications.

### **3 What more needs to be done to address the SHP gap?**

Given the close relationship between health, economic and social development it is important to address all issues in a comprehensive manner that goes beyond the health sector. That is particularly important with regard to malnutrition, disability, mental health and chronic diseases such as asthma, cancer, cardiovascular diseases, diabetes, hypertension and the conditions that require sustained long-term care (e.g. stroke patients' and post-injury rehabilitation). A recent study on social determinants of health in Sri Lanka has brought out more specific recommendations in this regard.

Investing in social protection (more broadly than just SHP) contributes to addressing these issues, enhancing labour productivity and social stability. A solid social protection approach as suggested by the ILO-WHO led UN Social Protection Floor Initiative<sup>15</sup> can act as a socio-economic stabilizer and has shown to be affordable at any stage of economic development. By providing essential social transfers in kind and in cash, it aims at providing a minimum income and access to at least essential services such as health care. Applying such a holistic approach allows any country to progress based on sustained development that meets the needs of all citizens, with a special emphasis on the most vulnerable.

#### **3.1 Reaffirming the welfare state concept**

Welfare state has been the guiding principle for Sri Lanka while shaping the national health system. Almost all of the Sri Lanka's health sector achievements can be attributed to the welfare state approach introduced in the 1940s. The concept in Sri Lanka included areas such as health, education, nutrition and social services. Therefore, it would be a natural and facile progression for Sri Lanka to develop a

<sup>15</sup> <http://www.ilo.org/gimi/gess/ShowTheme.do?tid=1321>

strategy for SHP within the welfare state model. It requires SHP to be placed high in the national agenda and SHP priorities to be identified for the next 4-5 years. Those priorities then need to be linked to the budget. Therefore, it is necessary to identify the priorities and link them with the budgetary process early.

As a first step, a national strategy could be developed for the improvement of SHP in line with other parts of social protection. The strategy should be based on a broad analysis of SHP issues, access deficits, financial and fiscal scenario, inefficiencies and waste, household reliance on OOPs for health care, managerial aspects, inventory of social security benefits that impact on the income situation e.g. of the disabled and elderly in need of long-term care, etc.

### **3.2 Resource prioritization at the provincial level**

In the Sri Lankan context where primary and secondary care responsibility is vested with the Provincial Councils, for equity gains, it is necessary for the provinces to play their role well to prioritize resources in areas where they are required the most. The Provinces currently are allocated about 15-20% of the budget resources. Of course, some provinces (e.g. Western Province) generate their own resources; but not all are that resourceful or fortunate to have a strong enough economic base as the Western Province which accounts for nearly 40% of the Sri Lankan economy. Therefore, it is important to develop evidence-based recommendations how the available resources can be used more effectively, efficiently and equitably. Some provinces were able to create new facilities due to local level political commitment but they could not run them due to the lack of supplies, equipment and human resources; this reflects the earlier point about the lack of comprehensive planning while locating health infrastructure.

One comparative advantage at the provincial level is that intersectoral cooperation and positive synergies are easier to obtain (due to their smaller size, and fewer ministries compared with the Center). In order to make this happen, they could make better use of their development reports to address population health needs. Issues identified in the reports could be prioritized and funded so that a need-based approach will gradually evolve – provided the Center allocates the resources according to the locally identified needs.

### **3.3 Inter-sectoral linkage**

Some health and health care inequities can be addressed directly through the actions of the MoH. On the other hand, some others might have emerged from (and/or have their solutions in) the actions of some non-health sectors and even from outside the country (e.g. pharmaceutical prices and availability, treatment protocols concerning NCDs, etc.). Such inequities can be addressed effectively only when the MoH joins hands with other Ministries and the provinces. An assessment of modalities for integrating and/or expanding existing complementary SHP schemes with a view to providing equitable benefits, creating a common administrative scheme, strengthening management and increasing cost-efficiency could be a starting point.

Integrated policy-making and governance for all social protection schemes including SHP within the government involving various ministries, e.g., MoH, MoFP, Ministry of Labor (MoL), Ministry of Social Services (MoSS), is important to create a common policy vision and increased effectiveness. Also, the new Ministry for Economic Development could be involved. Such linkages might release some portion of the MoH resources for filling some of the service gaps. In the long run, it is important to

view health as part of economic development, with which it has a two-way relationship. In addition, inter-ministerial dialogue could be initiated at the national level in order to address health issues that are cross-cutting in nature. Such a body could be situated, for example, under the Office of the President.

