

**A PRELIMINARY ASSESSMENT OF  
SRI LANKA'S HEALTH SECTOR  
AND STEPS FORWARD**

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Sri Lanka**

**Cambridge, Massachusetts, USA  
January 16, 2000**

## PREFACE

This study was carried out as part of a collaborative effort between the Government of Sri Lanka and the World Bank. We wish to thank the Government of Japan for providing funds for the work. We also wish to acknowledge the support of Anne Tinker for this effort.

This report was prepared by Prof. William Hsiao, with the invaluable assistance of the Institute of Policy Studies Health Policy Programme. Inputs were provided by several staff at IPS, including Jehan Mendis (Project Intern), Easha Ramachandran (Research Assistant), Aparnaa Somanathan (Research Officer), Dilshan Muhajarine (Programme Manager), Varuni Sumathiratne (Research Assistant) and Dushni Weerakoon (Fellow). Overall direction and co-ordination and substantial contributions were provided by Dr. Ravi Rannan-Eliya (Associate Fellow) and Sharmila Basnayake (Research Assistant). Tamara Dorabawila (Research Assistant) assisted with the final revisions. The report was substantially completed during 1998, with final revisions in 1999.

Advice and assistance was received from numerous people, including Prof. Indralal de Silva (Department of Demography, University of Colombo), Dr. Hemamal Jayawardena (UNAIDS/Colombo), and Hema Wijeratne (Insurance Services International).

The support and assistance of Dr. K.C.S. Dalpatadu, Deputy Director-General (Planning), MOHIM, and of other Ministry staff is gratefully acknowledged, although any errors and omissions are solely those of the authors. Any views expressed in the document are solely those of the authors and do not necessarily represent those of the Ministry of Health or the Institute of Policy Studies. MOH data reported in this report were the latest available at the time of preparation, which in most cases were from the 1997 MOH Annual Health Bulletin.

The objectives of the report were as follows:

- (1) To review the organization, structure and financing of Sri Lanka's national health system, providing basic descriptive parameters
- (2) To identify strengths and weaknesses of system, with reference to earlier performance and any available international benchmarks.
- (3) To identify emerging trends in the development of the health system.
- (4) To review current policy agenda and identify system issues.

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average length of stay
AMO	Assistant Medical Officer
AMP	Assistant Medical Practitioner
BOI	Board of Investment
CD	Central Dispensary
CD & MH	Central Dispensary and Maternity Home
CDD	Cosmetics, Devices and Drugs Act
CFS	Consumer Finance Survey
CWC	Ceylon Workers Congress
DALY	Disability Adjusted Life Year
DDT	Dichlorodiphenyltrichloroethane
DGHS	Director General of Health Services
DQAL	Drug Quality Assurance Laboratory
DRA	Drugs Regulatory Authority
EPF	Employees Provident Fund
EPI	Expanded Programme of Immunisation
GDCF	Gross Domestic Capital Formation
GDP	Gross Domestic Product
GMOA	Government Medical Officers Association
GNP	Gross National Product
GOSL	Government of Sri Lanka
GP	General Practitioner
GST	General Sales Tax
HIV	Human Immunodeficiency Virus
IHD	Ischaemic Heart Disease
IMPA	Independent Medical Practitioners Association
IMR	Infant mortality rate
IPS	Institute of Policy Studies
IPS HPP	IPS Health Policy Programme
JVP	Janata Vimukti Peramuna
LMP	Licensed Medical Practitioner
LSSP	Lanka Sama Samaj Party
LTTE	Liberation Tigers of Tamil Eelam
MCH	Maternal and Child Health
MDPU	Management Development and Planning Unit, MOH
MOF	Ministry of Finance
MOH	Ministry of Health
MOHIM	Ministry of Health and Indigenous Medicine
MOOH	Medical Officers of Health (usually work outside main hospitals)
MOMCH	Medical Officer for Maternal and Child Health
NHA	National Health Accounts
NO	Nursing Officer
OPD	Outpatient Department
PA	People's Alliance
PC	Provincial Council
PDHS	Provincial Director of Health Services
PHA	Provincial Health Authority
PHI	Public health inspector
PHNO	Public health nursing officer
PR	Proportional representation
PTF	Presidential Task Force
PTF1	1992 Presidential Task Force on National Health Policy
PTF2	1997 Presidential Task Force on National Health Policy
RMO	Registered Medical Officer

SLFP	Sri Lanka Freedom Party
SLIC	Sri Lanka Insurance Corporation Limited
SLMA	Sri Lanka Medical Association
SLNHA	Sri Lanka National Health Accounts
STD	Sexually Transmitted Disease
TB	Tuberculosis
TB	Treasury bills
TFR	Total Fertility Rate
UNP	United National Party
WHO	World Health Organisation

## INTRODUCTION

This is a preliminary report assessing the current status of Sri Lanka's health care system, its problems, future challenges, and issues to consider in the development of potential reform options. It provides an overview of the status of health system in the areas of organization, financing, performance in terms of meeting health status objectives, equity and efficiency, and the interface with the private sector. The health system is assessed in terms of both public and private components, but the description of the public sector is necessarily more detailed, since information on the private sector is weak, and since the public sector remains the dominant actor in the health system. The data and evidence presented is largely secondary owing to time and budgetary constraints, but some new data from a private hospital survey, carried out specially for this report, are used.

Preceding all this is a short description of the economic and fiscal context to provide critical background to assess the availability of increased general revenue funding for the health sector in the medium term future. This section indicates that the options for increasing general revenue funding will be extremely limited in the next few years, whether or not the internal conflict ceases. This constraint is not related to the priority which GOSL places on health, which has historically been high, but the limitations caused by decades of cost-cutting in other areas, and the necessary needs of internal security. Room for further cost-cutting in the budget does not exist, and if additional resources become available after peace is restored, the priority for public spending must be economic infrastructure.

The sections on organization and financing demonstrate that Sri Lanka's publicly dominated health care provision and financing has been highly effective in providing effective and equitable health care services to the whole population at low cost to both the economy as a whole as well as the public treasury. National health expenditures have been low, and have not inflated with time or with economic development and market liberalization post-1977. Contrary to reports previously by other commentators and by Sri Lankan observers, the empirical evidence demonstrates that the Sri Lankan public hospital system manages available resources highly efficiently, and achieves productivity and efficiency levels not only unrivalled in Sri Lanka's private sector, but also in any other comparable country. Nevertheless, the evidence points to an inability in the system to change or manage organizational reforms. The principle reason for this appears to be lack of resources at the margin to fund additional management capacity or to increase human and financial resources in the delivery of services. While Sri Lanka's public system is a centrally managed command and control system, it lacks the resources to shift to a more effective or responsive management structure. This constraint requires significant new financial resources to resolve, and must be dealt with before attempting major organizational changes.

In the course of each section, issues related to devolution are highlighted. In general, the evidence indicates significant problems in both the original conceptualization of devolved government as well as its actual implementation since 1987. A decade of experience with devolution has not resolved many of the real implementation and design issues. Political commitment to decentralization has also been lacking, and has manifested itself in all areas contributing to continued confusion and ambiguity.

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## EXECUTIVE SUMMARY

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Amongst the low-income and lower-middle income nations, Sri Lanka has achieved enviable results in its health sector. The nation spends a relatively small amount of its resources but produces impressive health status for its people. However, Sri Lanka has difficulty in maintaining its enviable record, because it is completing its epidemiological transition. The population now suffers increasingly from chronic diseases. The rapid economic development of Sri Lanka is accompanied by a high incidence of mental disorder, drug addiction and suicides. At the same time, raising per capita income also brings about increasing demand for better quality of health care and new expensive medical services. On the other hand, the government's budget is stretched beyond its limits partly due to the civil war.

### General Context

This report begins with selected background information on Sri Lanka, including a brief history of the nation, current political structure and distribution of power, macroeconomic conditions and public finance. Good policy analysis requires an understanding of a nation's history, culture, and social values since they shape public preferences and policy. Good technical or economic analysis is necessary, but insufficient to establish sound public policy. *Politics decide policy*. Thus we provide a description of the current political structure of Sri Lanka. A nation's macroeconomic conditions have to be examined along with what pressing demands are imposed on the treasury when we consider whether the government can provide sustainable public funding for health care

### History and Politics

Sri Lanka has placed high priority on equity since its independence. Even during periods of economic stringency, Sri Lanka had spent close to 10 per cent of its GDP on welfare compared with 6 per cent in Thailand and 3 per cent in Philippines (World Bank, 1981). Sri Lanka is one of the oldest democratic states in the developing and developed world. Since the 1950s, politics has been characterized by competition and alternation in power between two established political groupings. Health care and health continue to have high priority, as is evidenced by its relative protection in the annual budget negotiations, and the substantive role that health services have played in stabilizing Sri Lankan democracy at critical moments. Health policy has remained an area decided by bipartisan consensus. Currently, there is no bipartisan consensus on health sector reform. Polling data indicate that there is no widespread public dissatisfaction with the state of health services. Past reform efforts showed that any successful reform requires significant consultation of important stakeholders, including the public sector doctors and nurses unions, line ministry staff in MOH, as well as private sector leaders. This has not occurred yet.

### Macroeconomic Trends and Public Finance

Sri Lanka's open economy continues to display considerable resilience, despite 17 years of internal conflict, and other external shocks. Per capita income growth at ~3.5-5% per year is expected to continue in the medium term (3-6 years), even if the current conflict continues. During 1998, Sri Lanka escaped any direct impact from the regional economic crisis, with export growth and GDP growth remaining positive at 8% in dollar terms and 5% per annum. However, during 1998-99, as crisis-hit Asian economies recovered, economic performance slowed significantly with increased regional competition. Per capita income is over \$850. The country is no longer classified as a low-income economy. The present high unemployment rate is set to decline over the next decade, with a possibility of full employment by 2010.

Despite generally positive economic trends, the fiscal situation for the government is likely to remain tight in the medium term. The tax base, which was equivalent to 20% of GDP, has fallen to 17% recently, which should be of concern. Structural reasons may prevent the tax base increasing significantly above 20% in the near future. Close to 50 per cent of the budget is spent on defense and interest payment on public debts.

Although the privileged position of health and education in the budgetary process is likely to remain (health has been protected from budget cuts), it is unlikely the government can allocate a significantly higher portion of its budget to health care in the medium term (2-6 years). Defense expenditure and debt repayment take up all available discretionary revenue resources. Defense expenditures cannot be realistically cut in the next 2-3 years, as there is little prospect of an early end to the conflict. Even when peace returns, there is unlikely to be fiscal savings in the short term for two reasons: (a) military salaries keep a substantial proportion of rural households above the poverty line, and would have to be replaced by other income transfers for social and political reasons; (b) military expenditures have been funded largely by reducing investment in economic infrastructure, such as roads, telecommunications, rail, and ports. After peace returns, the first priority for government spending is investing in infrastructure, which has become a major constraint to more rapid economic growth. Moreover the government has to fund the reconstruction in the North-East region. In this fiscal context, general revenue financing is unlikely to be available to meet the resource gap in health care.

## **The Health Sector**

We describe and analyze the health status, emerging infectious diseases, and morbidity trends in Sri Lanka. They give indications of the past achievements in health and expected future demands and needs. Next, we analyze the organization of public and private health care provisions, the physician supply, the health care financing system, and the regulatory framework for the Sri Lankan health sector. These analyses provide us with an understanding of the strengths and weaknesses of the current system. Thus, we can assess what major issues and problems confronting Sri Lanka.

### **Health status and performance**

Sri Lanka was and remains a high performer in health status terms, with better health indicators than other low-income and lower-middle-income countries, statistical data problems notwithstanding. Mortality rates are low and continue to decline at above average rates, in comparison with other comparable countries such as China. Fertility is already below replacement level, and is expected to reach 1.4-1.7 by year 2015 if the current trend continues. With life expectancy projected to reach current US levels by 2020, the country faces a rapid aging process with an increasing portion of the population suffering from chronic diseases. The number of elderly is expected to increase rapidly after 2010. While there are some signs that MOH is re-orientating itself to the emerging health needs, there is yet to be a shift in the policy and priority. The epidemiological transition is well under way, but the country remains free of a major HIV/AIDS epidemic and of the resurgence of old diseases such as tuberculosis. This may be a testimony to the effectiveness of the public health and prevention programs in the existing health system.

### **Organization of health care delivery**

In the organizational analysis, we provide an assessment of the public and private provision of health care, a detailed description of the organizational structure of the public sector provision, the procedures and rules in allocating public funds, the organization of the Ministry of Health and how it directs and manages public sector health care, and of the training of physicians.

Public sector provision of health care is organized into discrete tiers, each supposedly providing a defined technical level of health care. The number of facilities and beds is largely determined by a population formula, but sometimes politics intrudes on capital investment decisions. Staffing is determined by the

level of facility and the number of beds. This allocation of beds and staff by formula often creates over- and under-supply of services since the formula doesn't take into account demand.

The central and provincial Ministries of Health allocate the budget for recurrent costs to each hospital largely on the basis of that hospital's historical budget, which is closely related to the number of beds and staffing of the hospital.

The Ministry of Health holds the power to assign physicians to their posts and to promote them. The provincial government has the power to assign and promote other health professionals. Sri Lanka has minimum administrative structure and staffing for its hospital operations, yet they are working very efficiently. Hospitals are organized into wards with 20-80 beds per ward. Clinical services are the responsibility of physicians, who typically work diligently and conscientiously, seeing 50-70 patients a day. A sister, who supervises nurses and nurse aids, manages the patient care on the ward.

The public sector provides more than 95 per cent of inpatient services, largely free to the patients. Outpatient care is largely provided by full-time private practitioners or by government doctors working in their private clinics during off-duty hours. Patients pay out-of-pocket for private sector outpatient services. Demand for non-western medicine is not as substantial as elsewhere in South Asia.

The MOH uses a top-down command and control approach in managing its operations. It has little capacity to plan and analyze health policy and programs. Under devolution, MOH decentralized a major portion of financial resources and responsibilities to provinces, but continues to control physician assignments and promotion. This severely limits what provinces can do, although arguably promoting equity.

## **Financing**

Health care is equally financed by the government and by households' direct out-of-pocket payments. Public financing declined as a share of total during the 1980s, but appears to have stabilized at approximately 50% of overall sectoral financing. Private financing is predominantly household out-of-pocket payments with little contribution from private insurance or employer sponsored prepayment plans.

Approximately three-fourth of the government health budget for recurrent expenses go to public hospitals. Sri Lanka achieved historically low levels of public health expenditures when medical technology was not so costly, along with low salaries for health professionals and centralized purchasing of essential drugs and supplies. However, as new expensive medical technology developed, the government has found that it cannot provide sufficient funds to sustain the progress

Meanwhile, overcrowding and long waiting lines induce patients to seek health care from the private sector whenever they can afford to pay. Over time, most of the outpatient services are provided through the private sector because most patients can pay the charges. However, since most of the population cannot afford the high private hospital charges, they continue to rely on public hospitals for inpatient and laboratory services.

## **Achievement and Problems**

### *Equity*

Despite inadequate funding, access to quality "basic" health services has been maintained, because of a high level of professional dedication by physicians, AMPs, sisters and nurses. The public sector runs an extensive network of health facilities throughout the whole island. Access to health services is high in all areas, as evidenced by a utilization profile in which poorer people have more physician contacts per capita than the richer households, and utilization favors the rural population.

On the whole, public sector financing, mostly from indirect taxation, appears to be regressive. On the other hand, most of the benefits (i.e., education, health care) went to the poor and lower middle income persons. Perhaps the existing system remains redistributive in its net fiscal impact. Since the 1980s, many affluent

patients chose to use private services, which has further enhanced equity. At the geographical level, equity is improved by the central control of capital investments, recurrent budgets, and health personnel. These resources are more equally distributed to all the provinces than what would occur, if each province is responsible for financing and delivery of its own health care.

#### *Income Protection*

As in most low- or middle-income nations, the income level of most Sri Lankans makes the cost of an episode of hospitalization unaffordable. Insurance markets also hardly exist in developing nations. Sri Lanka provides free hospital services to its population through the public health care system. In addition to giving patients access to hospital, it also prevents bankruptcy of households.

#### *Cost-effective*

The dominant public sector role in financing and the centralized public hospital delivery system have been cost-effective. National health expenditures have remained stable at 3.3-3.7% of GDP since the 1950s. There is neither evidence of systemic cost inflation, nor cost inflation in the private sector before 1996.

#### *Efficiency*

Technical efficiency of the public sector delivery system is high. Average length of stay is relatively low and declining, admission and occupancy rates are high, and output per staff exceeds most other nations. There is also efficient purchasing of essential drugs and supplies.

#### *Quality*

A nation's quality of health care has to be judged in an appropriate context. As a lower-income nation, Sri Lanka's public hospitals and clinics do give the public ready access to trained health practitioners, and these facilities have the essential drugs and supplies available for patient care.

## **Problems and Challenges**

While Sri Lanka can be proud of its achievements, the nation faces several major problems in its health sector. They include under-funding of health care, confused macro-organization of health care financing and delivery resulting from devolution, a lack of an overall health sector policy, a severe shortage of nurses and specialists, over-supply of physicians on the horizon, and arcane management practices.

#### *Under-funding*

The government has not been able to increase its funding sufficiently to keep pace with changing epidemiology, increases in population and medical progress. This is evidenced by the severe shortage of speciality services, overcrowded hospitals with occupancy rates that invariably exceed 100%, and hurried medical staff who have to treat more than 10 to 15 patients per hour.

The system is over-stretched. There are few resources available (human and financial) to improve the quality of patient services. It will require infusions of additional funding and human resources to reduce pressure on overworked staff, to reduce overcrowding and improve quality, and to reduce the waiting time. New resources are also needed for management capacity building, which is a necessary precondition in order to improve the current system without damaging the strength of the existing system.

Insufficient government funding for public health services has also kept physician salaries very low compared to what other equivalent professionally trained persons can earn in the private sector. As a result,

the chances of a large exodus of the best doctors and specialists to the private sector have always been great. In order to retain them, the government gave public sector physicians the privilege to do private practice in their off-duty hours. Removal of this concession, which may be desirable from the perspective of improving public sector quality, will not be possible without significant increases in staff salaries.

#### *Confused and fractured macro-organization*

In 1987, a foreign power forced Sri Lanka to decentralize the central government's power to provinces. Understandably so, it was implemented reluctantly and half-heartedly which resulted in considerable ambiguity and lack of clarity. For example, while the responsibility for health care delivery was decentralized, the central government's revenue was only partially redistributed and so was the power to tax. At the same time, the central government continues to control physician assignment, disciplines and promotions. Meanwhile, the provinces have only a few managerial positions and almost no qualified persons to take on the new responsibilities and exercise the newly acquired power. After a decade of devolution, provinces have extremely limited capacity to plan, manage and monitor health services for both financial and human resource reasons. Also information systems hardly exist to provide the information necessary for provincial level management.

Decentralizing the power to manage medical personnel would create a problem that needs to be addressed. If each province was responsible for recruiting and paying its own medical cadres, then either provinces would have to compete against each other for the limited number of doctors, placing poorer and less desirable provinces at a great disadvantage, or the subsidy and salaries for the less desirable provinces would have to be increased in order to allow them to compete effectively with the more desirable provinces. This potential problem may worsen with growth of the private sector, which is concentrated in Western Province.

#### *Arcane management practices*

The Ministry of Health still uses the command and control approach in planning and management of the financial and human resources. The current system largely runs on rules, norms and procedures, thus it lacks the capacity to think through, plan and implement major system changes to keep the health sector apace with economic development and people's needs and demand.

#### *Lack of coherent policy for private sector*

The private sector is important in the provision of ambulatory care, with a 50% market share. However, there is no consistent or coherent policy framework for the private sector, no mechanisms for regular consultation with the private sector, and a weakened capacity for regulation. Decentralization in 1987 made private sector registration a provincial responsibility, but no additional resources were given the provinces. Little resources have been given to the central ministry to develop and implement private sector regulation.

#### *Lack of policy and planning for human resources*

Sri Lanka has a severe shortage of trained nurses. A significant percentage of authorized nursing posts are unfilled. The nation also has an inadequate number of specialists. The demand for specialty services far exceeds the supply. Meanwhile by year 2000, the expected number of medical school graduates will exceed the internship slots available. In less than a decade from now, Sri Lanka will have an over-supply of physicians. These problems are result of dividing authority between two ministries. The Ministry of Education is responsible for medical education, and Ministry of Health is responsible for clinical training and placement of physicians. The Board of Investment appears to be subject to neither of these.

The major concern is the impending entry of new medical graduates into the private practice. As many of them would have had minimal supervised clinical training, they can do harm to patients when they enter into private practice without organized supervision.

### *Lack of overall Health Sector Policy*

Sri Lanka has no policy as to the respective roles of public and private sectors in health care financing and delivery. The government has, *de facto*, adopted a *laissez-faire* policy toward the private sector. The only active government intervention to date in the private sector is the provision of tax incentives to private hospital investors by BOI. There has been little assessment of the scheme, but some limited survey results indicate that hospitals which received BOI support are more capital intensive, and that there may be the beginnings of cost inflation in the private sector due to over-investment in high-technology equipment.

Currently, the public hospitals are already affected by the new technology installed in the private hospitals. First, the public hospitals want to maintain their reputation by purchasing the same or better medical equipment. Of course, this new technology can only be used properly by specially trained physicians. Thus, more and more specialists have to be trained and employed. So the medical arms race and expenditure inflation will accelerate. Second, more public sector specialists are now drawn to practice in these private hospitals. They spend less time for patient care in the public hospitals. Also, most public sector specialists want to be assigned to the few largest cities, where the private hospitals are located, which further exacerbate the shortage of specialty services in the provincial cities.

### **Presidential Task Force**

In January 1997 the President of Sri Lanka appointed a Task Force on Health Policy (PTF) to recommend how to respond to the changing demands on the health care system. Seven main recommendations were the result. In developing recommendations, the Task Force followed the principle that the health sector “should *respond* to the existing and emerging health needs of the community and ensure *equitable* access to health care of acceptable quality in an efficient and effective manner.” (PPHSF, 2, italics added) This statement suggests that the task force believes the health sector should *change* and *adapt* in response to newly-emerging conditions, needs, and demands. This also implies that it believes that the *equitable* distribution of health care to the people should take precedence over the quality and manner of provision of health care. The PTF made eight major recommendations (Presidential Task Force, 1997):

- (1) Reform the organizational structure to improve efficiency and effectiveness, especially in the context of devolution.
- (2) Establish mechanisms to provide care based on needs, set priorities and resource allocations equitably.
- (3) Increase accountability and responsibilities of provincial governments, health institutions, and individual providers.
- (4) Develop alternative financing mechanisms, including resource sharing between private and public sectors, and between allopathic and non-allopathic sectors.
- (5) Improve preventive and curative services to populations of special need (e.g. the elderly, disabled, victims of war and conflict, occupational health problems, health of schoolchildren, mental distress).
- (6) Improve hospital services in the districts in a planned manner.
- (7) Develop health promotional programs using formal education system and the media.
- (8) Rationalize human resource development and emphasize career development.

## Steps Forward

In sum, Sri Lanka's public health services are severely under-funded, bringing in question the ability of the system to sustain itself in the face of a growing and aging population, changing epidemiology and medical progress. There exists no coherent health policy framework that addresses the roles of the public and private sectors in the financing and provision of health services. It is imperative that these two issues are addressed. Sri Lanka must develop broad strategies for financing and provision of health care, and rationalize the roles of the public and private sectors. The nation needs to develop a concrete plan to provide adequate financing for its health services.

The PTF made extensive and serious efforts to evaluate the problems and challenges facing Sri Lanka. The task force was able to identify a number of major problems as well as set forth a set of health priorities, such as equitable distribution of health care. Among the eight major recommendations made by the PTF, three were focused on improving the organization and management, and upgrading the hospital facilities:

- Rationalize the organization of health care delivery by restructuring the MOH and devolving responsibilities and power to provinces and institutions;
- Modernize the public management of health institutions;
- Upgrade selected district hospitals.

While the above specific recommendations could improve the health care system in Sri Lanka, what is also needed is an overarching strategy for Sri Lanka to deal with issues of under-funding and appropriate public-private mix. In our preliminary analysis, we did not find inefficiency to be a major problem in Sri Lanka. Therefore, re-organization and improved management as recommended by the PTF (Presidential Task Force, 1997; Presidential Task Force on Health Policy Implementation, n.d.) may not yield measurable positive results. To examine the effective approaches in implementing some of the recommendations made by PTF, Sri Lanka can pilot test and move incrementally on several of the recommendations.

This PRELIMINARY report was prepared under a tight time constraint and with a small budget. Consequently, it was done with what data that existed and were available, knowing that certain information was missing. To have reliable information for establishing sound policy, Sri Lanka should undertake several studies shown below to assess the current health system and offer sufficient evidence to support its findings on its strengths and weaknesses, as well as developing viable strategic options to improve the current system. These studies would be designed largely by international consultants, but conducted by subcontractors in Sri Lanka. The studies needed include:

- (1) **A study of the industrial organization of the private sector financing and provision of health services.** This study should include an analysis of the factors that influence patients' demand for private sector services.
- (2) **A detailed analysis of the current funding for public sector health care.** This study should include an evaluation of the current resource allocation criteria, and an assessment of the projected financial gap between government's capacity and its ability to fund future requirements.
- (3) **A study to develop several viable financing options to sustain the delivery of adequate health care in the future, including social insurance.**
- (4) **A detailed analysis of the current organization, staffing and management of public sector health services.** This should include an assessment of the institutional and human resources requirements that have to be put in place to improve the organization and management of public sector health services (including the option of implementing devolution).
- (5) **Analysis of the potential human resources requirements in the health sector and strategies to meet them.**
- (6) **A study to provide a preliminary evaluation of the quality and efficiency of the current health care system,** and to develop several options for improvement.

# 1 - GENERAL CONTEXT

## 1.1 Economic Trends

Sri Lanka, like most developing countries, has had three main objectives since independence - that is, to achieve a reasonable rate of economic growth, greater equity, and greater self-reliance. However, it has placed greater emphasis on equity than most other developing countries with a similar per capita income status. Even during the late 1970s, Sri Lanka was spending on average 9.5 per cent of its GDP on welfare expenditure compared with 6.4 per cent by Thailand, 3.9 per cent by Korea and 3.1 per cent by the Philippines (Rannan-Eliya, Senagama, Weerakoon and Aturupane, 1999). Succeeding governments have committed themselves to a large number of social programs. Education, health services and a wide range of consumer subsidies have accounted for a large share of government spending. Sri Lanka has often been cited as an exemplary case of a developing country whose level of social progress has been quite high relative to the country's per capita income level (Isenman, 1980).

### Historical background

Sri Lanka is one of the most open economies in the developing world. A program of economic liberalization initiated in 1977 that aimed at reforms in the trade and payments sphere, financial deregulation and fiscal restructuring has resulted in marked structural changes in the economy with rapid acceleration in its rate of economic growth between 1978-1983, and again in the 1990s. Economic growth in the immediate post-reform period was to a large extent driven by massive public investment (particularly, the Accelerated Mahaweli Development Programme, which was largely donor funded and intended to provide irrigation and hydroelectric power generation). Gross Domestic Capital Formation rose sharply in the post-1977 period from 15-16 per cent of GDP to peak at 34 per cent of GDP in 1980 (Table 1.1.a).

In the late 1980s, Sri Lanka experienced a downturn in growth performance due mostly to unstable political and social factors. An insurgency by the resurgent Maoist JVP caused widespread disruptions to economic life. Economic growth slowed considerably reaching 1.5 per cent in 1987. The year 1989 saw an end to the social and political unrest in the southern parts of the country. The JVP insurgency was crushed through a brutal, but highly effective, counter-insurgency campaign by government security forces.

In 1989, the government launched the second phase of liberalization aimed specifically at liberalizing the business environment and existing payments restrictions, coupled with a broad-based program of privatization. The economy recovered strongly in 1990. GDP grew at an annual average of 6.2 per cent during 1990-93. Despite a change of government in 1994, economic policy remains committed to an 'open economy'. There is no major difference in the two main political groupings on general economic strategy.

Growth in 1999 is expected to come out at 3.5 per cent, because of continuing indirect effects of the regional currency crisis and reduced business confidence. Despite some loss in export sales to the most severely affected Southeast Asian economies, and some increased price competition, particularly from rubber product exporters in Indonesia, Sri Lankan exports held up well in 1998, but then declined with intensification of competition from other Southeast Asian economies in 1999. Total exports were down by 7.1% in dollar terms in the year to September 1999, with manufactured exports growth negative at -4.5%. Reduced economic growth is of concern as it reduces the future resources available for the country to fund social services.

From 1977, the share of agriculture in GDP has declined to only a fifth of GDP by the late-1990s. Growth in both the paddy and plantation sectors lagged the rest of the economy, although recently there has been vigorous growth in the newly privatized plantation sector. Manufacturing and services have grown in importance. Private sector manufacturing sustained growth rates in excess of 10 per cent for most of the time period, although this has had to compensate for falling output in public sector manufacturing. In the past three years, growth in this sector has reduced substantially from its higher previous levels. With the bulk of industry now in the private sector, manufacturing has emerged as the key engine of growth. Expansion in manufacturing, development of

the transport, communications and financial sub-sectors, and growth in ports services has led to an increased share in output of services, which now account for more than 50 per cent of GDP.

**Table 1.1.a: Selected Economic Indicators, 1978-1999**

<b>Indicator</b>	<b>1978-83</b>	<b>1984-89</b>	<b>1990-93</b>	<b>1994-99 (Estimated)</b>
	<i>Period average annual growth rate</i>			
Population	1.7	1.4	1.2	1.1
Per capita GNP	5.2	3.1	5.3	3.5
GDP	5.9	3.0	6.2	4.6
	<i>Percentage of GDP</i>			
Agriculture	27.7	26.9	25.6	22.3
Manufacturing	11.1	11.8	13.7	16.2
Services	45.9	47.7	50.2	52.4
Gross Domestic Capital Formation/GDP	28.4	23.4	24.3	25.4
Public investment/GDCF	54.8	55.3	36.5	25.8
Domestic savings/GDP	12.8	13.3	15.2	16.4
Public savings/GDP	-1.3	2.0	-1.4	-3.2
Budget deficit/GDP	18.6	12.9	10.3	9.7
Rate of inflation (period average)	15.2	9.8	13.8	9.5

*Source:* Central Bank of Sri Lanka, Annual Report (various issues); IPS staff estimates.

### **Labor trends and unemployment**

Expansion in manufacturing and services has created employment (Table 1.1.b). Nevertheless, almost 65 per cent of the country's population (of 18.0 million in 1996) remain largely dependent on agriculture. It provides employment for about 37 per cent of the labor force. Sri Lanka continues to have a vast pool of surplus labor with the current rate of unemployment estimated at around 10.7 per cent of the labor force (1997 first quarter).

High levels of unemployment have been an important factor behind political unrest since the 1960s. Despite improved growth, unemployment remains at 10 per cent of the labor force, although declining since 1990 (Table 1.1.c). With an estimated 140,000 entering the labor force each year, the country needs to maintain an annual growth rate in excess of 5 per cent in order to lower net unemployment. With current growth performance, given falls in the annual number of new entrants to the workforce because of earlier fertility decline, many observers (including at MOF and IPS) believe that full employment may be achieved by 2006.

### **Savings and investment performance**

Despite an initial surge in investment resulting from the government's public investment program in the 1980s, the ratio of investment to GDP has remained around 25 per cent. For much of the post-liberalization period, the average domestic savings ratio in Sri Lanka at 12-13 per cent of GDP changed little. In the second wave of liberalization after 1989, the savings ratio increased to over 15 per cent. National savings in the country have been higher than domestic savings, increasing from 15-16 per cent of GDP in the 1980s to 19 per cent of GDP by the mid 1990s, mainly due to the private remittances of Sri Lankan nationals working abroad (particularly in the Middle East). Net remittances have boosted net private transfers on the current account of the balance of payments, and consequently the level of national savings. During 1997-98, the domestic savings rate increased to 19% owing to higher private sector savings due to higher corporate savings and higher per capita incomes.

**Table 1.1.b: Labor Force and Employment (Third Quarter of the Year)**

Item	1993	1996	1997	1998	1 <sup>st</sup> q 1999
Household population (10 years and above) (thousand persons)	12,284	12,843	12,863	12,885	12,896
Labor force (thousand persons)	6,032	6,238	6,218	6,633	6,739
Total employed (thousand persons)	5,249	5,517	5,571	6,005	6,159
<i>By Economic Sector (% of work force)</i>					
Agriculture, Livestock & Fisheries	38.0%	33.3%	31.7%	36.7%	37.6%
Mining & Quarrying	1.1%	1.4%	1.3%	1.1%	1.0%
Manufacturing	12.3%	13.4%	14.5%	12.9%	12.5%
Electricity, Gas & Water	0.9%	0.4%	0.3%	0.5%	0.5%
Construction	2.8%	4.6%	4.8%	4.5%	4.1%
Trade & Hotels	10.5%	9.7%	11.1%	10.4%	8.6%
Transport, Storage & Communications	3.7%	4.4%	4.7%	4.2%	4.9%
Insurance & Real Estate	1.3%	1.7%	1.8%	1.7%	1.3%
Personal Services	12.9%	15.6%	15.4%	15.6%	16.5%
Other Services (Not Defined)	3.9%	3.9%	3.8%	2.8%	4.3%

Source: Department of Census and Statistics Quarterly Labour Force Survey.

Note: Excludes Northern and Eastern Provinces.

**Table 1.1.c: Estimates of Unemployment**

Year	1973	1978	1981	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
Unemployment rate (%)	18.3	14.8	17.9	14.1	15.9	14.7	14.6	13.8	13.1	12.3	11.4	10.4	9.7*

Source: Central Bank of Sri Lanka, Annual Report, 1997.

Note: \*Average for the first three-quarters only. This is not comparable with those of previous years due to a definitional change made by the Sri Lanka Labour Force Survey.

## Fiscal deficits and inflation

The public investment program contributed to a build up of significant inflationary pressures. The resulting macroeconomic imbalance in the economy was particularly severe because the increase in public investment went unmatched by an increase in public savings. High budget deficits led to double-digit inflation for most of the post-1977 period. Having peaked at nearly 26 per cent in 1980, the rate of inflation averaged around 12-15 per cent in the 1980s to early 1990s. It has fluctuated since 1993, before moderating in 1997-99 to approximately 9 per cent.

## External sector performance

Sri Lanka's trade performance following liberalization has been mixed (Table 1.1.d). Its external terms of trade has fluctuated around a downward trend (with a sharp temporary upturn in 1983/84 as tea prices saw an increase). Whilst export performance improved dramatically with the liberalization of the economy (exports as a percentage of GDP rising to an average of 25 per cent in the 1980s from an average of 15 per cent prior to liberalization), largely as a result of the rapid growth of textiles and garments exports, the country continued to experience high current account deficits. Export growth failed to keep up with import growth (as import tariffs were liberalized) or to narrow the deficit significantly.

In the 1990s, continued growth in the much expanded export base, which is now 30 per cent of GDP, prevented further worsening of the trade balance, and led in 1994-99 to declining current account deficits.

In addition, remittances from migrant workers made an increasingly important contribution to the country's external position. By 2000, such remittances are likely to account for greater net foreign exchange earnings than agricultural exports. While such earnings have stabilized the economy, they point to underlying weaknesses which need to be addressed.

