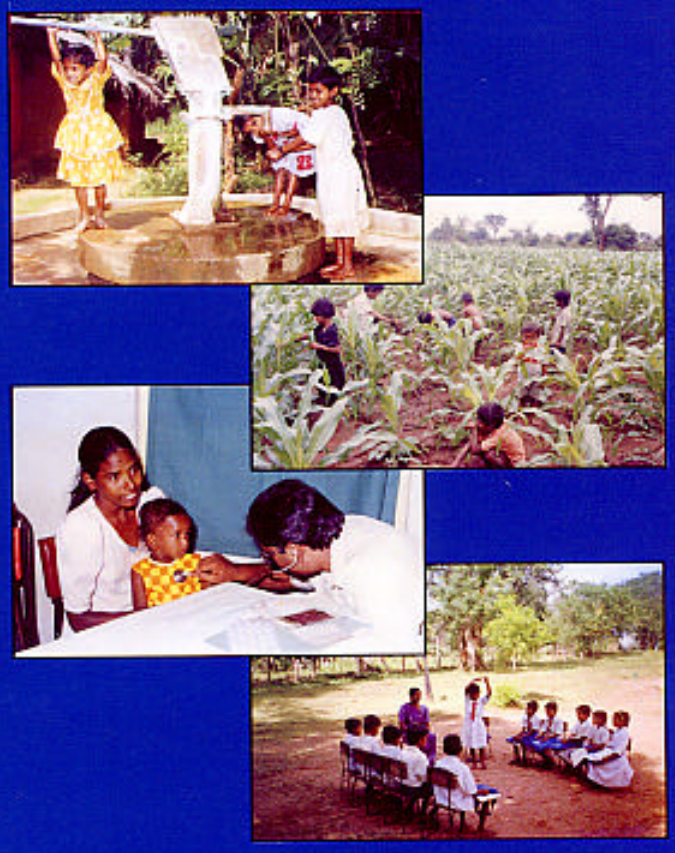
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INSTITUTE OF POLICY STUDIES

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Monitoring the 20/20 Compact: Sri Lanka

Executive Summary

Sri Lanka has long been known for its commitment to providing basic social services to its people. Access to basic social services has implicitly been regarded as a basic right of all Sri Lankans, and associated with this the necessity for public action to ensure such access. This commitment has been maintained, despite at times indifferent economic growth and employment generation. Underlying this commitment has been two continuing features of the Sri Lankan situation. Sri Lanka has enjoyed democratic self-government based on universal suffrage since 1931. This has been coupled with a general emphasis on the alleviation of suffering and poverty, which is found in all the four main religions observed by Sri Lanka's people, but especially Buddhism.

One additional feature of Sri Lanka's situation is also worthy of note. During its colonial occupation by the British, an extensive state administrative infrastructure was established for the purposes of maintaining internal security and the island's economic output. This administrative infrastructure, which stretches the whole length of the island, was built on as social services were expanded since the 1930s, and enables the state to tangibly reach every household in the country with its services, despite continuing poverty and a predominantly rural population.

The establishment of a democratic system of government in 1931 had two key impacts. Firstly, it created the mechanism, which forced successive governments in Sri Lanka to place high priority on the needs of the majority of its people, particularly those in rural areas, and to respond to those needs in an equitable manner. Secondly, it encouraged the government to expand its tax base at a fairly early stage in the country's economic development. The existence of a comparatively high level of fiscal resources, from the 1930s, permitted the government of Sri Lanka to commit itself to a relatively expansive and universal level of social services funded primarily through general revenues, and not through user charges or other private financing methods. This set of commitments was made many decades before the era of large-scale international donor assistance to developing countries. Sri Lanka had already established a system of financial sustainable and cost-effective social services by the 1960s, when it began to benefit from significant international financial assistance.

Based on the review conducted for this study, it is concluded that total government spending on basic social services falls below the targeted level of 20% of overall expenditures. Overall expenditure levels for basic social services have remained relatively stable in the past two decades, with significant variation observed only in the level of spending on nutritional subsidies. Aggregate spending levels in recent years have averaged approximately 12-16% of total government spending, with basic health accounting for 4-5%, basic education 2.5-4%, nutrition 4-6%, and water and sanitation for 1-2% (see graphs and tables following). With the exception of water and sanitation infrastructure, basic social services account for a higher proportion of recurrent government expenditures than of capital expenditures. This reflects the fact that the

greater part of Sri Lanka's infrastructure in the social sector was built in the 1930s-50s, especially hospitals, clinics and schools.

Donor expenditures on basic social services are lower as a proportion than is the case for government expenditures, and falls considerably below the targeted level of 20%. Unlike government expenditures, donor expenditure levels also show considerable fluctuation from year to year, as a consequence of the project-driven nature of donor assistance, and the reluctance of most donors to support recurrent expenditures.

While overall expenditures on basic social services are low by comparative regional standards, Sri Lanka does achieve far better coverage of these services and generally better outcomes than is the case in other countries. This is particularly the case with basic health and basic education, where universal access to basic services is largely achieved despite below-average expenditure levels. Three reasons largely appear to be central to this. The first is the relatively low cost of production of basic services in Sri Lanka. Health services appear to be delivered at unit costs far lower than observed elsewhere, and primary education unit costs are also relatively low. Reasons for the low costs include high volumes of utilisation of provided services, and relatively efficient allocation of inputs. For example, unlike many developing countries allocations in the health budget to non-salary inputs have averaged a high 50% or more, while the mix of health personnel, such as doctors and nurses, appears to have been more optimal than elsewhere.

The second reason is the relative equity of distribution and allocation of resources in the health and education sectors. Although Sri Lanka's governmental system was relatively centralised until the early 1990s, the geographical distribution of resources and expenditures does not show the gross inequities observed in other countries. The utilisation of basic health and education services is either relatively equal across all income groups (education), or substantially weighted towards the poorer households (health). The pro-poor distribution of health and education spending is due to two factors, which are that universal access has been largely achieved, and the lack of or modest level of user charges for basic services. The strong government presence in the basic social sectors and the belief that these services are the right of all citizens has ensured that universal access is maintained. Even when government financial resources have been limited, social sector funding has been protected in the government budget, often at the expense of critical areas of economic investment.

The third reason for high levels of basic services provision despite low national expenditures is that the government has allocated and continues to allocate, a high level of its social sector funding to basic services, and has eschewed substantial allocations to higher level tertiary services. More than 80% of the total health budget is devoted to basic health services, and more than 35% of the education budget is allocated to primary education.

While the relatively high level of services, despite low levels of expenditure, is reassuring, it does imply several problems. Firstly, the relative efficiency of service delivery in the education and health sectors is associated with little possibility for significant efficiency savings through organisational reform. The one area, which might seem attractive is decentralisation. However, experience to date in Sri Lanka, where there has been a devolution process since the 1980s, does not indicate substantial efficiency savings from decentralisation. In fact, the international evidence, according to WHO and World Bank studies, now indicates that decentralisation in the health sector most often increases costs. Secondly, the low cost of services is at the expense of quality. While Sri Lanka does provide universal access to basic health and education services, these are often of low quality, consumer quality in the case of health services, and technical quality in the case of education. Significant expansion of either coverage in basic social services or of quality will definitely require increases in budgetary resources. In fact, in several areas, such as health, any potential efficiency savings can only be achieved subsequent to an increase in budgetary resources.

Sri Lanka has not, and is not experiencing a fiscal crisis. Modest to good economic growth in the past decade has ensured that tax revenues and real per capita expenditures on social services have in fact increased. Nevertheless, significant increases in budgetary allocations to basic social services in the next three to six years are unlikely, as available discretionary funding is limited. The ongoing internal conflict (and an earlier insurgency during 1987-90) has resulted in increased expenditures on defence.

For obvious reasons related to national sovereignty, and the primary obligation of the state to ensure security, defence expenditures are unlikely to diminish until after the cessation of hostilities, or a substantial diminution in the intensity of the fighting. Even if the current internal conflict was to end, immediate fiscal savings are unlikely, as the salary costs of security force personnel will remain. Most of the soldiers are recruited from rural areas and, therefore, a large proportion of rural households are dependent on military salaries to remain above the poverty line. These salaries at least in the short term would have to be replaced by other income transfers in order to maintain living conditions in rural areas. In addition, expenditures on reconstruction and rehabilitation will have to substantially increase in order to secure the peace, and provide the means for economic activity and normal civil society to restart in the war-afflicted areas.

The direct costs of the internal conflict (military budgets and expenditures on the internally displaced) have been largely funded by cutting expenditures in other areas. Expenditures on basic social services have largely been protected in the budgetary allocation process. While some of the expenditure reductions have been desirable, such as curtailing transfers to loss making government parastatals, many of which have been privatised, other savings have not been desirable from a long-term perspective.

There is clear evidence that this under-funding of infrastructure is now constraining growth in Sri Lanka's economy. Since economic growth is a sine qua non for substantial improvements in social sector financing, the priority for government spending, if

additional revenues become available in the medium term future, should be economic infrastructure, and not expanded basic social services. The need for increased allocation of general revenue spending to economic infrastructure has been strengthened in the past year by the regional economic crisis which has increased the risk premium for private financing of infrastructure projects.

In this situation, increased funding for social services will have to wait or require mobilisation of resources from other mechanisms. As basic social services are by definition meant to assist in the alleviation of poverty, it is unclear how this can be achieved. The most that might be achieved would be to shift part of the government burden in the social service area to the private sector. The most likely area for this is education, where private participation in the funding and provision of secondary and tertiary education is limited. Increases in private sector participation in the education sector does require a new policy framework, but possibilities do exist for expanding tertiary education through private financing. Nevertheless, there is little scope for increasing private financing in the primary education sector, unless equity considerations are ignored. In the case of water and sanitation, there is little room for increased private sector financing. Although there is a strong argument for raising prices for water services, and this is in fact being pursued as policy, substantial expansion of rural water supplies and sanitation services is likely to be capital intensive, and require government support. In the area of health services, the case for increased resource mobilisation through public sector user fees does not exist, and private insurance cannot make a significant contribution. The only alternative may be to develop social health insurance, but the technical capacity to do this does not yet exist, although it could be created if a decision is made to do so.

In this context of severe government constraints on the funding side, there may be a case for increased donor spending in Sri Lanka's social sectors. This should recognise that the current limitations on increased public spending are temporary, due primarily to the ongoing conflict situation, and that Sri Lanka may need assistance to expand basic social services until the time that the war ends. Donor funding for technical assistance may also be critical to assist Sri Lanka develop other non-general revenue funding mechanisms to support expansion of basic health services as well as develop a stronger policy framework for the financing of the educational services.

Methodologically, this study has revealed a number of information problems in the social sector. The principal one is that decentralisation in Sri Lanka has resulted in a deterioration in the quality of available budgetary expenditure data. Under the system of devolution introduced in Sri Lanka in 1987, more than half of basic education and basic health expenditures are the responsibility of the provinces. Under the current constitutional framework, there is no legal authorisation for central ministries and agencies to obtain accurate and timely data on how the provinces spend their resources. Consequently, the quality and completeness of data collected was often worse for the most recent years than for the pre-1987 period. It should be noted that this has made and will make it difficult to monitor achievement of the 20/20.

Compact budgetary goals for government expenditures on social services, raises the issue of whether the central government can make such international commitments given that it is constitutionally debarred from making many of the relevant allocation decisions at the provincial level. As Sri Lanka's current system of devolution was based directly on the Indian Constitution, this experience suggests that countries pursuing decentralisation should think carefully about the details and adapt the principles of decentralisation to the local context, instead of simply copying systems from national situations which may be quite different. Another disturbing aspect of this weakness in the information systems is that the lack of data in central government agencies on provincial expenditures also means that the provincial electorates are themselves ignorant. Decentralisation is supposed to increase accountability of local services to communities, but in Sri Lanka's case the lack of information on provincial level activities would seem to prevent this.

In conclusion, Sri Lanka has long had and continues to have a strong national commitment to human development and poverty alleviation. However, there are issues which have emerged related to further expansion of the social sectors and increasing resources particularly to improve the quality of services. The 20/20 Compact Study has revealed the extent of expenditures for basic services and also implications in terms of monitoring expenditures particularly in the light of the decentralisation to the provinces. It is hoped that this effort will provoke discussion on developing mechanisms to increase resource mobilisation for basic social services, and that it will provide useful lessons to other developing countries and to Sri Lanka's international co-operation partners on how best to achieve the underlying goals of the 20/20 Compact in other countries which have not been as successful as Sri Lanka.

Note on estimates of expenditures on basic social services

Estimates of government and donor expenditures on basic social services are given in the following table and figures. The following should be noted.

- Donor expenditures on basic education services could not be compiled, because of difficulties in disaggregating donor expenditures on basic education from other education expenditures.
- Government expenditures on water and sanitation could not usefully be disaggregated into basic and non-basic, and into recurrent and capital, because of lack of sufficient information. Therefore all water and sanitation expenditures have been counted as expenditures on basic social services, and have been shown in the table as recurrent government expenditures.
- Some expenditure data were not available as far back as 1982 and 1987, and so the estimates for those years are partial. Basic education expenditures were only available from 1990 onwards.

Executive Summary

Figure A
Government Expenditures on Basic Social Services, 1982-1996

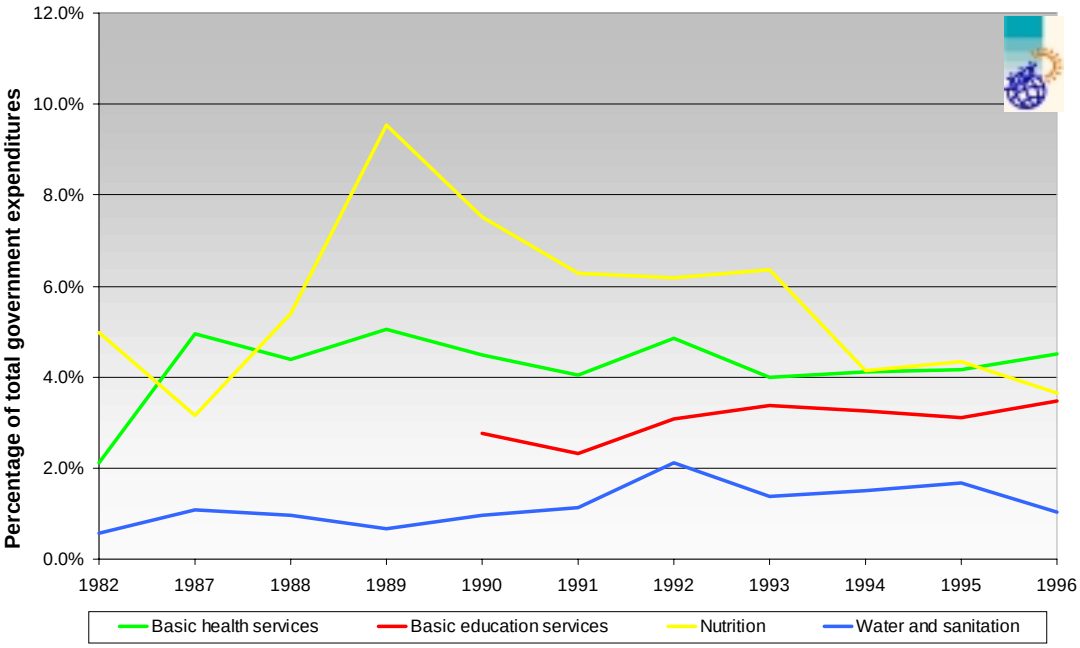
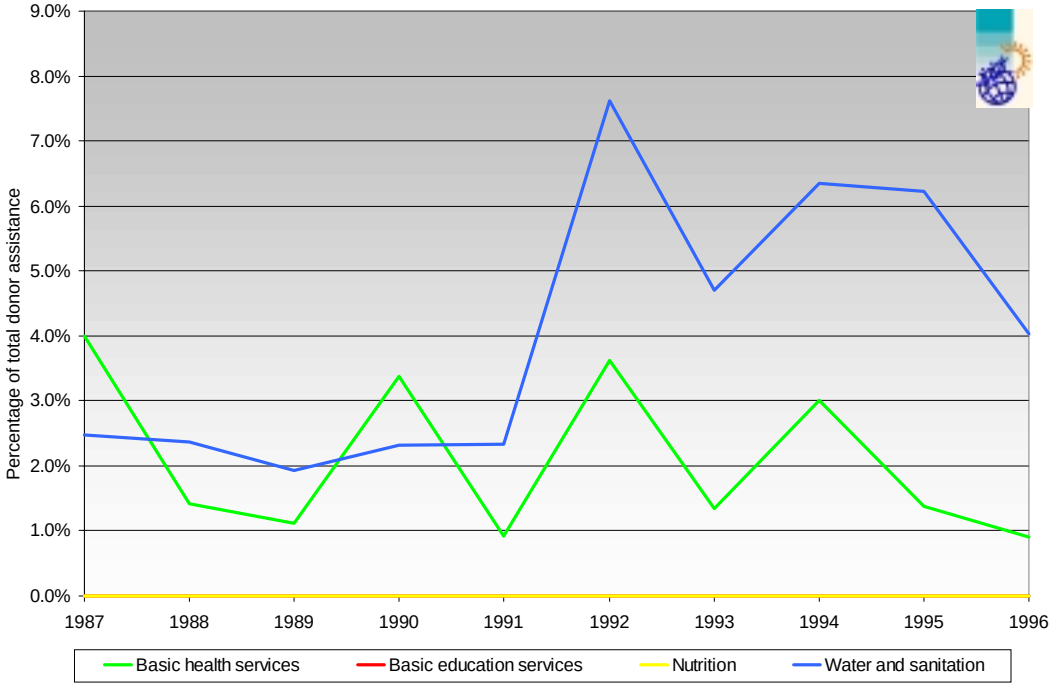


Figure B
Donor Expenditures on Basic Social Services, 1982-96



Monitoring the 20/20 Compact: Sri Lanka

Table A Expenditures on Basic Social Services, Sri Lanka 1982-1996 (Provisional Estimates)

Year	1982	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Government BSS recurrent expenditures (Rupees)											
Basic health services	609,765,378	2,135,317,669	2,124,434,996	2,840,272,068	3,341,024,941	3,700,727,126	4,277,394,935	4,486,558,005	5,864,500,766	6,962,330,749	7,698,748,077
Basic education services					2,388,000,000	2,306,000,000	2,844,000,000	3,251,000,000	3,709,000,000	4,262,000,000	4,645,000,000
Nutrition	1,714,000,000	2,071,000,000	4,006,000,000	7,966,000,000	7,369,000,000	7,314,000,000	7,368,000,000	9,092,000,000	6,929,000,000	8,995,000,000	7,962,000,000
Water and sanitation	196,980,000	707,631,000	714,695,000	549,553,000	936,756,000	1,312,956,000	2,533,875,000	1,986,789,000	2,532,660,000	3,459,304,000	2,276,669,000
Total	2,520,745,378	4,913,948,669	6,845,129,996	11,355,825,068	14,034,780,941	14,633,683,126	17,023,269,935	18,816,347,005	19,035,160,766	23,678,634,749	22,582,417,077
Government BSS capital expenditures (Rupees)											
Basic health services	122,370,630	1,117,019,900	1,118,464,427	1,371,232,110	1,071,957,915	1,011,552,085	1,510,531,282	1,242,348,907	1,030,662,837	1,657,262,164	2,193,434,660
Basic education services					313,000,000	377,000,000	823,000,000	1,593,000,000	1,726,000,000	2,187,000,000	2,937,000,000
Nutrition	-	-	-	-	-	-	-	-	-	-	-
Water and sanitation											
Total	122,370,630	1,117,019,900	1,118,464,427	1,371,232,110	1,384,957,915	1,388,552,085	2,333,531,282	2,835,348,907	2,756,662,837	3,844,262,164	5,130,434,660
Government BSS total expenditures (Rupees)											
Basic health services	732,136,008	3,252,337,569	3,242,899,423	4,211,504,177	4,412,982,856	4,712,279,211	5,787,926,217	5,728,906,912	6,895,163,602	8,619,592,912	9,892,182,737
Basic education services	-	-	-	-	2,701,000,000	2,683,000,000	3,667,000,000	4,844,000,000	5,435,000,000	6,449,000,000	7,582,000,000
Nutrition	1,714,000,000	2,071,000,000	4,006,000,000	7,966,000,000	7,369,000,000	7,314,000,000	7,368,000,000	9,092,000,000	6,929,000,000	8,995,000,000	7,962,000,000
Water and sanitation	196,980,000	707,631,000	714,695,000	549,553,000	936,756,000	1,312,956,000	2,533,875,000	1,986,789,000	2,532,660,000	3,459,304,000	2,276,669,000
Total	2,643,116,008	6,030,968,569	7,963,594,423	12,727,057,177	15,419,738,856	16,022,235,211	19,356,801,217	21,651,695,912	21,791,823,602	27,522,896,912	27,712,851,737
Total Recurrent Government Expenditure	18,341,000,000	39,559,000,000	46,132,000,000	56,884,000,000	71,771,000,000	83,756,000,000	89,638,000,000	102,288,000,000	127,084,000,000	154,159,000,000	170,629,000,000
Total Capital Government Expenditure	16,146,000,000	25,975,000,000	27,971,000,000	26,651,000,000	26,387,000,000	32,658,000,000	29,622,000,000	40,841,000,000	40,455,000,000	52,810,000,000	48,369,000,000
Total Government Expenditure	34,487,000,000	65,534,000,000	74,103,000,000	83,535,000,000	98,158,000,000	116,414,000,000	119,260,000,000	143,129,000,000	167,539,000,000	206,969,000,000	218,998,000,000
Government BSS expenditures (% of total government recurrent expenditures)											
Basic health services	3.3%	5.4%	4.6%	5.0%	4.7%	4.4%	4.8%	4.4%	4.6%	4.5%	4.5%
Basic education services	0.0%	NA	NA	NA	3.3%	2.8%	3.2%	3.2%	2.9%	2.8%	2.7%
Nutrition	9.3%	5.2%	8.7%	14.0%	10.3%	8.7%	8.2%	8.9%	5.5%	5.8%	4.7%
Water and sanitation	1.1%	1.8%	1.5%	1.0%	1.3%	1.6%	2.8%	1.9%	2.0%	2.2%	1.3%
Total	**13.7%**	***12.4%***	***14.8%***	***20.0%***	**19.6%**	**17.5%**	**19.0%**	**18.4%**	**15.0%**	**15.4%**	**13.2%**
Government BSS expenditures (% of total government capital expenditures)											
Basic health services	0.8%	4.3%	4.0%	5.1%	4.1%	3.1%	5.1%	3.0%	2.5%	3.1%	4.5%
Basic education services	0.0%	0.0%	0.0%	0.0%	1.2%	1.2%	2.8%	3.9%	4.3%	4.1%	6.1%
Nutrition	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Water and sanitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**0.8%**	**4.3%**	**4.0%**	**5.1%**	**5.2%**	**4.3%**	**7.9%**	**6.9%**	**6.8%**	**7.3%**	**10.6%**
Government BSS expenditures (% of total government expenditures)											
Basic health services	2.1%	5.0%	4.4%	5.0%	4.5%	4.0%	4.9%	4.0%	4.1%	4.2%	4.5%
Basic education services	0.0%	NA	NA	NA	2.8%	2.3%	3.1%	3.4%	3.2%	3.1%	3.5%
Nutrition	5.0%	3.2%	5.4%	9.5%	7.5%	6.3%	6.2%	6.4%	4.1%	4.3%	3.6%
Water and sanitation	0.6%	1.1%	1.0%	0.7%	1.0%	1.1%	2.1%	1.4%	1.5%	1.7%	1.0%
Total	**7.7%**	**9.2%**	**10.7%**	**15.2%**	**15.7%**	**13.8%**	**16.2%**	**15.1%**	**13.0%**	**13.3%**	**12.7%**
Foreign assistance for BSS (rupees)											
Basic health services	NA	690,547,049	293,794,950	229,430,198	870,894,158	327,723,040	822,598,107	346,746,843	828,453,427	454,931,691	287,317,548
Basic education services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA NA	
Nutrition	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA NA	
Water and sanitation	NA	427,217,000	489,360,000	397,883,000	597,290,000	839,188,000	1,731,460,000	1,217,753,000	1,752,349,000	2,042,447,000	1,297,170,000
Total	NA	1,117,764,049	783,154,950	627,313,198	1,468,184,158	1,166,911,040	2,554,058,107	1,564,499,843	2,580,802,427	2,497,378,691	1,584,487,548
Total Foreign assistance (rupees)											-
Total gross receipts	**15,120,000,000**	**17,308,000,000**	**20,673,000,000**	**20,686,000,000**	**25,780,000,000**	**35,944,000,000**	**22,712,000,000**	**25,917,000,000**	**27,641,000,000**	**32,840,000,000**	**32,145,000,000**
Grants	3,376,000,000	4,677,000,000	6,588,000,000	6,407,000,000	6,698,000,000	7,870,000,000	8,280,000,000	8,025,000,000	8,257,000,000	9,028,000,000	7,739,000,000
Loans - Gross receipts	11,744,000,000	12,631,000,000	14,085,000,000	14,279,000,000	19,082,000,000	28,074,000,000	14,432,000,000	17,892,000,000	19,384,000,000	23,812,000,000	24,435,000,000
Total net receipts	**8,120,000,000**	**10,308,000,000**	**13,673,000,000**	**13,686,000,000**	**18,780,000,000**	**28,944,000,000**	**15,712,000,000**	**18,897,000,000**	**20,055,000,000**	**24,910,000,000**	**22,792,000,000**
Loans - Net receipts	*4,744,000,000*	**5,631,000,000**	7,085,000,000	7,279,000,000	12,082,000,000	21,074,000,000	7,432,000,000	10,872,000,000	11,798,000,000	15,882,000,000	15,053,000,000
									1,000,000		
Donor BSS expenditures (% of total gross receipts of foreign assistance)											
Basic health services	NA	4.0%	1.4%	1.1%	3.4%	0.9%	3.6%	1.3%	3.0%	1.4%	0.9%
Basic education services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Nutrition	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Water and sanitation	NA	2.5%	2.4%	1.9%	2.3%	2.3%	7.6%	4.7%	6.3%	6.2%	4.0%
Total	NA	6.5%	3.8%	3.0%	5.7%	3.2%	11.2%	6.0%	9.3%	7.6%	4.9%

An introduction to the 20/20 Initiative

Although the 20/20 Initiative featured prominently during the Oslo meeting in 1996, it was five United Nations Organizations (viz, UNDP, UNESCO, UNFPA, UNICEF and WHO) that originally proposed it in a paper titled, "The 20/20 Initiative: Achieving universal access to basic social services for sustainable human development," in 1994. The Initiative called for the restructuring of government budgets and official development assistance (ODA) in favour of basic social services.

The essence of the 20/20 Initiative is to forge a consensus between donors and developing countries to cooperate in supporting well-defined goals in social development. In order to achieve the objective, national government should agree to allocate 20 percent of their public expenditure for basic social services (BSS) and, donors on their part, should commit themselves to allocate 20 percent of the ODA for the same purpose. The latter, meanwhile, is couched within the general agreement by developed countries to strive towards devoting 0.7 percent of their GNP for overall ODA at the earliest possible time (however, only a very few developed countries have as yet come close to fulfilling this obligation).

The Initiative was inspired by the successful experience in setting performance targets for selected areas of social development. A good example is universal child immunization (UCI-110), which raised the global average immunization level from 23 percent in 1981 to 81 percent in 1990. This and other experience have shown that international efforts to monitor progress can provide an important impetus and generate renewed political will to achieve set goals.

Within the human development agenda, basic social services have certain common characteristics that distinguish them from other priority areas. First, basic social services are of particular importance in reducing the worst aspects of absolute poverty. Ignorance, disease, hunger and powerlessness are the main factors that perpetuate the cycle of poverty. Basic education, basic (primary) health care (with reproductive health including family planning and sexual health), nutrition, supply of clean water, sanitation as well as the institutional capacity for delivering these services, are of prime imports in breaking that cycle.

Second, all basic social services yield high returns and are associated with strong positive externalities. This means that the society at large will benefit from their expended coverage and improved quality, both socially and economically. As such, a consensus has emerged that governments need to play a significant role in securing universal access to basic services.

Third, basic social services are characterized by strong complementarities. The ultimate impact and effectiveness of each of the basic social services will depend on the availability of other basic

services. The impact of health services, for instance, will be reduced if the literacy rate among women is low or their access to clean water is limited. Unintended population growth due to a lack of reproductive health information and services, in turn increases the burden of subsequent demand for services.

The current reality in terms of fulfilling the obligations of the 20/20 Initiative is as follows. A UNICEF Staff Working Paper by Parker and Jespersen in 1994 revealed that, available information allows only an approximate assessment of a nation's situation, in terms of national budget and ODA shares allocated to basic social services. Their assessment is that globally the ratio is approximately at 13 to 10, which means that an average of 13 percent of national budgets and an average 10 percent of ODA, are supporting the capacity-financial, human and institutional-to deliver basic social services.

Several national studies commissioned in Asian countries indicate that, in Sri Lanka, Thailand and Bangladesh the allocation to basic social services is around 13-14 percent of the public expenditure.

Constituents of Basic Social Services*

One of the primary functions performed by the 20/20 Initiative at the practical level is to provide a clear-cut and specific focus on basic social services, within the broad social development agenda. As stated earlier, basic social services (BSS) constitutes the provision of basic education, basic (primary) health care (with reproductive health including family planning and sexual health), nutrition, clean water and sanitation. In addition, the provision of BSS entails the improvement of the institutional capacity for delivering these services. If Sri Lanka is to improve its efficacy in delivering BSS, the provincial and local administrative machinery needs to enlighten itself on the subject, evolve its own initiatives and activate the process of delivery in as sustainable a manner as possible. The explanations below provide more details on the activities in each sector of BSS. However, the brief definitions are not meant to be exhaustive but serve to open the vistas of possibilities.

Basic Education

Primary schooling and alternative programmes: Curriculum development, teacher education, provision of learning materials, evaluation of learning achievements, and improved management at system and institutional levels.

* Excerpt from Annex 1 of paper, "Implementing the 20/20 Initiative: issues regarding definitions, modalities and monitoring," prepared for the Oslo meeting in April 1996.

Early childhood development: Child care and, stimulation and initial learning through family and community-based programmes and preschool institutions.

Basic education for youth and adults: Programmes in various sectors of activity that provide training in literacy and numeracy and other essential life skills. Basic education through traditional and modern media and, social action to enable individuals and families to acquire knowledge and skills needed for better living.

Basic Health ("Primary health care")

Disease control: Activities for the provision and control of specific diseases; includes the expanded programme of immunization (EPI), control of diarrhoeal diseases (CDD), AIDS/HIV and malaria, among other major programmes.

Maternal and child health: Prenatal and postnatal care, including the safe motherhood activities.
Basic curative care : Essential curative health services.

Reproductive health services: Family planning, counseling, education and services for prenatal care, safe delivery and postnatal care; breast-feeding, infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in the ICPD Plan of Action, including prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and responsible parenthood. Active discouragement of harmful practices such as female genital mutilation should also be an integral part of primary health care.

Family planning: Contraceptive commodities and services delivery; capacity-building for information, education and communication regarding family planning and population and development issues; national capacity-building through support for training; infrastructure development and upgrading of facilities; policy development and programme evaluation; management of information systems; basic services statistics and focused efforts to ensure good-quality care.

HIV/AIDS prevention: Mass media and in-school education programmes, promotion of voluntary abstinence and responsible sexual behaviour, and expanded condom distribution.

Health personnel development: Training of health staff all levels of primary health care services; includes training of nurses, auxiliaries, managers and other cadres, support for training facilities and training materials; excludes medical training for tertiary-level services.

District-level hospitals and health service management: Strengthening of health services in rural and urban areas with the goal of improving health knowledge and practices.

Data/policy/analysis: National capacity-building through support for demographic as well as programme relevant data collection and analysis, research, policy development and training.

