



BUDGET BRIEF: HEALTH SECTOR

SRI LANKA 2019

KEY MESSAGES:



Sri Lanka has provided free healthcare to all citizens, since independence. Whilst government-established and managed hospitals provide healthcare free of cost, privately established and managed hospitals provide healthcare on a fee levying basis. Sri Lanka's total expenditure on healthcare, both public and private, is 3.9 percent of GDP, similar to lower middle-income countries' health expenditure of 4 percent, but lower than upper middle-income countries' health expenditure of 5.9 percent.



In terms of public health expenditure (1.6 percent of GDP), Sri Lanka compares favourably with regional peers in South Asia (0.9 percent of GDP) and lower middle-income countries (1.3 percent) but spends just half the level of upper middle-income countries (3.2 percent). Over time, Sri Lanka's health expenditure has declined from 2.3 percent of GDP in the year 2000 to 1.6 percent of GDP in 2016. However, public expenditure on healthcare has increased in recent years with a 34 percent increase of actual spending in real terms (inflation adjusted) between 2013 and 2016. Public health expenditure budgets achieved, on average, 92 percent execution during this period.



Domestic sources of financing dominate public health expenditures. Between 2013 and 2019, domestic sources accounted for, on average, 94 percent of public health spending with foreign sources accounting for the balance 6 percent. Annual disbursements of Official Development Assistance (ODA) dedicated to health have declined significantly from USD 773.6 million in 2012 to USD 85.1 million in 2018.



As a share of total health expenditure, private health expenditure has been increasing in Sri Lanka from 45 percent in 2000 to 56 percent in 2016 with out-of-pocket expenditure being the largest contributor to private health expenditure.



Most of the public health expenditure in Sri Lanka is recurrent spending, averaging 78 percent between 2013 and 2018. Capital expenditure is largely focused on hospital development. At the Provincial Council (PC) level, the ratio of recurrent expenditure has been higher at 94 percent. Overall healthcare expenditure is relatively centralized with 73 percent of expenditure taking place at the central government level.



Provincial allocations of health expenditure are highest in per capita terms in the Northern and Uva Provinces, two of the more economically backward and impoverished regions in the country. The Western Province, the wealthiest province in Sri Lanka, receives the lowest per capita provincial health allocation. Therefore, decentralized public health expenditure is aligned with equity objectives.



Sri Lanka outperforms income and regional peers with regard to most health outcomes, including child and maternal mortality, and life expectancy. There has been considerable progress in eliminating several communicable diseases, including malaria, tuberculosis and measles. Nonetheless, challenges remain with regard to regional disparities in health outcomes, rising non-communicable diseases (NCDs) associated with an ageing population, and child malnutrition.



1. INTRODUCTION



This brief is one of four that explore the context of government budgets in Sri Lanka. The first brief, on budget processes, describes chronological events pertaining to the budgets of national and sub-national governments. The remaining briefs, on Water, Sanitation and Hygiene services (WASH) and education sector budgets, explore the extent to which these address the social concerns of citizens.

This brief, on Sri Lanka's health sector budget and expenditure, informs readers of trends in spending on these services in recent years. This analysis includes the underlying policy goals and the functional and regional distribution of budget allocations. The main objective of the brief is to function as an informative piece on the health sector budget. As such, the brief summarizes budget information in a manner that would be easily understood by different stakeholders, including civil society and the broader population who may lack technical knowledge on the subject. This piece also serves to increase transparency on how much is being spent to meet the goals of the

health sector. The brief is the result of a research partnership between UNICEF and Verité Research that aims to unpack the contours of government budgets in Sri Lanka.

Data for the brief was collected from Sri Lanka's Central Government Annual Budget Estimates 2013–2019. The sector includes budget allocations to the following line ministry: Ministry of Health, Nutrition and Indigenous Medicine (previously the Ministry of Health and Indigenous Medicine/Ministry of Health and Ministry of Indigenous Medicine).

Central government budget allocations have been added on to the budget given to each of Sri Lanka's nine PCs for health-related expenditures. Data on health-related expenditures was obtained from the Provincial Council Budget Estimates for each province. Individual expenditures relevant to health were obtained from each of the provincial-level ministries that governs the subject of health and indigenous medicine, including the Department of Health Services and the Department of Indigenous

Medicine/Ayurveda nested under the respective provincial-level ministries.

Data from Annual Central Budget Estimates and Provincial Council Budgets has been combined with publicly available data from other independent organisations such as the World Bank (WB). Finally, local authority-level [municipal councils (MC), urban councils (UC) and pradeshya sabhas (PS)] data has not been included in this brief because of the inherent difficulties and time constraints associated with accessing this information. For instance, data is not publicly available at the local authority level and would need to be obtained by physically visiting each of the approximately 340 local authorities. Further, disaggregated data for the health sector is not available at this level.

The brief was developed under several constraints:

✚ First, availability of and comparability of data/information varied over time. These variations are seen across

the central government and the nine PCs. For example, while central government budgets are available in electronic format, this is not the case with PCs. Instead, in the case of PCs, past budgets need to be physically sourced directly from these entities.

✚ Second, as a result of the delay in the release of budgets (see Sri Lanka Budget Brief 2019: Cycle & Processes) and ensuing time constraints, 2019 budget data at the PC level was not obtained. Moreover, disbursements at the local authority level have not been considered in this analysis.

✚ Finally, ministries apart from the line ministry also perform a few functions related to health. However, due to the highly scattered nature of such funding among various ministries, and due to the health component forming an insignificant proportion of their budgets, these monies have not been added to the central government health allocations used for this brief.

2. HOW IS THE HEALTH SECTOR DEFINED?



The public health sector consists of institutions that are funded by national and sub-national government budgets.

Although private health spending is significant, the scope of this report is limited to public health expenditure.

2.1 Institutional framework

Since 1987, health has been a partially devolved subject under the 13th amendment to the Sri Lankan Constitution. The Ministry of Health, Nutrition and Indigenous Medicine (MoH), also referred to as the line ministry¹, is the apex body at the central government level responsible for managing and developing the country's health sector.² This line ministry has authority over policy-making and strategic planning, financial management, health sector monitoring and evaluation and is responsible for regulating both public and private provision of healthcare. PCs³ and local government entities are entrusted with healthcare delivery of preventative and primary curative services and a significant share of secondary health services. These services are provided by nine provincial ministries under their respective PCs. While

the central government line ministry oversees policy and manages large specialized hospital services, provincial ministries manage regional access to healthcare.⁴

Additionally, there are four statutory boards and four state-owned enterprises (SOEs) under the line ministry operating in the health sector. The statutory boards are the Sri Lanka Medical Council, the Public Health Services Regulatory Council, the National Authority on Tobacco and Alcohol, and the National Medicines Regulatory Authority. The four SOEs are the State Pharmaceutical Corporation, the State Pharmaceutical Manufacturing Corporation, Sri Lanka Thripasa Ltd., and the Sri Lanka Ayurvedic Drug Corporation.⁵

1. Name of ministry as at 233th January 234.

2. The line ministry is also responsible for training health resources personnel. Doctors, for example, that trained either in state universities locally or recognized medical institutions internationally are recruited and deployed across the island by the ministry.

3. Constitutionally assigned powers over PCs' governance of the health sector are broad. According to Schedule Nine of the Constitution, PCs are assigned: (i) Health: establishment and maintenance of public hospitals, rural hospitals, maternity homes, dispensaries (other than teaching hospitals and hospitals established for special purposes); public health services, health education, nutrition, family health maternity and child care, food and food sanitation, environmental health; formulation and implementation of a province's Health Development Plan and Annual Health Plan; provision of facilities for all institutions under the province as stated previously, excluding the procurement of drugs. (ii) Indigenous medicine (Ayurveda, Siddha and Unani): establishment of ayurvedic dispensaries and hospitals; establishment and maintenance of herbaria.

4. Additionally, the military (Sri Lanka Army, Navy and Airforce) have autonomy over their hospitals. Health and nutrition programmes are conducted across government, including at the local authority level (such as is MCs, UCs and PSs).

5. Medical Statistics Unit, Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka, Annual Health Bulletin 235 (236), p.237–238.

TABLE 1 | Number of Healthcare Institutions by Ownership, as at August 2017

	Line Ministry	Provincial Ministries	Other Ministries
Administration & Evaluation			
<i>(including the MoH Office and the Ministry & Department Head Office,)</i>	3	394 ⁱ	-
Hospitals			
* Teaching	21	-	-
* Provincial General	3	-	-
* District General	10	9	-
* Base – Types A & B	8	71	-
* Divisional – Types A, B & C	5	485	-
* Specialty	3	1	-
* Prison & Rehabilitation	8	19	-
* PMCU	1	505	-
Other Clinics	1	104	-
Programmes / Campaigns			
Medical Education & Training Facilities			
* Faculty of Medicine	-	-	7
* NTS	18	-	-
* NIHS	1	-	-
* MLTT	3	-	-
* Training	9	2	-
* RTC	-	2	-
* Other	-	-	-
Other Health & Research Services			
* Bio-Medical Engineering	1	4	-
* Food and Nutrition	3	-	-
* Laboratory	1 ⁱⁱ	1	-
* Mental health related	2	1	-
* Port related	4	-	-
* Other ⁱⁱⁱ	9	2	2

Note: MoH = Ministry of Health; PMCU = Primary Medical Care Unit; NTS = Nurses Training Schools; NIHS = National Institute of Health Sciences; MLTT = Medical Laboratory Technician Training; RTC = Regional Training Centre.

Source: Ministry of Health, Nutrition and Indigenous Medicine, Website – Health Institution Numbers (HIN).

2.2 Strategic and Policy Framework⁶

The health sector is guided by the *National Health Strategic Masterplan 2016–2025* and other related strategies, such as the *National Strategic Plan on Child Health 2018–2025*, the *National Strategy for Infant and Young Child Feeding 2015–2020*, and the *National Strategic Plan on Maternal and Newborn Health 2017–2025*. The government has committed to achieving universal coverage, according to the Sustainable Development Goals' (SDGs) principle of 'leaving no one behind', by making efforts to ensure equity in service distribution, including for migrants as expressed in its *National Migration Health Policy*.

Through the *National Health Strategic Masterplan for 2016–2025*, the Government commits to developing people-centred healthcare, in the form of universal coverage. More specifically, this Health Master Plan, developed by the line ministry to inform the strategic direction of the sector for the next decade, sets out five categories: (i) framework for development of health services; (ii) preventive services; (iii) curative services; (iv) rehabilitative services; and (v) health administration and human resources for health. At its core, the plan prioritizes universal health coverage by providing solutions

to bridging identified policy/implementation gaps in four target areas. The status of universal health coverage in obtaining a specific service is assessed along four dimensions: (a) equity of distribution of services to all patients; (b) accessibility for each patient; (c) quality of services provided to each patient; and (d) financial protection of patients.

The Government of Sri Lanka has laid out strategic objectives specifically targeting newborn, and child and maternal health. In the *National Strategic Plan on Maternal and Newborn Health*, the government seeks to strengthen and invest in improving the quality of maternal and newborn care and address primary causes of maternal, perinatal and neonatal mortality and morbidity. In the latest *National Strategic Plan on Child Health*, the government has set out its objectives of strengthening nutrition promotion and growth monitoring, preventing childhood illnesses and injuries, achieving universal curative childcare, and focusing specific attention to underserved geographic areas and children with special needs. Finally, in the *National Strategy for Infant and Young Child Feeding*, Sri Lanka aims to improve overall child nutrition and address child malnutrition issues.

