Sri Lanka
State of the Economy Report 2011

Chapter 15
Social Determinants of Health

by
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15. Social Determinants of Health

15.1 Introduction

Shaping a healthy, equitable and sustainable future for all is a central goal of global health initiatives. Actions to narrow 'health inequities' - the result of imbalances in wealth and power and other resources at global, national and local levels - that ultimately finds expression in inequalities in quality of life, within and between countries, contribute to sustained and inclusive economic development. The major causes for health inequity are social conditions in which people live and work, referred to as the 'social determinants of health (SDH)'. The social determinants reflect different positions that people occupy with regard to social status, power and resources, where global experience suggests that a large burden of disease and health inequalities are caused by such factors.[1]

> ***"As the country aims to achieve rapid growth, Sri Lanka's health sector needs to take urgent action on the Social Determinants of Health approach to mitigate health inequities"***

The Alma-Ata conference of 1978 is recognized as an important milestone for SDH initiatives. The Alma-Ata declaration of 1978 adopted the concept of 'Health for All (HFA) by 2000', through improvements to primary health care (PHC). The HFA/PHC strategy encouraged the recognition of social determinants as a major public health concern. Consequently, the PHC model took a more comprehensive approach, recognizing that while PHC services themselves are important, they should also address underlying social, economic and political causes of poor health.[2] In the 1980s, the concept of 'Inter-sectoral Action for Health (IAH)' was adopted to drive and spread the HFA concept. Subsequently, in the mid-1980s, the first International Conference on Health Promotion adopted the concept of 'Ottawa Charter on Health Promotion' under which eight key determinants (prerequisites) of health were identified, namely: peace, shelter, education, food, income, a

[1] McGinnis J.M., et al., 2002, "The Case For More Active Policy Attention to Health Promotion", Health Affairs, Vol. 21, No. 2.

[2] WHO, 2005, *Action on the Social Determinants of Health: Learning from Previous Experiences*, WHO, Geneva.

stable eco-system, sustainable resources, social justice, and equity.

In 2005, the WHO initiated the Commission on Social Determinants of Health (CSDH) with the intention of encouraging governments, civil society groups, international organizations and donors to address the social and economic circumstances that influence health, particularly among the most vulnerable populations. The specific goals of the CSDH were:[3]

- to support health policy change in countries by assembling and promoting effective evidence-based models and practices that address SDH,
- to support countries in placing health equity as a shared goal to which many government departments and sectors of society contribute, and
- to help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

In 2008, the final report of the CSDH on 'Closing the Gap in a Generation: Health Equity Action on the Social Determinants of Health' was launched with a set of recommendations.

Following the CSDH, Sri Lanka - along with other member countries - initiated a National Commission on SDH in 2005 under the Ministry of Health in collaboration with the WHO country office. A working group comprising members who represent health, academia, social services, and civil society was appointed to develop a framework for SDH to address and take action on social conditions which reduce health inequities, especially in relation to groups across the country.

This policy discussion makes an attempt to understand the SDH concept and its approach -through health and inter-sectoral actions - to address adverse effects of health inequity in Sri Lanka. The relevance of the SDH approach will be looked at through select health outcomes such as life expectancy, infant/maternal mortality, crude death/birth rate, nutritional status, and morbidity patterns. Further, strategies under the SDH approach in Sri Lanka's efforts to achieve health equity, aimed at improving human capital for sustained growth will be discussed. Finally, possible policy options to strengthen participation in the SDH approach to mitigate adverse health outcomes due to social determinants in the country will be presented.

15.2 Growth, Social Inclusion and Health

The health of a country's population contributes crucially to economic and social development. Investing in health is necessary for both creating opportunities and easing access to such opportunities. Indeed, four links are typically identified between health and the economy, namely: (i) better health leads to greater productivity, (ii) better health leads to improved demographic dividend, (iii) better health improves human capital, and (iv) better health improves social capital. In principle, there is a reciprocal relationship between growth and health. A better health system - that is more efficient, equitable and accessible - is a prime input in producing human capabilities that in turn, contribute to growth.

