International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Sri Lanka

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Extending Social Health Protection in Sri Lanka: Accelerating progress towards Universal Health Coverage

1. Introduction

Sri Lanka has made remarkable progress towards Universal Health Coverage (UHC) over the years, through a social health protection system that evolved as a result of fundamental political changes initiated in the 1920s and 1930s. Sri Lanka's health care system can be characterized by a predominantly tax-funded public system, providing health care services to the population free at the point of use, which is supplemented by a fee-for-service private sector. The government's efforts have focused on the supply side to ensure publicly financed health care services for all through an equitable, efficient and low-cost public delivery system (Rannan-Eliya and Sikurajapathy 2009). At the same time, the system facilitates and depends on significant private provision. This private provision meets a substantial proportion of overall demand, allowing limited government spending to effectively cover the poor, and keeping the cost of public provision low.

This pragmatic mixed system has allowed the country to achieve exceptional health outcomes — better than any country at its income level, particularly with regard to the maternal and child health agenda and infectious disease control, with relatively good levels of financial protection. In recent years, Sri Lanka has also demonstrated progress in tackling the challenges associated with an ageing population and increasingly prevalent non-communicable diseases (NCDs). Sri Lanka is known for having achieved such results without major health financing reforms. However, the system is not without its problems. It is characterized by low levels of public spending (less than 2 per cent of GDP), which results in considerable dissatisfaction among middle-income Sri Lankans, who tend to prefer private services. As a result, there is pressure on politicians to enact reforms, but such change proves challenging in light of existing fiscal and political economy constraints.

2. Context

Sri Lanka has provided universal, free public health care services for the whole population since 1951, when user fees were abolished (Rannan-Eliya and Sikurajapathy 2009), but it has also enabled people to use private services as they so wish. The

development and characteristics of Sri Lanka's approach to social health protection was driven by two critical events during the 1930s. Firstly, in 1931, government powers were transferred from the British colonial government to a local legislature elected through universal franchise, which ensured that future governments had to take into account preferences of all voters on key social policies. Secondly, from 1934–1935, the island was struck by an unprecedented malaria epidemic that infected almost the whole population. The epidemic devastated rural areas, prompting the realization that charitable and market approaches to social protection were not adequate, which catalysed the requirement of direct state intervention to provide hospital care. Prioritization of the government health budget for allocation to hospitals and inpatient provision was reinforced by voters, and the approach of tax-financed, public provision of hospital services was institutionalized as the country's social health protection mechanism in 1947 by the Commission on Social Services (Commission on Social Services 1947).

In parallel with the provision of public health services, the provision of private services has also been advanced. Despite an extensive range of health care services that are free in practice and widely accessible, funding constraints have led to increasing dissatisfaction with public health services among upper and middle-income Sri Lankans, leading them to seek private services. This has prompted the establishment of a range of employer-financed and private medical benefit schemes. The Employees' Trust Fund (ETF) was established by the government in 1987 to provide coverage for a limited range of services for workers in the formal private sector. Because this excluded middle-income government employees who lack access to private insurance, a government-financed private insurance scheme was introduced in 1997 to cover civil servants. This was later converted into a statutory scheme known as Agrahara. In addition to these two schemes, the President's Fund was established in 1978 to provide ad hoc financial assistance for medical treatment to those in need.

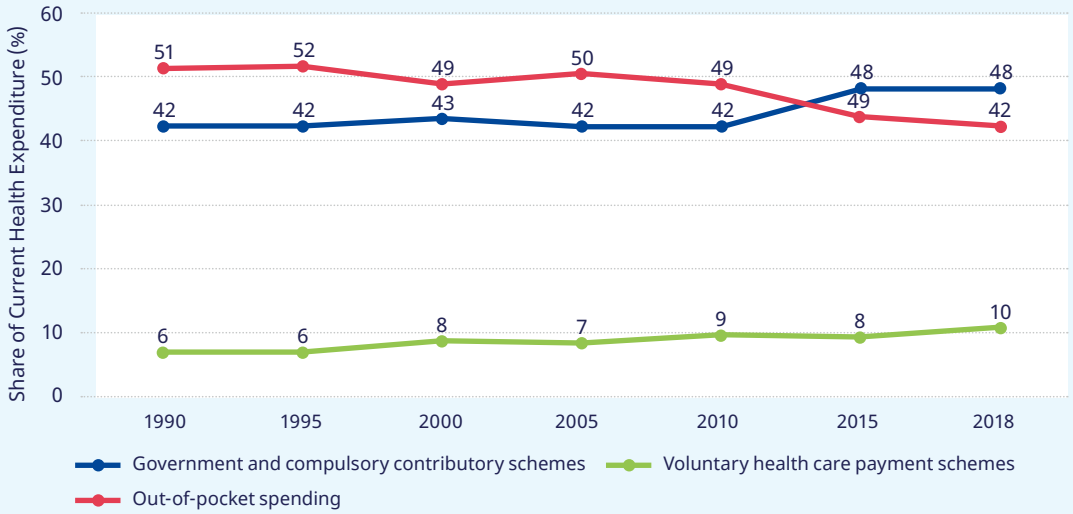
3. Design of the social health protection system