TABLE 2 | Health Sector Strategic Documents–Summary

Strategic Plan	Goals
National Health Strategic Masterplan 2016–2025 ^v	Developing people-centred healthcare, expressed in universal coverage: <ol style="list-style-type: none"> Equity of distribution of services to all patients living in all areas of the country Accessibility to health facilities by every patient Quality of service provided to each patient Financial protection of all patients
National Strategic Plan on Maternal and Newborn Health 2017–2025 ^v	Strengthen and invest in improving quality of maternal and newborn care Address main causes of maternal, perinatal and neonatal mortality and morbidity
National Strategic Plan on Child Health in Sri Lanka 2018–2025 ^{vi}	<ul style="list-style-type: none"> Strengthen nutrition promotion and growth monitoring Provide supportive environment for child growth and development, paying attention to children with special needs Prevent childhood illnesses and injuries Strengthen school health programs and interventions Improve access to healthcare for vulnerable children Achieve universal curative childcare Pay specific attention to underserved geographic areas and children with special needs
National Strategy for Infant and Young Child Feeding Sri Lanka 2015–2020 ^{vii}	<ul style="list-style-type: none"> Improve overall child nutrition Address child malnutrition issues
Sri Lanka Every Newborn Action Plan (SLENAP) 2017–2020 ^{viii}	Reduce neonatal mortality rate from 6.5/1000 live births (2013) to 4.2/1000 live births by the end of 2020 Reduce the stillbirth rate from 6.4/1000 births to 4.5/1000 births by the end of 2020

6. This section describes the strategic framework of the public health sector. At the time of writing, performance reports pertaining to the strategic plans listed here were not publicly available. Hence, this section is only for descriptive purposes, and the performance analysis carried out later in this brief is not linked to the strategic framework set out here, but rather to Sri Lanka's Sustainable Development Goals (SDGs).

Budget and Expenditure Analysis

This section of the brief analyses public sector spending trends in Sri Lanka’s health sector. This analysis is based exclusively on budget and expenditure data that is publicly available. Specifically, this section focuses on budget and expenditure trends for the years 2012–2018 at the central

and provincial government levels. Budget analyses for 2019 are limited to the central government level due to a lack of publicly available data at the provincial level, as at the time of writing.

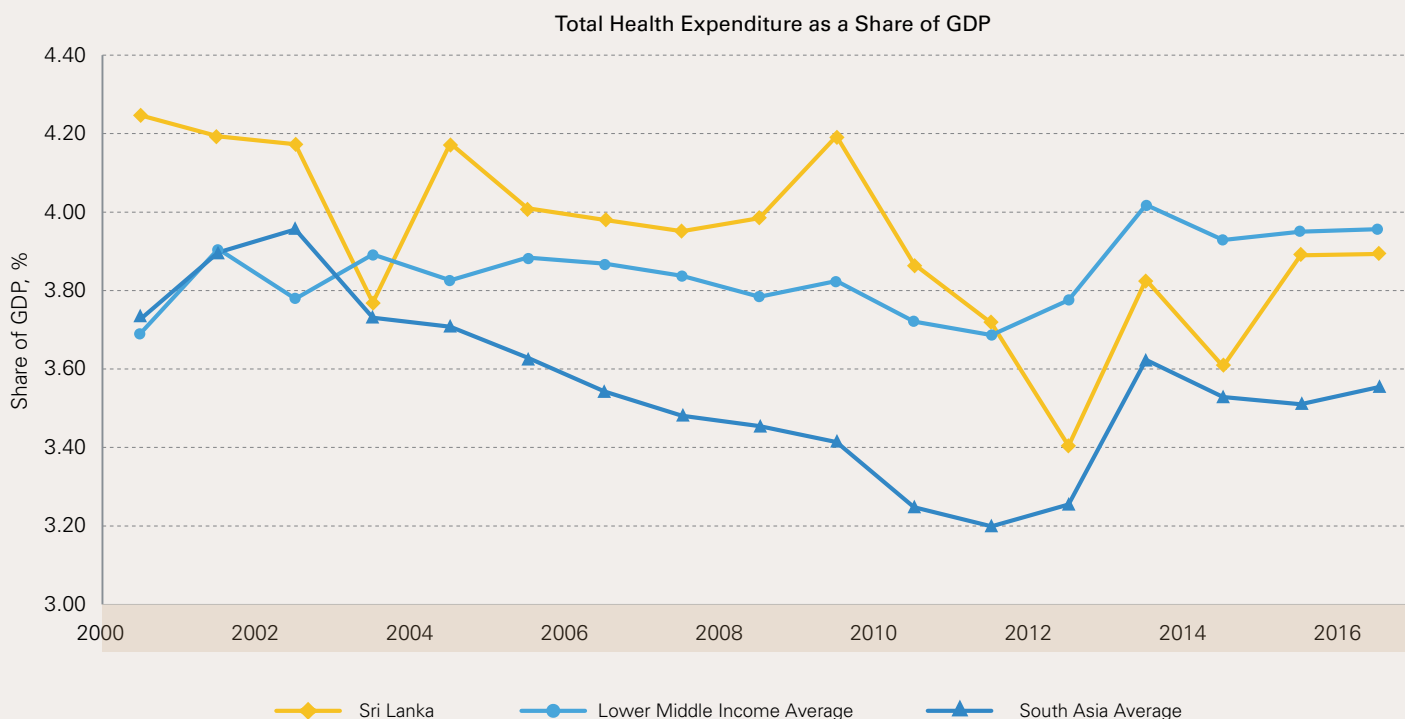
3. WHAT TRENDS EMERGE FROM THE HEALTH SECTOR BUDGET AND EXPENDITURE?



As per World Bank data, Sri Lanka’s total health expenditure as a share of GDP is 3.9 percent in 2016. (see Figure 1). This figure has slightly reduced from 4.1 percent in the year 2000. When comparing with peers, the share of health expenditure to GDP has increased from 3.7 percent to 4 percent for lower middle income countries while it decreased from 3.7 percent to 3.6 percent for South Asia.⁷ However, expenditure is higher in upper middle-income countries (5.9 percent of GDP), among whom Sri Lanka is categorized as of 2019. Domestic public health expenditure

accounted for 1.6 percent of GDP in 2016 and 2.3 percent in 2000. Although the share has dropped over time, Sri Lanka compares favourably with regional and income peers. Lower middle-income countries’ public health expenditure was 1.3 percent of GDP in 2016, an increase from 1.1 percent in 2000, and South Asia’s public health expenditure has averaged around 0.9 percent through the last decade. For upper middle-income countries, this figure rose from 2.9 percent in 2000 to 3.2 percent in 2016.

FIGURE 1 | Sri Lanka’s total health expenditure as a share of GDP



Source: World Bank, World Data Indicator Database.

The 2019 Approved Budget at the central level allocated LKR 185.5 billion for the health sector (see Figure 2). This represents a nominal increase of 4 percent relative to the approved budget estimates for 2018. In real terms, the 2019 central-level approved budget for the health sector decreased by approximately 1 percent relative to the 2018 central-level approved budget and by 5 percent relative to the 2018 revised estimate.

Aggregate health budget allocations have trended upward in the last six years both in nominal and real terms. Assessing aggregate budget allocations for the central and provincial levels, the health sector’s approved budgets increased by 85 percent in nominal terms and by 51 percent in real terms between 2013 and 2018.

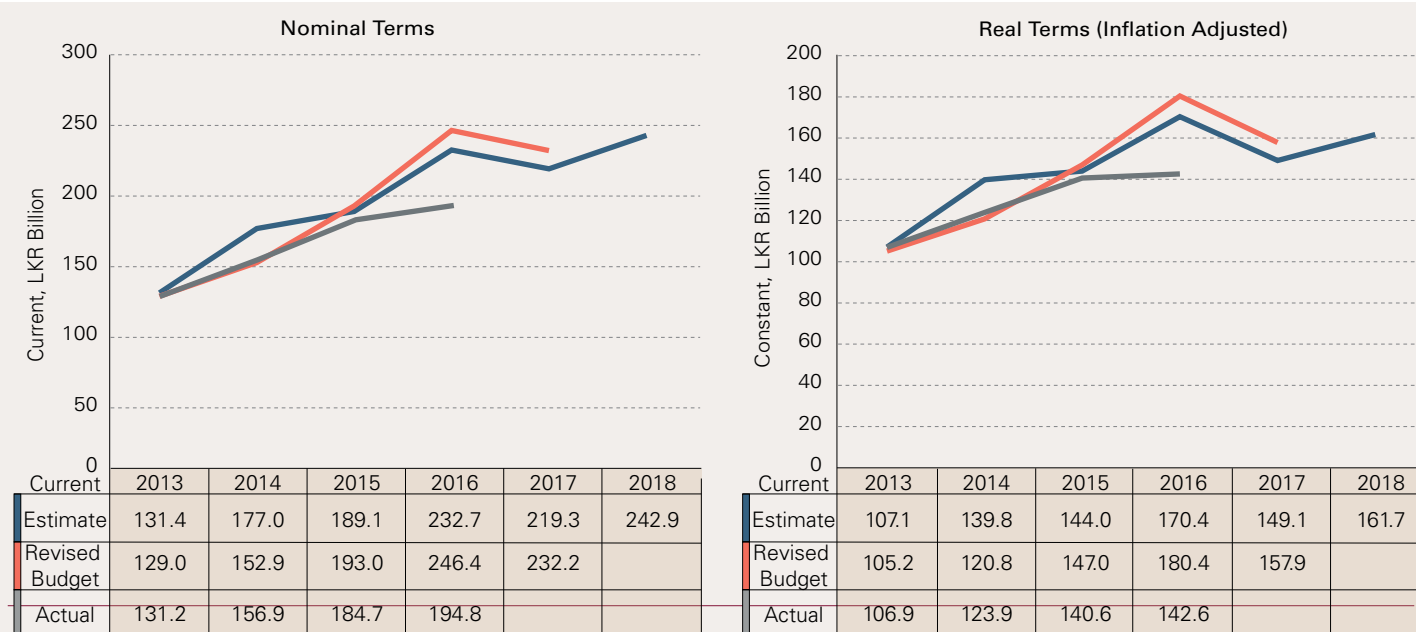
As a share of total health expenditure in Sri Lanka, domestic public expenditure decreased; external public expenditure remained stable, and both domestic private expenditure and out-of-pocket expenditure increased (see Figure 3). According to the World Bank, domestic public health expenditure as a share of total health expenditure decreased from 53.6 percent in 2000 to 43.1 percent

in 2016. Nevertheless, this share still substantially exceeds that of lower-middle income countries (which increased from 30 percent in 2000 to 32.2 percent in 2016) and of South Asia overall (which increased from 23.5 percent to 25.5 over the same period).

During the period 2000 to 2016, external health expenditure as a share of total health sector spending increased from 0.9 to 1.1 percent for Sri Lanka. Over the same period, lower middle-income countries’ external health sector spending increased from 2.7 to 3.2 percent, and that of South Asia dropped from 2.8 to 2.1 percent.

Sri Lanka’s domestic private health expenditure as a share of total sector spending increased from 45.5 percent in 2000 to 55.8 percent in 2016. Out-of-pocket expenditure, which accounts for the bulk of private health expenditure, increased from 40 percent of total sector expenditure in 2000 to 50.1 in 2016. Private health expenditure and out-of-pocket health expenditure as a share of total sector spending remain lower in Sri Lanka than in lower middle-income nations and South Asian peers.

