Sri Lanka
State of the Economy Report 2016

Chapter 8
Health Care Financing in Sri Lanka: Challenges and Alternatives

by
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8. Health Care Financing in Sri Lanka: Challenges and Alternatives

8.1 Introduction

Health is a crucial input into economic development and poverty reduction. The levels and distribution of health outcomes can be regarded as a key indicator of the inclusiveness of a country's economic growth; they also often serve as proxies for a government's concern for all its citizens.[1] By and large, Sri Lanka's health sector has contributed to the country's economic development, recording progress in achieving health indicators and maintaining their status. Indeed, Sri Lanka is considered as a success story for achieving most of the vital health indicators - such as on child mortality, maternal health, combating HIV/AIDS, malaria and other diseases set by the Millennium Development Goals (MDGs) - despite being a low spender on health.[2] The health status depicted by such indicators places Sri Lanka at a more advanced position than many of its developing country regional counterparts, and on par with developed countries.

Sri Lanka's considerable health sector achievements are financed through a combination of general taxation and out-of-pocket payments by households. However, in view of changing demographic and epidemiological patterns and economic context, it is questionable whether Sri Lanka will be able to finance health sector needs in a sustainable manner under the present financing system.

Sri Lanka's considerable health sector achieve-ments are financed through a combination of general taxation and out-of-pocket payments by households.

[1] Tandon A., and J. Zhuang (2007), "Inclusiveness of Economic Growth in the People's Republic of China: What Do Population Health Outcomes Tell Us?," Asian Development Bank, Manila.

[2] UN (2015), "MDG Country Report 2014 - Sri Lanka", United Nations, Colombo.

Thus, this chapter attempts a preliminary assessment of current financing gaps and possible alternative options for health care financing. It offers a general overview of health care financing, discusses the health care system and health policy and regulations in Sri Lanka; the present health care financing status; the need for alternative mechanisms to finance the health sector; the gaps in the existing financing system; the steps towards a sustainable health care financing system; some possible alternative health care financing models for Sri Lanka, and concluding remarks.

8.2 Models of Health Care Financing

In general, health care financing refers to the ways in which money is generated to pay for health services. Robust health financing systems are critical for reaching universal health care coverage; the financing levers lie in three interrelated areas: (i) raising funds for health; (ii) reducing financial barriers to access through prepayment and subsequent pooling of funds in preference to direct out-of-pocket payments; and (iii) allocating or using funds in a way that promotes efficiency and equity.[3] In order to ensure fair financing, while providing appropriate incentives to health care providers, countries need to reform and harmonize three interrelated sub-functions of financing, namely: (i) collection of revenue, (ii) pooling of financial resources; and (iii) purchasing of interventions. Of these sub-functions, pooling is of particular significance for fair financing.

There is a wide variety of health care systems around the world. These can be categorized into four main models: the Beveridge model, the Bismarck model, the national health insurance model, and the out-of-pocket model.[4] In the Beveridge model, health care is provided and financed by the government through tax payments. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government (e.g., Britain, Spain, most of Scandinavia and New Zealand). The Bismarck model uses an insurance system - the insurers are called 'sickness funds' - usually financed jointly by employers and employees through payroll deduction (e.g., Germany, France, Belgium, the Netherlands, Japan, and Switzerland). The National Health Insurance model has elements of both Beveridge and Bismarck. It uses private sector providers, but payment comes from a government-run insurance programme that every citizen pays into. Since there is no need for marketing, no financial motive to deny claims and no profit, these universal insurance programmes tend to be cheaper and much simpler administratively than for-profit insurance (e.g., Canada, Taiwan, and South Korea). The out-of-pocket model is one where cost-sharing, self-medication and other expenditures are paid directly by private households, irrespective of whether the contact with the health care system was established on referral or on the patient's own initiatives. The out-of-pocket model is what is used in most of the poorest countries.

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[3] WHO, "Health System Financing", available at http://www.who.int/healthsystems/topics/financing/en/.

[4] PNHP (2016), "Health Care Systems - Four Basic Models", Physicians for a National Health Programme, Chicago, available at http://www.pnhp.org/resources/health-care-systems-four-basic-models.

There are different sources of funding these health care systems. Most typically, the five primary methods of funding are: (i) general taxation to the state, county or municipality; (ii) social health insurance (a programme where risks are transferred to and pooled by an organization, often governmental, that is legally required to provide certain benefits); (iii) voluntary or private health insurance (insurance against the risk of incurring medical expenses among individuals); (iv) out-of-pocket payments (cost-sharing, self-medication and other expenditure paid directly by private households, irrespective of whether the contact with the health care system was established on referral or on the patient's own initiatives); and (v) donations to charities.[5]

8.3 Sri Lanka's Health Care System

Sri Lanka has a pluralistic system of care with many people utilizing a combination of systems including Western (allopathic or modern), Ayurveda (including indigenous, unani and siddha), homeopathic and Chinese medicine but by far, the dominant system is the Western system of care. The health system in Sri Lanka consists of public and private health care services, but the government plays the major role as the health care provider of the country. The role of the public sector in health care delivery is much significant in inpatient and preventive care. In 2012, the public sector treated 96 per cent of inpatients and 45 per cent of outpatients.[6]

Various policy interventions that took place in the pre and post-independence eras have contributed significantly in shaping the health system of the country. Granting of universal franchise in 1931 and forming a State Council with a dedicated ministry portfolio for health were some of these initial interventions. The elected representatives were able to leverage a larger allocation of resources for the provision of social services to the constituencies they represented. In addition, direct taxation on income was introduced in 1932 and provided finances needed for the various welfare schemes.

The present structure of the government health care system is a result of the Health Services Act of 1953 and the Provincial Council Act of 1987. The government health structure is basically a de-concentrated one. The government sector encompasses the entire range of preventive, curative and rehabilitative health care provision. From 1850s until the 1980s, government health services were managed by a central health department or ministry. By the 13th Amendment to the Constitution in 1987, responsibility for health services was devolved to Provincial Councils, each of which has its own Provincial Health Ministry. The central ministry is responsible for management of national facilities, medical education, formulation of health policy and bulk purchase of drugs and medical supplies and the nine Provincial Directors of Health (PDHS) are totally responsible for management and effective implementation of health services in the respective provinces.

While Sri Lanka has a free health care system based on the principle of citizenship, it does not meet the quality health needs of all people

[5] WHO (2014), "Regional Overview of Social Health Insurance in South-East Asia", World Health Organization, Regional Office for South-East Asia, New Delhi.

