



## **National Commission on Macroeconomics and Health**

### **The Case of Sri Lanka: First Lessons and Framework for Comparing Progress Between Countries**

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## **National Commission on Macroeconomics and Health (NCMH)**

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## Executive Summary

The 2001 Report of the WHO Commission on Macroeconomics and Health (2001 CMH Report) recommended that total funding from domestic resources in low-income countries increase from US\$ 50 billion in 2001 to US\$ 90 billion in 2015, while total donor commitments for health should increase from US\$ 7 billion in 2001 to US\$ 38 billion in 2015. In its 'plan of action', it also made 9 recommendations for making health a key instrument for economic development and the fight against poverty. Success in this undertaking now depends on the implementation of the CMH recommendations at the country level. Leaders among the countries to follow up on the 2001 CMH Report include Ghana, India, Sri Lanka, China, and Mexico.

*The objectives of the present report are to (a) summarize the first experiences made in Sri Lanka with the creation of the National Commission on Macroeconomics and Health (NCMH) in November 2002; and (b) define a framework which would permit to identify the key tasks to be undertaken by the NCMH, measure the progress made and compare experiences with other countries.*

*Section 1* reviews briefly the present health profile of Sri Lanka. *Section 2* summarizes the steps which led to the creation of the NCMH in November 2002, its organizational set-up, and its main strategies. *Section 3* proposes the framework referred to in the previous paragraph. *Section 4* makes a brief comparison between the main recommendations of the 2001 CMH Report and the case of Sri Lanka.

### ***Sri Lanka health profile***

Sri Lanka has long been recognized for its significant health achievements. Health indicators approach those of some developed countries. Life expectancy reached 70.2 years in 2002 (as compared to 43 years in 1946) while infant mortality rates declined from 35 (1980) to 16 per 1000 live births in 2002. Nevertheless, the following serious health problems remain at the present time: malnutrition (with 29% of children under 5 being underweight), rapid increase in noncommunicable diseases and serious pockets of malaria, TB, dengue and filariasis. These problems are compounded for the poor, with an estimated 25% of the population below the 'national' poverty line and 7% on less than one dollar/day. A source of concern in recent years has been the tendency for public health expenditures to decrease as a share of GDP under the pressure of increasing defense expenditures and lower central government revenues.

The central challenges for the coming years are whether Sri Lanka will be able to:

- (a) mobilize sufficient additional resources (public and private) and
  - (b) improve sufficiently the efficiency and effectiveness of health care delivery,
- to maintain its high health status. These questions will be at the core of the work of the National Commission on Macroeconomics and Health.

### ***The National Commission on Macroeconomics and Health***

*Creation.* The NCMH, co-chaired by the Minister of Health and the Minister of Finance,

was created as an advisory body in November 2002 by decision of the National Health Council (presided over by the Prime Minister). Its members included high officials from both ministries, the Commissioner of Ayurvedha, public and private research institutes, universities, the Central Bank, the Chamber of Commerce, WHO Sri Lanka and UNDP. Representatives from other ministries and institutions are invited to meetings of the NCMH according to agenda items. To help in its task, the NCMH created a Planning Committee, a Secretariat and two Working Groups.

*Terms of reference.* Its terms of reference include advising the Government on all broad policy issues and directions in relation to investments in health, including strategies, mobilization and allocation of resources, both in the public and private sectors, so that health can make an optimal contribution to the development of the country.

*Strategies.* In its first 20 months of activity (November 2002 – July 2004), the NCMH met six times and its Planning Committee eleven times. In the pursuit of the central objective of mobilizing more resources for health as an essential tool for economic development and fighting poverty, the NCMH applied the following strategies:

- (a) preparation of the National Health Investment Plan (scheduled for 2005)
- (b) studies in the field of economics and health
- (c) advocacy programme at the central and provincial levels
- (d) capacity building for medical administrators at the central and provincial levels
- (e) participation in international meetings dealing with economics and health issues
- (f) publication of a report reviewing the NCMH activities in 2005.

*First results.* Although it is too early to judge the concrete results of the work of the NCMH in terms of increased financial resources for health, improved efficiency and effectiveness of the Sri Lanka health services and improved access by the poor to effective health care, the efforts of Sri Lanka in the field of macroeconomics and health since the publication of the CMH Report in December 2001 have been remarkable in several ways. It was among the very first countries to make the decision to create a National Commission on Macroeconomics and Health, with a unique role to play with respect to the following:

- filling a knowledge gap with respect to health economics, including health priority setting and health system performance in Sri Lanka
- filling an institutional gap, i.e. bringing key actors together at the national, provincial and district levels
- filling a gap in international partnerships, i.e. linking up with international efforts in the field of economics and health
- translating this new knowledge into the National Health Investment Plan and other national planning documents
- monitoring its impact on increased resources for health, greater efficiency and effectiveness in health delivery and better health for the people, particularly the poor.

It also built an apparent consensus in broad circles of the Government and public opinion regarding the key role of health for economic development and fighting poverty; and the importance of increasing public investments in the health sector.

*Impact.* A first judgment on the actual impact of such a good start on the actual increase in resources for health and the better functioning of the health system, in particular for the poor population, will be possible starting in 2005.

*Factors of success and risks.* It appears that the factors which have contributed most to this first success are the traditional importance given to health and human development in Sri Lanka, commitment at the highest level of Government, technical assistance and financial support from

WHO (headquarters, regional and Sri Lanka office) and JICA (Japan International Development Agency), regular meetings of the Planning Committee and Working Groups, effective advocacy programme and dedicated NCMH Secretariat.

Some of the major risks which could affect the future functioning of the NCMH are:

- a shortage of human resources at the Secretariat level at present
- a shortage of financial resources for the running of the Secretariat and the financing of the studies on numerous health economic issues
- need to develop a system for a more systematic identification of the priority activities to be undertaken under the umbrella of the NCMH, as well as their synergies, interdependence and optimal time frame (a possible such system is discussed in Section 3)
- need to identify detailed indicators of performance at the central, provincial and district levels and to monitor results.