FIGURE 2 | Health sector budgetary allocations



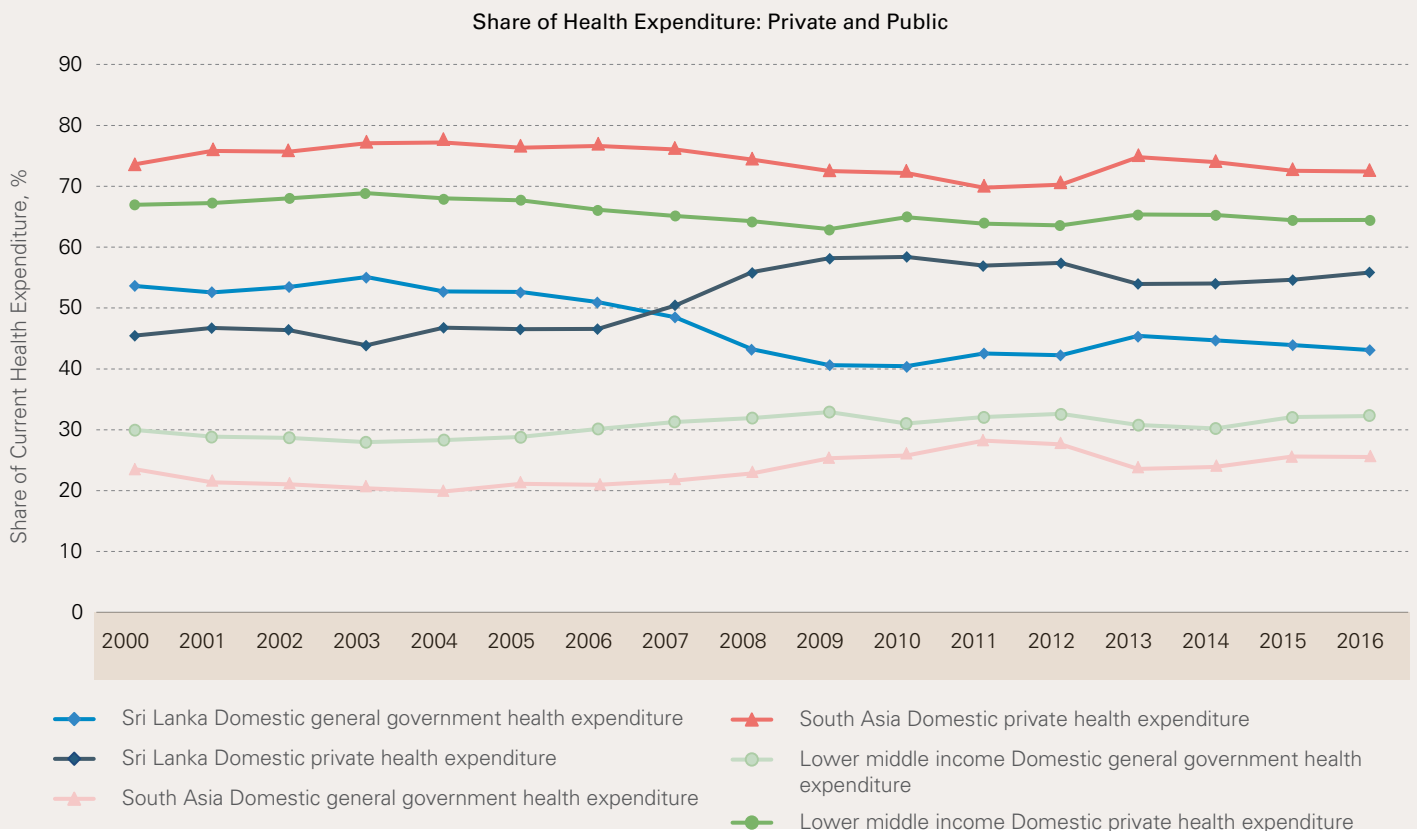
Source: Author’s own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019 and Provincial Council Budget Estimates 2013–2018.

Note: At the time of writing this brief, the 2017 public expenditure accounts had yet to be finalized.

7. Although Sri Lanka is an upper middle-income country in 239, it was a lower middle-income country in 240 when the data is reported. Therefore, we compare Sri Lanka with lower middle-income countries.



FIGURE 3 | Share of health expenditure: private and public



Source: World bank, World Development Indicator database.



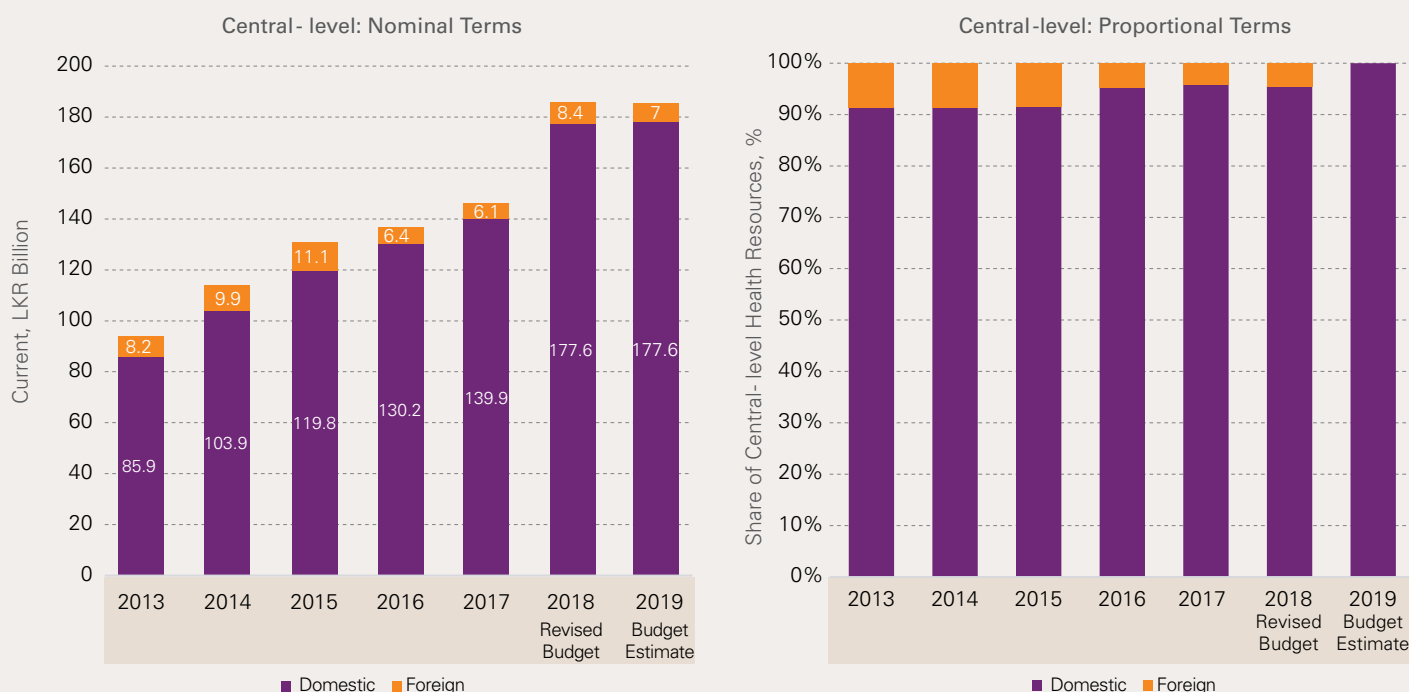
4. WHERE DO HEALTH RESOURCES COME FROM?

The health sector is financed by both domestic and foreign financing at the central (i.e. line ministry) and PC levels. Tax revenue, other government receipts and domestic borrowings provide most of the domestic contributions. Foreign financing consists of grants from international organizations/development partners and external borrowings. Foreign financing is channelled directly through the Treasury at the central level and through the Finance Commission [FC] (which in turn receives the funds from Treasury) at the PC level.⁸ At all levels of government, including at the lower tiers, the Treasury is the main channel of both domestic and foreign financing, although health revenue is also raised at the local administration levels.⁹

Government spending on the health sector in Sri Lanka is mostly financed through domestic resources

(see Figures 4 and 5). At the central level, domestic financing averaged 94 percent of health sector resources while foreign resources averaged 6 percent between 2013 and 2019. In the 2019 central-level approved budget, the domestic to foreign resources ratio in the health sector stands at 96 percent to 4 percent. At the provincial level, the internal to external resources ratio was 97 percent internal to 3 percent external resources for the 2013–2018 period.¹⁰ Donors make only a minor contribution to the country’s health budget, with most external resources coming in the form of loans (see Figure 4). Annual disbursements of Official Development Assistance (ODA) funds dedicated to health, recorded by the Department of External Resources (ERD), declined significantly from USD 773.6 million in 2012 to USD 85.1 million in 2018.¹¹

FIGURE 4 | Health sector sources of funding at central level



Source: Author’s own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019.

8. S. N. Amarasinghe, K. C. S. Dalpatadu, and R. P. Rannan-Eliya, Sri Lanka Health Accounts: National Health Expenditure 241–242 (Institute for Health Policy 243), IHP Health Expenditure Series (244), p.245–246.

9. For more information on provincial administration financing mechanisms, see: Sri Lanka Budget Brief 247: Cycle & Processes.

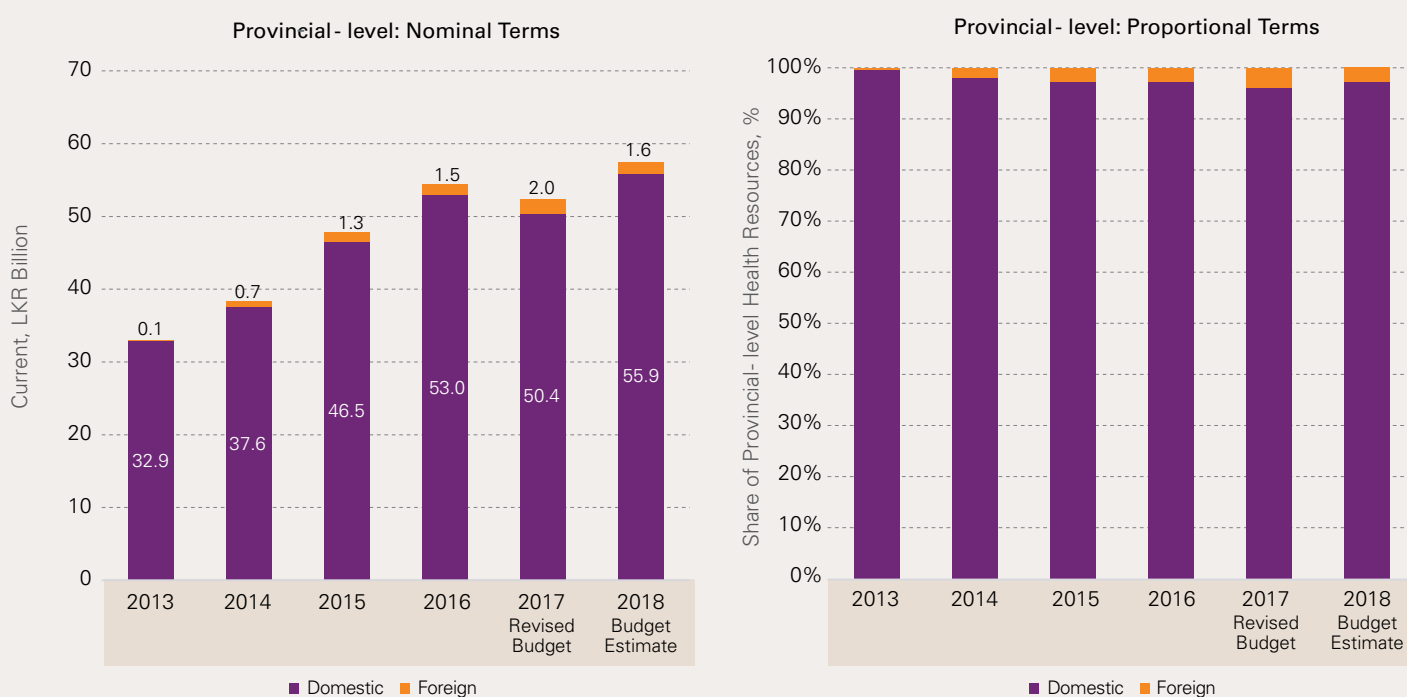
10. This figure only includes 248–249 data as 250 PC data is not available at the time of writing. Also, the figure does not include the Eastern and Central PCs for which it is not possible to identify financing sources.