[6] MOH (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

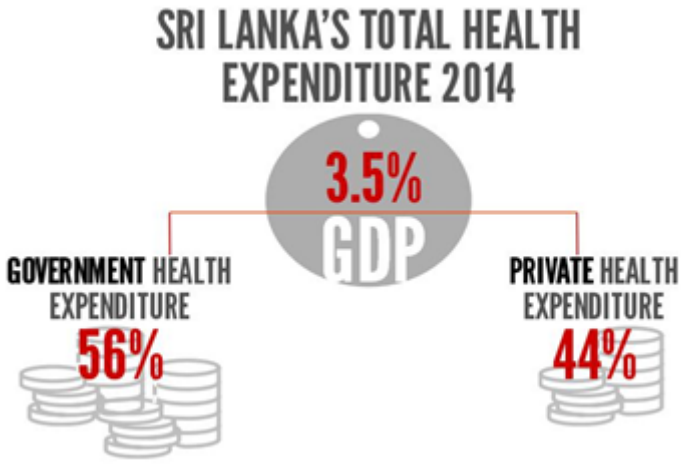
- a fundamental requirement of a universal health care system. Universal health coverage (UHC) is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services.[7] Conceptually, UHC requires that all people receive the health services of appropriate quality without exposing them to financial hardship. It encompasses three critical coverage dimensions - population (who is covered), services (which services are covered and at what quality), and cost (how much of the cost is covered).[8] With a two tier health system - comprised of a heavily subsidized public sector and a user charged private sector, and a context of sharing the total health expenditure almost equally between the public and private sector, a universal health care system does not exist in Sri Lanka.

8.4 Health Care Financing in Sri Lanka

Sri Lanka's health care financing strategy is essentially a combination of two resource mobilization methods; (i) general taxation and (ii) out-of-pocket payments by households. Sri Lanka's total expenditure on health (TEH) - including all expenditure on personal health services, community (public health and preventive) health services, and gross capital formation in health care providers stood at 3.5 per cent of GDP in 2014.[9] The share of total government spending was 56 per cent (or 2 per cent of GDP).

Private health expenditure plays a major role in health financing in Sri Lanka. It accounts for nearly a half of the total health expenditure of the country. It is evident that private sector financing has become more prominent over time; however, recent data shows a significant drop in the share of private expenditure from 2012 to 2013 (Figure 8.1).

Sri Lanka's TEH as a percentage of GDP has hovered around 3-4 per cent with a decline in more recent years (Figure 8.2). Whilst health expenditure is comparable with that of other lower middle income economies, the amount



[7] WHO (2014), "Making Fair Choices on the Path to Universal Health Coverage", World Health Organization, Geneva.

[8] WHO (2010), "Health System Financing: The Path to Universal Coverage', World Health Organization, Geneva.

[9] WHO (2014), "Global Health Expenditure Database", available at http://apps.who.int/nha/database/Select/Indicators/en.

Figure 8.1
Government Health Expenditure and Private Health Expenditure 2005-2014

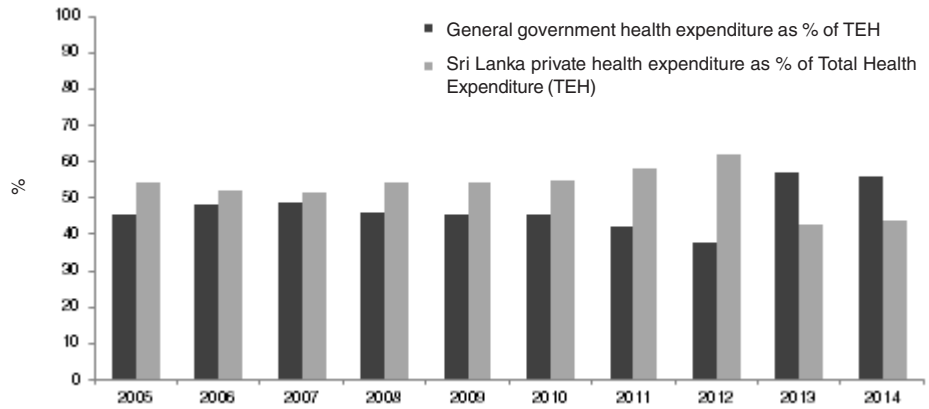
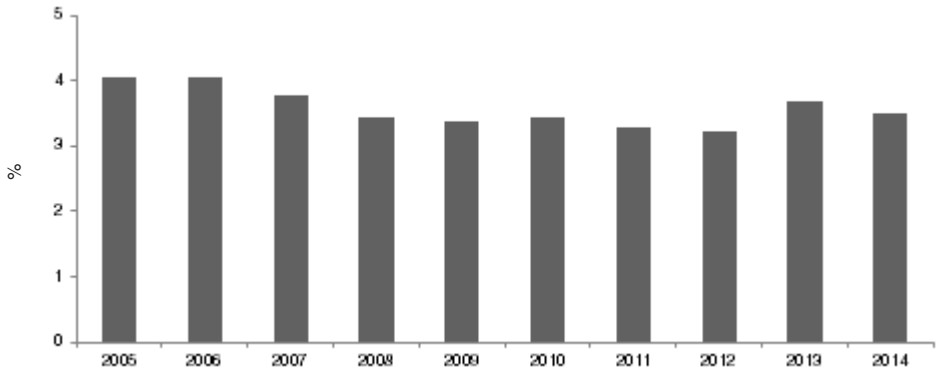


Figure 8.2
TEH as a % of GDP



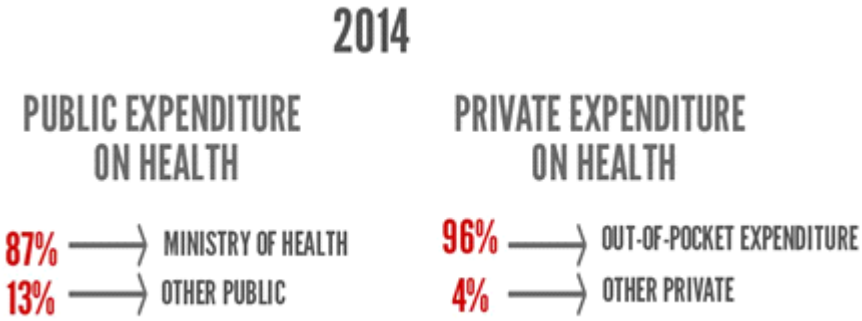
Source: WHO (2014), "Global Health Expenditure Database", available at http://apps.who.int/nha/database/Select/Indicators/en

of money allocated for spending is not adequate in the context of changing disease patterns which is more similar to a high income economy.