**Table 1.1.d: External Sector Indicators**

Year	Exports/ GDP	Imports/ GDP	Trade Balance/ GDP	Current Account/ GDP	Terms of Trade (1985=100)
1984	26.7	33.5	-8.4	-1.0	122.1
1985	24.4	33.8	-13.3	-7.7	100.0
1986	20.8	31.4	-13.0	-7.3	89.3
1987	23.1	33.6	-11.2	-5.7	98.7
1988	23.1	34.3	-11.9	-6.1	93.0
1989	24.6	34.3	-10.5	-4.9	91.4
1990	27.3	37.0	-9.7	-3.6	87.4
1991	24.4	37.5	-12.2	-5.9	85.7
1992	27.9	39.3	-11.8	-4.9	89.1
1993	30.5	42.3	-12.2	-5.9	90.9
1994	30.3	44.6	-14.7	-7.2	86.6
1995	32.6	43.4	-12.9	-5.5	85.8
1996	32.6	41.4	-10.4	-4.3	87.9
1997	30.8	38.8	-8.07	-2.6	93.9
1998	30.2	37.5	-7.3	-1.8	107.2

Source: Central Bank of Sri Lanka, Annual Report (various issues).

## 1.2 Overview of Public Finance

### Public Expenditure

The increase in civil unrest in the country and the associated increase in defense expenditure saw public expenditure rise to 36-37 per cent of GDP in the late 1980s. Although successive agreements with the IMF targeted reductions in the budget deficit, this became politically difficult in the late 1980s with the political violence following the Indo-Sri Lanka Peace Accord. In 1988, as a response to mounting insurgency in the south, an ambitious rural poverty alleviation program ("*Janasaviya*") was proposed, at an estimated first year cost of Rs. 10 billion (almost one-quarter of total government revenue) in 1989. This led to the IMF suspending disbursement of the second tranche of the structural adjustment facility, which was due in March 1989. Consequently, a slimmer version of the "*Janasaviya*" program was adopted. With the second wave of liberalization and the defeat of the JVP insurgency in 1990, macroeconomic management was tightened, and government expenditure as a percentage of GDP was reduced to 31 per cent in 1992-94. However, introduction of bread subsidies and intensification of the fighting in the north in 1995 has led to a subsequent deterioration in fiscal control in recent years. The results of the recently concluded Presidential Elections in December 1999, the LTTE's twin assassination attempts on the President and opposition leaders on December 18, 1999, and military set-backs in late 1999 suggest to many observers that high military spending is likely to continue in the immediate future.

**Table 1.2.a: Government Fiscal Operations (percentage of GDP)**

	1983-85	1986-88	1989-91	1992-94	1995-96	1997-98
Total revenue and grants	25.6	25.0	25.7	23.5	23.3	18.7
Total revenue	23.1	22.3	23.2	21.6	21.9	17.9
Tax	19.8	18.8	20.7	19.2	19.3	15.3
Non tax	3.3	3.5	2.5	2.4	2.6	2.6
Grants	2.5	2.7	2.5	1.8	1.4	0.8
Expenditure & lending	35.4	36.6	35.3	31.1	32.2	26.4
Recurrent	19.6	21.9	24.8	23.3	25.1	20.25
Capital	14.2	12.8	7.8	6.6	6.4	} 6.25
Lending minus repayment	1.5	1.9	2.7	1.2	0.7	
Current account	3.4	0.4	-1.6	-1.7	-3.2	-2.3
Budget deficit (after grants)	-9.8	-11.5	-9.6	-7.6	-8.9	N/A
Financing of deficit						
Foreign financing (net)	5.0	4.1	4.1	2.1	2.6	1.8
Domestic financing (net)	4.8	7.4	5.5	5.5	6.4	5.2
Other borrowings	0.1	1.2	0.5	-0.2	0.8	-0.6

Source: Central Bank of Sri Lanka, Annual Report, and various issues.

High among the policy objectives outlined by the government for the post-1977 period was the intention to bring about a shift in the allocation of resources from consumption to investment. In effect, given the government's own high profile investment program, it essentially implied a curtailment of recurrent expenditure in the budget and the generation of surpluses in the current account of the government budget to contribute towards capital formation. This did not happen, with current expenditure growing faster than capital expenditures throughout the entire period, rising as a share of GDP from nearly 20 per cent to 25 per cent of GDP during 1980-1996 (Table 1.2.b). Continuing high expenditures on defense is a major cause for high current expenditure on goods and services. Following the collapse of peace talks in April 1995, there was a change in military strategy which has led to even higher military expenditures in comparison to the earlier phase of the conflict. In addition, high interest payments on debt are a contributory factor. Such payments have risen from 5 per cent of GDP per annum during 1980-82 to 7 per cent of GDP per annum during 1995-95.

Since 1995, the government changed strategy, targeting reductions in capital investment as the means of reducing the deficit, and assuming reductions in defense expenditure with peace. The earlier decline in the share of capital expenditure in total government expenditure in capital expenditure was largely due to reductions in capital transfers to public programs such as the Accelerated Mahaweli Development Programme. In the 1990s, it has been due to reductions of investment in economic infrastructure (Table 1.2.b). While public investment in infrastructure has declined, private investment in infrastructure has failed to compensate adequately as hoped for. The recent regional economic crisis and the increased risk premiums for privately financed infrastructure projects has made it more difficult to mobilize private financing. This has led to an increasing investment shortfall in areas such as energy supply, transport infrastructure and communications, with consequent constraints to economic growth.

Although transfers to public institutions have declined over the years, social welfare transfers have remained steady and some have even increased. For instance, social welfare showed an 18 per cent increase in nominal terms in 1996 in comparison with 1995. Similarly, the escalation of the war in the north and east of the country resulting in expenditure on refugee related relief programs, has ensured that current expenditures on social transfers continue to persist above 6 per cent of GDP. An extensive program of privatization since 1990 is largely behind a decline in capital transfers to public enterprises (Table 1.2.b). However, this has been counterbalanced to some extent owing to continued poor performance at the two state banks largely owing to continued political interference and poor management, which has necessitated capital infusions by the state (International Monetary Fund, 1999).

Despite these fiscal pressures, all governments have continued to protect government expenditures on health. As a percentage of GDP, this has remained stable, increasing moderately in the late 1980s, while remaining level during recent years (Table 1.2.c).

**Table 1.2.b: Economic Classification of Government Expenditure (as a percentage of GDP)**

	1983-85	1986-88	1989-91	1992-94	1995-96	1997-98
Current expenditure	19.6	21.9	24.8	23.3	25.1	20.3
Goods & services	8.1	9.9	10.7	10.2	12.0	9.5
Salaries & wages	4.3	4.8	5.7	5.6	5.7	5.2
Other goods & services	3.9	5.2	5.0	4.6	6.3	4.2
Interest payments	5.2	5.8	6.6	6.9	6.5	5.8
Transfers	6.3	6.2	7.4	6.2	6.7	4.9
Public corporations	1.1	1.2	0.9	0.4	1.2	0.3
Households	4.0	4.6	5.8	5.2	4.9	4.0
Food subsidies	1.2	0.9	1.6	1.0	0.2	<i>n.a.</i>
Fertiliser subsidy	0.6	0.3	0.1	0.0	0.2	0.2
Janasaviya/Samurdhi	0.0	0.0	0.8	0.9	1.0	0.9
Capital expenditure	14.2	12.8	7.8	6.6	6.4	5.1
Acquisition of real assets	4.6	5.6	4.7	3.6	3.7	3.1
Capital transfers	9.6	7.0	3.1	3.0	2.8	2.2
Public corporations	9.3	4.3	0.7	1.0	1.1	0.7

*Source:* Derived from Central Bank of Sri Lanka, Annual Report (various issues).

**Table 1.2.c: Functional Classification of Total Government Expenditure (as a percentage of GDP)**

	1980-85	1986-88	1989-91	1992-94	1995-96	1997-98
Total expenditure	34.7	36.6	35.0	31.5	33.0	26.4
General public services	4.3	7.1	7.1	6.7	8.5	7.1
Civil administration	2.7	2.8	2.9	1.9	1.7	2.1
Defense	1.1	2.8	2.4	3.5	5.6	5.3
Public order and safety	0.6	1.4	1.8	1.3	1.2	0.9
Social services	8.6	8.8	10.0	10.1	10.7	7.9
Education	2.6	3.0	3.2	3.2	3.0	2.6
Health	1.4	1.7	1.8	1.7	1.8	1.4
Others	5.9	3.8	4.9	5.0	5.5	3.5
Community services	0.2	0.3	0.1	0.2	0.4	0.4
Economic services	15.4	14.0	9.2	6.8	6.8	4.6
Other	6.5	6.8	8.6	7.9	7.2	6.5

*Source:* Derived from Central Bank of Sri Lanka, Annual Report (various issues).

## Government Revenue

Total government revenues as a share of GDP have been relatively high for a low-income country. They were in the range of 20-22 per cent of GDP per annum during the period 1980-1996. Of this, total tax revenue as a percentage of GDP was fairly stable (Table 1.2.d). During 1995-98, tax revenues declined substantially from their peak in 1995 of 20% of GDP to reach 17.5% of GDP in 1998. This has been partly due to a loss in revenues following the introduction of the General Sales Tax in 1998.

The share of foreign trade taxes as a percentage of GDP has seen a continuous and sharp decline, falling from nearly 8 per cent of GDP in the early 1980s to less than 4 per cent of GDP by the mid 1990s. Tariff reform as part of the liberalization process can be cited as the major reason for the fall in trade taxes. As the share of trade taxes has declined, tax revenue from domestic goods and services as a percentage of GDP has risen over the period from just over 6 per cent of GDP per annum in the early 1980s to account for more than 11 per cent of GDP by the mid 1990s. The most marked increase has been recorded in turnover taxes, of which there are several.

**Table 1.2.d: Government Tax Revenue (as percentage of GDP)**

Item	1983-85	1986-88	1989-91	1992-94	1995-96	1997-98
Tax revenue	19.8	18.8	20.7	19.2	19.3	15.3
Taxes on foreign trade	7.8	6.7	6.6	4.8	3.9	2.9
Exports	3.2	1.0	0.6	0.1	0.0	0.0
Imports	4.6	5.7	5.9	4.8	3.9	2.3
Taxes on domestic goods & services	8.1	8.7	9.5	10.4	11.5	9.4
Taxes on net income and profits	3.5	2.7	2.6	2.8	2.9	2.2
Taxes on property	0.3	0.7	1.1	0.8	0.8	0.7
Non-tax revenue	3.3	3.5	2.5	2.3	2.6	2.6
Current revenue	3.3	3.5	2.5	2.3	2.6	2.6

*Source:* Central Bank of Sri Lanka, Annual Report (various issues).

Non-tax revenue increased consistently as a share of GDP during the period 1980-1987, but then declined thereafter to account for 2.3 per cent of GDP in 1996. The declines can be attributed to a fall in property incomes over the years. The grant element in total revenue has also continued to decline as a share of GDP throughout the period under discussion to account for just over one per cent of GDP by 1996.

Sri Lanka's tax system may have become more regressive over the years given the increase in the share of indirect taxation in total tax revenue. However, Moore (1990) observed that the switch from plantation export taxes to the current indirect tax profile was probably good from an equity and gender perspective. The old system of tea taxation in the long run hurt women and the poorest because any employment generation on tea estates disproportionately benefited poor women, and since estate workers are amongst the most deprived Sri Lankans. Definitive studies of the incidence of the tax system do not exist, so reliable conclusions cannot be drawn about the overall incidence of taxation.

In April 1998 the government implemented a value-added-tax, the Goods and Services Tax, (GST). While a well functioning GST, a revenue neutral tax, would be a positive development in theory, given the complex and unsatisfactory network of taxes it replaced, it is unlikely by itself to provide additional revenue in the short term. In fact, the GST to date has been associated with a substantial revenue loss equivalent to one tenth of the turnover taxes it replaced or one per cent of GDP. This unsatisfactory performance has been due to the low initial rate of 12.5%, and the narrow tax base owing to its non-application to the retail sector and other exempted industries. Following the 13<sup>th</sup> Amendment, the government no longer has the power to levy value added taxes on the retail sector, since this is reserved for the Provincial Councils (International Monetary Fund, 1999). The government's recent constitutional proposals do not make any provision for changes in this area, or for revenue sharing arrangements between the center and Provincial Councils which might be necessary to allow more effective tax mobilization. As GST is intended to be the main revenue instrument for the government, the allocation of tax powers and revenue sharing arrangements in the constitution may need to be reconsidered if the government is to be able to substantially increase its tax base in future

### **Debt and debt service payments**

The consequence of high fiscal deficits has been increased public debt. The government has avoided borrowing from the banking system, in recent years. Bank borrowing accounted for nearly 60 per cent of the total net domestic financing component in the early 1980, but fell to less than ten per cent by the mid 1990s. Deficits have been funded mostly through debt and foreign grants. Recourse to borrowing in international financial markets has been largely minimal, increasing in the mid 1980s to account for six per cent of GDP, but declining steadily thereafter to less than two per cent of GDP by the mid 1990s.

The grant element in budgetary financing has declined steadily as a share of GDP, but foreign finance has continued to cover the overall deficit substantially. The share of foreign financing of the budget deficit decreased from 40 per cent in the early 1980s to less than 30 per cent of the deficit requirement by the mid 1990s. Sri Lanka has been assisted heavily in its efforts to finance budget deficits by the increased grant

element in the foreign finance component with the adoption of market friendly reforms in the late 1970s, in effect allowing it to maintain lower debt service payments than might otherwise have been the case. Foreign loans alone accounted for around 35-40 per cent of the total financing requirement, and the great majority of these were obtained at concessionary rates of interest.

**Table 1.2.e: Government Debt Service Payments (as a percentage of GDP)**

Item	1980-85	1986-88	1989-91	1992-94	1995-96	1997-98
Debt service payments	8.1	9.9	11.2	12.6	11.9	10.9
Amortization	2.9	4.2	4.6	5.7	5.4	4.8
Domestic	2.0	1.8	2.7	4.0	4.0	3.4
Foreign	1.0	2.3	1.9	1.7	1.5	1.7
Interest	4.9	5.8	6.6	6.9	6.5	5.8
Domestic	3.9	4.3	5.3	5.7	5.5	5.1
Foreign	1.0	1.4	1.3	1.1	1.0	0.8
Interest payments/current expenditures	26.2	26.2	26.7	29.4	25.8	28.7
Debt service ratio	17.2	20.8	20.9	18.7	17.4	13.4

*Source:* Derived from Central Bank of Sri Lanka, Annual Report (various issues).

The continuing decline in foreign grants in relation to GDP and the availability of low cost credit from domestic financial institutions has led to increasing reliance on domestic financing to cover the deficit. Non-bank financing which accounted for just over 4 per cent of GDP in the mid 1990s accrue from primarily three sources:

- Employees Provident Fund (EPF) which is the single largest captive source of funds for financing the deficit, has almost 98 per cent of its total assets invested in Treasury Bills (TB) and other government securities;
- Employees Trust Fund which places nearly 65-70 per cent of its assets in TB;
- National Savings Bank, which mobilizes household savings and term deposits across the country places more than 80 per cent of its assets in government securities.

The first two are in practice controlled by the government, and to the extent that it can borrow these funds at below market rates, this form of financing represents an implicit method of taxation of the wages of those in the formal sector.

These trends in financing have led to only a modest increase in total debt as a percentage of GDP, with some reduction in recent years. Most of the increase in debt during the 1980s was in the form of foreign debt, but in the 1990s increases in the fiscal deficit were financed domestically. Foreign debt increased from just over 37 per cent of GDP per annum during 1980-82 to approximately 64 per cent by 1991, but has since fallen to 49 per cent in 1999. With concessional loans from government sources accounting for more than 95 per cent of total foreign debt, increases in debt servicing have been modest. On the domestic side, borrowing captive funds has ensured access to low cost credit (Table 1.2.e).

**Table 1.2.f: Composition of government debt (as a percentage of GDP)**

Item	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Domestic	46.4	41.5	45.1	47.6	46.2	49.0
Foreign	36.6	42.2	59.6	64.3	59.4	54.8
Multilateral	9.5	12.0	16.5	21.7	23.7	23.6
Bilateral	24.2	24.3	37.2	38.8	33.5	29.5
Financial markets	3.1	5.9	6.0	3.9	2.2	1.7
Total	83.0	83.7	104.8	111.9	105.6	103.7

*Source:* Derived from Central Bank of Sri Lanka, Annual Report (various issues).

Nevertheless, the ratio of total government debt service payments (amortization plus interest payments) to GDP has risen steadily from 7.4 per cent per annum during 1980-82 to over 12 per cent during 1990-92,

and falling slightly to 12 per cent during 1992-94. It has since remained around 12 per cent of GDP. Correspondingly, interest payments on total government debt as a share of GDP has risen from 4.5 per cent per annum during 1980-82 to nearly 7 per cent during 1992-94 before declining slightly to 6.5 per cent per annum by the mid 1990s.

In conclusion, the government bears a considerably debt burden, albeit one which has remained manageable. Considering this and the current position of the economy, the government is unlikely to be able to increase expenditure on health care. Even if a solution to the 17 year civil strife emerges, the government should concentrate on developing the economic infrastructure as its priority. Hence, an accepted sentiment would be that substantial additional government funding to increase spending on health care is unlikely.

## 1.3 Political Context

### Political and legal system

Sri Lanka is a Republic headed by an Executive President. The President exercises executive powers and is directly elected for a period of six years by a system of single-transferable vote. There is a single-chamber legislature, which is directly elected for a term of six years by a system of modified proportional representation.

An independent judiciary is headed by a Supreme Court, which has the power to review proposed legislation. In 1987, extensive powers were devolved to nine Provincial Councils.<sup>1</sup> These are directly elected and headed by a Chief Minister and provincial cabinet, consisting of three other ministers.

Sri Lanka has enjoyed democratic government based on universal suffrage for a longer continuous period than even most European nations. Other than its early origins, Sri Lanka's democracy is notable for other reasons. It is one of the few developing countries with a competitive two-party political system, and one that has existed since the 1950s. There have been frequent alternations in government at successive general elections in 1956, 1960 (twice), 1965, 1970, 1977 and 1994. Sri Lankan democracy has shown unique resilience. It has survived the pressures generated by two major Maoist insurgencies (1971 and 1987-1990), two periods of civil war (1983-87 and 1990 to date), and partial foreign occupation (1987-90), which between them have led to the deaths of more than 150,000 Sri Lankans. Sri Lanka's modern health care system is not only the product of this democracy, but it has in itself contributed to the survival of that same democratic system. The early expansion of free government health services played a key role in giving legitimacy to the new democratic structures post-1931, and over time contributed to the legitimacy and thus survival of the parliamentary system, when it faced the JVP insurgency in the late 1980s.

Sri Lanka's post-1978 electoral system is somewhat unusual in that it combines PR with some element of territorial identification, in that PR is applied on a district basis, with most districts returning 5-10 legislators, similar to the former Japanese and Irish electoral systems. As in Japan and Ireland (Calder, 1987) this forces legislators of the same political party to compete against each other, usually by their ability to distribute central government largesse to voters. This is of relevance to the health sector, as it reduces the willingness of central government legislators and ministers to transfer power over patronage and the distribution of health sector resources to lower level politicians and administrative levels, as well as encouraging them to ignore the constitutional separation of responsibilities between center and provinces.

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<sup>1</sup> The Northern and Eastern Provincial Councils were temporarily merged as part of the Indo-Sri Lankan Peace Accord, with a provision for a referendum in the Eastern Province within one year to allow voters a choice of permanent merger or demerger. This referendum has yet to be held, although most observers believe it would result in a vote in favour of demerger. Sri Lankan Tamil political representatives are on record as indicating that assurances were given to them by the Indian government before the signing of the Indo-Sri Lankan Peace Accord that the referendum would not be held, although the Sri Lankan government has not confirmed this.

Sri Lanka's politics is characterized by a two-party competitive electoral system, which has stabilized since the late 1950s. There are two broad groupings, based around the left of center Sri Lanka Freedom Party (SLFP), and the center-right United National Party (UNP). Governmental power has alternated between these two groups at every national election since 1956, with the exception of the 1982, 1989 and 1999 national polls. National politics has been characterized by considerable ideological polarization between these two groupings, which was the principle reason for a general oscillation in economic and social policy since the 1950s, and related to this the long-term failure to achieve Sri Lanka's long-term economic potential (Kelegama, 1998). However, in the 1990s, the SLFP alliance shifted its stance on economic policy, and now both major groups favor an open market economy as the basis for economic growth, and major ideological differences are now minimal.

Since the introduction of proportional representation and party-lists in the 1989 elections, the two party system has strengthened, and the electoral impact of independents and minor electoral parties has diminished. Coalition governments have been the norm since the beginning of electoral politics in the 1930s. The SLFP has generally governed in coalition with various leftist groups, including the Sri Lanka Communist Party and the LSSP (a Trotskyite party). The UNP has been associated with semi-permanent electoral alliance with the CWC (which represents the plantation sector Tamil vote) since the mid-1970s, although this alliance ruptured during 1999.

### Current political situation

The center-right UNP ruled the country during 1977-94. At the 1994 Presidential and General Elections, power was transferred to the People's Alliance (PA), an electoral alliance of thirteen parties grouped around the SLFP, and headed by Mrs. Chandrika Bandaranaike Kumaratunga, the current President. The current President was re-elected in December 1999. Following the 1994 General Elections, the PA gained a one-seat majority in Parliament, which in practice is sufficient as several small communal based parties support the government from outside, and because of strong control by parties of individual legislators. It is possible that General Elections may be advanced from their due date of August 2000. However, given that the President's majority in the Presidential Election declined from 62% to 51% between 1994 and 1999, it is not certain whether PA will be able to increase its presence in Parliament following a General Election. The most likely outcome is that the government will retain its overall majority despite a smaller number of seats for the PA by forming alliances with other minority party representatives.

There are eight Provincial Councils. The North-Eastern PC was dissolved in 1990 after it made an illegal declaration of independence, and it has not been possible to hold new elections since that time for security reasons. Following polls held in 1999, the government runs all the other seven councils, although it is dependent on minority parties for majorities in three of these, and has had to form a minority administration in the most important Western Province Council.

**Table 1.3.a: Composition of Parliament (post 1994 elections)**

Party	Seats held	Percentage of seats	Percentage of total votes cast
People's Alliance*	105	46.7	49.1
United National Party	94	41.8	44.1
Sri Lanka Muslim Congress*	7	3.1	1.8
Tamil United Liberation Front	5	2.2	1.7
Sri Lanka Progressive Party*	1	0.4	1.1
MEP	0	0	0.9
Independent 1 - Nuwara Eliya	1	0.4	0.3
TELO	0	0	0.3
Democratic People's Liberation Front	3	1.3	0.1
Independent 2 – Jaffna	9	4.0	0.1
EPRLF	0	0	0.1
Independent 1 – Colombo	0	0	0.1
Independent 4 – Moneragala	0	0	0.1
<b>TOTAL</b>	<b>225</b>	<b>100</b>	<b>100</b>

\* Parties contributing to government's official majority.

The implications of the December 1999 Presidential Elections, which were won by the incumbent President, remain unclear. Following the LTTE's twin assassination attempts against both the President and opposition leaders on 18 December 1999, many observers believe that voters have sent a message that there is little support by most of the electorate for any compromise with the LTTE, as long as it engaged in an armed campaign (Reuters wire reports, 1999, UPI wire reports, 1999, Asian Wall Street Journal, 1999). The President's 1999 re-election bid was enhanced by the endorsement of several political groups opposed to further constitutional devolution. Given this and the President's own calls for renewed efforts against the LTTE, it appears uncertain whether sufficient electoral support exists for any constitutional changes extending the current system of devolution, which would all require approval by more than 50% of voters at a national referendum.

**Table 1.3.b: Results of the 1994 and 1999 Presidential Elections**

Political Party	1994	1999
PA	62.3%*	51.1%*
UNP	35.9%	42.7%
JVP	0.3%	4.1%
Others	1.5%	2.1%
Total Valid Votes	7,561,526	8,435,754
Turn-out (% of registered voters)	70.5%	73.3%

\* Winning candidate Chandrika Bandaranaike Kumaratunga.

### Political prospects for health sector reform

There is lack of any general social consensus as to the nature of problems affecting the health sector. There is little political or public pressure for health sector reform. Conditions in the health sector were not a major issue in the December 1999 Presidential Elections, and opinion polls in the late 1990s indicate a relatively low level of public dissatisfaction with public health services (Table 8.2.a). The lack of widespread social support for any particular set of reforms is critical. Most of the reform proposals by the current Presidential Task Force (PTF) have not been welcomed either by line ministry staff or by public sector unions, other than the division of the health ministry into a department of health services and a separate supervising ministry. A consistent failure by the PTF to adequately consult or work closely with MOH and other health sector stakeholders has created a situation in which day-to-day implementation of any reforms is likely to be resisted by health sector stakeholders. This has been compounded by a failure to date to publish the text of the PTF proposals, which has both reduced awareness of their contents,<sup>2</sup> as well as making it easier for opposing groups to campaign against them by raising alarm at their implied contents. Opposition to the PTF proposals has been publicly voiced by both the doctors and nurses unions, and other key associations such as the Sri Lanka Medical Association and other groups representing private sector providers have indicated that they do not believe they were adequately consulted by the PTF.

This has been compounded by a worsening adversarial relationship between the government and the main public sector doctors and nurses unions, which led to several major strikes during 1999. As the PTF recommendations were developed without the support of any significant health sector stakeholders or of significant political interests, including representatives of political parties, it has been difficult for the government to counter such resistance by appealing to sections of the public or to organized party supporters. Most significantly, the PTF's proposals, which embody a significant element of increased devolution in the administration of health service, have since been contradicted by recent decisions on the system of appointments of medical doctors in the public sector. In 1998, the cabinet agreed measures to centralize the appointments of all public sector medical officers. Although this was not immediately implemented, following a major strike by public sector doctors in 1999 and the recommendations of a specially appointed government committee to review the issue, the government has agreed to place all

<sup>2</sup> An IPS survey of public sector hospital directors in seven districts in late 1998/early 1999, found that while 79% of those questioned were aware of the existence of the PTF, 79% were not aware of its proposals, and only 13% knew and approved of its recommendations.

doctors in an all-island service. Implicit in this is that control over these personnel will remain a central government responsibility and not be devolved to the Provinces.

Fiscal discipline deteriorated considerably during 1999, as might be expected in the run-up to national polls. Assuming the current administration is re-elected in General Elections due in 2000, there will be immediate pressure to consolidate public spending. This will not be easy given that recent military and political developments suggest that the government will seek to maintain a high level of military operations against the LTTE. These constraints and the apparent unwillingness of the Finance Ministry to release substantial new money for implementation of the PTF proposals to date imply that little substantial resources will be available to support major organizational changes in the public health sector in the near-term.

## 1.4 Devolution: Historical, social and political context

### Historical and social context

Some background to the current devolution in Sri Lanka is provided to give a better understanding of the potential constraints to the implementation of devolved government in Sri Lanka, and devolved administration of health services.<sup>3</sup>

Sri Lankan history since the 5<sup>th</sup> Century BC has been characterized by a continuing tension between the forces of centrepetalism and centrifugalism. During the periods, when rulers were able to exercise their writ throughout the island, the pursuit of centrepetalism has typically been a desirable objective of state policy. Like the other Theravada Buddhist influenced societies of South East Asia (Siam, Burma), Sri Lankan state and social structures were generally centralized in nature from the early 2<sup>nd</sup> Century BC. This feature of Sri Lankan history distinguishes the island from the rest of the South Asian region, which was characterized more by a history of relatively decentralized power structures. An illustration of this difference is the caste system in Sri Lankan Sinhalese society. Although Buddhism does not sanction the maintenance of caste, a caste system does exist amongst the Sri Lankan Sinhalese. However, unlike the Indian caste system, which can be regarded as a system for regulating relationships between social groups, the main feature of the Sri Lankan Sinhalese caste system was that it regulated relationships and obligations between social groups and the king, i.e., the state.

From the end of the 11<sup>th</sup> Century until the British succeeded in obtaining full control of the whole island, no Sri Lankan ruler had full control over the island, so the forces in favor of centralization were generally muted. Following their full occupation of the island in 1815, the British deliberately pursued a policy of centralization. In 1832, a united administrative system was established for the whole island, covering both the maritime areas as well as the newly captured Kandyan areas. A new system of provinces was set up, with the explicit and avowed objective of hastening the break up of the Kandyan kingdom - the last independent Sri Lankan kingdom, which had successfully resisted western invaders for a period of 200 years - and to weaken "national" feeling there by attaching its littoral regions to the maritime regions conquered earlier by the British from the Dutch. Several changes to boundaries were made, before the final system of nine provinces was established by 1889. The 1889 provincial borders have since survived intact and demarcate the current system of provincial councils, even though the provinces ceased to be administrative units in the 1950s, and despite significant population shifts in the past 100 years.

The system of administration in the early part of this century was evidently over-centralized, and successive government reports have called for decentralization. However, these efforts were all ineffective throughout the 1920s to 1950s. In retrospect, a key barrier was the reluctance of Ministers to accept a diminution of their powers of authority and patronage that decentralization represented. Moreover, the physical factors in

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<sup>3</sup> There is a long history of attempts by foreigners and other well-wishers to implement decentralised forms of government developed elsewhere in South Asia, which have failed because of a fundamental failure to understand the differences between Sri Lankan social structures and those in South Asia. For example, in the 1871 Village Communities Ordinance, the British introduced the concept of village governments, based on the Sinhalese *gansabha* (or village committee), to be comparable to the Indian village *panchayat*. This attempt failed, and more recent attempts to revitalise the "village community" have met the same fate (Moore, 1985).

favor of decentralization in the early part of the century, namely the problems of communication between Colombo and the periphery, have substantially altered with the establishment of modern roads and communications systems linking all parts of the country.

After the adoption of an ambiguous separatist/federalist platform by various ethnic Tamil parties in the 1950s, decentralization went from being a non-controversial and purely administrative efficiency issue to becoming a highly controversial one. Moves to devolution then became irredeemably linked to threats to the country's territorial integrity. Subsequent involvement of the Government of India as a partisan actor in the island's internal politics, and its consistent pressure for devolution in Sri Lanka from the early 1980s, only served to increase suspicions. Nevertheless, despite this resistance to decentralization, there has been progress in recent decades in deconcentration of line ministries to district and divisional offices. Deconcentration has not roused the same fears.

The current interest in devolved government stems from the problems in managing Sri Lanka's ethnic tensions since the late 1950s. Regionally-based Tamil political parties pushed for transfer of powers from the center to the north and east of the country from the late 1960s onwards. This has generally been resisted by the center, partly because such devolution of powers was seen in many quarters as a potential route to separatism. In addition, electoral support for increased decentralization has never existed. In fact, such pressure is limited to the Tamils of the North and the East of the island - for whom it is almost an obsession - with the majority of Tamils, who now live outside the North and East not especially interested, and strong opposition from all other ethnic groups, including the Muslims and Sinhalese, who are a majority in the Eastern Province. In the mid-1970s, this internal debate entered a new phase, as new political groups launched a violent campaign for a separate Tamil ethnic state. Sri Lanka has faced continuous internal conflict since that time.

During the 1980s, the Government of India became involved in the conflict by providing, from at least 1983 onwards, covert support (financing, military supplies, training and sanctuary) to Tamil ethnic insurgents waging a separatist conflict in the North and East of Sri Lanka.<sup>4</sup> In 1987, when Sri Lankan military forces appeared to be on the verge of retaking the main rebel stronghold, Jaffna, there was direct military intervention by the Government of India to discourage further military action by the Government of Sri Lanka. Given the unwillingness of Western countries to side with the Government of Sri Lanka in a dispute with India, the Government of Sri Lanka decided to accept Indian demands in order to prevent a direct Indian invasion and partition of the island. These demands related mostly to security guarantees for India, which had been concerned about the pro-Western tilt in Sri Lanka's foreign policy since the late 1970s. These concessions which covered areas such as use of Sri Lankan ports by foreign powers, the presence of US VOA transmitters in the island, and receipt of foreign military assistance, were contained in annexes to the Indo-Sri Lankan Peace Accord of 1987.

The main text of the Indo-Sri Lankan Peace Accord committed the Government of Sri Lanka to introduce extensive devolution through a Constitutional change, while India guaranteed the disarming of the separatist insurgents. Under the terms of the Accord the Northern and Eastern Provinces were temporarily merged, subject to the holding of a referendum to determine whether this should be made permanent. According to Sri Lankan Tamil political leaders, India provided them with secret assurances that such a referendum would not be held, but the Government of Sri Lanka remains officially committed to holding such a referendum in the future. The permanent status of the Northern-Eastern Province thus remains unclear and highly controversial. While the majority of the Northern Province population are ethnic Tamils, the majority of the Eastern Province are not and oppose merger with the Northern Province. A recent opinion poll reported that only 14 per cent of Eastern Province residents accepted a merger, and more than 70 per cent desired a referendum (National Peace Council, 2000).

The Government of Sri Lanka implemented its obligations under the Accord by enacting the 13<sup>th</sup> Amendment, which established Provincial Councils (PCs). This Amendment had little political support in Sri Lanka at that time. The text of the Amendment was presented without the option for negotiation or revision to the Sri Lankan cabinet and Parliament for approval. It was largely a direct copy of the relevant sections of the Indian Constitution governing India's federal system, reflecting that the main text had been prepared originally by Indian officials. The Cabinet meeting at which the Accord was discussed, was boycotted by the then Prime Minister, Mr. Ranasinghe Premadasa, who later became Executive President,

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<sup>4</sup> This has since been officially documented in the reports of the official Jain Commission, which investigated the murder of Rajiv Gandhi.

and the powerful Minister of National Security. In addition, there was widespread political agitation against the Accord, in which the then main opposition party and current ruling party, the SLFP, was closely involved. The Accord itself was signed in Colombo by the leaders of the two countries, with the whole island under curfew.<sup>5</sup>

Subsequently, the Indo-Sri Lankan Peace Accord and the related occupation of the North and East of Sri Lanka by the Indian Army, who were called in to disarm the separatist groups, provided the impetus for a serious Maoist insurgency by the Khmer Rouge-like JVP in the rest of the country. The JVP's campaign presented the Indo-Sri Lankan Peace Accord as a betrayal of the country's sovereignty, and the presence of Indian troops in the country as an invasion. This insurgency lasted until 1989, and brought the country almost to total collapse. By July 1989, the government's writ was ineffective in most of the island, the judicial system and police were inoperative, the schools and universities were closed, internal trade, transport and air and sea ports were disrupted, the country's foreign exchange reserves were down to two weeks, and civil society in general had collapsed. Although most foreign observers gave the government little chance of survival, the JVP insurgency was eventually crushed by a brutal anti-insurgency campaign, using methods which are unlikely to ever officially acknowledged by the Sri Lankan state. It should be noted that the methods which were used, would probably in most contexts have been counterproductive, because of their costs in terms of social repugnance, but in Sri Lanka's case the political system retained sufficient legitimacy to permit minimal social acceptance of the methods used. This legitimacy of the system amongst ordinary people owes much to the provision of basic social services by the Sri Lankan state. In this connection the historical provision of free government health services must be regarded as an important element in the country's internal stability. The JVP insurgency cost more than 60,000 lives.

In the meantime, following the withdrawal of Indian troops from the island in 1990, the then North-Eastern Provincial Council made a unilateral declaration of independence, and was summarily dissolved by the central government in 1990. The Northern and Eastern Provinces have since been ruled directly by the central government, and no provincial council has been re-established because of security problems in holding fresh elections. This is somewhat ironic, as it is in the North and Eastern parts of the country that the demands for devolved government originate from.

Given this background, many Sri Lankans have viewed the 13<sup>th</sup> Amendment as externally imposed for reasons other than good administration. In this context, and the lack of genuine commitment to the concept of devolution by successive political leaders since that time, the 13<sup>th</sup> Amendment has only been partially implemented. In many line ministries, including MOH, bureaucrats have generally resisted throughout the full devolution of powers to the PCs. At the political level - both in the center and in the provinces, there has been no effective counter to this administrative resistance, since the political parties themselves remain highly centralized. Practical illustration of the lack of commitment to devolution, despite political rhetoric suggesting otherwise, is the continued proclivity of national ministers, legislators and the President to administratively interfere in the running of provincial level services, and to fail to give up control of recruitment and transfers of public sector cadres. There has also been a long-run failure to make the system of financial allocations to provinces a matter for public debate or to provide resources to the Finance Commission to develop more rational methods for the determination of transfers. Also, it should be noted that while the center has been reluctant to give up powers, the PCs have not been enthusiastic in exercising their devolved powers. In the majority of areas in which the 13<sup>th</sup> Amendment granted PCs legislative responsibility, no PC has chosen to pass legislation, and where legislation has been passed, in most cases it has been directly copied from similar legislation passed by the Western Provincial Council. This reflects both lack of interest and lack of technical and legal drafting capacity in most councils.