11. Department of External Resources. Available at: http://www.erd.gov.lk/index.php?option=com_content&view=article&id=94&Itemid=216&lang=en#summary-of-foreign-financing-disbursements-of-official-development-assistance-2018

Development finance institutions have recently committed funds to strengthening Sri Lanka’s health-care system (see Figure 6). In 2018, the World Bank Group approved a USD 200 million loan for Sri Lanka’s primary healthcare to improve detection and management of NCDs in high-risk population groups, aiming to address

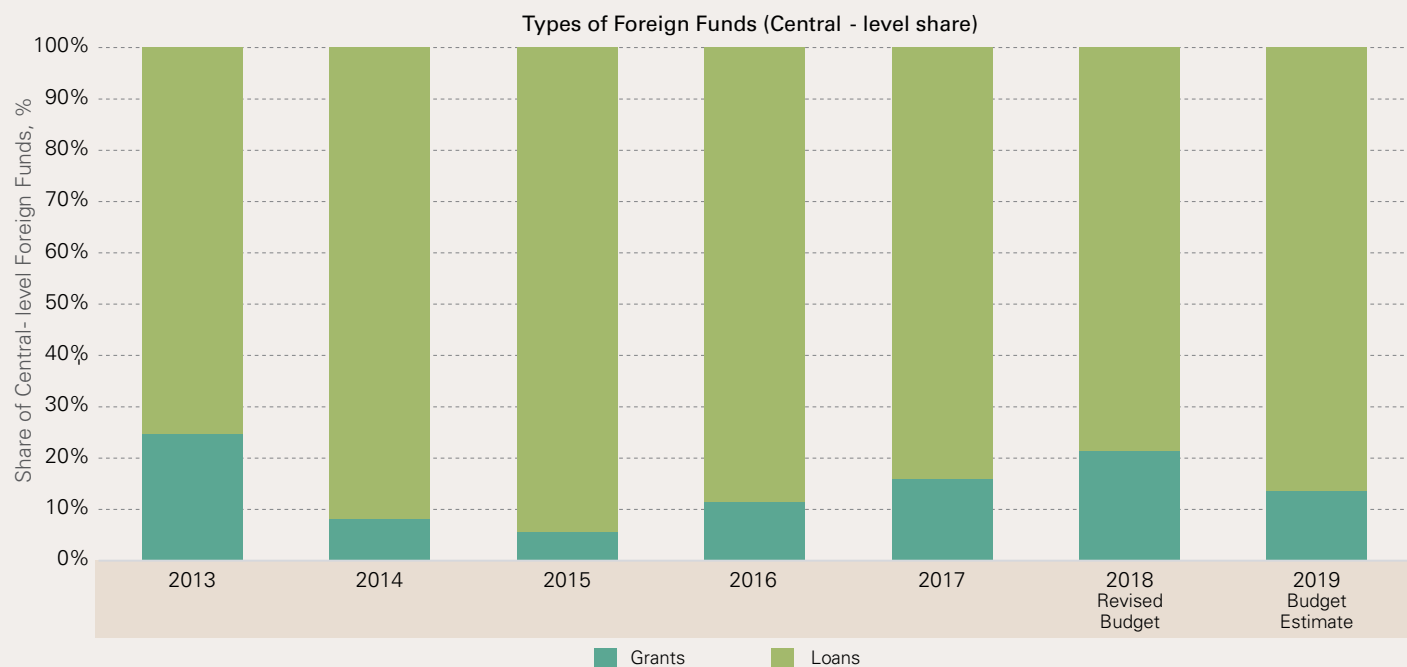
one of the health sector’s most pressing needs.¹² In the same year, the Asian Development Bank also approved a grant and loan package of USD 50 million to support the development of a more efficient and responsive primary healthcare system in four underserved provinces.¹³

FIGURE 5 | Health sector sources of funding at provincial level



Source: Author’s own calculation using Provincial Council Budget Estimates 2013–2018.

FIGURE 6 | Types of foreign funds



Source: Author’s own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019

12. ‘Sri Lanka to Improve Its Primary Healthcare Services’, The World Bank Website, 251 June 252. Available at: <https://www.worldbank.org/en/news/press-release/2018/06/27/sri-lanka-improve-its-primary-healthcare-services>

13. ‘ADB Provides \$253 Million to Enhance Sri Lanka’s Health System’, Asian Development Bank Website, 254 October 255. Available at: <https://www.adb.org/news/adb-provides-50-million-enhance-sri-lankas-health-system>



5. HOW ARE HEALTH SECTOR RESOURCES SPENT?

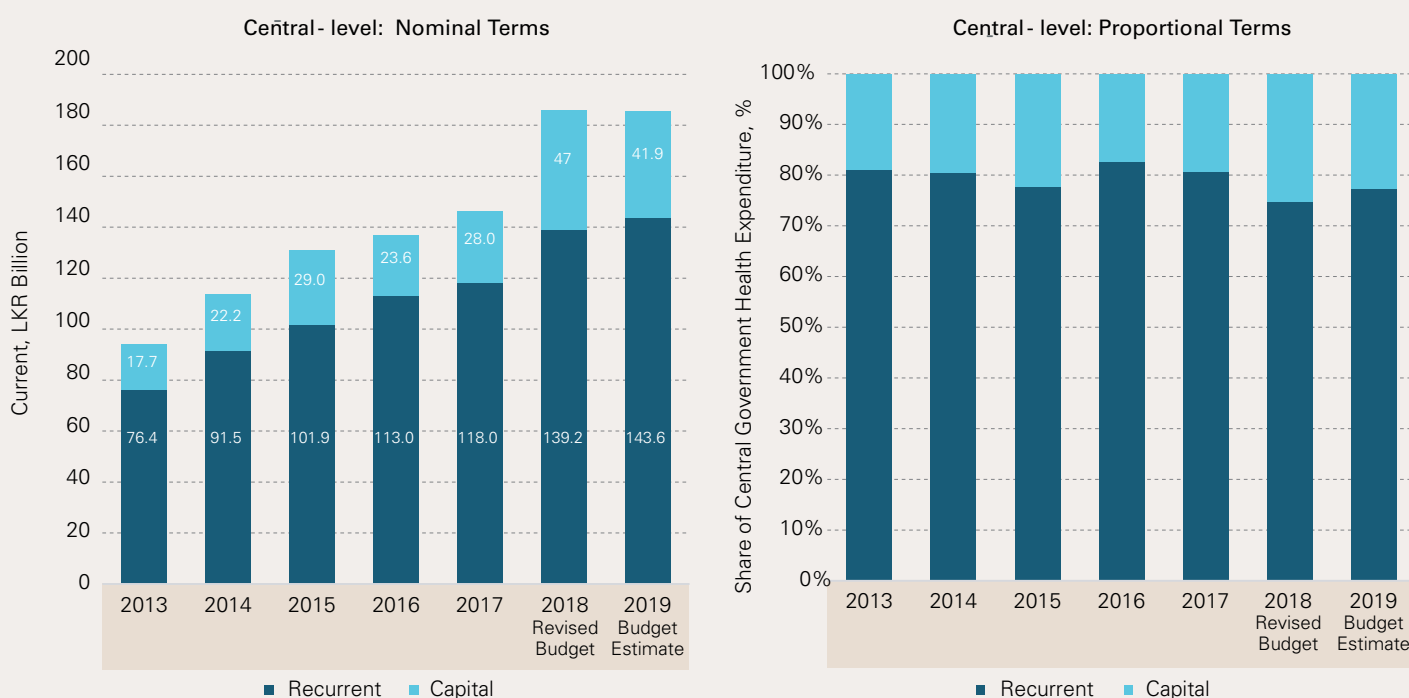
5.1 Recurrent versus capital expenditure

Public health spending in Sri Lanka is divided into recurrent and capital expenditure. Recurrent expenditure refers to spending on salaries/remunerations, goods and services, operating costs, transfers, and financial operations. Capital expenditure refers to spending aimed at improving access to health services and quality care (e.g. construction of clinics and hospitals, training of doctors and nurses, etc.).

Most of Sri Lanka’s public health expenditure is recurrent (see Figures 7 and 8). Between 2013 and 2018,

recurrent spending averaged 78 percent of total public health expenditure at the central level. At the PC level, recurrent expenditure averaged an even higher 94 percent of total public health spending. In the 2019 central-level health sector budget, the recurrent-to-capital spending ratio stands at 77 percent to 23 percent. Capital expenditure at the central level is predominantly allocated for the development of hospitals, whilst almost the entirety of recurrent expenditure is for the operation of hospitals and provision of medical supplies.

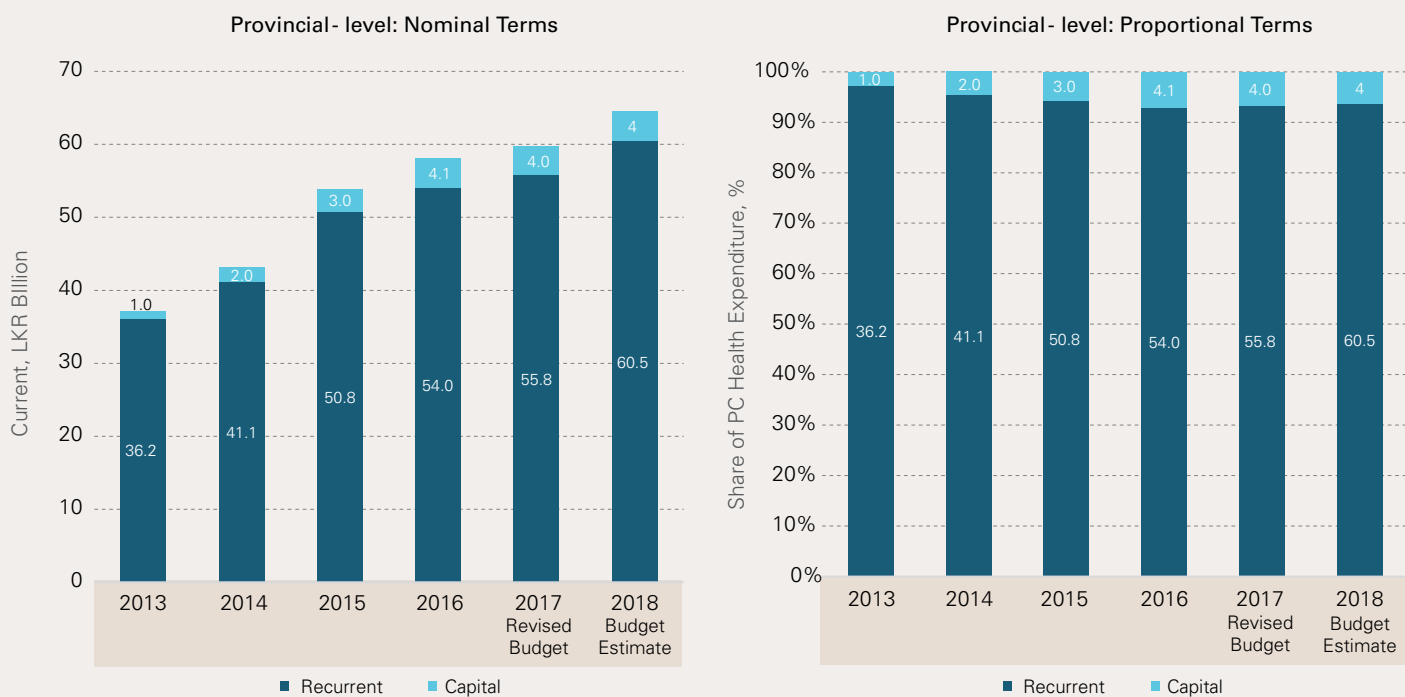
FIGURE 7 | Health sector recurrent versus capital expenditure at the central level



Source: Author’s own calculations using Ministry of Finance and Mass Media, Budget Estimates 2013–2019.