Water Supply and Sanitation ("Environmental health")

Low-cost technologies for water supply: Provision of water supply through low-cost technologies, costing less than $30 per beneficiary, including hand-pumps, gravity-fed systems and rainwater collection; provision of pumps, pipes, training of workers, development and strengthening of management procedures; excludes most piped-water systems, particularly in the urban areas.

Low-cost technologies for sanitation: Development of sanitation facilities through low-cost technologies, costing less than $20 per beneficiary, including VIP and other latrines; provision of materials, training, development and, strengthening of management procedures.

Hygiene, education and training: Information, education and communication activities to improve knowledge and behaviour related to water supply and sanitation.

Nutrition

Direct feeding programmes: Provision of food and associated management support for feeding programmes, including maternal feeding, school feeding and nutrition rehabilitation.

Nutrition information system: Monitoring of nutritional status at the community level; collection and processing of information at local and national levels.

Micro-nutrient malnutrition: Determination of micro-utrient deficiencies; provision of vitamin A, iodine, iron and other micro-nutrients through supplementation, fortification, and dietary change.
Household food security: Activities to improve access to food at the household and community levels; includes home gardening and education of the population.

Child feeding: Improvement of infant and child feeding; includes promotion, protection and support of breast-feeding and, improvement of weaning foods and practices through training, education and provision of food.

Chapter 1: Economic and Social Trends

1.1 Introduction

Sri Lanka like most developing countries has had three main objectives since independence - that is, to achieve a reasonable rate of economic growth, greater equity, and greater self-reliance or national control. However, it has placed greater emphasis on equity than most other developing countries with a similar per capita income status. Even during the late 1970s, Sri Lanka was spending on average 9.5 per cent of its GDP on welfare expenditure compared with 6.4 per cent by Thailand, 3.9 per cent by Korea and 3.1 per cent by The Philippines (World Bank, 1981). Succeeding governments have committed themselves to a large number of social programmes; free education, health services and a wide range of consumer subsidies have proven to be the most costly programmes that entered the government budget. Sri Lanka has often been cited as an interesting case of a developing country whose level of social progress has as a result been quite high relative to the country's per capita income level (Isenmen, 1980). In effect, the country was held up as a model for the school of thought that emphasised basic needs fulfilment as a necessary step in the process of development. (Streeten and Burki,1978). In 1993, Sri Lanka had an adult illiteracy rate of 12 per cent, compared with 41 per cent on average for all low-income economies; life expectancy at birth was 72 years, compared with 62 years for all low-income economies; and infant mortality was 17 per thousand live births, compared with 64 per thousand live births on average for all low-income economies (World Bank,1996).

1.2 Macroeconomic Trends

With market-oriented reforms sustained over a period of two decades, Sri Lanka remains one of the most open economies in the developing world. A programme of economic liberalisation initiated in 1977 that aimed at reforms in the trade and payments sphere, financial deregulation and fiscal restructuring, has resulted in some marked structural changes in the economy. The share of agriculture in GDP has declined continuously to account for a quarter of GDP by the mid-1990s, while manufacturing and services account for 15 and 50 per cent respectively. Nevertheless, almost 65 per cent of the country’s population (of 18.3 million in 1996) remains largely dependent on agriculture for their livelihood and it provides employment for about 37 per cent of the labour force. Sri Lanka continues to have a vast pool of surplus labour with the current rate of unemployment estimated at around 10.7 per cent of the labour force (1997 first quarter).

The singular most striking feature of the post-liberalisation economic performance was an impressive acceleration in its rate of economic growth between 1978-1983 (Table 1.2a). In comparison to an annual average 2.9 per cent growth rate for GDP during 1970-77, the economy

services. The impact of health services, for instance, will be reduced if the literacy rate among women is low or their access to clean water is limited. Unintended population growth due to a lack of reproductive health information and services, in turn increases the burden of subsequent demand for services.

The current reality in terms of fulfilling the obligations of the 20/20 Initiative is as follows. A UNICEF Staff Working Paper by Parker and Jespersen in 1994 revealed that, available information allows only an approximate assessment of a nation's situation, in terms of national budget and ODA shares allocated to basic social services. Their assessment is that globally the ratio is approximately at 13 to 10, which means that an average of 13 percent of national budgets and an average 10 percent of ODA, are supporting the capacity-financial, human and institutional-to deliver basic social services.

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Child feeding: Improvement of infant and child feeding; includes promotion, protection and support of breast-feeding and, improvement of weaning foods and practices through training, education and provision of food.

maintained a growth rate of just fewer than 6 per cent per annum between 1978 and 1983. This meant that the country was able to achieve a real per capita income growth of 3.5 per cent per annum in the same period. Economic growth in the immediate post-reform period was to a large extent driven by a massive public investment programme (particularly, the Accelerated Mahaweli Development Programme which was largely donor funded and intended to provide irrigation and hydroelectric power generation). Gross Domestic Capital Formation that had been no more than 15-16 per cent of GDP prior to liberalisation rose sharply in the post-1977 period to peak at 34 per cent of GDP in 1980. Concurrently, public investment as a proportion of GDP nearly doubled to 15 per cent by the early 1980s.

Table 1.2a: Selected Economic Indicators, 1978-1996

Item	1978-83	1984-89	1990-93	1994-96
	Period average annual growth rate			
Population	1.7	1.4	1.2	1.2
Per capita GNP	5.2	3.1	5.3	3.5
GDP	5.9	3.0	6.2	5.0
	Percentage of GDP			
Agriculture	27.7	26.9	25.6	23.3
Manufacturing	11.1	11.8	13.7	13.5
Services	45.9	47.7	50.2	51.5
Gross Domestic Capital Formation/GDP	28.4	23.4	24.3	25.6
Public investment/GDCF	54.8	55.3	36.5	N/A
Domestic savings/GDP	12.8	13.3	15.2	15.3
Public savings/GDP	-1.3	2.0	-1.4	-3.2
Budget deficit/GDP	18.6	12.9	10.3	10.5
Rate of inflation (period average)	15.2	9.8	13.8	

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

Economic growth was also accompanied by a consistent decline in the rate of unemployment, for the country initially (as seen below):

Table 1.2b: Unemployment Rate According to Government Survey

1973	24.0*	1990	15.9	1995	12.3
1978/79	14.8*	1991	14.7	1996	11.4
1981/82	11.2*	1992	14.6	1997	10.7
1985/86	14.1	1993	13.8	(First Quarter)	
1986/87	15.5*	1994	13.1		

Source: Dept of Census and Statistics, Labour Force & Socio-Economic Survey.
Note: * Central Bank, Consumer Finance Survey.

While data on comparable rates of unemployment over time have to be interpreted with some caution, available estimates suggest that the rate of total unemployment fell from 19.9 per cent in 1975 to 14.8 per cent in 1979. By 1982, the rate had fallen further to 11.2. The government's public investment programme provided the initial boost to employment generation. While the reduction in unemployment can be attributed in part to the liberalised trade policies, the rapid opening up of foreign labour markets for local unskilled, semi-skilled and skilled workers, particularly in the Middle Eastern countries, contributed a great deal to this reduction.

However, the economy was running into difficulties as early as 1980. The public investment programme not only ate into scarce resources, but also contributed to a build up of significant inflationary pressure. The removal of universal food subsidies and the introduction of a food stamp scheme in 1979 helped to reduce government expenditure. During 1970-77 food subsidies accounted for 3.6 per cent of GDP per annum, but during 1978-83 this figure was down to just 1.1 per cent. This improvement in the fiscal balance however was counter balanced by the massive increase in capital expenditure as a result of the public investment programme. The resulting macroeconomic imbalance in the economy was particularly severe because the increase in public investment went unmatched by an increase in public savings. Thus the scene was set for emerging budget deficits and soaring inflation.

These problems became evident in the early 1980s with budget and current account deficits running at approximately 25 per cent and 17 per cent of GDP and inflation recording a rate of 26 per cent in 1980. The Government at the behest of the IMF was forced to adopt a more prudent macroeconomic strategy. While some improvement in the macroeconomic balance was achieved on the domestic and external front by 1984, with the budget deficit down to just over 10 per cent of GDP and the current account deficit down to 6.6 per cent of GDP, the government was faced with new and escalating problems on the socio-political front. The economic problems facing the government were exacerbated by escalating civil unrest, which besides the structural damage inflicted on the economy as a result, served not only to undermine investor confidence in the country but also added to the budgetary burden via higher defence expenditure. The government's problems were exacerbated by rising unemployment. A survey of the labour force in 1985 put the rate of total unemployment in the country at 14.1 per cent.

From 1985, Sri Lanka began to experience a rapid downturn in its growth performance. A resurgent Marxist political force (the JVP), whose main aim was the destabilisation and overthrow of the Government, caused widespread disruptions to commercial life with the enforcement of illegal strikes. From 1986 to 1989, social and political unrest was widespread in all parts of the country and

as both direct and indirect repercussions of the civil disturbances percolated through the economy, economic growth slowed considerably. A five-year rolling investment and development plan for 1986-90, which envisaged a growth rate of 4.5 per cent per annum for the economy, proved far too optimistic in reality. Economic performance in 1987 was the poorest in the decade with a growth rate of only 1.5 per cent. Agriculture's share of output ensures that its performance still heavily influences the overall performance of the economy. Thus a severe drought in 1987 saw agricultural production falling by almost 6 per cent, adding further to the economic dislocations caused by civil strife.

The year 1989 saw an end to the social and political unrest, which had overwhelmed the southern and western provinces of the country since 1986 (although the civil war in the north and east of the country continues). The government undertook what it termed the second phase of liberalisation aimed specifically at liberalising the business environment and existing payments restrictions. After years of relatively poor economic growth, when GDP grew at only 3 per cent per annum during 1984-89 and only a marginal increase in per capita income of 1.6 per cent per annum, the economy showed visible signs of recovery from 1990. GDP grew at an annual average of 6.2 per cent during 1990-93 while per capita GNP recorded a growth rate of 5.3 per cent. Despite a change of government in 1994, Sri Lanka's economic policy remains broadly committed to an 'open economy'. The country was able to achieve an annual average growth rate of 5 per cent during 1994-96, which translated to a per capita growth rate of 3.5 per cent per annum over the same period.

However, despite renewed growth performance, unemployment continues to be an ever-present problem with the total unemployed estimated at approximately 12-14 per cent of the labour force. With an estimated 140,000 entering the labour force each year, the country needs to achieve an annual average growth rate well in excess of 7 per cent to realistically absorb new entrants and make inroads in to the backlog of the unemployed. Despite the initial surge in investment, which was very much a direct outcome of the government's public investment programme, the ratio of investment to GDP has continued thereafter to remain at around 25 per cent. Public investment continued to account for 55-60 per cent of total investment right up to mid 1980s, and only thereafter falling swiftly to around 37 per cent of total investment by the early 1990s. By contrast private investment, having declined to an annual average of 10-11 per cent of GDP during the crisis years of 1984-89 began to pick up from the 1990s with the renewed emphasis on privatisation and liberalisation. Private sector investment accounted for 15 per cent of GDP and 65 per cent of total GDCF by the mid 1990s.

The average domestic savings ratio in Sri Lanka has changed very little despite the changes that have taken place in other macroeconomic variables. Even during the initial post-reform period there is little evidence of any discernible mobilisation of domestic savings despite the impressive growth of output. Throughout most of the post-liberalisation period, domestic savings as a percentage of GDP at current market prices have averaged between 12-13 per cent in the 1980s, increasing to just over 15 per cent in the 1990s. National savings in the country have been somewhat higher than domestic savings, accounting on average for around 15-16 per cent of GDP throughout the1980s, and increasing to 19 per cent of GDP by the mid 1990s, mainly due to the inward private remittances of Sri Lankan nationals working abroad (particularly in the Middle East). Net remittances have been an important element in boosting net private transfers on the current account of the balance of payments (BOP), and consequently the volume of national savings in the economy. Net remittances rose to account for approximately 3 per cent of GDP per annum during 1980-83, before declining slightly for the rest of the period up to 1992-1996.

High budget deficits have also been accompanied by double-digit inflation for most of the period under discussion. Having peaked at nearly 26 per cent in 1980, the rate of inflation averaged around 15 per cent per annum between 1981-84 before declining significantly in the mid 1980s. However, inflation continued to remain around 12 per cent over the period 1988-1992, declining in 1994-95 to 8 per cent but increasing sharply to 16 per cent in 1996.

Sri Lanka's external sector performance during the period 1980-96 has also been mixed (Table 1.2c). Its external terms of trade has fluctuated around a downward trend (with a sharp temporary upturn in 1983/84 as tea prices saw an increase). Whilst export performance improved dramatically with the liberalisation of the economy (exports as a percentage of GDP rising to an average of 25 per cent in the 1980s from an average of 15 per cent prior to liberalisation) largely as a result of the rapid growth of textiles and garments exports, the country has continued to experience high current account deficits. Export growth has failed to keep up with import growth (as import tariffs were liberalised) and to narrow the deficit significantly. Sri Lanka has been able to maintain a deficit in the range of 5-6 per cent of GDP from the mid 1980s thanks mainly to a surplus in transfers from remittances of nationals working abroad.

Table 1.2c: External Sector Indicators

Year	Exports/GDP	Imports/GDP	Trade Balance/ GDP	Current Account/GDP	Terms of Trade (1985=100
1980	28.3	54.3	-26.2	-17.5	92.9
1981	26.5	45.9	-19.6	-10.7	87.1
1982	22.7	44.2	-21.5	-12.5	81.7
1983	22.0	39.9	-17.7	-9.8	100.4
1984	26.7	33.5	-8.4	-1.0	122.1
1985	24.4	33.8	-13.3	-7.7	100.0
1986	20.8	31.4	-13.0	-7.3	89.3
1987	23.1	33.6	-11.2	-5.7	98.7
1988	23.1	34.3	-11.9	-6.1	93.0
1989	24.6	34.3	-10.5	-4.9	91.4
1990	27.3	37.0	-9.7	-3.6	87.4
1991	24.4	37.5	-12.2	-5.9	85.7
1992	27.9	39.3	-11.8	-4.9	89.1
1993	30.5	42.3	-12.2	-5.9	90.9
1994	30.3	44.6	-14.7	-7.2	86.6
1995	32.6	43.4	-12.9	-5.5	85.8

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

Chapter 2: General Overview of Public Finance

2.1 Public Expenditure

Total government expenditure as a percentage of GDP declined consistently between 1980 and 1984 (from nearly 45 per cent of GDP in 1980 to 34 per cent of GDP by 1984) with the winding down of the government's heavy public investment programme, particularly the Accelerated Mahaweli Development Programme (Table 2.1a). Macroeconomic instability in the early 1980s also prompted the government to tighten its budgetary management by curtailing government expenditure to a certain extent. Tighter discipline was imposed on government expenditure and commercial borrowing, with investment spending being confined to ongoing projects.

Table 2.1a: Government Fiscal Operations (as a Percentage of GDP)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Total revenue and grants	22.6	25.6	25.0	25.7	23.5	23.3
Total revenue	18.9	23.1	22.3	23.2	21.6	21.9
Tax	18.0	19.8	18.8	20.7	19.2	19.3
Non tax	1.4	3.3	3.5	2.5	2.4	2.6
Grants	3.7	2.5	2.7	2.5	1.8	1.4
Expenditure & lending	38.5	35.4	36.6	35.3	31.1	32.2
Recurrent	19.2	19.6	21.9	24.8	23.3	25.1
Capital	16.3	14.2	12.8	7.8	6.6	6.4
Lending minus repayment	2.9	1.5	1.9	2.7	1.2	0.7
Current account	-0.3	3.4	0.4	-1.6	-1.7	-3.2
Budget deficit (before grants)	-19.6	-12.3	-14.2	-12.1	-9.5	-10.3
Budget deficit (after grants)	-15.8	-9.8	-11.5	-9.6	-7.6	-8.9
Financing of deficit						
Foreign financing (net)	5.6	5.0	4.1	4.1	2.1	2.6
Gross borrowings	6.4	6.1	6.4	6.0	3.8	4.0
Repayments	-0.8	-1.1	-2.3	-1.9	-1.7	-1.5
Domestic financing (net)	10.2	4.8	7.4	5.5	5.5	6.4
Market borrowings	9.6	4.7	6.3	5.0	5.7	5.6
Non bank	3.1	3.7	3.6	5.0	6.3	4.1
Bank	6.4	1.0	2.7	0.0	-0.6	1.5
Other borrowings	0.9	0.1	1.2	0.5	-0.2	0.8

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

The acceleration of civil unrest in the country and the associated increase in defence expenditure in mid 1980s saw public expenditure rising to remain in the range of 36-37 per cent of GDP for the rest of the decade. In 1988, the concept of a three-year economic policy framework was announced by the Ministry of Finance. Along with the Budget, the Plan was to be aimed at removing structural inefficiencies in the economy, and reducing budget and current account deficits. On the basis of this three-year framework, the IMF agreed to grant a three year SDR 141.7 million ($192m) structural adjustment facility loan together with an SDR 108.8 million ($148m) compensatory financing

facility. The new President who took office (from within the ruling party) in 1988, adopted a considerably more populist and expansionary policy stance than his predecessor. An ambitious rural poverty alleviation programme ("*janasaviya*") was proposed, at an estimated total cost of Rs. 10 billion (almost one-quarter of total government revenue) in 1989 and estimated to cost Rs. 84 billion in total. In the light of this, the IMF suspended disbursement of the second tranche of the structural adjustment facility, which was due in March 1989. As a consequence, a tighter economic policy was adopted in the latter part of 1989 under pressure from the IMF, including a toned down version of the "*janasaviya*" programme. With the second wave of liberalisation in 1990 and tighter macroeconomic management, government expenditure as a percentage of GDP was held down to account for 31 per cent in 1996.

Table 2.1b: Government Fiscal Operations (at 1982 Constant Prices)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
	Period average growth rate per annum					
Total revenue and grants	-4.0	14.5	-0.9	6.1	2.3	4.1
Total revenue	-4.3	18.6	-2.8	8.0	3.2	5.0
Tax	-9.1	15.7	-2.1	9.4	3.5	3.9
Non tax	12.7	48.2	-6.3	-1.4	1.8	17.3
Grants	-1.9	-9.9	16.7	-6.1	-7.2	-7.6
Expenditure & lending	-5.2	6.9	3.2	2.4	2.7	2.8
Recurrent	4.8	10.6	3.9	7.6	5.1	5.3
Capital	1.2	1.4	-5.4	-7.4	-1.5	6.1
Lending minus repayment	-83.1	-237.8	131.1	7.5	34.1	-40.2

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

High among the policy objectives outlined by the government for the post-reform period was the intention to bring about a shift in the allocation of resources from consumption to investment. In effect, given the government's own high profile investment programme, it essentially implied a curtailment of recurrent expenditure in the budget and the generation of surpluses in the current account of the government budget to contribute towards capital formation. Current expenditure which comprises expenditure on goods and services, interest payments on debt and transfers, however, remained well above capital expenditure throughout the entire period rising consistently as a share of GDP from nearly 20 per cent to 25 per cent of GDP during the period 1980-1996. Current expenditure in goods and services comprise the largest bulk and increased from around 9 per cent of GDP per annum in the early 1980s to account for 10.5 per cent by the mid 1990s. The continuing high expenditure on defence is a major cause for high current expenditure on goods and services.

Another major item of expenditure on the current account of the government budget is the persistently high interest payments on debt. Such payments have risen from accounting for 4.6 per cent of GDP per annum during 1980-82 to 7 per cent of GDP per annum during 1995-96, compounding the difficulties associated with a widening budget deficit.

Expenditure on current transfer payments which consist of transfers to public corporations, public institutions, and social transfers comprising of food subsidies, Janasaviya/Samurdhi programme, pensions and agricultural subsidies, declined in the first half of the 1980s with the abolition of universal food subsidies and other welfare tightening measures. However it indicates a sharp upturn in the early 1980s with the implementation of the Janasaviya programme. The period 1995-96 is also witness to a sharp upturn in expenditure on transfers with the decision to re-instate a wheat flour subsidy in 1994.

Though transfers to public institutions have declined over the years, social welfare transfers have remained steady and some have even increased. For instance, social welfare, consisting of pensions and which amounted to Rs. 34,706 million, showed an 18 per cent increase in nominal terms in 1996 in comparison with 1995. Although social schemes such as the mid-day meal programme was cancelled in 1996, there has been an increase in the total number of recipients under the Samurdhi programme from 1,213,535 in 1995 to 1,458,888 in 1996. Similarly, the escalation of the war in the north and east of the country has increased the number of displaced families. This has meant enhanced expenditure on refugee related relief programmes. These factors have ensured that current expenditures on social transfers continue to persist above 6 percent of GDP.

The share of capital expenditure in total government expenditure has experienced a continuous and sustained decline as a share of GDP over the period 1980-1996. The initial reduction in capital expenditure was largely due to reductions in capital transfers to public programmes such as the Accelerated Mahaweli Development Programme. As the government was faced with fiscal slippage on current expenditure, efforts at restraining fiscal deficits have fallen heavily on cuts in government capital expenditure.

The Sri Lankan government, as part of its structural adjustment initiative, has been involved in a strong programme of privatisation since the late 1980s. Starting in 1990, the government has made good progress in privatising public enterprises. By 1994, around 78 public enterprise (including plantations) were divested or leased. The programme has gained new momentum as the government is continuing to realise its inability to fund capital expenditures of public corporations and

companies. Thus, these new developments provide an explanation for the continuing decline in capital transfers.

2.2 Government Revenue

Total government revenue as a share of GDP has remained in the range of 20-22 per cent of GDP per annum during the period 1980-1996. Of this, total tax revenue as a percentage of GDP has remained over the 20 per cent mark for the same period (Table 2.1a). It is already considered high for a country of Sri Lanka's per capita income and offers little scope for significant enhancement in the short term.

Non-tax revenue increased consistently as a share of GDP during the period 1980-1987, but then declined thereafter to account for 2.3 per cent of GDP in 1996. The grant element in total revenue has also continued to decline as a share of GDP throughout the period under discussion to account for just over 1 per cent of GDP by 1996.

Tax revenue has averaged 20 per cent of GDP throughout the period 1980-1996. However, there have been changes in the composition of tax revenue over the same period. The share of foreign trade taxes as a percentage of GDP has seen a continuous and sharp decline, falling from nearly 8 per cent of GDP in the early 1980s to less than 4 per cent of GDP by the mid 1990s. Tariff reform as part of the liberalisation process can be cited as the major reason for the fall in trade taxes. Since the late 1970s, export revenue as a percentage of GDP has continued to decline with the abolition of duties on most exports, particularly on the main plantation crops. These were cut sharply as profit margins on tea declined under the twin pressures of weak tea prices and productivity problems associated with poor management in earlier periods. While the share of import revenue fell in the early part of the 1980s, it increased its contribution to revenue mainly on account of higher import prices in the mid 1980s. With the implementation of successive tariff liberalisation measures from the late 1980s, the share of import tariff revenue as a percentage of GDP has continued to decline.

As the share of trade taxes has declined, tax revenue from domestic goods and services as a percentage of GDP has risen over the period from just over 6 per cent of GDP per annum in the early 1980s to account for more than 11 per cent of GDP by the mid 1990s. The most marked increase has been recorded in turnover taxes. Imposition of a defence levy on all goods and services in 1994 is also another factor in accounting for the increase in tax revenue on domestic goods and services.

Non-tax revenue, which includes property income and interest payments to the government, declined as a share of GDP in the latter half of the 1980s and early 1990s after marking a sharp increase in the early 1980s. The declines can be attributed to a fall in property incomes over the years.

The increase in the share of taxes on domestic goods and services to bolster total government revenue falls indiscriminately on all sections of the population. Sri Lanka's tax system has thus become increasingly regressive over the years given the increase in the share of indirect taxation in total tax revenue. The emphasis on indirect taxes has been further enhanced by the implementation of the defence levy (now termed the National Security Levy).

Table 2.2a: Government Tax Revenue (as a Percentage of GDP)

Item	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Tax revenue	17.5	19.8	18.8	20.7	19.2	19.3
Taxes on foreign trade	7.9	7.8	6.7	6.6	4.8	3.9
Exports	4.5	3.2	1.0	0.6	0.1	0.0
Imports	3.4	4.6	5.7	5.9	4.8	3.9
Taxes on domestic goods & services	6.1	8.1	8.7	9.5	10.4	11.5
Turnover taxes	3.5	6.0	6.1	6.6	6.3	5.7
Excise tax	2.5	2.0	2.5	2.8	2.7	3.2
Defence levy	0.0	0.0	0.0	0.0	1.4	2.4
Taxes on net income and profits	3.0	3.5	2.7	2.6	2.8	2.9
Taxes on property	0.4	0.3	0.7	1.1	0.8	0.8
Non-tax revenue	1.4	3.3	3.5	2.5	2.3	2.6
Current revenue	1.4	3.3	3.5	2.5	2.3	2.6

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

The government has at long last implemented its proposed value-added-tax (Goods and Services Tax) in April 1998. While a well functioning GST would be a positive development, given the complex and unsatisfactory network of taxes it replaces, it is however, unlikely by itself to provide additional revenue in the short term. Indeed, a good performance is required in implementing and administering the GST if it is to generate revenue equivalent to that from the taxes it replaces. Sri Lanka's experience with GST is too soon to make any assessment of its revenue implications to date.

2.3 Budget Deficit

Despite the massive public investment programme undertaken by the government, there was little evidence to expect that it would be matched by a corresponding increase in the level of public savings. The net result of the government's handling of the budget was that the current account surplus did not reach any significant level until 1984. Public savings (taken here to be the current account surplus or deficit on the budget) accounted for 2 per cent of GDP per annum during 1984-

89. From the late 1980s, public savings again went into deficit, to account for -3.2 per cent of GDP per annum in mid 1990s. Given Sri Lanka's high debt to GDP ratio, real interest rates and growth rates, a primary surplus is necessary to stop the debt to GDP ratio from rising still further.

Persistent fiscal deficits continue to be a problem in macroeconomic management in Sri Lanka. While the overall budget deficit peaked in 1980 and was brought down to more manageable levels, it nevertheless remains far too high. Financial policies have failed to respond to exogenous shocks such as droughts, while high current expenditures on debt payments, public sector wages and high defence expenditures are the main reason for persisting high deficits in recent years (Table 2.1a).

The grant element in budgetary financing has been declining steadily as a share of GDP. Therefore, while the budget deficit before grants has declined from a high of 23.7 per cent of GDP in 1980 to 9.8 per cent of GDP in 1996, the deficit after grants has fallen from 19.5 per cent of GDP to only 8.6 per cent of GDP correspondingly.

The deficit is predominantly financed by foreign loans and grants and through domestic borrowing. Foreign finance has continued to cover the overall deficit substantially. As a share of GDP, net foreign financing of the budget deficit indicates a downward trend from accounting for as much as 5-6 per cent of GDP in the early 1980s to 2-3 per cent of GDP by the mid 1990s. The share of foreign financing of the budget deficit has decreased over the years from accounting for almost 40 per cent of deficit financing in the early 1980s to less than 30 per cent of the deficit requirement by the mid 1990s. Sri Lanka has been assisted heavily in its efforts to finance budget deficits by the grant element in the foreign finance component with the adoption of market friendly reforms in the late 1970s, in effect allowing it to maintain lower debt service payments than might otherwise have been the case. Foreign loans alone accounted for around 35-40 per cent of the total financing requirement and the great majority of these were again obtained at concessionary rates of interest.

The share of the net domestic financing component of the deficit indicates an upward trend. The continuing decline in foreign grants in relation to GDP and increasing prominence of domestic financial institutions as sources of low cost credit to the government have been important developments that have given rise to this pattern. A positive development of domestic financing of the budget deficit has been the shrinking element of bank borrowing. Bank borrowing accounted for nearly 60 per cent of the total net domestic financing component in the early 1980, but this share had fallen to less than 10 per cent by the mid 1990s.

Non-bank financing which accounted for just over 4 per cent of GDP in the mid 1990s accrue from primarily three sources: (i) the Employees Provident Fund (EPF) which is the single largest captive source of funds for financing the deficit, and which has almost 98 per cent of its total assets invested in Treasury Bills (TB) and other government securities; (ii) the Employees Trust Fund which places nearly 65-70 per cent of its assets in TB; and (iii) the National Savings Bank, which mobilises household savings and term deposits across the country and which places more than 80 per cent of its assets in government securities.

Chapter 3: Analysis of Budget Expenditure

3.1 Recurrent Expenditure

Debt Service Payments

As discussed previously, the increased budgetary imbalance during the early 1980s saw the relative importance of bank borrowing, whether in terms of GDP ratios or in terms of the overall budget deficit, increasing substantially. It was also noted that foreign finance also continued to contribute substantially to covering the overall deficit. The government was assisted heavily in its efforts to finance the deficit by the increased grant element in the foreign finance component in the post-reform period, in effect allowing it to maintain lower debt service payments than might otherwise have been the case. Foreign loans alone accounted for around 35-40 per cent of the total financing requirement and the great majority of these were again obtained at concessionary rates of interest.

As could be expected, high budget deficits in the post-reform period had knock-on effects on the public debt and its rapid accumulation has served to exert a further strain on fiscal management in the long run. High budget deficits and the consequent growth of public debt have made service payments on the public debt one of the fastest growing items of expenditure.

The total outstanding public debt as a ratio of GDP increased steadily from approximately 53 per cent per annum over 1972-77 to more than 110 per cent per annum by the early 1990s (Table 3.1-1). In more recent years, high fiscal deficits have not been reflected in a rising debt/GDP ratio because of high economic growth rates and external financing on concessional terms, as well as the high level of low-cost domestic financing obtained from large savings institutions.

While the share of domestic debt as a percentage of GDP has increased only marginally during the period 1980-96, the increased debt stock has largely been accounted for by a rising share in the foreign debt component. Thus, the foreign debt component of the public debt saw an increase from just over 37 per cent of GDP per annum during 1980-82 to approximately 64 per cent by 1991. However, despite the increase in foreign debt, Sri Lanka has been successful in mobilising such assistance in the form of concessional loans from multilateral and bilateral donors. These account for the vast majority of the foreign debt component, rising from 90 per cent of the total foreign debt during 1980-82 to over 95 per cent by the mid 1990s. Recourse to financial market borrowing has been largely minimal, increasing in the mid 1980s to account for 6 per cent of GDP, but declining steadily thereafter to less than 2 per cent of GDP by the mid 1990s.

Thus, despite Sri Lanka's total debt exceeding its GDP, debt service payments have by and largely been contained to a manageable level thanks to its success in mobilising concessional loans (Annex,

Table A1). Nevertheless, the ratio of total government debt service payments (amortisation plus interest payments) to GDP has risen steadily from 7.4 per cent per annum during 1980-82 to over 12 per cent during 1990-92, and falling slightly to 12 per cent during 1992-94. It has since remained around 12 per cent of GDP. Correspondingly, interest payments on total government debt as a share of GDP has risen from 4.5 per cent per annum during 1980-82 to nearly 7 per cent during 1992-94 before declining slightly to 6.5 per cent per annum by the mid 1990s. Despite the fact that domestic debt accounts for less than the total foreign debt, interest payments on the domestic component of the debt have been historically higher as a share of GDP. Interest payments on the foreign debt component rose sharply in the early 1980s as the government was forced to resort to higher foreign market borrowing to finance burgeoning deficits in that period.

Sri Lanka has as a result, seen its total domestic debt service ratio (debt service payments as a percentage of earnings from merchandise exports and non-factor services) rise from an average of 16.6 per cent per annum during 1980-82 to over 20 per cent per annum during the late 1980s. However, since the early 1990s, the debt service ratio has been declining steadily to account for just over 17 per cent by mid 1990s.

Economic Classification of Government Expenditure

Table A2 in Annex sets out the economic classification of government expenditure for the period 1980-96 as a share of GDP. Government current expenditure continues to be unacceptably high with expenditure coming to exceed its revenue by the early 1990s. Current expenditure has risen steadily from just over 19 per cent of GDP in the early 1980s to account for 25 per cent by the mid-1990s. There is considerable pressure exerted on current expenditure from increased spending on defence, debt servicing and payments on salaries and wages of state employees.