Although PCs have been in existence for more than a decade, they remain mere extensions of the national political contest. All parties treat the Councils as merely extended arenas in which to wage their national political struggles. The extent of this is evidenced by the fact that PC elections are generally regarded as litmus tests of national political opinion and not local concerns about the administration of individual councils. This feature militates against the effectiveness of PCs as agencies of local accountability and responsiveness to local particularities.

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<sup>5</sup> With the exception of President J.R. Jayawardene, who died in retirement, all the key actors in Delhi and Colombo in the events leading up to the Thirteenth Amendment were subsequently murdered by the LTTE. These included both Prime Ministers of India and Sri Lanka at the time, the Sri Lankan Minister of National Security who opposed the Accord, Mr. Gamini Dissanayake who played a key role in negotiating the Accord, and was its chief supporter in the Sri Lankan cabinet, and the leaders of the Tamil United Liberation Front.

## 1.5 Devolution: The Inter-Governmental Fiscal Transfer Mechanism

The Provincial Councils account for almost half the public sector's expenditures on health services, and are responsible for the administration of most government health facilities. The PTF proposals also imply significant increases in the responsibilities devolved to the PCs. Their financing is inevitably of importance.

The 13<sup>th</sup> Amendment to the Constitution marked the turning point in the process of the intergovernmental fiscal transfer mechanism, by introducing devolved units of administration. On implementation in 1987, based on the pre-existing provinces, eight Provincial Councils (the North and East were temporarily merged) were established and provided with legislative and executive powers. The President appointed the Provincial Governors, although the Constitution stipulated that they must act in accordance with the Provincial Chief Ministers and the Board of Governors (both elected by the Provincial Councils) (*Annex 1*). Recent decisions by the Supreme Court have established that the Governors cannot act as mere agents of the President, and must consult with the Chief Ministers.

The Constitution describes the devolution of fiscal powers based on three categories. The Constitutional provisions included in the lists were strengthened by Legislation in the Provincial Councils Act No. 42 of 1987. There are three lists:

- (1) **Provincial Council List** - List I: subjects and functions to be addressed by the Provinces
- (2) **Reserved List** - List II: subjects and functions to be addressed by the Center
- (3) **Concurrent List** - List III: subjects and functions to be addressed by both parties

### Provincial Council Expenditure

Provincial budgets are historically determined, and are allocated by the Central government. The PCs have discretion in the usage of allocations, and do not have to report either to the central government or to voters as to how those allocations are actually spent. The Constitution allows the Provincial Councils that autonomy, so there can not be a mandatory request to disclose their expenditures. In fact, PCs have refused to regularly report their actual expenditures to the Finance Ministry when requested.

The resource requirements of the Provinces are divided into two main categories:

1. **Recurrent Expenditure** - is utilized for the maintenance of public sector community services and facilities through the line Ministries (health, education, etc.), and is a Provincial Council's main responsibility. Revenues shared with the Center are utilized to meet these expenditures. In 1997, 94 per cent of total expenditure by the Provincial Councils was utilized for recurrent expenditure.
2. **Capital Expenditure** - include requirements for development projects, expansion of services and facilities, etc. Savings from the Province's total resource base, matching grants from the Center, and borrowing are utilized to meet these expenditures. In addition, the Integrated Rural Development Programmes (IRDP) and Medium Term Investment Programmes (MTIP) are used for sectoral activities, such as lands, education, transport, agriculture, health, irrigation etc., by the Provincial Councils in collaboration with the Central government Ministries

### Dispersing of Revenues

The Central government allocated 3.3% of its revenues to the Provincial Councils in 1997. These grants accounted for 77 per cent of Provincial Council's total revenue. The remaining 23 per cent of revenue consisted of their own revenues. Of total revenues mobilized by Provincial Councils, 90 per cent was collected by the Western, Central, Southern and North-Western Provincial Councils alone. The North-Eastern PC accounted for less than one per cent of such provincial own revenues.

The extensive disparities that exist between total expenditure and total revenue collected within the Provincial Councils (with exception to the Western Province) intensify the dependency of the Peripheries

on allocation of grants from the Center. Although the disparities between revenue bases and expenditure responsibilities are greater than in most devolved systems, there has been little effort to develop an appropriate system for inter-fiscal transfers (Wijesinghe, 1996).

**Table 1.5.a: Provincial Functional Recurrent Expenditure, 1997 (Rupees million)**

Departments	Total (%)	WP	CP	SP	NEP	NWP	NCP	Uva	Sabara-gamuwa
Divisional Administration	640 (2.9%)	74	73	105	129	83	47	70	59
Social Service	677 (3.1%)	165	80	72	137	75	41	50	58
Health	3,854 (17.5%)	654	534	545	526	513	447	347	289
Education	12,421 (56.3)	2,854	1,845	1,692	1,617	1,545	822	816	1,230
Local Government	1,739 (7.9%)	698	243	132	305	125	53	57	126
Other Departments	2,720 (12.3%)	860	346	295	337	312	208	173	191
<b>Total</b>	<b>22,055</b>	<b>5,305</b>	<b>3,121</b>	<b>2,841</b>	<b>3,051</b>	<b>2,653</b>	<b>1,618</b>	<b>1,513</b>	<b>1,953</b>
<b>Per Capita Expenditure</b>									
Total Recurrent Expenditure (per capita)	1,189	1,113	1,327	1,176	1,103	1,215	1,432	1,311	1,095
Total Health Expenditure (per capita)	208	137	227	225	190	235	396	301	162

Source: Provincial Councils Review of Financial Performance, Ministry of Provincial Councils and Local Government, Sri Lanka

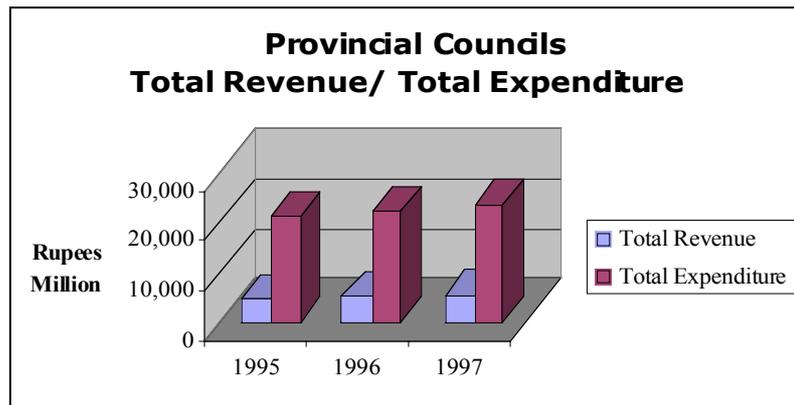
**Table 1.5.b: Distribution of revenues and expenditures between Center and Provinces - 1997**

	Center	PCs
Revenues collected (% GDP)	18.5	0.6
Share of total revenues collected (%)	96.8	3.2
Total recurrent expenditures (excluding debt/interest) (% GDP)	14.5	2.5
Share of total recurrent expenditures excluding debt/interest payments (% GDP)	85.4	14.6

Source: Central Bank of Sri Lanka, Annual Report 1997

All revenues dispersed to the Provinces are paid to the 'Provincial Fund' and the 'Emergency Fund'. The former is to meet the Provinces' needs, while the latter is used for emergencies such as droughts, floods, civil disorder, etc. The Governor of the Province is responsible for these two funds.

Figure 1.5.a

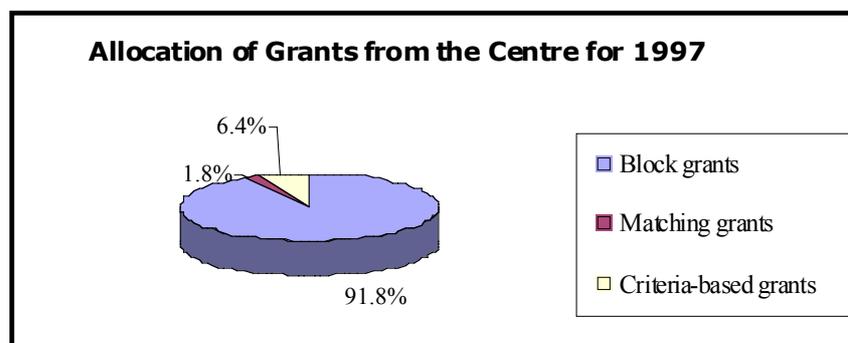


### Allocation of Grants from the Center

The central government fiscal allocation scheme consists of the following:

- **Block grants** - needs-oriented grants, which amounts to the difference between the estimated current expenditure and the estimated revenue collection for each Provincial Council. 92 per cent of total receipts from grants from the center was allocated for block grants in 1997. Distribution is generally based on previous year's expenditures, budget proposals of the provinces, and consultations between the center and provinces. Most of the grant is utilized for recurrent expenditure.
- **Matching grants** - provides an incentive for the Provincial Councils to generate additional revenues, proposed in 1989 and implemented in 1995. Due to financial constraints of the center, these grants were limited to Rs. 325 million. In 1997 they constituted 1.8 per cent of total receipts from grants.
- **Criteria-based grants** - the allocation is derived through a formulae devised by the Finance Commission, based on per capita income, social and economic regional disparities. It is the only tool available to achieve 'balanced regional development'. The criteria-based grants amounted to Rs. 1,168 million, and in 1997 constituted 6.4 per cent of total receipts from grants.

Figure 1.5.b



**Table 1.5.c: Indicators used to determine Criteria-based grants**

Criteria / Indicator	Weight
Per capita income	10%
Difference between per capita income of each province and the highest per capita income among Provinces	10%
Poverty Index	10%
Employment - Rate of Unemployment	15%
Education - Index of Educational status	15%
Health and Nutrition (Composite Index) <sup>6</sup>	15%
Economic and Social Infrastructure (Composite Index)	25%
Total	100%

Source: Wijesinghe, 1996. "Inter-Governmental Fiscal Transfer - The Case of Sri Lanka"

### Establishment of the Finance Commission

The Finance Commission was established under the 13<sup>th</sup> Amendment to the Constitution to oversee the fiscal transfer mechanism between the Central and Local authorities. The Finance Commission is represented by appointees from the Ministry of Finance, the Central Bank and three other members appointed by the President. Its main function is to ensure that the allocation of funds that can be afforded from the annual budget meet the needs of the Provincial Councils. They are actively involved in consultations with the Ministry of Provincial Councils, the Provincial Councils and the General Treasury, after which recommendations are presented to the President, who is required to report the findings to the Parliament. In addition, the Finance Commission is mandated to establish means of achieving balanced regional development, reducing social and economic disparities between Provinces taking per capita income and population data into account. It should be noted that the latter objective is unlikely to have been effectively pursued, since the national income accounts are not yet disaggregated on a provincial basis, and since the continuation of the conflict with the LTTE has prevented a national census being carried out since 1981, leading to considerable inaccuracies in the available data on the provincial population distribution.

**Table 1.5.d: Budget Out-turn for Provincial Councils (Rs. Million)**

	1995	1996	1997(a)
1. Total Revenue	4,440	4,884	5,395
1.1 Tax on Production and Expenditure	3,181	3,416	3,744
Turnover Taxes	2,335	2,464	2,734
Licence Fees	840	945	1,000
Other Taxes	6	6	10
1.2 Profits and Dividends	68	67	175
1.3 Sales and Charges	317	355	408
1.4 Stamp Duty	867	1,036	1,051
1.5 Other	7	10	17
2. Total Expenditure	20,852	22,128	23,455
2.1 Current Expenditure	19,795	20,941	22,055
Functional Basis	19,795	20,941	22,055
Provisional Administration	2,067	1,942	1,941
Economic Services	755	834	939
Social Services	16,973	18,166	19,175
Economic Basis	19,795	20,941	22,055
Personal Emoluments	16,031	16,263	17,067
Other	3,765	4,679	4,988
2.2 Capital Expenditure	1,057	1,187	1,400

<sup>6</sup> The weightage is based on a report by Dr. M.R.P. Salgado, written in 1987. The indicators taken into account per province include the number of persons per bed, the number lacking toilet facilities, inpatient and outpatient facilities, infant mortality rates, and per capita expenditure on food per month. The proportions assigned to provinces have not undergone any changes as there have been no significant increase in the criteria based grants.

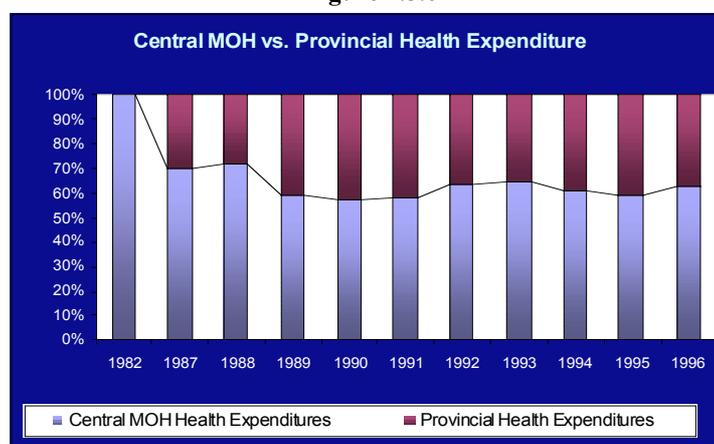
Acquisition of Capital Goods	594	757	729
Capital Transfers	66	53	55
Other	397	377	616
3. Financing	15,288	16,873	18,348
3.1 Block Grants	14,066	15,831	16,855
3.2 Criteria Based Grants	897	800	1,168
3.3 Matching Grants	325	242	325

Source: Central Bank of Sri Lanka, Annual Report 1997

## Health Services

The central Ministry of Health is responsible for the promotion and protection of people's health, as well as formulating policies, medical and para-medical education, management of teaching and specialized medical institutions and bulk purchase of medical requisites. The Provincial Councils are concerned with the prevention and the promotion of health care and administration of all lower level facilities. (Annex 2).

Figure 1.5.c



## Shortcomings of the Current Devolved Structure

The existence of a Finance Commission has not resolved several fundamental financial problems inherent in Sri Lanka's system of devolution. The major one is the disparity between the expenditure responsibilities and tax base of the PCs. The taxes devolved to the PCs, such as vehicle taxes, liquor licences, property taxes, etc. are not ones which have the potential to generate substantial revenues. Although turn-over taxes were partially devolved to the PCs, general government policy in keeping with international best practice has been to reduce these in favor of less distortionary value-added taxes, which by their very nature can probably only be levied on a national basis in Sri Lanka. However, the goal of improving tax revenues through the GST has been marred by the allocation of powers to levy taxes on retail sector to PCs by the Constitution. While the disparity between their expenditure responsibilities and own revenues is greater than in any other federation, there is no provision in the constitution to guarantee any share of central government revenues to the provinces. While this implies that the Center has considerable potential leverage over the PCs, there has been little effort by the PCs to question this, which is symptomatic of the lack of interest in devolved government outside the Tamil-dominated north-east of the country.

A separate problem inherent in the constitution is lack of procedures to ensure transparency and accountability in the operations of the PCs. The PCs do not have to report how they spend funds, even though most of these come from the central government, and the requirements for independent audit of PC financial operations is minimal. This has resulted in long-standing problems of weak expenditure management and control in PCs (International Monetary Fund, 1999). This has paradoxically meant that

data on government health expenditures are worse in the post-1989 period than before, since there is no system to report PC health expenditures on a standardized basis, let alone for PCs to maintain accounting systems allowing them to track expenditures according to functional use. For all provinces (except the centrally-administered North-Eastern PC), there are few data on how health expenditures are allocated by program and function, and where data are available they are lacking in any detail. Certainly it is difficult for either the central health ministry or other observers to assess the financial activities of the provincial departments of health.

It is evident that despite there being a devolved structure of financial mechanisms in Sri Lanka, 90 per cent of provincial government expenditure is still funded by the Center. Effectively, the objective of devolved fiscal management has not been achieved. With specific reference to health expenditure, as the Figure 1.5c shows, less than 40% of health expenditures are accounted for by the Provincial Councils.

Data available on PC expenditures are extremely poor. The Ministry of Finance and Planning and the Ministry of Provincial Councils do not have legislative authorization to request periodic data of actual expenditures from the Provincial Councils. The institution that may request such data, the Finance Commission, has not acted upon it as yet, and focuses only on Provincial allocations.

#### *Proposed changes to the current inter governmental fiscal mechanism - the Devolution Package*

A Legal Draft of Proposals by the Sri Lanka Freedom Party, the main constituent in the ruling People's Alliance, has been tabled in Parliament. Changes which have been proposed, some of which effect inter-governmental fiscal relations and the Finance Commission are as follows:

- The Republic of Sri Lanka will no longer be a "unitary state", but will be a "Union of Regions".
- There will not be a "concurrent list", only a "reserved list" (List 1) to be implemented by the centre and a "regional list", specifying the functions of the Regional Councils. It is envisaged that this will reduce the confusion, which has arisen due to the frequently overlapping functions of the Center and the Periphery.
- The provisions in the legal draft would give the Regional Councils the authority to collect excise duties leviable within its jurisdiction, although the size of such duties are minimal.
- Taxes leviable from a region will be assigned to the Regional Council concerned.
- The Regional Council will have the right to receive a percentage of tax on sales or income levied and collected by the Center. This will increase the tax base of the Regional Councils, and would guarantee a stable source of income.
- Two ex-officio members of the Finance Commission, Secretary to the Ministry of Finance and the Governor of the Central Bank will be excluded, in order to make the Finance Commission completely independent of the Center. Added functions of the Finance Commission will include:
  - (1) Prescription of excise duties to be collected
  - (2) Proportion of taxes on wholesale and retail sales attributable to the Capital territory, among the Regions.
  - (3) Formulation of principles with respect to inter regional trade or commerce
  - (4) Formulation of the percentage of taxes on sales or income to be dispersed to the Regions.

However, although the independence of the Finance Commission may be ensured, the body may face difficulties due to the lack of a member of the Finance Ministry, who could be involved in the allocation of resources.

## 2 - HEALTH STATUS

### 2.1 Review of Health Status

Sri Lanka is a country of both low mortality and low fertility rates. Variations in health status between different subgroups of the population are not as great as seen elsewhere. Even poor rural households with little formal education have mortality and fertility levels which are comparable to higher-middle income developing countries. By 1997, despite an income level of only US\$800 per capita, Sri Lanka had reduced its infant mortality rate to 15, its child mortality rate to 18, its total fertility rate to below replacement level at 2.0, and raised its life expectancy to 75 and 71 years at birth for women and men respectively (Table 2.1.a).

These low mortality outcomes are the result of rapid and continuous improvements over half a century (Meegama, 1986). During the early part of the twentieth century there was some decline in the average mortality rate, but this fluctuated greatly from year to year. After a rise during the Second World War, the IMR dropped rapidly during 1946 to 1953, falling from 141 to 71 per 1000 live births. This was as much the consequence of improved public medical and malaria control activities, as it was of improved food supplies following the end of war. Afterwards the IMR continued to drop, before beginning to plateau in the mid-1970s. The decline was marked by a reduction within the island of inter-district and interethnic disparities in mortality. The only exception was a stagnation in the health status of the plantation sector population until the late 1970s, when these disparities also started to diminish.

There has been some academic debate about whether Sri Lanka's achievements were merely the consequence of a very rapid initial decline, and how good its subsequent performance was (Aturupane, Glewwe, and Isenman, 1994). However, from the late 1970s onwards, the rate of decline in IMR has accelerated. This is itself exceptional, as for much of this period Sri Lanka experienced almost continual internal conflict and declining numbers of physicians. The acceleration in the reduction of the IMR can also be contrasted with the experience with the other developing economy which liberalized its economy at this time - China.

**Table 2.1.a: Long term trends in health and social indicators**

Indicator	1930	1950	1970	1990	1997
Birth rate	39	40	29	21	16
Death rate	25	13	7	5	6
Infant mortality rate	175	82	47	22	15
Maternal mortality rate	21	6	2	1	<1
Life expectancy at birth (years)					
Female	39	55	67	73	75
Male	41	56	64	69	71
Literacy		69	82	88	92
Total fertility rate		5.3	4.2	2.2	2.0
Total population (millions)	5.3	7.7	12.5	16.9	18.1
Population growth rate (%)	1.4	2.8	2.2	1.0	0.9
GDP per capita (1990 US\$)	150	225	260	475	600

Source: Official statistics and IPS estimates for 1997.

#### Accuracy of vital statistics

Sri Lanka has amongst the best quality vital statistics data in the developing world, on par with those in Malaysia, Mauritius and Barbados (Feachem et al., 1992). However, the quality of available vital statistics data has deteriorated since the mid-1980s, because of the security problems in the North and East, as well

as a result of decentralization of responsibility for data collection in the mid-1980s. Reporting of births is generally better than that of deaths, since birth certificates are necessary to enter school, obtain official identification documents, etc. In recent years, official IMR statistics have probably underestimated the actual IMR by 20-30%, with the actual 1995 IMR figure closer to 22-24 infant deaths per thousand live births instead of the official 18 (De Silva 1998).

## **2.2 Emerging problems**

There are increasing numbers of deaths in Sri Lanka from the diseases characteristic of later stages in the epidemiological transition, such as ischemic heart disease, cerebrovascular conditions and lung cancer. Although there have been considerable concerns that this has co-existed with a continuing burden from diseases characteristic of the first stage of the epidemiological transition, there is little evidence of this (see sections below). The available data point to no increase in older infectious diseases such as TB, measles, etc. Most EPI diseases are either almost eradicated (e.g., polio), or at very low levels (e.g., measles, tetanus, diphtheria). The only notable exceptions to these trends in recent years have been infections for which there are no effective vaccines available, or for which environmental or socially complex interventions are critical; these include viral haemorrhagic fever and cholera. Other significant health problems that exist include suicide, mental illness and problems associated with drug abuse.

Detailed discussion of the performance of the health system in dealing with the increasing burden from more chronic and non-infectious diseases is not possible in this report. Consideration of this area would require comprehensive morbidity data gathered at the population level and more detailed data on the services delivered by individual facilities, neither of which are currently available. Certainly, one would expect an increase in many diseases such as IHD, neoplasms, etc, with the decline in infectious diseases such as TB, measles, etc. However, to judge whether age-adjusted risks from these new diseases are increasing, or decreasing as in most developed countries, is not possible given the lack of data. The lack of data does point to the need to expand the data collection systems in the health system in future to allow health sector managers to more effectively manage these new priority problems.

### **Malaria**

Malaria has been one of the most important communicable diseases in Sri Lanka, with particularly devastating impacts in the 1930s and 1940s. Although vector control using DDT, and later malathion, was successful in bringing down transmission rates in the 1960s and 1970s, malaria incidence did not remain low and has risen since the early 1980s. However, while in earlier decades malaria killed tens of thousands annually, malaria mortality is much reduced since the 1980s. The reduction in case fatality is due to effective treatment being sought and obtained by patients, largely from public institutions. During the latter part of the 1990s, there was an increase both in the incidence and mortality due to malaria. In 1997, 323 deaths were reported. Much of this increase has been in the North-Eastern Province, which now accounts for more than half the total case load; operational difficulties MOH faces in the adverse security situation there seems to be the main reason. Nevertheless, there exists significant opportunity to further improve the effectiveness of anti-malaria control activities throughout the island.

### **Suicide**

The problem of suicide receives much attention in Sri Lanka, with a Presidential Task Force appointed to develop a strategy. However, while the reported suicide rate is relatively high, it is perhaps not as high in comparison to other countries as often reported, and has been declining substantially in recent years. As with many other Asian countries, social stresses resulting from imbalances in the development process are major causative factors, as well as culturally-specific norms concerning interpersonal communication and relationships. The incidence of suicide is only half that in China, another developing Asian country where rapid economic development has been associated with social stresses manifested in raised suicide rates. Recent years have seen a decline in the incidence of suicides, with the rate reported for 1998 one third less than at its peak in the early 1990s.

**Table 2.2.a: Annual reported suicides in Sri Lanka, 1987-98**

Year	Reported suicides	Incidence per 100,000 population
1986	6,784	42.1
1995	8,414	46.4
1996	7,344	40.1
1997	6,418	34.7
1998	6,010	32.2

Source: Police Department Administrative Reports, and Statistical Division of Police Headquarters.

Note: 1998 data are for first half of 1998 annualized for whole year.

## HIV/AIDS

Sri Lanka is adjacent to two major epicentres of the HIV/AIDS pandemic - Thailand and Southern India. From a conventional perspective, Sri Lanka has several predisposing factors favoring rapid HIV transmission, including a high percentage of Sri Lankans travelling and working overseas, large numbers internally displaced within the island, and late age at marriage. This has led many, including the World Bank,<sup>7</sup> to have concerns that the health authorities in Sri Lanka do not take sufficient cognizance of this problem. Although it is important that efforts to combat the impact of HIV should be strengthened, the problem should not be over-stated.

HIV/AIDS prevalence rates are low in Sri Lanka (Table 2.2.b), and actual case rates remain below originally anticipated levels (Table 2.2.c). The reported number of cases (<300) of course represent only a small proportion (<5%) of actual infections in the population at large. WHO/UNAIDS estimations of the wider hidden population prevalence using internationally accepted procedures suggest 7-8,000 cases in the island,<sup>8</sup> while MOH estimates that unreported AIDS-related deaths may only be 1,900 (Xinhua Press Agency, 1999). These low levels are substantiated by very low numbers of cases picked up in mass-testing of mothers at maternity centers and patients at STD clinics.

The reasons for the low rates are unclear, although official health education efforts early in the epidemic, a health-promoting culture and good access to decent health services may play a part. MOH secured its blood transfusion supplies relatively early in the epidemic in comparison with other countries. Of note is that the low HIV/AIDS seroprevalence rates persist despite relatively high reported rates of sexually-transmitted diseases. The high reported STD rates may be more a reflection of the effectiveness of reporting systems and organization in Sri Lanka's health system than of actually high rates of prevalence. A high level of effectiveness in finding and treating STDs would in itself be expected to reduce rates of HIV transmission.

**Table 2.2.b: HIV seroprevalence rates in selected countries (per 100)**

Country	Rates (end 1997)
Thailand	2.23
India	0.82
Malaysia	0.62
Singapore	0.15
United Kingdom	0.09
Sri Lanka	0.07
China	0.06
Japan	0.01

Source: UNAIDS Report 1998. Seroprevalence rates are those estimated for population at large including unreported and undetected cases, and are not those based on reported cases.

<sup>7</sup> The inclusion and design of the HIV/AIDS component of the current IDA Health Services Project in Sri Lanka was based on an exaggerated view of the nature of the HIV/AIDS epidemic in Sri Lanka, according to sources in UNAIDS and AIDS experts in the World Bank, Washington, DC.

<sup>8</sup> The Country Programme Manager for UNAIDS/Sri Lanka believes that even the official estimate is too high.

**Table 2.2.c: Annual reported HIV/AIDS cases in Sri Lanka, 1987-98**

Year	HIV cases reported			AIDS cases reported			
	Total	Male	Female	Total	Male	Female	Deaths
1987	2	2	0	2	2	0	
1988	3	3	0	2	2	0	1
1989	11	8	3	3	1	2	4
1990	7	6	1	2	2	0	2
1991	13	10	3	3	2	1	3
1992	27	19	8	10	8	2	10
1993	37	26	11	11	8	3	8
1994	23	15	8	14	13	1	10
1995	22	12	10	11	9	2	11
1996	30	20	10	11	9	2	8
1997	32	16	16	8	3	5	4
1998 (as of 10.98)	49	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL (as of 10.99)	256 (293)	137 (187)	70 (106)	77	56	18	61 (75)

Source: MOH, UNAIDS, Xinhua Press Agency (1999).

## Tuberculosis

Agencies such as the World Bank and WHO have identified TB as the major, unrecognized public health challenge in both developed and developing countries. Statistics for the incidence of tuberculosis in Sri Lanka are restricted to cases identified and treated by the health services. Model-based estimations on an annual basis of the Tuberculosis Infection Rate are not available. Nevertheless, since pulmonary TB is a severe disease almost always requiring the patient to seek medical advice, reported incidence and mortality trends provide a good indication of actual trends.

Table 2.2.d below gives recent trends in tuberculosis. Unlike in many other countries, both in the region and in the developed world, tuberculosis decreased in incidence throughout the 1990s, with a small increase during 1996-98. The WHO-recommended Short Course Chemotherapy is used by MOH, and DOTS (Directly Observed Treatments) has recently been introduced. The declining levels of new cases and low incidence rates in the younger age-groups indicate a high degree of organizational effectiveness in the health services involved, and that exogenous infection risks are low.

**Table 2.2.d: Tuberculosis Incidence and Mortality, 1970-96**

Year	Incidence per 100,000	Mortality per 100,000
1970	40	
1975	54	
1980	42	7.8
1985	37	7.4
1990	39	3.5
1991	36	-
1992	39	-
1993	39	-
1994	34	-
1995	31	3.1
1996	29	2.8
1997	36	2.9

Source: MOH Annual Health Bulletin

## **Hospital morbidity and mortality**

As most developed and developing countries, Sri Lanka does not collect routine and comprehensive population-based morbidity data. Public sector hospital morbidity data give only a partial perspective on trends in morbidity, since not all morbidity and mortality occurs in hospitals, and because of problems in the quality of disease coding in hospital admission data. However, since the public sector accounts for more than 95 per cent of all admissions, public sector data are representative of all hospital morbidity. For some conditions, which often result in admission, the data can suggest possible trends. Table 2.2.e gives the trends in causes of admission and death in hospital.

In the past three decades there has been an increase in hospital morbidity caused by ischemic heart disease and cerebrovascular conditions. The rate of increase suggests that at least for these two conditions that age-specific admission rates have been increasing, although this may reflect also declines in competing risks. Ischemic heart disease is already the leading cause of hospital-recorded deaths. However, hospital morbidity remains dominated by malaria, injuries and other infectious diseases.

The IPS Private Clinic Survey 2000 is collecting morbidity data for patients presenting at private general practitioners. These data will be available in mid-2000, and would provide a better profile of morbidity presenting at outpatient services.

**Table 2.2.e: Trends in hospital morbidity and hospital deaths at MOH facilities by diagnostic category, 1965-1996**

Disease Groups	Cases per 100,000 Population				Deaths per 100,000 Population			
	1965	1975	1985	1996	1965	1975	1985	1996
Injury, poisoning and certain other consequences of external Causes	1,655 (4)	1,751 (5)	1,669 (5)	2,603 (2)	21 (5)	21 (4)	26 (3)	22 (3)
Diseases of the respiratory system	3,501 (2)	2341 (4)	2,180 (2)	2,150 (5)	32 (3)	31 (3)	17 (5)	15 (5)
Infectious and parasitic diseases	2,633 (3)	2703 (2)	2,081 (3)	2,185 (4)	49 (2)	42 (2)	19 (4)	14 (6)
Neoplasms	127 (18)	156 (19)	121 (19)	200 (17)	8 (9)	9 (9)	7 (9)	12 (7)
Diseases of the circulatory system	538 (10)	575 (12)	659 (9)	940 (8)	32 (3)	42 (2)	38 (2)	50 (2)
Endocrine, nutritional and metabolic diseases	359 (14)	331 (16)	226 (16)	208 (16)	6 (10)	16 (5)	4 (11)	4 (9)
Diseases of the blood and blood forming organs	665 (7)	451 (13)	287 (14)	118 (19)	8 (9)	11 (7)	3 (12)	1 (12)
Diseases of the digestive system	935 (5)	900 (7)	613 (10)	869 (9)	11 (7)	13 (6)	8 (8)	14 (6)
Diseases of the genitourinary system	510 (11)	577 (11)	686 (8)	1012 (7)	5 (11)	5 (12)	3 (12)	6 (9)
Direct and indirect obstetric causes <sup>1</sup>	N/A.	2,420 (3)	1,806 (4)	2,468 (3)	29 (4)	10 (8)	4 (11)	1 (12)
Diseases of the skin and subcutaneous tissue	540 (9)	711 (10)	535 (11)	507 (12)	1 (14)	1 (15)	0 (15)	0 (13)
Diseases of the musculoskeletal and connective tissue	489 (12)	350 (15)	399 (13)	602 (11)	0 (15)	0 (16)	0 (15)	0 (13)
Congenital anomalies	22 (20)	34 (27)	24 (27)	39 (23)	2 (13)	6 (11)	2 (13)	2 (11)
Certain conditions originating in the perinatal period <sup>2</sup>	3,797 (1)	3,218 (1)	2,914 (1)	5,337 (1)	655 (1)	634 (1)	734 (1)	555 (1)
Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	279 (15)	920 (6)	1,353 (6)	1,062 (6)	12 (6)	16 (5)	11 (7)	7 (8)
Tuberculosis	120 (18)	114 (21)	74 (23)	53 (22)	9 (8)	8 (10)	4 (11)	3 (10)
Diphtheria	11 (22)	2 (29)	0 (30)	N/A.	1 (14)	0 (16)	0 (15)	N/A.
Whooping cough	19 (21)	10 (28)	3 (28)	0 (29)	0 (15)	0 (16)	0 (15)	N/A.
Rabies	N/A.	1 (30)	1 (29)	1 (27)	N/A.	0 (16)	0 (15)	0 (13)
Measles	19 (21)	37 (26)	59 (24)	1 (28)	0 (15)	0 (16)	0 (15)	N/A.
Viral hepatitis	47 (19)	110 (22)	42 (25)	39 (24)	1 (14)	1 (15)	0 (15)	0 (13)
Malaria	N/A.	800 (9)	437 (12)	290 (14)	0 (15)	1 (15)	0 (15)	0 (13)
Helminthiasis	617 (8)	231 (17)	112 (20)	15 (25)	5 (11)	2 (14)	0 (15)	0 (13)
Diabetes mellitus	N/A.	96 (23)	87 (22)	154 (18)	N/A.	5 (12)	2 (13)	3 (10)
Nutritional deficiencies	173 (16)	198 (18)	109 (21)	13 (26)	2 (13)	10 (8)	1 (14)	0 (13)
Anaemias	424 * (13)	431 (14)	278 (15)	101 (20)	5 (11)	9 (9)	2 (13)	1 (12)
Hypertensive disease	129 (17)	122 (20)	187 (17)	340 (13)	4 (12)	6 (11)	5 (10)	3 (10)
Ischaemic heart disease	N/A.	76 (24)	164 (18)	256 (15)	N/A.	8 (10)	16 (6)	17 (4)
Diseases of the liver	N/A.	39 (25)	41 (26)	91 (21)	N/A.	4 (13)	4 (11)	12 (7)
Abortions	811 (6)	829 (8)	811 (7)	792 (10)	2 (13)	1 (15)	0 (15)	0 (13)

Source: MOH Annual Health Bulletins, 1988, 1996 \* Iron deficiency anaemia only, \*\* N/A. not available

1. Rate per 100,000 females of the reproductive age group, excludes normal delivery and those admitted and discharged before delivery.

2. Per 100,000 live births.

## 2.3 Future Trends

Projections of future epidemiological trends are not available. Production of such data would require the prior existence of comprehensive population-based morbidity data, which is not the case. Table 2.3.a gives the most recent demographic projections for the country. Future trends in the fertility rate are difficult to predict, but if Sri Lanka's experience is similar to other middle-income Asian countries whose fertility has fallen to below-replacement level, then the TFR may fall to 1.4-1.5 before rising again. The population is expected to age rapidly in the next four decades, with the share over 60 years increasing from 8% currently to 13% in 2010 and 21% in 2025. The rate of population aging is expected to be more rapid than in China and other countries in Asia, and Japan historically.