FIGURE 8 | Health sector recurrent versus capital expenditure at the provincial level



Source: Author's own calculation using Sri Lanka's Provincial Council Budget Estimates 2013–2018.

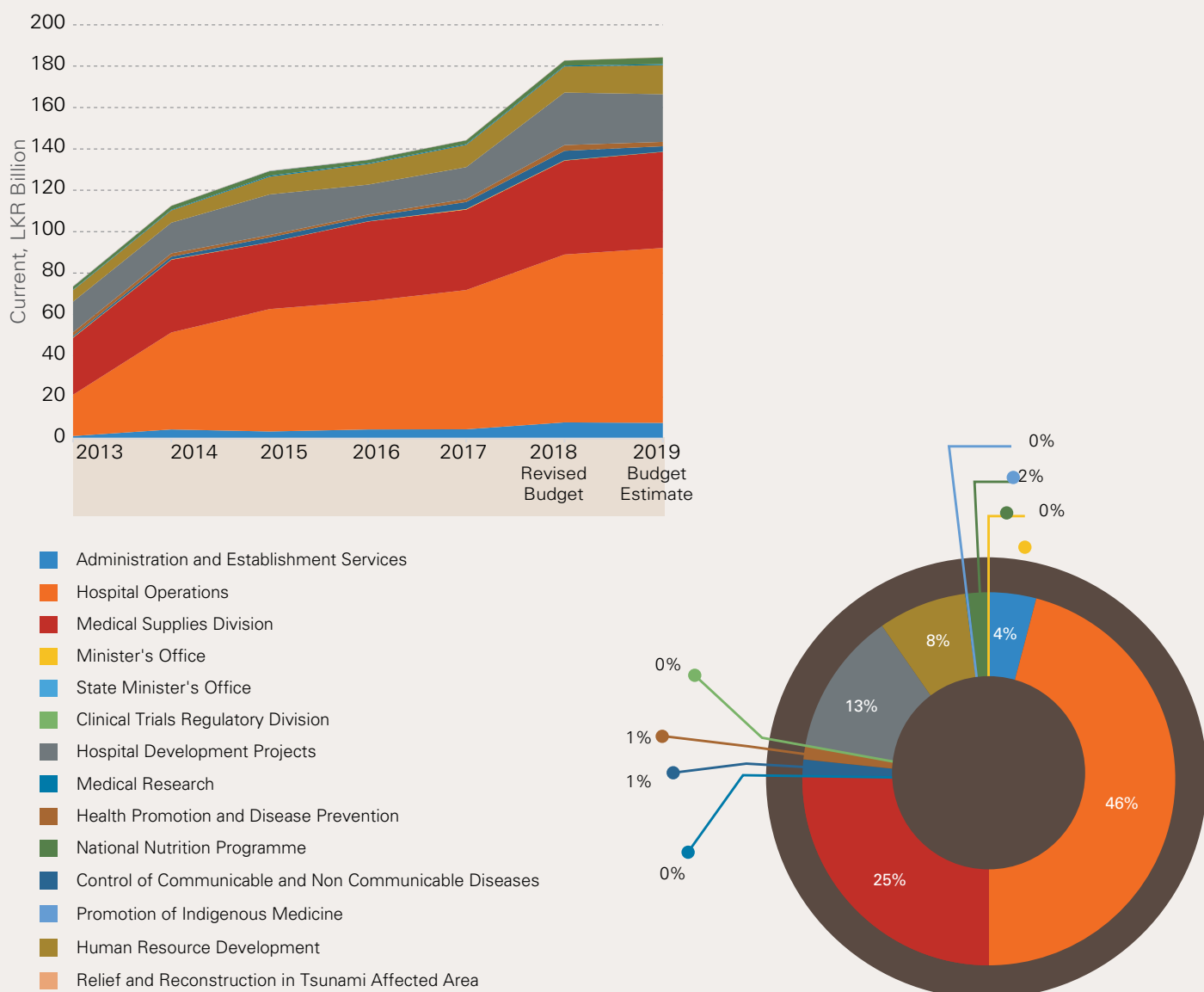
Note: At the time of writing, the 2017 public expenditures accounts had yet to be finalized; therefore 2017 numbers represent Revised Budget, 2018 represents Budget Estimate, while 2013 through 2016 represent actual expenditure.

5.2 Spending by functional classification¹⁴

Hospital operations and medical supplies dominated the expenditure of the Ministry of Health, Nutrition and Indigenous Medicine between 2013 and 2019 at the central level (see Figure 9). In the 2019 Budget, these two categories, both included in operational spending, received LKR 84.6 billion (46 percent of the line ministry's resources) and LKR 46.5 billion (25 percent of the line ministry's resources), respectively. Hospital development projects and human resource development have also been allocated substantial amounts of funding in 2019: LKR 23 billion (13 percent of the line ministry's budget) and LKR 14.2 billion (8 percent of the line ministry's budget), respectively. On the preventive side, control of communicable

and NCDs was allocated LKR 2.6 billion (1.4 percent of the line ministry's budget), while health promotion and disease prevention were allocated LKR 2.2 billion (1.2 percent of the line ministry's budget), in the 2019 central-level budget. While allocation to the former decreased by 24 percent relative to 2017 and by 43 percent relative to the 2018 revised budget, that of the latter increased by 42 percent relative to 2017 but decreased by 22 percent relative to the 2018 revised budget. The allocation for the National Nutritional Programme, accounting for 1.8 percent of the line ministry allocation, has increased considerably in 2019, an increase of 32 percent relative to the 2018 revised budget and 80 percent relative to 2017.

FIGURE 9 | Health expenditure functional classification



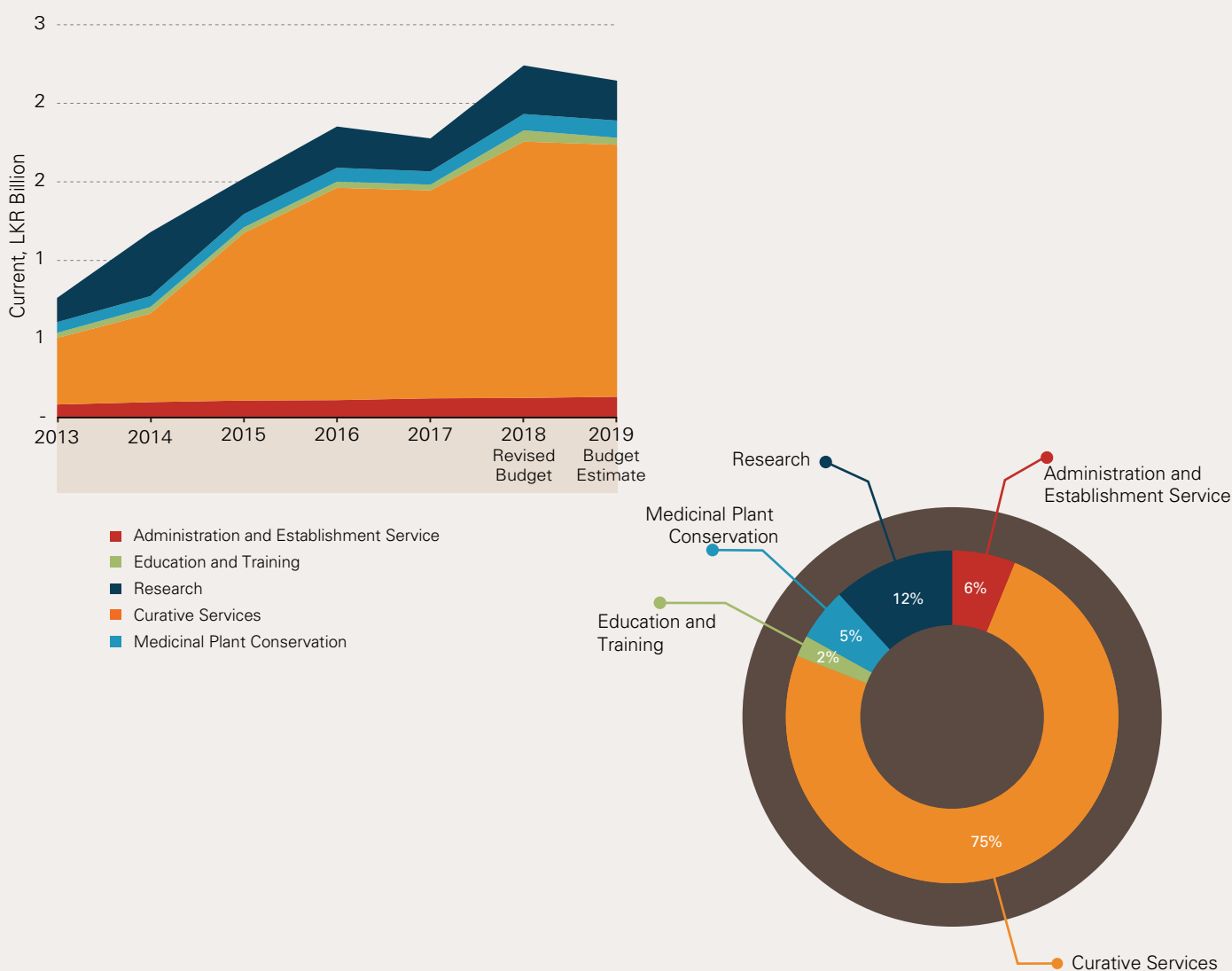
Source: Author's own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019.

14. Due to data limitations at the sub-national level, this figure only reflects programmatic classification by the line ministry.

Ayurvedic medicine spending at the central level amounts to LKR 2 billion in the 2019 approved budget, of which the largest share (i.e. 75 percent) is dedicated to curative services (see Figure 10).¹⁵ In Sri Lanka, Ayurvedic medicine is formally recognized by the state,

and falls under the Department of Ayurveda, which has a separate budget from the Ministry of Health specifically dedicated to indigenous medicine. There are 715 Ayurvedic institutions in the country, including 8 teaching and research hospitals.¹⁶

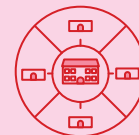
FIGURE 10 | Functional classification of the Department of Ayurveda



Source: Author's own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019.

15. Functional categories under the Department of Ayurveda include administrative costs, curative services, education and training, medicinal plant conservation, and research.
 16. Medical Statistics Unit, Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka, Annual Health Bulletin 256, p.257. Available at: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/AHB/2017/AHB_2016.pdf.

