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Chapter 6
Challenges to Health Financing in a Post-conflict Environment

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6. Challenges to Health Financing in a Post-conflict Environment

6.1 Introduction

Despite being subject to a prolonged conflict, Sri Lanka continued to do well in terms of its health outcomes in relation to its per capita income and level of social development. Publicly-funded health care services played a major role in this achievement, accounting for 97 per cent of inpatient care, 55 per cent of outpatients' services, and the bulk of preventive and public health services. The key priorities with regard to the health care system in general include ensuring good quality care that meet the expectations of the professionals and the needs of the people on one hand, and improving the equitability of access to health care services. However, in the post-conflict era, health care delivery is facing the twin challenges of maintaining the existing free health care service while restoring the severely damaged health system in the conflict-ravaged areas of the Northern and Eastern Provinces.

There are increasing numbers of deaths in Sri Lanka from diseases characteristic of later stages in the epidemiological transition, such as ischaemic heart disease, cerebrovascular conditions and lung cancer. There is also a recent resurgence in deaths from dengue, a high rate of malnutrition among children, and rising incidence of malaria. Some of these factors, more heavily concentrated in the North and East (N&E) of the country, reflect the consequences of the conflict which has severely disrupted the normal functioning of health care institutions, than a failure in the system as a whole.

Although Sri Lanka's health system has, and continues to do well in efficiency, effectiveness and equity in the use of public expenditures, improvements to equitable access to health services and risk-protection against diseases will require an increase in public expenditures. As the conflict imposed its own fiscal pressures, decades of expenditure constraints have left Sri Lanka's health care system with a diminishing ability to manage such changes. The lack of social safety nets to protect the affected populations from catastrophic incidents will compound this predicament further. This Chapter attempts to highlight some of the key policy challenges facing the health sector in its attempts to bring together a functioning national health system in the conflict-affected areas, while dealing with the problems arising from underinvestment in the publicly funded health system in the country as a whole.

6.2 Health Status and Challenges to the Health System in Sri Lanka

There have been several major reviews of Sri Lanka's health sector in the past five years, the most recent one being the Health Master Plan (HMP) commissioned by the World Bank and Japan International Cooperation Agency (JICA) which covered the period 2000-03. Accordingly, as stated in HMP, Sri Lanka's health system has and continues to do well. Efficiency, effectiveness and equity in the use of public expenditures for health have played a major role in this achievement. It has been able to do this through continuous and incremental organizational change over several decades.

6.2.1 Health Status

Sri Lanka has health indicators which are more akin to an upper-middle income economy than to a developing country. By 2008, despite an income level of US$ 2,000 per capita, Sri Lanka - excluding the N&E - had reduced its infant mortality rate to 11.3, its child mortality rate to 11 per 1,000 live births, its total fertility rate to below replacement level at 1.9, and raised its life expectancy to 75 and 72 years at birth for women and men, respectively. Controlling for its levels of income, education, nutrition and sanitation, Sri Lanka continues to perform far better than average for the Asia-Pacific region, for instance, in terms of health outcomes. An increasing body of evidence indicates that this is directly linked to a superior performance of both curative and preventive health services delivery in the country.[1]

Although Sri Lanka has achieved remarkable standards in health care, more government health care spending would be needed as Sri Lanka has an ageing population that will require attention on non-communicable diseases and certain communicable diseases. Malnutrition, urbanization and changing lifestyles are beginning to challenge the country's health sector. Chronic non-communicable diseases mortality rate in Sri Lanka is 20-30 per cent higher than in many developed countries. Cardiovascular diseases, diabetes mellitus, chronic respiratory diseases, renal diseases, and cancer are the major reported non-communicable diseases. The rising trend in non-communicable diseases demands additional financing for health care, placing further demands on resources of the government. Meanwhile, the reappearance of certain communicable diseases is challenging the country's health care sector.

