Commentary

Financing Common Goods for Health: Sri Lanka

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FINANCING COMMON GOODS FOR HEALTH: SRI LANKA

Health care is considered a basic human right in Sri Lanka, and, reflecting this priority, the government dedicates government tax revenues to ensure equitable access to all people in the country, regardless of whether they are a citizen. In particular, Sri Lanka has recognized the inherent market failures associated with financing health promotion and prevention related services, and has therefore prioritized investments in those areas. In building off of the conceptual foundation and definition of common goods for health (CGH), this commentary provides an in-depth look at the successes and challenges in the financing and provision of CGH in Sri Lanka. This reflection is particularly timely given the country’s current plans to transform primary health care to meet the growing demands placed on the system by non-communicable diseases (NCDs) and emerging and re-emerging diseases.

HISTORICAL EVOLUTION OF CGH PRIORITIZATION IN SRI LANKA

Sri Lanka’s prioritization of CGH has a long history, which is tied in part to its tradition of state activism in social and health provision and its welfare state approach to governance. A “support-led” strategy has been followed, with around 4% of GDP dedicated to free education and health services for the entire population in the country. In 1926, the government established its first Health Unit, primarily for maternity and child welfare services, which later expanded to include other health services. In the 1990s, the Ministry of Health (MoH) restructured healthcare institutions to establish primary, secondary, and tertiary levels of care. These lines, however, have become increasingly blurred, which has led to an initiative to set up and better delineate Primary Medical Care Units. This aims to expand services for NCDs alongside the strong preventive care system that is already in place. Additionally, this reform in part is meant to shift care seeking patterns away from secondary and tertiary levels of care, and also provide...
improved access to services, which are largely provided in the private sector with associated out-of-pocket payments.

COMMON GOODS FOR HEALTH IN SRI LANKA

For this commentary, two CGHs were selected which Sri Lanka has been able to effectively finance and provide: (1) the immunization program and epidemiological surveillance, and (2) national disaster preparedness and response. These CGH share features illustrating both policymaking and investments in the preventive and promotive services and their financing. They also demonstrate how specific contextual issues can accelerate or slow the implementation of certain programs related to CGH. The last part of this commentary provides examples of continued challenges, which serve as a basis to highlight key issues that arise when financing and providing CGH.

Immunization Program and Epidemiological Surveillance

With a history of immunization going back to the 19th century, Sri Lanka’s achievements in the immunization program have been significant and have contributed greatly to strengthening several CGH. Most notably, the last case of polio in Sri Lanka was in 1993, with the entire South East Asia Region taking until 2014 to be free of polio and to receive the Regional Polio free certification. The polio initiative also contributed to other areas of the Sri Lankan health system, including strengthening the entire immunization program, the expansion of laboratory facilities and surveillance systems to prevent other diseases, and an overall improvement in the health infrastructure.

Sri Lanka has been committed to expanding its immunization program for many decades. A clear demonstration of this commitment is that, even during times of conflict in the 1990s and early 2000s, fighting ceased on agreed Days of Tranquility expressly for polio vaccinations to take place. The MoH took advantage of these days to provide additional mother and child services and immunization to populations most at risk during the conflict.

As of 1978, vaccines that fell under the Expanded Program on Immunization (EPI) were donated by UNICEF. Since that time, the Sri Lankan government has gradually increased its own funding for all vaccines through its National Immunization Program (NIP). Exceptions to this policy include hepatitis B, Penta, and IPV vaccine, which are funded through GAVI. Given the public health priority placed on immunization services, the role of the private sector has always been limited (<5% of immunization spending). The MoH now has a dedicated budget line for vaccine procurement and has been self-procuring all vaccines for twenty years with immunization coverage obtaining around 100% of the eligible population. Approximately 0.2% of the annual total health expenditure has been allotted for vaccine procurement and has not been affected by changes in government. The costs of managing and delivery of the program are borne separately.