The most significant increase recorded under current expenditure has been on goods and services - nearly doubling its share of GDP from 6.9 per cent in the early 1980s to 12 per cent by the mid 1990s. Correspondingly, the proportion of current expenditure devoted to salaries and wages has increased steadily over the same period. This has occurred despite a stated commitment by government to reduce the public sector cadre in line with recommendations made by a government appointed Administrative Reforms Commission in 1987. The ARC estimated that there was 20 per cent over-employment in government (over an estimated base of around 450,000 employees) and recommended reducing over-staffing by 60,000 over a 3 year period. While a partial embargo on new recruitment was imposed (except in education, health and defence), the programme failed to achieve its purposes. Since 1992 alone, government employment has risen by more than 13 per cent and government salaries were raised across-the-board by 30 per cent in 1993. Expenditure on wages and pensions has

increased significantly as a result, adding to an already high fiscal burden. Given the limited scope for substantive increases in government revenue, further expansion in government sector employment and salaries are not sustainable unless measures to reduce the present level of government sector employment are initiated.

Current expenditure on other goods and services which include travelling expenses, electricity and communication charges, purchase of office materials, office supplies and defence related goods has also increased sharply from 2 per cent of GDP per annum during 1980-82 to over 6 per cent during 1994-96. This increase can be attributed to the increased defence outlays since the mid 1980s and the high level of investment undertaken by the government in the past which has necessitated the provision of increased maintenance expenditure on capital assets. Besides the increased defence outlays, expenditure on operation and maintenance are already considered to be inadequate and therefore it would be difficult to implement adjustments in that area under the existing government institutional structure.

Expenditure on transfer payments by contrast declined as a share of GDP from the early 1980s to the latter part of the decade. This was largely on account of a decline in the share of expenditure on food stamps and subsidies as a percentage of GDP. In 1978, the rice ration was restricted to the poorest half of the population, followed by a removal of the bread and wheat subsidies in 1980. Expenditure incurred under this heading includes food stamps, kerosene stamps, mid-day-meal scheme and expenditure on other support programmes such as free textbooks and infant milk subsidy. A sharp upturn in expenditure on food stamps and subsidies was recorded in the period 1989-91 due to enhanced expenditure on account of the Janasaviya programme and mid-day-meal scheme. By contrast, government current expenditure on the fertiliser subsidy has declined consistently as a share of GDP and was withdrawn in the early 1990s. In 1994, the fertilizer subsidy, which benefits all farmers (including large profitable tea estates), was re-introduced in the 1995 budget.

Transfer payments to public corporations remained consistently around 1 per cent of GDP till the latter part of the 1980s before declining sharply in the early 1990s. However, an electoral promise in 1994 to subsidise the price of bread cost the government more than Rs. 5 billion in 1995 and transfers to public corporations (in particular to the Co-operative Wholesale Establishment) increased on account of the large expenditure on wheat flour subsidy. The annual subsidy on wheat flour alone accounted for more than the subsidy on food stamps in 1995/96.

Functional Classification of Government Expenditure

The share of current expenditure allocated to general public services has risen consistently from 3.2 per cent of GDP per annum during 1980-82 to 7.8 per cent during 1995-96 (Annex, Table A3). While the

share of civil administration has declined in the 1990s after fluctuating in the 1980s, current expenditure devoted to defence and public order and safety (internal security) has risen consistently over the period. The sharpest increase in expenditure has been in defence. From accounting for just 0.6 per cent of GDP per annum during 1980-82, defence related expenditure has ballooned to account for 5.6 per cent of GDP per annum during 1995-96. With the escalation of widespread civil unrest in the country in the latter half of the 1980s, expenditure on internal security has also shown a marked increase to 1.4 per cent of GDP by the end of the decade. However, with the easing of social and civil unrest from the early 1990s (excluding the on-going conflict in the North and East of the country), expenditure on public order and safety has declined to less than 1 per cent of GDP by the mid 1990s.

While expenditure on social services as a percentage of GDP has also increased over the period 1980-1996, the increase has been much less relative to that of general public services. Expenditure on social services increased from around 7 per cent of GDP in the early 1980s to just over 9 per cent by the mid 1990s. Expenditure on education remained fairly stagnant for much of the 1980s averaging 2.2-2.5 per cent of GDP per annum before showing a more marked increase in the latter part of the decade and into the early 1990s to account for 2.7 per cent of GDP. However, its share as a percentage of GDP has declined during the period 1995-96 to 2.5 per cent per annum on average.

Current expenditure on health has remained fairly stagnant, rising only marginally from accounting for 1.1 per cent of GDP per annum during the early 1980s to remain at 1.2 per cent of GDP for the rest of the decade. Current expenditure on health in mid 1990s has since risen only marginally to 1.4 per cent of GDP per annum.

Current expenditure on welfare consist of the government's three major welfare programmes, namely, food and kerosene stamps, school mid-day-meal, uniforms and the Janasaviya/Samurdhi programme. This has increased its share of GDP, particularly in the latter part of the 1980s with the implementation of the Janasaviya programme. Welfare expenditure constituted 5 per cent of GDP per annum during 1995-96.

Current expenditure on economic services by contrast has seen a consistent decline as a share of GDP, falling from 2.8 per cent per annum in the early 1980s to 1 per cent by 1992-94 before rising to 1.3 per cent per annum during 1995-96. The decline has been most marked in the agriculture and irrigation services, with the completion of the Accelerated Mahaweli Development Programme by mid 1980s. While the share of expenditure on transport and communication increased up to mid 1980s, it has declined thereafter to account for 0.3 per cent of GDP per annum in the 1990s.

Given that interest payments on domestic debt accounts for 25-30 per cent of current government expenditure and is by its nature a mandatory expenditure, fiscal priority in social expenditure as a percentage of government discretionary expenditure is examined in Table 3.1a. The share of social expenditure in current government discretionary expenditure declined from accounting for 52 per cent per annum during 1980-82 to just under 45 per cent during the mid 1980s before climbing back to its original share of discretionary expenditure in the early 1990s. However, its share fell to 48.7 per cent during the period 1995-96.

Table 3.1a: Recurrent Expenditure on Social Services (as Percentage of Discretionary Current Expenditure)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Social services	52.1	47.0	44.7	48.7	52.3	48.7
Education	15.8	14.9	15.2	15.0	16.3	13.2
Health	7.8	8.1	7.6	7.3	7.9	7.5
Welfare	27.8	23.3	21.4	25.9	27.7	27.0
Community services	0.6	0.6	0.5	0.5	0.5	0.9
Housing	0.1	0.1	0.0	0.0	0.0	0.0

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

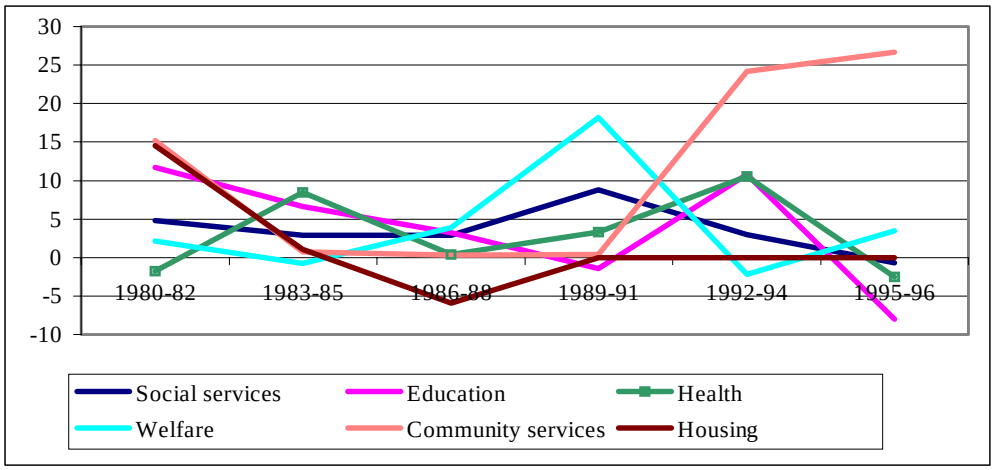
The share of education expenditure in current discretionary government expenditure accounts for a smaller proportion during 1995-96 in comparison to its share during 1980-82. The share of education expenditure, having remained stagnant for much of the period under discussion, increased briefly during 1992-94 and experienced a sharp fall during 1995-96. The shares of health expenditure and expenditure on welfare as a proportion of current government discretionary expenditure have not increased over the period, and in fact record a marginal decline over their levels during 1980-82.

Looking at trends in current social expenditure in real terms, there was a decline in real growth of social expenditure during the period 1983-88, a sharp increase during 1989-91 when real expenditure grew by over 10 per cent per annum, and a significant slowdown in real growth thereafter (Annex, Table A4). The sharpest decline in real expenditure growth has occurred during 1995-96, when total social expenditure grew by only 0.5 per cent per annum. Up to the mid 1980s, real growth in current expenditure was far greater than that of social expenditure, particularly on account of a substantive increase in expenditure on general public services.

The rate of growth on education expenditure declined continuously during the 1980s, and recorded a negative growth rate during 1989-91. While real education expenditure again grew substantially during the early 1990s, there was a sharp decline in real growth during 1995-96 when real expenditure growth recorded a negative rate of -6.8 per cent per annum. Expenditure on health has

recorded a similar trend, real growth declining for much of the 1980s, with a sharp increase in the early 1990s and followed by negative real growth during 1995-96. By contrast, real expenditure on community services having stagnated during the 1980s, has increased substantively in the 1990s, growing by more than 25 per cent per annum.

Figure 3.1a Per Capita Current Social Expenditure (Period Average Real Growth)



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

There are a number of factors impinging on high current government expenditure in Sri Lanka. First, debt servicing at nearly 30 per cent of current government expenditure is a heavy burden on the public purse. However, given that defaulting on debt service payments will not serve the long term interests of the country, Sri Lanka seems set to incur such a high non-productive expenditure for the foreseeable future. Second, defence expenditure has continued to rise and is a heavy drain on government resources. In the event of continuing civil conflict in the country, defence and defence related expenditure could be expected to increase further in the future. This is a highly non-productive and wasteful expenditure for any economy, but even more so for a developing economy. Containment or cutbacks in defence expenditure can be expected only in the event of a lasting solution to the country's ethnic conflict.

3.2 Development Expenditure

As current expenditure continues to remain unacceptably high, capital expenditure has increasingly come to bear the brunt of government efforts to curtail budget deficits. The share of total capital expenditure as a percentage of GDP has halved over the period 1980-96 -- declining consistently from 16 per cent per annum during 1980-82 to just under 8 per cent per annum during 1995-96 (Annex, Table A5). However, there is a high cost to sacrificing social and physical infrastructure to

shield the short-term imperatives of current expenditure, which are more often than not linked to political considerations. The long term development potential of the country may be put at increasing risk if governments fail to allocate sufficient expenditure on social and infrastructure investment.

Capital expenditure on general public services has fluctuated around 1 per cent of GDP per annum for the entire period 1980-96. Expenditure on civil administration has declined continuously as a share of GDP to account for 0.4 per cent of GDP per annum during 1995-96. Capital expenditure on public order and safety increased marginally in the latter half of the 1980s, but still accounts for around 2 per cent of GDP.

Capital expenditure on social services has averaged around 1.5 per cent of GDP per annum for the period 1980-1996. Its share in fact declined from 2 per cent of GDP per annum during 1980-82 to 1.4 per cent of GDP per annum during 1983-85 with the general tightening up of budgetary expenditure in that period. Capital expenditure on social services again saw a sharp decline during the period 1989-91, falling from 1.6 per cent of GDP per annum to 1.2 per cent of GDP before regaining its share of capital expenditure at 1.6 per cent of GDP per annum in the mid 1990s.

Capital expenditure on education has not shown any improvement as a percentage of GDP over the period 1980-96. Its share has continued to fluctuate between 0.5-0.6 per cent of GDP per annum. Expenditure on health has also remained stagnant after an initial increase in its share of GDP in the early 1980s. Thereafter, capital expenditure on health has been maintained at 0.4 per cent of GDP per annum. Capital expenditure on housing as a share of GDP has been 1.2 per cent per annum during 1980-82, and was comparatively much higher in relation to that spent on education and health. This was largely on account of the government's housing and urban development programme that formed part of its massive public investment programme in the early 1980s. However, with the fiscal tightening of the mid 1980s, capital expenditure on housing saw a sharp decline to 0.4 per cent of GDP per annum and has thereafter accounted for 0.2 per cent of GDP.

Capital expenditure on economic services accounted for 13 per cent of GDP per annum during 1980-82. With the slowdown of the public investment programme, its share has continued to decline and by mid 1990s accounted for approximately 5.5 per cent of GDP per annum. As would be expected, the most significant share of capital expenditure was in agriculture and irrigation (on account of the Accelerated Mahaweli Development Programme). Reflecting the overall curtailment in capital expenditure, most economic services have seen a deteriorating share of expenditure as a percentage of GDP. Capital expenditure in needed infrastructure sectors such as energy and transport and communication for

example, has declined as a share of GDP over the period, which in the long run would not bode well for the development potential of the economy.

3.3 Combined Recurrent and Capital Expenditure

As indicated in Table A7 in the Annex, total government expenditure as a share of GDP has remained fairly constant over the period 1980-1996, fluctuating around 35 per cent in the 1980s before declining to 33 per cent of GDP in the mid 1990s. The most significant gain in share of expenditure has been recorded in the category of general public services. The share of expenditure on social services has increased only marginally over the period from 9.2 per cent of GDP per annum in the early 1980s to 10.7 per cent of GDP per annum in the mid 1990s.

While only a marginal gain has been recorded in the share of expenditure allocated to education (rising from 2.7 per cent of GDP per annum during 1980-82 to 3 per cent by the mid 1990s), the share of expenditure on health has seen a more marked increase. Health expenditure as a ratio of GDP has increased from 1.3 per cent per annum in the early 1980s to 1.8 per cent per annum by the mid 1990s. The share of expenditure allocated to welfare has also risen over the period, particularly in the early 1990s with the implementation of the Janasaviya programme. Thereafter, there has been another sharp increase in mid 1990s with the introduction of the wheat flour subsidy in 1994.

By contrast, total government expenditure on economic services has declined sharply over the period, from 15.8 per cent of GDP per annum during 1980-82 to 6.8 per cent per annum in the 1990s. The largest and most sustained decline has been recorded in the agriculture and irrigation sector, while the ratio of expenditure on transport and communication alone has remained fairly constant over the period.

In terms of real growth, total expenditure on social services lagged well behind real expenditure growth up to mid 1980s (Annex, Table A8). During the latter half of the decade and in the early 1990s however, the rate of growth of total social expenditure has been much higher than that for total government expenditure. The exception was in more recent years when total social service expenditure growth at 1.7 per cent per annum lagged well behind real expenditure growth of 3 per cent per annum.

The rate of growth of real education expenditure has been slowing consistently from the early 1980s and in fact has recorded negative real growth in the latter part of the 1980s. After a sharp upturn in the early 1990s, real education expenditure once again has recorded a negative growth during 1995-96. By contrast, real expenditure on health has been more positive, recording negative growth during 1989-91

before registering a sharp increase in expenditure in the early 1990s. Real expenditure on economic services has been negative for most of the period under discussion and has recorded a marginal increase of 0.7 per cent real growth during 1995-96.

Sri Lanka's budgetary revenues, at nearly 20 per cent of GDP, is already quite high for a country of its per capita income level and level of economic development, offering little scope for significant enhancements in the medium term. The burden of fiscal adjustment therefore falls on expenditures and in the past this has tended to fall disproportionately on capital expenditure. Such a trend is not conducive to Sri Lanka's long term growth prospects as cuts in capital expenditure will lead to serious deficiencies in infrastructure development and supply-side bottlenecks in the future.

Fiscal adjustment has to fall on current expenditures in future. Expenditure cuts on civil service, pensions, and transfers to public enterprises and social transfers are the most likely to bear the brunt, given that an environment for an immediate cut in defence expenditure is unlikely to manifest in the near future. Opportunities to restructure current expenditures would therefore depend on the government's commitment to restrain the wage and pension bill and reduce transfers to households and public enterprises.

Chapter 4: Analysis of Education Expenditures

4.1 Introduction

The Government of Sri Lanka (GOSL) has an excellent record of offering educational opportunities to all children of school going age. Official government policy provides a primary school within one kilometre of the home of any child between 6-10 years of age. From the 1950s onwards GOSL undertook a major school build-up program to implement this policy. Currently, gross primary enrolment, for both male and female children, is over 100% of the relevant age group. The next step in the development of primary education in Sri Lanka is to improve the quality of the relevant age group of primary schools to international levels. GOSL is strongly committed to achieving this objective by introducing rational and strategic reforms to the education system.

UNICEF is seeking to assist member countries to develop efficient and equitable financing mechanisms to enhance their primary education systems. This chapter analyses the current pattern and composition of education financing in Sri Lanka and discusses alternative options for improving the level of resources available for primary education.

4.2 Education Expenditure in Sri Lanka: International Comparisons

The average proportion of GDP and government expenditure devoted to education in Sri Lanka in the recent past is shown in Table 4.2a. The share of GDP and government expenditure spent on education in selected Asian countries and other reasonably similar developing countries are also shown in Table 4.2a for purposes of comparison.

The information in Table 4.2a shows that, by international standards, Sri Lanka spends comparatively little on education. Over the past decade, the average share of education in GDP has been approximately 3% per year. This is less than the 3.5% mean for Asia and the 3.9% mean for developing countries. Further, among the Asian countries shown in Table 4.2a, only Bangladesh, China, Nepal and The Philippines allocated a lower proportion of resources to education. Among the other developing countries shown in Table 4.2a, the only nations which devoted a lower share of resources to education were Guinea and Nicaragua.

Table 4.2a: Education Spending in GDP and the Government Budget in Selected Countries

Asian Countries	Education (as a % of GDP)	Education (as % of Government Budget)
Average	**1990s**	**1990s**
Sri Lanka	***3.1***	***9.5***
Bangladesh	2.0	10.3
China	2.3	12.4
Hong Kong	3.0	17.4
India	3.5	11.2
Indonesia	3.7	15.5
Japan	4.7	16.2
Korea	3.6	22.4
Malaysia	6.9	18.8
Nepal	2.8	10.8
Pakistan	3.4	N/A
Philippines	2.9	10.1
Singapore	3.4	11.5
Thailand	3.8	20.0
Mean for Asia	**3.5**	***13.9***
Other Developing		
Egypt	**3.8**	10.6
Ghana	**3.3**	24.3
Guinea	**1.4**	21.5
Honduras	**4.2**	15.9
Lesotho	**3.8**	12.2
Mauritania	**4.7**	22.0
Nicaragua	**2.6**	12.0
'World' Mean	**3.9**	15.1

Source: Sri Lanka derived from Central Bank of Sri Lanka, Annual Report (various issues). Other countries calculated from UNESCO, World Tables.

The proportion of the government budget devoted to education expenditures is also relatively low by international standards. In recent years Sri Lanka has spent approximately 10% of the government budget on education. This is below the 14% average for Asia and the 15% average for developing countries. Further, among the countries shown in Table 4.2a, the proportion of the government budget allocated to education is lowest in Sri Lanka.

There are two main reasons for the low share of education in GDP and in government expenditures in Sri Lanka. First, education expenditure in the 1950s and 1960s was high, with an average of 5% of GDP and 15% of the government budget being devoted to education. This high spending reflected infrastructure build up to implement the government policies of providing access to free public education at primary and secondary levels to all school aged children. With the construction of basic school facilities to provide universal access to general education relatively complete by the early 1970s, the government allocated priority to other sectors in the budget, particularly agriculture and

energy, from the late 1970s onwards. However, this resulted in a sacrifice of quality inputs, teacher education, curriculum development, and maintenance and replacement activity in the education system. Educational quality at the primary level, in particular, was neglected. Second, from the mid-1980s onwards the government has borne a heavy military burden due to the civil war waged by the separatist Liberation Tigers of Tamil Eelam (LTTE). High defence expenditure has acted as a binding constraint on the capacity of the government to invest in human capital and social development.

4.3 Trends in Education Expenditures in Sri Lanka

The time pattern of the proportion of GDP devoted to education in recent years is as follows:

Table 4.3a: Trends in Government Education Spending

Year	As Proportion of GDP(%) (1)	As Share of Government Expenditure	Per Capita Expenditures on Education
1985	2.8	7.5	95
1986	3.1	8.4	218
1987	2.7	7.4	207
1988	3.1	8.5	221
1989	3.6	9.7	220
1990	3.3	9.6	254
1991	2.7	7.8	263
1992	3.2	10.5	276
1993	3.1	10.0	286
1994	3.4	10.5	471
1995	3.2	9.1	524
1996	2.9	8.8	557

The information given above (calculated from Ministry of Education Budgetary data and Central Bank of Sri Lanka Annual Reports – various issues).reveals that the highest share of education expenditures in GDP was 3.23 per cent in 1989. In many years, this share has been under 3 per cent. Further, in the most recent years, it has tended to decline, falling from 3.1 per cent in 1993 to 2.6 per cent in 1996.

The time pattern of education expenditures as a percentage of government expenditures in recent years is as follows (data from Ministry of Education Budgetary data and Central Bank of Sri Lanka Annual Reports – various issues):

The evidence stated above shows that the share of education in government expenditure has been generally higher, from 1992 onwards, in comparison to the period 1985-1991. During 1985-91 under 10 per cent of government expenditure was devoted to education spending. From 1992-95 the share of

education in the government budget rose above 10 per cent. However, this share has declined in the most recent years, falling below 10 per cent in 1996.

The pattern of overall education expenditures in Sri Lanka, is shown in Table 4.3b below.

Table 4.3b: Expenditure on Education in Sri Lanka, 1996 (Constant 1982 Prices) Rs Million

Year	Recurrent Expenditure	Capital Expenditure	Total
1985	2,957	675	3,632
1986	2,739	915	3,654
1987	2,853	605	3,458
1988	3,159	596	3,755
1989	3,480	805	4,285
1990	3,877	474	4,351
1991	3,180	471	3,651
1992	5,267	1,004	6,271
1993	5,345	1,355	6,700
1994	7,065	1,370	8,435
1995	7,516	1,965	9,481
1996	8,009	2,192	10,201

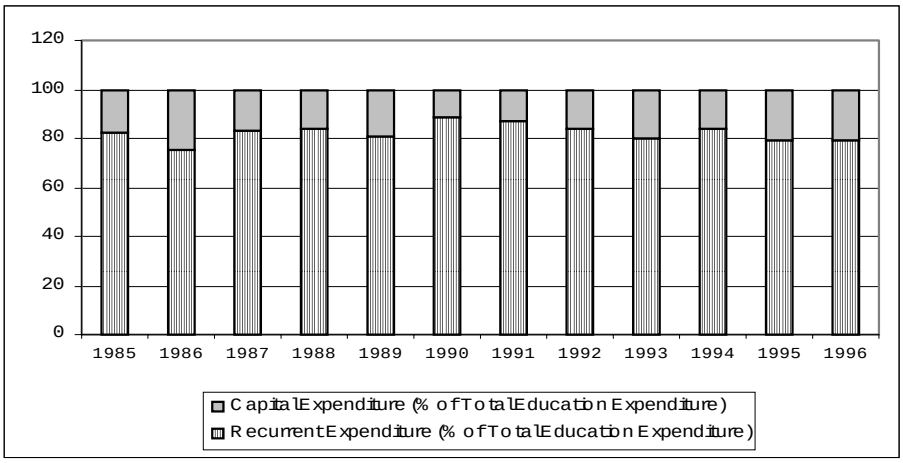
Source: Calculated from Ministry of Education budgetary data and Central Bank of Sri Lanka, Annual Reports (various issues).

The data in Table 4.3b reveal that educational expenditures have fluctuated sharply in the period 1985-1996. This is especially true of capital expenditures, which fell drastically during 1990-1991, but picked up again steeply in 1992. Capital expenditure on education in Sri Lanka is mainly financed through donor assistance. Hence, its level is highly sensitive to the time phasing and implementation of donor programs. The chief reason for the sharp decline in capital expenditures on education in 1990 was a politically destabilizing insurrection by the militant Janatha Vimukthi Peramuna (JVP) over the period 1987-1989, which caused implementation delays and prevented disbursement of donor funds. The steep increase in capital expenditures from 1992 onwards has been largely due to renewed flows of assistance from donors. Capital expenditures have been devoted chiefly to the construction of buildings, provision of basic services, and purchase of equipment and furniture.

Table 4.3b also shows a steep increase in recurrent expenditures from 1992 onwards. The main component of recurrent expenditure on education is the teacher salary bill. The increase in recurrent expenditures since 1992 have been caused chiefly by a substantial expansion of the teaching cadre in 1992, and a sharp rise in teacher salaries in 1995.

The division of educational expenditure between recurrent and capital spending is shown in Figure 4.3a.

Figure 4.3a: Recurrent and Capital Expenditure as a Percentage of Total Education Expenditure, 1985-1996



Source: Calculated from Ministry of Education budgetary data and Central Bank of Sri Lanka, Annual Reports (various issues).

The data in Figure 4.3a reveals that the proportion of education expenditure devoted to recurrent spending has been in the range 75-89 per cent, while the share of capital expenditure has been in the range 11-25 per cent. In general, recurrent expenditures have tended to crowd out capital expenditures. Only in 1986, 1993, 1995 and 1996 have capital expenditures accounted for 20 per cent or more of the education budget. The lack of capital spending has been reflected in a scarcity of resources for investment in long-term quality inputs, especially for primary schools (Type 3 schools) and the primary levels of poorer schools (usually the poorer Type 2 and Type 1C schools).

The pattern of per capita expenditures on education (1982 prices) over time is illustrated in Table 4.3a.

The pattern of expenditures shows that per capita educational spending has increased substantially from 1994 onwards. Real education expenditures per capita has risen from SLR286 per student in 1993 to SLR471 per student in 1994 (65% growth), SLR524 in 1995 (11.5% growth) and SLR557 in 1996 (6.3% growth). This reflects the higher priority accorded to education by the PA government, which assumed office in 1994.

Unit recurrent costs for the three education levels, primary (years 1-5), secondary (years 6-11) and upper secondary (years 12-13), over the period 1994-96, are shown in Table 4.3c below.

Table 4.3c: Unit Recurrent Cost per Student by Education Levels, 1994-1996 (Rs.)

Schooling Level	1994		1995		1996	
	Unit Cost	*Percentage Share of the Unit Cost of Total Education*	*Unit Cost*	*Percentage Share of the Unit Cost of Total Education*	*Unit Cost*	*Percentage Share of the Unit Cost of Total Education*
Primary (School Years 1-5)	2,929	25	3,430	27	4,066	29
Secondary (School Years 6 11)	3,476	30	3,906	31	4,428	31
Collegiate (School Years 12-13)	4,991	45	5,334	42	5,768	40
All Levels	3,298	100	3,768	100	4,343	100

Source: Calculated from MEHE budgetary data.
Note: The term's primary education, secondary education and upper secondary education refer to the education categories existing in 1996. These do not refer to the new junior and senior school structure, which has been proposed by the National Education Commission, but has not been implemented yet.

Table 4.3c shows that recurrent expenditure per student, in 1996, was Rs 4,066 for primary education, Rs 4,428 for secondary education and Rs 5,768 for collegiate education. In terms of percentage shares, 29 per cent of per student recurrent expenditure on education is devoted to the primary level, 31 per cent is devoted to the secondary level and 40 per cent is devoted to the upper secondary level.

The share of resources accruing to primary education has been increasing over time. In 1994, the proportion of resources devoted to primary schooling was 25% of the general education budget. This share rose to 27% in 1995 and 29% in 1996. This increasing trend in the financing of primary education has been matched by a declining trend in collegiate level education spending. In 1994, 45% of the general education budget was spent on collegiate education. This share declined to 42% in 1995 and 40% in 1996. This trend of education financing reflects greater importance being attached to primary schooling in education policy.

The cost per student at the primary and the secondary levels, in Table 4.3c, are quite close as the major proportion of recurrent expenditure consists of teacher salaries, and teacher pupil ratios tend to be lower in the primary cycle. This is especially the case in Type 3 schools in rural areas. The main reasons for the higher unit cost of upper secondary education is that they contain better qualified, more

highly paid teachers and that quality inputs, like equipment, consumables and materials, are generally more expensive at this level.

4.4 Central Government Expenditures on Education

Sri Lanka has a devolved system of education administration. The country is divided into 8 provinces, with each province assuming responsibility for the administration of the schools located within its borders, except those designated as national schools. The central government, through the MEHE, assumes responsibility for the administration of national schools.

The central Ministry of Finance and Planning allocates resources through two channels: recurrent expenditures through the Budget Division and capital expenditures through the Department of National Planning. The flow of recurrent expenditures are then channelled through the Finance Commission to the Provincial Education Authorities (PEAs), consisting of the Provincial Ministries of Education, Provincial Directorates of Education under the provincial ministries, and the Zonal Education Authorities (ZEA) which come under the Provincial Directors. The ZEAs channel the recurrent expenditures, including payment of salaries, to the schools that come under the PEAs, the Type 1AB schools, Type 1C schools, Type 2 schools and Type 3 schools. The recurrent expenditures for national schools, however, are channelled through the MEHE.

Capital expenditures are channelled by the Department of National Planning to the MEHE, based on requests for projects. The MEHE allocates this capital grant among schools. The actual delivery of capital resources is accomplished through the PEAs and the ZEAs.

4.5 Central Budget

The central government budget consists of two broad categories, recurrent expenditures, defined as items that are consumed within one year, and expenditures on capital items, which are defined as items that can be utilised over a period in excess of one year. The Central and Provincial Government education budgets are shown in Table 4.5a below.

Table 4.5a: Central and Provincial Education Capital and Recurrent Expenditures, 1996

	Recurrent Spending (Rs. Million)	Capital Spending (Rs. Million)	Total Spending (Rs. Million)	% of Recurrent Expenditure	% of Capital Expenditure
Central	7,400	4,037	11,438	65	35
Provinci	11,268	406	11,674	97	3
Total	18,668	4,443	23,112	81	19

Source: Ministry of Finance and Planning, MEHE and Provincial Education Authorities.

According to Table 4.5a the total central government education budget in 1996 was approximately SLR 11.5 billion. Recurrent expenditures were SLR 7.4 billion (65%) and capital expenditures SLR 4.0 billion. The principal items of central government recurrent expenditures are shown in Table A9 in the Annex.

Table A9 shows that the main components of central government recurrent expenditures were salaries of national school teachers and central administrative officials, SLR 2.8 billion (38% of total central government recurrent expenditure); transfers and subsidies, SLR 2.6 billion (35%); contractual services, SLR 808 million (11%); and textbooks, supplies, travel, in-service training and research, household transfers and other expenditures, SLR 1.2 billion (16%). The bulk of expenditures on subsidies are spent on free school uniforms, and scholarships and bursaries. Contractual services include consumables and materials for teaching science and technical subjects in schools, and minor repairs and maintenance activities. The principal items of central government capital expenditures are shown in Table A10 in the Annex.

Table A10 shows that the principal components of central government capital expenditures in 1996 were building construction, SLR 1.3 billion (45% of total central government capital expenditure) and acquisition of equipment, SLR 667 million (23%). The remaining 32% of capital spending covers the capital grants to provincial councils, SLR 700 million and rehabilitation and improvement of capital assets, SLR 253 million. The major proportions of these expenditures are financed by foreign donors.

4.6 Provincial Councils Expenditures on Education

Provinces receive grants from the Central government according to the size of their populations and their state of economic and social development. The values per student of the resources allocated to the Provinces through the block grants are shown in Table 4.6a below.

Table 4.6a: Per Student Block Grants for Education (SLR)

Province	1992	1993	1994
Western	1,446	1,803	1,944
Central	1,528	1,891	2,197
North Western	1,466	1,832	2,112
Sabaragamuwa	1,464	1,768	2,116
Southern	1,516	1,837	2,192
North Central	1,160	1,503	1,795
North Eastern	1,184	1,484	1,713
Uva	1,392	1,796	2,052

Source: Calculated from Finance Commission.