6. TO WHAT EXTENT HAS THE HEALTH SECTOR BEEN DECENTRALIZED?



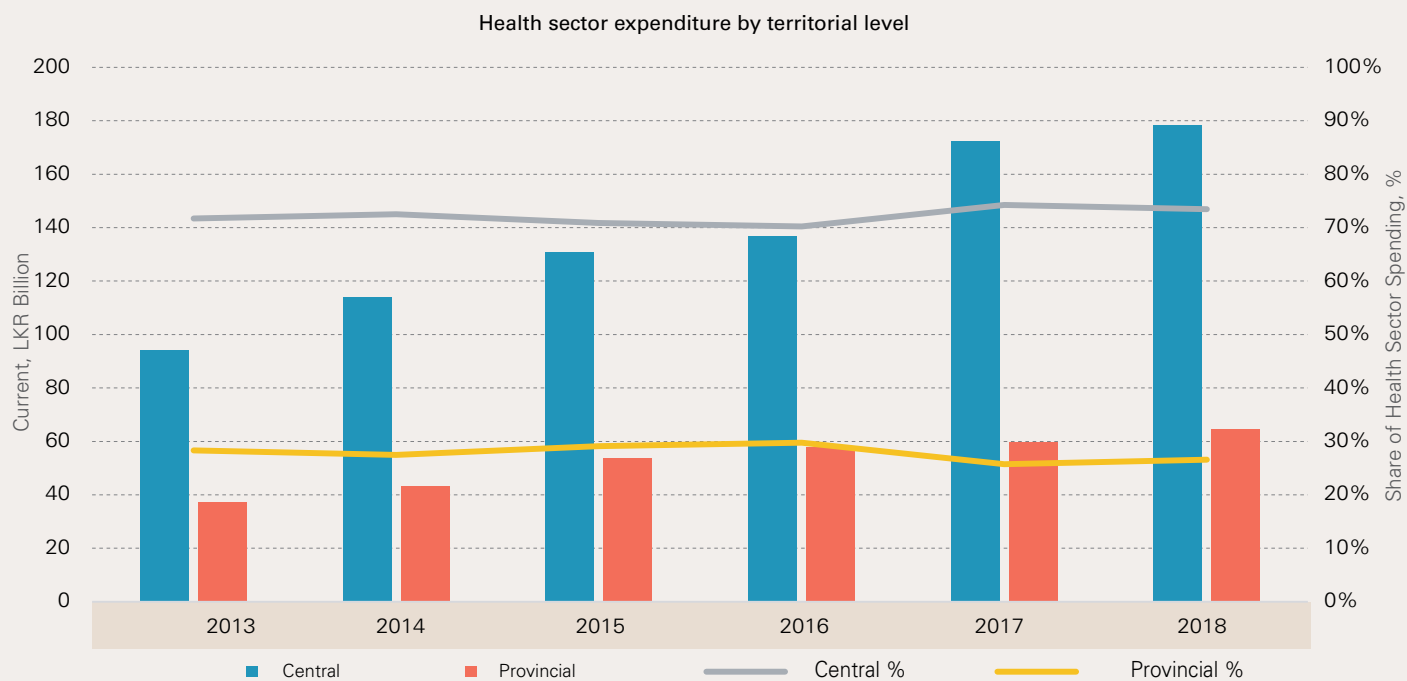
Public health spending in Sri Lanka is relatively centralized. Approximately 73 percent of resources, on average, were executed at the central level and the rest at the provincial level between 2013 and 2018 (see Figure 11). The nine Provincial Ministries of Health undertake most primary medical care services, including preventive care, and secondary levels of curative services.

The allocation of health resources, in nominal terms, varied substantially across different PCs over the years (see Figures 12, 13 and 14). The Western Province has consistently received larger shares of funding compared to other provinces. The 2018 budgeted funding for the Western Province was LKR 12.4 billion (19 percent of

provincial share), nearly double that of the second largest provincial budget assigned to the North Western Province. However, this is due to the Western Province having the largest population and hosting the largest number of healthcare facilities in the country. Health expenditure, in per capita terms, is in fact the lowest in the Western Province, accounting for LKR 2,017 in 2018 per person. The Northern Province has the largest allocation with LKR 5,701 per person in 2018. The Uva and North Central Provincial Councils received in nominal terms, in 2018, the lowest health sector budgets of LKR 5.1 and 4.7 billion, respectively. However, the same year, in per capita terms, allocations were second highest for the Uva Province and fifth highest for the North Central Province.

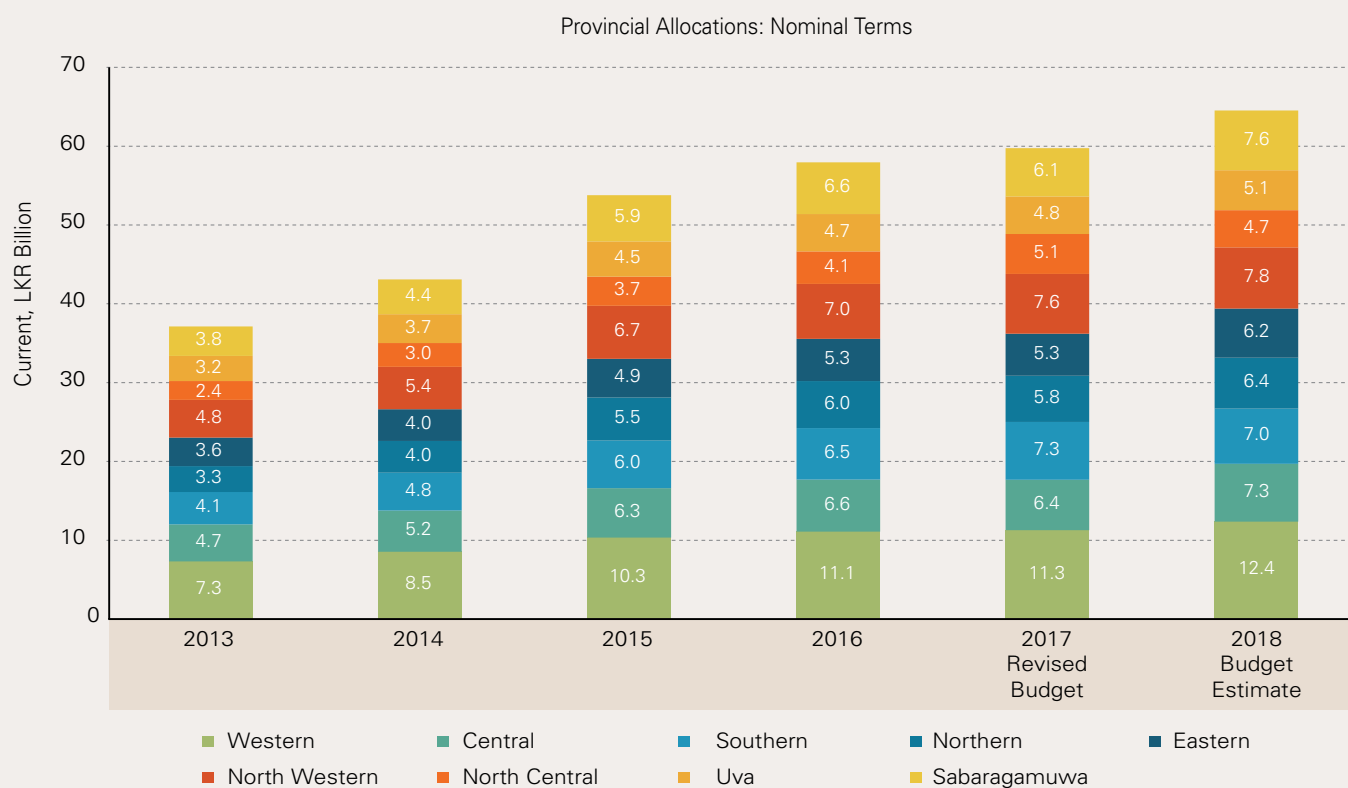


FIGURE 11 | Health sector expenditure by territorial level



Source: Author's own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2019 and Provincial Council Budget Estimates 2013–2018.

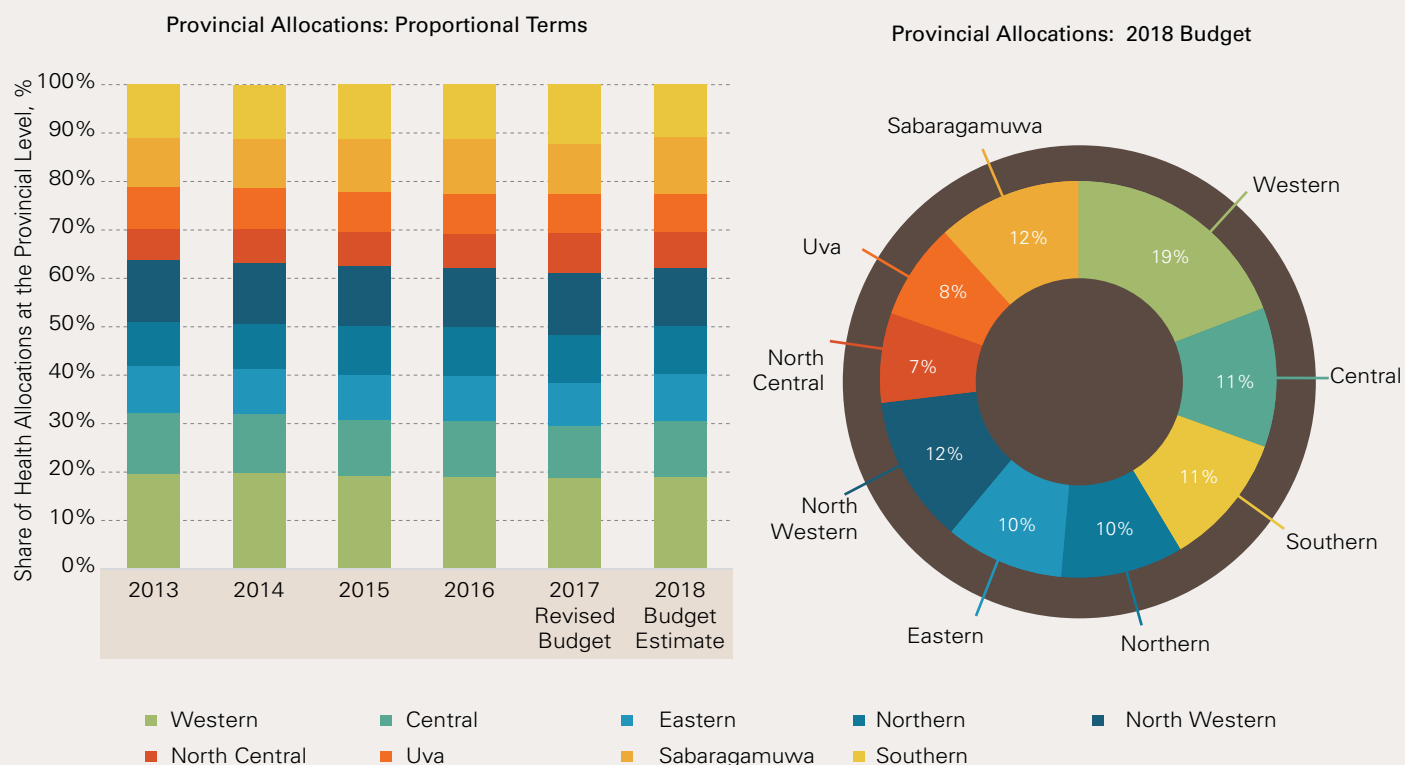
FIGURE 12 | Health expenditure by province



Source: Author's own calculations using Provincial Council Budget Estimates 2013–2018.