- Financing

An outstanding feature of the Sri Lanka health system model is the absence of the major health financing reforms that have been pursued in most low-income countries. Specifically, the country has not focused on a demand-side financing approach, there are no conditional cash transfers, very limited health insurance, and no targeting of the poor. In 2018, per capita current expenditure on health was US$122 or 2.9 per cent of GDP, and public spending constituted 48 per cent of government spending (Amarasinghe et al. 2021). This is relatively low compared to countries of the same income level (Amarasinghe et al. 2018; WHO 2019b). The two major sources of health financing in Sri Lanka are the government budget and out-of-pocket (OOP) payments. In 2018, OOP spending accounted for 43 per cent of health expenditure, government spending accounted for 42 per cent, employer spending accounted for 5 per cent and voluntary health insurance accounted for 4 per cent; international development assistance for health was only a minor health financing source, accounting for less than 1 per cent of health expenditure (Amarasinghe et al. 2021). In the same year, 52 per cent of health spending originated from private sources, 81 per cent of which was paid out-of-pocket, 9 per cent comprised employer benefits, 9 per cent comprised health insurance, and 1 per cent was sourced from from the non-profit sector (Amarasinghe et al. 2021).

As shown in Figure 1, the distribution among the three main sources of health financing has been relatively stable over the years, though public and private shares have fluctuated, with a slightly decreasing OOP contribution over the longer term. The public share has increased marginally in recent years, but it is not clear if this is a permanent shift associated with rising incomes, or a temporary fluctuation.

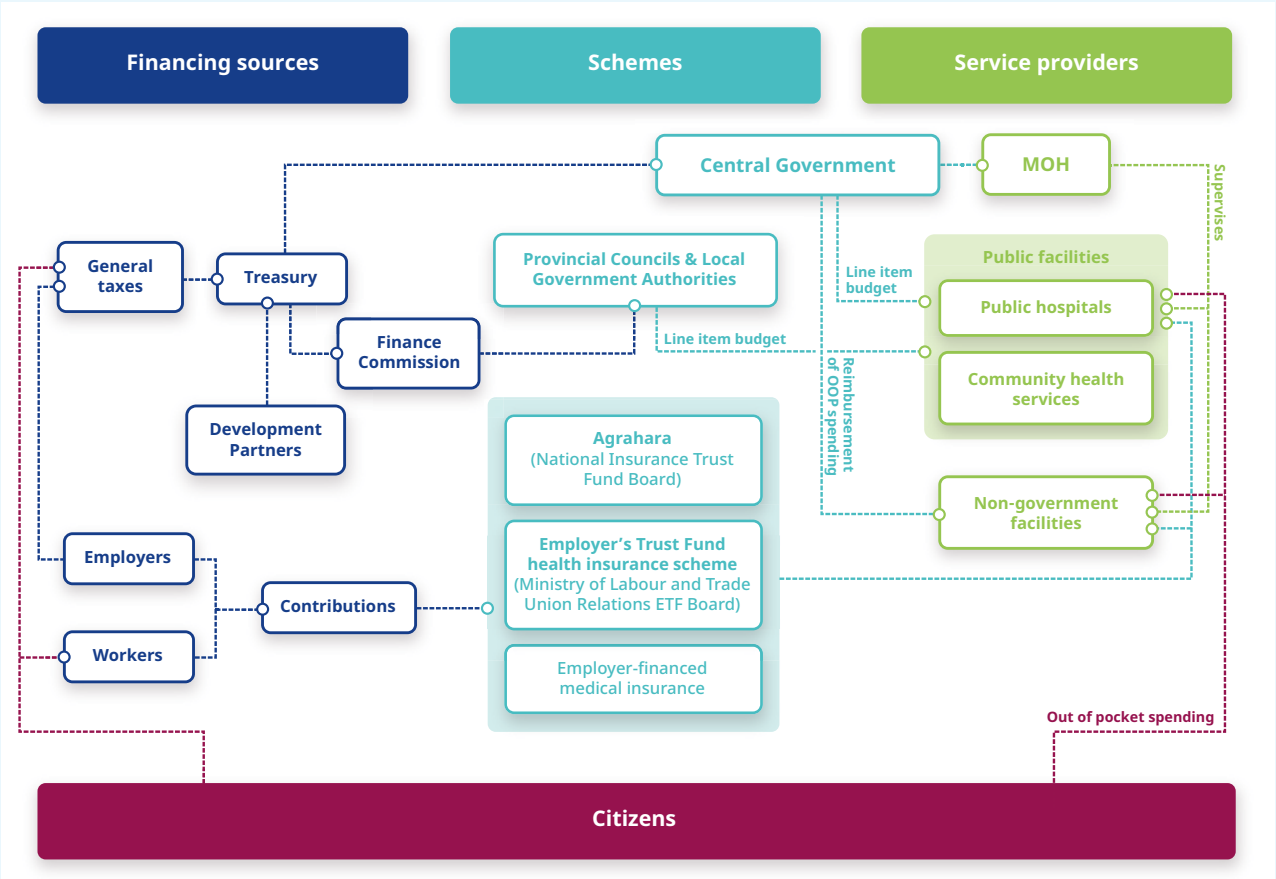
▶ **Figure 1. Current health expenditure by source of financing in Sri Lanka, 1990–2018**