In addition, 'social inclusion' - the provision of certain rights to all individuals and groups in society (such as employment, adequate housing, health care, education and training, etc.) - is vital for sustained growth

[3] WHO/SEARO (October 2007), "Social Determinants of Health: Report of a Regional Consultation", Colombo.

and development. Social inclusion is a key social condition of health that is addressed by SDH to narrow health inequity.

Including health policies in a country's development agenda is more likely to lead to inclusive growth rather than implementing social policies separately. This is vital as health is a goal in the development agenda itself, and a key development input towards other development goals. For example, due recognition was given in MDGs, where of the total eight goals, health related goals number three, namely; reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases for achieving good health status universally.

The WHO initiated the Commission on Macroeconomics and Health (CMH) in 2002 with a specific focus 'to assess the place of health in global economic development'. The Commission report on 'Macroeconomics and Health: Investing in Health for Economic Development', published in 2001 highlights that 'investing in health' is the pillar of economic growth/development. The report also emphasized the need for countries to develop their own strategies for improving health through macroeconomic development.

In Sri Lanka too, periodic reports that spell out the country's overall national development framework have generally focused on improving health status and equity in the health sector through development policies. Objectives of accelerated economic growth and improvements in socio-economic outcomes have underpinned targeted improvements in health status across the country.

15.3 Sri Lanka's Health Sector Achievements

Since the late 1930s, Sri Lanka has implemented universal free health coverage, and as a result, the country has experienced remarkable health outcomes with relatively low public health expenditure when compared with countries at similar levels of socio-economic development. Health indices such as infant mortality rate (IMR), maternal mortality rate (MMR) and life expectancy have shown positive trends in Sri Lanka. In addition, expansion in health service delivery - through staffing, institutions for each level of care, technology-intensive medical equipment, etc. - has also been provided through the state.

After the implementation of welfare policies in the 1930s, IMR and MMR have seen a significant decline (Table 15.1). Widely extended infectious disease control programmes by the state also resulted in a relatively low death rate of 5.8 per 1,000 population in 2007 relative to 11 per 1,000 population in 1955. In turn, Sri Lanka saw a rising life expectancy rate. By 2009, life expectancy on average was 71 years which was much higher than the prevailing average of 65 years for the South East Asian countries.[4]

The network of curative care institutions for each level of care - primary, secondary and tertiary - has been constructed in demarcated geographical areas across the country. In 1941, the number of hospitals was estimated at 129, excluding maternity homes and other health centres.[5] By 1950, this had increased to 263. In 2007, the total number of hospitals with in-patient care was estimated at

[4] WHO, 2011, *World Health Statistics*.

[5] Silva. K. Tudor, 2010, "Social Determinants of Health: Lessons from Sri Lanka", in S. Bhattacharya *et al.* (eds.). *Social Determinants of Health: Assessing Theory, Policy and Practice*, Orient Blackswan, New Delhi.

Table 15.1
Select Health Indicators

	1935	1950	1970	1990	1995	2000	2005	2009
IMR[a]	263	82.3	47.5	19.3	16.5	13.3	11	13
MMR[b]	265	55.5	14.5	9.1	2.4	2	n.a.	3.9
Life expectancy	42.3[c]	55	65	71	72	73	73	74

Notes: a: Per 1,000 live births; b: Per 10,000 live births; c: Figure refers to 1946; n.a = not available.

Sources: WHO, *World Health Statistics;* Ministry of Health, *Annual Health Bulletin* (2000, 2003 and 2007); WHO–Sri Lanka (2002), "Macroeconomics and Health Initiatives".