8.4.1 Sources of Health Care Financing

The main source for the public sector expenditure is contributions from the central government through the Ministry of Health (MOH).[10] In 2014, 87 per cent of the total public expenditure on health was incurred by the MOH. The rest (13 per cent) was borne by the Provincial Departments of Health (DOH), local governments, other ministries and government entities, the President's Fund, and the Employees' Trust Fund (ETF). Out-of pocket expenditure by households is the main source

[10] *Ibid*.



of finance for private expenditure on health and in 2014 it accounted for 96 per cent of total private health expenditure . Other financing sources for private sector health expenditure are private sector employers' health expenditure reimbursements, voluntary private health insurance, provider's own resources and NGOs.

8.4.2 The Need for Alternative Financing Mechanisms

Sri Lanka's changing demographic and epidemiological transition is the primary reason why the country needs to examine changes to its health care financing system. As a result, health care expenditure is likely to increase in the future owing to: (i) increased demand for more expensive treatment; with rising income levels along the transition to middle income status, there will be greater demand for more expensive treatment and higher service quality requiring more financial resources to be allocated; (ii) meeting health needs of an ageing population; and (iii) the increase in non-communicable diseases (NCDs) related to an epidemiological transition.

It is estimated that the 60 years and above population in Sri Lanka will double between 2011 and 2041, reaching nearly 5.4 million.[11] Further, the share of this age category will rise to 24.8 per cent by 2041 (from 12.5 per cent in 2011) indicating that one-in-every four people in Sri Lanka will be an elderly person. Elderly people need more health care and treatment than younger people and the pattern and causes of their illness are different as well (e.g., Alzheimer and dementia), which need special care and geriatrics treatment where costs are high.[12] The elderly are also more vulnerable to chronic illnesses such as heart diseases, stroke, lung and liver diseases, cancer, asthma and rheumatism and also degenerative diseases like hypertension, diabetes, cancer, etc., in their early ages of the elderly period. With the increasing number of elderly, the demand for intensive diagnostic tests, long-term hospitalization and better treatment as well as rehabilitation and social and clinical therapy will go up. Further, geriatric health care needs special medical training and skills. In order to meet this demand, the country's health service should be well equipped with required

[11] IPS, (2014), "Demographic Challenges of an Ageing Asia" in *Sri Lanka: State of the Economy 2014*, Institute of Policy Studies of Sri Lanka, Colombo.

[12] Siddhisena K.A.P., (2005), "Socio-economic Implications of Ageing in Sri Lanka: An Overview", Working Paper WP105, Oxford Institute of Ageing, UK.

Sri Lanka's changing demographic and epidemiological transitions is the primary reason why the country needs to examine changes to its health care financing system.

resources, both financial as well as non-financial resources.

Sri Lanka is experiencing an epidemiological transition (transforming the pattern of mortality and disease from communicable diseases to NCDs). Government hospital statistics indicate that 71 per cent of all annual deaths in Sri Lanka are due to chronic NCDs.[13] Cardiovascular diseases, diabetes, cancers and chronic respiratory diseases are the major NCDs in Sri Lanka. NCDs place more economic strain on individuals than communicable diseases as NCDs are permanent in nature and leave residual disabilities. From a health system perspective, a patient suffering from NCDs requires a longer period of supervision, observation and care with high priced medication placing a huge economic burden on the health system.

8.4.3Closing Existing Gaps in Health Care Financing

The most critical gaps in Sri Lanka's current system of health care financing are: (i) inadequacy of resource mobilization; (ii) allocative inefficiency in the distribution of health care provision outcomes amongst the population; and (iii) weaknesses in financial management.

The main gap in the present health care financing system is the inadequacy of resource mobilization for health. As described earlier, Sri Lanka's TEH - hovering around 3-4 per cent of GDP - is not sufficient to finance the future health care needs of the country. Indeed, the Health Master Plan (2006-2017) highlights how health expenditure should increase with rising life expectancy at birth. When life expectancy at birth was less than 68 years, it is estimated that Sri Lanka required TEH of 4.9 per cent of GDP; when life expectancy rose to greater than 68 years as currently (life expectancy at birth for males and females were 72 and 78 years, respectively, in 2013), TEH needs to be 5.8 per cent of GDP. Even though life expectancy has increased over time, there has been a failure to raise health expenditure accordingly.

Thus, the expectation is that the country will need to bear a larger financial burden if it is to provide health care services adequately and

[13] MOH (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

cater to the changing demographic and disease patterns. Even at present, health expenditure indicators for Sri Lanka are not satisfactory when compared with global averages (Table 8.1). Apart from low spending on health at an aggregate, the share of spending on social security by the government and private prepaid plans by the private sector, are also considerably low, while the share of out-of-pocket expenditure on health by the private sector is significantly higher than the global average.

Another critical area for improvement is allocative efficiency - i.e., how well the outcomes of health care provision are distributed among the population. Accordingly, questions of allocative efficiency in the health sector tend to revolve around what might represent the mix of services or interventions that maximizes health improvements, both within disease entities (such as prevention versus treatment strategies for HIV/AIDS) and across them (i.e., how the health of a population

Table 8.1
Health Expenditure Indicators: Sri Lanka and Global 2000 & 2011

	Sri Lanka		Global	
	2000	2012	2000	2012
TEH as % of GDP	3.7	3.1	7.7	8.6
General government expenditure on health as % of TEH	48.3	39.1	55.5	57.6
Private expenditure on health as % of TEH	51.6	60.9	44.5	42.3
General government expenditure on health as % of total government expenditure	6.8	5.9	12.9	14.1
External resources for health as % of TEH	0.3	2.0	0.3	0.5
Social security expenditure on health as % of general government expenditure on health	0.3	0.1	59.2	59.3
Out-of-pocket expenditure on health as % of private expenditure on health	80.8	83.0	52.2	52.6
Private prepaid plans as % of private expenditure on health	2.8	4.1	37.0	36.2
Per capita total expenditure on health at average exchange rate (US$)	32	88	487	1025
Per capita government expenditure on health at average exchange rate (US$)	16	34	281	615

Source: World Health Organization (2015), "World Health Statistics 2015", WHO, Geneva.

can be most improved with existing resources).[14]

When allocative efficiency is related to health financing, two issues are immediately identifiable, namely; (i) disparities in allocation between preventive care and curative care; and (ii) disparities in allocation for primary, secondary, and tertiary care. Although during the early post-independence years, nearly 20-25 per cent of TEH was allocated for preventive and promotional services, the share spent on preventive care has been decreasing gradually.[15] The allocation for preventive health services was 11 per cent of TEH in 1990, but dropped to 7 and 5 per cent in 1995 and 2000, respectively; from 2000 onwards, it has stayed at not more than 5 per cent.[16] This allocation is grossly insufficient even to sustain the achievements of the past. With the rapidly escalating burden of NCDs, more financing is needed for preventive services.