The Central and Southern Provinces enjoyed the highest grants, in per student terms, in 1994, while the North Eastern Province received the lowest grant, in per student terms. The North Western Province ranked fourth from the top, although the difference with the Sabaragamuwa Province is negligible. The Western Province, which is the wealthiest province, ranked sixth in the per student value of central government grants received. There are no special reasons for the variations in the per student block grant to the different provinces. The variations, which are relatively small, are generally due to varying differences between predicted and actual enrolments in provinces, in the particular year. The differences seem to have made a significant impact, in terms of provincial variations in per student allocations, only in the Western, North Central and North Eastern Provinces in 1994. The main components of provincial recurrent education spending are shown in Table A11 in the Annex.

The information in Table A11 shows that in 1996 the provincial total recurrent education expenditure was SLR 11.3 billion. Of this, salaries of provincial school teachers and education officials, which are paid out of the block grant, amounted to SLR 10.9 billion (97% of total provincial recurrent expenditures). Expenditures on other items, like office consumables, welfare bursaries, school uniforms, travel and transport, communications and utilities, amounted to only SLR 362 million (3%). Given the large share of the salary bill in provincial expenditures, the scope for quality improving investments at the provincial level is extremely low. The main items of provincial capital education spending are in Table A12 in the Annex.

Table A12 shows that the provincial capital budget, which is used by the provinces to supplement central capital expenditures, is small, just SLR 406 million for all provinces in 1996. Capital expenditures are composed mainly of civil works, purchase of instructional material, and repairs and maintenance activity.

4.7 Facilities and Equipment

4.7.1. Basic Facilities and Equipment

The availability of a stock of basic facilities and items of equipment was checked, for a sample of 30 schools in the North Western Province, in a survey in January 1997 [see Aturupane, 1997a]. The proportions of schools that possessed the stock of basic facilities, by type of facility, are shown in Table 4.7a.

The evidence in Table 4.7a reveals that only a minority of schools possesses the most basic of facilities, adequate classroom space. Only 50 per cent of National Schools, 83 per cent of Type 1AB

schools, 33 per cent of Type 1C schools, 20 per cent of Type 2 schools and 33 per cent of Type 3 schools, had sufficient class room space. The shortage of space is exacerbated by the absence of wall dividers in the class rooms of many schools, so that a high level of disturbance exists during classes.

The majority of schools possesses science rooms, although there is a shortfall in Type 1C schools and Type 2 schools. However, some of the equipment in such rooms, in the majority of schools, were not in working order. Maintenance activity was poor. In addition, due to the shortage of space, the science rooms are also used, sometimes, as classrooms and as storerooms. This speeds up depreciation of equipment, especially brittle items like glassware.

A shortage of workshops exists, especially in Type 1C schools and Type 2 schools. Storeroom space is also inadequate, particularly in Type 3 schools. Even in schools where storerooms existed, space was sometimes inadequate. Thus, broken items of furniture are stored in classrooms, or even the library, due to the shortage of storeroom space. The problem is compounded by the absence of a system of speedy disposal of broken items.

Table 4.7a: Availability of Basic Equipment and Facilities in Schools, by Type of School

Type of Equipment or Facility	National Schools Percent	Type 1AB Schools Percent	Type 1C Schools Percent	Type 2 Schools Percent	Type 3 Schools Percent
Adequate class room space	50	83	33	20	33
Possess Science Rooms	100	100	83	80	-
Possess Home Science Rooms	75	100	55	80	11
Possess Workshops	100	83	33	20	-
Possess Store Rooms	100	83	83	80	33
Possess a Staff Room	75	83	83	80	56
Possess a Library	100	100	83	80	11
Adequate Infant Desks	100	100	83	80	78
Adequate Infant Chairs	100	100	83	80	78
Adequate Medium Sized	100	100	60	80	89
Adequate Medium Sized	100	100	60	80	89
Adequate Pupil Desks	75	66	50	40	89
Adequate Pupil Chairs	75	66	50	40	89
Adequate Teacher Desks	25	17	50	0	56
Adequate Teacher Chairs	25	17	50	0	56
Adequate Office Tables	25	17	17	0	22
Adequate Cupboards	0	0	0	0	11
Water Supply Facilities	100	100	83	80	45
Telephone Facilities	100	100	17	17	0
Electricity Connection	100	100	66	80	11
Blackboards	75	50	66	60	66
Toilet Facilities for Students	100	100	100	100	100
Toilet Facilities for Teachers	100	100	83	100	100

Source: Aturupane, (1997).
Note: - = not applicable. Adequate classroom space is defined by the MEHE as an area of 12 square feet per student.

The majority of schools possesses science rooms, although there is a shortfall in Type 1C schools and Type 2 schools. However, some of the equipment in such rooms, in the majority of schools, were not in working order. Maintenance activity was poor. In addition, due to the shortage of space, the science rooms are also used, sometimes, as classrooms and as storerooms. This speeds up depreciation of equipment, especially brittle items like glassware.

A shortage of workshops exists, especially in Type 1C schools and Type 2 schools. Storeroom space is also inadequate, particularly in Type 3 schools. Even in schools where storerooms existed, space was sometimes inadequate. Thus, broken items of furniture are stored in classrooms, or even the library, due to the shortage of storeroom space. The problem is compounded by the absence of a system of speedy disposal of broken items.

It should also be noted that substantial additions to equipment, to bridge shortfalls and gaps, would increase the requirement for storeroom space.

Staff room facilities are inadequate, especially in Type 3 schools. The condition of existing staff rooms, in some schools, was also poor. In particular, where office space is inadequate, the staff room tends to double as an office. In addition, staff rooms are partially used as storerooms

Library facilities are poor. The majority of Type 3 schools have no libraries. Among the other types of schools, while a nominal library room exists, it is more a storage room for books and periodicals, donated at random in the past, than a properly functioning library. None of the schools surveyed had a trained librarian on the staff. Libraries also tend to be used as classrooms during school hours, due to the shortage of classroom space.

Type 1C, Type 2 and Type 3 schools experience a shortage of infant desks and chairs and medium sized desks and chairs. These are items of furniture used by primary school children. All types of schools experience a shortage of pupil desks and chairs, which are used by pupils in the secondary school cycle.

An acute shortage of facilities exists for teachers. This is partly a reflection of past teacher recruitment policies, where large numbers of teachers were employed as a solution to the problem of graduate unemployment. However, the shortage of facilities would clearly lower teacher performance.

Schools also experience a shortage of facilities for their offices. This impairs the efficiency of the school administration. In addition, cupboards for the storage of teaching materials and consumables are in short supply.

Type 3 schools are badly off in terms of basic utilities, water supply, telephone facilities and electricity connections. Type 1C schools and Type 2 schools also experience a shortage of telephone facilities. Electricity and telephone connections depend on the provision of electricity and the existence of telecommunication facilities in the area in which the school is located. Hence, this is a problem that would depend largely on improvements to the general level of infrastructure for its solution.

The inadequacy of classrooms is also reflected in a shortage of blackboards. Due to the health reasons mentioned earlier, the substitution of white boards for blackboards needs to be considered.
Sanitation facilities were generally adequate, partly due to past investments in such facilities through donor-assisted programmes and NGOs. However, the quality of sanitary facilities and hygiene levels appear to poor.

Overall, the evidence suggests that schools are under-resourced and poorly equipped. Further, Type 3 schools are the worst off. It also needs to be noted that the sample survey of schools was conducted in the North-Western Province, which is an average province in terms of wealth and level of economic development. Schools in the poorer, less developed provinces, like the Uva Province and the North Central Province, are likely to face far more acute shortages of equipment, furniture and basic facilities. In addition, schools in the war affected North-Eastern province would need reconstruction, after the war is over.

The shortage of facilities and equipment in schools is experienced most acutely at the primary level. In all types of schools, including the relatively well endowed National and Type 1AB schools, whenever shortages are experienced, they are invariably in the primary section. Interviews with principals and teachers showed that considerably greater importance is awarded to secondary education than to primary education, among school administrators, teachers, students and parents. There appear to be three main reasons for this. First, it is the GCE O/L and GCE A/L that determine the future employment and earnings prospects of students. Hence, these two schooling levels, which occur within the secondary cycle, are perceived as the two most important points in the education system. Second, the prestige of a school depends on the number of years of schooling it offers, and its grading in the classification scheme of the MEHE. Thus, National Schools are the most prestigious, followed by Type 1AB schools, while Type 3 schools are the least important. As a result, schools tend to attach greater importance to their highest grades. Third, the most visible achievements of a school, whether in scholastic attainment or sporting success, are obtained by older children. Hence, secondary education occupies a more prominent position in the public eye. The perception that secondary education is more important than primary education is reflected in the allocation of resources at the school level.

4.7.2. Medium and High Level Facilities and Equipment

The availability of teaching aids medium level and high level items of educational facilities and equipment was also checked in the school survey in the North Western Province. The results are summarised in Table 4.7b.

The information in Table 4.7b above shows those Type 3 schools, Type 2 schools and Type 1C schools are the worst endowed with facilities and equipment. In general, schools possess basic teaching aids like globes and charts. This is mainly the result of past donor assisted programmes, which have supplied such items. However, schools are poorly endowed with such items of equipment as

computers, printers, roneo machines and overhead projectors. Even where schools possess such items, quantities are very small. For instance, the average number of computers among National schools is 2, with the maximum being 4. Only one National school had an overhead projector. The average number of roneo machines, in National Schools, is between 2-3, with the maximum 4.

Table 4.7b: Availability of Teaching Aids and Medium and High Level Equipment in Schools, by Type of School

Type of Teaching Aid or Equipment	National Schools Percent	Type 1AB Schools Percent	Type 1C Schools Percent	Type 2 Schools Percent	Type 3 Schools Percent
Globes	100	83	100	20	33
Charts for Teaching	100	100	100	0	0
Roneo Machines	100	100	50	20	0
Photocopying Machines	25	33	0	0	0
Radio Sets	100	83	33	40	0
Television Sets	100	100	33	20	0
Video Cassette Players	100	83	0	20	0
Typewriters	100	100	83	80	33
Printers	50	17	0	0	0
Computers	75	33	0	0	0
Overhead Projectors	25	0	0	0	0

Source: Aturupane, (1997).

Overall, the availability and quantities of items of medium and high level equipment are negligible.

The majority of the items of equipment listed above have been obtained by schools either as donations from well-wishers or purchased from their facility fees or PTA contributions. There is, as yet, no entitlement to such items from the education budget. Further, the sources of financing of such items leads to their infrequent purchase, and the absence of a regular replacement cycle. Thus, some of the items of equipment, including nearly all the computers, were obsolete models, several years old.

The primary levels of schools tend to possess the lowest quantities of medium and high level equipment and quality inputs. For instance, no school allocated computers, printers, TV sets, video cassette players, radio sets, overhead projectors, roneo machines or photocopying machines for use in primary education.

4.8 Recurrent Expenditures at School Level

The pattern of recurrent expenditures of schools is analysed in this part. The analysis is based on a survey conducted for a study on Financing of the Social Sectors, ADB 1996 [see Aturupane, 1996]. This survey covered 120 schools in three provinces, the North Western Province, the Central Province

and the Western Province. The proportions of recurrent expenditures of schools, by type of category, are presented in Table 4.8a.

The evidence in Table 4.8a shows that the major proportion of recurrent expenditures, approximately 73 per cent, is spent on teacher salaries. This is normal for schooling systems, where teacher salaries are the highest item of recurrent expenditure. The next highest share of expenditure is incurred on school uniforms, 8.6 per cent, followed by school textbooks, 8.5 per cent. Teacher salaries, textbooks and uniforms, between them account for 93 per cent of all recurrent expenditures. Teaching material receives 1.3 per cent of recurrent expenditures at school level, laboratory material 0.5 per cent and library material 0.4 per cent.

Table 4.8a: Allocation of Recurrent Expenditure by Category and Type of School by Percentage

	National Schools	Type 1AB Schools	Type 1C Schools	Type 2 Schools	Type 3 Schools	All Schools
Teachers salaries	76.3	72.4	75.4	76.4	84.4	73.2
Other salaries	1.9	1.2	0.4	0.9	0.2	1.0
Teaching material	0.3	0.1	0.1	0.1	0.0	1.3
Library material	0.6	0.5	0.3	0.3	0.2	0.4
Laboratory expenditure	0.1	0.6	0.4	0.2	0.0	0.5
Sports expenditure	2.2	3.5	0.4	0.2	0.1	2.4
Extra-curricular activities	0.6	0.1	0.4	0.3	0.1	0.2
Other equipment	0.0	0.4	0.2	0.1	0.1	0.3
Maintenance expenditure	0.5	0.8	0.3	0.7	0.4	0.6
School uniforms	8.6	8.5	9.7	12.3	9.1	8.9
School textbooks	8.5	11.5	12.5	8.4	5.3	10.9
Other	0.4	0.3	0.1	0.2	0.1	0.3
Total	100	100	100	100	100	100

Source: Aturupane (ADB), 1996.

Generally, the level of spending on quality inputs, apart from textbooks, is low. Further, among different categories of schools, Type 3 primary schools spend less on quality inputs, in per capita terms, than other schools. Also, the primary sections of larger schools spend less on quality inputs than the secondary sections of schools. Teachers in primary schools and teachers in the primary levels of other schools, too, receive the lowest allocations for teaching material.

4.9 The Future: Student Enrolment and Teacher Availability in the Education Sector

The actual and projected pattern of primary student enrolment over the period 1994-2005 is presented, by school year and gender, in Table 4.9-1.

The trend in Table 4.9a reveals that primary enrolment is predicted to decline, for both boys and girls, over the period 1996-2005. Male primary enrolment, which was approximately 942,000 students in 1996, will have decreased to 822,000 students by 2005. Female primary enrolment will decline from 876,000 students in 1996 to 768,000 students by 2005. Total primary enrolment is projected to decrease from 1.8 million students in 1996 to 1.6 million students by 2005. This represents a 13 per cent decline over the period from 1996-2005, or approximately 1.3 per cent per year on average. The main reason for the declining pattern of student enrolment is a fall in birth rates in Sri Lanka.

Table 4.9a: Actual and Projected Student Enrolments, ('000s)

Years	Enrolment					Total Primary	Male	Female
	Year 1	Year 2	Year 3	Year 4	Year 5			
1994	360	381	388	403	396	**1,928**	999	929
1995	355	370	379	380	386	**1,870**	969	901
1996	350	364	368	370	365	**1,818**	942	876
1997	345	359	362	360	355	1,782	923	859
1998	341	354	357	354	345	1,751	907	844
1999	336	349	352	349	339	1,725	894	832
2000	332	345	347	344	334	**1,702**	881	820
2001	327	340	343	339	330	**1,679**	869	810
2002	323	336	338	335	325	**1,657**	845	788
2003	318	331	334	330	320	**1,634**	845	788
2004	314	327	329	326	316	**1,612**	834	778
2005	310	322	325	321	312	**1,590**	822	768

Note: 1994-1996 are actual numbers. 1997 onwards are projections.

Projected all island teacher requirements are shown in Table 4.9-2. Following the pattern of declining student enrolment, the demand for teachers, too, is predicted to decrease. In addition, the Ministry of Education intends to implement a policy by which the teacher pupil ratio, at the primary level, will become 1:26 in 2001 and 1:27 in 2003. At the secondary level, the teacher pupil ratio is to reach 1:22 in 2001. Overall, this will shift the teacher:pupil ratio from 1:22 in 1996 to 1:24 by 2001. The savings in teacher salary expenditure, due to the decrease in the stock of teachers, will be approximately SLR125 million per year over the period 1998-2005, or SLR1 billion over the entire period. This is a substantial cost saving. These resources can be used to increase quality inputs in the education system

as a whole. A rational plan needs to be developed to estimate the quality-input requirements of primary and secondary schools in relation to the curriculum. The extra resources saved, then, can be used to allocate quality inputs to schools according to this plan.

Table 4.9b: Actual Number of Teachers Compared with the Projected Number of Teachers for Years 2001 and 2003

Province	No of Teachers In 1996	No of Teachers Required in Year 2001		Total No Teachers Required in Year 2001	No of Teachers Required in Year 2003		Total No Teachers Required in Year 2003
		Primary	*Secondary*		*Primary*	*Secondary*	
Western	36,801	13,309	23,615	**36,924**	12,268	23,085	**35,353**
Central	24,540	9,380	14,698	**24,078**	8,669	14,385	**23,054**
Southern	26,514	8,737	14,806	**23,543**	8,091	14,490	**22,581**
Northern	8,096	4,304	5,944	**10,248**	3,980	5,824	**9,804**
Eastern	12,556	6,380	8,287	**14,667**	5,889	8,105	**13,994**
North Western	22,723	9,027	13,512	**22,539**	8,740	13,512	**22,252**
North Central	11,805	4,528	7,355	**11,883**	4,190	7,182	**11,372**
Uva	13,706	5,272	7,623	**12,895**	4,892	7,458	**12,350**
Sabaragamuwa	18,777	6,864	11,150	**18,014**	6,344	10,986	**17,240**
Sri Lanka	**175,518**	**67,801**	**106,990**	**174,791**	**63,063**	**104,937**	**168,000**

4.10 Conclusions and Recommendations

Based on the analysis in the preceding sections, the following principal conclusions can be drawn.

Serious shortages of facilities, equipment, materials and consumables exist at all levels of schooling in Sri Lanka. The scarcity of resources is particularly acute at the primary level.

i. The level of investment in education in Sri Lanka is relatively low in comparison to other developing countries. The scarcity of the stock of capital goods in the education sector can be attributed partly to the lack of resources.

ii. Declining student enrolment, caused by a low and falling birth rate, will lower the requirement for school teachers. The government should exploit this opportunity to generate cost savings in the education sector by a general freeze on teacher recruitment, and permitting natural attrition to reduce the stock of teachers over time.

iii. The resources saved from the lower salary bill should be used to increase the supply of quality inputs to the education system.

iv. Increasing the primary school teacher pupil ratio to 1:26 in 2001 and 1:27 in 2003 has the scope to further increase the resources available for education. Implementation of

recommendations (III) and (V) would release approximately SLR1 billion for the purchase of quality inputs and other system improvement. This step should be given priority.

v. Sri Lanka, by a law passed in 1962, does not permit new private schools to be opened in the country. This law was passed at a period when socialist oriented economic and social policies were popular. In the current pro-market economic environment in the country, there is a strong case for encouraging a private sector in education. Already, there is very strong demand and willingness to pay for quality education [Aturupane, 1997]. Hence, the possibility of lifting the ban preventing new private schools from being opened should be explored. Sri Lanka needs to develop a high quality private education sector.

Chapter 5: Analysis of Health Expenditures

5.1 Introduction

In comparison with the vast majority of other countries, the Government of Sri Lanka has an excellent record in terms of sustained action to ensure access to basic health services for all its people. The active intervention of the Government in this area has historical roots in the efforts of Sri Lankan kings in earlier centuries to provide health services to the people. However, the current health care infrastructure of the country which is available in all areas was established over a period of decades starting in the 1930s.

Today, virtually all Sri Lankans, with a few exceptions, have access to the most basic health care services, either from GOSL operated facilities or from private sector providers. The level of access is illustrated by the fact that overall levels of utilisation of health care services in the country are, measured by all standards, high, and by the unusual feature of Sri Lanka's health system in which the poorer sections of the population use health care services at the same per capita rates, if not higher, as the wealthier sections of the population. Although there are areas in which access to basic health services can be improved, Sri Lanka has largely achieved the goal of ensuring access to basic health services. Currently, the key issues in the health sector relate to resource mobilisation, improvements to the quality and consumer responsiveness of health services, control of expenditure growth, and management of the evolution of the health care system in a more liberalised market-oriented economy.

5.2 Analysis of Allocations to Health Sector

Accurate and reliable figures for national health expenditures in Sri Lanka are not currently available, as the country lacks a final system of national health accounts. Private health expenditures are believed to have accounted for an increasing share of total health expenditures since the 1970s, but the exact levels are uncertain, with estimates ranging from 30-60% of the total (Table 5.2a). In the mid 1990s, the best available estimates suggest that private health expenditures were in the region of 1.5-1.8% of GDP, consisting mostly of household spending on drugs and doctors' fees (Table 5.2b). Initial tabulations of data collected in the first three rounds of the Central Bank 1996/97 Consumer Finance Survey indicate that 2.2% of household expenditures were for health related items(personal communication from K. Ranasinghe, Central Bank, July 20, 1998) which would be equivalent to 1.6% of GDP. In comparison with other countries, this remains a low level, and is consistent with estimates made for earlier time periods in Sri Lanka.

In the absence of accurate private sector expenditure estimates, the discussion in this section will concentrate on public health expenditures.

Table 5.2a: Trends in the Composition and Use of Health Expenditures

	1953	1980	1990	1996
SOURCE OF NATIONAL HEALTH EXPENDITURES (%)				
Public	62	57	46	50
Private	38	43	54	50
Use of national health expenditures (%)				
Hospital	48	45	40	40
Non-hospital	52	55	60	60
SOURCE OF ALL HOSPITAL EXPENDITURES (%)				
Public	96	87	93	87
Private	4	13	7	13
SOURCE OF ALL NON-HOSPITAL EXPENDITURES (%)				
Public	30	31	16	26
Private	70	69	84	74
SOURCE OF MODERN NON-HOSPITAL EXPENDITURES (%)				
Public	70	40	19	27
Private	30	60	81	73

Source: IPS HPP estimates.
Note: "Modern' is defined as all non-scientifically-based forms of care, and thus excludes ayurvedic, ceremonial, homeopathic, and other treatments. 'Hospital' and 'non-hospital' refers to the location of care, and so outpatient care provided by government hospitals is classified here as hospital care.

Government health expenditures in Sri Lanka are almost exclusively through the Health Ministry (and provincial health ministries). There are some expenditures related to health services through other government agencies and units, such as the municipal councils, armed forces, and universities, but these are relatively insignificant. These other expenditures are ignored for the purposes of this description.

Table 5.2b: National Health Accounts Matrix, 1996 (Rs Million)

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

Sources: IPS HPP estimates derived from various data sources, including government budgetary records, IPS survey data for private health insurance companies, private hospitals, IMS (Lanka), Census and Statistics Department reports, etc. Most data sources did not apply to 1996, so some judgement has been applied to extrapolate from previous years to 1996.

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

5.2.1 Government Expenditures on Health Services

Percentage of GDP

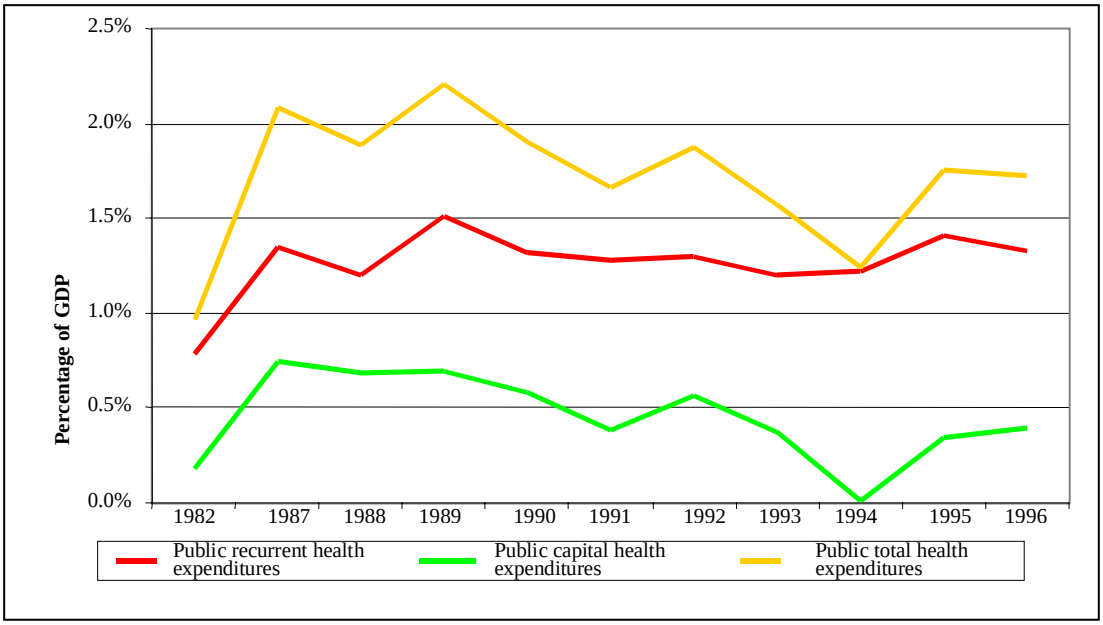
Table 5.2.3 presents data on total government health expenditures over time. During the period 1945-1995, government health spending as a percentage of GDP has varied in three distinct phases. During the first period lasting until 1960, health expenditures increased significantly from 0.7% of GDP to peak at 2.3% of GDP in 1959. Then from 1960 to 1982, health spending as a percentage of GDP gradually declined to reach a low of 1.1% of GDP in 1982. Since then, government health expenditures have fluctuated considerably largely due to several capital projects, but has shown an upward trend in the mid-1990s to reach 1.8% of GDP in 1995 (Figure 5.2a).

Real per capita terms

During the time since 1945, the Sri Lankan economic growth has been characterised by three phases. The period from 1945 to 1960 saw some moderate increase in economic output and in per capita incomes, which combined with the increasing percentage of GDP being spent on health by the government resulted in an almost tripling of real per capita government health expenditures from 1945 to 1959 (Figure 5.2a). From 1960 to 1977, the Sri Lankan economy stagnated, with per capita incomes increasing at a low rate (0 – 2% per annum). This, combined with a gradual decline in the

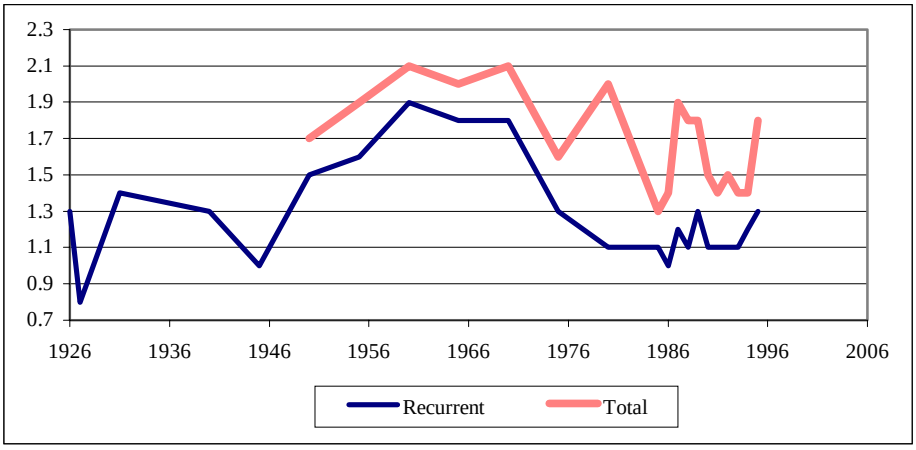
relative share of GDP being devoted to health services by the government resulted in little increase in government health expenditures in real per capita terms.

Figure 5.2a: Public Health Expenditures, 1988-1997



Since 1977, despite some declines in health spending as a percentage of GDP, strong and sustained economic growth has led to a real increase in government health spending. Figure 5.2b shows the trends in government health spending in recent years. However, there has been little increase in spending as a percentage of GDP during this time period, which one might expect with increased per capita incomes, and public health spending may not have kept pace with private health spending. As the World Bank (1993) notes: "As incomes increase, so do both the percentage of income spent on health, and the share of health spending that comes from public sources." Recent trends in Sri Lanka run counter to this general situation, and suggest that there may be an increasing justification for considering increases in the priority given to government health spending.

Figure 5.2b: Government Health Expenditures as a Percentage of GDP



Source: IPS database.

5.2.2 Government Expenditures on Basic Health Services

Defining Basic Health Services

For expenditures on Basic Health Services (BHS) to be measured and evaluated, it is first necessary to define what constitutes BHS. The definitions provided in the supporting documents for this project are not that specific or translatable into operational definitions. It was agreed during the course of the study that country teams can develop their own definitions depending on national needs and circumstances, in addition to using a core set of definitions agreed between participating countries.

In developing a set of definitions, the following criteria are considered relevant:

1. Definitions must be meaningful from a Sri Lankan policy perspective.
2. Definitions must be consistent with the proposed UNICEF approach, or at least mappable to proposed UNICEF definitions.
3. Definitions must allow some comparison with spending levels in other countries.
4. Definitions must be practically workable in terms of available data and feasible estimation procedures.

From the perspective of the first criterion, it must be noted that the original 20/20 concept as proposed in WSSD 1995 is highly normative. Basic social services (BSS) were seen as essential tools in the fight against poverty, complementing other development policies focusing on macroeconomic development, income promotion and shelter. Chapter 2 of WSSD elaborates by identifying BSS as a means to ensure that all people can meet their "basic human needs", but doesn't state what constitutes such essential needs.

There can be no universally acceptable agreement on what such needs are, as this would depend on the particular ethical viewpoint of the observer. However, while no such consensus is possible, the Sri Lankan analysis should be based on the ethical perspectives of Sri Lankan society and policy-makers as a whole. In this context, it is crucial to note that the Sri Lankan experience indicates that Sri Lankan society has generally taken a more universal and comprehensive view of what constitutes basic and essential human needs than most other developing countries. In the case of health care, essential health services have for a long time been regarded as extending from the lowest level primary health care services to higher level inpatient services, both preventative and curative. In addition, from the 1930s onwards, it has been implicitly accepted that one of the objectives of the government in providing health services is in fact poverty reduction or alleviation, and that this objective is served not only by providing cost-effective health promoting interventions, but also by providing basic inpatient services to protect poor families from financial catastrophe because of their inability to pay for such care. It can be said that in recognising that basic health services are a key mechanism in reducing absolute poverty, Sri Lanka is more than five decades ahead of the WSSD.

More recently, as Sri Lanka has achieved low mortality and relatively high health status for most of its population, what is considered basic or essential health needs has changed, and no longer comprises the most basic level of services that most other developing countries are still striving to provide universal access to. The Sri Lankan definition of BHS must therefore comprise a higher and more comprehensive level of services than will be the case for most participants in the 20/20 multi-country study. In addition, since Sri Lanka has operated for several decades a health care system which is universally accessible to its population, basic health services can be construed in the Sri Lankan context as being those services which public policy assumes should be part of the universal health care package available to all citizens.

While the above discussion provides pointers to identifying the boundaries of what constitutes BHS, it does not directly lead to a set of definitions for the various elements of BHS. The documentation provided at the Manila meeting gives some definitions, but these are not precise enough, or are not relevant to the context of Sri Lanka.

Unfortunately, there is no alternative set of internationally agreed health expenditures definitions. However, there has been substantial progress in recent years towards developing an internationally acceptable and comparable framework and set of such definitions. This draws upon the work done in several countries to develop national health accounts (NHA), efforts by the OECD to estimate comparable health expenditure estimates for its member countries, and an important attempt in the past six months by the OECD secretariat to develop an internationally comparable NHA framework

for use in OECD countries. Although the OECD proposed framework is based on earlier work done in developed countries, it is being currently revised with input from other international agencies, and from other countries. A network of national health accounts experts in the Asia-Pacific region was formed in March 1998 at the Inaugural Asia-Pacific Health Economics Forum meeting in Bangkok, and the objectives of this network are expected to include collaboration on development of comparable definitions, as well as dialogue with the OECD on the OECD proposals. It is possible that in 1999-2000 a modified version of this framework will officially be proposed by OECD and Eurostat for consideration by the UN Statistical Office and WHO as the global standard.