***Eight key tasks for the NCMH and a framework for identifying priority activities and comparing progress between countries***

Given the very broad and complex mandate of the NCMH, there is a need for a framework to (a) identify and give an overview of the mass of actors, documents, information and factors entering into the equation ‘economics and health’; (b) serve as a map to prioritize the NCMH strategies and activities; and (c) permit comparisons of progress between countries.

Such a framework is proposed in the form of a matrix taking into account institutional actors and economic factors affecting and determining the health level of a population.

The *institutional actors* are regrouped into the following 4 groups:

- individuals and local communities
- health ministry, health policies and systems, indigenous health systems, health research institutes and universities
- sectors other than health with a major impact on the health level of the population, such as environment, education, water, police, housing, transport, infrastructure
- macroeconomic policies of the Central Government.

The *economic factors* are regrouped under the following six categories:

- (a) disease burden (including mortality and morbidity)
- (b) determinants (causes) of the disease burden
- (c) present strategies and programmes of the Government to deal with the burden of diseases and their causes
- (d) future strategies and programmes of the Government to deal with the burden of diseases and their causes
- (e) present financial resources (public and private) to finance the present strategies and programmes
- (f) needed financial resources (public and private) to finance the future strategies and programmes.

The objective of the matrix presentation is to permit :

- plugging in all existing information regarding actors and factors affecting the health situation of the country; this could be described as the ‘economics and health map’ of the country;
- identifying the crucial points on the map where an ‘action’ by the NCMH would have the greatest impact on the improvement in the health situation of the country.

Using the framework proposed above, it is possible to identify the following 8 key tasks for the NCMH:

*Task 1: Mobilization of economic partners and institutions for better health in the country.* The creation of the NCMH in November 2002 gave impetus and focus to bringing together key *economic and health* actors in the Commission itself and in the Working Groups. In the coming year, it may be useful to map the main institutions in the country which are making a contribution to ‘*economics and health*’. This mapping of actors could be useful in the implementation of the various NCMH strategies, such as the formulation of the National Health Investment Plan, the health economic studies, the advocacy programme, as well as the capacity building programme.

*Task 2: Measurement of the country’s main health problems.* In December 2003, the NCMH initiated studies in the field of disease burden. In the coming year(s), it would be desirable for NCMH to pursue this effort and develop a work programme for the systematic gathering of data on disease burden, disaggregated by region, sex, age and income level to the extent possible.

*Task 3: Definition of new national targets for decreasing the disease burden.* Before the establishment of the NCMH in November 2002, ‘*Vision 2010*’ (a Government global policy document published in 2001) defined the country’s main national health targets for 2010. In the coming year, the NCMH would be ideally suited to review and make these targets more explicit, as well as integrate them into the National Health Investment Plan scheduled for 2005.

*Task 4: Analysis of the causes of the disease burden.* The 2003 draft Health Master Plan identifies the main problems with the functioning of the health system (organization, financing, resource inputs and health care delivery). In the coming year(s), the NCMH is in a unique position to follow up on these economic problems and to undertake an analysis of the causes related to individual behaviour, to other sectors than health and to macroeconomic policies. Although somewhat complex (due to the interaction between physiological, proximate and distal causes), these analyses would be very cost-effective to orient health investments toward actions with the largest impact on people’s health.

*Task 5: Monitoring the Government’s present health strategies and programmes from an economic point of view.* The 2003 draft Health Master Plan lists a number of key strategies for the improvement of people’s health, which can be considered as the present strategies of the country, until their finalization in the National Health Investment Plan planned for 2005. The NCMH has a unique role to play in monitoring these strategies from an economic point of view. A good understanding of the profound economic implications of these strategies is key to the success in their implementation.

*Task 6: Development of improved, more cost-effective strategies and programmes for health, based on the health research programme.* A number of economic studies are underway in various research institutes and universities in Sri Lanka, with implications for improving the delivery of health services in the country. To have an overview of these studies and make recommendations to the Government regarding the future health research programme, it would be useful for the NCMH to prepare a ‘*health research map*’ (as proposed in Annex 4).

*Task 7: Monitoring of present financial resources invested in health.* A better understanding of the present level of financial resources invested in the health sector and of their breakdown into key dimensions (such as public/private, central/provincial, preventive/curative, recurrent/capital,

national/foreign) could be very cost-effective as a basis for decisions regarding future levels and allocations of investments in health.

*Task 8: Proposals for future financial resources to be invested in health.* Based on the analysis made by the NCMH in task 6 and 7, it is a crucial function of the NCMH to make proposals regarding the desirable level of public investments in health in the coming years and their most cost-effective allocations.

*To be successful in the 8 tasks mentioned above, the NCMH and its Secretariat will need substantially increased human and financial resources, which will represent a very small fraction of public investments in health and will be highly cost-effective.*

### ***Comparison with the 2001 CMH Report ‘action agenda’ and conclusions***

A review of the 9 recommendations made by the 2001 CMH Report in its ‘action agenda’ indicates that Sri Lanka has indeed taken important first steps in the concrete implementation of these recommendations. In the pursuit of these efforts, the NCMH will be the central catalytic factor in the coming years.

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# National Commission on Macroeconomics and Health

## The Case of Sri Lanka: First Lessons and Framework for Comparing Progress Between Countries<sup>2</sup>

### Introduction

The 2001 Report of the WHO Commission on Macroeconomics and Health (CMH) recommended that total funding from domestic resources in low-income countries increase from US\$ 50 billion in 2001 to US\$ 90 billion by 2015, while total donor commitments for health should increase from US\$ 7 billion in 2001 to US\$ 38 billion by 2015. Following the CMH Report, the effort is now being pursued at the country level and two global consultations were organized by WHO in June 2002 and October 2003 to address the need to significantly increase investments in health and make a more efficient use of health resources.

The ‘macroeconomics and health process’ at the country level includes the following three phases:

- Phase 1: promotion of high-level awareness through national workshops with key stakeholders
- Phase 2: in-depth assessment of the country health situation and analysis of health infrastructure, including epidemiological surveys, analysis of the capacity of health systems to absorb additional funding, assessment of funding gaps. At the end of phase 2, countries develop multisectoral health investment plans, including high-priority and cost-effective interventions. Leaders among the countries to follow up on the 2001 CMH Report include Ghana, India, Sri Lanka, China, and Mexico.
- Phase 3: implementation of the health investment plan and monitoring of its impact.