The outbreak of dengue in 2009 placed a serious strain on the entire health sector. The number of dengue patients has risen above 11,619 from the beginning of 2010, with the highest number of deaths (35) reported in January 2010. Accordingly, from January-April 2010, the total dengue death toll has been 67.[2]

Childhood under-nutrition has improved markedly over the past two decades, allowing Sri Lanka to maintain its status as a country with the lowest prevalence of underweight children in South Asia. However, according to aggregate trends in underweight rates (1993-2000), Sri Lanka does not appear to be on track to achieve its Millennium Development Goal (MDG) target of 19 per cent prevalence of underweight children by 2015, unless significant improvements occur in the interim.[3] Nonetheless, the country is on track to achieve its MDGs for other health indicators. When considering Sri Lanka's national income and the remarkable achievements in other health-related sectors, the nutrition indicator should have been much better. Disaggregating the rates sub-nationally shows that under-nutrition rates are much higher among the rural population, especially in the estate sector, where the prevalence of stunting and underweight children is 42 per cent and 30 per cent, respectively.

A survey of pre-school children found that the prevalence of sub clinical Vitamin A

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[1] Caldwell, J., I. Gajanayake, P. Caldwell, and I. Peiris, 1989, "Sensitization to Illness and the Risk of Death: An Explanation for Sri Lanka's Approach to Good Health for All", *Social Science and Medicine*, 28(4):365-79.

[2] Ministry of Health Care and Nutrition, Epidemiology Unit.

[3] IPS/UNDP, 2010, "Millenium Development Goals: Sri Lanka Country Report 2008/2009".

[4] Jayatissa, R., MRI, Survey on Pre-school children, in Colombo, Ratnapura, Anuradhapura, Kurunegala, Tricomalee, Jaffna, Badulla, Nuwara Eliya and Hambantota carried out in 2009.

deficiency was 36.3 per cent,[4] which is high in comparison to other countries of South Asia. Iron deficiency anemia, which is generally lower than elsewhere in South Asia, is still high at 30 per cent. Iodine deficiency disorders have almost been eliminated. The other key micronutrient deficiencies such as Vitamin A and Iron have seen a reduction across population groups, but not adequately so. However, wasting or thinness among children under five years of age has been hovering around 14 per cent. Household food insecurity, limited access to safe water and sanitation, and poor maternal and child care practices have been identified as the causes of under-nutrition in Sri Lanka. Rising income inequalities between and within regions are bound to have an impact on childhood malnutrition, which could worsen in the absence of targeted, pro-poor intervention at state expense.

6.2.2 Health Status in the N&E

Although the overall health indicators stand at satisfactory levels, the socio-economic status of conflict-affected areas are not fully reflected in the national level indicators due to non-availability of data for the N&E. According to 2003 estimates of the Registrar General's Department, the infant mortality rate in Sri Lanka as a whole was 11 per 1,000 live births, but it was 14.7 in the N&E regions in 2000, with significant variations within the region itself (Table 6.1).

International evidence suggests that the return of refugees can make greater demands on already stressed systems, and possibly bring new sources of disease to the population. Displacement is a significant factor driving inequities in health status. Internally displaced persons (IDPs) frequently have higher mortality and morbidity than populations not displaced or refugees. A study using Disability Adjusted Life Years (DALY) to assess the long term impact of conflicts

Table 6.1
Selected Health Indicators for N&E (2000/01)

	IMR[a]	MMR[b]	Low Birth Weight[c] (%)	Underweight 0-5 Years[c] (%)	Home Deliveries[c] (%)	Safe Sanitation[c] (%)
Sri Lanka	11.2[d]	14[d]	16.7	29.4	4.0	72.6
N&E	14.7	81	25.7	46.2	19.4	48.2
Ampara	10.3	24	22.7	44.1	19.8	52.7
Batticaloa	15.8	117	24.3	53.2	31.4	28.4
Trincomalee	4.6	57	30.5	44.7	13.6	25.6
Jaffna	22.3	62	30.5	43.1	4.4	79.0
Kilinochchi	27.8	158	N.A	N.A	N.A	N.A
Mannar	22.3	97	12.7	38.3	39.4	70.9
Mullativu	20.3	123	N.A	N.A	N.A	N.A
Vavuniya	8.8	76	38.8	50.6	2.3	71.0

Notes: a: Infant mortality rate per 1000 live births in 2000; b: Maternal mortality rate per 1000 live births in 2000; c: Data for 2001; d: Data for 2002.