Ministry of Health is currently working on developing a set of annually estimated NHA for Sri Lanka, and is also participating in the international and regional discussions on the OECD framework. Given this, IPS incorporated into the proposed UNICEF approach many of the elements of the NHA approach to health expenditure estimation, as well as those definitions in the OECD work which are relevant. This approach has the advantage of producing statistics which are more likely to be produced on a regular basis in future years in Sri Lanka, as well as being comparable with statistics to be produced by a large cross-section of countries. The OECD perspective has an additional advantage in that it also reflects the policy concerns and issues of low mortality countries, which may be more relevant to Sri Lanka's health situation than those of most poor high mortality countries. At the same time, variants of the framework currently in use by OECD for health expenditure measurement have been accepted as the basis for health expenditure estimation by official agencies in several Asian countries, including the People's Republic of China, Bangladesh, The Philippines, Thailand, South Korea, and Hong Kong SAR, China.

Proposed framework for defining BHS in Sri Lanka

Documentation at the Manila meeting suggested that all health interventions/expenditures belong to one of two categories: (i) public health, and (ii) personal health services. For this study, IPS used an alternative approach, based on OECD Health Data 1998 and OECD (1997) which categorises all health expenditures as being used for (i) core health functions, and (ii) health related functions. Core health functions are further subdivided into:

1. personal medical services
2. distribution of medical goods
3. collective health services
4. health programme and administration.

Table A13 in the Annex presents a comprehensive classification of the functions for which Sri Lanka's health expenditures are used, based on the conceptual classifications used in OECD Health

Data 1998 and OECD (1997). All health expenditures are classified into specific functions, denoted by a series of codes: SLHA (Sri Lanka Health Accounts Codes). These codes disaggregate functions down to the level of three digits, and are defined in such a way as to provide a set of mutually exclusive categories. Table 5.2a is expected to correspond closely to the eventual classification of health expenditures that IPS will use for its compilation of NHA for Sri Lanka. Table A14 in the Annex shows how each item corresponds to the sub-categories proposed by UNICEF in its Manila documentation for BHS.

For some categories, such as hospital services, BHS only comprises a portion of expenditures in that category. The following notes complement Table A14 in defining what is measured as BHS in Sri Lanka for the 20/20 study.

Hospital services (1.1)

This is defined as including all expenditures by hospitals and other inpatient services, incurred by the hospital, and in the case of private hospitals billed to the patient by the hospital.

- BHS comprise only those expenditures in MOH hospitals below the level of provincial hospitals and national hospitals, plus an estimated proportion of inpatient and outpatient expenditures in the higher level hospitals which are for providing non-specialist basic medical and surgical care. These proportions were set at 50% for all national, general and base hospitals and other specialised inpatient facilities, and 75% for national-level specialised obstetric and gynaecological hospitals.

Ambulatory services (1.2)

These are defined as including all medical and dental services provided on an outpatient basis by outpatient or ambulatory providers and facilities. These include services provided by registered medical practitioners, nurses, paramedical personnel, traditional providers and others. Expenditures on providing outpatient services at hospital outpatient departments will be excluded and counted as part of 1.1.

- ❖ BHS are defined as consisting of all MOH expenditures in this category.

Health promotion and disease prevention (3.1)

Collective health services include services designed to enhance the health status of the population as distinct from the curative services which repair health dysfunction. Typical services are vaccination campaigns and programmes. With the shift of emphasis from infectious disease to chronic conditions and the specific demand of ageing populations, the latter play an increasingly important role. Collective health services are separated into health promotion and disease prevention (3.1) and other collective services (3.2).

Health promotion and disease prevention consist of the following items:

Maternal and child health (3.1.1)

Maternal and child health covers a wide range of medical services: genetic counselling and prevention of specific congenital abnormalities, pre-natal and post-natal medical attention, well-baby health care, pre-school and school child health.

- ❖ BHS comprises those MOH services administered by the Family Health Bureau, and not provided through MOH hospitals and other facilities to mothers and children.

Family planning (3.1.2)

All expenditures in separate programmes designed to provide contraceptive advice and services, as well as counselling.

- ❖ BHS comprises those MOH-financed services in this category.

Disease prevention and health promotion (3.1.3-4)

Includes prevention against both communicable and non-communicable disease. Includes compulsory reporting/notification of certain communicable diseases and epidemiological enquiry of communicable disease; efforts to trace possible contacts and origin of disease; prevention of tuberculosis and tuberculosis control (including systematic screening of high risk groups); immunisation/vaccination programmes (compulsory and voluntary); vaccination under maternity and child health care; interventions against smoking, alcohol and drug abuse; centres for disease surveillance and control; programmes for the avoidance of risks incurred and the improvement of the health status of the nation in general; general health education and health information of the public; health education campaigns; campaigns in favour of healthier life-styles, safe sex etc.; information exchanges: *e.g.* alcoholism, drug addiction; environmental surveillance and public information on environmental conditions. *Excludes*: vaccination for occupational health; vaccination for travel and tourism on the patients' own initiative; activities of self-help groups and health education campaigns of self-help groups.

- ❖ BHS comprise government and donor funded activities within this category.

School health services (3.1.5)

Health services provided through schools to school pupils for purposes of routine screening, health education, and emergency first aid.

- ❖ BHS comprise those services financed by the government in this category.

Food hygiene (3.1.6)

Includes monitoring of veterinary and other inspectorates designed to implement food hygiene standards.

- ❖ BHS comprise all those services financed by the government in this category.

Health programme administration and health insurance administration (4.)

Health programme administration and health insurance are activities of central and provincial administrations, private insurers and social security. Included is the planning, management, regulation, collection of funds and handling of all administration of the delivery system. *Excludes:* All facility specific administration, which is counted under 1.1 and 1.2.

- BHS comprise all those services in MOH related to administration of the national health system and discharging of statutory responsibilities.

The above functional categorisation was then used to classify all health- related expenditures by GOSL into specific functions. The amount devoted to BHS was then estimated as the total of those expenditures on BHS-related functions as identified in Table 5.2-5.

Analysis of GOSL budgetary data

The primary source for the analysis was the accounting reports kept by the Ministry of Health.These report actual expenditures for each year according to specific budget heads, subheads, programmes and projects. The data for all programmes were entered into a database. Each programme was then examined, and an estimate was made as to the proportion of each programme's expenditures which were related to health in general. Because of frequent changes in ministerial responsibilities, not all programmes in the Health Ministry are necessarily related to a health objective. For example, in 1996, a substantial proportion of official MOH expenditures were for the purpose of roads and highways construction. Then for each direct service programme with a health-related purpose, the health-related expenditures involved were allocated to one of the SLHA codes. In the case of some programmes, whose purpose is to support or provide logistics to other programmes (e.g., supply of medicines to hospitals), the expenditures were first allocated on an appropriate pro-rata basis to other programmes. In some instances, not all the expenditures under a specific programme were considered to be for BHS (e.g., hospital services delivered by specialist teaching facilities), and for these an estimated percentage was taken. These estimated percentages were proposed by the study team, and then reviewed by members of the official steering committee for the study.

It should be noted that the MOH accounting reports only detail expenditures in the projects and programmes directly administered by the central Health Ministry. For expenditures by the provincial health ministries, no such detailed accounting reports are available; only the total amounts allocated for health activities to each province by the central government are known by the central MOH. Provincial Departments of Health do publish details of their expenditures in annual estimates, which are available centrally at the Ministry of Provincial Councils. In addition, since 1997, the Ministry of Provincial Councils has been able to monitor actual expenditures on a monthly basis by the various provinces. However, these provincial estimates are not widely available. Moreover, the established programme budgeting system used by the central MOH collapsed at provincial level following devolution in 1987 (Russell and Attanayake, 1997). MOF took over responsibility for all recurrent resource allocations to the Provinces, and resources are allocated and monitored simply by standard budget headings (salaries, travel, etc) and by major programme headings (administration,

patient care services, etc.). This coupled with variations in the accounting systems used by individual provinces means that it is not possible to readily disaggregate provincial health spending in the same detail possible at the centre.

As no accurate data were available, it was assumed that all provincial council health expenditures were for BHS. This unavoidable assumption was not expected to introduce significant errors into the analysis, since according to the definition used for defining BHS in this study, most provincial health services are likely to be classified as being for BHS. In general, higher level hospital services are the preserve of the central government. Table 5.2c gives a breakdown of the use of MOH expenditures in 1996 according to SLHA codes, calculated in this fashion.

This methodology was applied to an analysis of MOH expenditures for the period 1982-1996. Table 5.2d gives the proportion of Health Ministry expenditures devoted to BHS during this time period.

During the period under review, expenditures on BHS are estimated to have ranged between 0.8% and 1.8% of GDP, with no obvious trend. Recurrent expenditures on BHS appear to have increased as a proportion of GDP from 0.6% to 1.0-1.2% of GDP. In real per capita terms, expenditures have increased substantially from SLR 90 to more than SLR 250 per annum (in constant 1990 rupees)

5.2.3 Impact of Expenditures

Ultimately, the appropriateness of the level and composition of health spending, including that on basic health services, must be judged in terms of the impact of that spending on the welfare and health of people. In practice, linking health expenditures directly to the health status of individuals is methodologically difficult, as health status is a function of many factors, most of which are not related to activities in the health sector, such as the level of education, nutrition, income, etc. or other exogenous factors such as climate and genetics. Some observers even deny a significant role for medical services and medical expenditures in determining the health status of a population.

Table 5.2c: Analysis of 1996 Central MOH Expenditures using ICHE-SLHA Classification

HA CODE	Category	Sub-category	*Health expenditures* Recurrent health expenditures	*Health expenditures* Capital health expenditures	*Functional expenditure analysis at one digit level* Rupees	Percentage of recurrent	Percentage of total
HA1	Personal Health Services		402,006	-	4,174,734,706	81%	55%
HA1.1		Hospital Services	4,006,903,486	10,954,115			
HA1.2		Ambulatory Services	139,080,406	10,954,115			
HA1.2.1		Registered Medical Practitioners	402,006	-			
HA1.2.2		Other Providers	-	-			
HA1.2.3		Laboratory Services	-	-			
HA1.2.4		Diagnostic Services	-	-			
HA1.2.5		Dental Services	27,946,802	-			
HA1.3	Psychological and socio-psychological services		-	-			
HA1.4	Residential nursing care/long term care for frail and elderly people		-	-			
HA1.5	Home care		-	-			
HA1.6	Patient transport and emergency rescue		-	-			
HA2	Distribution of medical goods		-	-	16,514,129	0%	0%
HA2.1	Pharmaceuticals		16,514,129	-			
HA2.2	Therapeutic appliances and medical equipment		-	-			
HA3	Collective Health Services		-	-	668,687,151	13%	9%
HA3.1	Health promotion and disease prevention		-	-			
HA3.1.1	Maternal and child health		263,179,974	-			
HA3.1.2	Family planning		24,723,702	-			
HA3.1.3	Disease prevention		302,892,042	-			
HA3.1.4	Health Promotion		39,999,118	-			
HA3.1.5	School health services		2,549,296	-			
HA3.1.6	Food hygiene control		1,666,049	-			
HA3.1.7	Control of drinking water, environmental surveillance		33,676,971	-			
HA3.2	Other collective health services		-	-			
HA3.2.1	Occupational health care		-	-			
HA4	Health Programme Administration and health insurance		20,544,472	3,201,645	20,544,472	0%	0%
HA5	Investment into medical facilities		-	2,399,488,345	2,424,598,219		32%
HA6	Education and training of health personnel		216,768,903	-	216,768,903	4%	3%
HA7	Research and development in health		46,039,353	-	46,039,353	1%	1%
HA8	Environmental health		-	-	-	0%	0%
HA9	Administration and provision of cash benefits		2,842,343	-	2,842,343	0%	0%
	TOTAL EXPENDITURES		5,146,131,057	2,424,598,219	7,570,729,277	100%	100%

BHS related expenditures shaded in blue. **Source:** IPS Health Policy Programme

Table 5.2d: Analysis of BHS Expenditures, Sri Lanka 1982-96

Year	1982	1987	1988	1989	1990
Central MOH Expenditures (SLRs)					
Recurrent Health Expenditure	744,998,710	1,773,574,563	1,684,935,642	2,265,234,250	1,794,975,111
Capital Health Expenditure	171,438,085	821,441,231	1,064,929,638	735,476,553	1,366,467,629
Total Health Expenditure	916,436,795	2,595,015,794	2,749,865,280	3,000,710,803	3,161,442,740
Recurrent Expenditure on BHS	609,765,378	1,515,583,232	1,366,992,638	1,658,875,318	1,294,504,941
Capital Expenditure on BHS	171,438,085	821,441,231	1,064,929,638	735,476,553	1,366,467,629
Total Expenditure on BHS	781,203,463	2,337,024,463	2,431,922,276	2,394,351,870	2,660,972,570
Percentage allocation to BHS					
Recurrent allocation	**82%**	**85%**	**81%**	**73%**	**72%**
Capital allocation	**100%**	**100%**	**100%**	**100%**	**100%**
Total allocation	**85%**	**90%**	**88%**	**80%**	**84%**
Provincial Health Expenditures (SLRs)					
Recurrent Health Expenditure		619,734,437	757,442,358	1,181,396,750	2,046,520,000
Capital Health Expenditure		496,284,769	329,270,363	856,297,448	327,761,000
Total Health Expenditure		1,116,019,206	1,086,712,721	2,037,694,198	2,374,281,000
Recurrent Expenditure on BHS		619,734,437	757,442,358	1,181,396,750	2,046,520,000
Capital Expenditure on BHS		496,284,769	329,270,363	856,297,448	327,761,000
Total Expenditure on BHS		1,116,019,206	1,086,712,721	2,037,694,198	2,374,281,000
Percentage allocation to BHS		**100%**	**100%**	**100%**	**100%**
Total GOSL Health Expenditures (SLRs)					
Recurrent Health Expenditure	744,998,710	2,393,309,000	2,442,378,000	3,446,631,000	3,841,495,111
Capital Health Expenditure	171,438,085	1,317,726,000	1,394,200,000	1,591,774,000	1,694,228,629
Total Health Expenditure	916,436,795	3,711,035,000	3,836,578,000	5,038,405,000	5,535,723,740
Recurrent Expenditure on BHS	609,765,378	2,135,317,669	2,124,434,996	2,840,272,068	3,341,024,941
Capital Expenditure on BHS	171,438,085	1,317,726,000	1,394,200,000	1,591,774,000	1,694,228,629
Total Expenditure on BHS	781,203,463	3,453,043,669	3,518,634,996	4,432,046,068	5,035,253,570
Percentage allocation to BHS					
Recurrent allocation	**82%**	**89%**	**87%**	**82%**	**87%**
Capital allocation	**100%**	**100%**	**100%**	**100%**	**100%**
Total allocation	**85%**	**93%**	**92%**	**88%**	**91%**
Total public recurrent health expenditure as a % of GDP	**0.8%**	**1.3%**	**1.2%**	**1.5%**	**1.3%**
Total public capital health expenditure as a % of GDP	**0.2%**	**0.7%**	**0.7%**	**0.7%**	**0.6%**
Total public health expenditure as a % of GDP	**1.0%**	**2.1%**	**1.9%**	**2.2%**	**1.9%**
Recurrent Expenditure on BHS as a % of GDP	**0.6%**	**1.2%**	**1.0%**	**1.2%**	**1.1%**
Capital Expenditure on BHS as % of of GDP	**0.2%**	**0.7%**	**0.7%**	**0.7%**	**0.6%**
Total Expenditure on BHS as a % of GDP	**0.8%**	**1.9%**	**1.7%**	**1.9%**	**1.7%**
BHS as a % of Recurrent Government Expenditure	**3.3%**	**5.4%**	**4.6%**	**5.0%**	**4.7%**
BHS as a % of Capital Government Expenditure	**1.1%**	**5.1%**	**5.0%**	**6.0%**	**6.4%**
BHS as a % of Total Government Expenditure	**2.3%**	**5.3%**	**4.7%**	**5.3%**	**5.1%**
Real Per Capita Recurrent Expenditure on BHS (1990	**90.2**	**191.2**	**168.4**	**202.7**	**196.6**
Real Per Capita Capita Expenditure on BHS (1990 Rs.)	**25.4**	**118.0**	**110.5**	**113.6**	**99.7**
Real Total Per Capita Expenditure on BHS (1990 Rs.)	**115.6**	**309.2**	**278.9**	**316.2**	**296.3**
Background data					
Population	15,189,000	16,373,000	16,599,000	16,825,000	16,993,000
GDP (Rupees)	94,679,000,000	177,731,000,00	203,516,000,00	228,138,000,00	290,615,000,000
GDPD as a % (in Central Bank Bulletin)	10.2	6.8	11.5	9.7	20.0
Central Bank implied GDP deflator (1990=100)	44.5	68.2	76.0	83.3	100.0
Real GDP (Rs Million)	212,761,797,75	260,602,639,29	267,784,210,52	273,875,150,06	290,615,000,000
Total Recurrent Government Expenditure	18,341,000,000	39,559,000,000	46,132,000,000	56,884,000,000	71,771,000,000
Total Capital Government Expenditure	16,146,000,000	25,975,000,000	27,971,000,000	26,651,000,000	26,387,000,000
Total Government Expenditure	34,487,000,000	65,534,000,000	74,103,000,000	83,535,000,000	98,158,000,000

Source: IPS Health Policy Programme

Continuation of Table 5.2.7……

Year	1991	1992	1993	1994	1995	1996
Central MOH Expenditures (SLRs)						
Recurrent Health Expenditure	2,202,496,35	2,674,233,351	3,233,559,628	3,226,385,639	4,370,375,342	5,146,131,057
Capital Health Expenditure	1,050,158,29	1,906,389,642	1,370,245,569	13,101,579	1,868,499,317	2,424,598,219
Total Health Expenditure	3,252,654,65	4,577,642,061	4,603,805,197	3,239,487,218	6,238,874,659	7,570,729,277
Recurrent Expenditure on BHS	1,598,178,12	1,903,240,935	2,276,882,005	2,171,725,687	2,895,142,749	3,584,879,134
Capital Expenditure on BHS	1,050,158,29	1,906,389,642	1,370,245,569	13,101,579	1,422,016,118	1,814,554,299
Total Expenditure on BHS	2,648,336,42	3,809,630,577	3,647,127,574	2,184,827,266	4,317,158,867	5,399,433,433
Percentage allocation to BHS						
Recurrent allocation	**73%**	**71%**	**70%**	**67%**	**66%**	**70%**
Capital allocation	**100%**	**100%**	**100%**	**100%**	**76%**	**75%**
Total allocation	**81%**	**83%**	**79%**	**67%**	**69%**	**71%**
Provincial Health Expenditures (SLRs)						
Recurrent Health Expenditure	2,102,549,00	2,374,154,000	2,209,676,000	3,161,690,000	4,067,188,000	4,113,868,943
Capital Health Expenditure	254,051,000	295,302,000	325,298,000	61,130,000	201,935,000	343,401,781
Total Health Expenditure	2,356,600,00	2,669,456,000	2,534,974,000	3,222,820,000	4,269,123,000	4,457,270,724
Recurrent Expenditure on BHS	2,102,549,00	2,374,154,000	2,209,676,000	3,161,690,000	4,067,188,000	4,113,868,943
Capital Expenditure on BHS	254,051,000	295,302,000	325,298,000	61,130,000	201,935,000	343,401,781
Total Expenditure on BHS	2,356,600,00	2,669,456,000	2,534,974,000	3,222,820,000	4,269,123,000	4,457,270,724
Percentage allocation to BHS	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total GOSL Health Expenditures (SLRs)						
Recurrent Health Expenditure	4,305,045,35	5,048,387,351	5,443,235,628	6,388,075,639	8,437,563,342	9,260,000,000
Capital Health Expenditure	1,304,209,29	2,201,691,642	1,695,543,569	74,231,579	2,070,434,317	2,768,000,000
Total Health Expenditure	5,609,254,65	7,247,098,061	7,138,779,197	6,462,307,218	10,507,997,659	12,028,000,00
Recurrent Expenditure on BHS	3,700,727,12	4,277,394,935	4,486,558,005	5,333,415,687	6,962,330,749	7,698,748,077
Capital Expenditure on BHS	1,304,209,29	2,201,691,642	1,695,543,569	74,231,579	1,623,951,118	2,157,956,080
Total Expenditure on BHS	5,004,936,42	6,479,086,577	6,182,101,574	5,407,647,266	8,586,281,867	9,856,704,157
Percentage allocation to BHS						
Recurrent allocation	**86%**	**85%**	**82%**	**83%**	**83%**	**83%**
Capital allocation	**100%**	**100%**	**100%**	**100%**	**78%**	**78%**
Total allocation	**89%**	**89%**	**87%**	**84%**	**82%**	**82%**
Total public recurrent health expenditure as a % of	**1.3%**	**1.3%**	**1.2%**	**1.2%**	**1.4%**	**1.3%**
Total public capital health expenditure as a % of GDP	**0.4%**	**0.6%**	**0.4%**	**0.0%**	**0.3%**	**0.4%**
Total public health expenditure as a % of GDP	**1.7%**	**1.9%**	**1.6%**	**1.2%**	**1.8%**	**1.7%**
Recurrent Expenditure on BHS as a % of GDP	**1.1%**	**1.1%**	**1.0%**	**1.0%**	**1.2%**	**1.1%**
Capital Expenditure on BHS as % of of GDP	**0.4%**	**0.6%**	**0.4%**	**0.0%**	**0.3%**	**0.3%**
Total Expenditure on BHS as a % of GDP	**1.5%**	**1.7%**	**1.4%**	**1.0%**	**1.4%**	**1.4%**
BHS as a % of Recurrent Government Expenditure	**4.4%**	**4.8%**	**4.4%**	**4.2%**	**4.5%**	**4.5%**
BHS as a % of Capital Government Expenditure	**4.0%**	**7.4%**	**4.2%**	**0.2%**	**3.1%**	**4.5%**
BHS as a % of Total Government Expenditure	**4.3%**	**5.4%**	**4.3%**	**3.2%**	**4.1%**	**4.5%**
Real Per Capita Recurrent Expenditure on BHS (1990	**193.3**	**201.3**	**190.6**	**204.3**	**242.9**	**236.6**
Real Per Capita Capita Expenditure on BHS (1990 Rs.)	**68.1**	**103.6**	**72.0**	**2.8**	**56.7**	
Real Total Per Capita Expenditure on BHS (1990 Rs.)	**261.4**	**304.9**	**262.6**	**207.2**	**299.6**	**302.9**
Background data						
Population						
GDP (Rupees)	17,247,000	17,405,000	17,619,000	17,865,000	18,112,000	18,315,000
GDPD as a % (in Central Bank Bulletin)	337,399,000,	386,999,000,00	453,092,000,00	523,000,000,00	598,327,000,00	695,934,000,0
Central Bank implied GDP deflator (1990=100)	11.2	10.0	9.5	9.4	8.3	12.3
Real GDP (Rs Million)	111.0	122.1	133.6	146.1	158.2	177.7
Total Recurrent Government Expenditure	303,963,063,	316,952,497,95	339,140,718,56	357,973,990,41	378,146,363,78	391,660,366,2
Total Capital Government Expenditure	83,756,000,0	89,638,000,000	102,288,000,00	127,084,000,00	154,159,000,00	170,629,000,0
Total Government Expenditure	32,658,000,0	29,622,000,000	40,841,000,000	40,455,000,000	52,810,000,000	48,369,000,00
	116,414,000,	119,260,000,00	143,129,000,00	167,539,000,00	206,969,000,00	218,998,000,0

Sri Lanka, fortunately, is a country for which there are a number of empirical studies supporting the positive role that health services have played in improving health status (Anand and Ravallion, 1993; Caldwell et al., 1989; Langford, 1996; Rannan-Eliya and de Mel, 1997). These studies have established that there is a general relationship between public health expenditures in Sri Lanka and overall trends in national health status, that the use of health services by individuals and households is related to their general mortality outcomes, and that modern health services are a significant mechanism in ensuring Sri Lankans' good health despite continuing income poverty and unhealthy environments. However, linking health expenditures in the short term or at the micro level to health outcomes remains methodologically elusive.

In this context, where it has been previously established that modern medical services do improve health, it is better to assess the pattern and levels of resources and services provided with those expenditures, and to assess the impact of these on access to health care services for the population and the overall levels of health care services delivered and utilised.

Basic health infrastructure

There is a long history of public provision of health infrastructure by the Sri Lankan state, preceding by many centuries the involvement in health care by states in Europe and elsewhere in China and the Middle East. Motivated by the need to alleviate suffering and the recognition that this was a natural responsibility of the state, Sri Lankan kings from the fourth century B.C. onwards built hospitals, nursing homes and other health facilities and provided for the availability of doctors for the people (Rannan-Eliya and de Mel, 1997).

The modern health infrastructure of the country however, dates from this century. In the early part of the century, interest by the British colonial state in social services for the population, as a whole was limited, and state action minimal. However, the granting of self-rule with universal suffrage to Sri Lanka by the British in 1931 had a profound impact, and led to a continuing responsiveness by the Sri Lankan state to the social conditions and needs of the population (Rannan-Eliya and de Mel, 1997). From the late 1930s onwards, an extensive government health infrastructure was established in every corner of the island. This infrastructure was not limited to urban areas only, and was dispersed throughout the rural areas of the country. At first, the level of facilities established was quite basic; in the 1940s and 1950s the emphasis was on the establishment of dispensaries and cottage hospitals. Later once these facilities were widely available, emphasis has been laid on further increasing the density and size of facilities, as well as upgrading their services. This process of continual upgrading has continued into the 1980s and 1990s. It is important to note that while the Health Ministry was and remains rather centralised, the distribution of health facilities has in fact

been quite dispersed. Sri Lanka's political system although centralised has always been rather sensitive to the concerns of local electorates.

As a consequence of these decades long efforts, Sri Lankans have unusually good access to basic modern health care services. Table 5.2e gives some data on the expansion of physical infrastructure in the health sector during the recent past, and Table 5.2f compares these levels with other countries.

Table 5.2e: Trends in the Provision of Government Health Facilities

	1986	1990	1995	1996
All hospitals	409	361	407	450
All hospital beds	46,005	42,079	47,665	51,866
Dispensaries/clinics	88	61	60	60

Source: Ministry of Health Annual Health Bulletins.

Table 5.2f: Comparative Numbers of Health Facilities

	Sri Lanka*	Bangladesh	Thailand	Malaysia*	Japan	USA
Year	***1995***	***1994***	***1995***	***1995***	***1995***	***1990***
All hospitals	407	919	1,280	118	9,606	..
All hospital beds	47,665	35,800	118,417	33,588	1,669,951	1,213,327
Beds per 10,000 population	27	3	20	17	133	47
Mental hospitals	3	1	12	4	1,059	..
Beds in mental hospitals	2,123	400	7,684	5,720	264,638	160,000
Beds per 10,000 population	1.2	0.0	1.1	0.8	37.8	6.2

Source: IPS database, national sources.
* Data refer only to public sector.

While Sri Lanka has a high level of physical infrastructure in the health sector relative to its population and income level, the quantity of human resources is not high. Tables 5.2-10 and 5.2-11 show trends in the numbers of health personnel employed by the Health Ministry over time and in comparison with some other countries.

Table 5.2g: Trends in the Numbers of Health Personnel Employed by Health Ministry

	1986	1990	1991	1992	1993	1994	1995
Doctors	2,217	2,440	2,934	3,345	3,713	4,047	4,627
Assistant Medical Practitioners	1,047	1,074	1,201	1,253	1,305	1,357	1,376
Nurses	11,310	12,418	13,618	17,460	18,460	17,577	17,960

Source: Ministry of Health Annual Health Bulletins.

Table 5.2h: Comparative Numbers of Health Personnel

	Sri Lanka*	Bangladesh	India	Thailand	Malaysia	Japan
Year	*1990*	*1994*	*1990*	*1990*	*1990*	*1990*
Doctors per 10,000 capita	1.4	2.2	4.1	2.3	4.8	18.4
Nurses per 10,000 capita	7.3	0.8	3.0	9.1	6.8	68.9
Nurses to doctors ratio	5.2	0.4	0.7	4.0	1.4	3.7

Source: Ministry of Health Annual Health Bulletin, World Bank World Development Reports, OECD (1993), National sources.
*Sri Lanka refers only to public sector.

The high levels of physical infrastructure, particularly beds, a policy of not charging user fees, and a historical tradition of not discouraging admissions have encouraged and resulted in a very high level of inpatient utilisation. Overall numbers of admissions and population admission rates to government hospitals are very high in comparison with other countries, and have remained at this level during the period under review (Tables 5.2.12, 5.2.13).

Table 5.2i: Trends in the Utilisation of Government Health Facilities

	1985	1990	1991	1992	1993	1994	1995
Inpatients ('000s)	2,494	2,533	2,629	3,023	3,174	3,204	2,953
Outpatients ('000s)	29,570	28,401	28,575	36,827	36,656	32,084	2,953
Inpatients per 100 capita	15.7	17.4	17.8	17.3	18.0	17.9	17.9
Outpatient visits per capita	1.9	17.4	17.8	17.3	18.0	17.9	17.9

Source: Ministry of Health Annual Health Bulletins.

Table 5.2j: Comparative Data for Utilisation of Public Health Facilities

	Sri Lanka	Bangla-desh	Indonesia	Thailand	Malaysia	Hong Kong	Japan*	UK*	USA
Year	*1995*	*1991*	*1995*	*1995*	*1995*	*1995*	*1995*	*1988*	*90/91*
Bed occupancy rate (%)	**75.0**	..	55.1	67.1	61.4	79.8	83.6	80.6	69.1
Inpatients per 100 capita	**17.9**	1.1	1.1	9.8	7.1	18.2	9.1	15.9	13.7
Outpatient visits per capita	**1.9**	0.3	..	..	..	2.9	14.0	5.7	5.5

Source: International Medical Foundation of Japan (1997), OECD (1993), national sources. *Japan/UK refers to publicly financed providers.

Given the relatively low level of human resources, particularly doctors, these imply very high levels of medical productivity, when measured in terms of average admissions per medical officer or hospital beds under supervision of the medical teams. The work-load of Sri Lankan government doctors and nursing staff is high in comparison with other countries (Table 5.2k). While patients may be having ready access to services, this high volume of services delivered by a small number of staff may be of concern, as it may be resulting in less than adequate quality. However, given the

extent to which Sri Lankan facilities appear to be staffed at ratios far below the levels seen in other countries, major improvements in quality will require a substantial improvement in staffing norms.

Table 5.2k: Comparative Data on Productivity in Public Hospital Systems

	Sri Lanka	Bangla-desh	China	Indonesia	Colombia	Hong Kong	Japan*	UK*	USA*
Year	*1992*	*1997*	*1986*	*1985*	*1979*	*96/97*	*1995*	*1988*	*90/91*
Bed days per staff	322	834	172	118	100	160	386	113	72
Medical doctors per bed	0.10	1.2	..	0.4	0.2	0.1	..	..	..
Total staff per bed	0.97	2.6	1.8	2.1	2.6	1.8	0.8	2.6	3.5
Admissions per Medical doctor	987	689	..	..	..	278	..	..	..

Source: International Medical Foundation of Japan (1997), Barnum and Kutzin (1993), IPS data, OECD (1993), national sources. *Japan, UK and USA refer to all hospitals.

Composition of staff

The composition of staff used to deliver medical services is important. For any level of financial resources, some staff mixes will be more efficient than others. In particular, certain categories of staff, such as nurses or paramedics, are cheaper than medical doctors, and may be able to substitute effectively for them. In comparison with other developing countries, Sri Lanka's MOH facilities uses relatively high numbers of nursing staff in comparison with medical doctors. In the Ministry as a whole there were approximately three nurses per medical doctor by 1996 (down from five in the late 1980s), and this is reflected at all levels of the delivery system. To this extent, the staffing ratios in Sri Lanka appear to be close to the optimal level, given its available budgetary resources; it has allowed MOH to deliver substantial volumes of health services despite limited numbers of medical doctors.

Wage versus non-wage expenditures

Salaries and other personal emoluments account for only 48-52% of total MOH expenditures (Figure 5.2b). This appears to be comparatively less than the norm in most other health ministries, where this component of spending is often as high as 80-90% of total recurrent expenditures. There is little evidence to suggest that high fixed salary expenditures are crowding out other non-salary inputs in Sri Lanka, as is the case in other countries. Again this points to relative high levels of economic efficiency in the delivery of government health services.