As the health financing strategy process unfolds, it would be important to engage in an institutionalized dialogue between all the stakeholders facilitated by accordant legislation. The proposed stakeholders' forum would include MoH, MoFP, MoL, MoSS, FC, provincial representatives, labour unions, employers' associations, professional associations, academia, other "social protection" linked ministries, NGOs, community groups and voices of the poor. The creation of such a forum for social dialogue on SHP could ensure consultation and participation of all stakeholders in the development of a comprehensive national strategy and has proved successful in many countries.<sup>16</sup> Issues like the performance of the private sector including the insurance vis-à-vis SHP can be addressed in this forum.

The proposed multi-sectoral mechanism for SHP needs a focal ministry/secretariat to ensure sustained action. A unit within the Ministry of Health could take forward and monitor the implementation of decisions arrived through multi-stakeholder consultations.

### **3.4 Capacity development**

The country requires additional capacity development in the area of health system analysis and management, particularly to support the government in policy making and implementation. Some skills that may be additionally developed and utilized, within the MoH, include (but are not limited to) health policy, health financing, health economics, health system analysis, and actuarial analysis. A Health Economics and Policy Unit within the MoH may be given the responsibility of linking with other Ministries and advising the MoH (after proper analysis and brainstorming) on matters related to health policy making, strategy development, health financing, regular preparation and interpretation of national health accounts, and monitoring of the successful implementation of national policies and strategies. This unit could also contribute to knowledge development through studies focusing on key areas like health system development, household actions and spending on health, the role and contribution of the private sector, community development, etc.

If the country wants to reorganize the primary health care system to suit the needs of people affected by non-communicable diseases and injuries, there is a need to retrain and reorient staff employed at that level. Issues concerning ageing, poverty, lifestyle, and disease management should be addressed in the training of staff.

Another area that can be explored is to complement allopathic health care services by those offered by traditional practitioners. Such an integrated strategy will reduce service delivery gaps to some extent besides enhancing local acceptance of health care through culturally sensitive approaches and promoting complementarities between the two systems of medicines.

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<sup>16</sup> Documented examples by ILO include Brazil, Canada, Chile, Ghana and United Kingdom <http://www.ilo.org/public/english/dialogue/sector/papers/health/wp189.pdf><http://www.ilo.org/public/english/dialogue/sector/papers/health/wp234.pdf>

Creation of a health system research and training institution with a good academic standing would be helpful for the country, so that Sri Lankans can be trained within the country. Moreover, this institution can also generate the necessary evidence-base for policy making.

### **3.5 Fiscal space**

Section 2.4 has elaborated the fiscal space issues facing Sri Lanka. MoFP has made it clear that serious actions to increase efficiencies from the current system are a pre-requisite for any additional allocation, and there is considerable merit in that position. However, MoH needs to continue making strong evidence-based arguments for increased health allocation. While Sri Lanka is understandably focusing currently on infrastructure development and economic growth, it would be a mistake to do that at the expense of the health sector. Lower investments in health and nutrition run the risk of making the children less educable, and the workforce less productive, directly impacting on economic growth. Complacency with regard to health investments because of the common impression that Sri Lanka is already doing well on health would be seriously misplaced; past achievements have been with respect to the so-called low-hanging fruits and just a continuation of past level of investments would simply not suffice.

It is also important to prepare the MoH to absorb more resources as and when the financing situation improves. For instance, higher GDP growth means more resources for health even if its GDP share remains the same. Similarly, there are opportunities such as the proposed Second Health System Development Project under consideration by the World Bank, and the Global Fund application that could be used to develop the health system in a more strategic way so that the questions about health system efficiency are put to rest once and for all.

### **3.6 Situation analyses**

In the short run, some situation analyses need to be carried out to understand the drivers of OOPs, existing health expenditure patterns and existing health financing mechanisms and their functioning vis-à-vis social health protection. Who pays? Where and for what? Who suffers the most? What effects would a persistent 50% OOPs level (or further increasing levels) have on the health sector, in particular on private sector development? OOPs should be looked at from both absolute and relative terms. For instance, the poor may contribute very little to OOPs relative to the richer population; but it could be significant enough to impoverish them in an absolute sense (and relative to their own income levels). Furthermore, it is unknown how many of the poor are opting out of care altogether, when faced with the compulsion of having to spend out of pocket for expensive services like cancer management and rehabilitation care. OOPs can be tricky to interpret; low OOPs among low-income households may actually indicate inadequate health care consumption due to financial barriers; it could also mean an equitable and effective access to the public system, thus warranting lower OOPs from the poor. A more careful analysis is warranted to understand this issue better.