Source: Ministry of Health, *National Health Bulletin*, various years; and World Health Report 2002.

that occurred during 1991-97 found that, as compared to a conflict free country, the loss of healthy years of life for girls under the age of five was 28.5 years per 100 girls.[5] That figure increased for extreme cases, such as Rwanda, to 53 years lost per100 children. Further, this reduction in healthy life years was associated with malaria, tuberculosis, respiratory infections, and other infectious diseases. Another study using WHO Health Adjusted Life Expectancy (HALE) on armed conflict found that each additional conflict a country experiences reduces the number of healthy years of life of its population by seven months.[6]

In Sri Lanka too, with the return of IDPs, key indicators including infant, child, and maternal mortality rates may remain at the conflict-time levels, or even increase as water, power, electricity and sanitation services remain severely strained, clinics remain damaged or unstaffed or understaffed, where health prevention programmes have been stalled, and other health workers have become scarce. The recent development programmes initiated by the government and donor agencies to reconstruct health institutions are an indicator of the needs in this sector.

6.3 Improving Health Care Facilities

A major challenge in rehabilitating or designing hospitals - or indeed any large-scale investment project - to be sustainable in the long term is the long time periods involved in planning, financing, construction and operation. The interval between concept and commissioning of major hospitals reconstruction can range from 3-5 years owing to complex administrative procedures, while several more years may be needed to construct a new hospital. This can mean that many hospitals, when beginning to operate, may not meet the current (or future) health needs of the population.

A key challenge facing policy makers in this regard is the compression of capital expenditure affecting long term reconstruction projects, and the dearth of donor funding for hospital projects due to the elevation of Sri Lanka to a status of a middle income economy. A good example that can be cited is that Sri Lanka's main cancer hospital located in Maharagama had a long felt need for a few fully fledged chemotherapy surgical theatres to meet demand, but these did not materialize due to the exorbitant costs involved. Due to this reason, it was the practice in the past to transfer serious patients to private hospitals at a cost borne by the state. Very recently, the necessary funds were made available by private donations to establish four operating theatres in a refurbished old building.

6.3.1 Repairing and Rehabilitating Health Facilities in the North and East

Substantial funds need to be directed towards reconstruction or rehabilitation of state health institutions damaged or devastated at the height of the conflict in the Northern and Eastern Provinces. The distribution of health facilities prior to the end of the conflict is given in Table 6.2. Given the damage incurred to health facilities over the course of Sri Lanka's protracted conflict, capital investment can be expected to play a major role in the rehabilitation process.

While long term investment projects take place, there is a dire need for accelerated investment to improve the operating efficiency of tertiary, secondary and primary hospitals in the conflict-affected areas. For instance, the Jaffna Teaching Hospital, which is the main state health institution in the peninsula

[5] Ghobarah, H.A, P. Huth, B. Russett, 2004, *The Post War Public Health Effect of Civil Conflict*, Harvard University, Cambridge.

[6] *Ibid.*

Table 6.2
Distribution of Government Health Institutions in the North and East by District (December 2005)

District	Teaching Hospitals	Provincial Hospitals	Base Hospitals	District Hospitals	Peripheral Units	Rural Hospitals	CDs & MHs[a]	Other Hospitals	CDs
Jaffna	1		1	6	6	4	9	1	15
Killnochchi				1	4		4		2
Mannar			1	3	1	1	2		3
Vavuniya			1	1	1	1	3		3
Mullativu				1	1	1	2	1	2
Batticaloa	1		1	5	1	4	2		18
Ampara			1	9	5	3	7	1	31
Tricomalee		1	1	2	3	5	3		12

Notes: a: Central dispensaries and maternal homes.
Source: Ministry of Healthcare and Nutrition, *Annual Health Bulletin 2005*.

catering to more than 650,000 people, is in need of major improvements to its children's wards to bring them on par with similar facilities in Colombo. The Ministry of Health (MOH) has taken several steps in recent months to develop the district's main hospitals. Work on a Japanese-funded project to build a new hospital building with more than Rs. 3 billion of investment is expected to commence soon. It will include a new laboratory complex, a radiological diagnosis department, a new operating theatre, including ICUs and a Central Supply and Sterilizing Department.[7]

Further, the government has allocated Rs. 350 million to uplift health care facilities in the Jaffna district, which includes the reconstruction of the Chavakachcheri Base Hospital. According to the Ministry of Rehabilitation and Reconstruction, the government has allocated Rs. 460 million under the 'Uthuru Wasanthaya' programme to improve health facilities in the Jaffna peninsula. Of this, Rs. 110 million is to be spent on upgrading the Jaffna Teaching Hospital.