With demographic aging, it is expected that morbidity and mortality from age-related diseases such as ischemic heart disease, cerebrovascular disease, diabetes, osteoporosis, etc will increase substantially. Recent research suggests a link between poor nutrition before birth and in infancy and higher rates of ischaemic heart disease and diabetes later in adult life (Barker, 1992). If incomes were to rise substantially as expected in Sri Lanka in coming decades and rates of malnutrition decrease, this may lead to very rapid increases in these two diseases, as many in current birth cohorts may experience malnutrition in their childhood, but be able to command a relatively affluent lifestyle when they have reached their 30's-40's.

**Table 2.3.a: Demographic projections, 1991 - 2031**

	1991	2001	2011	2021	2031
Total population (millions)	17.0	19.2	21.1	22.4	22.8
Median age (years)	25.0	28.5	32.6	37.0	41.1
Percentage in age group					
Under 15	31	25	22	19	15
15-59	60	65	65	63	62
60 & over	8	10	13	18	22
TFR	2.2	1.9	1.7	1.5	1.5
Life expectancy					
Female	74.0	77.0	78.8	80.3	81.6
Male	69.3	72.1	73.6	75.2	76.4

*Source:* Standard projections given in De Silva (1997).

## 3. ORGANIZATION OF HEALTH CARE DELIVERY

### 3.1 General organization

The health system in Sri Lanka consists of public and private health care services. Public services are the responsibility of the central Ministry of Health and eight Provincial Councils. Major municipalities provide services of a limited nature. The public sector delivers both inpatient and outpatient services, as well as preventive and promotive health activities. Private health care services largely consist of ambulatory services provided by full-time private practitioners, government medical staff working privately and pharmacies. There is a small, but growing, private hospital sector. The plantation estates have historically run their own facilities for their employees, but in the late 1990s a decision was made to integrate these into the MOH system.

From 1850s until the 1980s, the government health services were managed by a central health department or ministry.<sup>9</sup> Following the 13<sup>th</sup> Amendment in 1987, responsibility for health services was devolved to eight Provincial Councils, each of which has its own Provincial Health Ministry. The Provincial Councils are responsible for management of provincial health facilities and programs, while the central ministry is responsible for management of national facilities, medical education, formulation of health policy and bulk purchase of drugs and medical supplies.

The public sector runs an extensive network of facilities throughout the island. These are organized into a multi-tiered referral system of facilities ranging from maternity homes and dispensaries upwards to teaching hospitals and other national hospitals. These provide mostly modern western type care, but ayurvedic care is also provided by separate government facilities under the responsibility of the Ministry of Indigenous Medicine.<sup>10</sup> In 1996, there were 880 institutions with 52,613 beds and 377 dispensaries in the public health care system. Outpatient care is mostly provided through outpatient departments attached to the inpatient facilities, although some free-standing outpatient facilities also exist. In 1995, these facilities treated over 3.2 million inpatients and 36 million outpatients (Central Bank, 1997). This amounted to over 95% of all inpatient admissions, and approximately half of all outpatient consultations in the country (Table 3.1.a).

The public health care services employed 5,316 doctors in 1997 (up from 2,440 in 1990). In general they work as full-time employees, although most are also permitted private practice during their non-working time. In addition, the Health Ministry employs 1,464 Assistant Medical Practitioners (AMPs), who have received basic medical training during a three-year training program following graduation from 12 years of primary and secondary schooling. AMPs are permitted to diagnose and prescribe, and often work unsupervised in more peripheral units. The doctors and AMPs are supported by over 15,000 nurses and approximately 6,000 attendants.

Private health care services are largely ambulatory. Approximately, 500-800 full-time private general practitioners provide outpatient care from private clinics on a fee-for-service basis. The major portion, however, is delivered by government doctors in their private practice, who work from home, clinics or private hospitals.<sup>11</sup> There are approximately 10,000 traditional practitioners, mostly ayurvedic doctors, and less than 100 homeopathic practitioners, but they see vastly fewer patients in total than the western qualified

<sup>9</sup> In the modern era, a government department with primary responsibility for civilian health services was first established in 1858, with the creation of the Civil Medical Department. This later became the Department of Medical and Sanitary Services, the precursor of the contemporary health ministry. In recent decades, the Health Ministry has undergone various name changes as cabinet portfolios have been regularly rearranged, but it has remained essentially the same institution. It is currently called the 'Ministry of Health, Highways and Social Services'. In this report, it shall therefore be referred to as Ministry of Health (MOH), unless otherwise indicated.

<sup>10</sup> Following the last cabinet reshuffle, this ministry is now merged with the main Ministry of Health, and headed by the same cabinet minister.

<sup>11</sup> There are no data on the proportion of the private sector case load cared for by government doctors in their private practice, although it may be in the range of 50-70%. Reliable estimates will be available in mid-2000 with the completion of the IPS HPP Sri Lanka Private Clinic Survey.

doctors. Many private GPs dispense their own medicines, but a large number of private pharmacies also exist and account for a significant share of out-of-pocket spending. According to IMS, a private pharmaceutical market research firm, the percentage of private GPs who dispense is gradually declining over time, as this is not so profitable for the doctors concerned.

### Trends in use of providers

Outpatient medical consultations are provided almost equally by the public and private sectors. With the expansion of government health services in the 1930s-1940s, the use of western medical providers and government health facilities increased substantially. Since that time, the use of ayurvedic providers shows a secular decline, falling from more than 20% of all outpatient consultations in the 1960s to less than 5% in 1996/97. The liberalization of the economy since 1977 was associated with a modest increase in the share of private Western providers in total provision (although consultations at private ayurvedic providers fell by more). Private sector consultations have plateaued at 42-44% of total provision since the early 1990s (Table 3.1.a). It is unclear whether the latter trend was due to shortages in the supply of private services with the constraints in the availability of medical doctors, or for other demand-related reasons. Nevertheless, the continuing public sector dominance in the provision of ambulatory medical services is a contrast to the much lower levels reported in other South and Southeast Asian countries, such as India, Bangladesh, Malaysia, Thailand and Indonesia.

**Table 3.1.a: Sources of Treatment Used by Sick Persons**

Source of treatment	1978/79	1981/82	1986/87	1991	1996/97
Western government sector	42.6%	45.6%	44.1%	48.9%	50.7%
Ayurvedic government sector	1.9%	2.2%	1.9%	3.1%	2.0%
Western private sector	34.3%	34.2%	37.2%	37.5%	38.1%
Ayurvedic private sector	16.1%	12.1%	12.9%	9.0%	7.6%
Others	5.1%	6.0%	3.8%	1.5%	1.7%

*Source:* Central Bank Consumer Finance Surveys for 1978-97, and MOH/IDA Household Health Utilization Survey for 1991.

*Note:* The percentages are for those who reported falling ill during a 14 day reference period, and used any source of treatment; they exclude those who did not seek treatment (3.5% in the CFS 1996/97). Comparable data for utilization of providers for preventive services do not exist in tabulated form. Treatment includes both inpatient and outpatient care. Inpatient treatment is not disaggregated into public and private in the published reports, but the same surveys indicate that approximately 5% of treatment episodes involved inpatient care, of which it can be assumed approximately 95% was at government hospitals. The figures for 1996/97 are from special tabulations prepared by Central Bank for SLNHA, which do make that distinction. Western private includes private clinics, private hospitals and pharmacies.

Inpatient care by the private sector was traditionally limited, and restricted to a small number of nursing homes and hospitals in urban areas, which were staffed by both full-time private doctors and government doctors working in their off-hours. However, in the 1980s there was an increase in their number and the level of sophistication of their services. In the early 1990s there were approximately 75-100 private hospitals, accounting for approximately 2,000 beds. Statistics on private sector hospitals are not routinely collected by MOH. Table 3.1.c gives estimates for this sector based on a survey carried out for this report.

Taking both public and private sector utilization into account, Sri Lanka is characterized by relatively high levels of utilization for a country at its income level (Table 3.1.d). Outpatient physician contacts per capita per annum are high for a developing country, but are yet to reach the levels observed in more advanced Asian economies or the OECD region as a whole. On the other hand, inpatient utilization rates are amongst the highest observed. This latter feature must be balanced with the observation that lengths of stay in Sri Lanka are also relatively low in international comparison. Sri Lankan public sector physicians tend to exercise a lower level of tolerance when admitting unreferral inpatients than in developed countries. They often admit cases that might be handled on an outpatient basis in Europe or North America, simply because

they lack time to adequately assess all patients presenting in a given shift or because diagnostic facilities are not immediately available. Physicians, with experience of working in both Sri Lankan facilities and European ones, suggest that it is not feasible to lower the inpatient admission rate without increasing the time available for assessing patients. This in turn would require a substantial increase in the available physician staff, or provision of a publicly-funded general practitioner service accessible to lower income patients to screen patients.<sup>12</sup> Taking these observations into account, it can be concluded that Sri Lanka has succeeded in achieving relatively high levels of access to modern health facilities for all its population despite a low income level, but that added resources may be necessary to reduce the relatively high inpatient admission rate.

**Table 3.1.b: Trends in public and private provision of services, 1990s**

	1990	1992	1994	1996 (a)	1997
<b>Government sector</b>					
Beds	42,079	48,061	50,091	52,613	52,963
Doctors	2,440	3,345	4,047	5,117	5,628
Nurses	8,957	11,214	13,060	13,933	13,815
Other staff	6,781.00	-	-	-	-
Inpatient admissions ('000s)	2,533 (a)	3,023	3,204	3,339	3,454
Outpatient visits ('000s)	28,401(a)	36,827	35,276	35,348	39,503
<b>Private sector</b>					
Beds	1,872	1,886	2,138	2,275	2,305
Doctors (b)	~600	-	~1,000	-	-
Nurses	>2,000	>2,000	-	-	-
Other staff	>3,000	>3,000	-	-	-
Ayurvedic practitioners	13,284	13,131	13,624	14,808	15,078
Inpatient admissions ('000s)	117	135	153	176	204
Outpatient visits ('000s)	~30-34,000	~32-35,000			~32-36,000

*Note:* (a) Excludes some districts in Northern and Eastern provinces. (b) Full-time private physicians only. Private sector and ayurvedic numbers are estimates. Outpatient visits counts visits for both curative, preventive and family planning services.

*Source:* IPS staff estimates derived from Central Bank Annual Reports, Central Bank Consumer Finance Surveys, and MOH Annual Health Bulletins.

**Table 3.1.c: Trends in private hospital sector, 1990s**

	1990	1992	1994	1996	1997
Number of hospitals	-	76	-	-	-
Beds	1,872	1,886	2,138	2,275	2,305
Inpatients (admissions)	117,000	135,000	153,000	176,000	204,000
Outpatients (visits)	568,000	810,000	986,000	1,502,000	1,617,000
<b>Revenues</b>					
Rupees (million)	388	528	732	1,032	1,219
% of GDP	0.13	0.14	0.14	0.15	0.15

*Note:* National figures estimated using results of IPS/MOH survey carried out during July-August 1998. Survey sample is estimated to have covered ~65% of all private hospitals and beds.

<sup>12</sup> Personal communication from Dr. Sahan Rannan-Eliya, Radcliffe Infirmary, Oxford.

**Table 3.1.d: Annual contacts per capita with modern providers in Sri Lanka and other selected countries**

Country	GNP per capita in \$PPP (1996)	Time period	Outpatient visits per capita	Inpatient admissions per 100 capita
Zambia	860	1995	1	-
Bangladesh	1,010	1996	1	2
India (Tamil Nadu)	1,580	1997	3	14
Sri Lanka	2,290	1997	4	20
Egypt	2,860	1996	4	3
Indonesia	3,310	1993	-	1
Thailand	6,700	1993	2	8
Malaysia	10,390	1993	-	4
Taiwan	~15,000	1998	15	12
United Kingdom	19,960	1993	6	13
Germany	21,110	1991	7	21
Japan	23,420	1993/6	16	9
Hong Kong	24,260	1996	10	13
USA	28,020	1991/6	6	12

Source: OECD data, national statistics and IPS staff estimates.

### 3.2 Structure of public sector services

The public sector delivery system consists of central and provincial services. Together they comprise one co-ordinated system.

#### Central MOH

The central MOH has overall responsibility for national health policy. It manages and operates teaching and specialized hospitals, recruits and allocates public sector doctors and other key staff, and operates key vertical programs for disease control (including malaria, filariasis, tuberculosis, rabies, STD/AIDS, etc.). It also runs several specialized units, which provide technical support to both central and provincial health services, such as the National Blood Transfusion Service, Health Education Unit, Family Health Bureau, Medical Supplies Division, etc. The central ministry also administers several national research and training institutes, such as the Medical Research Institute (MRI) and the National Institute of Health Sciences (NIHS). Central units such as the Family Health Bureau also administer national programs, such as the Expanded Programme in Immunization (EPI).

MOH functions under the purview of the Secretary of Health, who is the Chief Accounting Officer, and who is responsible through the Minister of Health to the Cabinet and Parliament. There are currently two Additional Secretaries also appointed to the ministry. A Director-General of Health Services, reporting to the Secretary, administers the Department of Health Services, which is responsible for the health services structure. Several Deputy Director-Generals head each functional area. Unlike in other line ministries, only the Secretary (and Additional Secretaries) are members of the Sri Lanka Administrative Service (SLAS), and other senior ministry staff are career officials from within the ministry, typically medical doctors.<sup>13</sup>

#### Provincial Health Services

The provincial health ministries are responsible for the operation of health services in their respective areas, including secondary and primary level facilities, and implementing community health programs with guidance from central units. Provincial health facilities extend from the lowest level central dispensaries and maternity homes to Provincial Hospitals.

<sup>13</sup> This is similar to the practice in several other Asian countries, including Japan, Thailand and Malaysia.

In recent years, several provincial facilities have been transferred to central MOH control by being officially reclassified through administrative procedures as national hospitals or teaching hospitals, all of which come under the center's constitutional purview. In many cases, the justification for this has been minimal, although provinces have been in general happy to transfer facilities to the center as this removes them of a financial obligation. Such moves have typically been supported by the staff of the facilities concerned.

Provincial health ministries are headed by a Secretary, responsible to the Provincial Minister in charge of the health portfolio. Since the constitution allows only four Provincial Ministers, the Health Minister typically handles several other portfolios. Provincial Departments of Health are headed by a Provincial Director of Health, who is accountable to the Secretary of the Provincial health ministry. The provincial directors of health administer the provincial health facilities and programs.

Other than national health policy, which the constitution assigns to the central government, provincial councils have considerable discretion in setting health policy within their jurisdictions. However, in common with other areas of activity, provincial councils have only ever exercised a small part of their powers, which allow them to set different policies within their areas. This reflects both lack of interest in policy at the level of provincial legislators, and the lack of technical capacity to develop independent provincial policies.

## Health Facilities

Public sector health facilities are organized into several categories, according to the level of sophistication of medical services offered and general size. All hospitals have outpatient clinics, where hundreds of patients may be treated daily. The distribution of facilities and beds by category are given in Table 3.2.a.

**Table 3.2.a: Distribution of Beds and Institutions by Facility Category, 1997**

Category	Number of institutions	Number of beds	Percentage of total beds
Teaching hospitals	15	13,815	26%
Provincial hospitals	5	4,281	8%
Base hospitals	31	8,375	16%
District hospitals	149	13,162	25%
Peripheral units	104	4,745	9%
Rural hospitals	133	3,481	7%
Maternity homes and central dispensaries	67	672	1%
Other hospitals	17	4,432	8%
Central dispensaries	387	0	0%
<b>TOTAL</b>	<b>908</b>	<b>52,963</b>	<b>100%</b>

Source: MOH Annual Health Bulletin 1997.

### *Teaching hospitals*

These are the highest level referral facilities, where medical students are trained. Legally, they are automatically the responsibility of the central government. They typically have over 1,000 beds, and provide both inpatient and outpatient services. They offer the largest range of speciality services, such as cardiothoracic surgery and neurology, and generally have well-equipped accident and emergency services and intensive care units. In practice, at least 50% of their activities will involve provision of basic medical services, since as with all hospitals there is no restriction on access to their outpatient departments. There are some single speciality teaching hospitals, including two maternity hospitals and the Eye Hospital.

### *Provincial hospitals*

Located in the major urban centers of provinces, these typically have 600-1,000 beds. They are administered by the provincial health ministries. They are referral facilities, and offer several specialities, such as general medicine, surgery, obstetrics and gynecology, pediatrics, dental services, etc.

### *Base hospitals*

Situated in large towns, they typically range in size from 200 to 600 beds. They function as the first line referral facilities, although official district hospitals are supposed officially to perform this function. The ranges of specialities offered varies considerably, with many providing only basic specialities, such as medicine, surgery and obstetrics/gynecology. Base hospitals are equipped with laboratory facilities.

### *District hospitals*

Wide variation exists in this category. Bed sizes are typically 50-200. They differ from base hospitals in that they are generally run by non-specialist medical officers and AMPs, but are officially considered the lowest level referral facilities, although in practice most patients use them as the first point of contact for care.

### *Peripheral Units*

These are small hospitals with typically 20-80 beds. Generally run by a medical officer in-charge, they have a maternity ward and central dispensary, and offer only basic medical care.

### *Rural hospitals*

These provide inpatient and outpatient care, but lack a maternity ward. Usually administered by a RMP/AMP, they generally have 20-40 beds.

### *Central dispensaries and maternity homes*

These provide limited inpatient and outpatient care, and are staffed by one RMP/AMP only and one or two nurses. While they provided the backbone of the government health system in the 1930s, they are now grossly under-utilized, with bed occupancy rates typically less than 10%.

### *Maternity homes*

Maternity homes are run by midwives, and offer inpatient maternity care. Utilization is very low, with bed occupancy rates less than 15%. However, few of these facilities remain, and they are generally used also by Medical Officers of Health to conduct maternal and child health clinics.

### *Central dispensaries*

The smallest outpatient unit are run by single RMP/AMPs. They provide treatments minor illnesses and injuries only, such as dressing of minor wounds, and may also host special clinics such as those for family planning.

The bulk of patient services are provided at middle and higher level facilities; occupancy rates at maternity homes and central dispensaries are very low, and falling (Table 3.2.b).

**Table 3.2.b: Relative share of utilization by facility type, 1997**

Facility type	Share of beds (%)	Share of admissions (%)	Bed occupancy rate (%)	Share of outpatient visits (%)
Teaching hospitals	26%	28	93	11
Provincial hospitals	8%	9	102	3
Base hospitals	16%	19	82	14
District hospitals	25%	25	50	28
Peripheral units	9%	11	59	14
Rural hospitals	7%	5	41	11
Maternity homes and central dispensaries	1%	0	4	14
Total number	1,071	3,453,554	74	39,503,090

Source: MOH Annual Health Bulletin 1997.

### Preventive health services

Preventive health services are provided largely through the existing health infrastructure of MOH. Responsibility for coordination in many cases is assigned to specific national programs. Sri Lanka has a good record in the provision of preventive health services. In most cases, there is little sign of this tradition being threatened.

#### *Family health services*

Family Health Bureau (FHB) of MOH is responsible for planning, coordination and evaluation of MCH and family planning services. It conducts training and coordinates donor inputs and distribution of key inputs. Work is actually carried out by MOH staff, mostly in the MOOH and MCH units. MOOH staff and community midwives are responsible for visiting pregnant mothers and providing post-natal follow-up of all mothers in the community. These services generally perform well with limited resources, although there are areas in which improvements can be made.

#### *Family Planning services*

MOH is responsible for the bulk of contraceptive services in the country, particularly in the case of clinical methods, such as tubectomies and vasectomies. A social marketing campaign distributes condoms and oral contraceptive pills through the retail sector and NGOs. Sri Lanka reports high rates of contraceptive prevalence, and this is reflected both in a low incidence of unwanted pregnancies and low and rapidly declining fertility rates. The total fertility rate (TFR) is approximately 1.9 in 1999, with little difference in rates reported from urban and rural areas according to the 1993 Demographic and Health Survey (DHS).

#### *Immunization services*

The national Expanded Programme of Immunization (EPI) seeks to control six vaccine preventable diseases: TB, diphtheria, pertussis, tetanus, poliomyelitis and measles. Field health staff working under the supervision of Medical Officers of Health (MOOH) mainly implement this activity, with public hospitals also contributing, mainly by immunizing newborns with BCG and mothers with tetanus toxoid. Sri Lanka has already achieved zero prevalence of polio, and efforts continue to officially declare polio eradicated. These efforts have included national immunization days (NIDs) during 1996, 1997, 1998 and 1999. NIDs were successfully conducted on each occasion, with hostilities between LTTE rebels and security forces being suspended to ensure full coverage even in uncleared areas. Rubella vaccination was introduced by MOH during 1996, and expanded island-wide in 1997. Available epidemiological data indicate low levels of most EPI diseases, and Sri Lanka continues to maintain its excellent record in this area.

## *Leprosy control*

Leprosy control is carried out by a national campaign. This relies on short-term chemotherapy to treat all patients, and a national social marketing campaign to create awareness of amongst potential patients of the availability of treatment and to reduce social stigma. In the periphery, specially assigned Public Health Inspectors (PHIs) are responsible for case detection, supervising treatment of detected cases, health education and provision of field services to those with deformities. Both prevalence and incidence rates show a continuing decline, and prospects appear good for eventual elimination of leprosy.

### **3.3 Geographical dispersion of facilities**

MOH facilities are widely dispersed throughout the island (Tables 3.3a –b). This is the outcome of several decades of expansion of the network of government facilities since the 1930s. Observers have frequently noted that the location of facilities is not based on any rational criteria. Successive official reports (Cumpston, 1950) (Simeonov, 1975) (Presidential Task Force on Formulation of a National Health Policy for Sri Lanka, 1993) and interviews with health ministry officials of the time (Wanasinghe, 1996) indicate that the planning process within the ministry for locating new facilities was typically ineffectual. Although planners had some concept of rational expansion, new facilities were opened and located without any formal planning process being followed. New facilities were sited and built because of the lobbying of ministers by individual legislators. Since politicians were parochial and were only concerned with their individual electoral constituencies, this resulted in an health infrastructure which was geographically dispersed and reached every corner of the island. The incentive for each legislator was to provide facilities in their area, even if it was sub-optimal in terms of quality and irrational from the perspective of a national referral system. Nevertheless, these political pressures appear to have resulted in a public system, which is accessible to a larger proportion of the population than is the case in most developing countries. Moreover, while there is a concentration of staff and facilities in Western Province, the disparities between provinces do not seem to be large as observed on most other countries.

**Table 3.3.a: MOH bed and staffing levels by district, 1996**

District	Medical Officers	Medical Officers per 10,000 capita	Medical Specialists	Nurses	Nurses Per 100,000 capita
Colombo	1,610	7.6	227	3,564	167.5
Gampaha	405	2.5	67	1,106	69.3
Kalutara	221	2.2	23	604	61.1
Kandy	535	4.1	73	1,579	119.7
Matale	87	2.0	6	254	57.1
Nuwara Eliya	74	1.3	4	214	38.8
Galle	324	3.2	43	958	95.1
Matara	130	1.6	12	413	49.6
Hambantota	65	1.2	5	180	32.8
Jaffna	60	0.7	7	305	33.5
Mannar		0.2	-		8.7
Vavuniya	26	1.0	-	80	30.0
Batticaloa	73	1.6	4	258	56.0
Ampara	88	1.7	1	270	50.8
Trincomalee	50	1.5	3	109	32.4
Kurunegala	267	1.8	22	866	57.2
Puttalam	109	1.7	8	271	42.0
Anuradhapura	155	2.0	8	523	67.7
Polonnaruwa	73	2.1	5	169	49.1
Badulla	125	1.7	11	476	63.0
Moneragala	34	0.9	1	126	33.2
Ratnapura	167	1.7	17	515	51.8
Kegalle	108	1.4	9	426	55.1

Source: Annual Health Bulletin, 1996

**Table 3.3.b: MOH bed and staffing levels by province, 1996**

Province	Total Beds	Beds Per 1,000	Total Nurses	Nurses Per 100,000	Medical Officers	Medical Officers Per 10,000
Western	17,254	10.0	5,272	297.9	2,236	12.4
Southern	5,890	7.2	1,551	177.5	519	6.0
North Central	3,423	6.1	692	116.8	228	4.1
North Western	5,144	4.7	1,137	99.2	376	3.5
Central	7,469	8.9	2,047	215.6	696	7.4
Uva	3,009	5.2	602	96.2	159	2.6
Sabaragamuwa	4,277	4.8	941	106.9	275	3.1
Northern	2,272	6.4	404	72.2	90	1.8
Eastern	3,128	6.9	637	139.2	211	4.7

*Source:* Annual Health Bulletin, 1996

### 3.4 Overcrowding

Overcrowding is common in government facilities, although this is in practice a feature of higher level facilities only. Health ministry practice has been to tolerate this, despite the negative impacts on quality of services.

In the 1950s, the health ministry was well aware of the problems in maintaining quality of services given the levels of overcrowding that existed. However, while official instructions were issued to restrict hospital admissions to a maximum of 200% of available beds: this was ignored in the face of political pressure to admit everyone. As the Staffing Commission noted in 1948:

“The Ministerial policy has been that no one seeking admission to a hospital should be refused unless it is a clear case of malingering. The net result is that hardly any medical officer in Government service would take the responsibility of turning away a person seeking to be an inpatient however satisfied he may be that he does not need hospital treatment.”

“If the admitting officer accepts patients who have no right to treatment as inpatients, he stands little or no risk of reprimand; if he turns away a patient who has influential sponsors, or by an error in diagnosis, which is always possible, he is certain to get into hot water and his career may be ruined.”<sup>14</sup>

The political process acted to create provider incentives, which promoted increased hospital admission rates despite fixed hospital budgets. In effect, Sri Lanka has traded quality for equity of access.

### 3.5 MOH Budgeting and Resource Allocation Mechanism

The MOH as any other government ministry adopts a “Programme-based” Budgetary System. Annual Estimates are prepared for each budgetary unit according to the following classification:

- (5) Ministry (in this case MOH).
- (6) Department (Department of Health and Department of Ayurveda separately).
- (7) Programme (General Administration and Staff Services, Patient Care Services, Community Health Services, Indigenous Medicine).
- (8) Projects (each functional units or group of units such as General Hospital, Base Hospitals, etc.).

<sup>14</sup> Sessional Paper No. V of 1948, Paragraph 745 cited in Cumpston (1950).

- (9) Objects of Expenditure (Personal Emoluments; Travelling Expenses; Supplies and Requisites; Repairs and Maintenance; Transportation, Communication Utility and other Services).

The same procedure is followed in the preparation of annual estimates at Provincial level. However, following the implementation of the 13<sup>th</sup> Amendment some provinces have moved to change the accounting systems that they use.

Estimates are prepared on an annual basis in the public sector with the budgetary process commencing in early April. Estimates are reviewed and finalized towards July-August in order to facilitate incorporation into the National Budget which is traditionally presented to parliament in November each year. Procedures relating to the estimates process are set out in a Circular with regard to the preparation of budget estimates for the forthcoming financial year.

As adopted in the public sector in MOH, as well as at Provincial level, expenditure is categorized into two components, namely Recurrent and Capital. Preparation of estimates, allocation of resources and monitoring of actual expenditure are carried out according to the classification at all levels in the MOH and in the Provincial structure.

Recurrent expenditure is categorized into:

- Personal emoluments
- Travelling expenses
- Supplies and requisites
- Repairs and maintenance of capital assets
- Transportation, communication utility and other services
- Grants for specific purposes

Recurrent expenditure is to be estimated based on health requirements.

All capital expenditure needs to be approved and included in the Public Investment Programme (PIP) prior to funding being made available. The PIP is a medium term development plan normally covering a period of 5 years prepared on a "Rolling Plan Basis". The PIP contains macro level forecasts, sectional strategies and allocation of resources among the various development programs to be undertaken in the future. The PIP is the responsibility of the National Planning Department, MOF.

Annual estimates are prepared by:

1. MOH to cover recurrent and capital expenditure of the units under its jurisdiction. In addition, MOH reviews the Provincial capital expenditure estimates which are forwarded to be included in the PIP after approval. Major capital expenditure programs to be undertaken at provincial level are funded through MOH in the form of grants to provincial Councils and is indicated under the MOH capital expenditure estimates.
2. The respective Provincial Ministries of Health prepare estimates for their expenditures, which are consolidated with estimates of other ministries of the Province to arrive at the overall estimates of the Provincial Council. The capital expenditure estimates are forwarded to MOH for approval and to be included in the PIP.<sup>15</sup>

It should be noted that unlike in the case of central government expenditures, where actual expenditures data are routinely presented to Parliament and can be compared with the original estimates, there is no mechanism to ensure that actual expenditures by PCs are published. Consequently, detailed information on actual health expenditures by PCs is difficult to obtain.

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<sup>15</sup> Ernst & Young Report on "Health Strategy and Financing Study: Analysis of the existing financing system of the Health Sector in Sri Lanka"

### **3.6 Staffing of hospitals**

As part of this review, the staffing situation in two provinces was examined in detail through field visits during 1998. The situation revealed is presented below. The two provinces chosen, Western and Southern Provinces, can be taken to be typical of the situation in most provinces, with the exception of the Northern and Eastern Provinces, where services face specific staffing difficulties because of the civil disturbances.

#### **Staffing of curative services**

The current staffing of base hospitals in the Western (7 hospitals) and Southern (1) provinces is shown in Table 3.6.a. It is noteworthy that in both provinces there are vacancies in all categories of staff other than medical superintendent and the nursing officer supragrade. Both have a significant shortage of medical specialists and the upgrading of district hospitals to base hospitals serves little purpose. In these circumstances the creation of single specialist positions in district hospitals, as has been proposed recently, seems ludicrous (see Southern province data). The observed and alarming shortage of nurses must have affected the capacity to provide medical services. Of special note is the excess of medical officers and dispensers in the Western province while there is a limited supply in the Southern province. Also, it is noteworthy that, without cadre provision 25 dispensers have been positioned in base hospitals in the Western province. These data reveal that institutional upgrading has generally been unplanned, and that available resources are poorly utilized.

In the area of curative care there is a clear shortage of staff. In addition, comparison of staff distribution between and within the provinces reveals problems of deployment. The overwhelming picture is of a service that is not only under-staffed, but has trouble filling even the limited positions. There is a marked absence of administrative and managerial staff, and a lack of specialists in most facilities. The shortage of specialists might be expected to diminish over time, but this will take many years. In the meantime, there will continue both to be a lack of specialists as well as an imbalance between more junior and senior medical officers. This raises additional questions about the level of supervision being provided, and the quality of the clinical training imparted to junior doctors. The shortage of administrative staff in all facilities raises major concerns as to whether more responsibilities can be devolved to lower levels.

#### **Staffing of preventive services**

There are serious problems in the delivery of preventive care (Table 3.6.b). In nearly all categories there is a shortage of staff. There are no MOMCHs in the Southern province. Two of the divisions do not have MOOHs and there is a need for one more regional epidemiologist. Both Western and Southern provinces have no full-time supervising public health inspectors in position. Also, nearly a third of the PHI positions in the Western province and a fourth in the Southern province remain vacant. Until recently, nearly two-thirds of the public health nursing sister positions in the Western province were vacant. With the recent deployment of trained staff this has been reduced to about a quarter. According to data provided by the Southern provincial directorate their position remains unchanged after the recent deployment of PHNOs. The province still has a 50 per cent shortfall of PHNOs. In the Western province nearly a quarter of the school dental therapist positions and half of the anti-filaria field staff positions remain vacant. The Western province also has 13 per cent of its midwife positions vacant. The situation in the Southern province is slightly better (6 per cent shortfall) but it appears to have less supervisory staff in position with 50 per cent vacancies in both PHNO and supervising public health midwife positions.

**Table 3.6.a: Current staffing of curative care services in facilities - Western and Southern Provinces**

Category	Western Province Selected Cadres			Southern Province Selected Cadres		
	Approv- ed	Existing	(Vacancies) Excess*	Approv-ed	Existing	(Vacancies) Excess*
<b>Curative care services</b>						
<b>Base Hospital</b>						
<i>Number</i>		<b>07</b>			<b>01</b>	
Med. Supdt (Snr.Admin )	07	07	---	01	01	---
Specialist	68	31	(37)	11	02	(09)
Medical Officer	231	278	47*	96	69	(27)
RMO/AMO	38	30	(08)	03	01	(02)
Nurse Suprgrade	08	08	---	01	01	---
Nursing Officer Grade 1	110	26	(84)	05	01	(04)
Supernumerary Nursing Off. <sup>16</sup>	-	206	----	-	01	-
Nursing Officer	825	591	(234)	90	55	(35)
Pharmacist	67	67	---	06	05	(01)
Med. Lab. Technologist	51	43	(08)	04	04	---
Radiographer	21	14	(07)	02	00	(02)
ECG Recordist	14	08	(06)	02	01	(01)
Ophthalmic Technologist	07	05	(01)	01	01	---
Physiotherapist	16	10	(06)	-	-	-
Occupational Therapist	07	00	(07)	-	-	-
Administrative Officer	07	00	(07)	-	-	-
Medical Records Officer	07	00	(07)	-	-	-
Hospital Midwife	126	39	(87)	10	10	---
Attendant	406	410	4*	17	17	---
Dispenser	00	25	25*	02	00	(02)
<b>District Hospital</b>						
<i>Number</i>		<b>13</b>			<b>19</b>	
Specialist	00	00	00	06	01	(05)
Medical Officer	30	33	03*	87	49	(38)
Dental Surgeon	15	17	02*	18	17	(01)
RMO/AMO	46	41	(05)	44	46	02*
Nursing Officer Suprgrade	00	00	00	11	08	(03)
Supernumerary NO	-	82	-			
Nursing Officer Grade I	42	04	(36)	09	22	13*
Nursing Officer	177	117	(60)	354	300	(54)
Hospital Midwife	78	72	(06)	110	105	(05)
Pharmacist	10	04	(06)	21	16	(05)
Medical Laboratory Tech.	21	11	(10)	15	10	(05)
X ray Technician	-	-	-	01	01	---
ECG Recordist	-	-	-	04	02	(01)
Microscopist	-	-	-	05	03	(02)
Dispenser	11	11	---	19	21	02*
<b>Peripheral Unit</b>						
<i>Number</i>		<b>12</b>			<b>16</b>	
Medical Officer	21	24	02*	22	18	(04)
Dental Surgeon	11	11	---	09	07	(02)
RMO/AMO	37	44	07*	28	28	---
Nursing Officer Grade I	11	00	(11)	03	00	(03)
Supernumerary NO	-	22	-			
Nursing Officer	104	66	(38)	136	71	(65)

<sup>16</sup> Nursing Officer Grade 1 are officers who have successfully completed one years post-basic training and hold the rank of sister. Senior nursing officers who have not completed this training have been categorised as supernumerary nursing officers enabling them to receive compensation above the maximum of the salary scale to which they are entitled.