615, in addition to which 441 central dispensaries provided out-patient care services.[6] In turn, bed strength also increased progressively, estimated at 3.4 beds for 1,000 population in 2007 relative to 2.8 in 1985. In terms of key health personnel, the number of medical officers (MOs) rose from 2,035 in 1982 to 11,023 by 2007. Accordingly, doctors per 100,000 population have increased to 55.1 in 2007 from 13.9 in 1980, while nurses also rose to 157 per 100,000 population in 2007 from 75 per 100,000 population in 1997. Overall, Sri Lanka's achievements on availability of health facilities and health outcomes are the result primarily of state-led programmes by successive governments.

15.4 Relevance of SDH for Sri Lanka

The focus on SDH arises owing to the fact that while medical care itself can only prolong survival, social determinants exert significant influence on premature death and diseases, particularly amongst vulnerable groups such as women, children, the elderly, etc. Emerging trends - viz., increasing inequalities within and between countries, new patterns of consumption and communication, commercialization, global environmental change, and urbanization - can exacerbate existing inequities.

Overall, narrowing health inequity is the most critical goal underpinning policies and interventions on SDH. Health inequity refers to the presence of systematic disparities in health between groups with different social advantages/disadvantages. The SDH are broadly constituted by: (i) the structural factors - unequal distribution of power, income, goods, and services, globally and nationally; and (ii) individual level factors - consequent unfairness in the immediate, visible circumstances of people's lives (access to health care, schools, education, conditions of work/leisure, homes, communities, towns, or cities and chances of leading a flourishing life) including the health system.

In order to understand the relevance of SDH for Sri Lanka, an analysis of health inequity needs to done, as addressed in the discussion that follows.

15.4.1 Health Inequity

Inequity in health is known simply as unfair distribution of services. Inequity can be observed through three means, namely:[7] (i) health status/outcomes, (ii) access to services and, (iii) financial allocations. Five common measures for health system assessments are:[8] (i) overall level of health, (ii) distribution of health in the population, (iii)

[6] Ministry of Health, *Annual Health Bulletin 2007*.

[7] WHO–Sri Lanka, 2002, "Poverty, Transition and Health: A Rapid Health System Analysis".

[8] WHO, 2000, *The World Health Report 2000: Health Systems - Improving Performance*, WHO, Geneva.

Table 15.2
Infant Mortality Rate by Mothers' Education Level

	1993	2000	2006/07
No schooling	44.7	25.5	33
Primary	32.3	29.9	23
Secondary	22.7	17.6	19
GCE(O/L) and GCE(A/L)	18.0	13.6	13
Higher	18.0	13.8	17

Source: Ministry of Health, *Annual Health Bulletin 2007*.

overall level of responsiveness, (iv) distribution of responsiveness, and (v) distribution of financial contribution. Of these, three measures - distribution of health, responsiveness and finance - are related to equity. While equity has two objectives pertaining to both inputs and outcomes, the latter is vital. Even in developed countries, where input distribution is relatively equitable, outcome disparities can be present.

Inequity in health outcomes: Even though Sri Lanka has achieved exceptional health outcomes through universal coverage of free health services, some significant pockets of disparities remain in groups with different social conditions. For instance, IMR across different levels of education of mothers vary (Table 15.2). The IMR for those in the 'no schooling' group is relatively high compared to the group with tertiary education levels. Accordingly, it is evident that disparities in health outcomes owing to social status, remains a concern.

Second, variations for crude death rate (CDR) and crude birth rate (CBR) are to be found across districts. For example, the highest CBR (29.4 per 1,000 population for 2007) was reported from Kilinochchi district, while the lowest at 13.5 was recorded in Gampaha district.[9] Furthermore, the highest CDR (8.4 per 1,000 population in 2007) was reported in Colombo district despite a relatively high accessibility of care. It may be that deaths occurring in hospitals in the Colombo district - with such hospitals drawing high numbers from across the country - are recorded as deaths in the Colombo district itself. The lowest CDR of 3.3 per 1,000 population was recorded in the Monaragala district.