Several drivers enabled and pushed the government to fund the immunization program. First, there was increased health literacy, particularly from mothers, and their growing demand for immunizations. The health community, namely pediatricians and public health specialists, lobbied policy makers and educated mothers at the community level intensely on their importance. Second, social welfare policies, combined with MoH leadership, ensured that financing, infrastructure, and personnel were made available. With seed funds, and continued advocacy and technical support from international agencies, the government was able to orient itself to set up and fund sustainable systems reflecting the prioritization of these services.

Disaster Preparedness and Response

Disaster preparedness and response is another positive example of the financing and delivery of a CGH in Sri Lanka. The evolution of this priority holds a number of key lessons for other countries. Human activity, outbreaks of emerging infectious disease, extreme weather events, and human conflicts have increased in recent years and, as a result, people in the country are increasingly exposed to situations that threaten their health and well-being.

Prior to 1978, natural disasters that occurred seldom were primarily the responsibility of the MoH. However, the initiation of the ethnic conflict in 1978 added a new dimension, with increasing mass casualties resulting from suicide bombings and battles. This increased the importance of managing disasters and emergencies. During this violent time, which lasted for three decades, the MoH had to be constantly prepared for mass casualties.

To respond to this growing responsibility, a young surgeon and medical administrator voluntarily took the initiative to train health workers to manage and handle disasters. This had a great impact and, in seeing how critical this approach was in managing the crisis, the government became convinced of the urgency and need for such a program.

As of 2000, disaster management became a more formal system and a Disaster Operations Unit was created and placed under a senior director in the MoH. In December 2004, this function proved critical when the tsunami hit the country, taking nearly 40,000 lives and rendering hundreds of thousands homeless. This sparked the additional development of a National Disaster Management Plan (NDMP) and the Disaster Management Act, No. 13 of 2005 providing the...
legal basis for a national disaster management system. A National Council for Disaster Management (NCDM) has been established with stakeholders drawn from 18 other relevant Ministries and is chaired by the President.

Within this context, the health sector has developed its own NDMP and coordinates the multi-sector involvement in health-related disaster risk reduction. Due to its long experience in managing all types of disasters, the MoH is considered the leader within the public sector in facilitating these activities. Most recently, when the Good Friday bombings resulted in many casualties in three towns in the country, the health sector response in dealing with the disaster, particularly in Colombo, was well organized and helped to save many lives. Interestingly, the health sector officials and the Minister served as the spokespersons during this early response period.

Similarly, earlier in 2017 when Sri Lanka experienced a severe dengue epidemic that reported 80,732 dengue fever cases, including 215 deaths, the initial alerts came from the disaster management early warning systems and the response staff worked closely with the epidemiologists and health officials.

The following four main areas of disaster management are under the health sector and ensure the integrity of the system:

1. Preparedness and Response: understanding disaster risk and governance and mobilizing communities and public and private resources for risk management. The main elements include prehospital care, hospital care, management of the dead bodies, and public health service provision in the field. A results-based monitoring framework has been added to ensure the commitment of non-health stakeholders to health sector disaster management targets.

2. Capacity Building: Capacity in this context is defined as the sum of capability, infrastructure, resources, and relationships aimed at reducing illness, disability, and death from risks and at promoting health, safety, and security.

3. Training: Training for disaster management for different categories including the community. Training has also been added into basic programs as well as in-service and post graduate training, with a post graduate Diploma in Health Sector Disaster Management being offered at the Post Graduate Institute of Medicine. Community empowerment and mobilization is an integral part of this training.

4. The Safe Hospital Framework with a structured approach for actions to strengthen the safety and preparedness of health facilities for all types of hazards and to ensure the structural and functional integrity of the hospitals.

Two key lessons have emerged from Sri Lanka’s experience in disaster management over the past decades. First, it is critical to have clear organizational and accountability structures in place with salient objectives before a disaster strikes to enable an effective response. Second, outreach and information dissemination, like early warning systems, need to be in place and effectively activated, and regularly tested.

From a financing perspective, initially donor assistance was the main driver in setting up and strengthening the disaster management program in Sri Lanka, with WHO as the main resource. However, the government is now funding the programs and related functions. These programs are primarily funded through general tax revenues. Donor assistance, mostly in the form of technical assistance and capacity building for health staff, is still received in the wake of unanticipated disasters. In this respect, the Government of Sri Lanka is funding the preparedness aspect of disaster management, while donor assistance helps with response efforts when emergencies arise.