**Table 3.6.a (contd.): Current staffing of curative care services in facilities in the Western and Southern Provinces**

Category	Western Province Selected Cadres			Southern Province Selected Cadres		
	Approved	Existing	(Vacancies) Excess*	Approved	Existing	(Vacancies) Excess*
Hospital Midwife	52	54	02*	61	62	01*
Pharmacist	-	-	-	01	01	---
Medical Laboratory Technologist	07	01	(06)	01	00	(01)
Dispenser	17	10	(07)	16	13	(03)
<b>Rural Hospital</b>						
<i>Number</i>		<b>11</b>			<b>19</b>	
Medical Officer	10	09	(01)	20	20	---
Dental Surgeon	11	11	---	03	03	---
RMO/AMO	18	17	(01)	20	19	(01)
Nursing Officer	16	09	(05)	68	19	(49)
Hospital Midwife	35	23	(12)	57	58	01*
Medical Laboratory Tech.	-	-	-	00	01	01*
Dispenser	18	09	(09)	19	15	(04)
<b>CD &amp; MH</b>						
<i>Number</i>		<b>09</b>			<b>14</b>	
Medical Officer	01	01	---	02	01	(01)
RMO/AMO	09	09	---	14	15	01*
Hospital Midwife	25	20	(05)	30	31	01*
Dispenser	09	05	(04)	14	07	(07)
<b>Maternity Home</b>						
<i>Number</i>		<b>01</b>			<b>00</b>	
RMO/AMO	01	01	---	---	---	---
Hospital Midwife	03	02	(01)	---	---	---
<b>Central Dispensary</b>		<b>63</b>			<b>35</b>	
RMO/AMO	59	60	01*	35	34	(01)
Dispenser	59	24	(35)	35	16	(19)

Source: Offices of the Western and Southern Provincial Directors of Health. Status as at September, 1998

**Table 3.6.b: Current Staffing of preventive care services in divisions in the Western and Southern Provinces**

Category	Western Province Selected Divisional Cadre			Southern Province Selected Divisional Cadre		
	Approved	Existing	(Vacancy) Excess*	Approved	Existing	(Vacancy) Excess*
<b>Preventive Care</b>						
<i>Number of Divisions</i>		31			39	
MOOH	45	49	04*	39	37	(02)
Supervising PHI	35	00	(35)	22	08	(22)
Public Health Inspector (PHI)	236	160	(76)	196	147	(49)
Public Health Nursing Sister	116	85	(31)	38	19	(19)
Sup. Public Health Midwife	66	54	(12)	40	19	(21)
Public Health Midwife	980	849	(131)	774	729	(45)
School Dental Therapist	188	144	(44)	72	72	00
Microscopist	72	65	(07)	47	32	(15)
Field Staff AMC/AFC	417	208	(209)	227	272	(44)

### **3.7 Human resources - Training of Western Physicians**

During the late 1980s and early 1990s, Sri Lankan medical schools were closed, and no new doctors were graduated. Combined with natural attrition and increased emigration during the late 1980s, because of the deteriorating political and economic situation, this led to a reduction in the absolute numbers of doctors practicing in the country and in the public sector. With the country's return to normality in 1990, the universities reopened, and there was a significant expansion in the number of university places in the face of political and social demands, particularly in technical subjects. Consequently, the number of practicing doctors has increased substantially since 1991, and will do so even more after 2000 when the increased intakes of the mid-1990s start to qualify. MOH is rapidly shifting from a situation where its sanctioned cadres were underfilled, to a situation where it has filled all available junior posts, and will not have sufficient posts for all interns.

There are considerable fears that these trends will force MOH to push large numbers of young doctors without adequate clinical training into the private sector with negative consequences both for established practitioners and the general public. This has caused considerable alarm in the sector, and there was increased agitation during 1999 for a guarantee of employment for all new medical graduates in MOH. To be fair to MOH, the apparent over-production of medical graduates is not its responsibility. In December 1999, the government announced that it would guarantee internships in MOH for the next ten years for all new medical graduates plus 100 foreign medical graduates each a year. Although this will quell much of the concern amongst students and young doctors, it is unclear whether this will be accompanied by any efforts to evolve a more coherent policy over the output of new medical graduates.

While these trends have received significant attention amongst medical professionals, there has been little success in crafting a co-ordinated national policy on the training of doctors. Control of their production remains split between many different government agencies. While the increased numbers of medical students graduating in recent years present specific problems for MOH, the ministry itself is not responsible for policies, which determine the number of medical graduates produced each year. To a large extent this is determined as a result of political decisions made with regard to the university entry and the potentially in future the interests of BOI in increasing foreign investment in the medical sector. The following section reviews recent developments and discussions.

#### **Training and output**

The task of training physicians is vested in the University Grants Commission (UGC). It is responsible for the management of the universities including the allocation of resources and regulating admissions. Sri Lanka has six faculties of medicine to which around 800 students have been admitted per annum in the past few years. This number will be increased to 900 in the next academic year, and presumably increase further once the new medical school announced by the President in December 1999 for the Eastern Province is opened. The annual intake to the faculties of medicine is determined by the Ministry of Higher Education. This is essentially a political decision which is invariably taken without any reference to the Ministry of Health. A similar procedure has been followed in the establishment of medical schools and, it is noteworthy, that four of them were established in the period following the liberalization of the economy in 1977. There are no private medical schools in the country at present. However, Board of Investment approval has been obtained for the construction of a teaching hospital reportedly for the training of western physicians. The President announced in December 1999 that a new medical school would be opened in Eastern Province. It is unclear whether the health ministry was consulted over this decision, and whether this was part of any overall human resources strategy.

A total of 3,533 western physicians were trained over the period 1990 – 1997, compared with a total of 2,934 medical officers employed by MOH in 1991, and a total of 5,628 in 1997. The output by year is shown in Table 3.7.a. The analysis of the data need to be undertaken with caution. First, the data do not capture the output of the last medical school to be established. This school was commissioned in 1993 and the first group of students graduated during 1997/98. Second, there is a considerable time lag between selection for admission and receiving full registration of 10 to 11 years, though the medical course itself is of 5 years duration. Due to student unrest and management issues there is a considerable delay (2-3 years) between selection and actual admission to the University. A subsequent delay is experienced between graduation and registration due to: (i) lack of co-ordination in the conduct of the final examinations by the

faculties of medicine and the resulting delay in the compiling of the common merit list, and (ii) the inadequate capacity in the Department of Health Services to provide for internship training. The latter is largely attributable to the shortage of specialists. Currently up to 4 interns have been assigned to a single consultant. The provision of residential facilities will become an issue (if it is not one already) with the increasing numbers registering for internship training. For these reasons students who were eligible to enter the faculty of medicine in 1989/90 will be undertaking their internship training in 1999 and receive full registration by the year 2000, when most are aged 29-31 years.

**Table 3.7.a: Output of Western Physicians, 1990-1996.**

Year	1990	1991	1992	1993	1994	1995	1996	1997
Number of graduates	314	401	334	447	399	442	555	641

Source: Division of Planning & Research, University Grants Commission, and MOH Annual Health Bulletin 1997.

For a different perspective of the emerging issue, Table 3.7.b provides data on the intake into the faculties over the period 1988/89 to 1995/96. From this data and the analysis provided in the previous paragraph, it could be anticipated that the first group with an eight hundred intake (1990/91) will be receiving full registration in the year 2001.

**Table 3.7.b: Intake of undergraduates to the medical faculties, 1988/89 –1995/96**

Academic Year	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96
Intake	493	551	828	862	781	769	856	889

Source: Division of Planning & Research, University Grants Commission

In addition to the above, there are a couple of hundred students undergoing medical training in foreign schools of medicine. There is no method to ascertain their number. Some of the undergraduates are recipients of scholarships offered to the state by foreign governments. The majority are fee-paying students. Data on the number of foreign graduates obtaining temporary registration during the period 1992-1997 are provided in Table 3.7.c.

**Table 3.7.c: Foreign Graduates given Temporary Registration, 1992-1997**

1992	1993	1994	1995	1996	1997*
46	83	168	166	117	137

Source: Registrar, Sri Lanka Medical Council.

Note: Up to July 15, 1998 seventy seven foreign graduates were given full registration.

At a recently concluded workshop on 'Employment opportunities for doctors', it was estimated that the country's annual doctor output would be 1,000 – 1,400 doctors (Report of Workshop, 1998). The following assumptions were made in making this estimate:

Annual output from the Sri Lankan universities beginning 1998 = 800

Estimated annual number of returning foreign graduates = 200 - 400

## Training

The basic training program for Western practitioners is of five years duration, the greater part of which is undertaken in teaching hospital settings. Prior to the granting of full registration with the Sri Lankan

Medical Council graduates are statutorily bound to undergo a period of internship in institutions recognized by the Council.<sup>17</sup>

At present, an intern is expected to satisfactorily complete a set of clinical attachments in an approved hospital over a period of one year. Explicit statements are absent about the scope and objects of the internship and what skills and competencies need to be developed. There are no manuals for the guidance of trainers or trainees nor are there any organized training programs. Also, there appears to be little monitoring of the internship period by the registering authority, the training authority or the prospective employer.

In 1986, the University Grants Commission undertook an evaluation of the training given during the period of internship. For this purpose, both interns and consultants were surveyed. The following were among the major conclusions relevant to this report.

“The period on internship is inadequate and should be extended to a second year. . . . Instead of two specialities now covered, all four specialities<sup>18</sup> need to be included in the extended internship.”

Also of interest are some of the assessments made by the specialists. They opined that a third of the case notes recorded by interns were unsatisfactory or poor, nearly 25 per cent had poor diagnostic skills and 18 per cent had poor therapeutic skills. These issues have not been addressed so far. In fact, these problems of inadequate training may be further compounded by assigning 3-4 interns per consultant as at present. The prospects appear to be bleak with the PGIM unable to increase the rate of production of specialists<sup>19</sup> on the one hand and increasing intern numbers on the other. The evidence indicates that the recent increase in the number of medical graduates is presenting demands, which the system cannot meet, without impairing professional standards in future years.

Given this scenario it is important that Government give serious consideration to certain recommendations made at a workshop organized by the Sri Lanka Medical Association to discuss issues related to the “overproduction of doctors”. These include the funding of a training program to be organized by the College of General Practitioners to train doctors in general practice and to establish a training program for training specialists in the private sector for that sector. Also, the attention of the Government was drawn to the need for co-ordinating the manpower production activities of various agencies such as the Ministry of Health, the University Grants Commission, the Sri Lanka Medical Council, and the Sri Lanka Medical Association.

## **Employment opportunities**

The impending over-supply of physicians, especially ones without adequate clinical experience has galvanized the medical profession. The issue was addressed at a recent workshop specially convened by the Sri Lanka Medical Association (SLMA). Participants comprised:

- Deans of Faculties of Medicine.
- Representatives from the Medical Student’s Union, the College of General Practitioners, the GMOA and the MOH.
- Members of the Committee on Health Management (SLMA).

The following decisions were taken:

- The Sri Lanka Medical Council should ensure that the medical degree concerned is at least registered in their home country before recognizing it in Sri Lanka.
- Review in a systematic manner the registration of all foreign medical schools.

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<sup>17</sup> Internship is regarded essentially as a protracted period of induction during which special knowledge, experience and skills required for the practising of Western medicine within and outside the state sector is acquired.

<sup>18</sup> Medicine, Surgery, Paediatrics and Obstetrics and Gynaecology.

<sup>19</sup> This is partly due to trainees not returning to Sri Lanka on completion of their overseas training program.

- Maintain the standard of the Act 16 examination, so as to be comparable to local final MBBS examinations.
- Determine the optimum and maximum number of medical students each Sri Lankan Medical School can take annually. This would enable the Deans of Medical Faculties to inform the UGC of the optimum number they could take.
- Inform Board of Investment (BOI) to co-ordinate with SLMC regarding standards to be ensured before approval is given to set up medical schools in the country. Medical schools already approved by BOI should be requested by BOI to consult with SLMC if and when they want to commence operations.

#### *Role of SLMA*

- To inform the public that state job opportunities for doctors will be scarce by the year 2000 and afterwards. (Arrange for career guidance counseling programs conducted by the SLMA at Headquarters or through the Organization of Professional Associations or through visits to leading schools.)
- To inform the public that job opportunities for doctors may be comparatively very limited in the future, even in the private sector.

#### *Proposals to the Government*

- To increase the allocation of funds to the health sector in the future. This will help to develop health infrastructure and increase the medical officers cadre.
- To implement the labor laws to provide adequate medical care in the private sector institutions so that more medical officers would be employed by them.
- To urge the plantation sector to employ a sufficient number of medical officers to cater to the health needs of the plantation workers.
- To fund training programs for doctors to train them in general practice. The training program could be organized by the College of General Practitioners.
- It was agreed in principle that attempts should be made to train specialists in the private sector and for the private sector.
- To assess the health needs of the country and to emphasize the quality of patient care. This will enable the government to project the need for more medical officers.
- Government to organize non-profit making, but paying, medical institutions to cater to the middle class, who cannot afford in-door treatment in present private medical institutions, but who are unhappy with the comforts in non-paying institutions.
- Not to approve any more medical faculties.
- To have a system of regular co-ordination amongst the Ministry of Health, the UGC, the SLMC and the SLMA.
- Not to employ foreign medical graduates unless they qualify in the Act 16 examination.

#### **MOH strategy**

MOH has set up a committee to address the issue of future medical graduate employment. Graduate production is a function of the Ministry of Education and Higher Education, however. Up to the present the policy has been to train as many doctors as possible. There has been no dialogue with the MOH or with professional bodies, such as the Sri Lanka Medical Association. In mid-1998, the intake was increased by another one hundred to 900.

Given these circumstances and the perceived need for full-time physicians in the private sector, it is now argued by some in the ministry that market forces be allowed to determine the numbers applying for admission to the local faculties of medicine or for training abroad. If the demand for health care persists, there will be a continuing demand for admission to the medical faculties. If not, the number will decline. However, this approach does not make any recognition of the experience of other countries that the demand for medical education is subject to considerable market failure, and cannot be left to market forces. Given

that virtually all market-oriented economies, including USA, Singapore, Hong Kong, UK and Germany control the production of medical graduates though public intervention, it is unclear whether the free market approach makes sense in the Sri Lankan setting.

A proposal submitted for discussion (but yet to be accepted as policy) is that post-interns be given contract appointments for two years in supervised settings. On completion of this period of “extended training” they will be provided with low interest loans to establish themselves as full-time family (general) practitioners. This solution is essentially only concerned with removing these graduates from the public sector as rapidly as possible, and is not framed with any other objective such as the orderly development of the private sector. There are many problems that go with this proposal, including funding, training facilities, faculty, etc. Besides it is the considered opinion of the representatives of the College of Family Medicine that further training should be in family medicine and not in hospital-based practice. Internships and attachments alone in District Hospitals and below will not provide prospective family physicians with the required knowledge and skills.

## **4. REORGANIZATION OF THE CENTRAL AND PROVINCIAL HEALTH SERVICES**

### **4.1 Reorganization of the Ministry of Health**

This section addresses the question whether the provincial levels have the capacity to manage the current and proposed devolved health services.

The recent highlighting of deficiencies in health care delivery by the media has led to an increasing demand for improved management and health services reorganization. The Report of the Central Bank of 1997 too alludes to management shortcomings. In response to this concern the second Presidential Task Force (PTF2) was appointed in 1997 “to develop and recommend action plans for the implementation of National Health Policy”. The PTF2 identified four major areas of concern:

- a) Identification and prioritization of health needs
- b) Services to meet the health needs of the community
- c) Organization and management of the health sector
- d) Mobilization of resources for health.

According to PTF2 the health sector is essentially a centralized organization and management system that does not respond adequately to community needs in an efficient and effective manner. Such a system is also thought to be incongruous with the requirements of the evolving devolutionary process. Seven strategies have been proposed. However, doubts have been expressed as to whether these or other interventions are necessary, affordable, or if, in fact these would bring about the envisaged improvements in health care management. To give us some idea of what might be the likely outcome of their immediate implementation this section analyses the strengths and weaknesses of the current organization with special emphasis on the provincial health care delivery system that has been operational for a decade.

The establishment of provincial councils in 1989 under the 13<sup>th</sup> Amendment to the Constitution brought about major changes in the political and administrative structure of the country. Through this enactment certain functions were retained by the line ministry, others devolved to the provincial councils and the remaining functions that were included in the Concurrent List shared. The procedures to be followed were set out in circular GC No.1607 of 20<sup>th</sup> January 1989 (Annex 1). What the enactment and the circular did not provide was a complete list of roles and functions to be retained by the line Ministry. This issue has not been addressed to date.

According to List II (Reserved List) national policy on all subjects and functions is scheduled to be with the center. It could be presumed to be so even though no mention is made of the line ministry. Also, by implication, the management of teaching hospitals and hospitals established for special purposes was with the line ministry. Though there is no specific mention it has been assumed, and thus far accepted, that the line ministry retained all other functions for which the Ministry of Health was previously responsible. These include:

- (1) Establishment and maintenance of the national technical services such as the Blood Bank Services, the Bio-medical Engineering Services and the National Drug Quality Assurance Laboratory;
- (2) Procurement and distribution of drugs, supplies and equipment;
- (3) Establishment and providing technical support for the national public health programs such as Anti-malaria, Tuberculosis, Leprosy, Rabies programs; and
- (4) Management of all international matters related to health such as negotiating for external assistance for projects, training, scholarships and technical assistance and interacting with agencies of the United Nations such as the WHO, UNICEF, and UNFPA.

In addition, as indicated in the circular referred to above, the Ministry is responsible for management of its own personnel and all personnel absorbed into the “All Island Service”<sup>20</sup>.

There is no explicit reference to the role of the line Ministry in the formulation and enforcement of health legislation to ensure standards, norms and quality, health systems research or of its position as regards monitoring and evaluation of the health situation *vis-à-vis* strategies adopted and services provided.

The aim of the devolutionary process initiated in 1989 was to curtail the concentration of power at the center and to move in the direction of greater autonomy for the provinces. But for a variety of reasons this venture has not been particularly successful. For instance, there has been a woefully inadequate allocation of financial resources by the Finance Commission to the provinces, and in turn to the provincial health service. This has been largely due to an inadequacy of funds and not for the want of allocative criteria. These circumstances are not expected to improve in the near future.

The current devolutionary arrangements have led to considerable administrative confusion. Duplication and overlapping of function have led to an emergence of numerous grey areas where attribution of responsibility has become difficult. Much of this could be ascribed to political and administrative reluctance to sharing authority<sup>21</sup>, a lack of policy and forward planning and inadequate dialogue between the provinces and the center. Compounding the problem is a lack of adequately trained and experienced staff to carry out the functions of the Provincial Ministries of Health. Weaknesses in local management and political attitudes have resulted in the staff of the line ministry functioning with no significant change in role over the past ten years. Much of line ministry staff time is spent in undertaking the functions and responsibilities of the devolved units rather than carrying out the decreed mission of policy development and planning, regulating, directing and co-ordinating the many components of the health care system and monitoring and evaluating system performance.

## 4.2 The National Level Organization

The Presidential Task Force of 1992 (PTF1) identified the following as the main functions of the national level health organization:

- Converting policy into operational guide lines including technical, administrative and financial specifications for buildings, equipment, drugs, manpower, etc.
- Formulation of the master plan for national health development.
- Monitoring and evaluation of the implementation of policies, programs, services, etc.
- Technical support for management of services.
- Legislative matters.
- Professional education, basic and in-service training of health personnel.
- Medical and health systems research.
- Co-ordination with the other government sectors, private sector, major development projects, etc.
- Procurement of drugs and equipment.

Analysis by PTF1 of the national level organization and its functioning revealed certain shortcomings:

- (1) The line ministry performs many functions in compartments (curative vs. preventive), and not in an integrated fashion.

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<sup>20</sup> Of health sector personnel only western physicians and dental surgeons have been included in the “All Island Service” Though their salaries are paid for by the provincial administrations the appointing and disciplinary authority lies with the line ministry. The provinces are responsible for the management of all other categories of health care personnel. However, it needs to be emphasized that the line ministry is responsible for training of such personnel. The tendency is for center to satisfy its own needs before posting the remainder to the provinces.

<sup>21</sup> This is especially evident when the central and provincial governments are run by politically opposing groups.

- Middle level administrators are not delegated with adequate decision making authority commensurate with their responsibility and status.
- There is no organized mechanism in the health sector for developing staff capacity in planning and management at different (administrative) levels suited to the specific roles, responsibilities and functions of different categories of personnel. Nor does the present structure provide for “zeroing-in” on the function of education and training.
- Data that are available, their adequacy, reliability, completeness and timeliness of collection, analysis and reporting are generally far from desirable. The only exception is with respect to information on maternal care and vaccine-preventable diseases. It is attributed to two fundamental causes: (i) near absence of qualified personnel to handle the functions of data management (at all administrative levels), and (ii) inadequate funding, and the inclusion of these funds in the votes of another department.
- There is no regular mechanism to promote and direct medical and health research and disseminate relevant information to decision makers for use in health system development. Several reasons were identified of which the following are of relevance: (i) the absence of a focal point in the Ministry of Health to co-ordinate research efforts and ensure use of research information for strengthening the health system; (ii) inadequacies in research capabilities at various levels both in educational and training institutions and in the health delivery system; (iii) accurate records and data for planning, monitoring and evaluation are not available.
- The norms and standards for different types of hospitals, covering range of services, their quality etc. are presently inadequate and suffer for want of specificity and content. In view of this, the differences between Base Hospitals and Provincial Hospitals are marginal. One main reason for this situation is more historical in that hospital facilities evolved based on demand articulated through political process, availability of resources, etc. The system evolved more on an ad hoc basis rather than a systematically planned basis. The issues at secondary and tertiary levels of care are similar, but compounded by problems at the primary level resulting in (i) overcrowding; (ii) ineffective use of services etc.; and (iii) higher costs of these services.
- There are about 30 different health and health related legal enactments in Sri Lanka. These were enacted at different times in the past and have been enforced by different departments of Government. Many of them have been amended to make them responsive to the current needs. Some are found to be irrelevant to today’s context and are being considered for repeal. Further some new laws have been enacted to be in keeping with the latest trends of development needs.

Among the many recommended interventions were:

- Managerial processes and procedures will be strengthened at all levels to improve efficiency and cost-effectiveness of service provision. The present system of delegation of authority in the Ministry will be reviewed and rationalized to improve efficiency, speedy implementation of programs and projects etc.
- The existing staff will be suitably re-trained to imbibe additional skills and knowledge required, and if necessary, appropriately re-deployed.
- Plan, implement and monitor in-service and continuing education programs in health planning and management and hospital administration for lower level, middle level and senior level officials including specialized areas of management, namely human resource management, financial management, stores management, management of logistics, etc.
- Appropriate data bases and management information system(s) will be developed at divisional, provincial and national levels to support formulation, monitoring and evaluation of relevant, need-based plans and programs. The information handling capacities at all levels of the health organization will be enhanced and an adequate cadre of qualified statistical personnel, computer personnel and medical records personnel will be urgently created.
- Regular studies will be undertaken to assess (in respect of both government and of the private sector) the use/misuse/abuse of services provided and received, including costing of services.
- Effective enforcement of all health and health-related legislation will be ensured. For this purpose, (i) the existing legislation will be reviewed and revised, and (ii) mechanisms and procedures for enforcement and feed-back will be strengthened.
- The quality of care in all medical care institutions will be evaluated and regulated to conform to certain predetermine standards, and graded services (range, quality and quantity) for different institutions will be worked out.

- To monitor and improve cost-effectiveness of care, a system of unit costing will be developed for regular use to help plan services at every level.

If these recommendations are taken as examples of broad objectives for strengthening the capacity of the line ministry it will be seen that at the time of the writing of the PTF1 report there were gaps in the existing situation and the envisaged level of institutional development. The broad areas that required strengthening were identified to be in:

1. Policy Development
2. Health Planning, Monitoring and Evaluation
3. Information Systems Development and Utilization
4. Management Development
5. Human Resource Development and Management
6. Research for Health Development
7. Health and Health-related Legislation and Enforcement

An area that seems to have been overlooked was Financial Management and Budgetary Control. This need was recognized in the Staff Appraisal Report of the first IDA/World Bank Funded Health Project (Report No.7050-CE of 1988). Problems in financial management by PCs have also been highlighted as a serious issue by the International Monetary Fund (1999).

In the absence of a clearly formulated health strategy and plan, investments tend to be made on an ad hoc basis. At the margin, new project proposals from the health sector are in practice almost always for expensive tertiary equipment and facilities. Similarly, budget and staff allocations tend to take place on the basis of the status quo, reflecting more the existing allocations and relative political power of the participants than analytical assessment.

The current system of accounting and budget control does not provide health managers with processes or tools to ensure effective and efficient resource allocation to achieve program goals. Constraints and limitations in the present system (which have not been addressed as yet) derive from cumbersome procedures, absence of a goal-oriented budget, understaffing and lack of in-service training.

One of the main activities envisaged in IDA Health Project 1 was to strengthen health management at central and peripheral levels by designing and implementing financial management and budget control systems and by streamlining operational procedures. The proposed systems were to include budgeting, resource allocation analysis and decisions, financial and management accounting, financial information and evaluation of financial performance as it relates to program outputs. This part of the project was not implemented, and investigation of the reasons why may be warranted.

### **4.3 The Provincial Health Organization**

In 1992, PTF1 recognized a need for the restructuring of the provincial health organization if it is to effectively implement devolved powers and functions. At that time there were three administrative levels in the provincial health organization - the provincial MOH, the Regional Directorate of Health Services and the Health Units (now designated the Divisional Health Units). The PTF1 report argued for the disbanding and redeployment of the district organizational structure, because of the extensive powers devolved to the Provincial Council. The district organizational structure is considered an anachronism because it would unnecessarily lengthen the chain of command and cause delays the decision making process. Besides it is regarded as unnecessary to take the delivery of health care closer to the people through the divisional health structure.

The following major functions of the Provincial Director of Health Services (PDHS) were identified:

- (7) Develop a comprehensive provincial health plan closely linked with budgeting based on decentralized divisional health plans.
- (8) Ensure effective implementation of these plans through divisional health organizations, base and general hospitals through an inter-sectoral approach.

- (9) Design information systems and monitor service provisions and submit periodical reports to the national level and to the user level in the divisions.
- (10) Co-ordinate with other government sectors, private sector and the NGOs.
- (11) Undertake in-service and continuing education programs.

It was proposed that the PDHS be supported by two or three Deputy PDHSs (i.e., the present Regional Directors of Health Services - RDHSs ). Unlike in the past, the DPDHSs will be responsible for specific functions rather than the management of all matters related to health care within a geographical area (i.e., the district). Also, depending on the workload, an adequate numbers of assistant directors would be assigned to each DPDHS.

Manuals of procedure were to be updated to suit the proposed changes and the directorate was to be provided with adequate training.

Three units to further support the PDHSs were proposed:

- (1) Epidemiology unit headed by a provincial epidemiologist.
- (2) Health education unit headed by a provincial health education officer.
- (3) Information and informatics units headed by a provincial statistical officer supported by a data processing manager.

#### **4.4 Current Position**

Figure 4.1 shows the organization of the provincial health services as published in the latest available Annual Health Bulletin (1997). Other than the establishment of the office of the Provincial Director and the creation of certain supervisory and program specific positions there is little difference to the organizational structure as obtained in 1987 in the pre-provincial council period (Figure 4.2). Despite the recommendations made by the PTF, the regional organization was not disbanded nor was any serious attempt made to provide the Provincial Director with recommended technical support.

This may not have happened for several reasons. In the formative stages the same political party was in power at the center and in the provinces and little effort, if any, was made by the provincial ministries to wrest the constitutionally guaranteed authority from the center. The center for its part was comfortable with this arrangement. Secondly, the power vested in the provincial governor should have been delegated through the provincial public service commission to the chief secretary and through him to the provincial secretary of health and finally to the provincial director of health services (PDHS). This has not occurred, and there is a clear lack of uniformity in the delegation of authority within the provinces. In some, the authority delegated to the PDHS, is comparable to that of the DGHS. In others, the authority appears to have been retained to varying degrees by the chief secretary and the provincial secretary of health, with the provincial directorate sometimes functioning as a part of the provincial health secretary's office. In these circumstances there has been no felt need for strengthening the technical capacity of the provincial health directorate. Thirdly, the categorizing of medical officers as an "All Island Service"<sup>22</sup> enabled the center to indirectly control the pace at which the administrative and technical capacities of the provinces were developed. In a situation where the demand for all categories of trained personnel outstripped supply the center invariably satisfied its needs before distributing any surplus among the provinces. However, at the same time the retaining of medical officers in the "All Island Service", has enabled the center to use administrative coercion to ensure a more equitable distribution of medical personnel than would have otherwise occurred. Also, it needs to be noted that the increase of provincial cadres needs the concurrence of the line Ministry and the approval of the Cabinet. This occurred for the first time in 1996 and was mainly concerned in increasing the numbers of established categories of staff.

The current organization across provinces essentially fits Figure 4.2. However, in 1996, some of the provinces opted to strengthen their organization to meet their special needs. Among the few changes proposed were: the provision of two senior health administrators and three supervisory dental therapist

<sup>22</sup> Of health sector personnel only Western physicians and dental surgeons have been included in the "All Island Service". Though their salaries are paid by the provinces the appointing and disciplinary authority lie with the line ministry. The provinces are responsible for the management of all other categories of health care personnel.

positions for each of the three districts in the Western province; the establishment of the positions of assistant director (technical) in three provinces with the Western province being provided with four positions; and, the creation of the position of statistical officer in three of the eight provinces. The Salaries and Cadres Committee based the approved increase in cadre on certain principles of which the availability of financial provision was the foremost consideration. A breakdown of the management cadres in the offices of the provincial and regional directors in the Western and Southern provinces is provided in Table 4.4.a.

**Table 4.4.a: Management Staffing of the Western and Southern Provinces (current position)**

Category	Western Province Cadre			Southern Province Cadre		
	Appro- ved	Existing	(Vacancies) Excess*	Appro- ved	Existing	(Vacancies) Excess*
Provincial Director (Snr. Adm.)	01	01	---	01	00~	(01)
Med. Adm. (Snr. Adm. Gr.)	06	04	(02)	04	03	(01)
Deputy Director (SLAS)	01	00	(01)	01	01	---
Assistant Director (Tech.)	04	00~	(04)	00	00	00
MO (Maternal and Child Health)	03	03	---	03	00	(03)
Regional Epidemiologist	03	04	01*	03	02	(1)
Regional Dental Surgeon	03	04	01*	03	03	---
Regional RMO	04	03	(01)	03	01	(02)
Nursing Officer Suprgrade	01	00	(01)	-	-	-
Accountant	04	04	---	04	04	---
Administrative Officer	04	04	---	05	03	(02)
Statistical Officer	00	00	---	01	00	(01)
Statistical Survey Officer	04	03	(01)	03	01	(02)
Planning and Programming Officer	05	05	---	04	05	01*
Regional Health Education Officer	12	09	(03)	09	08	(01)
Regional Sup. Pub. Health NO	04	01	(03)	04	03	(01)
Div/Prov. Sup. Pub. Health Inspector	04	00	(04)	04	04	---
Sup. School Dental Therapist	09	06	(03)	03	02	(01)
Regional/Divisional Pharmacist	03	02	(01)	03	03	---
Regional Malaria Officer	00	00	---	01	01	---
Food and Drugs Inspector	03	03	---	03	03	---
Technical Officer (Bldg)	01	00	(01)	01	00	(01)

Source: Offices of the Western and Southern Provincial Directors of Health. Status as at September, 1998

Note: ~ acting

It is evident from the above data that, despite the approval given in 1996, many of the key positions remain vacant. At the time of the writing of this report the position of the PDHS, Southern Province, had been vacant for almost a year with the Deputy Provincial Director (Hambantota) deputizing for the same. In the Western province two senior medical administrator positions, one deputy director (administration) position and four technical assistant director<sup>23</sup> positions remained vacant at end of 1998. A medical officer had temporarily filled the technical director position of MO (Planning). Worthy of note is that the Southern province has no provision for technical director positions. Also of interest, from the viewpoint of the development of the health information system, are the vacancies in the statistical officer (1) and statistical survey officer (3) positions in the Southern province. Neither province has a full-time provincial health education officer or the required number of full-time provincial supervising public health inspectors.

<sup>23</sup> The prospective appointees will function as (i) Provincial Epidemiologist; (ii) Provincial MOMCH; (iii) MO Planning; and (iv) MO Special Campaigns.

The distribution of technical staff between the office of provincial director and the offices of the regional directors in the two provinces and the existing shortfall (excess), by category is shown in Table 4.4.b.

**Table 4.4.b: Deployment of Staff between Provincial and Regional Offices**

Category	Western Province Deployment of Staff			Southern Province Deployment of Staff		
	Existing Cadre (Vacancy)	Prov- ince	Region	Existing Cadre (Vacancy)	Provi- nce	Region
Provincial Director (Snr. Adm.)	01	01	-	(01)	(01)	-
Med. Adm. (Snr. Adm. Gr.)	04+(02)	-	04+(02)	03	-	03
Deputy Director (SLAS)	(01)	(01)	-	01	01	-
Assistant Director (Tech.)	(04)	(04)	-	-	-	-
MO (Maternal and Child Health)	03	-	03	03	-	(03)
Regional Dental Surgeon	03+1*	00	03+1*	03	-	03
Regional Epidemiologist	04+01*	-	04+01*	02+(01)	-	02+(01)
Regional Dental Surgeon	04+01*	-	04+01*	03	-	03
Regional RMO	03+(01)	01	03	01+(02)	01~	(02)
Nursing Officer Suprgrade	01	01	-	-	-	-
Accountant	04	01	03	04	01	03
Administrative Officer	04	01	03	03+(01)	01~	02+(01)
Statistical Officer	00	00	00	(01)	(01)	-
Statistical Survey Officer	03	02	01	(03)	-	(03)
Planning and Programming Officer	05	01	04	04+01*	01	03+01*
Prov. Health Education Officer	09+(03)	(01)	09	08+(01)	(01)	08
Regional Sup. Pub. Health NO	01+(03)	(01)	01+(02)	03+(01)	(01)	03
Div/Prov. Sup. Pub. Health Inspector	(04)	(01)	(03)	04	01	03
Sup. School Dental Therapist	06+(03)	-	06+(03)	02+(01)	-	02+(01)
Regional/Divisional Pharmacist	02+(01)	-	02+(01)	03	-	03
Reg. Malaria Officer	-	-	-	01	-	01
Food and Drugs Inspector	03	-	03	03	-	03
Technical Officer (Bldg)	(01)	(01)	-	(01)	(01)	-

Source: Offices of the Western and Southern Provincial Directors of Health. Status as at September, 1998. Refers only to Provincial Directors and Deputy PD positions; ( ) Vacancy; \* Excess: ~ acting

Of the many recommendations in the PTF1 Report, some have been implemented, others are in the pipeline, and several are being held in abeyance. Organizational changes were recommended for all three levels of administration at the center, at the provincial level and at the divisional level. The current organization at the center reveals that a selected number of the recommended director positions has been established. The new appointees assumed duties recently and are adjusting themselves to their new roles guided by their immediate supervisors. Some have completed the MSc. course in medical administration but will need special on-the-job training.

In the case of the provinces it is evident that, over the past decade, little progress has been made in strengthening their capacity to assume the full responsibilities of a devolved structure. Firstly, it has not been possible to provide the various provincial administrative levels with the full complement of staff. Secondly, there have been only a few training programs for strengthening the technical and management capabilities with a provincial focus. For example, in 1998 the MDPU has made a concerted effort to remedy the weaknesses in the provincial planning process. Thirdly, an information system with a provincial focus has yet to be developed in the country. Currently, the information system, to a greater or lesser extent, is driven mainly through the regional directorate to the line ministry as has happened in the pre-1989 period (see section 4.5 for further details). For these and other weaknesses previously referred to it is clear that at

this point of time the provinces do not have the capacity to assume additional responsibilities envisaged in the reforms recently proposed.

## **4.5 Management Information and its usage**

There are several information collection systems operating in the public health sector. Information may be collected routinely or through special surveys. Other than for the notification of communicable diseases, there are no arrangements for the collection of routine information from the private sector. Currently we have little information on the number of health care facilities, physicians, dental surgeons or hospital beds in the private sector. Information on the utilization of private health care facilities and related expenditures are gathered periodically through surveys conducted by the Department of Census and Statistics and the Central Bank, but the frequency of these may not be sufficient for effective planning purposes.

### **Patient Care Services**

Information regarding patient care services in the public sector is obtained through the following returns:

- Quarterly Indoor Morbidity and Mortality Return
- Notification of Communicable Diseases
- Quarterly Outdoor and Clinic Return
- Monthly Maternity Return
- Annual Bed Strength and Staff Return

This information is submitted to the Medical Statistics Unit. The quality of the data provided and the timeliness of return submission varies from province to province. Planning and Programme Officers (PPOs) and Statistical Survey Officers are directly responsible for collating and submission of data in the prescribed format. They receive regular training, but their performance is a reflection of the value of information and its usage by regional and provincial management and the supervision that ensues. It is worthy of note that in some provinces PPO and SSO positions remain vacant and in others their services are being utilized mainly for work connected with the capital budget.