*The objectives of the present report are to (a) summarize the first experiences made in Sri Lanka with the creation of the National Commission on Macroeconomics and Health (NCMH) in November 2002; and (b) define a framework which would permit to identify the key tasks to be undertaken by the NCMH, measure the progress made and compare experiences with other countries.*

*Section 1* reviews briefly the present health profile of Sri Lanka. *Section 2* summarizes the steps which led to the creation of the NCMH in November 2002, its organizational set-up, and its main strategies. *Section 3* proposes the framework referred to in the above paragraph. Finally, *Section 4* makes a brief comparison between the main recommendations of the 2001 CMH Report and the case of Sri Lanka.

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## **Section 1: Macroeconomic and Health Profile of Sri Lanka<sup>3</sup>**

*Economic performance.* In spite of serious ethnic disturbances and times of political and economic uncertainty, Sri Lanka's economy has grown steadily at a rate estimated at 4.3% over the period 1990-2002 (or 3.4% on a per capita basis). GDP per capita reached US\$ 870 in 2002. Despite significant poverty levels and decades of ethnic conflict, Sri Lanka has been able to attain high levels of literacy (92%), improved water supply and sanitation (77%), and health standards.

*Health achievements.* Sri Lanka has long been recognized for its significant health achievements. Health indicators approach those of some developed countries. Life expectancy reached 70.2 years in 2002 (as compared to 43 years in 1946) while infant mortality rates declined from 35 (1980) to 16 per 1000 live births in 2002, due to a combination of high percentage of attended deliveries, improved antenatal care, high immunization levels, and nutrition programmes. Maternal mortality rates decreased to 2.3 per 10'000 live births (as compared to 155 in 1946).

*National health expenditures.* This performance has been reached in spite of comparatively limited national health expenditures estimated at 3.6% of GDP in the 1990s (half of which was financed by public sector general taxes and half by the private sector, mostly out-of-pocket). A source of concern has been the tendency for public health expenditures to decrease as a share of GDP in the past two years under the pressure of increasing defense expenditures and lower central government revenues.

*Main health problems today.* Nevertheless, the following serious health problems remain in Sri Lanka at the present time:<sup>4</sup>

- Malnutrition (with 29% of children under 5 being underweight), particularly affecting the poorer and more vulnerable communities
- rapid increase in noncommunicable diseases, in particular cardiovascular diseases, diabetes, intestinal tract diseases, cancer, and mental health disorders, due to a rapidly ageing population and lifestyle changes,
- violence and injuries (intentional and unintentional)
- serious pockets of malaria, TB, dengue and filariasis
- the above-mentioned problems are compounded for the poor population, with an estimated 25% of the population below the 'national' poverty line and 7% on less than one dollar/day.

*Key policy questions for the coming years.* The central challenges for the coming years are whether Sri Lanka will be able to (a) mobilize sufficient additional resources (public and private) and (b) improve sufficiently the efficiency and effectiveness of health care delivery, to maintain its high health status, in view of the rapid increase in NCDs (and the high costs associated with their treatment) and the need to ensure health care services to the poorer segments of the population. *These questions will be at the core of the work of the National Commission on Macroeconomics and Health.*

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<sup>3</sup> See Annex 1: "Sri Lanka Macroeconomic and Health Profile", written by Padma Shetty, Public Health Officer, WHO, Geneva, 2004.

<sup>4</sup> Ministry of Health, Nutrition and Welfare, *Health Master Plan Sri Lanka (draft)*, Colombo, November 2003.

## **Section 2:**

### **The National Commission on Macroeconomics and Health (NCMH)**

#### **1. Early efforts (1989-2002)<sup>5</sup>**

The creation of the NCMH in November 2002, only a few months after the publication of the Report of the Commission on Macroeconomics and Health in December 2001, was preceded by a number of efforts by the Government of Sri Lanka to improve the economic performance of health services. The main phases of these early efforts, *which prepared the ground for the creation of the NCMH*, can be summarized as follows:

- The 13<sup>th</sup> amendment to the Constitution in 1989 devolved greater powers to the 8 Provinces, allowing them to establish their own provincial health ministries, including administration and management of provincial hospitals and field health services.
- A Presidential Task Force was created in 1992 to formulate a comprehensive national health policy, including a number of economic considerations.
- This policy was revised in 1996 putting emphasis on the following main strategies, many of which have profound economic implications:
  - improvements in preventive health programmes and existing medical facilities
  - improvements in the accessibility and quality of health care
  - commitment to providing basic health care services free of charge in public health facilities
  - access to safe, effective, affordable and acceptable methods of family planning
  - more efficient and cost-effective health care
  - implementation of a national drug policy
  - involvement of the community in health care
  - allocation of resources between provinces based on their respective needs and national priorities
  - greater coordination between Government agencies and NGOs for better health care
  - development and regulation of the private health care sector and better coordination with this sector
  - promotion of health systems research
  - development of human resources
  - development of programmes for the elderly, mentally ill and displaced populations
  - development of indigenous systems of medicines and homeopathy

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<sup>5</sup> Reference documents:

- WHO Sri Lanka, *Poverty, Transition and Health: A Rapid Health System Analysis*, Colombo, Sri Lanka, March 2002.
- WHO Sri Lanka, *Macroeconomics and Health Initiatives*, Colombo, Sri Lanka, August 2002.
- Ministry of Health, Nutrition and Welfare, *Health Master Plan Sri Lanka (draft)*, Colombo, November 2003.

- increase in public sector resources for health promotion and prevention.
- In 2001, the Government of Sri Lanka launched *Vision 2010*, a new plan for accelerating the economic development of the country with ambitious macroeconomic and sectoral goals. In the field of health, objectives were set with respect to the elimination of malnutrition for children under 5, reduction of iron deficiency anaemia among pregnant women, reduction of the incidence of NCDs, special programmes in TB and malaria, and development of comprehensive health services with particular emphasis on the disadvantaged populations.
- In 2002, following several drafts of the *Poverty Reduction Strategy Paper (PRSP)*, the Government outlined its strategy in the *Regaining Sri Lanka Report*, which included a chapter on health, with similar concerns as those expressed in *Vision 2010*.