Currently, ongoing projects include the construction of a new administrative building and an Out Patient Department (OPD) of the Chavakachcheri Base Hospital, construction of a maternity ward complex for the Manipayi hospital, construction of an OPD building for the Karaveddi hospital, construction of a primary medical clinic at Illavalai and construction of maternity wards in Thennmarachchi and Kodikamam, among other planned projects. The above indicates the significance and importance of capital expenditure requirements which is essential for the normalization in hospital services delivery.

6.4 Public Expenditure on Health

6.4.1 Overall Expenditure on Health

The total health budget of the government in 2009 amounted to Rs. 71.4 billion which was 44 per cent of the total health expenditure of the country.[8] There are around 555 government health institutions functioning at different levels, with 68,800 beds - translating to 3 beds per 1,000 persons. The health staff included 13,603 qualified doctors and

[7] *The Island*, "Hospitals First, Hotels Can Wait", 20 April, 2010.
[8] IPS, "Preliminary Sri Lanka National Health Accounts 2009".

25,549 nurses in 2009.

In Sri Lanka, total expenditures on health consist of current expenditures on medical care and capital formation. Public health expenditures as a proportion of GDP averaged around 1.6 per cent throughout the 1990s and reached 2 per cent in 2008.[9] Two-thirds of this was channelled through the central government, and one-third through Provincial Councils (PCs), but more than 95 per cent of this was ultimately financed through central government's tax revenue. This low level of public health expenditures of 1.5-2.0 per cent of GDP itself is the culmination of several decades of expenditure compression in the government health sector, which has seen public expenditure on health decline continuously from its peak of around 2.5 per cent of GDP in the late 1950s.[10]

The largest proportion of government expenditures of 63 per cent is incurred at hospitals.[11] This level of expenditure being spent on inpatient and outpatient care services does not represent a significant change from the spending levels during the past fifty years. Taking into account that hospitals are the main mechanism for providing inpatient care, the network of hospital facilities in the country and associated minimal barriers to access by the poor, a high level of efficiency is needed to achieve the desired health care delivery output in the hospital sector, via enhanced allocation of financial resources to close the gaps in manpower needs. Shortage of health delivery personnel at primary care level due to geographical barriers in the plantation sector is the best example of gaps in manpower needs.

6.4.2 Expenditure on Preventive and Curative Care

Public expenditures for preventive public health programmes measured in real terms stagnated continuously until 2005 as central MOH expenditures declined. This in turn is largely explained by a decline of more than 90 per cent in malaria control expenditures, due to adoption of a more efficient vector-control strategy in accordance with the 'Roll-back Malaria' programme and thus represents a productivity improvement. The overall performance of the malaria control programme was maintained, reflected in declining case loads throughout the decade. Unfortunately, the reduction of allocation for other preventive services has impacted on community health in recent times. The prevailing dengue epidemic is a case in point. Although analysis of the reasons why preventive services expenditures declined, and evidence of increasing pressure on curative services, do not support the argument that allocational efficiency of public expenditures will be improved by increases in the relative allocation to preventive health. There should be a reasonable increase in expenditures on the preventive side, but the priority should remain curative services (Figure 6.1).

