



COUNTRY CASE STUDY

UNIVERSAL TAX FUNDED HEALTH SYSTEM IN SRI LANKA

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1. OVERVIEW OF POLITICAL, SOCIO-ECONOMIC AND HEALTH CONTEXT

Sri Lanka is classified as a lower-middle income country. The service sector, in which the largest components are tourism, telecommunications and banking, employs the largest percentage of the labour force. The next largest sector is agriculture (particularly rice, tea, rubber and coconut products), while industry (textile, clothing, leather and rubber being the most important products) is still quite limited in Sri Lanka.

Macro- & socio-economic and demographic indicators	
GDP (USD 2005 Billions)	23.5
GNI per capita (USD 2005)	1,160
Gini coefficient (2000)	33.2
Urbanisation (% total population)	15
Literacy (% population aged 15+)	90.7
Population (Millions 2005)	19.6
Unemployment rate (2004)	7.8

Labour Force Structure by sector (% of labour force) (1998)	
Services sector	45
Agriculture	38
Industry and manufacturing	17

Health Sector Financing/Expenditure Statistics (2003)	
Health expenditure, total (as a percentage of GDP)	4
Health expenditure, public (as a percentage of GDP)	2
Health expenditure, public (% of total health expenditure)	45
Health expenditure per capita (\$)	31

Health Status Indicators	
Infant mortality rate (per 1000 live births)(2004)	12
Under 5 mortality rate (per 1000 live births)(2004)	14.1
Maternal mortality (per 100, 000 live births)(2000)	92
Life expectancy at birth (years)(2004)	74.4

Sources: WHO National Health Accounts website for health care financing statistics; World Bank website for all other data

The development path followed by Sri Lanka has been described as ‘support-led security’, in which public provision and funding of health and other social services has promoted social progress even though the economy was small and growing at a low rate. This policy existed even before independence in 1948. For example, there was a very rapid expansion of government schools and health facilities in the 1930s and 1940s. Free education was introduced in 1947, and free health care in 1953. In addition, until the 1980s, free or heavily subsidised rice was distributed. Along with

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strong support for publicly funded social services, the commitment to social justice, with particular emphasis on addressing the needs of the worst-off, was a key feature of state policy.

Sri Lanka is widely regarded as a classic example of a 'success story'. Despite having low income levels and only gradual economic growth, as well as relatively low levels of spending on health (with public health care expenditure only being equivalent to 2% of GDP), it has achieved remarkably good health status. It has also achieved a high literacy rate. It has been stated that these achievements are testimony to the effectiveness of sustained public spending on social services and the consistent commitment to equity and social justice, which is also borne out by the relatively equitable distribution of income (with a Gini Index of only 33).

Mortality (overall and infant mortality) began declining as early as the 1920s, but fell particularly rapidly in the 1940s and 1950s, and with a slower downward trend being sustained after this period. Life expectancy increased from 43.9 years for males and 41.6 for females in 1946 to 70.7 for men and 75.4 for women in the late 1990s.

Sri Lanka is currently undergoing an epidemiological transition with a growing burden of illness due to chronic diseases, particularly ischemic heart disease, diabetes, and cancers. However, the major cause of death is acute respiratory infections, followed by diarrhoeal diseases. These are also the major causes of morbidity along with dengue hemorrhagic fever. Infectious diseases and injuries are also still the major reason for admission. Malnutrition remains a major health problem for young children.

Recent Sri Lankan governments have introduced increasingly neo-liberal policies, supporting privatisation and reductions in government expenditure. There are concerns that recent reductions in spending on education led to a drop in rates of school attendance, particularly for girls, and literacy rates.

2. DEVELOPMENT OF HEALTH SYSTEM

Early government spending on the health sector was primarily directed at preventive interventions to address cholera, smallpox and other infectious diseases. The first health unit (facility) was established in 1926 by the Ministry of Public Health, and more were gradually established. Following a very serious malaria outbreak in the mid 1930s, the government decided to establish health units across all rural areas. A well developed and distributed network of health facilities (both primary care facilities or dispensaries and hospitals) existed across the country by the late 1940s. Tertiary hospitals are located only in the major urban centres. Outreach services were also introduced, focusing on identifying pregnant women to encourage them to seek antenatal care and delivery in a facility with trained midwives, and identifying young children needing immunisations. These efforts have been very successful, with 92% of births taking place within a health facility and assisted by a trained midwife by the late 1990s, and over 80% of young children being fully immunised.

Until recently, management of public sector health services was highly centralised. In the late 1980s, all health facilities other than teaching and specialised hospitals were devolved to newly established provincial Ministries of Health. These authorities were given considerable responsibility for the management of health facilities. The provincial Ministries are dependent on financial resources allocated from the central level for running their services. Public sector facilities are allocated budgets.