*While remaining general in their formulation, these documents gradually opened the door to a number of economic concepts in the field of health, which facilitated the discussion of the recommendations of the Commission on Macroeconomics and Health when its Report was published in December 2001.*

## **2. The Creation of the National Commission on Macroeconomics and Health**

In June 2002, the Minister of Health of Sri Lanka led a delegation to participate in the 'First Consultation on National Responses to the 2001 CMH Report' in Geneva. This First Consultation recommended that each country develop 'a specific plan of action appropriate to its situation' to implement the broad parameters of action outlined in the CMH Report, including, in particular, the following activities:

- mobilizing more political support and advocacy for investing in health as an essential tool for economic development and fighting poverty
- developing a national health investment plan, with particular emphasis on the needs of the poor population
- estimating funding needs and mobilizing additional financial support, domestically and internationally
- securing better coordination among the main actors in the field of national health.

Following this Consultation, the Minister of Health briefed the National Health Council (highest policy-making body in the health sector) about the importance of these issues and urged that a National Commission on Macroeconomics and Health be set up, which would provide the needed impetus and focus on these issues.

*In August 2002, the decision was made by the National Health Council (presided over by the Prime Minister) to create the National Commission on Macroeconomics and Health (NCMH), to be co-chaired by the Minister of Health and the Minister of Finance.*

The NCMH was formally established in November 2002, with the nomination of its members as follows:

- Ministry of Healthcare, Nutrition and Welfare
  - Minister of Healthcare, Nutrition and Welfare Development (co-chair)

- Deputy Minister of Healthcare, Nutrition and Welfare Development
- Secretary, Ministry of Healthcare, Nutrition and Welfare Development
- Director General, Health Services
- Ministry of Finance
  - Minister of Finance (co-chair)
  - Secretary, Ministry of Finance
  - Director, National Planning
  - Director, General External Resources
- Commissioner of Ayurvedha (public indigenous system of medicine)
- Emeritus Chairman, Marga Institute (research NGO created in 1972)
- Institute of Policy Studies (autonomous public agency, reporting to Min of Finance)
- Post-graduate Institute of Agriculture, University of Peradeniya
- Governor of the Central Bank
- Chairman, National Chamber of Commerce
- WHO Representative for Sri Lanka
- Resident Representative UNDP
- Representatives of other ministries and institutions are invited to meetings of the NCMH according to agenda items.

### **3. Terms of reference of the National Commission**

The terms of reference of the NCMH are very broad and encompass the responsibility for advising the Government and the Minister of Health on all aspects related to increasing investments in health and ensuring the optimal contribution of the health sector to economic development and fighting poverty. They are formulated as follows:

- (a) To advise the Government and the Minister of Health on all broad policy issues, policy options and directions in relation to investments in health, both in the public and private sectors so that health could make an optimal contribution to development of the country.
- (b) To recommend new approaches and strategies for scaling up health interventions, particularly those aimed at the poor, and increasing investments in health.
- (c) To commission appropriate studies in different aspects of macroeconomics and health that will support the work of the Commission.
- (d) To recommend modalities for mobilizing increased external resources for health development and to advise on broad policies and strategies for their optimal utilization.
- (e) To advise the Minister of Health on all aspects related to economics and health for overall health and human development in Sri Lanka.

### **4. Governance**

The June 2002 ‘First Consultation on National Responses to the 2001 CMH Report’ in Geneva underlined that the macroeconomics and health work at the national level could be taken forward in a variety of different ways and recommended that “countries select the inter-ministerial arrangement that best fits national conditions by building on existing structures, while ensuring a wider circle of interest, high level engagement and minimal incremental work, without compromising priority focus on health”. The options listed at this First Consultation were the following:

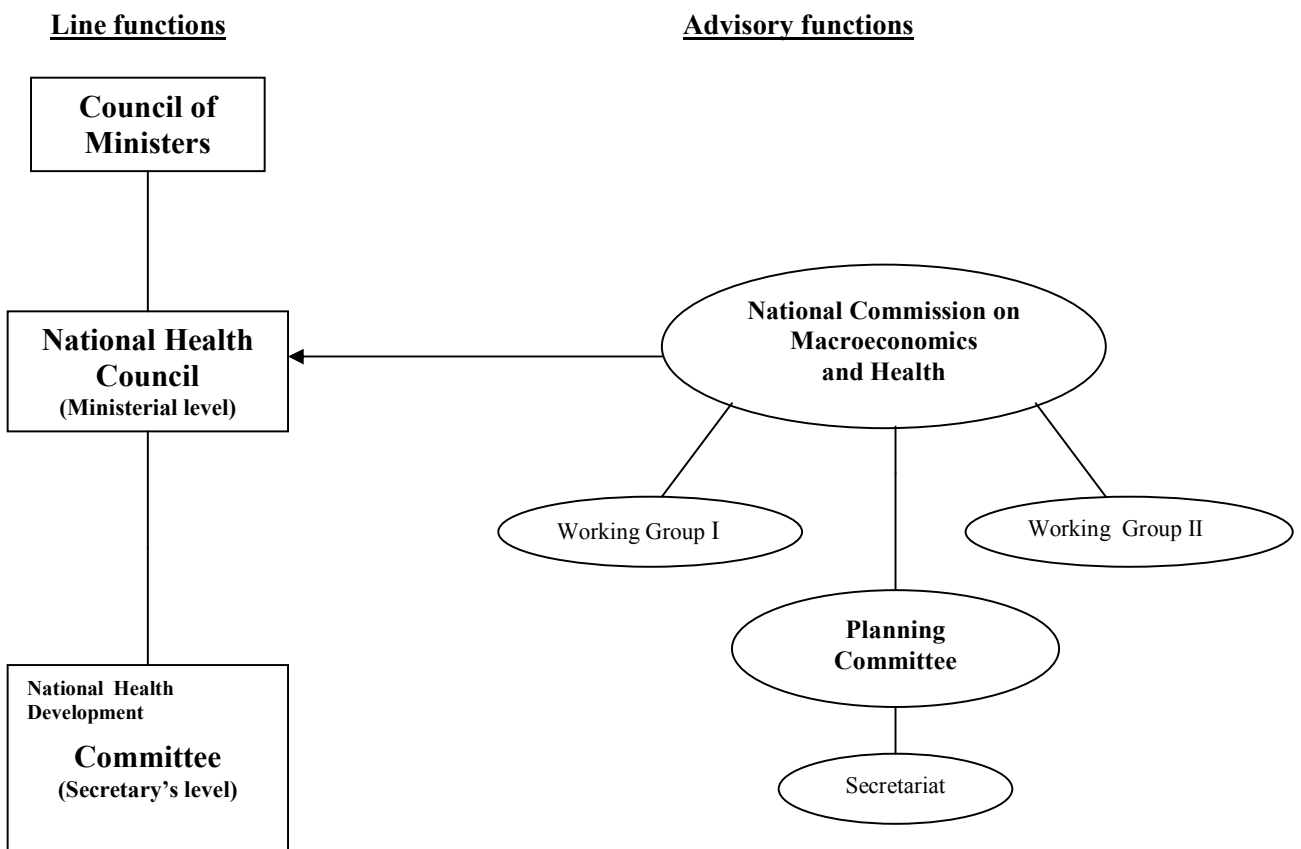
- health working group of the PRSP national steering committee