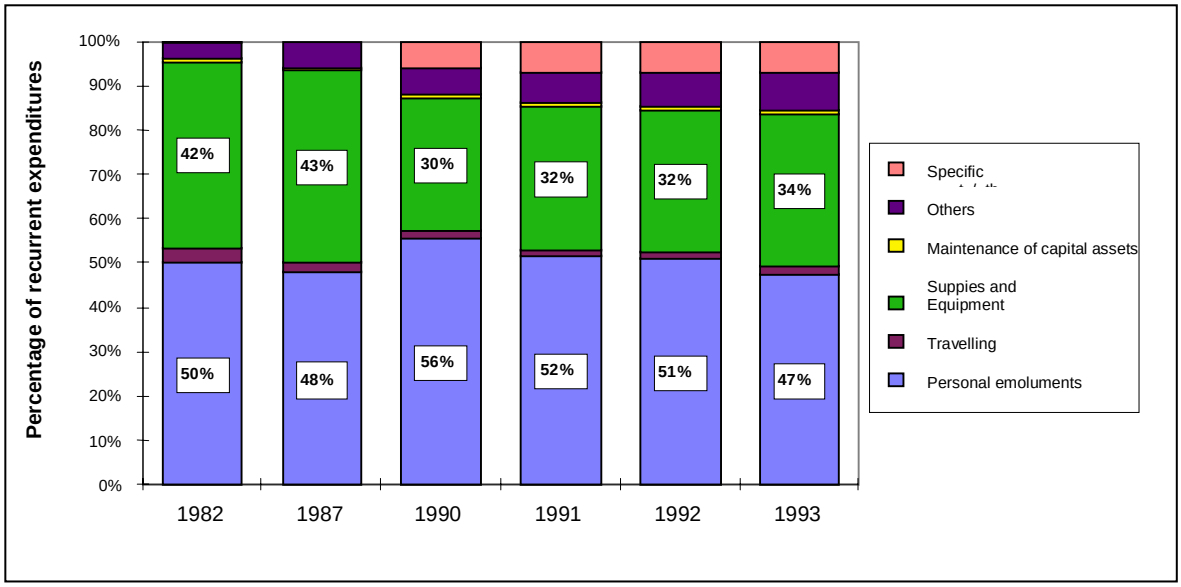
Provision of drugs and supplies

The relatively low level of proportion of recurrent expenditures devoted to salaries and personal emoluments allows the Ministry to spend a relatively high proportion of expenditures on supplies.

The budget line item for supplies and equipment is spent mostly on drugs. It averaged 40-45 per cent of total recurrent expenditures in the 1980s, and 30-35 per cent in recent years, but the data show a modest improvement upwards in the mid-1990s (Figure 5.2b). The relatively high level of allocations to drugs must also be judged in the context of an effective drug procurement process. Ministry drugs have long been centrally procured through international tender, and an essential drugs list system has been in operation for many years, in fact longer than this has been recommended by UNICEF and WHO. This allows government drug expenditures to go further than might have otherwise been the case.

Pilferage and leakage of drugs from the public sector distribution system are believed to be problems. However, survey evidence indicates that in contrast to the picture seen in other countries, availability of drugs at all levels of facilities is relatively good.

Figure 5.2b: Allocation to Inputs in MOH Expenditures



Utilisation of basic health services

Assessment of the extent to which people use basic health services is difficult, owing to the lack of data. However, it is possible to make some assessment of overall access to health services using available household survey data and MOH facility statistics.

Utilisation of Primary/Ambulatory Care Services

The government provides outpatient services principally through the outpatient departments of hospitals, dispensaries and other outpatient facilities. Although, the Ministry does provide specialist consultation services in its higher level hospitals, the bulk of outpatient visits in MOH facilities are for primary care, and thus more data can be regarded as being representative of the level of basic health services provided.

The private sector in Sri Lanka also provides outpatient services. Recent survey data show that the extent of private sector provision in this area has been increasing in recent decades. However, it must be noted that there is a strong income gradient in the use of private services, with poorer people using fewer private services than rich ones. However, the lower use of private outpatient services by the poor is compensated for by a higher use of government outpatient services. As a consequence, the overall level of utilisation of outpatient services in Sri Lanka indicates that poorer people make greater use of modern medical services than rich people, which is relatively unusual in the context of a developing country. Government health services clearly play the predominant role in ensuring this state of affairs, and do appear to ensure that poor people despite their poverty, do have as much access to basic health services as rich people.

In comparison with other developing countries, Sri Lankans also appear to make above average use of outpatient medical services. Again this suggests that at least in relation to international benchmarks, access to outpatient based basic health services in Sri Lanka is generally a reality for most of the population.

Utilisation of hospital inpatient services

In contrast to outpatient services, the government health system is overwhelmingly the predominant provider of inpatient services. Available survey data suggest that MOH hospitals treat 95% or more of all admissions in the country. Again as with outpatient services, there appears to be relatively high use of hospital services across all income groups, and there is no evidence that the poor face significant barriers in access to this basic service. Moreover, the overall levels of utilisation of inpatient services when measured in terms of per capita admission rates are extremely high - in fact higher than for any developed or developing country for which there is data (Table 5.2m). Although

this high admission rate might be considered inefficient or excessive, it does at least suggest that there is no major problem in Sri Lanka of people being unable to access inpatient services when they need to.

Table 5.2m: Comparative Data for Utilisation of Public Health Facilities

	Sri Lanka	Bangla-desh	Indonesia	Thailand	Malaysia	Hong Kong	Japan*	UK*	USA
Year	*1995*	*1991*	*1995*	*1995*	*1995*	*1995*	*1995*	*1988*	*1990/91*
Bed occupancy rate (%)	**75.0**	..	55.1	67.1	61.4	79.8	83.6	80.6	69.1
Inpatients per 100 capita	**17.9**	1.1	1.1	9.8	7.1	18.2	9.1	15.9	13.7
Outpatient visits per capita	**1.9**	0.3	..	..	..	2.9	14.0	5.7	..

Source: International Medical Foundation of Japan (1997), OECD (1993), national sources.
* Japan/UK refers to publicly financed providers.

5.3 Scope for Additional Resource Mobilisation for BHS

5.3.1 Intra-sectoral Restructuring - Health

Trends in overall health spending – summary

During the period under review, overall public health expenditures have increased in real per capita terms, but shown little increase as a percentage of GDP. Basic health expenditures have shown similar trends. In 1995-96, total health expenditures by government amounted to 1.7-8 per cent of GDP, of which 80-85 per cent can be considered to have been for basic health services, or 1.4 per cent of GDP.

The following section mainly refers to total health spending by government. However, as more than 80 per cent of total government health expenditures are for basic health services, the discussion in general applies without qualification to BHS.

Sectoral policy issues

Level of public spending on health services

The importance of public spending in the financing of overall health services has declined over time. During the 1980s and 1990s, Sri Lanka's per capita income level has continuously increased, but the relative level of public spending on health as measured as a percentage of GDP has shown little substantial change. The evidence and pattern of spending in other countries suggests that this trend observed in recent years is counter to the generally observed international norm. In general, as countries become richer they rely more on public financing for delivering health services (World Bank 1993). This has not occurred in Sri Lanka for three principal reasons: (i) the ongoing civil war, internal insurgencies and growing interest payments have crowded out increased social sector spending; (ii) despite considerable development in the economy, the country's tax base has not expanded, largely because improvements in the yield of newer tax instruments have only been sufficient to compensate for a decline in yields from the traditional instruments of import and export taxation; and (iii) policy-makers appear not to have placed a high priority on increasing social sector spending and may even have thought that increasing affluence implies a greater role for private financing in health care, and not less as actually observed in international experience.

The increasing use of private services in health care, particularly for ambulatory care, is driven more by deficiencies in quality of service as perceived by patients than by lack of access to public services. These trends, little evidence for major inefficiencies in the government health system as noted in this chapter, and high levels of productivity observed in the government health sector, strongly suggest that the government is spending at below optimal levels in the health sector given levels of social demand, and this has been noted even by the World Bank in its most recent review of the health sector (Preker, 1997). Improvements in the quality of basic health services in the public sector, as opposed to increases in actual volumes, will certainly require increased spending, in addition to or regardless of any other organisational reforms of the delivery system.

Desirability of relying on private financing to mobilise additional resources for health sector

The difficulty in increasing public financing for health services in Sri Lanka's current fiscal context, and the increasing acceptance of markets and the private sector by policy makers in general, do raise the issue of whether increased reliance on private financing for health is feasible or desirable. Reportedly, current unpublished draft proposals by the Presidential Task Force on Health Policy do imply or suggest that this is a potential major policy approach being considered by some government policy-makers,[1] and many senior officials do in practice believe that the government has too great a

1. At the time of publication, the proposals of the Presidential Task Force had not been finalised or published, and were

role in the financing of health care services. There has also been continued interest in encouraging private health insurance as a financing mechanism in the health sector, despite considerable evidence that the commercial insurance market in Sri Lanka demonstrates all the market failures that have been observed internationally (Rannan-Eliya and de Mel, 1997), and which prevent private health insurance ever making a substantial contribution to health sector resource mobilisation in any country (Hsiao, 1995). At this stage, it must be stated that the empirical arguments and general experience of most countries strongly indicate that these approaches, if adopted, would be unfruitful.

Firstly, the existence of fundamental failures in the markets for health services provides an economic rationale for major public involvement in the financing of health care services, particularly to ensure the provision of basic health services for the poor and the chronically sick (Hsiao, 1995). The poor lack purchasing power, and insurance markets fail universally to provide adequate affordable insurance for major health events to the poor, aged and those in informal sector employment. Secondly, because of these basic market failures, the global experience has been that countries increase the share of government financing in overall health financing as per capita incomes increase, and that the level of private financing for health care is not income elastic (World Bank, 1993). Thirdly, there is a strong argument for maintaining public dominance on the financing side, simply because when private financing is dominant it is very difficult, if not impossible, for constraints to be imposed on the systemic pressures which lead to cost inflation amongst medical providers. Failure to impose such constraints is ultimately self-defeating, since as prices of medical care increase in the private market, governments are forced to pay more in the public sector for the same services, because of market pressures on the price of inputs and medical personnel. For this reason, the International Monetary Fund has recently raised concerns about the situation in many South-East Asian countries, where government policy currently is to emphasise private financing for health care at the expense of a greater public effort (Heller, 1997).

not available to most senior Health Ministry officials. This discussion therefore is based on personal communications from unnamed government or external co-operation agency officials.

Patterns in the allocation of government health spending

Regardless of the overall level of funding commitments by GOSL to the provision of basic health services, it is important to examine the extent to which available resources are allocated, and whether the existing resource base can be better used to achieve accepted goals. In general, the nature of allocation of government expenditures to and on basic health services appears to be already close to desirable patterns, suggesting that the scope for resource mobilisation for BHS through restructuring is extremely limited.

UNICEF (1995) identifies a number of areas in which misallocation of resources have occurred in practice in many countries. These include the following:

- urban bias in distribution of facilities, human resources and budgetary expenditures
- allocation of expenditures in favour of higher level facilities at the expense of lower level preventive and basic curative facilities
- neglect of investment in training in public health, health policy and management
- sub-optimal allocation of budgets to the key inputs - salaries and drugs
- poor targeting of subsidies to the non-poor

The following section examines the extent to which such and other patterns of misallocation may have occurred in Sri Lanka's case.

(i) Elimination of urban bias

UNICEF (1995) refers to the elimination of urban bias since independence. In Sri Lanka's case this temporal categorisation is inappropriate, since health policy and expenditures were determined by Sri Lankans for almost two decades before formal independence in 1948. The relevant starting point for analysis is 1931, when self-rule based on universal suffrage was granted.

Certainly, in 1931 Sri Lankan health policy and government health expenditures were characterised by significant bias in favour of urban residents and the plantation labour force employed in export agriculture. British colonial policy had generally not regarded the welfare of the majority rural population as of major concern, or of sufficient priority to require government spending and intervention. Government intervention was limited to providing some health services in urban centres, and mandating the provision of basic health services to plantation workers to be paid for through a special export tax.

The introduction of representative government changed this scenario, and successive governments have generally worked towards the elimination of urban bias. In the case of plantation labour, this process was so successful that by the 1960s, the non-estate rural population enjoyed better health

services than the estate population, who were provided for through health services managed by the mostly foreign estate companies. This resulted in a gradual slippage in the relative health status of the estate population, from experiencing above average health status in the 1930s to experiencing the worst health indicators of any population sub-group by the 1970s.

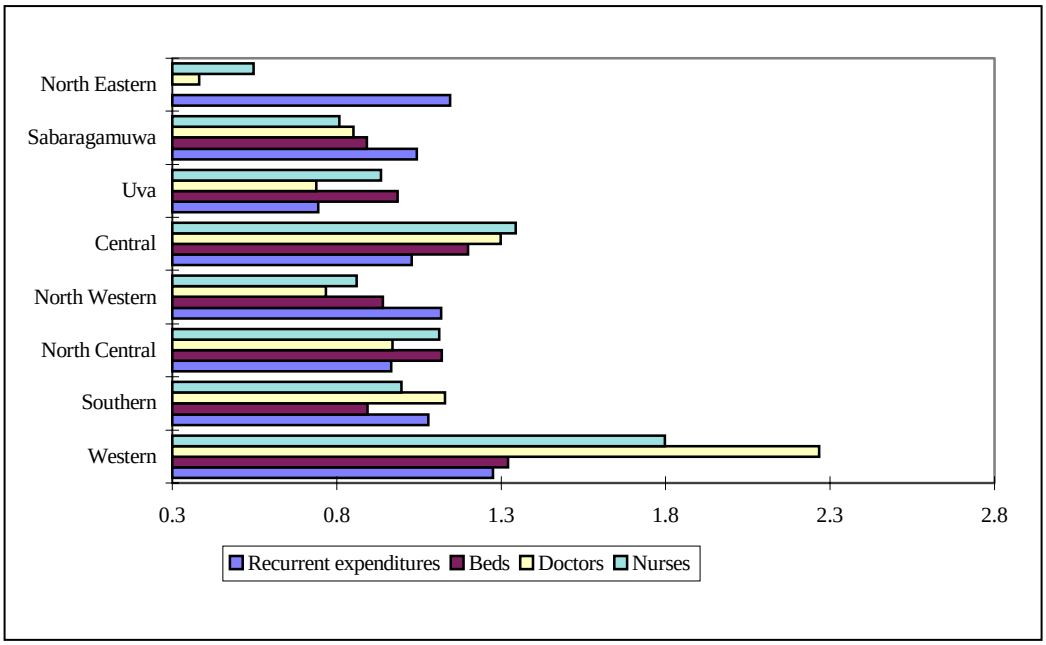
Since the mid-1980s, consequent to the nationalisation of the estates and later privatisation to local interests, there has been a substantial improvement in the health status of the estate population. This has been brought about through greater investment of public and donor funds, and the decision in 1997 to take over estate medical facilities and bring them under direct MOH administration.

For the general population, it is more difficult to find objective measures of change in urban bias. Sri Lanka is relatively small and densely populated, and until recently a good public transport system has ensured that most rural people have ready access to health facilities in urban centres. Nevertheless, immediate access to basic health services is good, since there is a dense network of government facilities in all rural areas, which means that most rural people live within 5-10 km of a peripheral health facility. Practical evidence of this ready access is provided by the lack of an obvious difference in utilisation rates between urban and rural households. The lack of any rural-urban migration in Sri Lanka in the past half-century is also partly due to the lack of any significant difference in access to basic health services. There are still pockets where this is not the case, but these appear to be generally few, with the exception of the uncleared areas in the North and East where provision of government health services is disrupted by the ongoing internal war.

(ii) Geographical equity

Another indicator of the distribution of health care resources is their geographical distribution. Figure 5.3a and 5.3b show the relative distribution of provincial health budgets and health care resources by province. Although there is a concentration of health personnel in the Western Province (which contains Colombo), the disparities in other provinces do not appear to be great.

Figure 5.3a: Comparative Ratios for Inputs and Spending



Source: Ministry of Health, Annual Health Bulletins.

Figure 5.3b: Provincial Bed Ratios

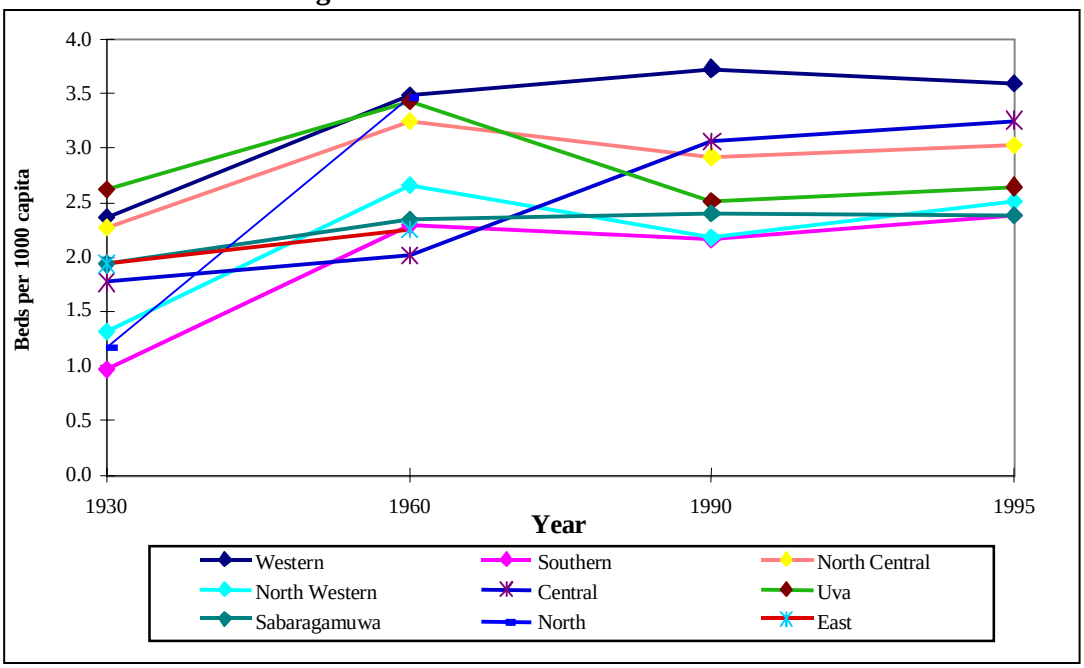
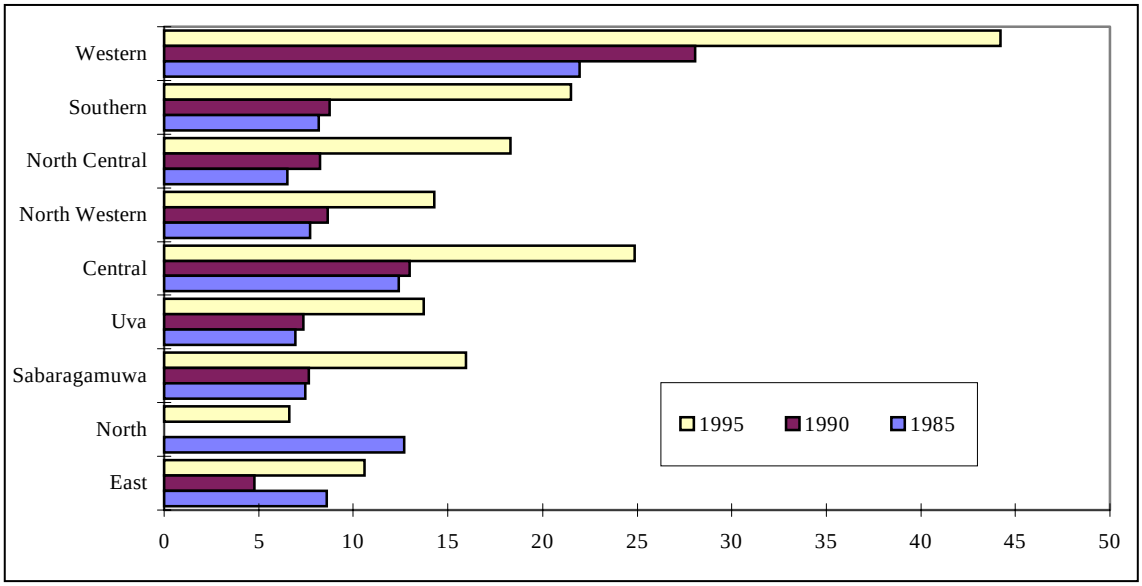
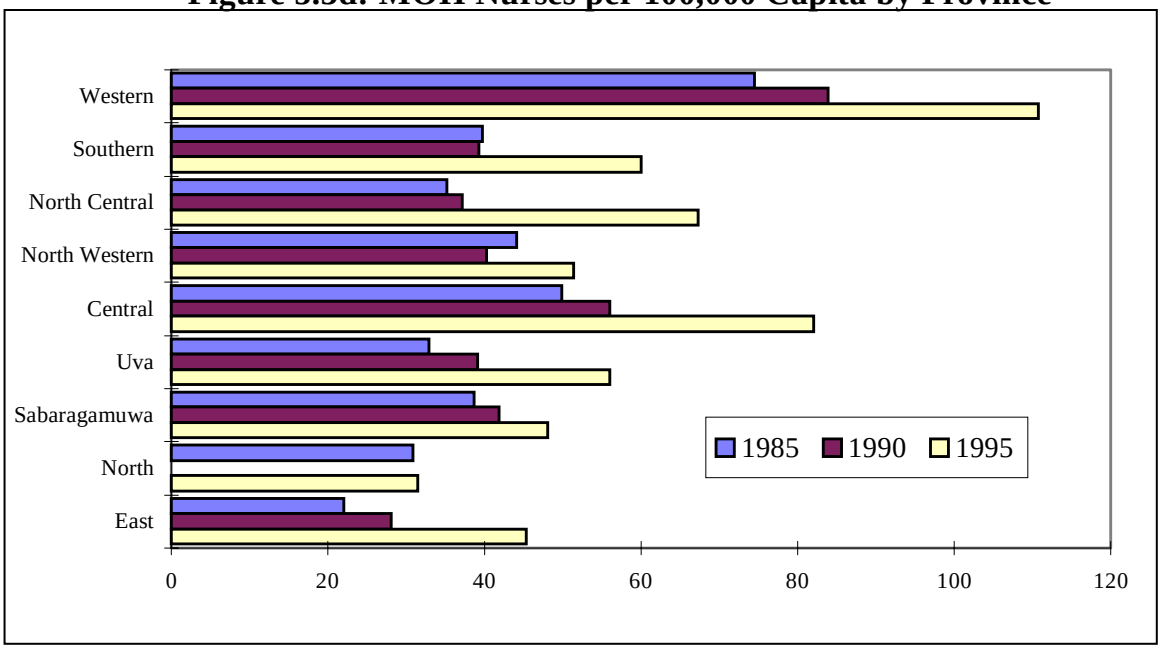


Figure 5.3c: MOH Doctors per 100,000 Capita by Province



Source: Ministry of Health, Annual Health Bulletins

Figure 5.3d: MOH Nurses per 100,000 Capita by Province



In the long run, there appears to have been considerable stability in the spatial distribution of MOH resources in different parts of the country. Figure 5.3b shows the changes in population bed ratios for each province from 1930 until 1995. As can be seen, the patterns observed in the 1930s continue to persist over time. However, it should be noted that the disparities observed are not as great as in many other developing countries, for example in the Indian states or Chinese provinces. There is also some evidence that these disparities may even have reduced during the 1980s and 1990s, and while the relative ranking of provinces shows little change, the relative differences between provinces have clearly reduced (Figure 5.3b).

The only exception to these positive trends appears to be the distribution of personnel in the Northern and Eastern Provinces, which has clearly deteriorated in recent years. In the mid-1980s, in the provision of doctors, these two provinces ranked second and fourth, but by the mid-1990s they had the lowest rankings (Figures 5.3c and 5.3d). One of the unfortunate consequences of the separatist conflict being currently waged by LTTE rebels has been the relative deprivation of these two provinces over time, as MOH personnel have been reluctant to serve in unsafe areas for understandable reasons.

That the level of personnel in the two provinces has not fallen even lower in absolute terms is largely due to the coercive powers of the central Health Ministry, which has been able to appoint doctors even to undesirable postings. As in many other developing countries, particularly in Asia, Sri Lanka has regulations in effect which require junior medical graduates to serve a minimum time period in rural and peripheral postings before being permitted to enter private practice or take higher level appointments in the public sector. However, unlike many of these other countries (e.g., Bangladesh, Indonesia, Zambia), these regulations are enforced in practice, and it is extremely difficult, if not impossible, for individual doctors to change their postings through use of personal influence or bribery, or to simply ignore central MOH instructions with impunity.

The other factor which has served to prevent the emergence of greater disparities in the distribution of medical personnel appears to be the failure to devolve fully the responsibility for medical recruitment and employment to the provinces after 1987. The existence of a single national personnel system for medical doctors has prevented medical doctors exercising significant market power for their services. If each province was responsible for attracting, recruiting and paying its own medical cadres, then either provinces would have had to compete against each other for the limited number of doctors, placing poorer and less desirable provinces at a great disadvantage, or the subsidy for the less desirable provinces would have had to be increased in order to allow them to compete effectively with the more popular provinces.

(iii) Allocation of expenditures to higher level facilities

Expenditures by the government for direct patient services delivered through MOH facilities are classified under the category 'patient care services'. This category can be further subdivided into:

- Provincial and base hospitals
- District hospitals
- Peripheral Units and Rural Hospitals
- Maternity Homes
- Central Dispensaries
- Laboratory Services
- Anti-TB campaign

This classification was used by MOH prior to the decentralisation of health services, and most provinces continue to maintain this classification in their financial accounting. A study by Ernst and Young (1994) revealed the following allocation of funds between levels of facilities in the early 1990s in the five provinces of Central Province, Uva, NWP, NCP and Southern Province (the other three provinces did not maintain information on this basis):

Table 5.3a: Allocation of Budgets to Patient Care Facilities in Provinces

	1990	1991	1992	1993	Average
Provincial & Base Hospitals	37.5%	38.9%	38.4%	37.4%	38%
District Hospitals	28.8%	30.9%	30.8%	30.6%	30%
Peripheral & Rural Hospitals	22.7%	21.2%	21.9%	22.8%	22%
Maternity Homes & Central Dispensaries	8.8%	6.8%	6.8%	7.1%	7%

Source: Ernst & Young (1994).

It is not expected that this pattern would have changed greatly since 1993, since expenditure patterns are largely determined by pre-existing facility and staff deployments.

Table A15 in the Annex indicates the extent to which these allocations vary between provinces. As is clear, on average 60% of provincial health budgets are allocated to the primary care level (classified by MOH as district hospitals and below). Given that a substantial share of work at higher level provincial facilities is also primary care in nature, it is evident that the bulk of provincial health expenditures (>80%) are for provision of primary health care services, and all provincial health expenditures would be classified as for basic health services. Based on the data collected by Ernst & Young in the early 1990s, there is no evidence that the allocation patterns are changing with time.

Given the allocation of responsibilities between provinces and centre in the Constitution, higher level tertiary facilities are exclusively the responsibility of the central MOH. Despite that, a significant proportion of central budgetary health expenditures are destined for primary care facilities. These include allocations for medical supplies and drugs for the provinces, investment in provincial infrastructure, several vertical programmes, and others.

Although higher level facilities do receive a significant share of overall financial resources, it must be kept in mind that the bulk of their actual service provision involves basic health services both at outpatient and inpatient level. The evidence as a whole indicates that MOH resources are allocated already at high levels to basic health services, delivered either from lower level facilities or from higher level facilities, and that there is little scope for reallocation from higher level to more basic services.

(iv) Expenditure allocation across inputs

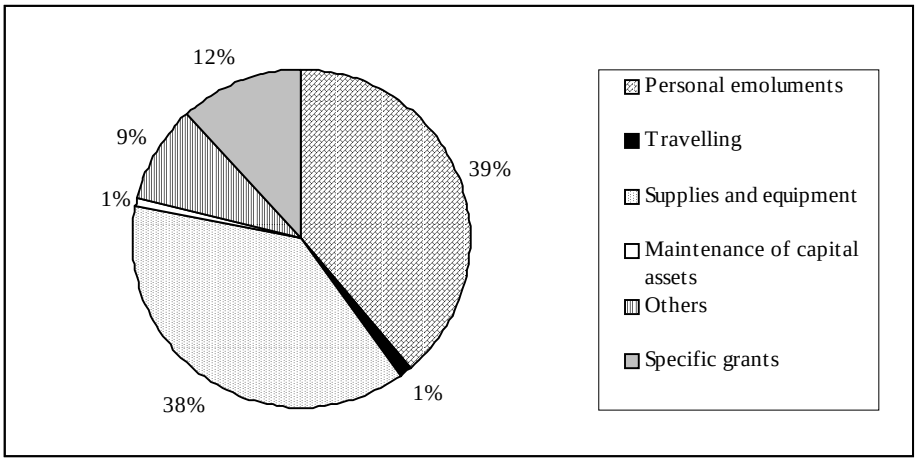
Public sector recurrent expenditures are classified for official accounting purposes into:

- Personal emoluments
- Travelling
- Supplies and equipment
- Maintenance of capital assets
- Others including utility costs
- Specific grants

Figure 5.3e and Figure 5.3f give the trends in the allocation of expenditures under these headings during 1987 - 1993 for the whole Health Ministry including PHAs.

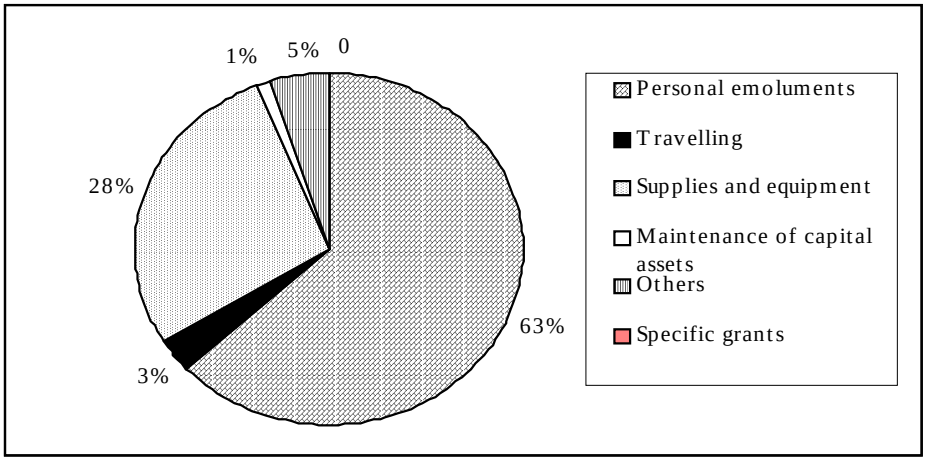
These allocations are for the whole health ministry. These Figures give the average percentage breakdown during 1990-93 for the provincial and central ministries separately. Personal emoluments account for a larger share of provincial expenditures, but this would be consistent with their greater focus on delivering patient care services. A large percentage of Central MOH expenditures on supplies is also for medical supplies for provincial health ministries, especially drugs which are procured centrally.

Table 5.3e: Analysis of Recurrent Expenditures at Central Health Ministry



Source: Ernst & Young (1994).

Table 5.3f: Analysis of Recurrent Expenditures at Provincial Health Ministries



Source: Ernst & Young (1994).

Table A16 and Table A17 in the Annex give an estimate of the contribution of inputs to outpatient and inpatient services respectively in a sample of MOH facilities in 1995.

Taken with other survey data of relative good drug availability at most facilities, there is little evidence that allocations in Sri Lanka's Health Ministry are leading to sub optimal provision of drugs at any facility level.