A key tenet of health policy in Sri Lanka was, and still is, universal access to free care at all levels of care. With the introduction of free care in 1953, all fees at primary health care and hospital level were abolished (except for family planning services). Every Sri Lankan is entitled to use government health services without any payment.

Although all Sri Lankans have this entitlement, those who can afford to can choose to use private sector services. The private health sector only began to develop in earnest during the 1960s. It focuses particularly on ambulatory care in the form of general practitioners. Although there are some full-time private general practitioners, most private provision takes the form of dual practice by doctors who are employed in the public health sector and have a limited private practice outside of official working hours. There are also traditional health care practitioners. Sri Lanka has successfully

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avoided the development of unqualified informal providers (such as drug vendors) that are widespread in some other Asian and many African countries. By the late 1990s, the private sector was providing almost half of ambulatory consultations, but only 6% of admissions (with the vast majority - 95% - of hospital admissions being in the public sector). Private providers are paid on a fee-for-service basis.

3. CURRENT STRUCTURE AND FUNCTIONING OF THE HEALTH SYSTEM

As indicated above, the core of the Sri Lankan health system is public sector facilities, with almost all Sri Lankans using public hospitals for inpatient care and about half doing the same for outpatient care. By the early 2000s, the public health sector infrastructure included nearly 500 hospitals and more than 400 dispensaries. The population per public sector doctor was just over 2,400 people.

In relation to health care financing, approximately 50% is attributable to general tax resources with the other 50% attributable to out-of-pocket payments. As there are no user fees for public sector services, these out-of-pocket payments relate particularly to payments to private practitioners for out-patient services but also include purchase of medicines at private pharmacies by public sector patients when a public facility has a 'stock-out'. There is also evidence of 'informal fees' being charged by some public health care providers.

Direct taxes (e.g. personal and company income tax) only account for 21% of general tax revenue, with the vast majority (65%) coming from indirect taxes (such as taxes on goods and services) and the remaining 14% being attributable to non-tax revenue. While direct taxes are strongly progressive, in that such taxes are restricted to high income earners, indirect taxes are roughly proportional (i.e. all income groups contribute the same percentage of their income to these taxes). Out-of-pocket payments were marginally progressive, given that these payments were primarily incurred by higher income groups.

There is a relatively even distribution of benefits from public sector facilities across different socio-economic groups, particularly in hospitals. The table below highlights

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that the poorest households benefit disproportionately from inpatient and outpatient care at hospitals relative to higher income households, but the reverse is true for care provided at dispensaries and other non-hospital health facilities. In terms of the value of these services used, the poorest households benefit slightly more than higher income groups. Benefits from public sector health services are much more equitably distributed than for most other countries for which such data are available. One of the contributory factors is that although hospitals in Sri Lanka are relatively small (other than the higher level referral hospitals) they are very widely distributed across the country and geographically accessible to the majority of the population.

	Poorest 20% of households	Richest 20% of households
<i>Utilisation</i>		
Hospital inpatient	23%	16%
Hospital OPD	22%	14%
Non-hospital	19%	25%
<i>Value of subsidy</i>		
Hospital inpatient	21%	18%
Hospital OPD	21%	17%
Total	21%	18%

A relatively high proportion (69%) of government health care funding is allocated to hospitals. This is seen as important in ensuring that all Sri Lankans can use hospital services without having to pay any fees. Given that costs, and hence fees, at hospital level particularly for inpatient care can be relatively high, this could protect households against incurring catastrophic health care related costs. Indeed, a recent study has indicated that only 3-3.5% of households incurred health care expenses that were 10% or more of household consumption expenditure, which is a 'cut-off' point frequently used for measuring catastrophic costs. This was the lowest level of six Asian countries included in the study. Of importance is that there was very little difference in the occurrence of catastrophic levels of health care expenditure between rural and urban areas.

4. KEY ISSUES

Sri Lanka is a good example of a country that has achieved excellent health status, which is almost comparable to that in high-income countries, despite having limited economic resources. A key factor underlying this achievement is the government commitment to promoting equitable economic development through sustained tax funded spending on health and other social services, which are available universally without a user charge. It has managed to do this at relatively low levels of health care expenditure in the public sector, which suggests efficient service provision. However, there is a growing burden of non-communicable diseases, such as diabetes and cancer, which many remote facilities are not equipped to deal with, resulting in physical access to required services and associated transport costs becoming an increasing problem. Although many challenges face the Sri Lankan health system, such as the need to provide relatively more expensive services to address the growing chronic disease burden, it illustrates what can be accomplished within a universal tax funded health system.

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