Source: Adapted from Amarasinghe et al. (2021).

Figure 2 illustrates the flow of funds in the Sri Lankan health system (both public and private).

▶ **Figure 2. Overview of main financial flows of the social health protection system in Sri Lanka**



Source: Adapted from Amarasinghe et al. (2018).

Health facilities are resourced through a line-item budget at the level of hospitals or groups of facilities in the case of lower-level units, while some staffing costs and most medical supplies are financed by higher level budgets at provincial and national levels. Resource allocations are essentially input-based and not directly related to performance. However, gradual shifts in funding allocations have occurred in response to changes in patient demand, with a reallocation of financing and human resources towards secondary and tertiary facilities in recent decades, reflecting public preferences. Public funds are allocated to the central health ministry as part of the central government budget allocation, while provincial governments are financed primarily through the Finance Commission using block or criteria-based grants (Amarasinghe et al. 2018).

Government spending on public facilities and services is central to overall financing flows, whereas the contribution of government health insurance and reimbursement schemes, namely Agrahara and ETF is minimal (Amarasinghe et al. 2021). Specifically Agrahara, the insurance scheme that covers civil servants, accounts for 0.8 per cent of overall health financing, the President's Fund accounts for 0.3 per cent and the ETF accounts for 0.04 per cent. Employer financed medical benefit schemes account for 5 per cent of current expenditure on health, and commercial private medical insurance, which is mostly employer-financed group insurance for employees, accounts for 4 per cent.

Employer schemes typically reimburse workers for using private providers, or directly provide them with medical services. In recent years, the trend has been for employers to shift from directly managing such schemes to paying for group medical insurance schemes, whereby insurance firms manage the administration and payment of claims. Employer-financed group medical insurance accounts for 80 per cent of all private medical insurance, since high costs resulting from adverse selection effects reduces uptake of individual private medical insurance. Owing to typical insurance market failure, private medical insurance has withdrawn from the outpatient market, and generally only covers inpatient and specialist medical services, making no meaningful contribution to financing primary care services.

The ETF is financed by contributions to the fund, comprising 3 per cent of an employee's monthly salary, which is paid by employers. For the self-employed and migrant workers, who pay their own contributions, the minimum monthly contribution is 500 Sri Lankan Rupee (LKR), amounting to approximately US$2.65, and LKR1,000 (US$ 5.30), respectively. For the Agrahara scheme, contributions are paid by the government as the employer of beneficiaries. In 2018, LKR4,017 million (US$22.0 million), was collected in contributions, while LKR4,033 million (US$22.1 million) was paid out to reimburse benefit claims under the Agrahara insurance scheme (National Insurance Trust Fund Board 2018). This represents less than 1 per cent of total health spending in the country. Given government fiscal constraints, it is unlikely that Agrahara will increase this contribution to health financing. The President's Fund is financed by revenues from the Development Lotteries Board and public donations (President's Fund, 2020a). It represented only 0.3 per cent of Current Health Expenditures in 2018 (Amarasinghe et al. 2021).

- Governance

<u>Government health services</u>

Government health care services are managed and provided by the Ministry of Health (MOH) and the nine provincial Departments of Health (DOHs) (Rannan-Eliya and Sikurajapathy 2009).

<u>Agrahara</u>

Agrahara was originally established as a government-financed, private medical insurance policy, but it has since been converted into a statutory scheme (Sri Lanka Ministry of Finance 2019). Since January 2006, the scheme has been managed by the National Insurance Trust Fund Board under the National Insurance Trust Fund (NITF), which operates under the oversight by the Ministry of Finance (Karunaratna et al. 2019).