- national health council or commission
- national commission for macroeconomics and health
- subregional group (such as in the Caribbean).

Although a ‘National Health Council’ (level of the Ministers concerned) and a ‘National Health Development Committee’ (level of the Secretaries concerned) already existed, the conclusion was reached that the creation of a separate National Commission on Macroeconomics and Health, functioning in an advisory capacity and reporting to the National Health Council, was justified for the following reasons:

- large size of the ‘National Health Council’ and of its agenda (chaired by the Prime Minister, with eight ministers and 35 officials attending the August 2002 meeting)
- large size of the ‘National Health Development Committee’ and of its agenda (chaired by the Secretary of Health, it includes Provincial Secretaries of Health, Provincial Directors of Health, Chairmen of Boards under the Ministry of Health, Director General of Health Services, and representatives from the Ministry of Finance, Treasury and Department of National Planning, among others)
- complexity and technicity of the economic and health issues
- size of the economic and health agenda.

To support the work of the Commission, a Planning Committee and two Working Groups were set up, as well as a Secretariat located in the Ministry of Health. The functional relations can be represented as follows:



*The Planning Committee*, chaired by the Secretary of Health, is the *executive arm of the NCMH*, meeting on a monthly or bi-monthly basis. Its members are the following:

- Ministry of Health: Deputy Director General Management Development; Director Organization Development; Director Planning
- Heads of Working Groups I (Budgeting Issues) and II (Financing Issues)
- Representative of the Institute for Policy Studies (under Ministry of Finance)
- Representative of the Marga Institute (Research NGO)
- WHO Sri Lanka Office: Director and Deputy Director.

The two *Working Groups* are chaired by two Senior Lecturers in economics at the University of Colombo and comprise economists and public health specialists from the Ministry of Finance, and a number of directly concerned institutions from the public and private sectors (**Annex 3: Composition of Working Groups**).

The *Secretariat* is located in the Ministry of Health, Nutrition and Welfare and includes a Secretary (on a part-time basis) and two Assistants.

## **5. Strategies and activities**

In its first 20 months of activity (November 2002 – July 2004), the NCMH met six times and its Planning Committee eleven times. In the pursuit of the central objective of mobilizing more resources for health as an essential tool for economic development and fighting poverty, they applied the following strategies:

- (a) National Health Investment Plan:* a number of important documents have been prepared in recent years identifying the main priorities in the health sector. In 2005, the NCMH plans to finalize the National Health Investment Plan on the basis of these early documents, taking fully into account new evidence developed in the field of economics and health by Working Groups I and II and other sources. It also plans to link up with the Sri Lanka PRSP and the MDGs.
- (b) Economic studies:* in the first meeting of the NCMH in December 2002, a number of issues in the field of economics and health had been identified by the participants as requiring urgent attention, such as the following: drastic drop in funding for preventive health services; need to develop some mechanisms to minimize hospital admissions; efficient utilization of peripheral services; prevention of wastage of drugs; need to identify new financial resources (earmarked tax, paying wards, community financing); need to make more efficient use of human resources.

In May 2003, a call for proposals on ‘economics and health issues’ identified by the NCMH was issued and 34 letters of interest were received. On this basis, the NCMH approved a number of studies to be undertaken under the supervision of Working Groups I and II, in particular the following:

- review of cost studies of health services
- evaluation of taxation and fiscal incentives to support health sector development
- review of the current basis for the allocation of health resources by the Central Government to the Provinces
- economic cost of five common diseases and productivity losses incurred (asthma, hypertension, ischaemic heart disease, diarrhea, viral fever)

- occupational health study
  - cost implications of establishing a Community Nursing Service in Sri Lanka.
- (c) *Advocacy*: the advocacy programme includes presentations at the level of the National Health Council and National Health Development Committee; materials for mass media; seminars for politicians and media (central and provincial levels); translation of the ‘Macroeconomics and Health Initiative’ into Sinhalese and Tamil; publication of a newsletter (first issued in April 2004); and opening of a website.
- (d) *Capacity building*: programme with the World Bank Development Institute for a distance learning course on ‘Health Outcomes and the Poor’ to be offered to Medical Administrators at the central and provincial levels; seminar on ‘Policy Issues in Health Financing’ for senior policy makers (held in July 2003); in the longer run, development of a concept and proposal for a National Center for Macroeconomics and Health.
- (e) *Participation in international meetings*: under this strategy, the objective is to share the country’s experiences in the field of economics and health and benefit from international experiences. Senior Government officials and NCMH members participated in a number of international meetings where macroeconomics and health issues were discussed, in particular the following: First Consultation on National Responses to the CMH Report (Geneva, June 2002); Regional Conference of Parliamentarians (December 2002); SEARO Regional Consultation on Macroeconomics and Health (New Delhi, August 2003); Second Global Consultation on Macroeconomics and Health (Geneva, October 2003).
- (f) *Publication of a Report of the NCMH after two years of activity*: the objective of this Report is to review the NCMH activities. A first such Report is due in 2005. Following the publication of the Report, it is foreseen to hold a national consultation.