6.4.3 Financing of Emerging Health Issues

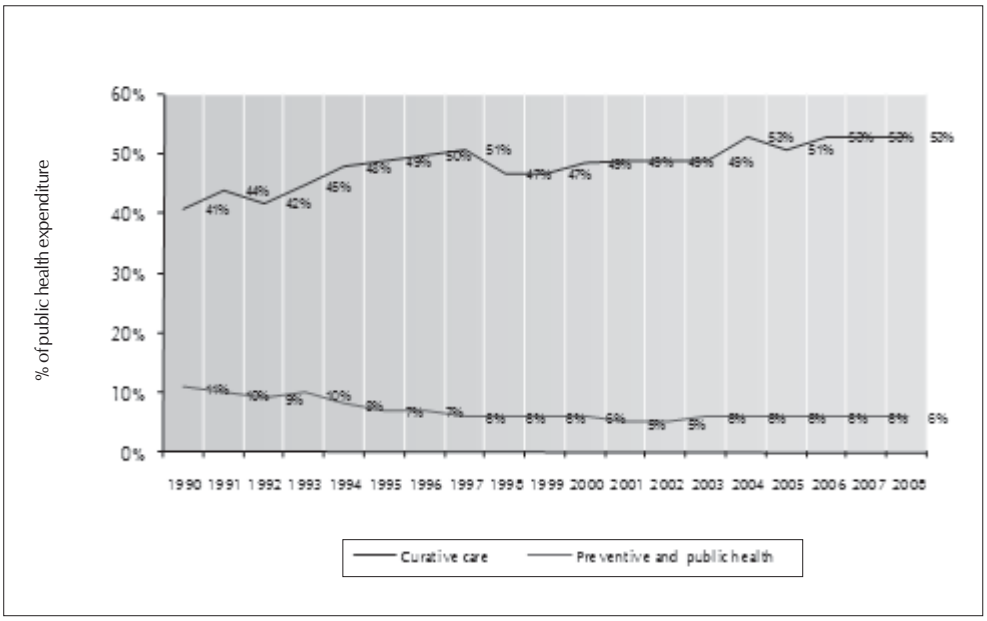
Health care expenditures in developed countries have been growing rapidly over the past fifty years. In most of these countries, expenditures on medical treatment increased at a faster rate than GDP. This rapid growth indicates an improvement in life expectancy and quality of life, but also jeopardizes the sustainability of public budgets. Sri Lanka is now quite advanced in its epidemiological and demographic transitions. The experience of other demographically advanced econo-

[9] IPS, Sri Lanka National Health Accounts data base.

[10] IPS, "Sri Lanka Public Expenditure Review: Health Sector 2004".

[11] IPS, "Sri Lanka National Health Accounts 2008".

Figure: 6.1
Public Health Expenditure for Curatve and Preventive Service,1990-2008



Source: IPS, Sri Lanka National Health Accounts data base.

mies - most of which allocate higher proportions of health expenditure to hospitals - would indicate that Sri Lanka will need to increase the allocation of expenditures to hospital services in the coming years. Since private financing is able to fund limited hospital services, there is a need for real increases in public expenditure on hospitals services in years to come. This situation will be compounded by the demand for more capital expenditure for post-conflict restoration of devastated or damaged hospital infrastructures and other health institutions in the Northern and Eastern Provinces.

As noted by the World Bank, Sri Lanka's health sector will require much higher resources in the future to cater to the needs of an ageing population, the growing non-communicable disease burden, and rising expectations of citizens. Based on the average for lower middle income countries, it is estimated that the public health expenditure would need to increase from the currently 2 per cent of GDP to around 4 per cent of GDP.[12]

6.5 Different Means of Meeting Financial Needs

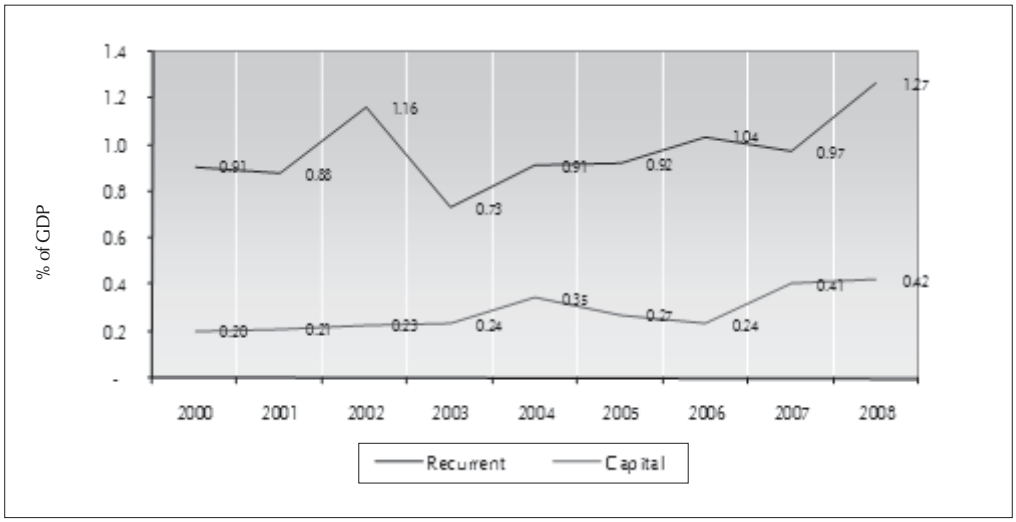
6.5.1 Public Finance

Government spending on health from domestic sources is an important indicator of its commitment to the health of its people, and is essential for the sustainability of health programmes. The average public expenditure for health over the years in Sri Lanka remained static between 1.7-2.0 per cent of GDP.