<u>Employees' Trust Fund (ETF)</u>

The ETF was established through Act No. 46 of 1980 to manage the implementation of the fund with oversight by the Ministry of Labour (ILO Country office for Sri Lanka and the Maldives 2016). Oversight has since shifted to the Ministry of Finance, Economy and Policy Development. The ETF Board is a semi-governmental institution (Employees' Trust Fund Board 2018), with tripartite representation. The board is responsible for the collection of contributions, investment of funds, maintenance of individual accounts, issuance of member balance statements, enforcement of the Act by tracking non-compliant employers, and the

enrolment of self-employed persons (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

The President's Fund is a social assistance programme introduced under Act No.7 (President's Fund 2020a). Services provided by the fund are approved by the Board of Governors of the Fund, which is responsible for issuing grants to children of low-income families who have attained certain distinctions in school (President's Fund 2020a).

- Legal coverage and eligibility

Government health services

Sri Lanka provides free public health care services for the whole population. Non-citizens, including migrant labourers, can also access health services for free, although no specific policy on this exists.

Agrahara

As a compulsory scheme, all public sector employees, pensionable public sector employees and their dependents are enrolled by default into the Agrahara scheme.

Employees' Trust Fund (ETF)

ETF covers workers in formal employment, including private sector employees and public sector employees who are not entitled to the Agrahara scheme. Enrolment is mandatory, with the exception of specific categories of workers. Exemptions include religious, social or charitable institutions employing fewer than ten employees, institutions training juvenile offenders, orphans or persons who are destitute, deaf or blind, and businesses where only family members are employed. The self-employed and migrant workers can join this scheme voluntarily and pay for their own contributions (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

To be eligible for social assistance through the President's Fund, beneficiaries must satisfy all of the following conditions: (i) the monthly income of the family, including the patient, spouse and unmarried children, must not exceed LKR150,000 (US$835) (President's Fund 2020a); (ii) he/she is ineligible to obtain an amount equivalent to 50 per cent or more of the total cost incurred for surgery/ treatment from any other institution (including insurance coverage, medical schemes or welfare schemes); and (iii) if the beneficiary is a retiree, s/he should be ineligible for Agrahara Insurance benefits.

- Benefits

Government health services

In principle, all services provided at public facilities are free-of-charge, with the exception of fees charged for contraceptive commodities. However, in practice, owing to financial constraints, public sector patients may be directed to private pharmacies and diagnostic services to obtain medicines and laboratory tests if these are not available in the public facility. In general, the Government does not use public funds to pay for or subsidize private services, and government doctors are not allowed to use public facilities for their off-duty private practice. The only exceptions are some very limited financing of private services by the President's Fund and the Agrahara insurance scheme.

The range of preventive health care services which are provided free-of-charge is relatively comprehensive, ranging from ante-natal and post-natal care, child growth monitoring, immunization, family planning, health promotion, nutrition counselling, communicable disease prevention, school and environmental health, food safety, and any health issues related to disaster management. The curative care network offers a comprehensive list of services, defined implicitly, which includes cosmetic surgery, oncology drugs (such as Herceptin and cardiac angioplasty) and cardiac transplants. However, these expensive services are often limited in availability and access is restricted by waiting lists.

Agrahara

Agrahara mainly covers a list of inpatient care services. In the early stages of the scheme, outpatient care was reimbursed, but this was discontinued due to excessive claims, paralleling the collapse of coverage in the private medical insurance market. Today, only spectacles and hearing aids are reimbursed as outpatient services (Karunaratna et al. 2019). Agrahara covers both public (non-fee levying) and private (fee levying) hospitals (Karunaratna et al. 2019), with no co-payments. However, in practice the Government has minimized the fiscal costs by use of reimbursement ceilings and burdensome administrative procedures that have reduced claims. In 2016, the scheme was upgraded to provide more benefits to retired public sector employees until the end of life (National Insurance

Trust Fund Board 2016). In the same year, two additional options called the Gold and Silver packages were introduced, allowing beneficiaries to upgrade their benefits package voluntarily by paying a top-up contribution.