Additionally, the prevalence of stunting amongst income groups vary. For instance, the percentages in the poorest and richest quintiles were 24 and 4 per cent, respectively, in 2000.[10] When considering wasted children, the poorest income quintile reported the highest rate of 20.1 per cent, while the richest quintile recorded 3.5 per cent in 2000.

Inequity in access to services: Improving health services through appropriate matching of facilities and recruitment of manpower in Sri Lanka remains an issue in the absence of adequate needs assessments. Most of the tertiary (teaching/special/provincial hospitals) and secondary care (district base hospitals) facilities are located in urban and semi-urban areas. In addition, health staff also prefer to work in these areas because of other facilities such as availability of accommodation in hospital premises or outside, schooling, transport, availability of safe

[9] *Ibid*.

[10] Rannan-Eliya, R., 2008, "Activities at Regional Level to Address Social Determinants and Health Inequalities", paper presented at seminar on 'Social Determinants of Health in the Maldives', October 2008.

drinking water, electricity, etc. Though people in rural or estate areas have access to primary care level facilities (divisional hospitals, including primary medical care units), they tend to by-pass these owing to unavailability of health staff and essential medicines/equipment at primary care level.[11] This phenomenon has adverse effects on inequalities in health outcomes between rural and urban sectors, as well as between income quintiles.

In 2006/07 for instance, IMR in the urban sector was 10 per 1,000 live births whilst for the rural and estate sectors it was 19 and 29 per 1,000 live births, respectively.[12] When considering health personnel, the majority of specialist doctors for curative care are to be found at higher level facilities in urban areas. Of a total 852 specialists in the country, 229 were in Colombo and a further 83 in Kandy in 2007. Moreover, skilled birth attendance by the poorest quintile in 2000 was 91 per cent while the richest was 99 per cent. Thus, the above figures reveal existing disparities in health facilities that in turn, constrain accessibility for care to patients.

Inequity in health financing: Financial risk protection is another pillar of attaining equity in health. In Sri Lanka, free health care is available to all citizens, but whether they are protected from financial risk in practice or whether services are free at the point of delivery is quite doubtful. Out-of-pocket expenditure for health (OOPE) is a valuable means of showing inequity in health financing in the context of free health services. In 2009, OOPE was 51 per cent of total health expenditure on average,[13] which is quite high compared to Thailand (34 per cent) which also has a well developed universal coverage existing within a mixed health financing system.

High OOPE has important implications. In Sri Lanka, unequal distribution of public health infrastructure may push people to poverty and impoverishment. At the same time, better quality of services in private rather than public facilities may increase demand for private care that results in rising 'catastrophic' expenditure - i.e., catastrophic impact signifies households with health care spending greater than 15 per cent of total household consumption.[14] Sri Lanka reports a figure of less than 2 per cent of households who fall into this category, better than countries with successful health systems like Thailand (2 per cent) and Taiwan (3 per cent).[15]

The recommendation by the WHO is that OOPE should not exceed 30-40 per cent of total health expenditure to achieve universal coverage.[16] In other words, as OOPE goes beyond 40 per cent of total health expenditure, it increases the financial risks of care seekers and that can contribute to rising inequity.

15.5 Way Forward on SDH Approach in Sri Lanka

Sri Lanka has been successful in acting on SDH through its national Commission. Two South East Asia Regional Consultations on SDH took place in 2007 and 2009 in Sri Lanka. As documented in the Consultation Report 2007, Sri Lanka aims to have a framework with regard to scaling up of sustain-

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11 de Silva, U.H.S and N. Attanayake, 1992, "Utilization of Resources at Peripheral Health Care Institutions in Gampaha District", mimeo.

