

Health financing options for Sri Lanka

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Abstract

The purpose of this paper is to renew and stimulate the national discourse on how to further Sri Lanka's aspirational goal of achieving Universal Health Coverage (UHC [1]) in line with the global sustainable development goals (SDG) to which Sri Lanka is a signatory. After a brief status update about UHC in Sri Lanka, the paper focuses on the financing function, justified on the basis of its central role in addressing the problems confronting the health system, in terms of its inherent inefficiencies as well as the specific context of the economic crisis which the country is currently facing. The paper argues for a well-managed prepaid, pooled health financing mechanism (such as the current tax-based system or social health insurance schemes), incorporating strategic purchasing approaches, leveraging the private sector (both for-profit and non-profit), in order to increase efficiency, equity and accountability by separating the financing and purchasing functions from service delivery.

Introduction

The overall goal of providing Universal Health Coverage (UHC) for all Sri Lankans could be broken down into the following three objectives: (i) Increase Access, Utilization and Coverage of Essential Health Services; (ii) Improve quality of care at all levels; and (iii) Enhance financial protection of individuals and households from expenditures on health care. In order to achieve these objectives and fulfil Sri Lanka's aspirations for UHC, a more equitable and efficient health financing mechanism would be a critical prerequisite. In short, in the Sri Lankan context, mobilizing "more money for health", and obtaining "more health for the money" are key priorities on which to focus.

UHC in Sri Lanka – current status

Sri Lanka's UHC service coverage index increased from 59 in 2010 to 66 in 2020 (which is better than the

regional average). With respect to financial risk protection, the percentage of the population that incurred catastrophic health expenditure remained almost unchanged between 2012 (5.3%) and 2016 (5.4%). The proportion of impoverished registered a slight decline from 0.8% to 0.7% during the same period (using the poverty line of US\$ 3.20 per capita per day) [2].

In Sri Lanka, the Government is the dominant provider of healthcare (nearly 100% of preventive services, 90% of inpatient curative care and about 50% of ambulatory curative care). Almost all of these services (except at a few hospitals like the Sri Jayawardenapura General Hospital and Wijeya Kumaratunge Hospital and paying wards in some other hospitals, which levy user fees) are financed by the Government from tax revenues (supplemented marginally from external financing). Current health expenditure (CHE) was estimated at 3.8% of GDP in 2018, down from 4.2% in 2009. Domestic government expenditure (DGE) on health was slightly down from 1.7% in 2009 to 1.5% in 2018 as a proportion of the Gross Domestic Product (GDP), but increased slightly as a proportion of the total Government expenditures from 7.8% to 8.3% during the same period [3].

Most of the private healthcare is privately financed by out-of-pocket expenditures (OOPE) by individuals / households on their healthcare. Taken together, DGE (40.7%) + OOPE (50.7%) account for over 90% of current health spending in Sri Lanka. Health insurance contributes only fractionally (2.4%) to the health sector, through Agraphara, which covers the government employees and their families and a few voluntary health insurance plans offered by private firms, either directly to the beneficiaries or through employers. External funding (by international donors / financiers) also constitutes only a small fraction (2.3%) of the current health expenditures [4].

Though a benefit package i.e., the Essential Health Services Package (EHSP) was developed in 2019, it requires further specificity, and costing; and though it has been used to formulate the service delivery, especially

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in the pilot clusters that are currently functioning in selected districts, it is not yet fully functional throughout the country. If UHC should be achieved in its true sense, and all catastrophic and impoverishing health expenditures should be eliminated, it is necessary to define, cost and adopt access to EHSP as a universal right.

Challenges confronting the Sri Lankan health system

The Sri Lankan health system needs to address insufficient resources for health services, as indicated by almost every relevant indicator showing that Sri Lanka spending lower than countries of comparable economic status, inefficiencies, e.g. the need to prioritize cost-effective interventions, avoid duplication, waste and system loss; and inequities, i.e. gaps in access due to geographical, social and economic factors, e.g. the estate population. Though the proportions of population experiencing catastrophic and impoverishing health expenditures are relatively small compared with other countries in the region, more work needs to be done to eliminate catastrophic and impoverishing impact of health expenses by households and individuals. More efficiencies can also be squeezed through Public Financial Management (PFM) improvements, starting with the incremental line item budgeting system wherein health managers have little say in their allocation, and inadequate monitoring and accountability systems. Issues of Human Resources for Health include the need for a more appropriate skill-mix, revision of service delivery cadres, better data on health workforce availability, especially in the private sector, streamlining of training programs especially for allied health cadres, improved performance management systems and enhanced opportunities for professional development. Finally, there is a need to foster greater synergies between private and public actors which can leverage private financing and provision towards the public policy goal of UHC. Despite the dominant position of the public sector in health care, the private sector does have a significant “market share” and UHC requires the private and public sectors to work together.