## 6. Accomplishments

Although it is too early to judge the concrete results of the work of the NCMH in terms of increased financial resources for health, improved efficiency and effectiveness of the Sri Lanka health services and improved access by the poor to effective health care, the efforts of Sri Lanka in the field of macroeconomics and health since the creation of the NCMH in November 2002 have been remarkable in many ways:

- It was among the very first countries to make the decision to create a National Commission on Macroeconomics and Health with a unique role to play in the following fields:
  - filling a knowledge gap with respect to health economics in Sri Lanka
  - filling an institutional gap, i.e. bringing key actors together at the national, provincial and district levels
  - filling a gap in international partnerships, i.e. linking up with international efforts in the field of economics and health
  - translating this new knowledge into the National Health Investment Plan (to be published in 2005) and other national planning documents
  - monitoring its impact on increased resources for health, greater efficiency and effectiveness in health delivery and better health for the people, particularly the poor.
- It created an effective governance structure with the setting up of the Planning Committee, the Working Groups and the Secretariat.
- It succeeded in launching a number of studies which should prove important to increase the efficiency and effectiveness of resources invested in health.

- It built an apparent consensus in broad circles of the Government and public opinion regarding (a) the key role of health for economic development and fighting poverty; and (b) the importance of increasing public investments in the health sector.
- It contributed much to the international debate on macroeconomics and health.

A first judgment on the actual impact of such a good start on the increase in resources for health and the better functioning of the health system, in particular for the poor population, will be possible starting in 2005.

## 7. Factors of success and risks

It appears that the factors which have contributed most to this *first success* are the following:

- traditional importance given to the health sector and human development in Sri Lanka since the time of Independence (fertile ground for launching the NCMH)
- commitment of the Minister and the Secretary of Health following their participation in the First Global Consultation on Macroeconomics and Health (Geneva, 2002)
- commitment of the Deputy-Minister of Finance, co-chair of the NCMH
- focus by the NCMH on issues of economics and health
- technical assistance and financial support by WHO Headquarters (Coordination for Macroeconomics and Health Unit) and key role played by the WHO Sri Lanka Office, an important member of the NCMH and of its Planning Committee
- technical assistance and financial support by JICA
- regular meetings of the Planning Committee (a limited group of highly motivated individuals)
- regular meetings of the Working Groups
- dedicated Secretariat
- NCMH advocacy programme directed at decision makers, politicians and media at the Provincial and District level.
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Some of the *major risks* which could affect the future functioning of the NCMH are the following:

- *Shortage of human resources* at the Secretariat level: at present, the Secretary of the NCMH is on a part-time basis and has only limited staff. Meeting the ambitious objectives defined in the NCMH terms of reference will require a substantial increase in human resources.
- *Shortage of financial resources* for the running of the Secretariat and the financing of the studies on the numerous health economic issues. WHO and JICA resources have played a crucial role in the early financing of these expenses but it is crucial that it be continued and for other donors (such as the health project approved by the World Bank in June 2004 for an amount of US\$ 60 million over a five-year period to support health activities at the central and district levels) to join in the financing of the NCMH Secretariat and the studies.
- In the coming months, as the NCMH activities take much broader dimensions, it will be important to develop a system for a more *systematic identification of priority activities* to be undertaken under the umbrella of the NCMH (as well as their synergies, interdependence and optimal time frame). A possible such system (framework) is discussed in Section 3 below.
- Finally, monitoring results will require the identification of *detailed indicators of performance* at the central, provincial and district levels.

### **Section 3: Eight key tasks for the NCMH and framework for comparing progress between countries**

Given the very broad and complex mandate of the NCMH (see terms of reference in Section 2.3), there is a need for a framework to (a) give an overview of the mass of actors, documents, information and factors entering into the equation ‘economics and health’; (b) serve as a map to guide the NCMH strategies and activities; and (c) permit comparisons of progress between countries. Such a framework has to take into account the various actors and factors determining the health level of a population. Schematically and to simplify, we can distinguish between *institutional actors* and *economic factors*.<sup>6</sup>

The *institutional actors* may be regrouped into the following four categories:

1. individuals and local communities, whose behaviour, practices, traditions and resources play a large role in determining people’s health
2. health ministry, health policies and systems, indigenous health systems, health research institutes and universities (at the central, provincial and district levels)
3. sectors other than health with a major impact on the health level of the population, such as environment, education, water and sanitation (which are often mentioned) and police, housing, transport and infrastructure (which are less often mentioned but which also have a profound influence on people’s health)
4. macroeconomic policies of the Central Government such as budgetary allocations (including foreign aid), taxation, subsidies, governance, civil service policies.

The *economic factors* determining the health level of a population can be regrouped under the following six categories:

1. disease burden: this is measured by the number of healthy life years lost to morbidity or premature mortality for each disease (expressed in DALYs or other index combining the burden of morbidity and mortality)
2. determinants of the disease burden: analysis of the causes for the high disease burden
3. present strategies and programmes of the Government to deal with the burden of diseases and their causes
4. future strategies and programmes of the Government to deal with the burden of diseases and their causes
5. present financial resources (public and private) to finance the present strategies and programmes
6. needed financial resources (public and private) to finance the future strategies and programmes.

These four institutional groups of actors and six categories of economic factors can be represented in a matrix form as under Table 1 below. The objective of the matrix presentation is to permit:

- plugging in all existing information regarding actors and factors affecting the health situation of the country; this could be described as the ‘economics and health map’ of the country;
- identifying the crucial points on the map where an ‘action’ by the NCMH would have the greatest impact on the improvement of the health situation in the country.

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<sup>6</sup> A similar framework has been proposed by the Global Forum for Health Research for the identification of health research priorities. See Global Forum for Health Research, *The 10/90 Report on Health Research 2003-2004*, Geneva, May 2004 (pages 67-104).