Employees' Trust Fund (ETF)

The ETF provides financial assistance for a very limited list of health services. It provides coverage through the Shramasuwa Rekawarana Hospitalization medical scheme. Members are eligible to claim costs related to hospitalization treatment up to a maximum amount of LKR25,000 (US$132) per year, and LKR500 (US$2.63) per day of treatment as an in-patient in a government hospital for up to 10 days. This is conditional upon continuous contribution to the ETF for five years, and the length of hospitalization, which should be at least 48 hours. In addition, ETF also provides financial protection up to a certain predetermined amount on an ad-hoc basis for serious illnesses that require hospitalization and surgery. Procedures covered are limited to heart surgery, intra-ocular lens transplants and kidney transplants (ILO Country office for Sri Lanka and the Maldives 2016). The ETF also provides non-health benefits, including automatic life insurance cover for active members, disability benefits, housing loans at concessionary rates and scholarships and grants for children of active or disabled members who are unable to work anymore (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

The President's Fund covers medical expenses for specific diseases only, defined through an explicit list. This includes heart surgery, kidney disease, cancer, brain surgery, orthopedic implants, spinal disease, bone marrow transplant, liver disease, eye surgery and hearing aids (President's Fund 2020b). President's Fund beneficiaries must apply for reimbursement on an ad-hoc basis after seeking care at public hospitals and approved private and foreign hospitals. To apply for reimbursement through the President's Fund, the application must be submitted within 30 days from the date of discharge, and the surgery or treatment must have been performed in a hospital approved by the Fund.

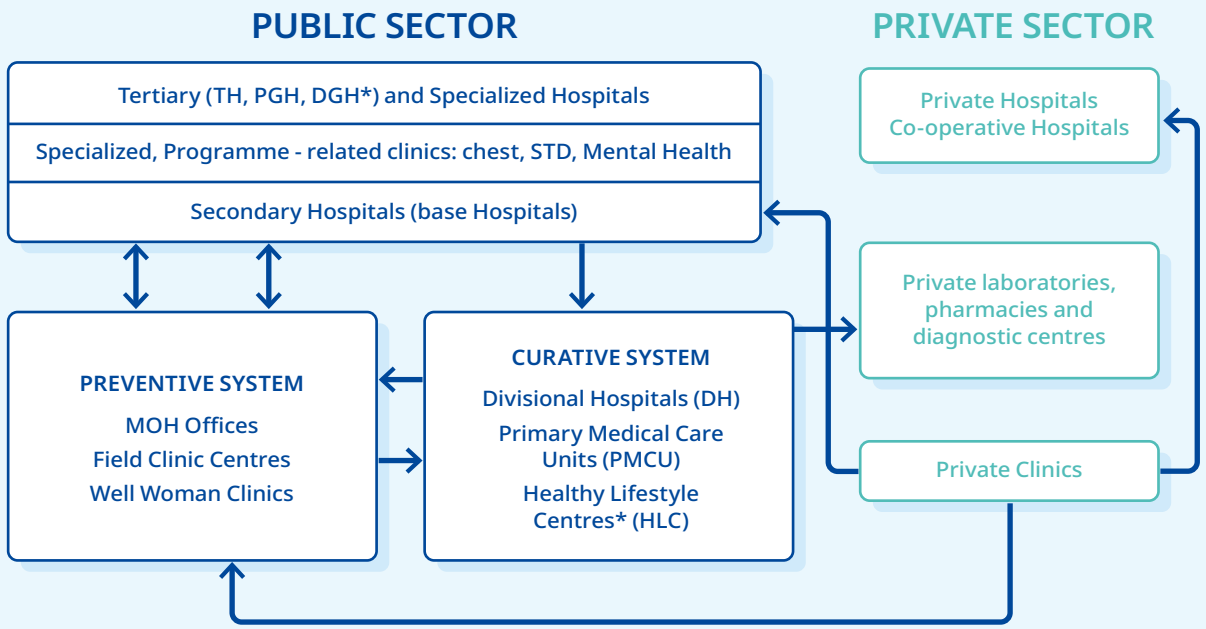
- Provision of benefits and services

Government services are provided through a well-organized network of facilities across the country under the management of local medical offices. The Government health system has three levels of care (primary, secondary and tertiary care), in which primary care is divided into preventive and curative functions. The clear separation between preventive and curative service provision at the local level is a unique feature of the system. Although there have always been some formal rules requiring referral between the different levels, in practice, there is no referral system or gate-keeping mechanism, allowing Sri Lankans full freedom of choice to visit any public facility on the island and to bypass their nearest primary level facilities in favour of secondary and tertiary care facilities if they wish to (Smith 2018; WHO 2017). This reflects the emphasis placed on universal access over quality. In practice, almost all tertiary and secondary hospitals also provide primary care through their general outpatient clinics, but access to specialist clinics in these hospitals is accessible only via referral through general outpatient clinics.