Why focus on the FINANCING function

Efficient and equitable health financing is the key to solving most, if not all, the challenges identified above. All 3 components of Health Financing need to be considered: Collection (sourcing and gathering of funds: who pays how much; how and when the contributions are made – prepayment vs. payment upon receiving services; taxes vs insurance vs direct payment to providers), pooling of funds (the size of the pool, who is included / excluded, who holds and manages the pool), and the allocation and expenditure (allocative efficiencies, PFM including budget management, provider-payment mechanisms, accountability, operational efficiencies, equitable distribution according to need).

Currently, the collection of funds for health care services happens largely either through taxation by the Government or through OOPE for the privately provided services at the point of care, with prepaid insurance (social or voluntary) playing just a marginal role. While taxation is a form of prepayment, it is not always as efficient or equitable as it could be. Payment at the point of care carries a high risk of catastrophic or impoverishing impact. Another downside of direct payment to providers at the time of receiving care is that it provides no mechanism for improving efficiency – as allocative decisions are made by the individuals and households as per their perceived needs, with no consideration of public policy goals of efficiency or equity. Taxation – without clear earmarking for health also poses budgetary challenges to the Ministry of Health, which has little say in how much the Ministry of Finance allocates for health, in the face of competing priorities from non-health sectors.

The main function of pooling the funds is to provide cross-subsidies from the rich to the poor and from the healthy to the sick, thus enhancing equity of access; the other advantage of pooled resources is the increased efficiencies obtained through economies of scale (the manager of the pooled funds can negotiate better prices while purchasing the services and other health care inputs on behalf of the beneficiaries). Currently, taxation provides the only significant form of pooling in Sri Lankan health financing; while it has the advantage of being a large pool and of financing the free health services available to the poor, it is often not progressive, and it does not capture the considerable bulk of the resources being spent on healthcare through OOPE thus missing out on a significant source of funds which, if pooled, could increase equity and efficiency.

For the publicly financed and publicly provided health services, the allocation happens through the traditionally incremental line-item budgetary process, which is not very amenable to rational allocation according to epidemiological need and cost-effectiveness of interventions. Even though an EPHS has been defined, it has yet to be formally adopted as a mechanism that directs allocative decisions. There are other PFM issues in the publicly financed publicly provided health system, such as the need for more rigorous monitoring, accountability and efficiency. Typically, in this part of the system, the providers are compensated through salaries, which are not linked to outputs or results. Capitation fees or fee-for-service mechanisms, which have their own merits and demerits, cannot be easily adopted in such a context. The private sector services, largely financed through OOPE, on the other hand, adopts fee-for-service as the main mode of provider compensation, which incentivizes over-provision, e.g. unnecessary procedures – investigative or surgical, and longer hospital stays than might be warranted. In a managed healthcare setting, where all the resources and risks are pooled and managed by an entity responsible for rational decision-making, PFM issues can be addressed more effectively.

Box 1.

**Main options for health financing mechanism
(Most countries have a mix of these mechanisms)**

- Collection, pooling and spending of finances for health are all done wholly by the Government (mostly financed from general tax revenues – supplemented by donors in some cases; health surcharges / earmarked taxation could be additional sources).
- Pay-as-you-go systems (individuals and households simply purchase services as and when they need them, and pay the providers directly at the point of care). These would be the least equitable and least efficient, as they provide no protection against catastrophic health spending nor do they allow for increasing allocative efficiencies.
- Collection, pooling and spending are done by private entities (as in private health insurance plans). While these systems carry the advantages of prepaid, pooled financing, as they are wholly in the private sector, they are driven by profit motive and thus the poorer and underserved populations tend to be excluded from such plans.
- Collection is done by the Government, but pooling and spending are managed by an autonomous body (or an outsourced private management company), which purchases the services from private and/or public providers, on behalf of the beneficiaries. This might take the form of national health insurance / or social health insurance schemes. Such a mechanism, if managed well, could be the best option for Sri Lanka, both for mobilizing more resources, for utilizing them equitably and efficiently and ensuring greater accountability.

Established principles of good financing mechanisms for UHC

The following principles are internationally accepted as best practice for health systems which seek to achieve UHC: pooling of risks and resources (the rich should subsidize the poor and the healthy should subsidize the sick); the pool should be as large as possible (ideally one pool that covers the whole population's contribution and health care expenditures) to ensure adequate cross-subsidies between the rich and the poor and between the healthy and the sick; participation in the health financing pool must be mandatory, i.e. the people of higher economic status and people with lower health risks must not be allowed to opt out; prepayment is superior to payment at the point of care (to avoid catastrophic shocks); separation of financing, purchasing and providing functions is important to ensure accountability; it is critical that both the public and private (for-profit and non-profit) actors play their appropriate roles.

Pre-requisites for health financing reform

If Sri Lanka wishes to embark on a significant transformation of its health financing mechanism, the following are some of the prerequisites that need to be in place.