The Medical Statistics Unit currently reports directly to DDGP. It appears to be functioning independently of the newly established Information Unit within the MDPU, and there is a critical need for the establishment of a Steering Committee to manage information. The Annual Health Bulletin is the annual publication to key public sector officials within and outside the health sectors; it summarizes mostly statistical returns from the public sector and its activities. Summaries are sent to all Deputy Provincial Directors of Health. This publication is available only in the English language.

### **Community Health Services**

The following returns are required for the management of the community health services.

- (1) Quarterly maternal and child health return
- (2) Quarterly family planning return
- (3) Quarterly immunization return
- (4) Quarterly sanitation return
- (5) Quarterly sanitation return
- (6) Quarterly school health return
- (7) Weekly return of communicable diseases
- (8) Quarterly dental statistics.

## Campaigns

Monthly statistics on the following campaigns are gathered:

- Malaria
- Filaria
- Leprosy
- Rabies
- Sexually transmitted Diseases
- Respiratory diseases (TB).

Here too, timeliness and quality of response vary. A recent improvement in compliance with the stipulated requirement has been observed and is attribute to the intensive training programs given and the monthly conferences for MOMCHs, MOHs and SSOs. The Annual Report of the Family Health Bureau too is published only in the English language and is distributed among senior medical administrators and MOHs. It provides an analysis by District (i.e., Deputy Provincial Director Division).

## Vital statistics

The following information is available from the Registrar-General's Department:

- Birth Rate
- Death rate
- Maternal Mortality rate
- Infant Mortally rate
- Still Birth Rate
- Neo-natal Mortality Rate

The absence of a national census since 1981 has indirectly effected the quality of these statistics, since it has not been possible to monitor deficiencies in the vital registration system by direct comparison with census data.

## Epidemiological Information

The information system on notifiable diseases is working reasonably well insofar as the public sector is concerned. The Divisional Medical Officer of Health is notified daily, who in turn submits weekly returns to the epidemiology unit of the line ministry through the regional epidemiologist. Special campaign information is forwarded to the epidemiology unit and the medical statistical unit quarterly. The EPI program is well managed and regularly receives the following information – weekly returns of infectious diseases including zero reporting; quarterly returns of immunization coverage and monthly vaccine returns. This information is being regularly used for the control of disease and in management and planning.

However, there are a few weaknesses in the system. These include meager reporting from the private sector, poor surveillance work by regional epidemiologists and problems related to the appointment and training of MOOHs in the public sector.<sup>24</sup>

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<sup>24</sup> Generally post-interns with little job-specific training are appointed as MOOHs for a two-year period. Many are transferred out by the time they become eligible for the formal training program. MOOH positions are being used by MOs to prolong their stay in stations of their choice. They avoid formal training, and their lack of commitment to community health undermines the delivery and management of community health activities of the divisions of which they are in-charge.

## **Financial Information**

Information on expenditures (based on the budget format) is gathered routinely. It is worthy of note that at the divisional level the smaller institutions are not allocated a separate budget, so directors of these facilities do not have access to information on their facilities own expenditures. Instead, all institutions of a given category share a common budget. Cost information is not gathered, and there is no plans to set up a cost analysis system.

Provincial ministries are included in the health information network depending on the extent to which information is utilized in planning and decision making. The required information is obtained from the regional offices. There is no human resource information system at present. This information is generally extracted from the personal files maintained in the regional offices. Regional and other offices gathering routine information experience considerable difficulty in consolidating returns due to delays in the submission of returns. In many areas quarterly returns are delayed by several months. Moreover, the required staff for the development of an information system are not in position. Also, among those in position, some have not received a formal training. Information that is available is not always presented in a format conducive to operational planning and monitoring. The issue of data quality has yet to be addressed. Additionally, the impact of decentralization following the 13<sup>th</sup> Amendment has increased complexity in the information flows, making it even more difficult for local and national managers to have access to comprehensive information. Recent proposals by the 1997 PTF do not address these issues.

Though information is available, health services development has been more towards meeting ad hoc demands generally based on political exigencies rather than need . An information-based management culture has yet to develop. Consequently little value is been given to completing basic, yet essential, tasks such as recording the disease or the primary cause of death in a bed head ticket or the notification of a communicable disease. Though information is gathered at service centers they are seldom analyzed locally or at the middle levels of administration to make informed management decisions. Analysis is generally undertaken at the center and these reports are generally available a year later, e.g., Annual Report on Family Health. Vital Statistics, district-wise indoor morbidity and mortality data, data from special programs such the anti-malaria and filaria campaigns, STD campaign etc. are published annually by the Ministry of Health in the Annual Health Bulletin. Data on outpatient visits by illness are not routinely collected, nor are surveys of outpatient morbidity routinely carried out.

Support was provided under the IDA Health Project 1 to establish a HRIS data base. Collection of data commenced in the 1993, but this work has not been completed to date. External support will be obtained to complete this task by the end of next year. Support has been made available for the development of a MIS under the second IDA Health Project (Rs.96 million cost). This activity is now underway. Under this project, one Central Data Base and eight Provincial Data Bases are to be established. The General Hospital, Badulla and the Teaching Hospital, Kandy have been selected to develop a hospital information system.

Currently, there is provision for a cadre of 21 medical record officers (MROs) in the line ministry. Of these 20 positions have been filled. Medical record assistants have filled sixteen such positions. They are graduates brought into the ministry under a graduate-training program and subsequently recruited into these positions. Both MROs and MRAs have been given training by the medical statistician. Two hundred and eighty data entry operators are to be recruited for the implementation of the MIS project.

## **National Health Accounts**

MOH is currently engaged in establishing a comprehensive national health accounts system for Sri Lanka. This is being designed according to the latest international standards, and is planned to enable MOH to have access to annually updated statistics on both public and private spending on health care. The system is expected to provide information on the flow of funds within the health care system, the use of expenditures by functional purpose, and the distribution of health care expenditures by province. This should allow MOH for the first time to make informed decisions about the health sector in its role as manager of both private and public health care systems. First results are expected in early 2000, and decisions will have to be made at that time as to how the system will be maintained on a regular basis thereafter. Annual NHA estimates would be desirable in order to allow MOH to take a more proactive role in management and regulation of the private sector.

## 5.1 Health care financing strategy

### Overview

The government funds approximately half of national health expenditures, and government services use an equivalent amount. There is very little public funding of private provision, or private funding of public services. Public funding is concentrated on the provision of hospital services, specifically inpatient care, while private funding is mostly for outpatient services and purchases of medicines in the private sector (Tables 5.1.a – 5.1.b). The following section reviews the development health financing strategy in Sri Lanka.

### Development of Sri Lanka's health financing strategy

The resources mobilized by Sri Lanka's health sector have always been modest. Sri Lanka completed its demographic transition from a situation of high mortality and fertility rates to a situation of low mortality and low fertility in a period of fifty years, but maintained total national health expenditures at a level of less than US\$8 per capita per annum.<sup>25</sup> This is less than currently being spent from all sources in countries comprising about 75% of Sub-Saharan Africa's population (World Bank, 1994). Throughout, total public spending on health averaged less than 2% of GDP and US\$5 per capita per year, and was never greater than US\$6 per a year. This was considerably below the estimated US\$13 per capita that it would cost to provide the World Bank's "cost effective" package of basic preventive and curative health services (World Bank, 1994).

**Table 5.1.a: Public and private contributions to financing and provision of health services, 1996**

	Public	Private	National total
Funding of national health expenditure	50%	50%	3.4% of GDP
Use of national health expenditure	51%	49%	3.4% of GDP
Hospital services			
Funding	87%	13%	1.4% of GDP
Beds available	96%	4%	3.0 per 1000 capita
Inpatient admissions	96%	4%	19.4 per 100 capita
Outpatient services			
Funding of all non-hospital services	26%	74%	2.0% of GDP
Funding of modern non-hospital services	27%	73%	
Outpatient visits per capita	48%	52%	3.9 per capita

*Source:* See Tables 5.1.b – d.

*Notes:* See Tables 5.1.b – d.

<sup>25</sup> Measured in constant 1990 US dollars.

**Table 5:1.b: National health accounts matrix (millions of rupees), 1996**

	Sources of funds				Subtotal
	GOSL	Employers	Insurance	Households	
Public Providers					
MOH hospital	8,800	.	5	~100	8,900
MOH non-hospital	3,128	.	.	.	3,128
Other government	~600	.	.	.	
Subtotal	12,628	.	5	~100	12,733
Employer facilities	~200	.	.	.	~200
Private Providers					
Private hospitals	0	~240	110	~900	1,250
Private clinics	0	~85	5	~4,000	~4,090
Pharmacies	.	~25	.	~6,500	~6,525
Traditional	0	.	.	~1,000	~1,000
Insurance administration	0	.	70	.	70
Subtotal	0	~350	185	~12,400	~12,935
TOTAL (Rs. Million)	12,828	~350	~190	~12,500	~25,868
TOTAL (% GDP)	1.7%	.	.	1.6%	3.4%

*Sources:* Sri Lanka's official national health accounts are under preparation by MOH, and are slated for release in mid-2000. In the interim, these IPS HPP estimates are derived from various data sources, including government budgetary records, IPS survey data for private health insurance companies, private hospitals, IMS (Lanka), Census and Statistics Department reports, etc. Most data sources did not apply to 1996, so some judgement has been applied to extrapolate from previous years to 1996.

*Notes:* 0 indicates that the amount concerned is believed to be zero. "." indicates that the amount is believed to be non-zero, but minimal. "~" indicates that the amount is an estimate. The estimate for household spending is derived from unpublished tables from the Central Bank Consumer Finance Survey 1996/97, and is subject to significant uncertainty.

Sri Lanka did this by adopting a resource mobilization strategy that used available public and private funds in an effective, efficient, equitable and sustainable manner. This strategy has essentially depended only on two resource mobilization methods: (i) general taxation and (ii) out-of-pocket household spending. While the overall policy framework has not changed over half a century, the respective roles of these two mobilization methods has, with household spending increasing its share and contribution to overall health sector efficiency. Sri Lanka has been relatively successful in increasing the contribution of private financing. This was not achieved overnight, but is itself the result of previous resource mobilization through general taxation.

User fees and private insurance have been used for resource mobilization in Sri Lanka, but the overwhelming experience to date has been that they are inferior to the two major methods of general taxation and direct household spending. The evidence indicates that they are generally inefficient, inequitable and most importantly ineffective methods of resource mobilization. User fees are also politically sensitive, so much so that they will not be officially debated in public.

Health financing strategy in Sri Lanka has not changed fundamentally in more than five decades, and what changes have occurred have been gradual, and involved changes more in emphasis than in fundamentals. The policy framework has also often not been explicitly stated, but actual practice is a relatively good indication of policy as understood implicitly by policy makers. Policy makers have faced most of the current policy questions in financing repeatedly over several decades, and through a process of trial and error, judged ultimately by the electorate, have evolved the current framework. To place current strategy in context, to emphasize its evolutionary nature and the forces that have actually determined policy, and to explain why certain policy dilemmas have been solved with particular solutions, the following sections summarize the development of the current health financing strategy.

## 1930s - 1950s

Average income in constant 1990 US dollars was around \$150 per capita and falling, and the health status of the population was poor with the IMR in the range of 150 to 200 per 1000 live births. Modern medical services were largely restricted to public provision in urban areas and employer provided care in the estate sector, while most rural people depended on ineffective traditional forms of treatment provided in the private sector. Most of the population lived at subsistence level. Household savings were minimal, and when severe illness struck, families were impoverished by being unable to work or maintain themselves during sickness. Private charitable actions did support some hospital and clinic services, but these efforts were completely unable to meet the need for services. Means-tested user fees were already being charged in the public sector, and were being mostly paid by urban residents, since rural people were too poor to be eligible. Modern health service provision by the fee-paying private sector was limited.

The possibility of expanding access to modern curative services through private financing was small. Although rural people were paying for traditional services, rural demand for western medicine was much less. Experience with western medicine was so limited, that even if modern private services had expanded, individuals would not have made maximum use of provided services, and they would not have been able to discern for themselves between modern providers of different quality. This and rural poverty precluded substantial expansion of modern medical services through public sector user fees or through private financing of private providers.

In the 1930s and 1940s, two critical changes were made to the policy framework. First, modern medical services were expanded throughout the country through public supply, and this was funded by increased taxation of the plantation sector. Second, substantial public funds were allocated to malaria vector control, with the introduction of DDT in the late 1940s. Initially, a contracting economy prevented any significant real increase in public expenditures. When in the late 1930s, fiscal constraints were removed, there was massive expansion of publicly-provided and run health services into rural areas. This expansion continued until the late 1950s, when fiscal constraints again came into play.<sup>26</sup>

In retrospect, this expansion of publicly financed supply addressed three areas of market failure in the health sector, as well as meeting the social and political objective of poverty alleviation through income redistribution:

1. **Provision of a pure public good** - the control of mosquitoes to reduce malaria, and one which disproportionately benefited poor, who lived in the dry zone districts, as well as contributing to economic growth by enabling the expansion of irrigation agriculture.
2. **Insurance market failure** - the provision of public inpatient care provided the population with insurance against some of the effects of severe illness, a need which was not being met by the existing insurance market.
3. **Imperfect information amongst consumers** - it inadvertently dealt with the lack of information about the benefits of western medicine, by exposing the rural population to it through free public supply. Given that household preferences favored traditional medicine, the low price of the public services in terms of access costs (dispersed infrastructure) and money prices (zero user fees and free hospital meals) were critically important in encouraging individuals to try the new treatments. Exposure through repeated visits began to provide households with the information which would allow them to select the most effective forms of care when ill.

In expanding public services, Sri Lankan policy makers avoided a major failure of public supply in other countries. The expansion in public services disproportionately benefited the rural poor, as expansion was achieved in a highly dispersed manner throughout the island. While taxation was regressive, the net fiscal impact was progressive, as the value of implicit subsidies to the poor through the health system, not only was greater than their tax burden, but was also greater as a share of their income than for the rich.

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<sup>26</sup> Sri Lanka's public health infrastructure was already established by the late 1950s. Even at that time Sri Lanka had achieved levels of physical infrastructure provision in the health sector, which were higher than has been achieved by most South Asian countries even by the late 1990s. Consequently, low levels of capital expenditures in subsequent years are not necessarily as great a problem as might first appear.

Expansion of publicly-financed medical services in the 1930s and 1940s provided the whole population with ready access to modern medical services. Public supply had two effects on the market for modern medical services: (i) it increased household demand for such services as households acquired information about western medicine through exposure at government health facilities, and (ii) it reduced the supply constraints to increased private provision, by placing government doctors throughout the country and allowing them to do private practice, and by increasing the overall numbers of medical personnel in the country. During the 1950s and 1960s, as household demand for modern medical services increased, expenditures on western sources of care rose, while expenditures on traditional forms declined or remained unchanged. Household preferences having shifted once from traditional treatments to public western services in the 1930s to 1950s, began to shift again from public modern services to private western services. This shift can be observed in the decreasing role of public financing in the provision of modern non-hospital services from the 1960s onwards (Table 5.1.c).

Although demand for modern medical services rose dramatically, it was not accompanied by an increase in the ability of households to pay for inpatient care. While households valued such care and presumably were willing to pay actuarially fair rates to protect themselves from the cost, the insurance market continued to fail to provide catastrophic health insurance. While market failures (i.e.: information, supply constraints) in the ambulatory sector became less significant, the major market failure (lack of insurance) in the inpatient sector continued. So while by 1980, almost two thirds of financing for modern non-hospital care was from private sources, nine-tenths of hospital care was still being financed from general revenues (Table 5.1.d). General tax revenues were increasingly concentrated on paying for inpatient care.

It is readily apparent that this policy approach of heavy hospital spending did not have as a paramount objective the maximization of cost-effectiveness in the use of scarce public funds. It is also clear that from the 1950s onwards, technical and professional opinion in the health ministry and amongst international experts believed that such emphasis on hospital spending was misplaced, and this led to repeated policy statements that spending would be reallocated towards non-hospital services. This never happened. The reason was political. Ever since the initial expansion of government services in the 1930s and 1940s, policy makers had in fact been responding primarily to the social demand for more publicly-financed hospital care, which had been identified in official reports, was apparent in the increasing overcrowding of government hospital facilities, and was communicated through the electoral mechanism as individual legislators attempted to win votes by meeting public demand for government services.<sup>27</sup> The state responded to aggregate social preferences as expressed through the ballot box, when it emphasized hospital care, and not to some technical view of what was optimal or rational.

The continued rise in utilization of publicly-funded services was not met by commensurate increases in the availability of general revenues. Instead, public services delivered an increasing volume of services by halving unit costs during the 1950s to 1970s through using personnel and infrastructure even more intensively (Table 5.1d). This has relevance to the one policy option that was not considered at this time, namely the public financing of private providers. If such an option had been tried, there are essentially only two reimbursement mechanisms which could have been used: (i) fee-for-service payment, in which payment is linked to the volume of services provided, and (ii) capitation-based payments, in which private providers were paid a fixed sum for treating all patients in a population group on the basis of a fixed budget. In either case, there is an implicit price for a certain volume of services. However, if GOSL was fiscally constrained, as it was, it would have had to persuade its contracted private providers to provide ever more services at lower and lower negotiated prices. Given the pluralistic nature of the Sri Lankan polity it is a moot question how successful GOSL would have been in bargaining such a reduction in unit prices with an organized medical profession, which would have had considerable exit options in the form of private practice and emigration. If GOSL had had to negotiate, then the level of implied unit costs would have been transparent, inviting invidious comparison with other countries.<sup>28</sup> One recent World Bank study (Griffin, Levine, and Kelly Eakin, 1994), which mistakenly overestimated hospital unit costs by a factor of three,

<sup>27</sup> This process closely resembles events in the UK in the 1940s, where public opinion and rising demand for hospital services were also critical in persuading officials to accept radical health services reforms (Jacobs, 1993), and in Hong Kong in the 1960s, where the official decision to expand hospital care was due to similar reasons (Chu, 1994).

<sup>28</sup> The UK NHS reforms in the 1990s, which created a provider-purchaser split, made the historical variation in unit costs between different providers transparent for the first time, and has led to open debate amongst providers and policy makers about the fairness of such differences.

still concluded that “the apparent low cost of State . . . hospital stays . . . could be due to many different -- not necessarily desirable -- reasons: extremely high efficiency beyond almost anything humanly imaginable . . . and extreme overcrowding that economizes on hotel costs through tremendous sacrifices by the patients.”

**Table 5.1.c: Trends in the composition and use of health expenditures**

	1953	1980	1990	1996
<b>Source of national health expenditures (%)</b>				
Public	62	57	46	50
Private	38	43	54	50
<b>Use of national health expenditures (%)</b>				
Hospital	48	45	40	40
Non-hospital	52	55	60	60
<b>Source of all hospital expenditures (%)</b>				
Public	96	87	93	87
Private	4	13	7	13
<b>Source of all non-hospital expenditures (%)</b>				
Public	30	31	16	26
Private	70	69	84	74
<b>Source of modern non-hospital expenditures (%)</b>				
Public	70	40	19	27
Private	30	60	81	73
<b>National health expenditures (% GDP)</b>				
	3.3	3.1	3.3	3.4
	%	%	%	%

*Source:* Derived from IPS HPP estimated national health accounts for these years.

*Note:* “Modern” is defined as all non-scientific-based forms of care, and thus excludes ayurvedic, ceremonial, homeopathic, and other treatments. ‘Hospital’ and ‘non-hospital’ refers to the location of care, and so outpatient care provided by government hospitals is classified here as hospital care.

**Table 5.1.d: Trends in the level of public sector services and financing**

	1953	1970	1980	1990	1996
<b>Source of national health expenditures (%)</b>					
Public	62	N/A.	57	46	50
Private	38	N/A.	43	54	50
<b>Beds available per 1000 population</b>					
Public	2.79	3.13	2.94	2.75	2.90
Private		N/A.	N/A.	0.11	0.13
<b>Inpatient admissions per 100 capita</b>					
Public	11.1	16.4	15.8	15.0	18.4
Private		N/A.	N/A.	0.7	1.0
<b>Outpatient visits per capita</b>					
Public	1.7	2.8	2.2	1.9	1.9
Private			~2	~2	~2
<b>National health expenditures (% GDP)</b>					
Public	2.1%	2.1%	1.7%	1.6%	1.7%
Private	1.2%	N/A.	1.4%	1.7%	1.7%
Total	3.3%	N/A.	3.1%	3.3%	3.4%

*Source:* Derived from IPS HPP estimated national health accounts for these years, and other IPS data.

*Note:* N/A. means not available or not yet estimated.

Yet this forced reduction in unit costs was vital to avoiding the pro-rich distribution of general revenue-funded health services in other countries, which typically stems from an emphasis on urban facilities and from hospital admission procedures which are easier for wealthier patients to exploit. In Sri Lanka, maintenance of quality of available services was traded for universal access and dispersion. Again, as with the emphasis on hospital spending, this was the consequence of the political mechanism. Consequently, the government health infrastructure and health personnel are widely dispersed throughout the whole island (Table 3.3.a and 3.3.b)

## 5.2 Recent trends: 1980s - 1990s

The 1980s saw a continuing shift of ambulatory care provision to the private sector, and financing to direct household spending, which appears to have stabilized during the 1990s. Health expenditures are now half public and half private in origin (Table 5.1.b). Comparison of financing trends with the provision of services suggests that during the 1990s, the public sector continued to reduce unit costs at a lower rate than in the 1960s-70s, with an increased volume of services and infrastructure being provided for a constant cost in terms of GDP (Table 5.1d).

The extent of market failure is not as significant as might have been expected in the 1930s. Consumers are better informed; they are better able to recognize illness and better able to choose amongst the various options for primary care. In the 1990s, more than 80% of household expenditures are for western medicine, and not traditional treatment, and the majority of primary health care contacts are in the private sector. However, market failure continues to exist in the provision of insurance for catastrophic illness. Private health insurance has limited ability to extend population coverage beyond 2%, and it is characterized by all the insurance market failures seen in other countries with unregulated private health insurance. These include responses to adverse selection through restrictions on eligibility for coverage, abuse of policies by providers, and high administrative and marketing costs.

So while outpatient utilization of MOH facilities declines, inpatient use has shown a slight increase. In this situation, the actual allocation patterns of the health ministry, which reveal increasing allocation of taxation revenues to inpatient services may be sensible, given a decline in the potential for market failure in primary care relative to the problem of market failure to provide insurance.

The current policy framework, which uses: (i) general revenues to finance public goods (e.g., malaria control, AIDS/HIV control, etc.), inpatient care for 95% of people and outpatient care for the poorer half of the population, and (ii) household spending for the rest, seems to be reasonably effective at maximizing social welfare and health status given limited public resources. Households have the information and resources to ensure that 20 to 60% of such cost-effective interventions as immunization and ORT are delivered privately, but they continue to be unable to afford hospitalization.

Private health insurance has developed, but it lacks the potential to expand beyond the small formal sector. It remains unable to directly address the major policy objectives of Sri Lankan health policy in the past, i.e., income redistribution and poverty alleviation, and insurance against catastrophic illness. Neither the poor or those most likely to be sick – the chronically ill and old – are covered by private health insurance. Actuarially fair premiums for these high-risk groups to access private insurance would be so great that they would be unable to purchase. In this situation, the provision of risk-protection through the public hospital system may be worth more to these groups than those who do have affordable access to private insurance. Although utilization of inpatient care does not show the same income gradient as for outpatient care, it may thus be more pro-poor in its net welfare benefits than the pure fiscal incidence suggests. In addition, the cost-escalating impact of private insurance is already apparent, and this can only have negative implications on the ability of the public sector to keep costs low.

User fees have been a policy option in Sri Lanka, but they are not acceptable to the electorate. There might be heavy political costs for policy makers in pursuing this option. These political costs and the economic costs of designing effective means testing systems to protect the poor continue to make this option undesirable and unlikely to raise significant net resources.

### 5.3 Case Study: Public Servants Medical Insurance Scheme

The Sri Lanka Insurance Corporation initiated its Scheme for Public Servants in January 1997 following a request made by the government. This indemnity insurance scheme covers all public servants (estimated to be 600,000) and their dependants (estimated to be 1.3 million) for accidents and illness. Accidents covered are limited to those arising out of motor cycling, riots and civil commotion. Also included in the coverage are the costs of childbirth, spectacles, specific medical tests and travel. (See attached form). The policy, while covering the cost of a private hospital room, also provides an allowance for those opting to receive free treatment in a state hospital.

The cost of this non-profit scheme is borne by the Ministry of Public Administration. The claim rate to date is 80% of the funds allocated. 14,600 claims were made for the year 1997.<sup>29</sup> However, claims were still being accepted in 1998 for 1997, because of complaints made by members, who were unaware of the existence of this scheme. According to the Asst. General Manager, SLIC, they have not made a loss on this scheme so far, but since claims are still being accepted for 1997, it is possible that they could run a loss. At the end of each year, SLIC will review the figures and adjust the premium accordingly. However, the premium for both 1997 and 1998 was 160 million rupees.

The claims can be made, according to the official documentation of the SLIC (see attached form), from any branch office or regional office. According to sources at SLIC, however, the claims can be made only to a regional office. In addition, members in the provinces of the North and East have to make their claims to the head office in Colombo. As instructed by the Ministry of Public Administration, some government departments present collective claims to the Sri Lanka Insurance Corporation.

According to industry sources, no actuarial estimates were made as to the cost of the scheme before it was implemented. As is readily evident, if all public servants made full use of the scheme, costs would be substantially greater than hitherto. The low level of claims (8 claims per thousand beneficiaries) compares with the annual hospitalization rate of 190 admissions per 1000 capita. It is unclear whether the Finance Ministry envisaged funding the insurance premiums if full use of the scheme was made, but the introduction and subsequent implementation of the scheme illustrate the lack of planning that can occur with policies which have the potential to have major financial implications.

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<sup>29</sup> SLIC regards a collective claim made by a Government Department on behalf of its employees as one claim. At the same time, an individual claim is also represented as one claim. Therefore, this figure does not accurately indicate how many individuals benefited from the scheme in 1997. The quality and availability of data at the SLIC seems to be somewhat limited. SLIC could not provide aggregate data on total number of claims per individual beneficiary, or any disaggregated data on claims experience by age group, etc. SLIC has not, as yet, introduced computers to its offices, and administration of this scheme is done using paper and hand.

Certificate of Insurance

**POLICY NO:**

**CERTIFICATE NO:**

1. The Policy covers expenses for medical and surgical treatment as defined in the scale of benefits, necessitated as a result of a Member sustaining accidental injury or/and contracting any illness after thirty days, the Policy is effective.
2. The Cover operates throughout the 24 hours of the day whether at work or during leisure.
3. The Policy provide for excess expenditure incurred due to an abnormality of Maternity, e.g. Caesarian or Forceps delivery, if the Claimant had been insured for a continuous period of 10 months.
4. The Policy covers accidents arising out of :
  - (a) Motor Cycling
  - (b) Riots and Civil Commotion
5. Exclusions under the Policy include expenses:
  - (a) Occasional by or happening through attempted suicide(whether felonious or not). Alcoholism, Venereal Disease, Insanity.
  - (b) Incurred as a result of engaging in hunting and racing of all kinds, polo playing , winter sports.
  - (c) In respect of eye tests or dental treatment, expecting repair or replacement of injury sound unfilled natural teeth.
6. Scale of Benefits
  - 6.1 Hospital or Nursing Home Maintenance Charges  
(The Room Charges Limited to Rs. 500/- per day) Rs. 6,000/-
  - 6.2 Hospital or Nursing Home Medical and Operational Expenses for Special Treatment and Nursing provided on the recommendation of Consulting Specialist and for the use of the Operating Theatre Rs. 6,500/-
  - 6.4 Consultants and Specialist Fee as an in-patient in Hospital or Nursing Home or on the recommendation of General Physician (MBBS) or a Medical Officer registered under clause 41 of the Medical Act. Rs. 7,500/-
  - 6.5 Specialists Services including :  
Deep Therapy Treatment, X- Ray, Radiological and Radium Examination and Treatment  
Electrical Treatment and Massage Rs. 8,000/-
  - 6.6 Expenses incurred for travel within Sri Lanka to obtain Emergency Treatment for which benefits is payable under (1) to (5) Rs. 2000/-

6.7 For normal child birth	Rs. 3,000/-
6.8 Spectacle for the member prescribed by an Eye Specialist or changing of lenses once in three years	Rs. 2,000/-
6.9 Outdoor Treatment – (including dental treatment)	Rs. 2,000/-
6.10 Allowances for Hospitalization in a Government Hospital	
Rs. 300/- per day up to 30 days	
Any one event	Rs. 40,000/-
Any one year	Rs. 50,000/-

7. **Claims**

Any event that may result in a claim should be intimated to the Head Office or to the nearest Regional or Branch Office of Sri Lanka Insurance Corporation Limited without delay, but in any event within fourteen days of the occurrence of the injury or of the commencement of illness. Claims should be made on the prescribed Form which will be available on application and all receipted Accounts including relevant prescriptions for purchase of drugs should be attached, it should be noted that all questions of the Claim Form should be answered fully and precisely in the affirmative or negative and that no question should be unanswered. If there is any question that is inapplicable to the particular should be marked “Not Applicable”.

Full Name of the Insured Member -----

Ministry/ Provincial Council/Department :-----

Identification Number :-----

Name of Dependants :-----

## 6 - PRIVATE SECTOR ISSUES

### 6.1 General

Systematic assessment of the private health sector has not been previously carried out, and is anyway difficult owing to the lack of regular and comprehensive statistics. Currently, MOH does not have a reporting system to even compile annual data on the numbers of private hospitals, their capacity, and the numbers of private doctors. In fact, over time there appears to have been a deterioration in the availability of statistics at MOH. In the 1950s and early 1960s, MOH would publish each year data on the number of private hospitals and beds in the country, but this practice stopped in the mid-1960s. A new directorate for private sector health services was established during 1998, and this may lead to more systematic collection of data on the activities and trends in the private sector, although it is unclear whether the necessary resources have been allocated for this purpose

#### Profile of private sector

Private sector medical services deliver both Western medical care, as well as other forms (Ayurvedic and other indigenous forms, homeopathy, and Chinese traditional medicine). Although there are more ayurvedic providers than Western practitioners, the bulk of private services delivered (>85%) consists of Western medical care.

Available data suggest that the private sector provides 6% of overall inpatient admissions, and 40-50% of total outpatient contacts (see tables elsewhere in report). The limited data available suggests little change in these patterns during the 1990s, except for a modest increase in the share of inpatient admissions. Table 6.1.a gives estimates of the number of private providers in the island.

**Table 6.1.a: Estimated number of private providers, 1992**

Type of provider	Number
Private GPs	800
Traditional practitioners	>12,000
Pharmacies	1,287
Diagnostic laboratories	N/A.
Nursing homes, private hospitals	85

*Source:* Presidential Task Force (1992)

#### Private outpatient services

Private outpatient services are provided by:

- Full-time private doctors, and other health workers, who work full time at private clinics, private hospitals, pharmacies and laboratories.
- Government medical doctors, who work privately outside duty hours (before 8.00 am and after 4 p.m.), seeing patients in their own government hospital quarters, at private clinics, private hospitals and private channelling centers.<sup>30</sup>

<sup>30</sup> Channelling refers to the provision of medical consultation services by government specialists. These doctors see patients in their off-duty hours at special channelling centres. Patients queue in the morning to pick a number, which determines their place in the queue, and then return in the evening to see the specialist.

### *Private general practitioners*

Most private doctors are general practitioners (GPs) engaged in family practice, and there are very few full-time private specialists. Most private doctors are located in Western Province, perhaps as many as two thirds, and virtually all in urban areas. There are virtually no full-time private clinic doctors in rural areas, and in these areas private medical practice is mainly provided by government doctors in their off-duty hours. Exact totals for the number of private practitioners are not available, but most recent estimates put the total at 700-900. These private GPs tend to be relatively old, and virtually all have previously worked in the public sector. During the 1990s when the medical schools were closed, it is likely that the overall number of these doctors declined, as few doctors were leaving MOH for private practice. In future, with the anticipated surplus of medical graduates compared with MOH requirements, it is expected that numbers may necessarily increase.

Private practitioners are paid on a fee-for-service basis. Approximately half also dispense medicines, and in these cases their fees are often charged only for the medicine. Although the practice of dispensing is not approved by members of the profession, it reflects a continuation of the dispensing tradition of ayurvedic practitioners, and is expected by many patients.<sup>31</sup> However, according to industry sources, the percentage of doctors who dispense is declining, since it is not economical for many to maintain adequate stocks. There is no regulation of prices, and fees are set by the doctors themselves. Many, if not most, price discriminate charging less from patients deemed poorer, but the majority of their patients are from the upper half of the income range. In the mid-1990s, average fees were in the range of Rs. 30 – 50 per consultation. In 1998, the net income of an established GP may have been in the range of Rs. 35,000 – 60,000 per month. Patient numbers are typically in the range of 30-100 patients per doctor per day. Most GPs practice single-handedly, although some are organized into multi-partner practices.

There are few reliable data on the practice patterns of private GPs, and estimating even their income requires some conjectures. The most detailed picture of private practitioners emerges from a study by Varnam (1987). He conducted a comparative study of patient care by private general practitioners and MOH medical officers in the mid-1980s. The MOH providers consisted of medical officers in the OPD of a base hospital, who are typical of the staff used to provide the bulk of primary care provision by MOH, while the private providers were a sample of 40 private general practitioners. Data were collected using direct observation and self-recording. The private GPs were older, all had completed the compulsory five years government service, and a quarter had received post-graduate training in primary health care. The MOH medical officers on the other hand tended to have only one year of experience post-qualification, and none had any additional training in primary health care provision. The MOH doctors were found to spend an average of 1.5 minutes per patient, while the private practitioners spent an average of 2 minutes per patient. Patients consulting at the OPD were more likely to be presenting with new illness episodes, than at the private clinics. Patients at the private clinics presented with more cases of diarrhea and pregnancy, and were more likely to be seeking immunizations. The private GPs were more likely to write some type of clinical patient record (61% versus 8% in MOH), perform immunizations (5% versus 2%) and conduct tests (13% versus 4%). Patients were much more likely to be referred elsewhere by the MOH doctors (16%) than by the GPs (4%), which may reflect the greater training and experience of the private practitioners.

Private practitioners show a similar workload pattern to government doctors: high patient numbers with short consultation times, although private practitioners may spend modestly more time with the patient, and probably are more likely to keep patient records, refer patients, and take an interest in continuity of care. Some other cross-country studies indicate that Sri Lankan GPs tend to be more likely to prescribe generics and engage in rational prescribing for common conditions such as diarrhea or upper-respiratory tract infections than both public and private sector doctors in India, Indonesia, Bangladesh and Central America (Tomson, 1990). This pattern of drug prescribing probably reflects the initial training GPs would have received in the public sector, where generic prescribing and restricted drug formularies have been the norm since the 1950s, the higher profit margin on generic drugs, as well as a high degree of professional dedication to maintaining standards. The limited data suggest that the quality of medical practice by these GPs is relatively high, but clearly more research is needed to investigate this, as well as the factors, which may be behind it.

Private GPs have through their own volition established their own academic college, the College of General Practitioners, which organizes formal training and post-graduate qualifications for GPs, based on those

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<sup>31</sup> This parallels the continuance of dispensing by medical practitioners in Japan, Taiwan and Hong Kong.

developed by the UK College of General Practitioners. College members believe that it is important that future entrants to general practice be trained in family medicine under supervision of an experienced GP, as well as receiving a minimum amount of training in referral level MOH hospital departments. However, except for one medical faculty which has commenced sending its undergraduates for training programs organized by the college, there is a general lack of interest to date both by the medical schools, which tend to be dominated by medical specialists, as well as by MOH. Current MOH policy is that two to three years exposure to hospital medicine is sufficient for junior doctors to enter private practice. The current PTF proposals do not make any further recommendations to address this lacuna.