Public health facilities are mainly financed through line-item budgets, which are not performance based, and management of public facilities is hierarchical and led by doctors. There is no purchaser-provider split, and financing and provision of services are fully integrated within the public system, at central and provincial levels. There are no co-payments and limited informal payments requested from patients in public facilities, although fees are charged for family planning commodities. Beneficiaries of the ETF can use public and approved private providers and, in some cases, they can use providers abroad.

The private sector is staffed mostly by government doctors engaging in private practice outside official hours. This is most significant in the outpatient sector, where private provision accounts for half of all visits, but is limited in the inpatient sector where private hospitals account for only 4–5 per cent of inpatient visits, largely owing to the OOP cost of care.

Figure 3. Network of health care providers in Sri Lanka



Source: Adapted from Ministry of Health, Nutrition and Indigenous Medicine (2019).

4. Results

- Coverage

As previously noted, Sri Lanka provides free public health care services for the whole population, supplemented with the option of private services to enhance the level of coverage for beneficiaries of insurance schemes. Overall, employer-financed medical benefit schemes and private medical insurance schemes cover about 10 per cent of the population, mostly comprised of formal sector workers and their dependents. However, they do not provide meaningful coverage of the poor, the chronically ill or the elderly, who would most benefit from improved health care financing. In 2018, there were around 82,416 employers in the scheme and there were 14.6 million ETF accounts, though 12.0 million accounts were inactive, leaving only 2.6 million active members (Employees' Trust Fund Board 2018). In 2018, there were 183,688 ETF claims for reimbursement, but these accounted for less than 0.1 per cent of total financing; as such, the ETF makes a negligible contribution to social health protection. The Agrahara scheme covered approximately 850,000 people in 2016 (National Insurance Trust Fund Board 2016), and the President's Fund covered around 7,752 beneficiaries in 2017 (President's Fund 2020c).

- Adequacy of benefits/ financial protection

While OOP payments remain very high as a share of financing, at 42 per cent of current health expenditure in 2018, Sri Lanka experiences a low incidence of catastrophic health spending, which stood at 0.4 per cent in 2015. This is due to the fact that almost half of total OOP expenditures are incurred by the richest households in private facilities, while forced spending among the poor is minimal. In fact, the share of total OOP expenditures only appears high due to the low level of public health spending and the high cost-efficiency of the system. The actual level of OOP spending is in fact relatively low (less than 1.4 per cent of GDP) compared to other countries in the region (Smith 2018). Therefore, despite a high OOP share, Sri Lanka performs well in terms of providing financial protection to those who need it most, with a situation comparable to that in Malaysia (Rannan-Eliya et al. 2016). However, low levels of public financing does result in gaps in provision, which not only affects

the supply of medicines and lab tests, but also those who require treatment for chronic diseases. OOP expenditures on medicines and lab tests accounted for about 61 per cent of total OOP spending in 2018 (Amarasinghe et al. 2021), and a proportion of this was related to public sector consultations.

- Responsiveness to population needs

    o Availability and accessibility

The public system is able to provide Sri Lankans with high volumes of health services at reasonable levels of clinical quality and at low cost, in such a way that prevents income inequalities in access to most services. The health care network in Sri Lanka is extensive, with the co-existence of both public and private providers, which positively contributes to the accessibility of health care services. Indeed, the country has a dense network of health facilities. Most Sri Lankans live within three kilometres of a health facility, approximately 93 per cent of the population lives within 15 kilometres from the nearest hospital and the average distance between households and maternity clinics is just 2.5 kilometres. The provision of widely accessible public health care services is reinforced by a relatively high population density (Smith 2018). Furthermore, despite potential disadvantages, the lack of enforcement of a referral system prevents inequalities in access that would arise if people living in disadvantaged areas could only access services in their immediate vicinity.

This relatively high level of access is indicated by several metrics. In the case of critical preventive services, coverage rates for essential immunizations are typically 98–99 per cent, which is higher than the OECD average. As for curative care, doctor consultations averaged 7.7 per capita in 2018, which was higher than the OECD average of 6.8 in 2017. Easy access to hospitals is reflected by very high hospital discharge rates, which reached 34.5 per 100 capita in 2018, compared with an OECD average of 15.4 in 2017.

In general, the average Sri Lankan, including Sri Lankans living below the poverty line, make more frequent use of physicians and hospitals than the average citizen of other South and South-East Asian countries, with the single exception of Singapore. These high levels of health care use translate into low levels of unmet need. According to preliminary results from the Sri Lanka Health and Ageing Survey 2019, which is comparable to the European Union (EU) survey to track unmet need, 5.3 per cent of Sri Lankans had experienced unmet needs for medical care (Institute for Health Policy, unpublished). This can be compared with an EU average of 2.6 per cent in 2016, 0.3 per cent in Germany and 5.5 per cent in Italy. Sri Lankan survey respondents attributed unmet needs in the past 12 months to financial costs, travel barriers or waiting times.