Political will at the highest levels is a sine qua non for any reform to be successful. Broad buy-in is also absolutely essential, as without it, even if the highest levels

of government have the political will, reforms would meet with stiff resistance from certain quarters, as any reforms would entail “winners” and “losers” – both real and perceived. Intensive dialogue and consensus-building process among all stakeholders, including public and private actors – for-profit and non-profit, civil society, opinion leaders would therefore need to take place at various levels, through the different stages of planning and implementation of reforms.

A clearly defined and costed benefit package is another critical step for any health financing reform aiming at the achievement of UHC; without a clear definition of the scope of services being guaranteed, UHC is likely to remain a rhetoric; similarly once the package is defined, its costing is vitally important, so that resources can be mobilized and if the costs prove unaffordable for a given country the package may need to be revised accordingly. This is likely to be an iterative process based on epidemiological need, cost-effectiveness of interventions, societal preferences and availability of resources. It should be clear what the package represents; it should not necessarily represent “free government services”; rather it would be the set of services that every citizen would have access to, whenever (s)he needs them, without undue financial burden – regardless of whether the provider is public or private and irrespective of the beneficiary's ability to pay for the services.

Establishment of institutional mechanisms would be another important pre-requisite for health financing reforms

for UHC. For instance, an organizational home would need to be identified for the pooling and management of funds; whether it should be the Ministry of Health or an autonomous body which is accountable to the Ministry of Health needs to be debated and determined by the country. If MOH is responsible for policy-making and monitoring, with the autonomous body being vested with the responsibility for the pooled funds for healthcare, such an arrangement might promote greater accountability and efficiency.

Provider-payment mechanisms and contractual arrangements are also essential aspects on which agreement / decisions would have to be reached. There are mainly four different ways in which healthcare providers are compensated: salaries, capitation fees, fee-for-service, and diagnostic-related groupings (DRG) based arrangements. These methods differ by the basis on which the compensation is paid: salaries are paid based on time (per day, per week, per month, etc.) spent by the provider, regardless of the quality or quantity of service rendered; fee-for-service on the other hand is paid per item of service rendered, e.g. per X-ray done or per surgery performed; capitation fees are paid per person covered for a predefined package of services for a specified period of time (e.g. for one year) – this is usually applied to ambulatory primary care services; and DRG-type arrangements (which were introduced in the US as a cost-containment measure in the 1980's) are usually employed for hospital care, with an agreed lumpsum amount for treating each case, depending on the diagnosis and severity, regardless of what procedures and services may be needed. Each method carries different incentives and disincentives and an appropriate mix would be needed with different methods being adopted for different sets of services.

One might consider strategic purchasing decisions as a way of leveraging the non-state actors (both for-profit and non-profit) towards public policy goals. Such arrangements carry the advantage of improving efficiency and quality through competition and better accountability, through the use of results-based financing. If such an approach is under consideration, establishing public-private partnerships would be a pre-requisite for success.

What should Sri Lanka do now?

The following sequence of next steps could help Sri Lanka move forward with the process of health financing reforms towards UHC, in the short-term:

- Revisit the budget process to make it more responsive to the health sector needs; consider moving towards results-based/performance-linked budgeting; introducing a health surcharge, which would be earmarked completely for the health sector (either as a supplement to the general taxation or as a complete replacement for the health budget from the general taxation); Increased and earmarked taxes on tobacco,

alcohol, sugary foods, etc. adding a health surcharge to motor vehicle insurance policies and earmark a portion for the health sector to cater to the treatment of traffic injuries.

- Review the composition of out-of-pocket expenses for health and consider measures to: reduce the proportion of OOPE's contribution to total health expenditures, by a combination of measures such as the expansion of prepaid pooled financing such as social health insurance schemes to cover the currently uninsured / underinsured populations especially the poor as well as the employees in the informal sector, and increased coverage under the publicly financed services by mobilizing more resources; eliminate catastrophic and impoverishing health expenditures; increase synergies between the current OOPE and the tax-based health financing by exploring ways of creating one large health finance pool that would ensure better cross-subsidies (from the rich to the poor and from the healthy to the sick)
- Develop an organizational set-up for health financing, which can enhance efficiency, equity and accountability: decide on an institutional home (autonomous body?) for the collection, pooling and allocation functions of health financing; develop a robust M and E function, focusing on key health financing indicators
- Leverage the non-State actors (for-profit and non-profit private entities) towards public policy goals, with a view to: strategic purchasing / franchising / other modes of PPP; regulation of the private provision of healthcare (quality); clarification of the roles of the private sector in terms of financing and provision, and also data-sharing

References

1. Universal Health Coverage (UHC) is defined as everyone receiving the healthcare that they need without undue financial burden (i.e. regardless of their ability to pay for the care, and without being pushed into poverty due to expenditures related to the healthcare that they need to access).
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