(v) Distribution of BHS subsidies to the poor

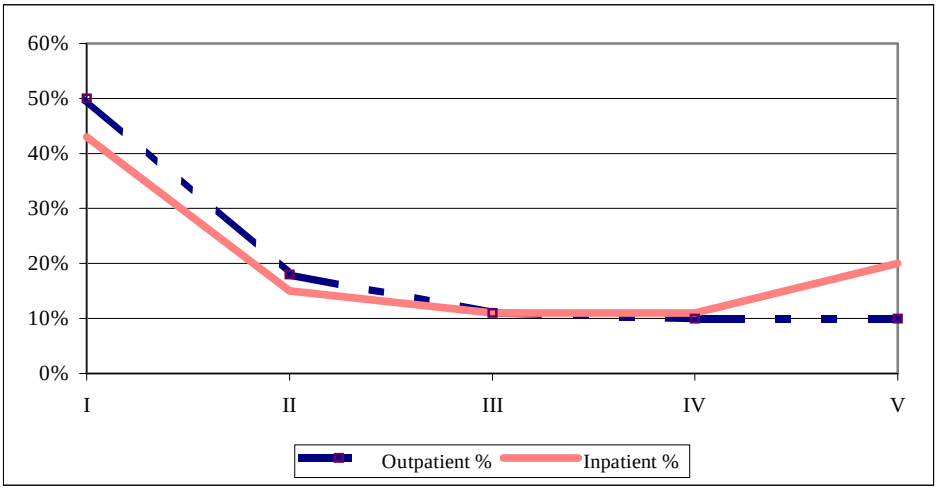
Few quantitative studies have been carried out of equity in health services in Sri Lanka. Therefore, survey results given in the most recently published Central Bank *Report on Consumer Finances and Socio Economic Survey 1986/87* have been used to calculate the distribution of health expenditures/subsidies across different income groups. This is the most recent available national survey giving data on utilisation of health care services with credible data on household income levels.

A classical benefit incidence analysis was carried out for government health subsidies. There are few cost studies available, but a data set on facility expenditures is available from the World Bank and Ministry of Health's 1992 Facility Survey. Using this existing data source, IPS calculated the average distribution of inpatient and outpatient costs in government hospitals and facilities. It was found that inpatient costs and outpatient costs on facilities accounted for 75% and 25% respectively of total recurrent expenditures. These ratios were then applied to total MOH recurrent health expenditures on personal health services for 1987. The resulting amounts give the total MOH personal health expenditures allocated to inpatients and outpatients.

In order to calculate distribution of a health subsidy across different income groups, recurrent MOH personal health expenditures were then distributed across income groups according to the utilisation rates reported in the Central Bank 1986/87 Consumer Finance survey.

As shown in Figure 5.3g a larger proportion of the health subsidy benefits the lowest income quintile (about 45% of the health subsidy). Those in the lowest income quintile use higher volumes of both inpatient and outpatient services. There are two main reasons that may explain this. Firstly, it can be assumed that poorer Sri Lankans fall ill more than richer Sri Lankans and thus they are in greater need of health care than richer Sri Lankans. Secondly, wealthier households prefer to use private doctors and private hospitals and make limited use of public facilities. Hence, the majority of health care spending is benefiting households in the lowest income quintiles.

Figure 5.3g: Government Health Expenditure by Quintile on Personal Health Services, 1986/87



Source: IPS Health Policy Programme calculations from 1986/87 Central Bank Consumer Finance and Socio Economic Survey.

Equity in Basic Health Services

It is not possible to use the data to analyse separately the distribution of expenditures on basic health services by income quintile. However, outpatient services are more likely to be basic services than inpatient services, and the poorer groups more predominantly use outpatient services.

Table 5.3b shows that relative to other countries, Sri Lanka enjoys one of the most equitable distributions of government health expenditures. For instance, in Sri Lanka the richest quintile has the lowest health subsidy allocated to them, at 10%, while 50% of the subsidy is allocated to the country's poor. Looking at the total health subsidy as a percentage of per capita private expenditure, government health subsidies represent 9.2% of the income of the lowest income quintile, and only 0.3% of the income of the richest quintile. In comparison with many other government subsidy and transfer programmes, such as the wheat subsidy, subsidies to parastatals (e.g., Air Lanka), etc., government expenditures on basic health services predominantly benefit the poor, and probably represent a major input into maintaining the general welfare of the poorest groups.

Table 5.3b: Incidence of Public Spending on Health in Selected Countries

	Primary Facilities		Hospital Outpatients		Hospital Inpatients		All Health		Total Subsidy as a % of p.c. expenditure	
	Poorest	*Richest*	*Poorest*	*Richest*	*Poorest*	*Richest*	*Poorest*	*Richest*	*Poorest*	*Richest*
Africa										
Ivory Coast (1995)	14	22	8	39	..	..	11	32	2	1.3
Ghana (1992)	10	31	13	35	11	32	12	33	3.5	2.3
Guinea (1994)	10	36	1	55	..	..	4	48	..	..
Kenya (1992)	13	26	23	15	..	..	14	24	6	1.1
Madagascar (1993)	14	30	10	29	..	..	12	30	4.5	0.5
Tanzania (1992/3)	18	21	11	37	20	36	17	29	..	..
South Africa (1994)	18	10	15	17	..	..	16	17	28.2	1.5
Asia										
Sri Lanka (1987)	**n.a.**	**n.a.**	**50**	**10**	**43**	**20**	**45**	**17**	**9.2**	**0.3**
Hongkong (1996/7)	31	12	26	11	25	16	25	15	..	..
Indonesia (1990)	18	16	7	41	5	41	12	29	1	0.5
Vietnam (1993)	20	10	9	39	13	24	12	29	2.1	0.9

Source: IPS Health Policy Programme work in progress, and World Bank data.

5.3.2 Cost-Efficiency Improvements in Expenditures for BHS

As shown, the Government of Sri Lanka already devotes a high percentage of its total health spending to the provision of basic health services, which are in practice available to all, and in particular to the poorer households. The scope for reallocating resources from higher level services to lower level services is thus limited, and cannot in any way be regarded as a major option for increasing resource availability for basic health services. Other than increasing the level of government tax funding, the only other option for increasing the provision of basic health services is to seek cost-efficiency improvements in the current delivery system.

In practice, the evidence suggests that this will be difficult, and is unlikely to yield significant savings. As indicated in the previous sections, the empirical evidence and international comparisons strongly indicate that the Sri Lankan public health sector produces services not only at relatively low cost, but with a degree of production efficiency which is far greater than observed in any comparable public sector delivery system. Overall unit costs are amongst the lowest observed, and the allocation of inputs (human resources, budgets, etc.) do not display the inefficient patterns frequently observed in government health systems. In addition, a greater proportion of government health expenditures benefit the poor than in other countries, which implies little scope for better targeting of health expenditures to the poor.

Options suggested by UNICEF in the background documentation for this study are not relevant to Sri Lanka, or are unlikely to yield much benefit. The options suggested include:

1. Concentration on a basic package of essential clinical services for the poor.
2. Charging of user fees from affluent patients in the public sector to better target government health spending on the poor.
3. Promotion of self-financed insurance for the well-off, in order to free government funds for public health programmes.
4. Use of a national service mechanism to ensure that physicians trained at public expense are required to serve in rural areas for a few years.
5. Cheaper procurement of drugs for the government health sector, and lowering of drug costs through national essential drug lists.
6. Decentralisation of health services to regional and district levels to allow greater community management in the use of resources.

These options are reviewed briefly below.

1. Concentration on a basic package of essential clinical services for the poor

As shown, GOSL already devotes 80% of total health care spending to basic health services, and more than 35% of total government health spending benefits the poorest quintile. It is possible that further improvements in these shares can be made, but given that Sri Lanka's performance is already better than most countries in this respect, and given that less than 20% of government health expenditures are devoted to non-basic services, the scope for major benefits must be very small. It should also be noted that the average per capita health spending by the Sri Lankan government during the 1950s-70s averaged only $5-6, and yet with this amount of resources, the government provided a far more extensive package of services to the population than the very restricted package of cost-effective services recommended by the World Bank (1993), which is expected to cost $13 per capita.

2. Charging of user fees from affluent patients to release resources for poorer patients

User fees by increasing the price of services have a greater impact on poorer households than the rich, as the poor are more price sensitive than the rich. By themselves, they will act to reduce net utilisation by the poor more than the rich, in addition to imposing greater welfare losses on the poor, who must reduce consumption on other basic necessities in order to pay user fees. Despite an emphasis on user fees in the 1980s, this conclusion is now accepted by both the World Bank and WHO (World Bank, 1997). Theoretical arguments and empirical evidence in other countries is supported by previous experience in Sri Lanka, where the imposition of very modest user fees in 1972 resulted in a 30% reduction in utilisation of government outpatient services. Given that the vast majority of the users of such services are in the poorer half of the population and that almost half are below or near the poverty line, universal user fees would be extremely detrimental to the poor.

An alternative to universal user fees is to means test the user and charge user fees only on the more affluent. However, experience with means testing in Sri Lanka has not been very successful, and any means testing procedure which allows all poor people to have access is likely to also permit many other people to have free access. As it is, Sri Lanka's health services which are not means tested still achieve a better targeting of the poor than any national health system which explicitly means tests access. This suggests that the existing mechanisms, whereby richer patients self-select out for reasons of waiting times and poor consumer quality, may be more effective than explicit means testing (Rannan-Eliya and de Mel, 1997).

Even if means testing was to be effectively carried out, there is still a concern that if only some people are eligible to access such services, political support for free heath services for the poor may be reduced. These political economy considerations suggest that some universality in access is necessary to safeguard the interests of the poor.

3. Promotion of self-insurance

Private voluntary insurance markets are characterised by fundamental market failures, which prevent them from covering most people who are willing to pay for insurance, and to exclude those who are at greatest risk of illness. Private insurers have incentives to exclude costly conditions or to minimise their risks through use of benefit caps and exclusions (World Bank, 1997). All these are observed to be the case in Sri Lanka, where private insurance coverage is restricted in practice to those in the formal sector workforce between the ages of 25 and 45 years, who are also the ones least likely to have used health services. Private insurance is most likely to cover those, who would have not used government services in the first place, so the ability of private health insurance to reduce pressure on

government services is small. In addition, because of the ability of private providers to price discriminate and raise prices for insured patients, the major result of expanded private insurance coverage is not greater access to health services but increased incomes for providers. Private health insurance is thus unlikely to increase access to basic health services for the poor.

4. National service requirements for medical graduates

This is already in effect in Sri Lanka, where new medical graduates are required to do two years in internship positions before being fully registered to practice.

5. Centralised drug procurement and essential drug lists

Sri Lanka has procured drugs centrally through international tender for several decades. The prices obtained by Sri Lanka's MOH through these mechanism are often lower than the prices quoted by UNICEF's own procurement division. Within the government health system, essential drug lists have been in effect since the 1950s, when they were developed as hospital formularies to save funds. There is little area for improvement in drug procurement procedures and essential drugs policies.

6. Decentralisation of health services management

Sri Lanka devolved health services to the Provincial level following the passage of the Thirteenth Amendment to the Constitution in 1987. Not all health services were devolved, but all peripheral and facilities below the level of teaching hospitals, which are the ones which deliver most basic health services, were transferred to the responsibility of the Provincial Councils. The Thirteenth Amendment was not introduced for reasons of improving the performance of the health sector, but as part of an overall constitutional change imposed with the threat of military force on Sri Lanka by the Government of India. It was drawn up not in Sri Lanka, but in New Delhi, where it was based on similar provisions in the Indian Constitution.[2] It was not desired by most Sri Lankans, and by the majority of health sector and MOH personnel. For this and other reasons, the actual extent of decentralisation of responsibility in practice has been limited, with the central Health Ministry continuing to exercise considerable de facto authority and control of resources.

It should be noted that the argument that decentralisation will increase community participation in the management of resources, may not be necessarily applicable or relevant to Sri Lanka. Unlike in many other countries, the centralised health care system in Sri Lanka has historically been subject to considerable public pressure and accountability through legislators in the national parliament. In

[2] Presentation on "Proposed Reforms and their Constitutional Implications" by Sarath N. Silva, Attorney-General, at "Seminar on Health Sector Development and Reforms with reference to Organisational Structure proposed by the Presidential Task Force", held by the Ministry of Health and Indigenous Medicine at Hotel Galadari, Colombo, 22 July 1998.

fact, the development of a highly dispersed health infrastructure providing mostly basic health services to all at no charge was the direct consequence of the susceptibility of the Health Ministry to democratic pressures. Since Sri Lanka has been democratic for far longer than any other country in the Asian region (self-government based on universal suffrage was granted in 1931), the electoral process at the national level has provided and continues to provide an effective mechanism to ensure public accountability over the use of resources and general health policy. At the same time, it should be noted that the establishment of Provincial Councils does not appear to have increased the degree of local accountability at provincial level, or at least in a way which can be empirically observed. Reasons for this include continued interference by national level politicians in the running of provincial health services, lack of mechanisms to ensure accountability at local level such as provincial level mass media, lack of regular meetings of the provincial councils, etc., and lack of discretion in the use of funds by the Provincial Councils, since human resources are still largely controlled by the Centre.

Accountability and greater efficiency in the use of resources at the provincial level would depend on two preconditions; (i) the existence of local capacity to manage resources, and (ii) the existence of information to allow accountability and management. In neither case, has this been satisfied. Devolution post-1987 has not been accompanied by any serious effort to build-up capacity at provincial level for management. This is due partly to the lack of interest on the part of national level politicians and officials and the consequent lack of resources for such capacity-building, and partly to the lack of interest on the part of the Provincial Councils themselves. The post-1987 experience is most remarkable for the lack of interest shown by Provincial Councils and Councillors in taking powers from the Centre, even where such authorities are granted under the Constitution to the provinces. This reflects perhaps the continuance of centralisation within the major political parties, who in their own affairs have shown little interest in increasing provincial autonomy. At the level of information to permit greater local accountability and management, the information systems to allow provincial managers to manage health care resources remain grossly inadequate, and in most provinces there is no provincial-based mass media which would permit an informed public to hold their provincial councils accountable with regard to day-to-day management.

There is no evidence that the partial devolution and decentralisation that has occurred in the past ten years in Sri Lanka has yet led to major improvements in efficiency, and concern has been expressed in many quarters that devolution to date may even have led to negative consequences, such as reduced attention to disease control programmes, e.g., malaria (Russel and Attanayake, 1997; Seminar on Health Sector Development and Reforms with reference to Organisational Structure proposed by the Presidential Task Force", held by the Ministry of Health and Indigenous Medicine

at Hotel Galadari, Colombo, 22 July 1998). Given this experience, some external international observers have even suggested that recentralisation of health services may be desirable in Sri Lanka's case in order to promote better health outcomes and delivery of basic health services.[3]

[3] Presentation by Prof. William Hsiao, World Bank Consultant, at "Seminar on Health Sector Development and Reforms with reference to Organisational Structure proposed by the Presidential Task Force", held by the Ministry of Health and Indigenous Medicine at Hotel Galadari, Colombo, 22 July 1998.

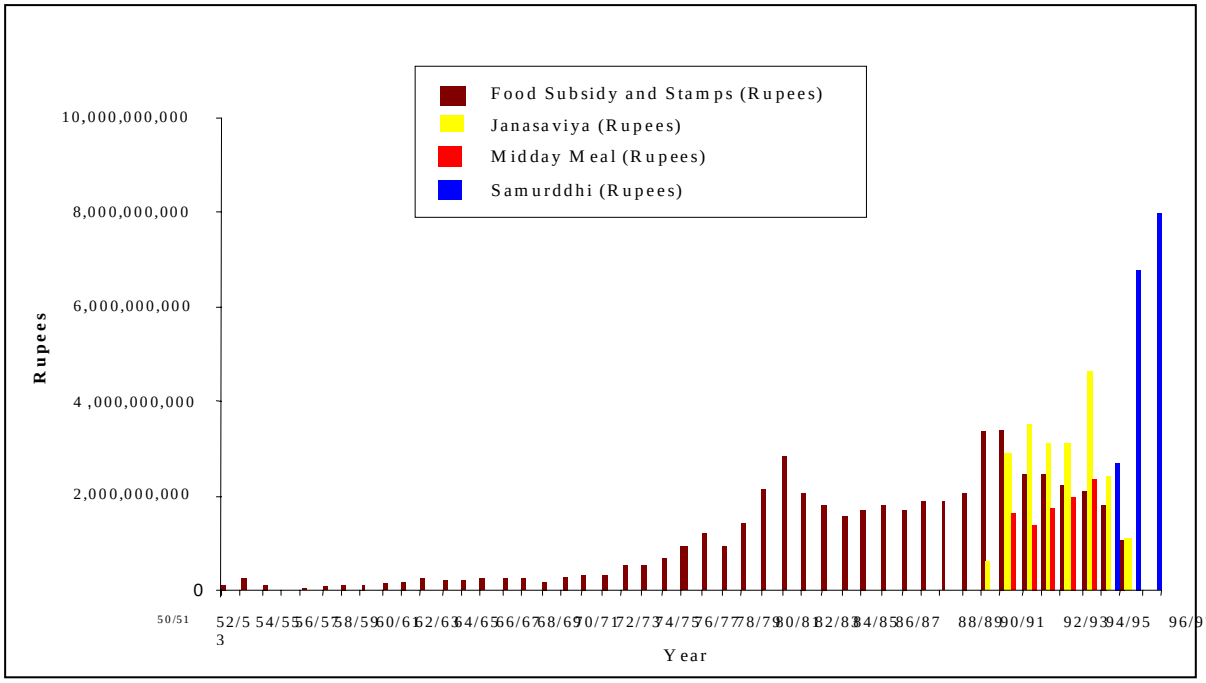
Chapter 6: Analysis of Nutrition Expenditures

6.1 General

Sri Lanka has a long tradition of providing basic nutritional support to the population through universal or comprehensive food and nutritional support programmes. There has been a persistent emphasis on protecting minimum consumption levels of the population and ensuring that worst aspects of destitute poverty are ameliorated through direct consumption transfers.

GOSL has provided major food subsidies since the early 1950s. These initially started as universal food subsidy programmes for rice in the form of rations. The expense of these programmes has been substantial from the very beginning, and it has also been recognised that being universal programmes, many of the beneficiaries have not necessarily been poor. However, food subsidy programmes have enjoyed significant political support as they have traditionally played a key part in electoral politics, with successive governments bidding for votes at general election time through new subsidy programmes. This prevented any substantial scaling back in support for these subsidies until the 1970s (Figure 6.1a).

Figure 6.1a: Expenditures on Nutrition Support Programmes



Source: Ministry of Finance and Planning.

In the late 1970s, the universal food subsidy was replaced by a targeted food stamps scheme. This allowed the government to gradually reduce budgetary expenditures on these subsidies since the

value of the food stamps was rapidly eroded through inflation. In addition, as fewer people received food stamps than the earlier rice ration, it was politically less costly to subsequently reduce expenditures on these programmes. However, it should be noted that the decision to reduce food subsidies in this manner was directly linked to a decision to substantially increase infrastructure spending in the government's lead development programme, the Mahaweli Irrigation Scheme, and it was explicitly recognised by senior political leaders that the Mahaweli expenditures had to substitute for the diminished food subsidy expenditures. So even though food subsidy programme expenditures were reduced substantially during the 1980s, it did not necessarily result in any net substantial budgetary savings. Subsequently, it can be observed that the reduction in the number of people receiving food stamps made it less costly for governments to allow the value of these transfers to reduce, since the people most affected were politically less vocal.

In 1989, the Janasaviya Programme (JSP) was introduced as the primary poverty reduction programme of the government. This again was a targeted programme, which linked income transfers and food subsidies to promotion of self-employment. The original objective was to reach the poorest 50% of the population, but in practice as with food stamps, targeting was not perfect and many richer households would have benefited, as well as poorer eligible households not benefiting.

1995, JSP was discontinued and replaced by the Samurdhi Programme, which is currently the government's major vehicle for poverty reduction. It also covers 50% of the population, and consists both of direct income support in the form of food coupons, as well as activities to support self-employment. Since its introduction, Samurdhi has absorbed several other programmes with nutritional support elements, including the School Mid-day Meal Programme, kerosene and food stamps.

6.2 Expenditures on Nutrition Programmes

Over time, government expenditures for nutrition support programmes have clearly declined as a proportion of total expenditures, with the exception of the early 1990s, when expenditures rose with the introduction of JSP (Table 6.2a). Since then, expenditures have again fallen, reaching less than 4% of total government expenditures in recent years. It has not been possible to obtain data on expenditures on these schemes by donors.

Government expenditures on JSP, Samurdhi, Food Stamps, and School Mid-day Meal Programme have been categorised as basic social service expenditures as their primary purpose is poverty alleviation, even though it is widely recognised that many recipients may not be poor. It should be borne in mind also that the Sri Lankan experience suggests that while perfect targeting of subsidies

may appear desirable, too close a restriction of subsidies to the very poor also results in reduced political support for such programmes and ultimately is damaging to the interests of poorest.

Table 6.2a: Government Expenditures on Nutrition

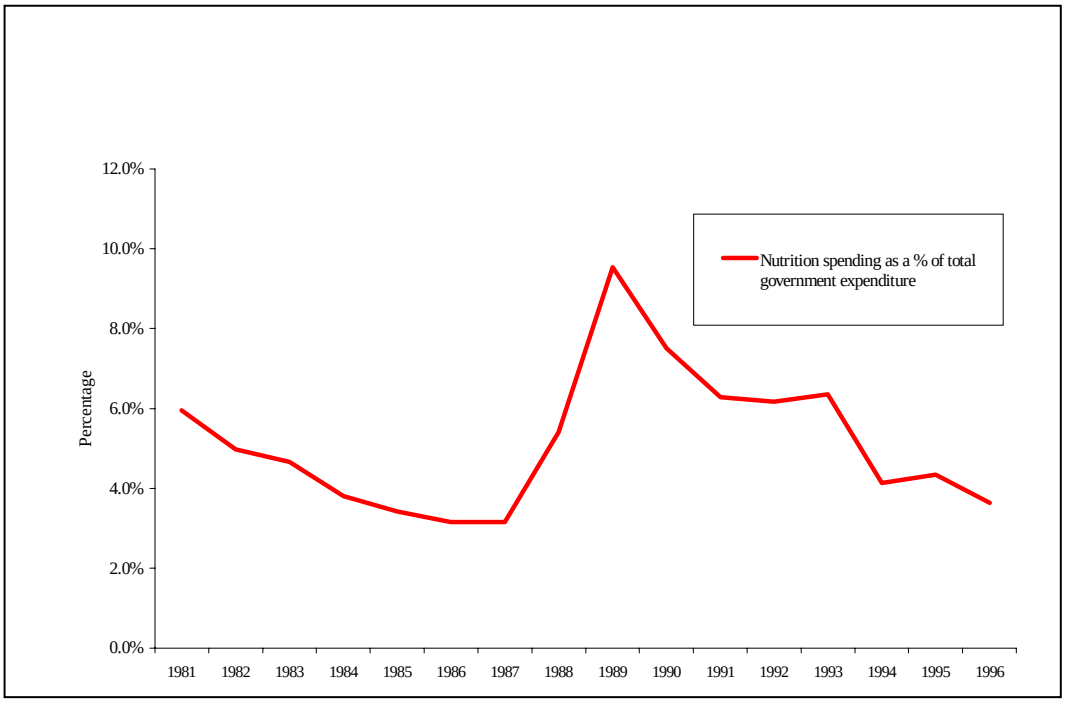
Year	Total government expenditure (Rs. Million)	Total nutrition spending Rs. Million)
1981	26,468	1,575
1982	34,487	1,714
1983	38,666	1,802
1984	45,448	1,728
1985	55,172	1,885
1986	59,871	1,886
1987	65,534	2,071
1988	74,103	4,006
1989	83,535	7,966
1990	98,158	7,369
1991	116,414	7,314
1992	119,260	7,368
1993	143,129	9,092
1994	167,539	6,929
1995	206,969	8,995
1996	218,998	7,962

Source: National Planning Department, Central Bank Annual Report (various issues).

In addition to the above programmes, the government also launched a bread subsidy programme in 1995. This scheme functioned by reducing the retail price of bread, and is therefore available to all consumers. This programme primarily benefited the richer households who consumed more bread, and would have not contributed significantly to poverty alleviation. By reducing the price of bread relative to rice, which is domestically produced unlike wheat, this programme is reported to have had negative impacts on rice farmers in Sri Lanka, and therefore may have had a net negative impact on poverty in Sri Lanka. However, by supporting increased purchases of wheat from the USA, it may have contributed to income support programmes for American wheat farmers. For these reasons, it was decided not to include expenditures on the wheat subsidy as part of government expenditures for basic social services.

In future, better targeting of food subsidies is warranted, but it must be borne in mind that accurate targeting of subsidies is impossible, and that there is some trade-off between the accuracy of targeting and the continuance of political support for programmes which are important in maintaining the consumption levels of the very poorest.

Figure 6.2a: Nutrition Spending as a Share of Total Government Expenditure



Source: National Planning Department.

Chapter 7: Analysis of Water and Sanitation Expenditures

7.1 General

Water supply, drainage and sanitation are the responsibility of a single government agency – the National Water Supply and Drainage Board (NWSDB). This is the apex agency responsible for expansion, improvement and provision of water supply facilities. It provides water connections in both rural and urban areas, and so cannot be regarded as concentrating solely on urban residents. In 1997, more than half the new connections were supplied in the rural sector. According to NWSDB, by 1997 64% of the population had access to safe drinking water (pipe borne water facilities, tube wells and protected wells), while 64% had access to sanitation facilities. Access is better in urban areas (91%) than rural areas (64%), but further expansion of NWSDB services will gradually reduce this imbalance, which was to be expected initially.

NWSDB has traditionally been financed by government expenditures and foreign assistance, but current policy is to look to increase the degree of private financing, since only this will allow mobilisation of sufficient resources to support expansion of services to all rural people. This increase in private financing is expected to come from a more rational pricing policy, under which the subsidy for domestic consumers will be reduced and prices brought closer to the cost of production. Although this will increase the burden on households, since the bulk of NWSDB services benefit urban or richer rural households, this policy can be expected to benefit the poorer households if the funds generated are used to support expansion of connections to the rural sector, and if they are not expected to pay the same charges as urban residents.

7.2 Expenditures on Basic Water Services

Detailed descriptions of water and sanitation projects were not available from the National Water Supply and Drainage Board. Therefore, it has not been possible to distinguish between projects that are basic and non-basic.

The data could only be analysed in terms of government and foreign spending in rural and urban areas. The largest proportion of expenditure is incurred by the urban sector, while only a marginal proportion of expenditure is allocated to the rural sector.

As can be seen in Figure 7.2a, urban expenditure has risen steadily over the years, whereas rural expenditure has remained stagnant throughout the period. Total spending by both government and foreign expenditures has risen steadily and reached a peak in 1995, before falling again in 1996. Figure 7.2b illustrates this.

However, though both government and foreign contributions have risen collectively, when urban and rural sectors are considered separately, the increases are more marked in the urban sector. This is largely due to the fact that traditionally, the National Water Supply and Drainage Board has always put emphasis on developing the urban sector. In the rural sector, on the other hand, foreign expenditure has contributed the bigger share of the spending, as shown in Figure 7.2d.

There is a dramatic rise in foreign assistance in the late 1980s. This was a result of increasing donor funding by the World Bank, DANIDA and FINNIDA during this period (according to UNICEF sources), which subsequently led to increases in government spending in the rural sector. During the early 1990s, however, donor funding for projects in the rural sector decreased and as a result, government contributions also decreased.

Table 7.2a summarises total NWSDB expenditures as a proportion of total government spending and of foreign assistance in recent years. Government expenditures on all water supplies have averaged around 1.0-2.0% of total government expenditures in recent years.

Table 7.2a: Government Donor Expenditure on Water and Sanitation

Year	Government Expenditures	Donor Assistance	Total Expenditure	Allocation to Water and Sanitation Service		Total Government Expenditure
				Government Expenditure	*Foreign Assistance*	
1982	196,980,000		196,980,000	0.6%	0.0%	34,487,000,000
1987	280,414,000	427,217,000	707,631,000	1.1%	2.5%	65,534,000,000
1988	225,335,000	489,360,000	714,695,000	1.0%	2.4%	74,103,000,000
1989	151,670,000	397,883,000	549,553,000	0.7%	1.9%	83,535,000,000
1990	339,466,000	597,290,000	936,756,000	1.0%	2.3%	98,158,000,000
1991	473,768,000	839,188,000	1,312,956,000	1.1%	2.3%	116,414,000,000
1992	802,415,000	1,731,460,000	2,533,875,000	2.1%	7.6%	119,260,000,000
1993	769,036,000	1,217,753,000	1,986,789,000	1.4%	4.7%	143,129,000,000
1994	780,311,000	1,752,349,000	2,532,660,000	1.5%	6.3%	167,539,000,000
1995	1,416,857,000	2,042,447,000	3,459,304,000	1.7%	6.2%	206,969,000,000
1996	979,499,000	1,297,170,000	2,276,669,000	1.0%	4.0%	218,998,000,000

Source: National Water Supply and Drainage Board.

Since not all urban services would qualify as basic water services, these figures may considerably over-state GOSL expenditures on basic water services. However, the bias on urban water supply should be seen in perspective. Firstly, it is cheaper on a unit cost basis to build the infrastructure to provide water services in densely populated urban areas than in rural areas. On cost grounds therefore, as government resources are limited, emphasis initially on meeting demand in urban areas

can be justified. Secondly, public health considerations might place higher priority on supplying urban households first, since the negative externalities of inadequate water supply and sanitation will be greater there because of the higher risks of epidemic illnesses in densely crowded urban settings, where few households will have access to their own sources such as wells. Since almost complete coverage of urban households is now within reach, a policy of raising charges in urban areas and using the resources mobilised to finance expansion of coverage in rural areas may be feasible. Moreover, a reorientation of donor assistance to support expansion of clean water supplies to peri-urban and semi-rural areas would be more equitable than continuing with the current emphasis on urban projects.