**Table 1: Economics and Health Map - A Practical Framework for Organizing Information**

		ACTORS AND FACTORS DETERMINING THE HEALTH LEVEL OF A POPULATION (INTERVENTION LEVELS) <i>(Task 1)</i>			
	Global level	(a) Individual and community level	(b) Level of health ministry, health and health research systems	(c) Level of sectors other than health	(d) Level of central government and macroecon. policies
<b>1. BURDEN OF DISEASE</b> (present level and future objectives)	<i>Task 2</i> <i>Task 3</i>				
<b>2. WHY DOES BURDEN PERSIST?</b> (analysis of causes)		<i>Task 4</i>	<i>Task 4</i>	<i>Task 4</i>	<i>Task 4</i>
<b>3. PRESENT STRATEGIES</b> (and programmes)		<i>Task 5</i>	<i>Task 5</i>	<i>Task 5</i>	<i>Task 5</i>
<b>4. FUTURE STRATEGIES</b> (and programmes)		<i>Task 6</i>	<i>Task 6</i>	<i>Task 6</i>	<i>Task 6</i>
<b>5. PRESENT FINANCIAL RESOURCES</b>	<i>Task 7</i>	<i>Task 7</i>	<i>Task 7</i>	<i>Task 7</i>	<i>Task 7</i>
<b>6. NEEDED FINANCIAL RESOURCES</b>	<i>Task 8</i>	<i>Task 8</i>	<i>Task 8</i>	<i>Task 8</i>	<i>Task 8</i>

**Using the framework proposed above, it is possible to identify 8 key tasks for the NCMH (see Table 1) which would permit measuring the progress made in the NCMH work and make comparisons with other countries.**

**Task 1: Mobilization of economic partners and institutions for better health in the country**

The creation of the NCMH in November 2002 gave impetus to bringing together key *economic and health* actors in the Commission itself and in the Working Groups (see Section 2.4 Governance).

In the coming year(s), it may be useful to map the main institutions in the country which are making a contribution to ‘economics and health’. Applying the framework proposed above, this mapping could take the following format:

**Table 2: Institutions contributing to ‘economics and health’ (public and private)**

	Institutions acting at the community level (including NGOs)	Ministry of health, health systems, indigenous medicine, research, pharmas	Institutions in other sectors than health (public + private)	Government institutions defining policies in M&H
Country level				
Provincial level				
District level				

This overview would permit the NCMH to have a systematic approach to the following:

- mobilization of more institutions for ‘economics and health’, in their respective field of activity
- identification of these activities
- establishment of useful links and synergies between them.

This mapping of actors could be useful in the implementation of the various NCMH strategies, such as the formulation of the National Health Investment Plan, the health economic studies, the advocacy programme, as well as the capacity building programme.

**Task 2: Measurement of the country’s main health problems**

There exist only fragmented studies of the main health problems in Sri Lanka as measured by burden of disease (combining a measure of mortality and morbidity). The accuracy of the data is also problematic as morbidity figures are only available for patients who seek treatment as inpatients at Government hospitals. Thus there is no collection of data for outpatients at

Government hospitals, private hospitals, general practitioners or at alternative medical care facilities<sup>7</sup>. Thus the evidence on which to base public health decisions is relatively limited.

In December 2003, the NCMH initiated two studies in the field of disease burden (economic cost of five common diseases and occupational health problems). Other studies pertinent to the disease burden have been undertaken in Sri Lanka in the past years but have not been gathered systematically. In the coming year(s), it would be desirable for the NCMH to make a review of the existing studies and develop a work programme for the systematic gathering of data on disease burden, disaggregated by region, sex, age and income level to the extent possible. In this exercise, the NCMH would exchange views and experiences with countries with similar characteristics.

### **Task 3: Definition of new national targets for the disease burden**

Before the establishment of the NCMH in November 2002, 'Vision 2010' (a Government global policy document published in 2001) defined the country's main national health targets for 2010 as follows:

- elimination of malnutrition for children under 5 by 2010
- reduction of iron deficiency anaemia among pregnant women from 30% in 2000 to 10% in 2010
- keeping the incidence of NCDs at a low level
- keeping control over HIV and decreasing TB and malaria
- high quality comprehensive health services, including preventive, curative and rehabilitative care
- decreasing the overcrowdedness of public hospitals and the shortage of nurses.

In the coming year, the NCMH would be ideally suited to review and make these targets more explicit, as well as integrate them in the National Health Investment Plan scheduled for 2005.

### **Task 4: Analysis of the causes of the disease burden (analysis of risk factors and determinants)**

Ideally, this analysis should distinguish between the following causes:

1. causes related to the behaviour of individuals
2. causes related to the functioning of the health systems and policies
3. causes related to the functioning of sectors other than health (including their policies)
4. causes related to the central government macroeconomic policies.

Before the establishment of the NCMH, isolated studies have been undertaken on (1), (3) and (4), and a good analysis was made of (2) i.e. causes related to the functioning of the health systems and policies, as summarized in the draft Health Master Plan (Ministry of Healthcare, November 2003). According to this document, 'hospital management is not a well-developed area, as compared with the management guidelines used for running airports or large manufacturing entities'. It identifies the following main problems with the functioning of the health system:

- organization:
  - overcrowded main hospitals due to the absence of a referral system
  - unclear definition of responsibilities between central, provincial and district levels

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<sup>7</sup> WHO Sri Lanka, *Macroeconomics and Health Initiatives*, Colombo, Sri Lanka, August 2002.

- decrease in preventive services in recent years
- indigenous health systems (ayurveda, siddha, unani) not fully integrated into the planning process
- insufficient resources
- management:
  - administrative approach rather than management approach
  - overcentralization of health services
  - lack of appraisal mechanism
  - need to improve human and financial management
  - need to update health legislation
- financing
  - decrease in public health resources in recent years as percentage of GDP
  - increasing health costs due to the increase in noncommunicable diseases
  - only 6% of health allocations from the central to the provincial governments via 'criteria-based grants'
  - no systematic evaluation of value for money or application of a contracting mechanism
- resource inputs: insufficiencies in human resource management, drug supply management, equipment and facility management, knowledge management.
- health care delivery: lack of integration of the preventive, curative and welfare arm of health care delivery.

*In the coming year(s), the NCMH is in a unique position to follow up on the economic problems mentioned above and to undertake an analysis of the causes related to individual behaviour, other sectors than health and macroeconomic policies. Although somewhat complex (due to the interaction between physiological, proximate and distal causes), these analyses would be very cost-effective to orient health investments toward actions with the most impact on people's health, particularly the poor.*

#### **Task 5: Monitoring the Government's present health strategies and programmes from an economic point of view**

Although still in draft form, the Health Master Plan (Ministry of Healthcare, 2003) lists a number of key strategies for the improvement of people's health, which can be considered as the present strategies of the country, until their finalization in the National Health Investment Plan planned for 2005.