A referral system is absent in Sri Lanka. Hence, patients tend to bypass primary medical institutions, particularly those in the rural areas mainly because of the erroneous belief that the outpatient treatment in the secondary and tertiary institutions is superior to those in the periphery, and lack of confidence in the primary institutes.[17] Health expenditure trends confirm the decline in persons using primary care. In 1991, primary care level facilities obtained between 30-35 per cent of total recurrent patient care expenditure and 65-70 per cent were allocated to secondary and tertiary institutes. However, this disparity has widened whereby one-quarter of allocation is for primary level institutions and three-quarters for secondary and tertiary level care institutions.[18]

Gaps related to allocative efficiency also exist in financial management. The present management set-up of the public sector care is more a command-control type of administration. It offers only very limited flexibility and authority for individuals to manage the delivery of services locally, considering the population distribution and terrain, as standards and norms are set centrally. Managers face difficulties in taking decisions not only on finance but also on other matters such as staffing and resource utilization because of the management structure. Further, the present managerial and financial systems are inadequate and there is a shortage of trained staff.[19] The Provincial Council system has also resulted in a confused macro organization of health care financing and delivery.

8.5 Towards A Sustainable Health Care Financing System and Alternative Mechanisms

Ensuring sustainable health care financing is vital. It allows a country to secure sufficient

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[14] Dan C., and B.E. David (2010), "Improving Health System Efficiency as a Means of Moving Towards Universal Coverage", background paper for World Health Report 2010, World Health Organization, Geneva.

[15] Fernando, J. (2013), "Health Care Financing in Sri Lanka: Retaining Welfare and Promoting Markets", *OPA Journal*, Vol. 28.

[16] IPS (2014), "Sri Lanka National Health Accounts 2010-2011", Institute of Policy Studies of Sri Lanka, Colombo.

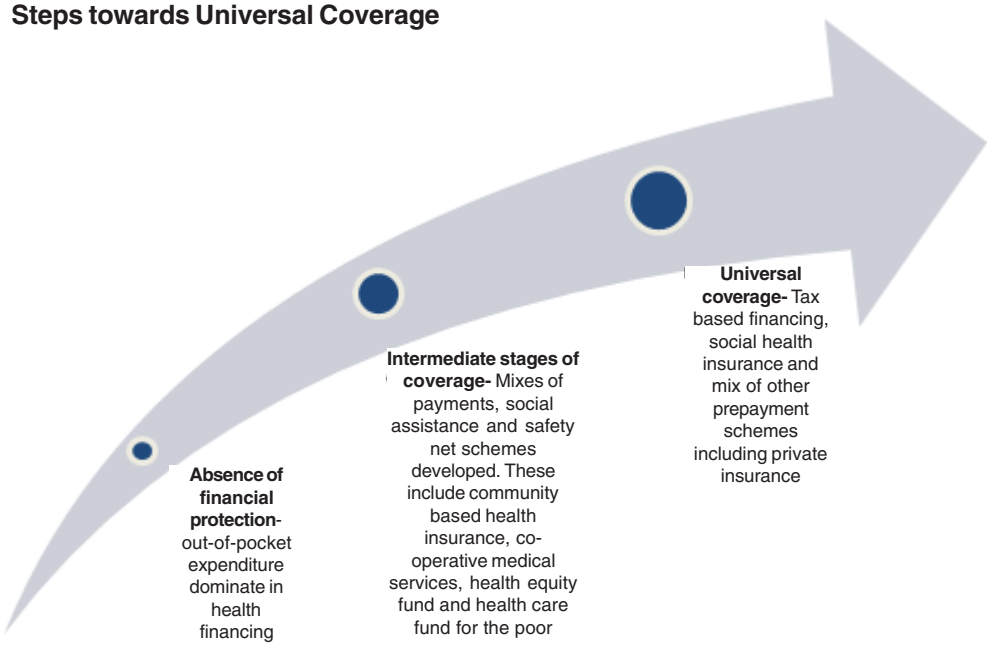
[17] Fernando, J., (2011), "The Urgent Need for a Well-planned Referral System for Health Care Delivery in Sri Lanka", *Sri Lanka Journal of Medical Administration*, Vol. 13.

[18] *Ibid*.

[19] *Ibid*.

resources; enables improvements in the effectiveness of health care; allows resources to be used effectively and efficiently to meet health needs, to carry out these functions on a continuous basis, and to perform them with minimum external inputs. For Sri Lanka to ensure sustainable ealth care financing, new and innovative mechanisms need to be explored. Innovative financing mechanisms can be defined as "non-traditional applications of official development assistance (ODA), joint public-private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground".[20] At present, Sri Lanka has a combination of general taxation and out-of-pocket payments by households as the financing mechanism for the health sector. As discussed earlier, the share of out-of-pocket payments by households is increasing over time, placing a considerable financial burden on them. In fact, the current focus of the international debate is on the need to move away from excessive reliance on out-of-pocket payments as a source of health financing towards a system which incorporates a greater element of risk pooling, and thus affords greater protection for the poor.[21] A

Figure 8.3
Steps towards Universal Coverage



Source: World Health Organization (2009), "Health financing strategy for the Asia Pacific region (2010-2015)", WHO, Geneva.

[20] Gargasson, Jean-Bernard Le and Salomé Bernard, (2010), "The Role of Innovative Financing Mechanisms for Health", background paper for *World Health Report 2010*, World Health Organization, Geneva.

[21] Bennett, S., and L. Gilson (2001), "Health Financing: Designing and Implementing Pro-poor Policies", DFID Health System Resource Center, London.

Ensuring sustainable health care financing is vital. It allows a country to secure sufficient resources; enables improvements in the effectiveness of health care; allows resources to be used effectively and efficiently to meet health needs, to carry out these functions on a continuous basis, and to perform them with minimum external inputs.

gradual decrease in out-of-pocket expenditure is a salient feature of stepping towards universal coverage in health (Figure 8.3).