It is worth noting that, at lower-level public hospitals, there are significant variations in available services, though public tertiary hospitals generally provide most of the services they have been assigned to provide (Sri Lanka Ministry of Health, Nutrition and Indigenous Medicine 2019). However, not all services are readily available, as there can be significant waiting lists or limited availability of the required specialized human resources, equipment and drugs for certain services (Smith 2018). Ten of the 48 essential medicines were available in more than 95 per cent of facilities, while another ten medicines were available in less than 50 per cent of the facilities. These shortages are officially managed by providing some public sector patients with prescriptions which they can take to private pharmacies.

    o Quality and acceptability

In general, public services do relatively well in providing extensive preventative and curative services for the population. Intensive use of modern medical services has been a key driver of Sri Lanka's impressive health outcomes for several decades, ranging from child health and maternal outcomes to the elimination of malaria (Amarasiri de Silva et al. 2001; Caldwell et al. 1989; Rannan-Eliya and Sikurajapathy 2009) A critical factor in this is the relatively high quality of clinical care provided in both public and private sectors. Available evidence indicates that public sector services often provide better quality of care than equivalent private services, and that overall quality levels compare favourably with other developing countries (Rannan-Eliya et al. 2015).

However, the limited availability of human resources, equipment and drugs required for certain specialized services at public facilities, such as angioplasty for coronary artery disease, potentially hinders the system's responsiveness to population needs, particularly in relation to NCDs, for which medications and diagnostic services are essential inputs. As previously noted, general financial constraints in the public sector have led wealthier patients to opt for private facilities, but it is not necessarily the case that this results in

pro-rich inequities in quality of care, including for the management of chronic NCDs. In fact, recent data collected by the Sri Lanka Ageing Survey 2019 indicates a skewed, pro-poor use of specialist services for NCD care because of the availability of such services in the public sector.

Generally, there are high levels of public support for public sector health services, with high levels of satisfaction, although dissatisfaction increases with income level (Bhatia et al., 2009; Rannan-Eliya and de Mel 1997). Although management reforms have continued to generate large increases in operating efficiency, the failure to increase government spending as a share of national income results in shortfalls in consumer quality of free public services. Health policy has implicitly focused on driving continuous productivity improvements to minimize public sector costs and improve targeting of the limited public spending by focusing on maximizing physical access and clinical quality. This has taken precedence at the expense of consumer aspects of quality such as waiting times, doctor choice, minimal amenities and crowding, which tend to matter more to higher-income Sri Lankans.

Quality issues resulting from low levels of government health spending can be attributed to a political economy that gives voice to better-off Sri Lankans and economic interests opposed to increased taxation. This has resulted in a stable compromise, whereby the Government delivers an extensive range of health care services that are free in practice and widely accessible, but, due to funding constraints, are not sufficient to provide upper-income Sri Lankans with the level of non-clinical quality that they would like. Consequently, they prefer to opt for private services, which provide comparable or lower levels of clinical quality compared to the public sector (Rannan-Eliya et al. 2015). However, middle-income patients who prefer private services are often dissatisfied by the cost of private care, which leads to considerable dissatisfaction within the top two income quintiles. Nonetheless, most Sri Lankan voters express high levels of satisfaction with and support for public health services.

▶ 5. Way forward

Sri Lanka's approach has proven remarkably resilient to shocks and demonstrated a strong ability to learn and adapt to new challenges while minimizing costs. Evidence indicates that the health system is coping well with the cost pressures from population ageing and epidemiological transition, and that it is incrementally adjusting service provision and quality to meet the increasing burden of NCDs. The system does well in maximizing health outcomes and financial risk protection, and experiences of comparable mixed systems indicate that the overall system has the capacity to meet the needs of the population as the country develops.

However, Sri Lanka's population is ageing relatively rapidly compared with most other countries at a similar income level. This will result in upward cost pressures in the health system, with challenges likely to arise in the resourcing of long-term care (LTC). Currently, Sri Lanka has no financing mechanisms to pay for LTC (Asian Development Bank 2019), which in developed economies, now accounts for 2–4 per cent of GDP. However, the Sri Lankan health system has proven to be quite resilient to cost pressures, with overall volumes and quality of care actually increasing in the past two decades, despite health spending falling as a share of GDP. Repeated analyses have concluded that Sri Lanka's ability to constantly reduce unit costs through productivity improvements may enable Sri Lanka to substantially mitigate cost pressures arising from ageing and to maintain overall health care costs at a level substantially lower than other countries of a similar income level (Rannan-Eliya 2008; Rannan-Eliya et al. unpublished).