#### *MOH doctors practicing privately*

These doctors provide more care than the full-time GPs, as their numbers are in the range of 2,000 – 3,000. Virtually all specialists in the private sector are also MOH employees. Most clinicians in MOH engage in private practice as a means of supplementing their salary. The need for doing this has been recognized for more than a century, and this has been the official justification, especially in the case of doctors posted to rural facilities. The junior staff often work for other doctors, including private GPs, while hospital specialists will run their own clinics. The level of fees charged varies depending on the reputation, experience and speciality of the doctor, and can range up to Rs. 300 – 1,000 per consultation. Hospital specialists may earn up to Rs. 100,000 – 250,000 per month in some cases, with many staff able to earn several times their regular salary from their private practice. Specialists often supplement their patient fees with other fees from suppliers of diagnostic services for patients referred by them. This description is based on generally accepted belief, but there are no reliable data on the work profiles of these doctors in their private practice.

The admitting doctors in private hospitals are generally these MOH specialists, with the full-time private hospital staff limited to junior staff providing routine cover only. Little is known about the quality of care provided by these doctors, although it is argued by private GPs that MOH staff are not able to provide the same level of quality – the junior ones because of lack of training and experience, and the specialists, because they mostly treat minor common illnesses that they are not specially trained to do.

Private practice rights have always been associated with abuse of the privilege. A large proportion of MOH doctors are believed to abuse their rights by doing private practice during official work hours. However, the large majority of MOH staff will be at post at any one time. Although private practice incomes are substantially higher than MOH salaries, most MOH staff are content to remain in MOH employment. Several factors explain this. First, junior staff have a strong incentive to remain in MOH in order to receive the training required to become a specialist; specialist training is not feasible in the private sector given the small-scale of most hospitals. Second, reputation plays a significant role in determining potential private practice earnings, and reputation and experience is largely signaled to patients by the rank held in the public sector. Third, until the 1990s, the most advanced medical equipment was the preserve of the public sector and private hospitals lacked the infrastructure, such as skilled nursing care, blood banks, diagnostic equipment, etc., to provide complex treatments, which would have acted as a disincentive for highly trained physicians to leave. It is unclear what the implications are of the establishment in the 1990s of fully-equipped private tertiary facilities.

The implementation plan for the PTF proposals outlines the removal of private practice privileges from all MOH doctors by end-2002, starting with the initial removal of private practice rights for new recruits in 1998 (Presidential Task Force on Health Policy and Implementation, n.d.). This has yet to happen. In addition to facing almost certain resistance from public sector doctors, these proposals are unlikely to be feasible without providing for substantial increases in public sector salaries to compensate for the loss of income. Current salaries are below market-clearing levels, because doctors have been willing to accept low salaries knowing that private practice income would compensate. It should also be noted that government doctors engaged in private practice meet 20-35% of total outpatient demand (10-20 million outpatient consultations per year). Removing this source of provision would inevitably reduce access to services, and place considerable pressures on already overcrowded private GP and MOH OPD services.

## Private inpatient services

The private hospital sector has historically been small in size. Private hospitals are generally concentrated in Western Province (Table 6.1.b), and are generally small in bed size in comparison with those in the public sector. However, in the 1990s, there has been a trend to larger facilities with expansion of existing ones as well as establishment of large new hospitals (Table 6.1.c). Table 6.1.c indicates that the number of full-time doctors employed by private hospitals is small, in some areas less than one per hospital. Admitting specialists in the private hospital sector are virtually all employed independently or mostly in MOH. Junior staff are only employed to provide routine supervision of patients.

**Table 6.1.b: Distribution of private hospital capacity in 1992**

Province	No. of hospitals (%)		No. of beds (%)		Private doctors(%)	
Western	31	(41)	1,154	(61)	90	(64)
Central	7	(9)	125	(7)	18	(13)
Southern	8	(11)	245	(13)	12	(9)
North-Eastern	17	(22)	85	(5)	3	(2)
North West	7	(9)	164	(9)	14	(10)
Uva	3	(4)	69	(4)	2	(1)
Sabaragamuwa	3	(4)	44	(2)	1	(1)
North Central	N/A		N/A		N/A	
Total	76	(100)	1,886	(100)	140	(100)

Source: Russell and Attanayake (1997).

**Table 6.1.c: Colombo hospital bed size distribution, 1990 and 1997**

No. of beds	1990		1997	
	Number	% of beds	Number	% of beds
<10	5	26	3	16
10-25	4	21	4	21
26-50	3	16	4	21
51-100	6	32	5	26
101-200	1	5	2	10
201-300	0	0	0	0
>300	0	0	1	5
Total	19	100	19	100
Mean size	43 beds		64 beds	

Source: IPS/MOH survey of private hospitals, July/August, 1998.

In the absence of any routine data collection in the private sector by MOH, a survey of private hospitals was carried for this assessment. Some results are given in Table 6.1.e. These show that during the 1990s, there was only modest expansion in the installed bed capacity of the private hospital sector, while utilization at both inpatient and outpatient levels rose substantially. Bed occupancy rates have been rising, typically from 50-70% in 1990 to 70-90% in 1997. In 1998-99, some large private hospitals have reported occupancy rates in excess of 100%. The reasons for the disparities between bed capacity expansion and utilization are not clear, but may be due to a time lag between increased demand and profit margins in the early 1990s and completion of new hospital projects. Certainly in 1999, it is known that several large hospital projects are expected to open during 1999-2001, adding another 1,000 beds in Colombo alone.

The other feature to be noted in these trends is that private hospitals are becoming larger and more sophisticated in the services offered, and there has been increasing purchases of high-technology equipment, such as CATs and MRIs. Much of the investment in equipment has been made possible through the granting of duty waivers on imports and tax holidays on resulting earnings by the Board of Investment (BOI). It is also generally believed in the industry that these equipment are important to attract patients, and not necessarily because of their inherent profitability. However, specific data on this are not available, although a ratio of 4 CATs and 3 MRIs 2,000 beds and only 2 blood banks is suggestive that the pattern of investment is not appropriate to provide a balanced mix of care.

During 1998-2000, new hospital projects have or are expected to introduce such services as CABG surgery, telemedicine with link-ups to US/Singaporean hospitals, and in-vitro fertilization facilities. The pace of

these recent developments points to rapid change in the future in the characteristics of the Sri Lankan private hospital sector. The full implications of this do not appear to have been fully understood by planners. As technical standards in the private sector rise substantially above those in the public sector, this may have both equity and cost implications. As middle-class patients switch to the private sector, public support to maintain quality in public sector services may decline, while the public sector may find it more expensive to keep high quality medical staff from exiting.

**Table 6.1.d Trends in private hospital sector, 1990s**

	1990	1992	1994	1996	1997
<b>Number of hospitals</b>	-	76	-	-	-
<b>Beds</b>	1,872	1,886	2,138	2,275	2,305
<b>Inpatients (admissions)</b>	117,000	135,000	153,000	176,000	204,000
<b>Outpatients (visits)</b>	568,000	810,000	986,000	1,502,000	1,617,000
<b>Revenues</b>					
Rupees (million)	388	528	732	1,032	1,219
% of GDP	0.13	0.14	0.14	0.15	0.15
<b>Installed facilities*</b>					
CAT	1	-	-	3	4
MRI	0	-	-	2	3
Blood banks	1	-	-	1	2
Number registered with BOI*	0	-	-	-	3

*Note:* National figures estimated using results of IPS/MOH survey carried out during July-August 1998. \* indicates results are for survey sample only, which covered ~65% of all private hospitals and beds.

## 6.2 Government policy to the private sector

In general, the policy towards the private sector has been passive, enforcing very minimum entry standards, and implicitly encouraging private hospital growth through financial incentives. The risks in an expanding private sector as they relate to quality of care are recognized. Many policy makers implicitly believe that these negative features can be managed through better regulation and stronger consumer information, while the benefits of reduced demand for public services can result.

The interface between MOH policy makers and the private sector is generally weak. Private sector doctors in particular feel that they are not consulted on policy decisions affecting them, and that there is little sharing of information, the most recent example being the deliberations of the PTF. However, the MOH's ability to respond to private sector concerns or deal with private sector issues has been weak, with insufficient financial, human and information resources being available.<sup>32</sup> It should be noted that the difficulties of MOH in managing the private sector have increased since the 13<sup>th</sup> Amendment which devolved responsibility for licensing private hospitals to the Provinces, none of whom have administrative resources to effectively perform this function. In 1998, a new director of private sector health services was appointed, but he appears to have been allocated no staff other than the minimum administrative office support.

There is a general recognition in MOH that their ability to respond is weak and insufficient, and the concerns of officials can be gauged from the responses to an ad hoc survey of officials reported by Russell and Attanayake (1997) (Table 6.2.a). Major concerns for MOH officials appear to be abuse of private practice privileges and the effects of financial incentives on inappropriate care. However, there is little concern expressed the exodus of MOH staff to the private sector. Favored solutions appear to involve closer monitoring, and provision of tax incentives to encourage private hospitals outside Colombo.

<sup>32</sup> Much of this section is based on Russell and Attanayake (1997).

**Table 6.2.a: Main concerns of MOH officials about private health services and possible responses**

The concern, issue or response	Number of times raised (n=22)
<b>Concerns</b>	
Government doctors abuse of private practice privilege	17
Exodus of staff from the public sector	0
Profit motive leads to overcharging	13
Profit motive leads to excessive investigations and prescriptions	12
Unregulated sale and irrational use of drugs	15
Profit motive leads to cost cutting / poor quality care	16
Poor referral practices	10
No information about diseases treated	15
Over concentrated in Colombo - no private facilities in peripheral districts	9
<b>Responses</b>	
Prevent abuse of private practice, e.g. Through new peer Review Committees	12
Improve registration of private providers	13
Start to monitor the number of and structural quality of private providers	16
Stricter monitoring of pharmacies	7
Start to co-ordinate the mix of public and private services at the divisional level	4
Provide tax incentives to enable private nursing homes in peripheral districts	11
Harness private financial resources to meet health needs of the population	13

## 6.4 Board of Investment Incentives for the development of Medical Services

The major government policy intervention with respect to the private medical sector in the 1990s is a program of incentives, which were offered to private hospitals through the Board of Investment (BOI). BOI was set-up in 1990 as a investment promotion agency responsible for boosting foreign investment in the economy. Its major instrument is the provision of tax holidays and exemptions for qualifying investments. Although medical services were not originally identified as an area needing support, investment incentives were later offered to private hospital operators. These incentives were subsequently modified, by extending the criteria for eligibility, generally making it easier to qualify. Details are given below. It should be noted that when GST was introduced in 1998, health services were included in the exempt list, so all private medical services are now exempt from value-added taxation.

MOH was not responsible for initiating the BOI private hospital privileges, and according to MOH sources has never been consulted about the BOI policy itself, although it is consulted about new project approvals. The initial policy was introduced following lobbying of the then President by one private hospital operator who wished to import duty-free some expensive medical equipment into the country. It is unclear whether any analysis of the impact of or need for such a policy from a health policy perspective was ever made, and MOH certainly was not consulted. Some of the existing private hospital operators contacted during the research for this assessment complain that the current BOI schemes are discriminatory as they favor large capital-intensive hospitals at the expense of the more traditional small nursing homes, and since they do not benefit existing operators.

In recent years, a number of new hospitals have been established, or expansion projects of existing hospitals launched with BOI support. Details of these are given in Table 6.4.a below. Several of the new hospital projects approved involve investments by foreign hospital operators from Singapore, India and UK. Most of the private sector hospital expansion in the post-1994 period appears to involve BOI projects. Most, if not all, the high-technology imports in recent years by the private sector, e.g., CAT and MRI scanners, have been by BOI approved projects.

## **BOI Investment Criteria for Private Hospitals**

Prior to 1993, one set of criteria had to be met in order to obtain BOI approval:

- A minimum investment of US\$ 2.5 million, and
- A minimum of 100 beds

After 1993, two schemes have been offered, as described below. One of these was under existing criteria for non-hospital projects, and the second reveals a thinking that BOI incentives can be used to expand services in the provinces, and also to the poor by making private hospitals provide free services. The linkage of free care to investment privileges resembles similar schemes in India, which in practice have not resulted in significant care being provided to poor patients, as non-poor patients are admitted into those same facilities, with efforts to restrict access to the free care. It is not known whether these potential problems were considered when initiating this scheme.

### **Applicability of Scheme A**

*Project meeting the following characteristics:*

- Large scale infrastructure, OR
- A minimum investment of Rs.500 million

### **Applicability of Scheme B**

*Two tier hospital meeting the following requirements:*

- At least one ward with a minimum of 25 beds and an OPD for non-paying patients
- If located:
  - Within Colombo: investment of Rs.75 - 499 million
  - Outside Colombo: investment of Rs.50 - 499 million
- Minimum new employment – required: N/A

*Incentives provided:*

Full tax holiday:	10 years
Concessionary Tax at 15%	N/A
Import duty exemptions:	
On capital goods:	During the project implementation period. Thereafter, as per customs exemptions list (list attached)
On raw materials:	N/A
Exemption from exchange control	N/A
Minimum new employment – required:	N/A

**Table 6.4.a: BOI private hospital approval statistics**

Year	Applications	Applications approved but not signed	Applications signed	Approved projects starting commercial operation	Total Capital Investment (Rs. Mn)
1992	2	2	2		281
1993	1				103
1994	4	5	3	Asha Central Hospital (Pvt.) Ltd New Nawaloka Hospital (Pvt.) Ltd.	2,269
1995	1	1	2	Ruhunu Hospital (Pvt.) Ltd	327
1996	1	1	1	Victory Hospital (Pvt.) Ltd	561
1997	5	4	-		3,786
1998	1	6	-	Asha Central Hospital (Pvt.) Ltd New Nawaloka Hospital (Pvt.) Ltd Ruhunu Hospital (Pvt.) Ltd Victory Hospital (Pvt.) Ltd	169

Source: Board of Investment

**Table 6.4.b: Investment Criteria and concessions offered under Scheme A**

Minimum investment Rs. Mn	Incentives				Exemption from exchange control
	Full tax holiday yrs.	Concessionary tax at 15% after tax holiday	Import duty exemptions Capital goods	Raw materials	
500 – 1,499	10	As per IR law	Excluding	No, unless	Yes
1,500 – 2,499	12	after tax	textiles, during	used for	
2,500 – 4,999	15	holiday	project	exports	
above 5,000	20		establishment period		

### The procedure to approve the development of medical facilities under the BOI

The BOI directs all investment applications in relation to the provision/construction of medical facilities to the Secretary/Ministry of Health. The MOH has the authority to reject/approve any of the applications. Thus the final decision is in the hands of the MOH.

## 6.5 Policies towards private health insurance market

The Presidential Task Force appointed in 1992 recommended that private voluntary health insurance be encouraged in order to shift some of the burden from public hospitals to the private sector. There has been no active government intervention since then to achieve this, except that private health insurance premiums

paid by employers were made tax-deductible for corporate tax purposes. This tax deduction is fiscally inefficient, since it reduces tax yields by more than the treatment costs in the public sector which might be saved if consumers switch from the public sector to the private sector (Rannan-Eliya and de Mel, 1997), and economically inefficient in that it alters the way in which consumers choose to spend their income. To the extent that the implicit tax subsidy is worth more to the average insuree than the government spends to provide medical services to the average Sri Lankan, this subsidy is also inequitable. A decision was announced to withdraw the tax concession in 1997. To date no action has yet been taken on this by MOF.

Currently, private health insurance covers less than 1.5% of the population, and coverage is generally paid for by employers. Its contribution to financing is minimal in that less than two per cent of total health sector financing is from health insurance. However, in the case of larger private hospitals, insurance may now cover 25% of their inpatient clientele. Although there is anecdotal evidence of price escalation because of insurance, the available data are mixed (Rannan-Eliya and de Mel, 1997). Continued close monitoring of trends in the insurance market is desirable, and would be aided by government efforts to require reporting of basic data on medical insurance schemes by the insurance firms, as is the case in other countries.

## 7. REGULATION

### 7.1 Regulatory Framework

The legal and regulatory framework is analyzed by categorizing the legislation into 3 main types: (a) legislation which targets health practitioners, regulates the practice of medicine by doctors in both the public or private sectors; (b) legislation which targets private health care facilities, and which aims to regulate health care provision within these facilities; and (c) legislation which targets individuals and firms involved in the manufacture, import, sale, purchase and distribution of drugs.<sup>33</sup>

Two general points about Sri Lanka's regulatory framework are worth noting.

#### *1) Outdated legislation*

The only Act which regulates private health care facilities, the Nursing Homes Act (1949), is no longer relevant to the market or organization context in Sri Lanka. The Act only applies to nursing homes, not the numerous private GPs and government doctors who practise privately. And since decentralization in 1987 there has been confusion over responsibility for policy implementation.

#### *2) A passive regulatory approach and aim to establish only minimum standards of quality*

Monitoring of professional conduct by professional bodies appears to be passive, with the Medical Council setting minimum standards and then waiting for complaints. The regulatory framework aims to provide minimum standards for the training of staff and the structural quality of private facilities. Process quality (e.g., prescription practices) or the consultancy and inpatient fees charged by private providers are not regulated.

### Regulation of health professionals

Medical Ordinances have established the professional bodies which give legal authority to the different medical professions to be self-regulated, and defend their interests (e.g. the Medical Council). They set the training and qualifications standards for different types of health professional (doctors, pharmacists, nurses, midwives, dentists, etc.), rules on professional conduct and rules regarding registration with the Medical Council (SLMC). Without being registered, it is illegal to practise any of the medical professions. This registration procedure, and the Medical Council's power to refuse or withdraw registration, is therefore the main regulatory mechanism which controls the quality and quantity of health care professionals in Sri Lanka, including those working in the private sector.

Other than the SLMC and the provisions of the normal law, the medical professions are largely left to themselves. It is hoped that they themselves will use peer pressure to enforce standards. Other than SLMC there is, however, no other body capable of enforcing standards. There are private sector organizations, which perform representational roles, such as the Independent Medical Practitioners Association (IMPA) and the Association of Private Hospitals and Nursing Homes (APHNH), but these rarely attempt to set standards. The College of General Practitioners does however attempt to encourage higher standards through providing formal training programs and a system of qualifications to recognize additional training in Family Medicine.

MOH informants argue that the specialists and doctors working in private nursing homes would, as professionals, ensure that standards were maintained. This culture and practice of self-regulation has advantages (Bennett et al,1994): (a) doctors and their professional organizations have relatively easy access to information about provider behavior; (b) they have the professional knowledge enabling them to regulate; (c) it is in the interests of the profession to identify impostors and those who will bring the

<sup>33</sup> This section is based on Russell and Attanayake (1997).

profession a bad name. Nevertheless, self regulation raises questions about regulatory effectiveness because the interests and objectives of the regulatory actor(s) may be similar to those being regulated.

The general observations made above suggest that the legal basis for regulating the private sector is outdated, passive and weak. Moreover, nowhere within this framework is there legislation or a forum to co-ordinate or plan the development of the private sector, which could bring together the various actors such as the MOH, IMPA, Medical College/Council etc. The MOH aims to partially address these weaknesses through a new piece of legislation to replace the Nursing Homes Act- the Private Medical Institutions (Regulation) Act of 1997.

Two regulatory policies are explained in more detail below: the Nursing Homes (Regulation) Act (1949), which is targeted at private facilities, and; the Cosmetics, Devices and Drugs (CDD) Act (1980), targeted at the private pharmaceutical market.

### **Regulation of private health care facilities**

The Nursing Homes (Regulation) Act of 1949 was legislated to regulate the private health facilities. The Act provides for the registration of nursing homes and generally for the regulation, supervision and inspection of nursing homes so registered.

The main problem with this Act is it only applies to private nursing homes, and not to private clinics or private doctors which grew rapidly in number during the 1980s. Moreover, the Act did not provide a framework for private-public co-ordination. Responsibility for implementation of the Nursing Homes Act used to lie at the highest level with the Director General of Health Services (DGHS). The DGHS could also authorize officers to carry out inspections of private nursing homes. After decentralization, official responsibility for implementing the Act shifted to the provinces under the authority of the Provincial Directors, but they were given no special units or staff to implement the Act, monitor the private sector, or co-ordinate planning with the private sector.

### **Regulation of Cosmetics, Devices and Drugs**

The Cosmetics, Devices and Drugs (CDD) Act was introduced in 1980 to regulate some of the problems created by economic liberalization, primarily through registration of pharmaceutical products. The Act has the following broad objectives:

“An Act to regulate and control the manufacture, importation, sale and distribution of cosmetics, devices and drugs, to establish a Cosmetics, Devices and Drugs Technical Advisory Committee, and to provide for matters connected therewith or incidental thereto.”

The CDD Act established the Cosmetics, Devices and Drugs Technical Advisory Committee (CDDTAC), a high level advisory committee set up to advise the Minister on drug policy. Every drug in Sri Lanka must be registered under the CDD Act by this Committee. An important sub-committee is the Drugs Evaluation Sub-Committee (DESC), which plays the key role of approving pharmaceutical products.

Implementation of the CDD Act, and the decisions of the CDDTAC and DESC, is largely carried out by the Drugs Regulatory Authority (DRA) and the national Drug Quality Assurance Laboratory (DQAL). The two key DRA divisions responsible for implementation and enforcement are:

- (1) The Registration and Licensing Division: processes the registration of all imported and locally manufactured drugs approved by the DESC; registers and provides a license (Certificate of Registration) to all relevant organizations, including drug importers, manufacturers, distributors, pharmacies.
- (2) The Enforcement Division, which is critical to the effective implementation of the CDD. Its roles include quarterly inspections by Authorised Officers (Food and Drug Inspectors) of all pharmaceutical organizations to ensure they are licensed, meet standards of hygiene etc. This includes drug importers, manufacturers, distributors, sales outlets and pharmacies. In particular inspections of pharmacies to

ensure they are licensed and do not sell prohibited and unregistered drugs. This sometimes involves surprise inspections in response to professional or public complaints about the sale of unsafe drugs or other irregularities. The Enforcement Division has 25 inspectors who visit each pharmacy in their district four times a year.

The DQAL's main functions include annual inspection of local manufacturers for Good Manufacturing Practice (GMP) certification; sampling of local products for quality control; occasional testing of imported drugs; and testing of any drug in response to complaints by professionals or the public.

Responsibility for CDD Act implementation was decentralized in 1988. Deputy Provincial Directors of Health Services are now responsible for the registration and deregistration of pharmacies and other drug sellers. The central DRA advises the provinces, and its Food and Drug Inspectors still play a prominent role in monitoring drug sellers, which sometimes generates confusion over roles.

## 7.2 MOH performance of regulatory roles

Table 7.2.a lists official MOH regulation and facilitation roles for each level of the MOH, and provides an overview of organizational performance problems in the last two columns: is the function actually performed, and how many times was a problem with performance mentioned in interviews

Key weaknesses in performance of regulatory roles include:

- (9) Weak information systems to monitor the private sector, and failure to register many private practitioners.
- (10) No policy framework or forums to allow private-public discussion or co-ordination.
- (11) Until the drafting of the 1997 Private Medical Institutions Act, the MOH had not established any clear priorities, objectives, responsibilities or guidelines for regulation of private providers.
- (12) Little done to address abuse of private practice by government doctors;

Some details of performance problems are examined below.

### Control of abuse of private practice by government doctors

No reliable data exist on how prevalent the practice is. This critical problem remains to be firmly tackled by the MOH. The 1992 PTF (1992: 113) strongly recommended policy measures which would enable "better supervision and firm punitive action to control misuse of the privilege," but no specific actions have been taken. One measure recommended was the establishment of local Peer Review Committees to inquire into alleged abuse of private practice. Again no action has been taken to set up these self-regulatory bodies.

The most recent Presidential Task Force has proposed gradual elimination of rights to private practice by 2002. However, although this has been included in the planned program of implementation, no action has been taken to date. It is unclear how feasible this is without any steps being taken to raise public sector salaries. A 1998/99 survey of MOH hospital directors revealed that most (69%) opposed the abolition of private practice rights, if compensation for medical doctors remained at current levels, but a large majority (81%) would support such a measure if compensation was raised adequately.<sup>34</sup> The problem of private practice in the public sector remains that it provides a means for public sector doctors to supplement their low salaries. Removal of that option would force many to leave the public sector to the private sector or to emigrate (as in fact occurred in the 1970s when a similar policy was implemented). Since these are likely to be the more competent and experienced staff, who have the greatest earning potential in the private sector, this would be to the detriment of the public sector, and particularly to the lower-income groups who are reliant on MOH services. However, the same survey mentioned of MOH hospital directors also found that

<sup>34</sup> Unpublished results of IPS/MOH survey of public health facilities in seven districts. Final results are expected to be published in 2000.

almost a half of those who gave an estimate believed that salaries of MOH doctors would have to be raised by more than 100% to sufficiently compensate. Given this, considerable more thought needs to be given to this problem and what is the most effective solution.

### **Implementation of the Nursing Homes Act**

The Central MOH barely concerns itself with the Act's active implementation (Table 7.1.a). Although the provinces have been responsible for the Act's implementation since 1988, very little is done in practice. The law does not cover private clinics or doctors, and registration procedures appear to be a formality, with no inspections to check that standards are being maintained. Overall, the Act appears to be moribund. In the past it has been a potential stick in the hands of government that could be used if cases of blatant negligence were reported, rather than a proactive mechanism to ensure effective medical practice. Self-regulation by professional bodies and individuals in private facilities has been assumed to be adequate for the task of ensuring standards. Table 7.2.b summarizes MOH respondents' opinions about the Act's implementation as reported by Russell and Attanayake (1997).

Provincial informants argue that people keep 'their ears open' for cases of severe malpractice, but feel the Act was no longer relevant to the needs of the provinces anyway, since it did not cover the numerous private GPs operating in the towns, nor government doctors who run their own clinics. Finally, at the divisional level the regulatory functions envisaged for DDHSs are not actually being performed (Table 7.1.a).

### **Implementation of the CDD Act**

Government performance of pharmaceutical regulation received less criticism, but is still weak in some areas. According to a senior official in the MOH:

“The weaknesses (of pharmaceutical regulation) are rooted mainly in the implementation and monitoring aspects. The implementation of the drug regulations is not efficient or effective.”

In contrast, the Director of the DRA states this view is extreme and misplaced, and argues drugs and premises which sell them are mostly registered, and inspections of drug sales are regularly conducted. The DRA's Enforcement Division has 25 Drug Inspectors, one per district, and each inspector visits each pharmacy 4 times a year and sends a report to the DRA.

The main performance weaknesses appear to be:

- The DRA fails to register all premises engaged in drug selling. One source estimated that there are 500 unregistered pharmacies in the country (Dalpatadu 1995). The DRA Director qualified this figure by stating that while numerous unregistered pharmacies were known to the DRA: “it was not the practice of the DRA to deregister or take legal action hastily.” The DRA permitted unregistered pharmacies to continue sales, especially in rural areas, because they were often the only supplier of drugs in the area;
- Regulations also specify that each registered pharmacy must have a qualified and registered pharmacist on the premises, but according to the DRA head many pharmacies have unqualified personnel working on the premises, especially in rural areas. Again the justification for this situation was to maintain access to drugs:

“We cannot deny that unqualified people are selling drugs, but even if we could tighten upped the regulations, in a way we have to tolerate this. If we close them, the rural people may not be able to gain access to medicines.”

- The sale of 'prescription only' drugs listed in the Schedules of the CDD Act, is a common practice in Sri Lanka (PTF, 1992). For example:

“antibiotics - from Ampicillin to Erythromycin - can be bought over the counter from most pharmacies in our country, even though it is illegal for them to be sold without a prescription” (Sunday Times, 19/5/96).”

**Table 7.2.a: Regulation of the private sector: performance overview**

Level	Indirect provider roles	Role actually performed?	Frequency problem mentioned(n=30)
Central	Control abuse of private practice by government doctors	Y	21
	Develop information systems on the private sector	B	27
	Co-ordinate planning with private sector	N	
	Enable private sector development through incentives	JS	
	Implementation of Nursing Homes Act	B	
	Implementation of CDD Act (by the DRA)	Y	
Province	Co-ordinate planning with private sector	N	7
	Implement of nursing Homes Act	B	15
Division	Establishment of divisional health co-ordination committees	N	2
	Register all private providers	N	
	Establish information base on private providers	N	
	Co-ordinate public/private mix of health service provision at the divisional level	N	

Key: Y=Yes; N=No; JS=Just Starting; B:Barely.

**Table 7.2.b: Effectiveness of the Act in ensuring good medical standards: Views of MOH officials**

Response	Frequency
The Act did not operate in practice	(26%)
Minimum effectiveness – ensured registration	(63%)
Moderately effective – minimized malpractice	(5%)
Highly effective	(0%)

Note: Number interviewed = 19.

Despite weaknesses with private sector pharmaceutical regulation, critics also praise the government's essential drugs policy in the state sector. Essential drugs are centrally purchased in bulk from international markets by the State Pharmaceutical Corporation (SPC), and each facility level has an essential drug list. Since the 1960s, drugs in Sri Lanka have only been approved after clinical trials. The MOH has introduced modules into the medical curriculum on rational drug use, generic prescribing and essential drugs, and Guidelines for Intern Medical Officers (1994) provide instructions on rational drug use. The MOH has also made efforts to improve information dissemination through "The Prescriber" journal and the Drug Information Bulletin, published by the DRA.

### 7.3 Causes for weak performance

Observers identify several reasons for the weak performance of regulatory functions by various agencies of the government:

#### Capacity: explaining regulatory performance

The MOH's slow response to rapid private sector growth in the 1980s has made regulation or ennoblement more difficult in the future because the private sector is now larger and more complex, and provider and

user interests more established and diverse. The MOH's weak relations with the private sector can be explained by both weak organizational capacity at the MOH, and by wider social, political and economic factors beyond its control. But disentangling the web of causality to identify the precise interests, motives or explanations for this situation is difficult. For example, take perhaps the easiest function which the MOH could have performed during the 1980s, but which it did not perform comprehensively - the registration of private providers. Informants identify various reasons for this poor performance. Firstly, it could have been the weak legislative framework, which only empowered the MOH to register nursing homes. Secondly, the registration list created was likely to be inaccurate and unsustainable because the MOH does not have the human resources to constantly check and update such a database. Thirdly, senior staff did not perceive registration to be a useful exercise: the MOH could not actually use the information to improve the quality of private care, unless it could specify standards such as what constitutes good or bad medical practice, had the resources to check the standards of all private providers on the list, and the legal power to enforce these standards. Fourthly, a professional culture of self-regulation, and the fact that most private providers are government doctors, may have reduced the perceived need and pressure for registration. Finally, since the 1980s the MOH has faced difficulties in managing information from its own hospitals effectively, so the development of a new information system may have been a low priority.

### **Organizational capacity**

The bureaucratic structures and procedures of control may have contributed to the MOH's inertia in the face of private sector expansion, although precise mechanisms are difficult to identify. There may have been an inflexible attitude towards new public-private initiatives amongst senior officials, and only top level decision-makers may have had the ability or nerve to push this agenda. Within the MOH it appears there was no perceived need for an official which would facilitate public-private co-ordination: "Let the private sector get on with it" was said to be the dominant attitude during the 1980s, and may partially be explained by the fact that top government doctors earned large private incomes. However, in mid-1998, a new Director for Private Sector Health Services was appointed, although he was provided administrative resources, which appear insufficient to carry out his functions of managing the private sector.

As an organization the MOH has no overall strategy, clear objectives or practical initiatives directed at the private sector. There was until recently no unit or staff within the MOH responsible for the registration, monitoring or co-ordination of private providers, at any level of the organization. This structural weakness means the MOH has not been able to develop its staffing or informational capacity in this area, or to develop an appropriate strategy.

Before 1988, responsibility for regulation was centralized. This probably weakened regulatory effectiveness as explained by Bennett et al (1994):

"...regulatory capacity requires a considerable degree of decentralization, and local responsibility and authority. Private sector interests are often powerful and local health managers may have difficulty asserting authority over private providers"

Decentralization to the provinces in 1988 did not, however, improve the MOH's capacity to co-ordinate with private providers or monitor standards, because new responsibilities for policy implementation were not clearly specified. The central DRA can no longer directly intervene in pharmaceutical regulation at the provincial level, but has an advisory role; and responsibility for the Nursing Homes Act was transferred to the provinces without any new guidance;

Potential informational advantages following decentralization have not been exploited: provincial offices have not formed Co-ordination Committees or local databases on private sector activities as proposed by the PTF (1992).

### *Weak information systems*

Information is the key to better ennoblement and management of private sector activities, but the MOH has not developed them due to incapacities or political constraints: lack of resources to develop an accurate database on providers and their activities; no perceived need for information systems on the private sector;

professional self-interest; the MOH's inability to regulate private practice for fear of strikes by government doctors; and an outdated and passive policy framework.

#### *Staff numbers and motivation*

There are no staff devoted specifically to regulatory tasks at any level. Attitudes towards private sector regulation amongst government doctors is generally lukewarm. They typically feel that despite a small number of bad doctors, they are professionals who could and should be trusted:

“It would be a waste of people's time and money to go about checking on us all. We do private practice, but so what? We are professionals who need to earn a decent living, like you. If we do start to behave dishonestly, we are risking much - our job, our future, and respect.”

In relation to the CDD Act, the head of the DRA stresses that more Food and Drug Inspectors were needed to improve performance. They only have 25 inspectors, one for each district, and in some areas there are too many pharmacies and other sellers to be inspected regularly. Access to vehicles and per diems to improve inspection coverage is limited by resource constraints. Low salaries are also seen as a problem and there appears to be suspicion that inspectors are often easily 'influenced' by the pharmacist (Russell and Attanayake (1997)).

#### *Resource constraints*

An overarching constraint to MOH capacity to regulate or enable is lack of financial, and consequently human, resources. Budget constraints and strict Treasury cadre approval procedures prevent recruitment of the inspectors needed to implement the Nursing Homes or CDD Acts effectively. Financial constraints also prevent the development of information systems to improve capacity to register, monitor and co-ordinate with private providers.

#### *Weak policy content*

The Nursing Homes Act (1949) is considered to be moribund, and since the Act was introduced in 1949 no Minister has passed a Gazette through Parliament which sets standards for structural quality, medical practice, information flow from the private sector, medical fees etc. Self-regulation was largely relied upon in practice, and the maximum fine for an offence has now become nominal with inflation. The new Private Medical Institutions (Regulation) Act to be passed seeks to address some of these policy content weaknesses.

Pharmaceutical regulation policy content is less problematic. One weakness is the DRA's capacity to reduce the number of 'unnecessary' brand names on the market. This is because if the Drug Evaluation Sub-Committee (DESC) approves a substance, numerous brands of the same drug can be registered even if they are expensive or 'unnecessary'. Criteria for approval and registration for drugs is based on safety and efficacy, not price or need. The most extreme example of multiple brands is the 70 different brands of ampicillin available in the country (Weerasuriya, 1995). Although the then PTF (1992) recommended that a cost/need clause be added to the legislation, nothing has been done.

#### *Professional versus consumer interests*

As in other countries, the medical profession forms a powerful interest group and political lobby. The philosophy and practice of self regulation is dominant, and raises the potential for 'regulatory capture', which was evident in the case of private practice because senior consultants who are in a position to discipline abusers also practise privately themselves. They have a strong interest to sustain private practice, and therefore to 'turn a blind eye' to abuses unless they are extreme cases.

Weak regulation may also be explained by the Sri Lanka legal, social and cultural context, in which users have no protection by law, are poorly organised (no user forums) and have a weak voice vis-à-vis the

medical profession. The 1979 Consumer Protection Act can, in principle, be used by consumers to redress grievances concerning drug sales (i.e. a seller-buyer situation), but offers no protection to consumers against medical malpractice by private doctors (i.e. Legally interpreted as a personal service situation).