The WHO's Health Financial Strategy for the Asia Pacific proposed the following four indicators to monitor and evaluate overall progress in attaining universal coverage in countries, and in the Asia Pacific region specifically: (i) out-of-pocket spending should not exceed 30-40 per cent of TEH; (ii) TEH should be at least 4-5 per cent of GDP; (iii) over 90 per cent of the population should be covered by prepayment and risk pooling schemes; and (iv) close to 100 per cent coverage of vulnerable populations should be covered with social assistance and safety-net programmes.[22] However, Sri Lanka is still working towards these indicators, implying that the country's health financing system need reforms and innovative mechanisms to be sustainable in the long run. When increasing health care financing, three dimensions have to be considered; breadth (proportion of population insured); depth (scope /range of services available); and the height (proportion of costs covered).

In this backdrop, examining the alternative and innovative financing options available for Sri Lanka is important in order to fill the gaps in the existing system and to achieve universal coverage in health. Various innovative and alternative health financing methods ranging from market-based systems to government financed systems, from community funded to donor funded systems are to be found in practice. Of these alternatives, more focus is

[22] WHO (2009), "Health Financing Strategy for the Asia Pacific Region (2010-2015)", World Health Organization, Geneva.

paid to four options - PPPs, social health insurance, community based health insurance, and user fees - to assess their possible benefits and potential to be adapted in Sri Lanka's context.

8.5.1 Public-Private Interventions and Private-Public Partnerships

The public sector can use a wide range of policy instruments to engage and create partnerships with the private sector in health care delivery. Contracting out, licensing and accreditation, private-public partnerships (PPPs), and social marketing are some of the available options. These are practised in various countries as indicated in Table 8.2.

Of alternative options, PPPs have become a major force in health care delivery and financing owing to three primary reasons: (i) a shift in philosophy about the roles of the public and private sectors; (ii) a recognition by both the public and private sectors of their interdependence; and (iii) a better understanding of how each party can gain from a partnership with the other.[23] A PPP is defined as a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance. The most common reason for entering into a PPP is financial. This might take the form of increasing resources or through reductions in cost. In either case, each of the partners sees a long or short-term financial gain that will come about from the partnership. Other than financial benefits, both the parties stand to gain from greater efficiency and transfer of technical knowledge through a PPP.

A PPP is not a new concept in Sri Lanka; there have been various PPPs in practice informally for the last few decades. The government provides only minimal support for private participation in public health programmes. For example, during 2007-10, only 25 per cent and 10 per cent of reviewed private facilities received financial and technical assistance, respectively, for programmes on childhood vaccination; similarly, only 25 per cent and 8 per cent, respectively, received financial and technical support for antenatal care.[24] Given the benefits of PPPs (e.g. improving access and reach, improving equity by reducing out-of-pocket expenses, and better efficiency) steps should be taken to mobilize the responsible development of PPPs. Developing and enforcing quality standards by providing financial and technical support to the existing regulatory body (Private Health Regulatory Commission) and modifying existing policies and regulations to foster the role of the private sector (e.g., streamlining bureaucratic processes that limit market entry, liberalizing human resource regulations, reducing tariffs and other import barriers) are some of the measures that can be taken in this regard.[25]

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[23] Mitchell, M., (n.d.), "An Overview of Public Private Partnerships in Health", Harvard School of Public Health, Massachusetts.

[24] IPS (2015), "Health Sector Reforms" in *Sri Lanka: State of the Economy 2015*, Institute of Policy Studies of Sri Lanka, Colombo.

[25] Dayaratne, G. D., (2015), "Transforming Health Care Delivery in Sri Lanka- Public Private Partnerships (PPP)", Health Economic Series No. 02, Institute of Policy Studies of Sri Lanka, Colombo.

Table 8.2
Public-Private Interventions in Health Care Delivery

Intervention	Description	Expected Results	Where it is happening
Contracting out	Governments contract with private providers (non-profit and for-profit) to deliver health services.	Can expand private sector coverage of particular services via public funding and may improve (through contracts pecification) the quality of care; can improve efficiency and quality through competition.	Afghanistan, Bangladesh
Licensing and accreditation	Governments can extend licensing and accreditation systems to include provisions for private sector providers.	Can strengthen quality of private health services and help governments monitor the care that private providers offer.	Brazil, South Africa, Tanzania, Zambia
Regulation	By updating and harmonizing laws, policies, regulations, and procedures, governments can authorize private provision of services and products by certain health professionals in specific settings.	Can promote competition and organization (e.g., multi-pharmacy chains) more conducive to quality or lower prices. Can increase private sector contribution by removing obstacles and creating incentives that motivate the private sector to provide public health services and products.	Tanzania
Provider networks and franchises	Networks and franchises group health care providers under an umbrella structure or parent organization.	Ensures standard quality and prices and encourages individual private providers to scale up their services.	Bangladesh, Benin, Cameroon, Ethiopia, Ghana, India, Kenya, Lesotho,Madagascar, Malawi, Mali, Pakistan, Philippines,Rwanda, SierraLeone, South Africa, Swaziland, Togo, Vietnam, Zimbabwe
Public-private partnerships	Private providers and businesses join with governments, international organizations, or non-profits to address social needs.	Leverages private sector resources and expertise to deliver health products and services.	Brazil, Czech Rep., India, Lesotho, Mexico, Romania, South Africa, Republic of Yemen
Social marketing	Use commercial marketing techniques to make subsidized products available more widely. The programmes can distribute and promote products such as contraceptives, oral rehydration salts, and insecticide-treated bed nets.	Increases access to and use of essential health products.	Many countries, for family planning products and services and bed nets.
Training and continuous education for private providers	A variety of training techniques – including direct training, long -distance learning, continuous medical education, and detailing – can improve the knowledge and skills of private health care providers.	Can improve private providers' knowledge, skills, and the quality of the care they provide in areas that address public health objectives.	India
Vouchers	Governments can give vouchers to target populations to subsidize the price of health services and products, which makes them more affordable and more likely to be used.	Can increase consumer choice and make private sector care more affordable through subsidies. Vouchers also create financial incentives to private providers to offer services and products they might not otherwise deliver. Can motivate quality improvement via provider eligibility requirements.	Ghana, India, Indonesia, Nicaragua, Tanzania
Insurance	Government-funded insurance, commercial insurance, and community-based mutuelles pool financial risk across large population groups.	Can expand financial protection and ease burden on households, paying out-of-pocket for health services. Insurance can reduce financial barriers to seeking health care, especially for preventive health services.	Colombia, Ghana, India, Mali, Namibia, Nigeria, Rwanda, Senegal

Source: CGD (2009), "Partnerships with the Private Sector in Health: What the International Community Can Do to Strengthen Health Systems in Developing Countries", Center for Global Development, Washington D.C.