While the health system successfully addressed the maternal and child health agenda, additional investment will be needed to address the changing health needs of the population to prevent and respond to the increasing burden of NCDs. This would include addressing human resource constraints and availability of NCD diagnosis and treatment, particularly at outpatient level. However, system performance in managing NCDs is relatively good compared to other developing countries, with recent evidence indicating comparatively high levels of diagnosis and control of diabetes, as well as rapid reductions in age-specific cardiovascular disease mortality, which is beginning to close the gap with developed nations (Sri Lanka Ministry of Health and Harvard TH Chan School of Public Health 2016). Organizational and clinical governance reforms may well be needed too, but these promising signs suggest that the current system still has capacity to improve

performance with additional investment, and to incrementally adapt services and strategies.

Overall, increased resources for health are needed, but the Government first needs to create additional fiscal space. The main constraint on government spending for the last four decades has been a tax policy that has continuously shrunk the tax base, with general revenue tax mobilization reaching a low of 12 per cent of GDP in 2019. Tax cuts in late 2019, combined with the impact of COVID-19, are projected to reduce revenue to 9 per cent of GDP in 2020 (Central Bank of Sri Lanka 2019). This level of tax mobilization is far lower than other countries at the same income level. Taxes have also shifted towards reliance on indirect taxes (VAT); however, in the 2019 budget, these were also cut. Generating additional resources by raising corporate and personal income tax rates and widening the tax base is needed. However, this requires a fundamental rethinking of tax and economic growth strategies to align them more closely with public preferences in favour of increased taxation, especially increased direct taxation, to pay for public services (Rannan-Eliya 2020).

As previously noted, Sri Lanka's approach to social health protection represents a compromise between the political pressures from its poorer voters for universal access and risk protection, and the opposition from wealthier voters and economic interests to increased taxation to pay for coverage of the non-wealthy. This compromise critically depends on continuing to collect taxes from the wealthy but using differences in consumer quality to persuade them to voluntarily opt out of free, tax-funded public services and self-pay for private services. The introduction of insurance schemes covering the non-poor would likely damage this balance and hurt the poor by undermining willingness of higher-income Sri Lankans to continue paying taxes for services that they opt out of. Any social health insurance scheme would therefore have to be universal in coverage, since the creation of two public tiers that provides subsidized access to private providers for better-off voters would be opposed by most of the population. Such opposition could threaten stability in the country.

Any new insurance-financed public scheme which subsidizes access to the private services that middle-income voters prefer to use would inevitably cost more than the current public system and would have to be financed either through increased taxation or new social insurance contributions. Since poorer voters have access to free services, they will not be able or willing to contribute to any new insurance scheme. While middle-income voters may express support for paying into an insurance scheme to assist in paying for private services, it is not likely that they will support making additional contributions to a scheme to pay for poorer Sri Lankans to obtain the same access to subsidized private care.

For these reasons, there is likely to be a continued cycle of proposals to introduce insurance mechanisms, and interest by some development partners in supporting such proposals, followed by failure to implement them. Without substantial increases in taxes or mandatory contributions, the most feasible changes would involve more modest increases in taxation or contributions to extend public financing to partially cover private providers. However, with growing fiscal deficits and continuing declines in tax collection, even such modest changes are currently unfeasible.

6. Main lessons learned

- Strong outcomes can be achieved without adopting complex financing systems. The performance of a model depends more on good governance, strong political leadership and efficient management.
- It is possible to design pro-poor social health protection without targeting the poor. Sri Lanka's success involved eliminating means testing, removing co-payments and minimizing informal payments at the point of care through the public scheme. Effective universal access to this has been achieved by maintaining an organized, highly distributed, accessible and efficient network of public health facilities. The absence of targeting mechanisms, known for incurring large exclusion errors, and the lack of user charges, which can discourage access by the poor, have reinforced universal access.
- Despite the high share of OOP spending, at around 40 per cent of total health spending, Sri Lanka performs well in terms of financial protection, with a modest incidence of catastrophic health spending and relatively minimal impoverishing OOP spending. This is because OOP spending is largely

concentrated among wealthier populations. By using policies that shift the burden of OOP spending to the better-off, who voluntarily choose to use private services, minimizing OOP spending among those who use free public services, and prioritizing public spending to cover expensive hospital and inpatient care, financial protection has been maximized despite low levels of government spending.

- Mixed systems, like those of Sri Lanka, Malaysia and Hong Kong, are far more stable and resilient to change than casual observers imagine, and they represent a low-cost alternative to the Beveridge and Bismarckian approaches to achieving UHC. This warrants attention from other developing nations with limited financial resources.

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