In some cases, OOPs on health care per se may be smaller than that of the OOPs to meet access costs (e.g. transport cost). There is a view that the private sector in Sri Lanka is diverting the richer population away from the public sector, allowing the latter to be used more freely by the poorer. The assumption behind this approach of developing the private sector to attract the rich is that the rich automatically choose private facilities and incur OOPs even if the free public facilities are effective and

provide high quality care. This assumption has not been robustly tested. A related question might be 'Is it ideal or ethical to make public health care facilities exclusively for the poor?'

Some situation analyses and studies have already been carried out. Such analyses and reports could be revisited to discuss the potential policy implications and to contribute to policy development, before undertaking newer studies. This would also minimize possible duplication to produce similar reports. Studies being undertaken under the Social Determinants for Health project may also be used to generate some additional synergies for SHP.

There could also be policy studies to explore and develop support measures for those affected (in terms of denial of care, partial care and impoverishment) by OOPs. In this regard, it may be worth exploring the health system development during the last 20-30 years, particularly from the point of view of increasing access and preventing OOPs.

### **3.7 Revisiting *the Agrahara Scheme***

This scheme already covers a significant proportion of the country's population. But, it has certain drawbacks including the lack of actuarial studies and sufficient information of the insured on the benefit package and other aspects and premium fixation. The flat rate premium is regressive because its share in the income is negligible for the highest paid employee while it is significant for the lowest paid staff. To result in fair burden-sharing the premium has to be fixed as a proportion of the income. The scheme is now extended to employees of semi-government institutions, but with different premium structure. It is necessary to revisit the scheme before it expands further. The benefit package also needs to be examined to ensure that it caters to the real needs of the intended beneficiaries, taking account of what is already available in the free public sector health facilities. At present, it is not clear who the beneficiaries of the scheme are and whether it promotes or disturbs equity and burden-sharing towards SHP. Claims in excess of contribution are not a sufficient indicator for SHP or financial risk protection.

### **3.8 Development of health financing options**

The review of existing study reports and documents on health financing, universal coverage, SHP, as well as newly carried out analytical work should feed into strategic discussions with relevant stakeholders and form part of the development of health financing options for achieving and maintaining UC/SHP. Hence, it is recommended to integrate and align all future analytical and conceptual works on health financing to the (proposed) national strategy process towards UC/SHP.

## **4 The road map for possible P4H support**

The goal of this road map is to explain how P4H partners will support Sri Lanka in developing the national health financing strategy for achieving UC/SHP. The nature, content, and scope of the strategy, however, will be defined by the Sri Lankan government. The role of P4H is to provide technical support that will facilitate the development of the strategy. The P4H partners offered to jointly support this roadmap. The MoH will take the lead in implementing the above agenda in close collaboration with key national stakeholders. The WHO and the World Bank country

offices in Sri Lanka would play a major role in providing the integrated P4H support, which will be complemented by P4H partners at regional and global levels as required (and depending on available resources). The P4H Coordination Desk will follow-up on the implementation of the agreed areas of support and facilitate the coordination of inputs from regional and global levels.

*Suggested support activities possible from P4H within the next 6-12 months are listed under four areas here.* They include analytical work and pilot interventions ranging from efficiency and fiscal space issues; cost effectiveness analysis of the existing primary health care (PHC) system and possible piloting of a new PHC model including a specified services package of curative care, NCD care, preventive care and mental health services; the role of the *Agrahara scheme*; the feasibility of social health insurance and different provider payment mechanisms and capacity building for the health sector to improve its functions on health financing within the MoH.

#### 4.1 Analytical work

P4H could provide joint technical support to carry out some of the analytical works that are required for a deeper understanding of the level of SHP in Sri Lanka and possible options to finance social protection efforts in health. Some recommendations in no particular order are given below.

The first task could be to **review the existing study reports and situation analyses** from SHP perspective and with a policy orientation. This is basically a revisit of those documents and provision of an analysis.

The second analytical work should contribute to a better understanding of the size, **characteristics and drivers of OOP spending**. It could also include an analysis of how it prevents people from accessing and completing care.

The third possibility is an analysis to understand how much gain in resources is possible out of efficiency improvements.