The government recognized the importance of disaster preparedness, particularly as the events have become more frequent, and it prioritized domestic funding for these functions. Additionally, the government has realized the annual costs of managing disasters after they have occurred are roughly 15 times larger than the costs of disaster management programs. Generation of such evidence is now a regular function of the Disaster Management Unit.

CHALLENGES AND A WAY FORWARD FOR SRI LANKA

While Sri Lanka has had many successes in terms of financing and providing critical population-based functions and public goods, there remain ongoing challenges, particularly in regulating air, water, chemicals, and environment quality. Water quality in many agricultural zones is contaminated by chemicals and heavy metals and air quality has deteriorated, in both urban and rural areas. The emergence of a near epidemic of Chronic Kidney Diseases of unknown origin (CKDu) in the past decade seems a result of such failure, along with the increasing prevalence of asthma and chronic respiratory diseases in the urban population. Decentralization has contributed to an unequal distribution of health resources which is exacerbated by an emphasis on expanding specialized services, consequently reducing funding available to provide CGH.

These issues need to be tackled along with Sri Lanka’s investments in a transformed health system that can efficiently manage the increasing prevalence of NCDs and issues of the elderly. As an initial step forward, the government has established a Medicines Regulatory Authority that ensures the quality and the affordability of essential medicines, which are provided free of cost to the population. There is also in place a multisectoral NCD Council that includes the private sector as well.
Additionally, the MoH, with support from the World Bank and the Asian Development Bank, has embarked on a Primary Health Care (PHC) System Strengthening Project (PSSP) to increase the utilization and quality of primary health care services, with an emphasis on detection and management of NCDs in high-risk groups.\textsuperscript{16}

The proposed reforms of the primary health care sector include three main components:

1. PHC strengthening (i.e. upgrading infrastructure at peripheral levels and enhancing PHC demand & utilization)
2. Strengthening of health and disease surveillance capacity and information systems
3. Policy development on primary health care services delivery

In relation to CGH, the reorganization plans to strengthen disease control policies and strategies and risk assessment in environmental health in areas such as antimicrobial resistance (AMR), waste management, and air pollution, and improve community engagement to bring behavior change. There is a research and innovations component and the creation of a central health information system, which will merge the several uncoordinated systems that are currently used. It will emphasize emergency preparedness and response in the form of capacity building to respond to emerging infections and health issues due to climate change. While there is no accurate estimate of the funding required for managing and mitigating the environmental hazards, significantly increased funding is deemed to be essential in the early stage. International agencies will need to collaborate with the MoH to develop sound technical programs and to convey urgency to policymakers.

In recent years, government health spending has averaged 1.3–1.7% of GDP.\textsuperscript{17} As investments are made in PHC reorganization, both from national budget and donor assistance, it is critical to emphasize the importance of maintaining Sri Lanka’s commitment to prevention and population health and expanding further into environmental CGH. This is a responsibility that should not be overlooked nor allowed to go by default.

As it is now, the relative share of investments in population-based services that could have an impact on providing CGH has shown a slow but gradual decline. This has partly been a consequence of the slow growth of our economy as well as the continuous demand from politicians for more curative services, such as attractive and resource intensive hospitals, and the reduced funding requirements for the malaria program.

Additionally, policy making, both at the central and provincial levels is getting highly politicized and it will be a challenge to maintain consistent health policies that support CGH amidst these frequent political changes. The community also shows divisions along national political lines.

Furthermore, intersectoral and multisectoral action, except in a few areas like disaster management, have not been coordinated effectively due to the large number of ministries and institutions in the country. Better coordination amongst these bodies and improved management will be necessary to adequately provide CGH.

Correcting this situation will need advocacy among the political leadership and policy makers, particularly by health professionals, backed by staunch support from the community. Leadership and governance is essential to have both strong government action and effective citizen engagement to ensure CGH in Sri Lanka.

**DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST**

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