Box 8.1
PPP Involvement in Sri Lanka's Health Sector

- Government doctors doing channeling practice in private hospitals during their off-duty hours;
- Government doctors doing their own General Practice in privately owned dispensaries who work as a catalyst to referral system with government or private hospitals;
- Involvement of traditional health care providers- Ayurveda, Homeopathy;
- Supply of equipment and drugs by the private sector;
- Clinical investigations and admissions to the state sector hospitals through private channel consultations and vice-versa;
- Medical consultation services, laboratory and other diagnostics services in public sector are obtained from private laboratories;
- TB/ influenza prevention/vaccination programmes available in the private sector funded by the government;
- President's Fund providing assistance in major surgical procedure treatment in the private sector;
- Provision of government servant's insurance, such as 'Agrahara' to obtain treatment by the private sector;
- National Blood Bank operation to provide blood to the private sector;
- Representatives from major private hospitals serving as members of the Private Health Regulatory Commission;
- Outsourcing of facility services such as cleaning, clinical waste management, laundering, cafeteria, etc.

Source: Dayaratne, G. D. (2015).

8.5.2 Social Health Insurance

A social health insurance (SHI) mechanism allows health services to be paid through contributions to a health fund. The SHI system is different from a government funded insurance scheme, commercial or private insurance schemes, and community health insurance (Table 8.3).

Table 8.3
Selected Characteristics of SHI Compared to other Forms of Health Insurance

Type of Insurance	Financing Source	Nature of Contribution	Funds Ear-marked for Health	Membership
SHI	Employer and/or employee contributions from wages and salaries	Mandatory	Yes	Contributing members and usually their dependents
Private insurance	Out-of-pocket payments of premiums	Voluntary	Yes	Contributing members and usually their dependents
Community prepayment health "insurance"	Out-of-pocket payments	Voluntary	Yes	Contributing members and usually their dependents
National insurance	Government general revenue and other taxes	Funded	No	All citizens

Source: Hsiao, W. *et al*. (2007), *Social Health Insurance for Developing Nations*, World Bank, Washington, D.C.

SHI has three distinctive characteristics. First, social insurance is compulsory; the second characteristic relates to eligibility -citizens only become entitled to receive benefits when they have paid the required premium. The third characteristic is that SHI premiums and benefits are described in a social compact, which is usually set out in the legislation that establishes the economic exchange between the two parties: enrolees and the social insurance plan.[26] An SHI in principle involves compulsory membership amongst the entire population. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary towards this end. In general, membership of SHI schemes is mandatory, although for certain groups (such as the self-employed) it might be voluntary. While for workers and enterprises, the contribution is usually based on the worker's salary, the contributions of self-employed persons are either flat-rate or based on estimated income.

Governments may provide contributions for those who otherwise would not be able to pay, such as the unemployed and low-income informal economy workers. The health fund is usually independent of the government but works within a tight framework of regulations. Premiums are linked to the average cost of treatment for the group as a whole, not to the expected cost of care for the individual. Hence there are explicit cross-subsidies from the healthy to the less healthy. Countries such as Austria, Belgium, Costa Rica, Germany, Israel, Japan, Republic of Korea, and Luxembourg are some examples which have transited to universal coverage via SHI.[27] SHI system has several strengths - i.e., mobilizing new, stable funds for health, pooling risks widely and providing insurance protection, enabling the government to target new public funds to the poor - and the potential to shift existing public resources to the poor by having formal sector employees and their families pay for 'free' public health services they currently use. It can be a strategy to reform the health care delivery system to produce higher quality and more efficient services.

The viability of SHI for Sri Lanka is questionable given the large informal sector in the country. There is also a vast and extensive administrative operation involved in the implementation of SHI schemes, such as registration, collection of contribution, contracting and reimbursement of providers that would also make it a challenging option for Sri Lanka. Collecting premiums would be difficult with the high level of informal employment in the country and the additional costs involved would have to be financed either by the government, by employers or by the people. Preliminary studies need to be undertaken to estimate the levels of contribution that can be expected, and the general feasibility of setting up such a system. Free enrolment for the poor and the informal sector, offering insurance on a voluntary basis to the non-formal sector, and a sliding scale fee for voluntary enrolment for those above a certain level of economic status in the informal sector are some of the steps that can be taken in order to capture the informal sector under SHI system.[28]

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[26] Hsiao, W. *et al*. (2007), *Social Health Insurance for Developing Nations*, World Bank, Washington, D.C.

[27] Carrin, G., and C. James (2005), "Social Health Insurance: Key Factors Affecting the Transition Towards Universal Coverage", *International Social Security Review*, 58(1).

[28] Acharya, A. *et al*., (2012), "Impact of National Level or Social Health Insurance for the Poor and the Informal Sector: A Systematic Review for LMICs", University of London, UK.

8.5.3 Community-based Health Insurance

Community-based health insurance (CBHI) schemes are based on three principles, namely; community cooperation, local self-reliance, and pre-payment. There are also five characteristics that CBHI schemes share, namely: (i) community-based social dynamics and risk pooling, where schemes are organized by and for individuals who share common characteristics (geographical, occupational, ethnic, religious, gender, etc.); (ii) solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks; (iii) participatory decision-making and management; (iv) non-profit character; and (v) voluntary affiliation.[29] They are intended to facilitate health-financing at the sub-national and/or community level (e.g., households in a village or district; socio-economic, professional or ethnic groups), and provide limited coverage to population groups that are typically difficult to reach. Membership in CBHI schemes is usually voluntary and not linked to employment status, where funds are collected from the members and typically held by a private non-profit entity. In some cases, funds come from donor and government subsidies, but as a smaller percentage.