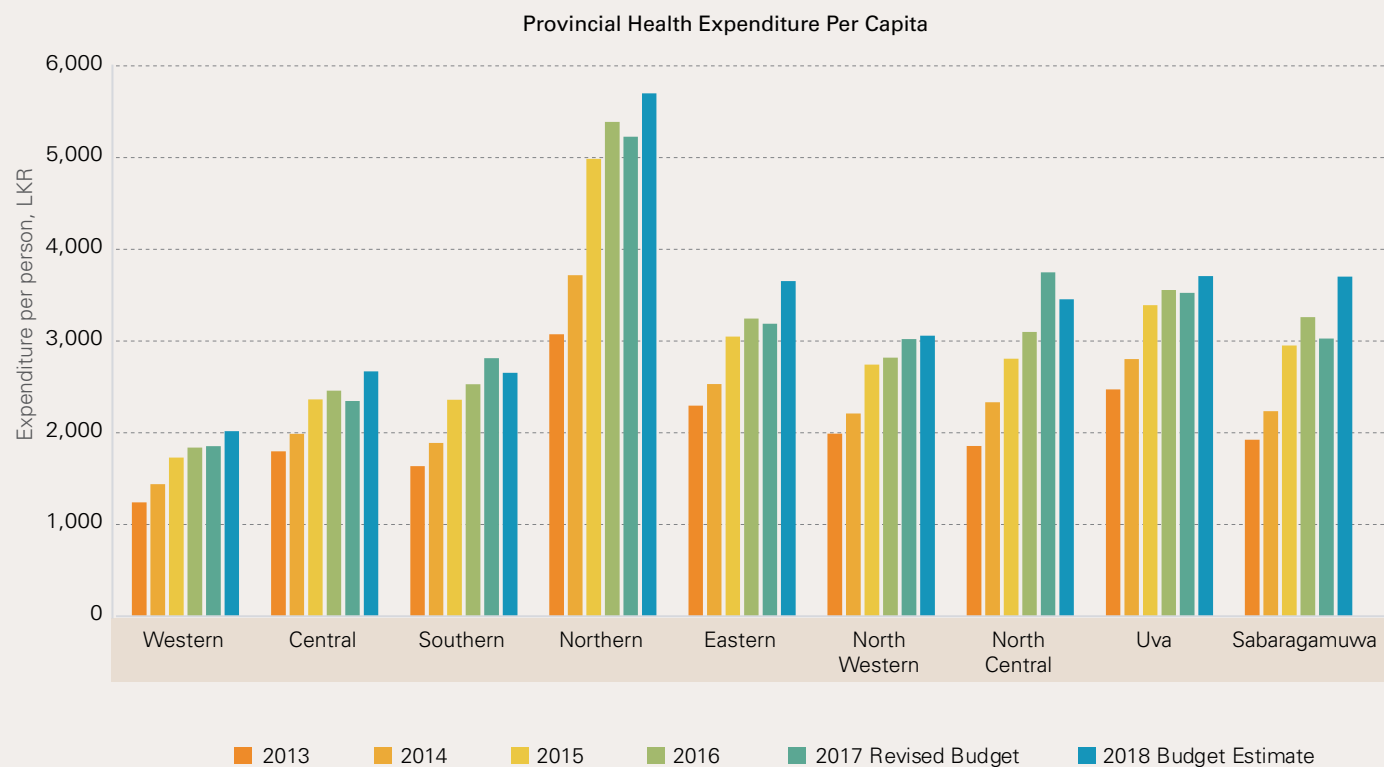
Note: At the time of writing, the 2017 public expenditure accounts had yet to be finalized, therefore 2017 numbers represent the Revised Budget, 2018 represents the Budget Estimate, and 2013 through 2016 represent actual expenditure.

FIGURE 13 | Health sector share of provincial allocations



Source: Author's own calculations using Provincial Council Budget Estimates 2013–2018.

FIGURE 14 | Provincial health expenditure per capita



Source: Author's own calculations using Department of Census and Statistics, Sri Lanka and Provincial Council Budget Estimates 2013–2018.



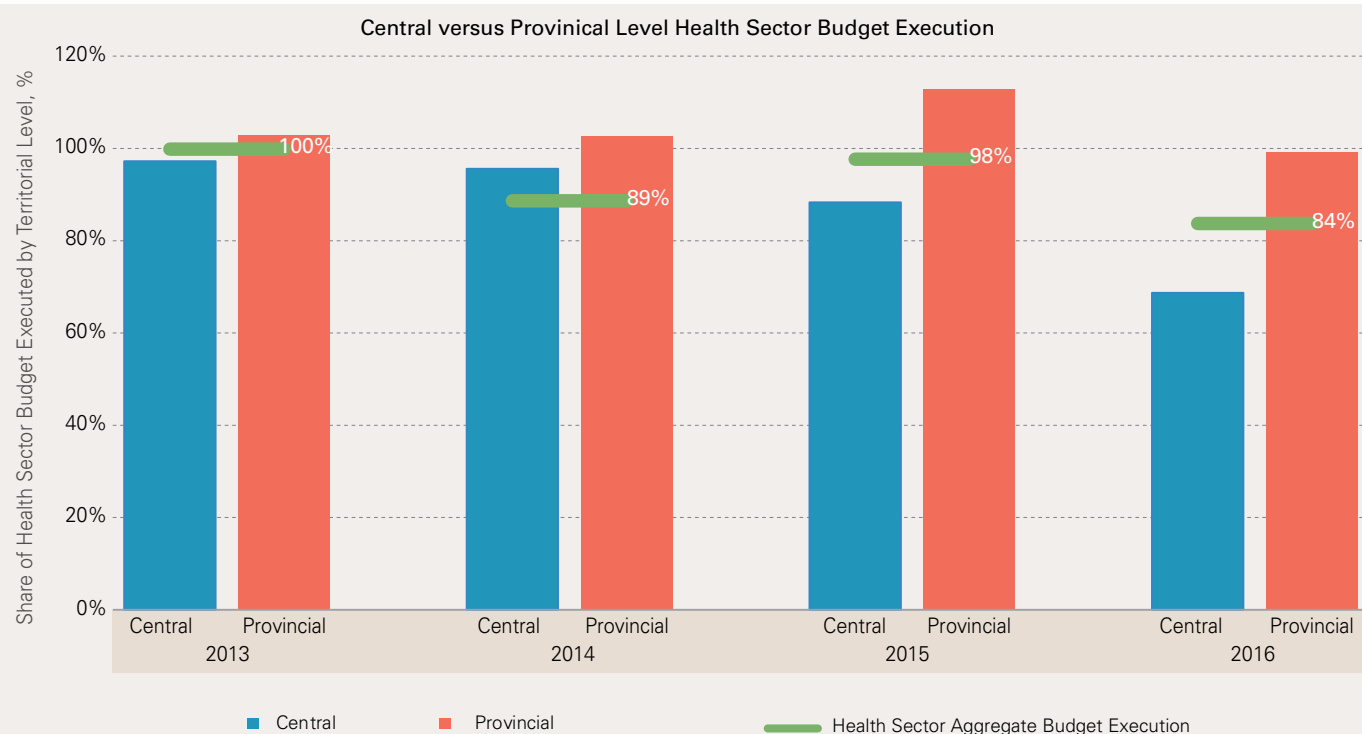
7. HOW WELL HAS THE HEALTH SECTOR EXECUTED ITS BUDGETS?



Sri Lanka's health sector executed, on average, approximately 92 percent of its budgets between 2013 and 2016 (see Figure 15).¹⁷ This is approximately 5 percentage points above the average execution rate of the central-level budget for the years 2013–2017. The allocations to the sector were fully executed in 2013, while the execution rates in 2014, 2015 and 2016 were 89 percent, 98 percent and 84 percent, respectively.

The execution rate of the sector's budget differs between central and provincial levels. Between 2013 and 2016, budget allocations at the PC level were over-executed by an average 12 percentage points. Meanwhile, the central-level budget remained under-executed with an average execution rate of 87 percent between 2013 and 2017.

FIGURE 15 | Health sector budget execution



Source: Author's own calculation using Ministry of Finance and Mass Media, Budget Estimates 2013–2018 and Provincial Council Budget Estimates 2013–2018.

17. At the time of writing, 258 execution data for PCs is not available. Hence, the latest available data of aggregate budget execution rate at the central and provincial levels is 259.

8. HOW WELL HAS THE HEALTH SECTOR PERFORMED?

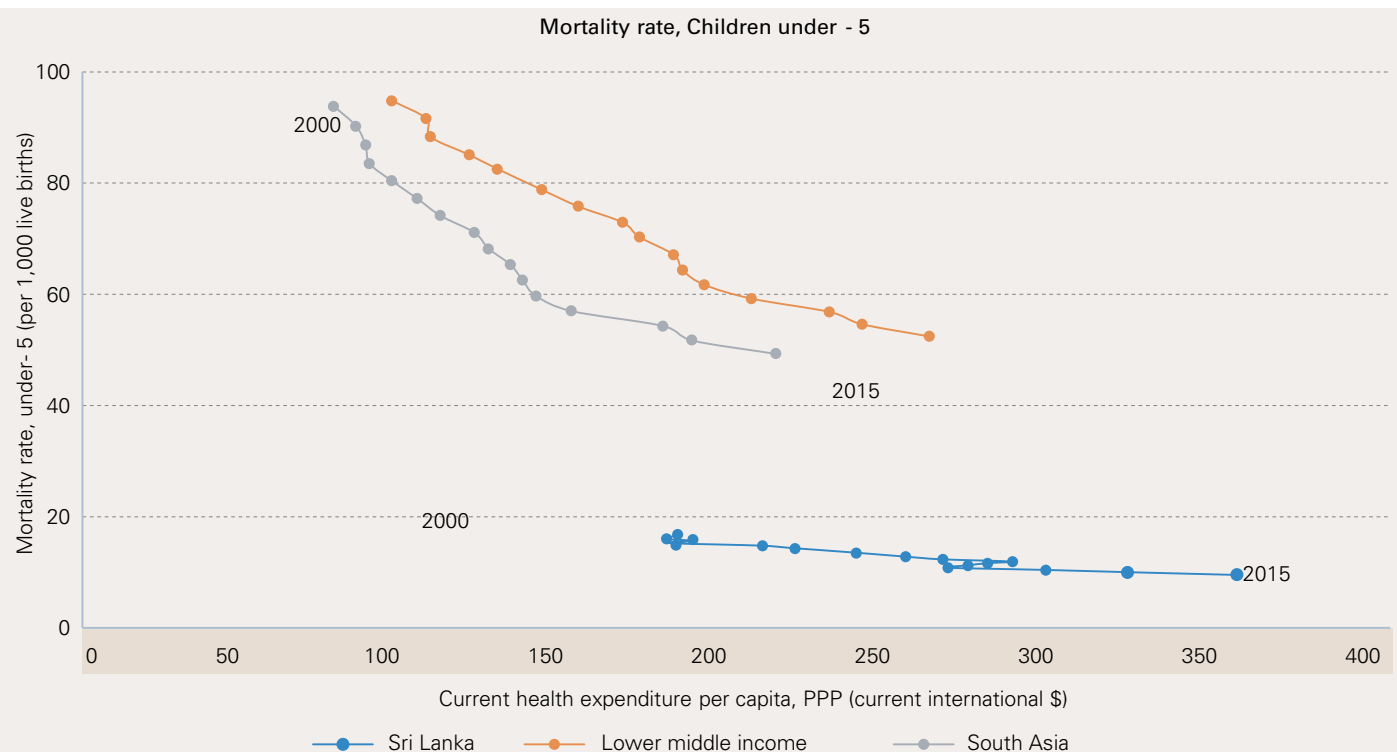


Sri Lanka has achieved significant progress in ensuring quality and universal access to health services, according to the SDG principle of ‘leaving no one behind’. Sri Lanka is lauded for strong health outcomes, low cost of health services and financial protection, which testify to the sector’s efficiency.¹⁸ Nonetheless, significant policy challenges pertaining to regional and urban disparities in access to quality healthcare, as well as a surge in NCDs related to lifestyle and an ageing population, remain. Malnutrition is also a lingering public health issue with the government currently concentrating its efforts on improving nutrition outcomes.