12 Ministry of Health, *Annual Health Bulletin 2007*.

13 Central Bank of Sri Lanka, *Annual Report 2010*.

14 Catastrophic expenditure refers to percentage of consumption at individual household level.

15 Central Bank of Sri Lanka, *Annual Report 2010*.

16 WHO, 2009, *Health Financing Strategy for the Asia Pacific Region 2010-2015*, WHO, Geneva.

able action to address health inequities using an SDH approach. Three approaches have been identified, namely: (i) equity as an explicit and key objective of policy, (ii) SDH as an approach to narrow inequities, and (iii) PHC and inter-sectoral action as strategy. Actions on SDH in Sri Lanka have been implemented through the Sarvodaya and Shramadana Movement, the Gemidiriya Community Development and Livelihood Improvement Project, and a geo-spatial approach analysis. The Sarvodaya and Shramadana Movements work as NGOs while the Gamidiriya Project is financed by the state with foreign assistance. All development activities come through household level at the village and in turn, the benefits also go to the participants.

There are also other significant policy developments in relation to SDH. The WHO has proposed a project to strengthen national level policy formulation and implementation to tackle health inequities in Sri Lanka using an SDH approach, which in turn, is expected to provide support to develop interactions with other sectors. Second, two other interventions have been initiated - linked, although not directly targeted to SDH - including a pilot project on strengthening PHC by the Ministry of Health, and a pilot project on WHO Package of Essential Non-Communicable Disease Interventions (WHO PEN) for primary care in low-resource settings. While these are positive developments, given the many disparities faced by Sri Lanka's health sector due to social and economic conditions, actions to mitigate such disparities are few.

15.6 Conclusion and Policy Implications

Equity is vital to maintain good health outcomes and achieve economic and development objectives. It is evident that the greater share of health inequity is due to the social conditions in which people live and work. In Sri Lanka, socio-economic disparities in various forms continue to persist. In particular, income inequality becomes the main social condition for pushing people out from accessing opportunities. Unless checked, the gap between the poor and rich can widen further.

At present, Sri Lanka is attempting to address inequalities via SDH approach through limited economic and social interventions. However, it is clear that progress remains slow. Although inter-sectoral collaboration is a key strategy of Sri Lanka's SDH framework, its absence between health and other sectors in the country is the main constraint to make progress on issues of health equity. Previously, the National Health Council facilitated inter-sectoral actions, but its non-functionality at present, and the absence of an alternative high level stakeholder assembly, is a factor for the slow progress. Accordingly, a proper institutional mechanism to facilitate inter-sectoral actions on health, needs to be initiated by the Ministry of Health.

Health in All Policies (HiAP) is a key path of intersectoral actions for health. In the context of Sri Lanka, HiAP is still not formalized. Therefore, as a first step, stakeholders need to be convinced of the benefits of HiAP. Second, effective policy formulation to implement the HiAP concept could be developed thereafter.

Sri Lanka, as a lower-middle income country, is grappling with accelerating growth on one hand, and changing morbidity/mortality patterns and lifestyles with an ageing population due to transitions of demography and epidemiology, on the other. As a result, NCDs and a rapidly ageing population are on the rise. Such transitions may cause existing health inequities in the country to increase. Thus, while PHC as a major strategy of SDH approach is currently being strength-

ened, an effective, efficient, equitable and accessible health service with formalized health policies need to be implemented to tackle health outcome inequities, especially through PHC. Second, to manage equity in health financing, existing health financing policy needs to be revisited, in particular to ensure that the poor and vulnerable groups are protected from financial risks.

Overall, addressing SDH is urgent to mitigate health inequity in Sri Lanka. The CSDH provides technical guidance through regional consultations and other forms. The 2008 report of the CSDH called for global recognition to tackle health inequity through its three recommendations,[17] namely: (i) improving daily living conditions, (ii) tackling inequitable distribution of power, money and resources, and (iii) measuring and understanding the problems and impacts of inter-sectoral actions and PHC. Thus, Sri Lanka's health sector - together with other sectors - needs to take urgent action on SDH approach to mitigate health inequities as the country aims to achieve rapid growth. It is with the bridging of inequities that Sri Lanka will achieve the broader objective of inclusive economic development.

[17] WHO, 2008, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, WHO, Geneva.