The fourth work could be an analysis of existing **health financing options** such as taxation, private insurance, community-based financing mechanisms, the *Agrahara Scheme* and any other mechanisms with a view to leveraging all complementary schemes towards the common goal of UC/SHP. These mechanisms could be analyzed from a SHP perspective to see whether they contribute to or damage the social protection system in health, particularly regarding the extension of coverage, sustainability and efficiency in administration. The analysis could assist in identifying current gaps and opportunities by assessing the health financing functions, i.e., resource generation, risk and resource pooling, purchasing function and provider payment options. If some mechanisms are useful, their national level expansion could be pursued. Alternatively, if some are contributing negatively, measures to make them work better could be developed. Some experiences from outside the country such as the Cambodia Health Equity Fund or the Rashtriya Swasthya Beema Yojana (RSBY), the National Health Insurance Scheme in India may also be relevant for Sri Lankan context.

The fifth area of analytical work is possibly to study **the roles and regulation of the private sector**, particularly in service provision. More specific focus of the analysis could be on how it can be best used to achieve UC/SHP objectives.



The sixth area of analytical work could be to better understand the current expenditure patterns in the public health sector (both provincial and central levels and within different programmes and by types of expenditure), and provide recommendations for efficiency gains in the sector in the context of the goals of UC/SHP.

## 4.2 Capacity building

P4H could support the **MoH capacity** e.g. strengthening the planning and policy units, creation of a new health economics and policy unit (or strengthening the skill-set in the existing planning / policy unit). It could also support the creation of new cadres in skill areas currently missing such as health economist, health policy analyst, etc. It could also support capacity-building outside the MoH (e.g., in the MoFP, MoL, MoSS). The capacity building can be extended beyond the government ministries and departments (think-tanks and institutes, such as IHP, Marga Institute, IPS).

Study tours could be facilitated to understand the functioning of certain systems that are helpful from a SHP perspective. Study tours can be useful to gain further insights on analytical and planning skills, forecasting changes and enlightening the decision-making process (e.g. High Council for the Future of Health Insurance in France). Additionally, there could be seminars organized to share the international experience on UC/SHP.

As part of the development of health financing options, one could consider a study tour or seminar on the “coordinated treatment path” which was introduced in France in 2004 in order to improve the monitoring of patients and the coordination of treatment. It shows that despite the principle of freedom of choice within the healthcare system one can introduce some kind of regulation. France could also offer its support in the following areas:<sup>17</sup>

- Public health care policy,
- Definition of the “treatment package”,
- Merger of various existing funds and schemes,
- Complementary health protection

## 4.3 Participatory process and mechanisms (multi-sectoral)

P4H could provide technical support in the area of **national and social dialogue** and its organization. Such an approach includes developing a common knowledge base, mapping the current situation, and setting an agenda of social dialogue e.g. recognizing needs, prioritizing agenda items and integrating core issues.

In this context, the team suggests to establish/revive a **national forum** for public discourse on SHP – including government Ministries (health and non-health), civil society, academia, professional groups, unions, employers, general community, the poor, elderly and women.

Secondly, the team recommends the establishment of an inter-Ministerial Committee/Council with the formal mandate for developing and implementing the

<sup>17</sup> Description of French expertise :  
[http://www.gipspsi.org/GIP\\_FR/content/download/4971/44413/version/2/file/GIPSI\\_plaquette\\_savoir\\_faire\\_GB.pdf](http://www.gipspsi.org/GIP_FR/content/download/4971/44413/version/2/file/GIPSI_plaquette_savoir_faire_GB.pdf)

national strategy on SHP. This would facilitate broad ownership and lay the foundation for effectively dealing with potentially conflicting values, interests and preferences of various stakeholders. It would create an enabling environment for sustainable systems development by fostering harmonization of social and economic objectives.

The team also recommends the formation of a small in-country core group to drive the road map process for SHP. Led by the MoH, the group could include selected national experts/institutions and P4H partners.<sup>18</sup> The formation of such a group is important to ensure continuity of the national process. P4H could provide support in forming the group.

#### 4.4 Policies and Programs

P4H could provide technical support in the area of health financing strategy development based on the principles of equity, solidarity, and social justice. The core of the strategy relates to strengthening of these principles, efficiency and effectiveness to develop fiscal space, and embedding social health protection in a broader development environment based on access to at least essential benefits provided in a social protection floor along the related ILO-WHO led UN Initiative. It is important to develop policies that go beyond the health sector and are effectively linked with broader social protection measures. This can be facilitated by institutionalizing the dialogue between all stakeholders for developing a comprehensive social protection approach that meets the need of the population.