Sri Lanka significantly outperforms its peers on major health indicators, such as reducing the child and maternal mortality rate and increasing life expectancy at birth (see Figures 16 and 17). Sri Lanka’s child and maternal mortality indicators are already lower than the relevant targets under SDGs and are on par with those of

developed countries. SDG Target 3.2 aims to end preventable deaths of children under 5, with all countries aiming to reduce under-5 mortality to at least as low as 25 per 1000 live births. The under-5 mortality rate in Sri Lanka, already significantly lower at the baseline than that of its peers, further decreased from 16.5 in 2000 to 7.4 per 1,000 live births in 2018. At the same time, lower middle-income countries decreased their under-5 mortality rate from an average of 95.4 to 49.1, while South Asian countries on average decreased their child under-5 mortality rates from 94.0 to 42.1. SDG Target 3.1 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. In Sri Lanka, maternal mortality decreased from 56 in 2000 to 36 per 100,000 live births in 2017, according to World Bank data¹⁹. Similarly, Sri Lanka’s life expectancy at birth increased from 71 years in 2000 to 77 years in 2017, compared to the lower middle-income country average increase from 62 to 68, and the South Asian average increase from 63 to 69.

FIGURE 16 | Comparison of Sri Lanka’s mortality rate of children under 5 year with peers



Source: World Bank, World Development Indicator database.

18. Owen K. Smith, Achieving Pro-Poor Health Coverage without Health Financing Reforms (World Bank Group 260) Universal Health Coverage Study Series (261), p.262.

19. World Bank, World Development Indicators. Available at: <http://datatopics.worldbank.org/world-development-indicators/>. WHO, Tuberculosis Country Profiles: Sri Lanka (263). Available at: <https://www.who.int/tb/country/data/profiles/en/>.

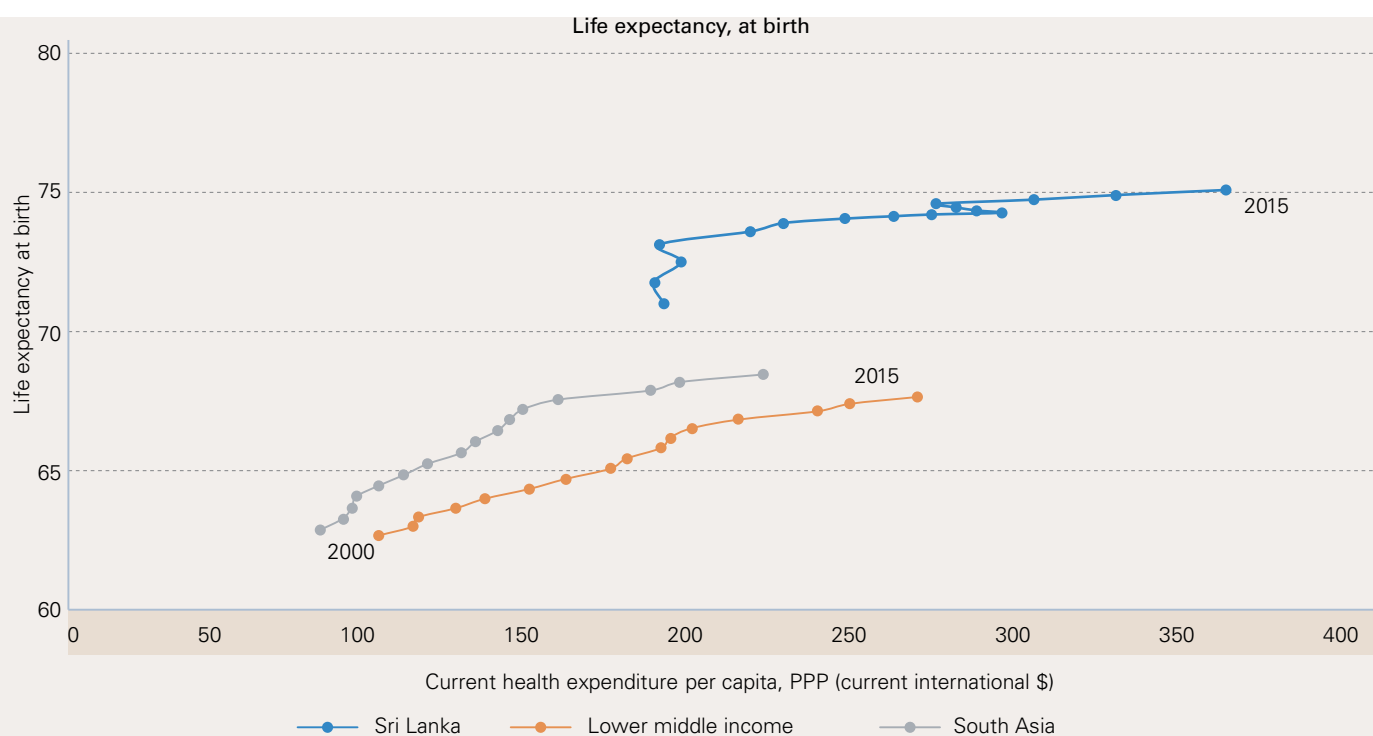


Sri Lanka has also achieved remarkable progress in mitigating communicable diseases, such as malaria and tuberculosis. In 2017, Sri Lanka’s tuberculosis incidence was 64 per 100,000 population,²⁰ as compared to the South East Asia average of 226.²¹ The World Health Organization (WHO) declared Sri Lanka as malaria-free in 2016 and measles-free in 2019. Efforts are still needed to reduce the incidence of other communicable diseases, particularly dengue, which would also require improvements in multi-sectoral coordination.²²

Nevertheless, malnutrition remains a major issue affecting child health in Sri Lanka. The percentage of children affected by malnutrition has been static for over a decade, without registering significant improvement since 2000.²³ Anaemia also represents a concern in children under five years. According to the 2012 National Nutrition and Micronutrient Survey²⁴, 15.1 percent of children in this age group are affected by anaemia.

The rise in NCDs, accompanied by the ageing population and population lifestyle changes, have altered the country’s healthcare needs in recent years. Most deaths

FIGURE 17 | Comparison of Sri Lanka’s life expectancy at birth with peers



Source: World Bank, World Development Indicator database.

20. WHO, Tuberculosis Country Profiles: Sri Lanka (2018). Available at: <https://www.who.int/tb/country/data/profiles/en/>.
 21. WHO, Global Tuberculosis Report 264 (265). The WHO Southeast Asia region comprises Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.
 22. Government of the Democratic Socialist Republic of Sri Lanka, Voluntary National Review on the Status of Implementing Sustainable Development Goals (Ministry of Sustainable Development, Wildlife and Regional Development 266), p.267-268. Available at: https://sustainabledevelopment.un.org/content/documents/19677FINAL_SriLankaVNR_Report_30Jun2018.pdf.
 23. Family Health Bureau (269), p.270.
 24. Ibid.

in 2017 (81 percent) were due to NCDs.²⁵ Managing this new threat will require close attention to ensure progress under SDG Target 3.4 (reducing premature mortality from NCDs and promoting mental health and well-being).

Road safety remains a major concern, as the rate of injuries and deaths due to road accidents is rising. The daily death rate on the road increased from 6.6 in 2014 to 7.5 in 2015.²⁶ This sets Sri Lanka behind in achieving the SDG Target 3.6 (reducing deaths and injuries from road traffic accidents).

The quality of Sri Lanka's public healthcare still needs improvement. The situation is particularly challenging in the estate sector, where the population has lower access to healthcare and lower levels of nutrition, compared to their counterparts in urban and rural areas.²⁷ Further, the absence of a proper referral system and the shortage of primary healthcare facilities lead to overcrowding of secondary and tertiary healthcare units, prompting people to seek healthcare with private institutions, thereby increasing their out-of-pocket expenditure.²⁸

Endnotes

- i. There are 9 Provincial Councils, 9 Provincial Directors of Health Services, 26 Regional Director of Health Services and 350 Medical Officers of Health.
- ii. This is the National Institute of Health Sciences Food Laboratory.
- iii. The institutions under the purview of the line ministry are: Health Education Services; Institute of Legal Medicine and Toxicology; Medical Research Institute; Medical Technology and Supplies; National Blood Transfusion Services; National Drug Quality Assurance Laboratory; Office of the School Medical Officer; Public Health Veterinary Services; and Occupational Health Services. The two institutions under the provincial authorities are: the Colombo Municipal Council (CMC) Public Health Department and the Sabaragamuwa Provincial Council Medical Centre. The Medical Statistics Unit and the Health Centre at the University of Peradeniya function under other ministries.
- iv. Ministry of Health, Health Master Plan 2016–2025 (Policy Analysis and Development Unit, Ministry of Health 2016). Available at: http://www.health.gov.lk/enWeb/index.php?option=com_content&view=article&id=327&Itemid=102.
- v. Family Health Bureau—Ministry of Health, National Strategic Plan on Maternal and Newborn Health (2017–2025) (UNFPA Sri Lanka 2018). Available at: <https://srilanka.unfpa.org/en/publications/national-strategic-plan-maternal-and-newborn-health-2017-2025>.
- vi. Family Health Bureau, National Strategic Plan on Child Health in Sri Lanka 2018–2025 (Family Health Bureau—Ministry of Health, Nutrition and Indigenous Medicine 2016). Available at: https://drive.google.com/file/d/1afrhLVy4SicEs1pBHJiFu8q_mQmqqlik/view.
- vii. Family Ministry of Health, Nutrition and Indigenous Medicine, National Strategy for Infant and Young Child Feeding Sri Lanka 2015–2020. Available at: https://drive.google.com/file/d/17cVGP_RN7FA-KEKiOIfKyxGEqD_5wMum/view.
- viii. Family Health Bureau—Ministry of Health, Sri Lanka Every Newborn: An Action Plan to End Preventable Morbidity and Mortality (SLENAP) 2017–2020 (2016). Available at: <https://drive.google.com/file/d/1pt5cf7Ci5n5rSe8RWUp5sq4tSaxK8eMX/view>.

25. IHME (271). Available at: <https://vizhub.healthdata.org/gbd-compare/>.

26. Ibid.

27. Government of the Democratic Socialist Republic of Sri Lanka (272), p.273.

28. Government of the Democratic Socialist Republic of Sri Lanka (274), p.275.

GLOSSARY OF BUDGET TERMS:

Approved Budget Estimate: The first allocation of funds, approved by Parliament

Revised Budget Estimate: A revised allocation of funds, approved by Parliament

Expenditure: Allocated funds spent on Health investment and recurrent costs

Budget Execution: Percentage of allocated funds spent out of the total revised allocation

Nominal/Current Values: Numbers not corrected for the effect of inflation

Real/Constant Values: Numbers corrected for inflation

ABBREVIATIONS:

ADB:	Asian Development Bank
ERD:	External Resources Department
FC:	Finance Commission
GDP:	Gross domestic product
LKR:	Sri Lankan Rupee (Local Currency)
LMC:	Lower Middle-Income
MC:	Municipal Council
MoH:	Ministry of Health
NCD:	Non-communicable diseases
ODA:	Official Development Assistance
PC:	Provincial Council
PS:	<i>Pradeshya Sabha</i>
SDG:	Sustainable Development Goal
SOE:	State-owned enterprise
UC:	Urban Council
USD:	US Dollars
WHO:	World Health Organization