When looking at post-conflict health financing, a very real concern is that overall capital expenditure, or long term government investments, may continue to be sacrificed at the expense of recurrent expenditure. In 2009,

[12] World Bank, "Sri Lanka Health Sector-Aide Memoire of Identification Mission", March 8-19, 2010.

Figure 6.2
Public Expenditure on Health (2000-08)



Source: Ministry of Finance, Budget Estimates 2000-09; IPS, Sri Lanka National Health Accounts.

for instance, total capital expenditure for all sectors was estimated at Rs. 368.2 billion, but the actual outturn amounted to Rs. 312.5 billion,[13] registering a decline of over 15 per cent from the budgeted amount. A tendency to underestimate current expenditures and overestimate revenues in budgets has been a recurring feature of Sri Lanka's public finances, with the obvious result being recurrent expenditures overshooting targets and capital expenditure being cut or sacrificed in the process as expected revenues are not received.

The government's capacity to increase allocation for financing the health sector has to be viewed in the background of Sri Lanka's current fiscal scenario where many competing sectors demand urgent attention. As a result, a dearth of capital investment was visible in many sectors, including health (Figure 6.2). A widening gap between recurrent and capital expenditure in the health sector over the years poses a significant challenge in addressing post-conflict health infrastructure restoration efforts.

As emphasized, increased public expenditures for health is the central and most critical element in any strategy to improve overall sector performance. The temptation always exists to attempt organizational change even if such funding is not available. However, it remains necessary to observe the strong recommendation that attempting change without fixing the financing system is likely to damage the system and thus its ability to protect the poor.[14] If the financing gap can be resolved, then it would be possible and desirable to turn to other stages of reforms.

6.5.2 Development Assistance

In all developing countries, public financing of health from domestic sources in constant dollar terms is estimated to have increased

[13] Central Bank of Sri Lanka, *Annual Report 2009*.

[14] Hsiao, W., 2000, "A Preliminary Assessment of the Health Sector of Sri Lanka and Way Forward", IPS/HPP.

by nearly 100 per cent during the past decade. Overall, this increase was the product of rising GDP. In nominal terms, Sri Lanka increased its spending on the health sector from Rs. 11,000 million in 1995 to Rs. 59,000 million by 2006. This includes overseas development assistances (ODA) for health, amounting to an increase from Rs. 1,200 million in 1995 to Rs. 1,320 million in 2006.[15]

When it comes to capital expenditure requirements, ODA for health plays a crucial role, but the elevation of Sri Lanka's economic status to a middle income country slowed the inflow of foreign financial assistance. Further, with the introduction of MDGs, a larger share of ODA for health focused on disease specific funding to bridge gaps in government spending. In 2008, concerns that under-funded and weak health systems are impeding the achievement of the health MDGs in low and middle income countries led to the creation of a High Level Task Force on Innovative International Financing for Health Systems. Accordingly, the Global Fund for HIV, Tuberculosis and malaria, and the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), have both provided funding opportunities for health systems. Sri Lanka is well ahead in achieving MDGs in HIV, Malaria, TB and immunization goals, but the country is still open to receive humanitarian assistance from bilateral sources, provided there is greater encouragement to accommodate the private sector and NGOs to participate in the health sector development process.