In order to address efficiency and equity issues, the role of possible policy and programme interventions that are currently being discussed in the health sector could be explored and their possible contribution for achieving Universal Social Health Protection assessed.

Support could also be provided to pilot testing possible program interventions such as the reorganization of primary health care services, restructuring and expanding the *Agrahara* scheme to all organized workforce, or small-scale community-based mechanisms to re-channel current OOPs into a pooled prepayment system.

P4H could provide policy support to Mo based on well-conducted analytical work, to develop and implement policy actions that could contribute to increased efficiency, e.g., designing a referral system to be tested out on a pilot basis in a district, engaging in dialogue with professional groups and associations who might have a stake in policy decisions about working hours or inpatient admissions.

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<sup>18</sup> The group could decide to what extent it would be useful to formalize it e.g. signing of MoU, ToR, etc. 'Formalizing' the group (even without signatures) could signal commitment and make the contributions of various stakeholders more effective, transparent and predictable, and facilitate continuity of support.

## Annex

## List of experts or policymakers met

*(Alphabetically by family name)*

<b>Name of the Expert/Policy maker</b>	<b>Affiliation</b>
Dr. Palitha ABEYKOON	Consultant, World Health Organization
Dr. Nisha ARUNATHILAKE	Research Fellow, Institute of Policy Studies
Prof. Nimal ATTANAYAKE	Prof. of Economics, University of Colombo
Ms. Nayana GODAMUNNE	Business Development Specialist, Centre for Poverty Analysis
Ms. Azra CADER	Senior Professional, Centre for Poverty Analysis
Dr. Hilary COORAY	Consultant, Organization of Professional Association
Dr. Shanti DALPATADU	Senior Fellow, Institute of Health Policy
Prof. Amala DE SILVA	Prof. of Economics, University of Colombo
Mr. A. FERNANDO	Consultant, Agrahara Scheme, National Insurance Trust Fund
Dr. Joel FERNANDO	Consultant, Organization of Professional Association
Ms. Karin FERNANDO	Team Leader, Poverty Impact Monitoring Programme
Dr. Chandana GAJANAYAKE	Deputy Director, Medical Supply Division, Ministry of Health
Dr. Vijith GUNASEKARA	Deputy Director, Lady Ridgeway Hospital for Children
Dr. Godfrey GUNATHILAKE	Chairman, Marga Institute
Mr. Ariyadasa HEWAGE	Chairman, Finance Commission
Prof. Saroj JAYASINGHE	Prof. of Clinical Medicine, University of Colombo
Dr. P.B. JAYASUNDARA	Secretary, Ministry of Finance
Dr. Lanka JAYASURIYA	National Professional Officer, World Health Organization
Mr. J.L.M.K. JAYATHILAKE	Deputy Director General, Bio-Medical Service, Ministry of Health
Mr. Shashika JAYATHILAKE	Assistant Manager- Reinsurance, National Insurance Trust Fund
Mr. Shogo KANAMORI	JICA Adviser, Ministry of Health
Mr. H.M.B. KARUNARATHNE	Chief Accountant, Ministry of Health
Ms. Nayomi KARUNARATNE	Programming Assistant, Finance Commission
Mrs. D.C.M. MADURAWALA	Director, Finance (Planning), Ministry of Health
Ms. Sunimalee MADURAWALA	Research Officer, Institute of Policy Studies
Dr. P.G. MAHEEPALA	Additional Secretary/Medical Service, Ministry of Health
Mr. W.H. MUNASINGHE	Secretary, Finance Commission
Dr. Anuruddha PADENIYA	Vice-President, Govt. Medical Officers Association
Mr. P.A.P. PATHIRATNE	Deputy Director General/Finance-II, Ministry of Health
Mr. Ranga PERERA	Consultant (Information Technology), Finance Commission
Mr. Priyantha RATNAYAKE	Director, Department of National Planning
Dr. Ravindra RUBERU	Secretary, Ministry of Health
Mr. Mahinda SAMARASEKARA	Co-ordinating Secretary to the Hon. Minister
Mr. Upali TENNAKOON	Director, Finance Commission
Ms. Dilrukshini WATUDURA	Senior Economist, Central Bank
Ms. Dammika WEERA KOON	Finance Manager, National Insurance Trust Fund
Mr. Chandana WICKRAMASOORIYA	Assistant Director, Department of National Budget, Ministry of Finance
Dr. M. YOUNUS	Health & Nutrition Specialist, UNICEF