The success of a CBHI depends on many factors including technical strength and institutional capacity of the local group, financial control as part of the broader strategy in local management and control of health care services, support received from outside organizations and individuals, links with other local organizations, and diversity of funding. Even though less than 10 per cent of the informal sector population in the developing nations has health coverage from a CBHI, the number of such schemes is growing rapidly.[30] Unlike SHI schemes, CBHI normally covers those outside formal sector employment. There is evidence that CBHI provides some financial protection by reducing out-of-pocket spending and that such schemes improve cost recovery. The main policy implication is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing.[31] CBHI is considered as an important social protection device by reducing out-of-pocket payments of their members, and in improving access to health services. Weak management, poor quality government health services, and limited resources that local populations can mobilize to finance health care are some of the issues faced by CBHI systems. Because of their financial viability due to lack of resources they may have to depend on national subsidies; further, their coverage is usually extended to a small percentage of the population.

Sri Lanka can consider the CBHI as a complement to strong government involvement in health care financing. The government can provide incentives to CBHI schemes in many ways, for instance by creating a supportive environment, building technical and

[29] Soors, W. *et. al*. (2010) "Community Health Insurance and Universal Coverage: Multiple Paths, Many Rivers to Cross", background paper for World Health Report (2010), World Health Organization, Geneva.

[30] Tabor, S. R. (2005), "Community-based Health Insurance and Social Protection Policy", Social Protection Discussion Paper Series, World Bank, Washington, D.C.

[31] Ekman Björn (2004), "Community-based Health Insurance in Low-income Countries: A Systematic Review of the Evidence", *Health Policy and Planning*, 19(5).

management capacities of the CBHI, and providing some form of subsidies.

8.5.4 User Fees

Under a system of user fees, patients are requested to pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. User fees may encourage more efficient utilization patterns if they are graduated by level of the system - a by-pass fee is introduced in areas where the primary care network is adequate, and referred patients are exempted at higher levels of the system - and are associated with quality improvements that promote utilization at the primary level.[32] Improved consumption efficiency, demand rationing (to counter moral hazard) and better targeting are the other main arguments used in favour of user fees.[33] Where user fee revenue is used to increase quality, utilization by the poor could actually increase, suggesting that fees might not always reduce access for the poor. The general notion on user fee is that it impedes access to health care, especially of the poor, and there is a vast literature to support that argument too. However, on a positive note, user fees have the potential to improve access to better quality services. If the extra revenue earned from fees is re-invested into the health system, or if fee payment allows consumers to insist successfully on better service, demand is likely to increase. This would partially or fully off-set the negative price effect of user fees. At the peripheral level, the revenue generated by fees can be significant and can be used to upgrade health facilities when government systems fail to adequately shift funds to the peripheral level.

Considering the positive effects of the user fee option, it can be considered in Sri Lanka given the tendency to bypass primary medical institutions, and its potential to generate income and upgrade available health services, especially in rural areas. In fact, user fees have been a policy option in Sri Lanka in the past; for example, government hospitals charged user fees prior to the 1930s. When the principle of free health care was established in 1951, user fees were abolished since it was no longer considered as a revenue collection mechanism. In 1971, it was re-introduced - charging 25 cent for OPD visits, a substantial amount in terms of price. It also reduced utilization by 30 per cent, but it did not contribute appreciably to overall revenue mobilization,[34] and was once again abolished in 1977. A more recent example is Sri Jayawardenepura General Hospital (SJGH) mobilizing revenue through patient charges since its inception in 1984. In 2012, 54 per cent of total revenue of the SJGH was generated from hospital care.[35] However, user fees are not readily acceptable to the electorate, and there can be heavy political costs for policy makers in pursuing this option. Such political costs, and the economic costs of designing effective means testing systems to protect the poor, continue to make user fees an unattractive option.

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[32] Gilson, L., (1997), "The Lessons of User Fee Experience in Africa", *Health Policy and Planning*, 12(4).

[33] James, C. D. *et al.* (2006), "To Retain or Remove User Fees? Reflections on the Current Debate in Low- and Middle-Income Countries", *Applied Health Economics and Health Policy*, 5(3).

[34] Rannan-Eliya, R., and N. De Mel, Nishan, (1997), "Resource Mobilization in Sri Lanka's Health Sector", Harvard School of Public Health, Massachusetts.

[35] SJGH (2013), "Annual Report 2012", Sri Jayewardenepura General Hospital, Sri Lanka.

Box 8.2
Best Practices

Singapore's Innovative Approach

Singapore's health financing system combines universal medical saving accounts with supplementary programmes to protect the poor and address potential market failures in health financing. This approach has been able to get impressive results with low costs, excellent health outcomes, and full consumer choice of providers and quality of care. In Singapore, both the public and private sector provide health care. The public sector provides 20 per cent of primary care and 80 per cent of hospital care through two integrated care networks. The private sector dominates primary health care, providing 80 per cent through its 1,900 clinics. The 13 private hospitals account for 20 per cent of inpatient admissions. Patients have the choice of selecting their provider at all levels. Rates are regulated and subsidized at government polyclinics and all the citizens are entitled to basic medical services provided in these institutes. Patients are expected to pay part of the cost, and to pay more when they demand higher levels of service. Rates at private clinics and hospitals are unregulated. There are four complementary programmes within Singapore's health financing system namely: (1) Medisave, (2) Medishield, (3) Medifund, and (4) ElderShield. These programmes are designed to promote individual responsibility, protect the poor, and address potential market failures.

Medisave: Under this programme introduced in 1984, employees contribute 6-8 per cent of their monthly salary (with the share depending on their age) to an individual medical savings account (MSA), while employers make a matching contribution. Medisave contributions are part of a broader compulsory savings programme in which employees contribute 16 per cent of salaries, and employers 20 per cent, to a central provident fund to cover hospitalization (Medisave), pensions, and mortgages.

Medishield: Medisave account holders face the risk that a catastrophic illness could wipe out their MSAs. To address this risk - in the absence of a traditional national health insurance programme - Singapore introduced the Medishield programme in 1990. All Medisave account holders under age 80 are eligible to buy Medishield insurance and can pay their premiums using their MSAs. Medishield covers hospital expenses (surgery, intensive care) and some high-cost outpatient treatments.

Medifund: To ensure that no Singaporean is denied good basic care because of inability to pay, the government set up Medifund in 1993 to subsidize health care for the poor (roughly 10 per cent of the population).

ElderShield: This was introduced as a low-cost insurance programme in 2002. ElderShield provides financial protection for people with severe disabilities. Medisave account holders are automatically enrolled in ElderShield when they reach age 40 unless they opt out. ElderShield pays a monthly cash allowance (for a maximum of 60 months) to those unable to perform three or more basic activities of daily living.