This contrasts with the situation in India, where a growing middle class are starting to exert pressure to improve protection against medical negligence. The Indian 1986 Consumer Protection Act, following several test cases, now covers private medical practice because in court it has been successfully argued that medical services are not a 'personal service' (exempted from the Act), but involve a 'contract for service' (covered by the Act). The Indian Medical Association unsuccessfully challenged this judgement in the Supreme Court (Bhat,1996). The Act also established consumer complaints forums at district, state and national levels, which have proved to be important for providers and consumers to establish standards and address concerns about interpretation of the law. For example it has been established that a mistaken diagnosis is not necessarily a negligent one; and that when things go tragically wrong it is not necessarily the doctors fault (Bhat,1996). However, it should be noted that available evidence suggests that the quality of care provided by the average full-time private practitioner in Sri Lanka, despite this lack of consumer protection legislation, may be far superior to that provided by the average private practitioner in India, indicating that other factors are also important.

## 8.1 Assessment of Efficiency

### Allocative efficiency

There are insufficient data and time to properly assess the impact on allocational efficiency of public taxation based health spending. Instead, an incomplete assessment is made by examining one crude proxy measure of allocational efficiency (Kutzin, 1995), public funding of hospital versus non-hospital based care.

It is possible to obtain an approximate estimate of the proportion of general revenues being allocated to hospital care by assuming that the 'patient care services' line item<sup>35</sup> in the health ministry budget is used to pay for hospitals. This indicates that public funds in Sri Lanka are mostly allocated to hospital care, and that the proportion is, and has been for a long time, significantly higher than in most other developing countries. Estimates by various authors also indicate that most (>75%) hospital expenditures have also been used to pay for inpatient care, as opposed to outpatient care (Abel-Smith, 1967; Simeonov, 1975).

**Table 8.1.a: Proportion of MOH expenditures devoted to hospitals**

Year	Recurrent expenditures	Capital expenditures	Total expenditures
1958	75%	NA	NA
1973	NA	NA	65%
1986	77%	59%	75%
1991	78%	86%	80%
1994	81%	58%	77%
1996	74%	-	-

*Note:* These numbers should be regarded as indicative estimates, and because of the different sources used, may not be strictly comparable.

*Source:* Owing to lack of time, secondary sources have been used instead of direct examination of MOH records, including Abel-Smith (1967), Simeonov (1975), MOH Annual Health Bulletins (various years), World Bank (1995, 1996).

Both international and Sri Lankan observers have frequently recommended reducing this proportion or to reallocate money towards non-hospital based care.<sup>36</sup> These have been repeatedly incorporated into official policy and budgetary plans, but they have never been implemented as noted by Simeonov (1975). From the perspective of the cost-effectiveness approach to resource allocation, this persistent pattern of high hospital spending is inefficient, because typically the most cost-effective types of treatment are usually delivered on an outpatient basis (World Bank, 1993). However, this simple criterion to determine cost-effectiveness overlooks another major purpose of government's financing of health care. Besides a handful of examples such as prevention, maternal and child health, and essential drugs, modern medicine is not particularly efficacious. Hence, much of the function of government hospital spending was not to improve health (or increase DALY's), but in effect to provide insurance for the population.

Over the past few decades, per capita incomes have risen considerably so that fewer Sri Lankans today live on the edge of subsistence. Yet although the health benefits of much hospital treatment would have significantly improved, the cost of such care remains expensive for most households. So the continued social demand for hospitals reflects a need for insurance provision, which remains unmet by the commercial insurance market. The concentration of government funding on hospital care may serve to

<sup>35</sup> In previous years equivalent to the 'medical services' line item.

<sup>36</sup> The World Bank has been remarkably consistent in that successive missions to Sri Lanka from the very first Bank mission to Sri Lanka in 1951 have made recommendations along these lines (International Bank for Reconstruction and Development, 1953) (World Bank, 1984).

improve social welfare more than spending it on more cost-effective ambulatory care, which many Sri Lankans already pay privately for. If this is the case, then the emphasis on inpatient care in the government budget may well be allocatively efficient.

In their regression analysis of cross-national health status in 1990, Govindaraj and Rannan-Eliya (1994) examined which countries do best in terms of their positive deviation from expected health status controlling for income level. In Asia the best four performers overall were in descending order Japan, Sri Lanka, Hong Kong and China. This suggests either that the latter three achieve their exceptional health indicators despite seriously mistaken government allocation patterns, or that these same allocation patterns are inextricably linked to their superior health achievements.

### Technical efficiency

Availability of data and study resources do not allow a proper assessment of technical efficiency of taxation funded health services in Sri Lanka. The predominance of hospital services in the public sector means that efficiency in the hospital system is reflective of overall system efficiency. From an international perspective, the Sri Lankan MOH system is highly efficient in its use of physical and human resources, whichever set of indicators are used.

Tables 8.1.b and 8.1.c provide show the levels and range in inputs, outpatient visits delivered, admission rates and unit costs at various levels of the MOH delivery system in four districts in 1992. Results from the recent IPS/MOH Public Facility Survey are not yet available, but provisional data indicate that unit costs were lower in 1997, and throughput indicators had increased. As can be seen high occupancy rates, often in excess of 100%, and minimal staffing levels are the norm at all except the lowest levels. At the lowest levels occupancy rates are low. This suggests that there may be a possibility of resource savings through facility rationalization and shifting of personnel and resources to higher level facilities where demand is greatest. However, the overall benefits in reducing pressure on higher level facilities will be modest, since only a small portion of MOH resources is allocated to the lowest level facilities.

**Table 8.1.b: Unit costs in public sector facilities at different levels in four districts, 1992**

	Outpatient visits (rupees)			Admission (rupees)			Bed-day occupied (rupees)			N
	Mean	Min.	Max.	Mean	Min	Max.	Mean	Min.	Max.	
Teaching hospital	100	31	374	1,980	981	5,033	333	126	772	8
Provincial hospital	37	37	37	930	931	931	218	218	218	1
Base hospital	68	29	143	379	208	473	105	47	181	3
District hospital	25	8	28	791	155	6,469	96	31	187	15
Peripheral Unit	14	5	44	395	146	859	196	47	249	21
Rural hospital	14	6	30	471	215.5	702	142	50	294	17
Maternity home and Central dispensary	17	5	65	976	316	1,902	569	58	967	13

*Source:* IPS analysis of data from MOH/IDA 1992 survey of all public sector facilities in Colombo, Galle, Matale and Polonnaruwa.

*Note:* More recent cost estimates for 1997 from a larger cross-section of facilities in all eight provinces will become available in mid-2000, when results of the IPS/MOH survey of public health facilities are released.

**Table 8.1.c: Admissions and bed-occupancy rates in public sector facilities at different levels in four districts, 1992**

	Average bed-occupancy rate			Average number of admissions per year			N
	Mean	Minimum	Maximum	Mean	Minimum	Maximum	
Teaching hospital	96.9	62	183	40,734	1,824	139,104	8
Provincial hospital	149.3	149.3	149.3	29,892	29,892	29,892	1
Base hospital	98.6	73.2	136.9	36,204	32,232	38,268	3
District hospital	105.4	43.9	149.1	6,998	2,220	10,608	15
Peripheral Unit	57	30.4	94.3	4,083	0	7,908	21
Rural hospital	59.2	15.3	109.9	2,058	0	4,332	17
MH/CDs	5	0	13.4	189	0	600	13

*Source:* IPS analysis of data from MOH/IDA 1992 survey of all public sector facilities in Colombo, Galle, Matale and Polonnaruwa.

This high throughput is not associated with higher levels of staffing intensity. Tables 8.1.d – 8.1.f compare the overall staffing ratios in the Sri Lanka system in 1991-97 with data for public hospitals in other developing countries in recent years for which data were available. Countries have been ranked by staffing ratios for each type of indicator. The Sri Lanka numbers are based on aggregate system-wide numbers and therefore overestimate the staffing per bed within hospital facilities, as not all staff are employed in hospitals. As can be seen, Sri Lanka's tax-funded hospital system uses staff and available beds more intensively than other countries. Moreover, on an activity-weighted basis, productivity in the use of staff and bed resources increased significantly during the 1990s from already high levels.

**Table 8.1.d: Staffing ratios in public hospital systems for selected countries**

Physicians per bed			Bed-days per staff		
Country	Year	Ratio	Country	Year	Number
Bangladesh	1997	0.1	Fiji	1987	176
Niger	1986-87	0.1	Indonesia	1985	193
Papua New Guinea	1988	0.1	China	1986	195
Colombia	1979	0.2	Jamaica	1985-86	211
Fiji	1987	0.2	Belize	1985	224
Jamaica	1985-86	0.2	Papua New Guinea	1988	283
Sri Lanka	1991	0.2	Bangladesh	1997	290
Indonesia	1985	0.6	Sri Lanka	1991	324
Dominican Republic	1989	0.9			

*Source:* Barnum and Kutzin (1993) and IPS database as reported in Rannan-Eliya and Somanathan (1999).

*Note:* Comparisons are given for non-tertiary level hospitals. More recent data for Sri Lanka will be available from ongoing IPS Public Facility Efficiency Study in early 2000.

**Table 8.1.e: Occupancy rates in public hospital systems for selected countries**

Level I hospitals			Level II & III hospitals		
Country	Year	Rate	Country	Year	Rate
Colombia	1980	73	Colombia	1980	57
Indonesia	1985	75	Rwanda	1984	58
Tunisia	1989	76	Ethiopia	1983-85	59
Jamaica	1985	79	Sri Lanka	1991	64
Papua New Guinea	1988	80	Sri Lanka	1997	65
Fiji	1987	83	Jamaica	1985	66
Niger	1986-87	87	Papua New Guinea	1988	67
Zimbabwe	1987	89	St.Lucia	1986-87	74
China	1986	94	Bangladesh	1997	79
Sri Lanka	1991	96	Zimbabwe	1987	79
Sri Lanka	1997	95	China	1986	89
Bangladesh	1997	110	India (AP)	1990	93

*Source:* Barnum and Kutzin (1993) and IPS database as reported in Rannan-Eliya and Somanathan (1999).

*Note:* Level I category refers to higher level hospitals, and Level II category to more basic facilities. Indian figures are for Andhra Pradesh.

**Table 8.1.f: Bed turnover rates in public hospital systems for selected countries**

Level I hospitals			Level II & III hospitals		
Country	Year	Rate	Country	Year	Rate
China	1986	14	Papua New Guinea	1988	21
Ethiopia	1983-85	15	China	1986	21
Bangladesh	1997	47	Jamaica	1985	32
Tunisia	1989	28	Indonesia	1985	33
Indonesia	1985	29	Belize	1985	38
Papua New Guinea	1988	29	Colombia	1980	41
Bangladesh	1997	30	Zimbabwe	1987	44
Jamaica	1985	35	Malawi	1987-88	47
Colombia	1980	38	Fiji	1987	48
Zimbabwe	1987	42	Lesotho	1985	55
Fiji	1987	42	India (AP)	1990	56
Lesotho	1985	51	Sri Lanka	1991	57
Sri Lanka	1991	65	Sri Lanka	1997	63
Sri Lanka	1997	71	Bangladesh	1997	77

Source: Barnum and Kutzin (1993) and IPS database as reported in Rannan-Eliya and Somanathan (1999).

In general, tax-funded health services in Sri Lanka have very low unit costs, both in absolute terms and in international comparison. The reason appears to be high levels of utilization coupled with intensive use of available staff and beds. Moreover, the system trend is towards even more intensive use of available resources during the 1990s, indicating that organizational incentives are conducive to achieving productivity improvements. However, those incentives are not well understood.

## 8.2 Assessment of quality

A basic assessment of health care quality for low income countries can be done by examining the availability of trained medical professionals, drugs, and supplies. These structural components of quality are all readily available in Sri Lanka's health care system. However, more advanced quality assessments would incorporate reviews of technical quality (e.g., treatment processes and clinical outcome measures).

It is not possible to directly assess the actual technical quality of clinical treatment provided in MOH facilities owing to lack of data. However, one indication of the quality of curative treatment provided can be judged from the following. In 1991, public hospitals reported 121,439 admissions for malaria, of which 93 resulted in death. These numbers are unreliable due to incomplete reporting of notifiable diseases, and so the implied case fatality rate of less than 0.1% may be an overestimate. This case fatality rate is highly commendable, and indicates that public health facilities are relatively effective at providing the correct treatment in an appropriate manner, once patients present themselves.

### *Satisfaction with services*

According to recent polls, Sri Lankans are generally satisfied with the services available from most providers. Satisfaction with MOH facilities is higher than for other facilities amongst those who had actual experience of use. User dissatisfaction is greatest for those who use private providers (Table 8.2.a).

**Table 8.2.a: Satisfaction with services available at different providers**

Health service provider	Very satisfied		Not satisfied	No experience	N
		Satisfied			
Government health facilities	18	54	27	1	2,273
Private clinics	11	54	26	9	2,223
Private hospitals	12	44	26	17	2,210
Pharmacies	9	47	30	15	2,071

Notes: Total number of people interviewed was 2,312.

Source: IPS Health Policy Programme/Research International 1995 opinion poll carried out in all parts of the country except for Northern Province.

Dissatisfaction with MOH facilities increases from 16% amongst those with no education to 41% amongst those who have an incomplete university education. The richest Sri Lankans (38%) have higher levels of dissatisfaction than the very poor (21%), but satisfaction with private facilities displays the opposite pattern, with poorer and less educated people being more dissatisfied than average. When only those who use private clinics and hospitals are examined, there are no major differences by education and income level. This suggests that dissatisfaction with private facilities amongst poorer Sri Lankans may be related to problems of cost.

**Table 8.2 b: Satisfaction with services**

Service	Satisfied (%)	Not Satisfied (%)	No Answer (%)
Doctors	48	51	1
Nurses / hospital staff	46	53	1
Availability of medicine / beds	42	57	1
Electricity	57	41	2
Condition of Roads	45	54	1
Transport Facilities	47	52	1
Law / Police	53	46	1
Credit Facilities	33	64	3
Agricultural Subsidies	22	74	5
Garbage Collection / Cleaning	26	69	5
Other Municipal Services	25	68	6

*Source:* Opinion poll by Research International in March 1995. Sample: 3,500 persons

### 8.3 Assessment of equity

#### Equity in benefits

Tables 8.3a - 8.3d compare the relative distribution of public health spending for Sri Lanka and some other developing countries. As evident, the incidence of health spending in Sri Lanka generally favours the poor. The distribution of the benefits of inpatient spending has been relatively equally distributed, but the distribution of outpatient services has tended to be much better targeted, and in each case the distribution has become more favourable to the poor over time. The poorest quintiles receive a greater share of the benefits of taxation funded health spending than do the richest quintiles. This pro-poor distribution increased during the 1980s according to available data, but may have decreased during the 1990s according to provisional estimates. If the latter finding is confirmed, the reasons for this are unclear.

**Table 8.3.a: Incidence of public health spending in Sri Lanka in 1979**

Household quintiles	Ayurvedic (% of total)	Western (% of total)	Total (% of total spending)
1 <sup>st</sup> (poorest)	1	28	30
2 <sup>nd</sup>	1	21	22
3 <sup>rd</sup>	0	18	18
4 <sup>th</sup>	1	18	18
5 <sup>th</sup> (richest)	0	9	9

*Source:* Authors' estimates derived from Alailima and Mohideen (1983)

**Table 8.3.b: Incidence of public health spending in Sri Lanka in 1992**

Household quintiles	Outpatient services (% of total)	Inpatient services (% of total)	Combined (% of total)
1 <sup>st</sup> (poorest)	28	22	24
2 <sup>nd</sup>	23	20	23
3 <sup>rd</sup>	20	19	18
4 <sup>th</sup>	18	21	19
5 <sup>th</sup> (richest)	10	20	15

*Source:* Authors' estimates

*Notes:* Estimated from tabulations of 1991 World Bank-sponsored household health expenditure survey. Household income measure used in this survey does not allow direct comparison with the incidence estimates for other years.

**Table 8.3.c: Incidence of public health spending in Sri Lanka in 1996/97**

Household quintiles	Outpatient services (% of total)	Inpatient services (% of total)	Combined (% of total)
1 <sup>st</sup> (poorest)	21	20	20
2 <sup>nd</sup>	22	20	20
3 <sup>rd</sup>	21	19	20
4 <sup>th</sup>	19	23	22
5 <sup>th</sup> (richest)	17	19	18

*Source:* IPS Health Policy Programme provisional estimates using tabulations provided by Central Bank from Consumer Finance Survey 1996/97, as part of work being carried out for preparation of Sri Lanka National Health Accounts (SLNHA).

*Notes:* These are provisional estimates using limited data. More reliable data will be available when SLNHA estimates are released in mid-2000. Note that CFS 1996/97 did not survey Northern Province and most of Eastern Province, which contain predominantly persons in the lower income deciles, so figures understate relative incidence on poor.

**Table 8.3.d: Incidence of public health spending in selected countries**

	Year	Share of subsidy (%)	
		Poorest quintile	Richest quintile
Sri Lanka	1991	30	9
Brazil	1985	17	42
Jamaica	1989	30	9
Indonesia	1989	12	29
Malaysia	1989	29	11
Vietnam	1992	12	29
Kenya	1993	14	24
Ghana	1992	11	34

*Source:* Authors estimates based on Alailima and Mohideen (1983), Demery et al (1995), and authors' estimates.

## Equity in financing

More than 95% of all government revenues are collected by central government. They are derived from three main sources: (i) direct taxes on individuals and companies, (ii) indirect taxes consisting of sales and excise taxes and trade taxes, and (iii) non-tax revenues consisting of income from state corporations, lotteries, etc. The broad structure of government tax revenues has shown considerable stability since the 1930s, when direct taxes on income were first introduced, although it has shown significant slippage in recent years. The amount of resources mobilized through the tax system as a percentage of GDP has gradually risen from approximately 15% of GDP in the 1930s to 25% of GDP in the 1990s, but has fallen during the late 1990s to 16-18% of GDP.

The authors of this report were unable to locate any study on the incidence of direct taxes in recent years, and so no empirical assessment is attempted here. The only significant increase in the contribution of direct taxes took place in the early 1930s, when the introduction of universal suffrage led to the introduction of income taxes. The incidence of public taxation is thus closely related to the incidence of indirect taxes, which have always accounted for the bulk of general revenues.

Indirect taxes consist in the main of two types: (i) trade taxes, which are import and export duties, and (ii) sales taxes. Historically export duties were the principle source of government revenue, and their incidence was seen to fall directly on plantation owners, as they were unable to pass on the duties to their customers, operating as they were in a global commodity market in which they were price takers. Since the plantations were owned by foreign and domestic capital, these taxes could be regarded as being progressive at the margin (Indraratne, 1992). However, in the long run it is debatable how progressive these taxes were, as they acted to reduce foreign investment in the estate sector and thus reduced growth of estate employment and national exports. To the extent that lower employment growth and reduced economic growth, because of foreign exchange scarcities, hurt the poor the most, it is reasonable to conclude that the ultimate incidence of these export duties bore most heavily on the poor (Moore, 1990).

Trade liberalization from the late 1970s, and the increased acceptance by policy makers of the importance of export-led growth and the virtual bankruptcy of the nationalised plantation sector from the late 1980s have led to a shift in the composition of indirect taxation towards domestic taxes on goods and services. This has led to an increase in the regressiveness of indirect taxes (Indraratne, 1992). Indirect taxation in Sri Lanka is regressive in that the ratio of indirect tax to income decreases with increasing income. Nevertheless, wealthier households do pay more indirect taxes overall. In comparison to developed countries, indirect taxation in Sri Lanka is not markedly more regressive (indirect taxation in Italy is more regressive), but overall taxation is much more regressive. This is not because of less regressive indirect taxation, but primarily because of greater reliance on more progressive direct taxes in the developed countries.

### **The net benefit**

Government health spending in Sri Lanka does perform a redistributive function, and is important for the poor. For the poorest groups, government health spending represents the equivalent 6-10% of their gross consumption before receipt of subsidized services. Even if the taxation system is regressive, redistribution of resources to the poor will still occur because of the skewed distribution in use of government health services.

### **Geographical distribution of government services/expenditures**

Sri Lanka is relatively small and densely populated, and until recently a good public transport system has ensured that most rural people have ready access to health facilities in urban centers. Nevertheless, immediate access to basic health services is good, since there is a dense network of government facilities in all rural areas, which means that most rural people live within 5-10 km of a peripheral health facility. Practical evidence of this good access is provided by the lack of an obvious difference in utilization rates between urban and rural households. There are still pockets where good access is not the case, but these appear to be generally few, with the exception of the uncleared areas in the North and East where provision of government health services is disrupted by the ongoing internal war.

### **Geographical equity**

Although there is a concentration of health personnel in Western Province (which contains Colombo), the disparities in other provinces do not appear to be great. In the long run, there appears to have been considerable stability in the spatial distribution of MOH resources in different parts of the country. The patterns observed in the 1930s continue to persist over time. However, it should be noted that the disparities observed are not as great as in many other developing countries, for example in the Indian states or Chinese provinces. There is also some evidence that these disparities may even have reduced during the 1980s and 1990s, and while the relative ranking of provinces shows little change, the relative differences between provinces have clearly reduced.

The only exception to these positive trends appears to be the distribution of personnel in the North and Eastern Provinces, which has clearly deteriorated in recent years. In the mid-1980s, these two provinces ranked second and fourth in the provision of doctors; they had the lowest rankings by the mid-1990s. One

of the unfortunate consequences of the separatist conflict being currently waged by LTTE rebels has been the relative deprivation of these two provinces over time, as MOH personnel have been reluctant to serve in unsafe areas for understandable reasons.

That the level of personnel in the two provinces has not fallen even lower in absolute terms is largely due to the coercive powers of the central health ministry, which has been able to appoint doctors even to undesirable postings. Sri Lanka has regulations in effect which require junior medical graduates to serve a minimum time period in rural and peripheral postings before permitted to enter private practice or take higher level appointments in the public sector. These regulations are enforced in practice, and it is extremely difficult, if not impossible, for individual doctors to change their postings through use of personal influence or bribery, or to simply ignore central MOH instructions with impunity.

## **8.4 Problems and Challenges**

While Sri Lanka can be proud of its achievements, the nation also faces several major problems in its health sector. They include underfunding of health care, confused macro-organization of health care financing and delivery resulted from devolution, lack of overall health sector policy, severe shortage of nurses and specialists, over-supply of physicians on the horizon, and arcane management practices.

### *Underfunding*

The government had not been able to increase its funding sufficiently to keep pace with changing epidemiology, increase in population and medical progresses. This is evidenced by the severe shortage of speciality services, overcrowded hospitals with a more than 100 per cent occupancy rate constantly, and hurried medical staff who have to treat more than 10 to 15 patients per hour.

The system is over-stretched. There are little resources available (human and financial) to improve the quality of patient services. It will require substantial infusions of additional funding and human resources to reduce pressure on overworked staff, reduce overcrowding and to improve quality and reduce the waiting time. New resources also needed for management capacity building which is a necessary precondition in order to improve the current system without damaging the strength of the existing system.

Insufficient government funding for public health services had also kept physician salary very low as compared to what other professionally trained persons can earn in the private sector. As a result, there was a high probability of large exodus of the best doctors and specialists to the private sector. In order to retain them, the government gave public sector physicians the privilege to do private practice in their off-duty hours. Removal of this concession, which may be desirable from the perspective of improving public sector quality, will not be possible without significant increases in staff salaries.

### *Confused and fractured macro-organization*

In 1987, a foreign power forced Sri Lanka to decentralize the central government's power to provinces. Understandably so, it was implemented reluctantly and half-heartedly which resulted in considerable ambiguity and lack of clarity. For example, while the responsibility for health care delivery was decentralized, the central government's revenue was only partially redistributed and so was the power to tax. At the same time, the central government continues to control physician assignment, disciplines and promotions. Meanwhile, the provinces have only a few managerial positions and almost no qualified persons to take on the new responsibilities and exercise the newly acquired power. After a decade of devolution, provinces have extremely limited capacity to plan, manage and monitor health services for both financial and human resource reasons. Also information systems hardly exist to provide the information necessary for provincial level management.

Decentralizing the power to manage medical personnel would create a problem which needs to be addressed. If each province was responsible for attracting, recruiting and paying its own medical cadres,

then either provinces would have had to compete against each other for the limited number of doctors, placing poorer and less desirable provinces at a great disadvantage, or the subsidy for the less desirable provinces would have had to be increased in order to allow them to compete effectively with the more desirable provinces.

#### *Arcane management practices*

The Ministry of Health still uses command and control approach in planning and management of the financial and human resources. The current system largely runs on rules, norms and procedures, thus it lacks the capacity to think through, plan and implement major system changes to keep the health sector apace with economic development and people's needs and demand.

The private sector is important in the provision of ambulatory care, with a 50% market share. However, there is no consistent or coherent policy framework for the private sector, no mechanisms for regular consultation with the private sector, and a weakened capacity for regulation. Decentralization in 1987 made private sector registration a provincial responsibility, but no additional resources were given the provinces. Little resources have been given to the central government to develop and implement private sector regulation.

#### *Lack of Policy and Planning for Human Resource*

Sri Lanka has a severe shortage of trained nurses. A significant percentage of authorized nursing posts are unfilled. The nation also has an inadequate number of specialists. The demand for specialty services far exceeds the supply. Meanwhile by year 2000, the expected number of medical school graduates will exceed the internship slots available. In less than a decade from now, Sri Lanka will have an over-supply of physicians. These problems are the result of dividing authority between two ministries. The Ministry of Education is responsible for medical education, and Ministry of Health is responsible for clinical training and placement of physicians.

The major concern is the impending entry of new medical graduates into the private practice. As many of them would have had minimal supervised clinical training, they can do harm to patients when they enter into private practice without organized supervision.

#### *Lack of Overall Health Sector Policy*

Sri Lanka has no policy as the respective roles of public and private sectors in health care financing and delivery. The government has, de facto, adopted a laissez-faire policy toward the private sector. The only active government intervention to date in the private sector is the provision of tax incentives to private hospital investors by BOI. There has been little assessment of the scheme, but some limited survey results indicate that hospitals which received BOI support are more capital intensive, and that there may be the beginnings of cost inflation in the private sector due to over-investment in high-technology equipment.

Currently, the public hospitals are already affected by the new technology installed in the private hospitals. First, the public hospitals want to maintain their reputation by purchasing the same or better medical equipment. Of course, these new technologies can only be used properly by specially trained physicians. Thus, more and more specialists have to be trained and employed. So the medical arms race and expenditure inflation will accelerate. Second, more public sector specialists are now drawn to practice in these private hospitals. They spend less time for patient care in the public hospitals. Also, most public sector specialists want to be assigned to the few largest cities where the private hospitals are located which will further exacerbate the shortage of specialty services in the provincial cities.

## 8.5 Presidential Task Force

In January 1998 the President of Sri Lanka appointed a Task Force on Health Policy (PTF) to recommend how to respond to the changing demands on the health care system. Seven main recommendations were the result. In developing recommendations, the Task Force followed the principle that the health sector “should *respond* to the existing and emerging health needs of the community and ensure *equitable* access to health care of acceptable quality in an efficient and effective manner.” (PPHSF, 2, italics added) This statement suggests that the task force believes the health sector should *change* and *adapt* in response to newly-emerging conditions, needs, and demands. This also implies that it believes that the *equitable* distribution of health care to the people should take precedence over the quality and manner of provision of health care. The PTF made eight major recommendations (Presidential Task Force, 1997):

The eight recommendations are as follows:

- 1) Reform the organizational structure to improve efficiency and effectiveness, especially in the context of devolution.

Devolution has resulted in a blurring of responsibilities and accountability between the central and local governments. Reform of the organizational structure on three levels—national, provincial, institutional—would clarify channels of accountability and responsibility, resulting in a more efficient allocation of resources.

On the national level, a National Health Commission (NHC) would be established. The NHC would have representation from the Provincial Councils, and would be an independent policy-making body formulating national and provincial health policy and strategy. It would be staffed by persons of the highest caliber and would serve as an advisory to the Ministry of Health (MOH); mechanisms would be in place to ensure that their advice is not ignored without adequate reason being announced. The MOH would set national guidelines for the implementation of policy. It would also maintain standards for health service. The MOH would be staffed by experienced medical administrators and others specialized in policy management. The Department of Health Services (DOHS) would provide at a national level those services which, due to economies of scale or technical reasons, cannot be provided at a provincial level. It would also set policies and standards regarding drugs and equipment, as well as channeling resources to provider institutions in the provinces.

In a continuation of devolution, more accountability and responsibility would be given to individual provinces and provider institutions. The provincial Ministries of Health would be replaced by Provincial Health Authorities (PHA). PHAs would NOT directly administrate provider institutions, but would allocate to them financial, human, and material resources based on the guidelines and policies decided by the NHC and the MOH. PHAs would also conduct health planning for the area. On the institutional level, Boards of Management (BM) would be created at all major hospitals as well as at some clusters of hospitals and institutions. These “front-line” management structures would receive increasing autonomy and responsibility, e.g. responsibility for all personnel management functions, including (gradually) recruitment.

These organizational reforms would be implemented in a pilot province. The experiences gained would be used to replicate this structure in other provinces.

- 2) Establish mechanisms to provide care based on needs, set priorities and resource allocations equitably.

Currently the budget for health facilities is set by giving an incremental increase to the prior year’s budget. This system tends to perpetuate any existing inequities. The PTF recommends rationalizing resource allocations, basing them on needs, fund utilization, and performance. The precise method of prioritizing would be left to each province. Non-medical issues would be considered when prioritizing, e.g. “degree of inequities” and “humaneness of care.” A hospital could then choose, for example, to prioritize a value-based issue (e.g. providing waiting halls for visitors from distant areas) over a medical one (e.g. provision of an intensive care unit).

- 3) Increase accountability and responsibilities of provincial governments, health institutions, and individual providers.

Quality of care is deteriorating in some institutions and for various types of health providers. Reasons suggested include private practice by state sector health professionals, political interference, lack of explicit guidelines and standards for care, and inadequate institutionalization of quality assurance. The PTF recommends appraisal of personnel and institutions, establishment of Quality Circles in institutions, and development of clinical guidelines by medical staff.

Patient care would be used as the basis for evaluation of the performance of health providers. Doctors, nurses, and other health professionals would be responsible for such things as ensuring patient satisfaction, treating patients with dignity and empathy, maintaining good documentation, and maintaining good rapport with other members of the patient care team. These outcomes would be assessed by other medical professionals in the hospital who will act as Appraisers. Appraisals of each institution as a whole would also be made by Hospital Development Committees consisting of representatives from the institution's staff as well as members of the surrounding community.

- 4) Develop alternative financing mechanisms, including resource sharing between private and public sectors, and between allopathic and non-allopathic sectors.

The PHAs would map the needs, services, and resources of the public and private, allopathic and non-allopathic sectors, using a community-based, institutionalized Information Management System. Methods used would include epidemiological research and collection of data from health providers, hospitals, and dispensaries. "Sentinel" sites would be identified for collection and quality control of all data. Supervision of health needs information gathering would be the responsibility of the Planning Unit in each provincial MOH.

Human, financial, and physical resources would then be developed accordingly to produce a comprehensive service of adequate quality, which ensures equity of access to care. Allocative mechanisms at all levels would include equity of access as a criterion in decision-making. For example, consideration of indices such as allocation to providers/institutions based on a per capita basis would allow resources to be allocated to the neediest areas. Resources and health policies would also be developed in a coordinated fashion so that they are complementary across provinces.

- 5) Improve preventive and curative services to populations of special need (e.g. the elderly, disabled, victims of war and conflict, occupational health problems, health of schoolchildren, mental distress).

Currently, the non-profit sector (NGOs and community organizations) provides most of the caring for persons with special needs. Private sector provision is limited to the few who can afford it. The goal is to develop a comprehensive system to pool the resources of NGOs, social services, and the public and private sectors to meet needs for these populations. A pilot program would be conducted in five districts to assess community needs and health service requirements in these areas, and to implement pilot interventions accordingly. These pilot projects would then be extended to the rest of the country, and the necessary provider networks, organizational structures, human resources, and financing strategies would gradually be developed.

Health services and outcomes in the estates (plantations) continue to lag behind those in other sectors. Existing facilities and health needs would be assessed, then additions and upgrading of existing hospitals would be made. Health education of females and preventive health services would be strengthened.

- 6) Improve hospital services in the districts in a planned manner.

District hospitals are often bypassed because they do not have the modern medical services or perhaps the quality that patients want. Consequently, patients go to the provincial or city hospitals. This often results in overcrowding in larger city hospitals. To improve hospital services in the districts, one hospital in each district will be identified for upgrading over a period of 5 years.

- 7) Develop health promotional programs using formal education system and the media.
- 8) Rationalize human resource development and emphasize career development.

There are concerns of the quality of health providers, especially attitudinal aspects and communication skills. The PTF recommends:

- a) Develop planned human resources development for identifying the needs and training of health professionals.
- b) Devolve personnel recruitment and deployment to the provinces.
- c) use a more contractual arrangement for recruitment.
- d) Promote the teaching of communication skills, caring of patients, and professional attitudes in the training institutions.

## 9. NEXT STEPS

In sum, Sri Lanka's public health services are *severely underfunded*, bringing to question the ability of the system to sustain itself in the face of a growing population, changing epidemiology and medical progress. There exists *no coherent health policy framework that addresses the roles of the public and private sector roles* in the financing and provision of health services. It is imperative that these two issues are addressed. Sri Lanka must develop broad strategies for financing and provision of health care, and rationalize the roles of the public and private sectors. The nation needs to develop a concrete plan to provide adequate financing for its health services.

The PTF made extensive and serious efforts to evaluate the problems and challenges facing Sri Lanka. The task force was able to identify a number of major problems as well as set forth a set of health priorities, such as equitable distribution of health care. The PTF devoted a substantial effort and made major recommendations in the following areas:

- rationalize the organization of health care delivery by restructuring the MOH and devolving responsibilities and power to provinces and institutions;
- modernize the public management of health institutions;
- upgrade selected district hospitals.

While the above specific recommendations could improve the health care system in Sri Lanka, what is also needed is an overarching strategy for Sri Lanka to deal with issues of under-funding and appropriate public-private mix. In our preliminary analysis, we did not find inefficiency to be a major problem in Sri Lanka. Therefore, re-organization and improved management as recommended by the PTF (Presidential Task Force; Presidential Task Force on Health Policy Implementation, n.d.) may not yield measurable positive results. In some other areas, however, Sri Lanka may want to pilot some of the recommendations.

This preliminary report has major shortcomings. We had limited time and a very small budget to prepare the report. As a result, the decision was made to base this preliminary assessment on existing data rather than attempt to conduct primary data collection. As a result, there are several major data gaps. They need to be filled in order to provide a comprehensive and in-depth sector assessment so that Sri Lanka can develop sound strategies to strengthen the health care sector and transform it gradually to meet the future needs of the people. These studies should be designed largely by international consultants but conducted by subcontractors in Sri Lanka. The studies needed include:

- (1) **Study of the industrial organization of the private sector financing and provision of health services.** This study should include an analysis of the factors that influence patients' demand for private sector services.
- (2) **Detailed analysis of the current funding for public sector health care.** This study should include an evaluation of the current resource allocation criteria, and an assessment of the projected financial gap between government's capacity and its ability to fund future requirements.
- (3) **Study to develop several viable financing options to sustain the delivery of adequate health care in the future, including social insurance.**
- (4) **Detailed analysis of the current organization, staffing and management of public sector health services.** This should include an assessment of the institutional and human resources requirements that have to be put in place to improve the organization and management of public sector health services (including the option of implementing devolution).
- (5) **Analysis of the potential human resources requirements in the health sector and strategies to meet them.**

- (6) **Study to provide a preliminary evaluation of the quality and efficiency of the current health care system**, and to develop several options for improvement.
- (7) **Evaluation of the resource allocation, organization and management of preventive, promotive, and community care**, and development of options to improve them, particularly to meet the future needs and conditions in Sri Lanka.

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