Figure 7.2a: Total Spending on Water and Sanitation, 1982-1996

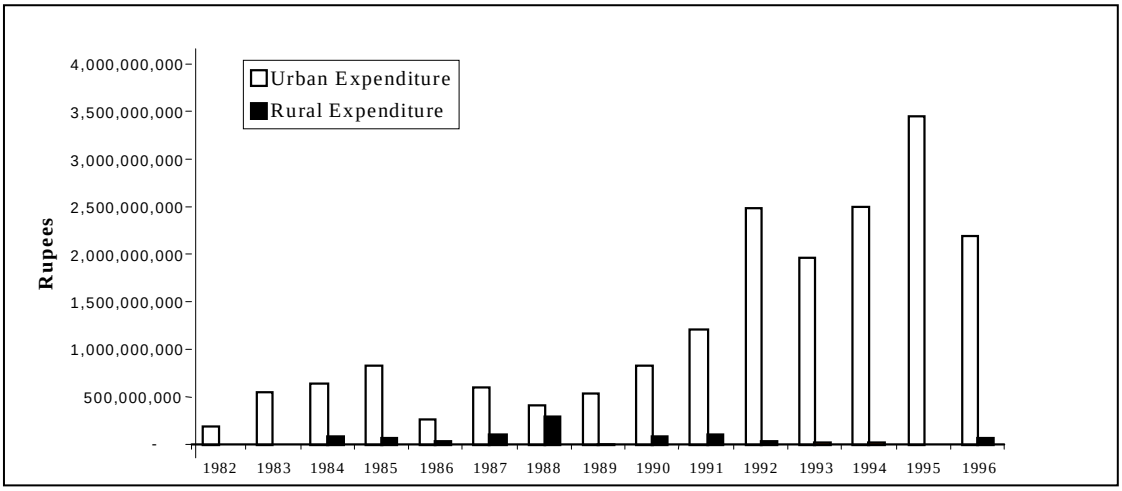
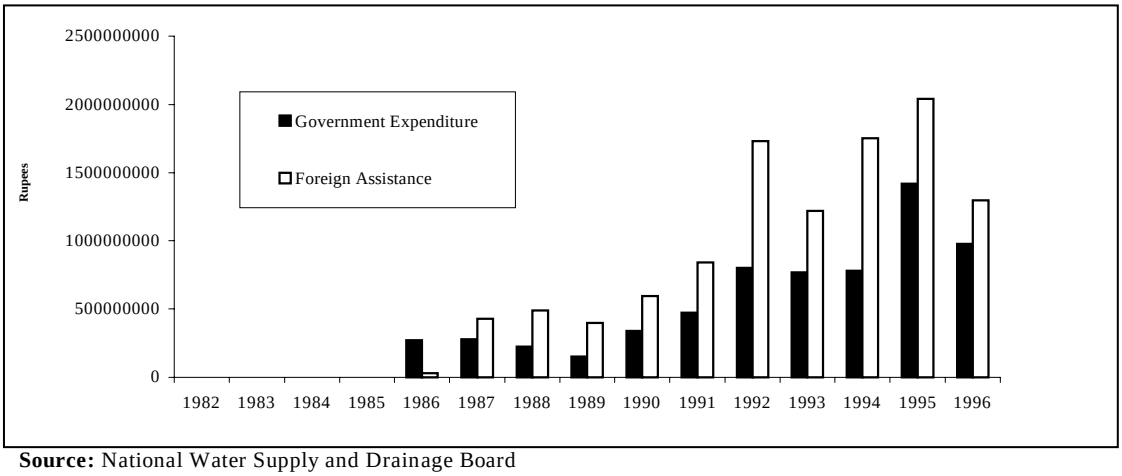


Figure 7.2b: Government and Foreign Expenditure on Water and Sanitation, 1982-1996



Source: National Water Supply and Drainage Board

Figure 7.2c: Government Spending and Foreign Expenditure on Water and Sanitation in Urban Areas, 1986-1996

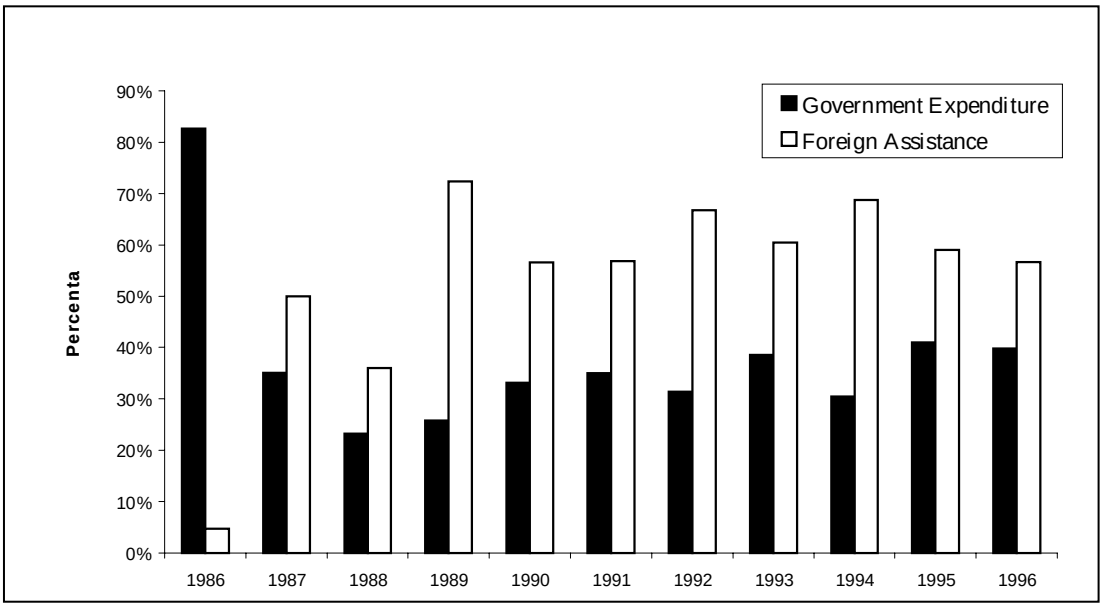
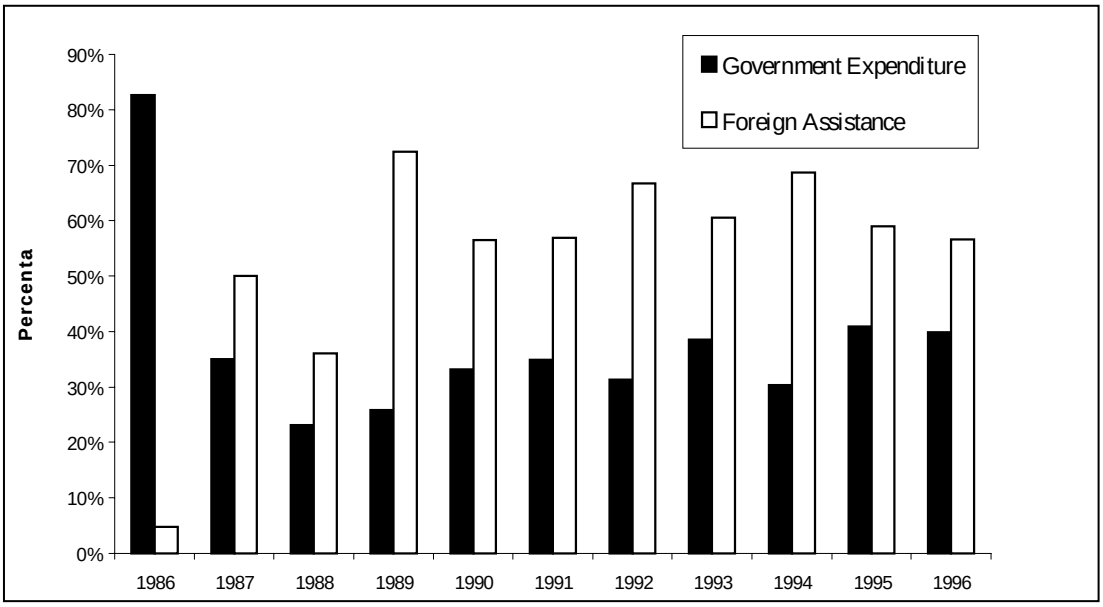


Figure 7.2d: Government Spending and Foreign Expenditure on Water and Sanitation in Urban Areas, 1986-1996



Source: National Water Supply and Drainage Board

Chapter 8: Scope for Inter-sectoral Restructuring

In the short to medium term, there is little scope for inter-sectoral restructuring of public expenditure patterns to allow greater allocations for basic social services. This is not because the government faces a fiscal crisis, but owing to considerable inflexibility in current expenditure patterns and the importance of other priority areas for spending.

The country does not face a fiscal crisis which would require cutting back of allocations to basic social services, but at the same time the presence of a large fiscal deficit implies that an increase in government borrowing is not prudent. During the 1980s and 1990s, government revenues and expenditures have increased in real terms throughout. The government has run a fiscal deficit throughout this period of time, and this has been financed by government borrowing from the domestic banking system and through loans. Although borrowing from the banking system has been deliberately reduced in recent years, there has been no increase in the net debt burden or in the level of debt servicing. This has been possible primarily because most of the public sector foreign debt has been from multilateral non-commercial sources, which are associated with lower real interest rates. In addition, the increase in the value of the debt and yearly debt payments has not been greater than general economic growth and export earnings.

External debt relief unlikely

The prospects for increasing the share of multilateral/bilateral debt at concessional rates in total debt in future years is limited, given that such debt already accounts for the bulk of foreign debt. Domestic borrowings are themselves at relatively low interest rates already since government is able to make use of captive savings deposited in the national provident funds (EPF and ETF), which permits it to borrow at lower interest rates than would be the case if it was to borrow only in the open market. Cancellation of bilateral debt according to the Trinidad, Pronk or Naples terms is not a realistic option. Either the country is not eligible for such terms, or it would not be considered a priority for such concessions given that the country's external debt position does not face the same problems as many other countries in the region currently.

In the medium term, it is inevitable that the government may need to rely less and not more on concessional loans. Given the country's rising per capita income, Sri Lanka is close to graduating from eligibility for highly concessional loans from the World Bank's IDA facility. In this situation, the government will need to increase its ability to tap commercial financial markets, and not the

opposite. That requires an international credit rating, which will depend on establishing a record as a reliable and prudent borrower.

Reducing domestic debt

In the longer term, reducing domestic debt would release additional resources for discretionary spending. However, this would require that government expenditures increase at a slower rate than government revenues, and this will remain difficult given the demands on government spending.

Military expenditures

Military expenditures constitute the fastest increasing element of government expenditures in recent years. They account for approximately a fifth of total government expenditures, and constitute the principal reason for the difficulties in reducing the overall fiscal deficit, as well as the difficulty in increasing discretionary spending in other areas. In the short to medium term, reductions in this item of expenditure are unlikely.

While reallocations from military spending to spending on basic social services may be desirable in many countries, it is not feasible or desirable in Sri Lanka's national context. The possibility does not exist for reallocations from defence and internal security to other areas in the current situation. The sole reason for the high defence expenditures in recent years has been the internal conflict in the country. Before this started in the mid-1970s, Sri Lankan governments had allocated minimal sums to defence, and defence expenditures were lower than in the majority of developing countries. The current high level of military expenditures is dictated by unavoidable circumstances.

Although successive governments have made repeated attempts to negotiate a peaceful solution to the conflict, the rebel Liberation Tigers of Tamil Eelam (LTTE), which has been waging an insurgency against the government, has not been willing to enter into a negotiated settlement based on the principles of the democratic process and of an undivided Sri Lanka. These are the amongst the minimum conditions that are acceptable to the Sri Lankan government and the Sri Lankan electorate, and they appear unacceptable to the LTTE at the present moment. The current conflict, which dates from April 1995, commenced when the LTTE unilaterally broke a cease-fire established for negotiating a peaceful settlement.

The primary obligations of the state are to protect national sovereignty and to ensure security for the people and for the democratic process. From the perspective of achieving access to basic social services, the last is most important. Without security it is difficult to ensure that public services are

provided. More importantly, it must be emphasised that the accountability associated with the democratic process is the principal reason why successive Sri Lankan governments have introduced and maintained public policies which have ensured access to basic social services for virtually all Sri Lankans. The maintenance of the democratic process is not only the most important means to ensure the continued commitment of the state to ensuring access to basic social services for all, but it is also the fulfilment of the basic political rights of all Sri Lankans which rank alongside those rights related to the fulfilment of the basic physical needs of people. Military spending by the Sri Lankan state does not conflict with the objectives underlying the provision of basic social services, but must be seen ultimately as supporting these same objectives.

Given that the LTTE continues to reject the democratic process and has chosen to use force to achieve its aims, and that the Sri Lankan electorate is not willing to countenance alternatives, the government has no choice but to use military means to contain the LTTE. The issue as to whether the government allocates and uses military spending in an efficient and appropriate manner for this purpose would have a bearing on the availability of funds for basic social services, but these questions are beyond the purview of this study.

In the event of the current conflict ceasing, it is not evident that the funds currently spent on the military will immediately become available for spending on basic social services. A large proportion of rural households are now dependent on military salaries to remain above the poverty line. In the event of military demobilisation, it may be necessary to replace these transfers with other transfers to avoid an increase in rural poverty. In addition, if peace is restored, there will be a need to reconstruct much of the Northern and Eastern Provinces where infrastructure has been destroyed or damaged, and to make up for the lost development in those areas. Internal security considerations may also demand this, since prevention of future conflicts will depend on restarting normal social and economic activities in these areas as quickly as possible. Although this would partly involve bringing levels of social service provision up to the levels in the rest of the country, it would mean that fewer resources would be available for expanding services elsewhere.

Pension expenditures

Pension expenditures are an item of government expenditures which are frequently identified as an area for possible savings. The government currently spends a little over 2% of GDP on pension payments to retired civil servants, and this proportion has been rising relatively fast in recent years with the ageing of the population. Potential options that have been suggested include conversion of the existing pension schemes with some sort of contributory savings schemes. However, these options are not likely to reduce government expenditure commitments, and in fact are more likely to increase government budgetary spending. To replace the existing scheme with a contributory scheme would require that the government continues to pay for the existing pensioners, while putting aside funds for the future pensions of currently working civil servants. The logic of this, which is supported by the experience of other countries which have attempted this in recent years, is that government expenditure commitments will increase for several years while such changes are being made. In a context of high fiscal deficits these solutions will be difficult to implement, and would present a significant risk that they would endanger the level of resources available for basic social services.

Other government expenditures

As noted in the first part of this report, the scope for reductions in other areas of the government budget is limited. During the past decade, reductions have been achieved in several areas of government spending, principally transfers to parastatals and economic infrastructure. The government has been engaged in a concerted process of commercialising and privatising state enterprises since the early 1990s. This has both reduced the need to use government revenues to cover the losses of such enterprises, and enabled many to find alternative methods of raising resources to pay for necessary capital investment.

Spending on economic infrastructure has already been cut substantially. There appears little scope for further savings in this area, and the evidence suggests that the current level of public expenditures may even be sub-optimal. Future economic growth depends on ensuring adequate, reliable and low-cost communications, power supplies and transport infrastructure. Lack of these have all emerged as constraints to more rapid growth.

Industrial growth and expansion of electricity access in rural areas depends on increased power generation capacity. Continued exploitation of Sri Lanka's geographical comparative advantages as a transport hub and expansion of exports depends on increasing capacity in the country's ports and transportation services, et cetera. In many of these areas, the government has attempted to reduce the

need for public spending by encouraging private sector provision or private financing. However, success in this to date has been limited. Except for the telecommunications sector, where market liberalisation has been effective, there has been little success in the areas of power generation, roads and port infrastructure, where BOO and BOT projects have been attempted.

The early development experience of the more successful Asian economies, such as Japan, Korea, Taiwan, Singapore and Hong Kong, indicates that public investment in infrastructure is a necessary precondition for more rapid growth. Moreover, the recent currency crises in Asia and ensuing economic recessions have made foreign private investors more wary of investing in Asian infrastructure projects, and has increased the cost of such private capital. Given these developments, there is a strong case for increasing and not decreasing government allocations to this area, especially if additional government resources become available in the future. Since increased funding for basic social services ultimately depends on economic growth, and since infrastructure has emerged as a critical constraint to future growth, allocation of budgetary resources to this area must have higher priority than social services in the medium term future.

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ANNEX

Table A1: Government Debt and Debt Service Payment (as a Percentage of GDP)

Item	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Total debt	83.0	83.7	104.8	111.9	105.6	103.7
Domestic	46.4	41.5	45.1	47.6	46.2	49.0
Foreign	36.6	42.2	59.6	64.3	59.4	54.8
Multilateral	9.5	12.0	16.5	21.7	23.7	23.6
Bilateral	24.2	24.3	37.2	38.8	33.5	29.5
Financial markets	3.1	5.9	6.0	3.9	2.2	1.7
Debt service payments	7.4	8.8	9.9	11.2	12.6	11.9
Amortization	2.3	3.6	4.2	4.6	5.7	5.4
Domestic	1.6	2.5	1.8	2.7	4.0	4.0
Foreign	0.7	1.1	2.3	1.9	1.7	1.5
Interest	4.5	5.2	5.8	6.6	6.9	6.5
Domestic	3.7	4.0	4.3	5.3	5.7	5.5
Foreign	0.8	1.2	1.4	1.3	1.1	1.0
Interest payments/ current expenditures	23.7	26.6	26.2	26.7	29.4	25.8
Debt service ratio	16.6	17.7	20.8	20.9	18.7	17.4

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

Table A2: Economic Classification of Government Expenditure (as a Percentage of GDP)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Current expenditure	19.2	19.6	21.9	24.8	23.3	25.1
Goods & services	6.9	8.1	9.9	10.7	10.2	12.0
Salaries & wages	4.9	4.3	4.8	5.7	5.6	5.7
Other goods & services	2.0	3.9	5.2	5.0	4.6	6.3
Interest payments	4.6	5.2	5.8	6.6	6.9	6.5
Foreign	0.8	1.2	1.4	1.3	1.1	1.0
Domestic	3.7	4.0	4.3	5.3	5.7	5.5
Transfers	7.7	6.3	6.2	7.4	6.2	6.7
Public corporations	1.0	1.1	1.2	0.9	0.4	1.2
Transfers to households	4.9	4.0	4.6	5.8	5.2	4.9
Food stamps & subsidies	2.1	1.2	0.9	1.6	1.0	0.2
Fertilizer subsidy	1.1	0.6	0.3	0.1	0.0	0.2
Janasaviya/Samurdhi	0.0	0.0	0.0	0.8	0.9	1.0
Capital expenditure	16.7	14.2	12.8	7.8	6.6	6.4
Acquisition of real assets	5.1	4.6	5.6	4.7	3.6	3.7
Capital transfers	10.1	9.6	7.0	3.1	3.0	2.8
Public corporations	10.0	9.3	4.3	0.7	1.0	1.1

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

Table A3: Functional Classification of Recurrent Government Expenditure (as a Percentage of GDP)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Current expenditure	18.9	19.6	21.9	24.8	23.3	25.1
General public services	3.2	4.0	6.1	6.1	6.1	7.8
Civil administration	2.2	1.8	2.1	2.3	1.5	1.3
Defence	0.6	1.6	2.8	2.4	3.5	5.6
Public order and safety	0.5	0.6	1.1	1.4	1.1	0.9
Social services	7.2	6.7	7.2	8.8	8.6	9.1
Education	2.2	2.1	2.5	2.7	2.7	2.5
Health	1.1	1.2	1.2	1.3	1.3	1.4
Housing	0.0	0.0	0.0	0.0	0.0	0.0
Welfare	3.9	3.3	3.5	4.7	4.6	5.0
Community services	0.1	0.1	0.1	0.1	0.1	0.2
Economic services	2.8	2.3	2.1	1.6	1.0	1.3
Agriculture and irrigation	1.6	1.0	0.7	0.3	0.4	0.6
Manuf. & mining	0.2	0.2	0.1	0.1	0.1	0.0
Energy & water supply	0.1	0.2	0.0	0.2	0.1	0.1
Transport & communication	0.5	0.7	0.8	0.6	0.3	0.3
Trade & commerce	0.1	0.1	0.1	0.2	0.0	0.1
Other	5.8	6.6	6.5	8.3	7.6	7.0
Interest	5.1	5.2	5.8	6.6	6.9	6.5

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

Table A4: Functional Classification of Current Government Social Expenditure (Period Average Real Annual Growth Rate)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Current expenditure	13.0	10.6	2.3	6.1	4.3	4.1
General public services	12.0	35.8	5.5	-0.9	4.5	20.9
Civil administration	21.0	4.3	21.4	-15.4	-11.8	32.8
Defence	-8.5	15.1	-5.2	16.6	11.8	32.8
Public order and safety	-0.4	25.0	22.9	2.0	7.5	-16.1
Social services	6.2	4.3	4.5	10.3	4.2	0.5
Education	13.2	8.2	4.9	-0.1	12.1	-6.8
Health	-0.5	10.1	2.0	4.7	11.9	-1.3
Housing	16.0	2.5	-4.4	0.0	0.0	0.0
Welfare	3.5	0.6	5.6	19.8	-1.0	4.8
Community services	16.8	2.1	1.9	0.9	25.7	28.3
Economic services	17.0	-10.6	11.6	-13.9	6.9	7.6

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

Table A5: Functional Classification of Total Government Expenditure (as a Percentage of GDP)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Total expenditure	34.9	34.5	36.6	35.0	31.5	33.0
General public services	4.0	4.7	7.1	7.1	6.7	8.5
Civil administration	3.0	2.4	2.8	2.9	1.9	1.7
Defence	0.6	1.6	2.8	2.4	3.5	5.6
Public order and safety	0.5	0.7	1.4	1.8	1.3	1.2
Social services	9.2	8.1	8.8	10.0	10.1	10.7
Education	2.7	2.6	3.0	3.2	3.2	3.0
Health	1.3	1.5	1.7	1.8	1.7	1.8
Housing	1.2	0.4	0.3	0.2	0.2	0.2
Welfare	3.9	3.3	3.5	4.7	4.8	5.3
Community services	0.2	0.2	0.3	0.1	0.2	0.4
Economic services	15.8	14.9	14.0	9.2	6.8	6.8
Agriculture and irrigation	9.4	7.7	5.0	2.3	1.6	1.5
Fisheries	0.2	0.1	0.1	0.1	0.1	0.1
Manuf. & mining	0.9	0.8	0.6	0.2	0.2	0.1
Energy & water supply	1.3	1.5	2.0	2.2	1.2	1.0
Transport & communi.	2.6	3.7	4.5	3.1	2.4	3.0
Trade & commerce	0.3	0.2	0.3	0.2	0.1	0.1
Other	5.9	6.9	6.8	8.6	7.9	7.2

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

Table A6: Functional Classification of Total Government Expenditure (Period Average Real Annual Growth Rate)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Total expenditure	17.6	6.3	0.4	1.2	2.4	3.0
General public services	24.0	27.5	8.2	-3.1	3.2	20.9
Civil administration	36.9	0.3	24.2	-16.3	-8.9	24.9
Defence	-8.5	115.1	-5.2	16.6	11.8	30.0
Public order and safety	-1.5	25.1	27.3	4.3	4.7	-10.5
Social services	0.6	2.8	5.3	6.9	6.1	1.7
Education	10.8	9.9	2.8	-1.3	13.3	-3.9
Health	1.1	15.3	13.7	-4.1	9.6	2.7
Housing	-28.2	-27.1	-0.8	-11.1	7.2	36.2
Welfare	3.6	0.4	5.5	19.7	0.9	3.1
Community services	-1.9	3.0	14.7	0.0	56.6	23.9
Economic services	27.5	-0.2	-2.9	-7.7	-1.9	0.1
Agriculture and irrigation	46.9	-8.0	-17.4	-15.8	-6.5	0.7
Fisheries	-2.0	-17.8	13.3	16.0	16.6	-11.2
Manuf. & mining	73.7	10.1	-27.7	-1.1	50.7	19.3
Energy & water supply	-25.0	14.2	41.5	-6.3	-11.3	-6.2
Transport & communication	33.9	14.3	9.7	6.4	19.4	-5.6
Trade & commerce	21.5	-11.0	25.6	8.0	-7.6	158.8
Other	16.5	16.1	-4.6	14.0	3.8	-2.8

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

Table A7: Functional Classification of Total Government Expenditure (as a Percentage of GDP)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-
Total expenditure	34.9	34.5	36.6	35.0	31.5	33.0
General public services	4.0	4.7	7.1	7.1	6.7	8.5
Civil administration	3.0	2.4	2.8	2.9	1.9	1.7
Defence	0.6	1.6	2.8	2.4	3.5	5.6
Public order and safety	0.5	0.7	1.4	1.8	1.3	1.2
Social services	9.2	8.1	8.8	10.0	10.1	10.7
Education	2.7	2.6	3.0	3.2	3.2	3.0
Health	1.3	1.5	1.7	1.8	1.7	1.8
Housing	1.2	0.4	0.3	0.2	0.2	0.2
Welfare	3.9	3.3	3.5	4.7	4.8	5.3
Community services	0.2	0.2	0.3	0.1	0.2	0.4
Economic services	15.8	14.9	14.0	9.2	6.8	6.8
Agriculture and	9.4	7.7	5.0	2.3	1.6	1.5
Fisheries	0.2	0.1	0.1	0.1	0.1	0.1
Manuf. & mining	0.9	0.8	0.6	0.2	0.2	0.1
Energy & water supply	1.3	1.5	2.0	2.2	1.2	1.0
Transport & communi.	2.6	3.7	4.5	3.1	2.4	3.0
Trade & commerce	0.3	0.2	0.3	0.2	0.1	0.1
Other	5.9	6.9	6.8	8.6	7.9	7.2

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

Table A8: Functional Classification of Total Government Expenditure (Period Average Real Annual Growth Rate)

	1980-82	1983-85	1986-88	1989-91	1992-94	1995-96
Total expenditure	17.6	6.3	0.4	1.2	2.4	3.0
General public services	24.0	27.5	8.2	-3.1	3.2	20.9
Civil administration	36.9	0.3	24.2	-	-8.9	24.9
Defence	-8.5	115.	-5.2	16.6	11.8	30.0
Public order and safety	-1.5	25.1	27.3	4.3	4.7	-
Social services	0.6	2.8	5.3	6.9	6.1	1.7
Education	10.8	9.9	2.8	-1.3	13.3	-3.9
Health	1.1	15.3	13.7	-4.1	9.6	2.7
Housing	-28.2	-	-0.8	-	7.2	36.2
Welfare	3.6	0.4	5.5	19.7	0.9	3.1
Community services	-1.9	3.0	14.7	0.0	56.6	23.9
Economic services	27.5	-0.2	-2.9	-7.7	-1.9	0.1
Agriculture and irrigation	46.9	-8.0	-	-	-6.5	0.7
Fisheries	-2.0	-	13.3	16.0	16.6	-
Manuf. & mining	73.7	10.1	-	-1.1	50.7	19.3
Energy & water supply	-25.0	14.2	41.5	-6.3	-11.3	-6.2
Transport & communication	33.9	14.3	9.7	6.4	19.4	-5.6
Trade & commerce	21.5	-	25.6	8.0	-7.6	158.
Other	16.5	16.1	-4.6	14.0	3.8	-2.8

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

Table A9: Central Government Recurrent Expenditure (SLR Million)

Year	1994	1995	1996
Personal Emoluments	2,932	2,800	2,830
Travelling	28	25	31
Supplies	146	133	157
Contractual Services	576	562	808
Other Expenditure	91	91	132
Transfers to Households	206	11	17
Other Current Transfers and Subsidies	1,708	1,789	2,566
Design In-Service Training and Research	76	230	209
Textbooks	473	551	651
Total	6,207	6,193	7,400

Source: Ministry of Education.

Table A10: Central Government Capital Expenditure, 1994-1996 (SLR Million)

Year	1994	1995	1996
Rehabilitation and Improvement of Capital Assets	87	183	253
Acquisition of Equipment	396	645	667
Construction of Buildings	816	1,218	1,286
Capital Grants for Provincial Councils	577	640	700
Others	26	4	10
Total	1,902	2,690	2,916

Source: Ministry of Education.

Table A11: Provincial Government Recurrent Expenditures, (SLR Million)

Year	1994	1995	1996
Provincial Salaries	7,928	9,931	10,906
Provincial Non-Salary Expenditure	163	202	362
Total	8,091	10,133	11,268

Source: Provincial Councils.

Table A12: Provincial Government Capital Expenditures, (SLR Million)

Year	1994	1995	1996
Provincial Capital Budget			
Instructional Material	89	45	53
Construction of Buildings	223	89	269
Repairs and Maintenance	79	49	84
Total	391	183	406

Source: Provincial Councils.

Table A13: Functional Classification of Health Expenditures in Sri Lanka

FUNCTION	SLHA Code
Core functions of health care	
1. Personal health services	1
• Hospital services	1.1
• Ambulatory services	1.2
— Registered medical practitioners	1.2.1
— Other providers	1.2.2
— Laboratory services	1.2.3
— Diagnostic services	1.2.4
— Dental services	1.2.5
• Psychological and socio-psychological services	1.3
• Residential nursing care/long term care for frail	1.4
• Home care	1.5
• Patient transport and emergency rescue	1.6
2. Distribution of medical goods	2
• Pharmaceuticals	2.1
• Therapeutic appliances and medical equipment	2.2
3. Collective health services	3
• Health promotion and disease prevention	3.1
— Maternal and child health	3.1.1
— Family planning	3.1.2
— Disease prevention	3.1.3
— Health promotion	3.1.4
— School health services	3.1.5
— Food hygiene control	3.1.6
— Control of drinking water, environmental	3.1.7
• Other collective health services	3.2
— Occupational health care	3.2.1
4. Health programme administration and health insurance	4
Health related functions	
1. Investment into medical facilities	5
2. Education and training of health personnel	6
3. Research and development in health	7
4. Environmental health	8
5. Administration and provision of cash-benefits	9

Source: IPS Health Policy Programme work in progress.

Table A14: Basic Health Services Components within IPS Classification of Health Expenditures in Sri Lanka

FUNCTION BY SLHA CODE	ICHE Code	CORRESPONDING UNICEF ITEM
Core functions of health care		
1. Personal health services		
1.1 Hospital services		Basic curative care - secondary care
1.2 Ambulatory services		
1.2.1 Registered medical practitioners		Basic curative care - primary care
1.2.2 Other providers		
1.2.3 Laboratory services		
1.2.4 Diagnostic services		
1.2.5 Dental services		Basic curative care - primary care
1.3 Psychological and socio-psychological services		
1.4 Residential nursing/long term care for elderly people		
1.5 Home care		
1.6 Patient transport and emergency rescue		
2. Distribution of medical goods		
2.1 Pharmaceuticals		
2.2 Therapeutic appliances and medical equipment		
3. Collective health services		
3.1 Health promotion and disease prevention		
3.1.1. Maternal and child health		Mother and child health
3.1.2 Family planning		Family planning
3.1.3 Disease prevention		Disease control
3.1.4 Health promotion		Disease control; health eduation
3.1.5 School health services		
3.1.6 Food hygiene control		Prevention of communicable diseases
3.1.7 Control of drinking water/environmental surveillance		
3.2 Other collective health services		
3.2.1 Occupational health care		
4. Health programme administration and health insurance		
Health related functions		
5. Investment into medical facilities		
6. Education and training of health personnel		Health personnel development
7. Research and development in health		
8. Environmental health		
9. Administration and provision of cash-benefits		

Source: IPS Health Policy Programme work in progress.
Note: BHS –related items shaded in grey.

Table A15: Variation in Provincial Allocations to Facility Levels

	Lowest	Highest
Provincial & base hospitals	28%	48%
District hospitals	23%	36%
Peripheral & rural hospitals	13%	29%
Maternity homes and dispensaries	4%	10%

Source: Ernst & Young (1994).

Table A16: Allocation of Inputs for Outpatient Services (% of Total)

	Personal emoluments		Complementary inputs		Total unit cost
Level of facility	*MOs and AMOs*	*Other*	*Drugs*	*Other inputs*	*(Rupees)*
Provincial hospitals	14%	16%	68%	2%	139
Base hospitals	21%	30%	46%	3%	42
District hospitals	13%	69%	16%	1%	43
Peripheral units	24%	51%	23%	1%	23
Rural hospitals	25%	46%	26%	3%	12
CD & MHs	19%	46%	32%	4%	15
Total	16%	28%	54%	2%	59

Source: Data for 1995 from Uniquest (1996).

Table A17: Allocation of Inputs for Inpatient Admissions (% of Total)

	Personal emoluments		Complementary inputs		Total unit cost
Level of facility	*MOs and AMOs*	*Other*	*Drugs*	*Other inputs*	*(Rupees)*
Provincial hospitals	13%	53%	17%	17%	1,119
Base hospitals	12%	46%	27%	15%	872
District hospitals	8%	61%	9%	22%	607
Peripheral units	11%	56%	14%	19%	394
Rural hospitals	12%	53%	6%	29%	575
Total	12%	53%	17%	18%	891

Source: Data for 1995 from Uniquest (1996).

IPS HPP Publications

Number	Title
1	De Silva, W Indralal,1997. 'Population Projections for Sri Lanka: 1991-2041'. Colombo: IPS, Research Studies: Human Resource Development Series No.2.
2	Rannan-Eliya, Ravi P., and Nishan de Mel. 1997. 'Resource Mobilization for the Health Sector in Sri Lanka' Boston: Harvard School of Public Health.
3	Rannan-Eliya, Ravi P., Dananjanee Senagama, Dushni Weerakoon and Harsha Aturupane. 1999. Monitoring the 20/20 Compact on Budget and Aid Restructuring in Sri Lanka' Colombo: Institute of Policy Studies, Health Policy Series Paper No. 1
4	Rannan-Eliya, Ravi P., and Aparnaa Somanathan. 1999. Bangladesh Facility Efficiency Survey. Working Paper No. 16. Dhaka: Health Economics Unit, Ministry of Family Health and Welfare, Government of People's Republic of Bangladesh.
5	Somanathan, Aparnaa, Kara Hanson, Tamara Dorabawila and Bilesha Perera. 2000. Operating Efficiency of Public Health Facilities in Sri Lanka: Measurement and Institutional Determinants of Performance. Small Applied Research Paper No. 12. Bethesda, MD: Partnership for Health Reform Project, Abt Associates Inc.
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