UpliftHealth Mutual Fund (HMF), India

This is a community-based health insurance scheme which was launched in 2003 and relies on strong community structures in urban and periurban slums to build and maintain health insurance. The programme originated in Pune slums and then spread to rural Marathwada (one of the five regions in the Indian state of Maharashtra) and Mumbai slums. It has an ongoing membership of more than 65,000. The implementer of this programme is an Indian non-profit organization, UpLift India Association. HMF's operations are 60 per cent self-financed, and the remaining 40 per cent is financed by domestic and international organizations and private funders. Families in the informal sector and living in ghettos - mostly daily wage earners who lack access to social protection schemes - are the target population of this programme.

HMF is designed to reduce the financial shock of an unforeseen health emergency through community risk-pooling. The insurance is introduced and marketed through local community groups such as self-help groups and village microfinance organizations. They also process claims and reimbursements. Any organization working with the informal sector is eligible to join the programme and receive support, including marketing, servicing, and funds management. Whenever possible, members are encouraged to use free public services in order to maximize the resources of the insurance pool. By doing this, the programme has been able to maintain a broad benefits package including inpatient surgical services, some outpatient services, and all primary health care consultations. Members are also entitled to a lost wages benefit. Community ownership, operational partnerships, and claim settlement are the key components of this programme.

Sources: The World Bank, (2003), "Financing Health Care: Singapore's Innovative Approach", Public Policy for the Private Sector, Private Sector and Infrastructure Network, Note No. 261, , The World Bank Washington DC; Dimovska, D., Sealy, S., Bergkvist S., and Pernefeldt, H., (2009). "Innovative pro-poor health care financing and delivery models'. Results for Development Institute, Washington DC.

8.6 Conclusion

Health is an important contributing factor for economic development. Sustainable financing of the health sector is of great importance in order to have a properly functioning health system and to generate positive health outcomes and indicators. Given the demographic and epidemiological transitions taking place in Sri Lanka, and gaps in the existing health care financing mechanism, Sri Lanka too has to look for alternative financial mechanisms. Sri Lanka's health care expenditure is likely to increase in the future owing to increase in income levels, an ageing population, and the increase in NCDs. In order to cater to these changes, the health sector needs more resources, financial as well as non-financial.

The main gap in the present health care financing system is the inadequacy of resource mobilization for health. Sri Lanka's TEH has been around 3-4 per cent of GDP for a considerable time period, which is lower than the global benchmark average. Current spending on health is not adequate in the context of changing disease and demographic patterns which are more similar to a high income economy. Further, private sector financing has become more prominent over time to become the main source of financing; at present, more than 50 per cent of the TEH is borne by the private sector. Of this, more than 80 per cent is out-of-pocket payments by individuals and households, indicative of a significant financial burden on households. Moving away from excessive reliance on out-of-pocket payments as a source of health financing assures greater protection for the poor.

Apart from the inadequacy of funding and heavy economic burden on households, allocative inefficiencies, and inefficient management practices are weakening the present system. Disparities in allocation between preventive and curative care, and disparities in allocation for different levels of institutes are the main defects in the allocation of financial resources. Further, the present system is also characterized by notable administrative rigidities, adversely affecting the efficiency of the system.

Mechanisms such as PPPs, SHI, CBHI, and user fees are some of the possible financing policy options available for Sri Lanka. Among these options, PPPs and user fees are not novel concepts to Sri Lanka. Government doctors engaging in private practice at private hospitals, supply of medical equipment and drugs by the private sector, and laboratory and other diagnostic services done in private laboratories for the public sector are some examples of existing PPPs. For Sri Lanka, there is a vast

Mechanisms such as PPPs, SHI, CBHI, and user fees are some of the possible financing policy options available for Sri Lanka.

opportunity to take advantage of existing and emerging private sector operators entering PPPs. Government support can come in various ways to strengthen the PPP system in the country (e.g., by providing financial and technical support to the existing regulatory body of the private health care service and modifying existing policies and regulations to foster the role of the private sector). Although it is challenging to utilize the profit driven private sector to serve public health objectives, with proper organizational arrangements and close monitoring, the desired objectives could be achieved.

The SHI scheme is ideal for formal sector workers. It helps prevent people from falling into poverty due to health care costs as SHI combines prepayment and risk pooling with mutual support. Further, SHI can mobilize additional resources for the health system, such as funding from employers. However, the huge administrative challenge, capacities and infrastructure requirements have to be taken into account. Offering free enrolment for the poor and the informal sector, offering insurance on a voluntary basis to the non-formal sector, and introducing a sliding scale fee for the informal sector are some of the measures that can be taken to cover the informal sector under the SHI scheme.

Similarly, given the large informal sector in the country and the experience in operating community based organizations, CBHI schemes can be considered as a complementary health financing option for Sri Lanka. CBHI reduces out-of-pocket spending and improves cost recovery; it is also important as a social protection device. Weak management and limited resources are the major challenges faced by CBHI systems. Governments can ease these challenges by creating a supportive environment, building technical and management capacities of the CBHI, and providing subsidies.

Although Sri Lanka has previous experiences in applying user fee as a financing option, those were not successful in most cases. Nonetheless, there is a possibility of using user fee as a suitable approach of improving quality and promoting resource utilization at the primary level given the positive effects of this option (e.g., improved consumption efficiency, demand

Experiences from other countries show that a combination of alternative financing options can result in positive outcomes while addressing market failures as well.

rationing, better targeting, and revenue generation at the institution level). The main argument against user fees option is that it impedes access to health care, especially of the poor. But some studies suggest that fees might not always reduce access for the poor, and it has the potential to improve access to better quality services. However, the political sensitivity of applying user fees and the public notion of 'free health care' make it doubtful whether Sri Lanka can apply this as an alternative financing mechanism for the health sector.

It is obvious that Sri Lanka's health system needs more financial resources with changes in the demographic structure, disease pattern, and rise in income levels where the existing financing mechanism is not geared to mobilize adequate funding to accommodate this change and to provide the desired levels of health care for the whole population. Hence, finding alternative and innovative financing mechanisms is essential. Each of the health financing option discussed in this chapter has benefits as well as drawbacks. Experiences from other countries show that a combination of alternative financing options can result in positive outcomes while addressing market failures as well. The available options have to be analyzed comprehensively considering the socio-economic context and the political economy of the country and have to be implemented with the aim of achieving Sri Lanka's health objectives and ensure universal health care coverage.