Enhancement of public financing of health is important for the long term financial sustainability of the post-conflict health sector. If donor funding declines or stops, the continuation of health programmes will be difficult without increased financial support from the government. Furthermore, any lag in financing could force households to pay more from their own pockets and thus push them below the poverty line as a consequence of high health payments. Also any reduction of government allocation for health from domestic sources in anticipation of foreign donor assistance is inconsistent with many goals of international donors and domestic agencies, such as the Ministry of Health. Cross-country experiences indicate that ODA to the health sector has a negative and significant effect on domestic government spending on health, such that for every US$1 of ODA for health, government health expenditures from domestic resources were reduced by US$ 0.43-1.14.[16]

6.5.3 Increasing Private Participation

To bridge the gap in health financing in Sri Lanka's post-conflict development effort - that is needed to restore normalcy in health care delivery - the potential role of the private sector is perhaps the area which is most debated. The private sector plays a significant role in providing health care in Sri Lanka. It provides services to about 5 per cent of all inpatients annually and 53 per cent of outpatients. However, the overall responsibility of patients' protection and ensuring patients obtain value-for-money for the health care services paid for, lies with the government. In this context, the private sector regulatory council, which was established in 2007, would need to take necessary measures to ensure consumer protection. The private sector has a role in raising and investing capital, and providing health insurance, health services, and resources that are needed for health care in conflict-affected areas. It might assume this role on its own behalf, or on

[15] IPS, Sri Lanka National Health Accounts data base.

[16] Chunling Lu, *et al.*, 2010, "Public Financing of Health in Developing Countries: A Cross-national Systematic Analysis", *The Lancet*, Vol. 375, Issue 9723, pp. 1375-87.

contract to the state (e.g., to build facilities, provide services, distribute drugs and medical supplies, etc.). There could be some scepticism with regard to the desirability and feasibility of private insurance on account of affordability issues of the users. With respect to health care provision, there is limited positive evidence on whether investment in private sector delivery reaps health care benefits, specifically for the poorest people in conflict areas.

6.5.4 Out-of-Pocket (OOP) Expenditure

Out-of-pocket expenditures for health can have a direct impact on poverty because of their potential to impact on net consumption levels of poor households, and for catastrophic expenditures on impoverished households. In Sri Lanka, OOPs for inpatient care as a share of total household consumption is highly progressive relative to the ability to pay, with a ten-fold difference between the richest and poorest quintiles' shares. This can be attributed to the availability of free hospital care that poor households do have good access to. This finding confirms that Sri Lanka's focus on hospital services in its public expenditure is effective, as it was originally intended to, in protecting most households from financial burdens when ill.[17] The OOP expenditure for outpatient care and drugs as a share of household consumption is only mildly progressive or proportional to ability to pay. This is not surprising since even poorer households will resort to self-treatment, and also can afford small payments for private outpatient care and medicines.

6.6 Conclusions

Sri Lanka's health care system has done well by international and regional standards in various dimensions of equity, in particular its targeting of public expenditures to the poor, and the effectiveness of public expenditure in protecting households against the impoverishing impacts of catastrophic illness. The relatively sound performance demonstrates that the general approach of relying on public expenditure as the primary funding source for the health system, concentrating public expenditures on hospital services and maintaining the principle of universal access has been effective in ensuring equity on the delivery and risk-protection side. Further improvements in this area will depend on increasing the share of public expenditure in total health system financing so as to reduce the burden of out-of-pocket payments.

Public financing remains a challenge in view of competing demands for government expenditures. Government health expenditure accounted for 44 per cent of total expenditure on health in 2008. During the last five years, the public expenditure share has dropped from 50 per cent to 44 per cent, while inpatients and outpatients treated in government hospitals increased by 5 per cent and 6.5 per cent, respectively, over the same period. Over time, these challenges - alongside new post-conflict priorities of rehabilitating health services in the N&E - are likely to drive the wedge further between the access and quality of health care services available for the rich and the poor.

Sri Lanka's health system needs to reorient its attention to problems in service delivery for children (nutrition, stunting, etc.) and expectant women with high and continuing prevalence of foetal and maternal under-nutrition, and towards the problems associated with service delivery to adult males and females, particularly for treatment of chronic diseases such as diabetes, ischaemic heart disease, etc. This requires increasing emphasis on the expenditure side on delivery of medical services, as mortality reduction in many of these diseases requires more effec-

[17] IPS, "Sri Lanka Public Health Expenditure Review 2004".

tive case management and treatment. Indeed, Sri Lanka will need to make significant changes to its health system in order to face new challenges from epidemiological and demographic transitions and also to adequately prepare for threats that may have to be faced in the future. Therefore, these emerging challenges in post-conflict Sri Lanka, which includes changing demographic and disease patterns, limited resources, increased demand and expectations by the public, and the need for equity and fairness in service delivery should be given priority in the formulation of future policy reforms.