*The NCMH has a unique role to play in monitoring these strategies from an economic point of view. A good understanding of the profound economic implications of these strategies is key to the success in their implementation.*

These strategies are summarized below, applying the framework suggested in Table 1 above:

1. *Strategies to improve the health behaviour of individuals and mobilizing community health actions*  
 Under this heading, the strategy is to empower communities and households toward more active participation in maintaining their health through:
  - (a) improving public awareness of their rights, responsibilities and options for care, with a view to maximizing their involvement
  - (b) improving the participation of civil society and NGOs in promoting behavioural and lifestyle changes based on epidemiology, treatment cost and effectiveness factors (particularly with

- respect to nutrition, exercise, relaxation, tobacco, alcohol, substance abuse, unsafe sex and road safety)
- (c) improving the health system to better answer people's legitimate expectations.
2. *Strategies to improve the functioning and management of the health systems*  
The following three main strategies are listed to improve the functioning of the health systems:
- (a) ensure the delivery of comprehensive health services, in particular for the poor and vulnerable populations, including the following:
- preparation of a detailed National Health Service Plan up to 2010 with optimal configuration of services for a given level of total annual health expenditures and an appropriate referral strategy between the district, provincial and central hospitals
  - development of cost-effective treatment protocols for high-burden diseases and introduction into all training activities
  - systematic improvement in the quality of services through clinical accountability, peer review, clinical audit and monitoring of patients
  - regulations for the functioning of the private health system
  - strengthening of public-private partnerships for more efficient health service delivery
  - ensuring adequate drugs, material and equipment
  - strengthening stewardship and management of the health systems under the Ministry of Healthcare at the central, provincial and district levels, training at all levels and Introduction of performance management systems
  - strengthening stewardship and management for the indigenous system of medicine, including restructuring of the Ministry of Indigenous Medicine (MIM)
- (b) improve human resources for health development and management, including projections of human resource needs for the next 20 years, adequate in-service training, management training, career development, correction of significant imbalances between provinces
- (c) improve health financing, resource allocation and utilization, including substantial increase in public health financing, improvement in the allocative efficiency of public funds, contracting out when justified, focusing as much as possible on promotion and prevention, strengthening financial management, exploring new sources of financing for the health sector (private or social health insurance, fee for services, earmarked taxation), and optimizing the role of the private sector health system.
3. *Strategies to be applied in other sectors than health*  
The November 2003 document attaches much importance to strengthening coordination and partnerships between the health sector and other sectors having a particular impact on people's health, in particular school education, road traffic accidents, environment, etc. and proposes to establish sub-committees for health in the District and Divisional Development Councils.
4. *Strategies to be applied at the Central Government macro-policies level*  
The main macro-policies listed in the draft Health Master Plan are the following:
- increasing budgetary allocations for the health sector in the overall central government budget
  - maintaining the share of state subsidies to low-income groups
  - removing subsidies that benefit the better-off (for example tax deductibility of private insurance contributions).

*In the coming year(s), the NCMH could play an important role in keeping an overview of these strategies and monitoring their application.*

### **Task 6: Proposals for improved, more cost-effective strategies for health, based on the health research programme**

It is a key function of the NCMH to make proposals for the improvement in the formulation and application of the Government health strategies. The evidence for such proposals is to be found in the results of research, hence the crucial role of the research programme to be guided by the NCMH. The research programme can be considered as a tool to be applied strategically to enlighten the questionable areas of the 'economics and health map' presented in Table 1 above.

In its first months of activity, the NCMH commissioned a number of studies which it considered important to enlighten the future health strategies of the Government (see Section 2.5 above). A number of other studies are underway in various research institutes and universities in Sri Lanka, with implications for improving the delivery of health services in the country. To have an overview of these studies and guide its recommendations to the Government regarding the future health research programme, it would be useful for the NCMH to prepare a 'health research map', such as proposed in Annex 4 (which plugs in the six studies mentioned in Section 2.5 above as examples).

The objective of course is to plug in all information regarding Sri Lanka's health research activities, which would permit the NCMH to better identify the crucial gaps in research and thus to formulate a priority research programme for 2005 and the coming years.<sup>8</sup> Based on the results of the research programme, the NCMH will be able to propose improved and new health strategies and programmes, so as to obtain the greatest gains in people's health for the available financial and human resources.

### **Task 7: Monitoring of the present financial resources invested in health**

Before the establishment of the NCMH, a number of studies undertaken by the Government and WHO Sri Lanka on the financing of the health sector in Sri Lanka showed the following:<sup>9</sup>

- public health expenditures decreased gradually in the past 20 years from 1.5 – 2% in the 1970s to 1.3% in the past two years (under the pressure of the defense budget and lower overall Government revenues as a share of GDP)
- the public sector accounted for slightly less than 50% of total health expenditures in recent years
- foreign aid is estimated to amount to about 6% of Government health expenditures
- the central government makes block grants to the provincial governments for the financing

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<sup>8</sup> For a detailed discussion of the methodology for defining national health research priorities and some applied examples, see the following publication: Global Forum for Health Research, *The 10/90 Report on Health Research 2003-2004*, Geneva, May 2004.

<sup>9</sup>Reference documents:

- Draft *Health Master Plan Sri Lanka*, Ministry of Healthcare, Nutrition and Welfare, Colombo, November 2003.
- WHO Sri Lanka, *Macroeconomics and Health Initiatives*, Colombo, Sri Lanka, August 2002.
- NCMH Secretariat, *MacroHealth Sri Lanka*, Newsletter No. 1, April 2004.

- of their overall budget, including health
- private health expenditures are mostly out-of-pocket (as insurance plays a very limited role, estimated at 1% of total health expenditures)
- the percentage of public sector financing going for prevention, which amounted to an estimated 20% in 1990, decreased to about 11% in 1999
- total health expenditures (about 3.6 % of GDP in the 1990s, or somewhat less than US\$30 per capita) is low by international standards for a country with per capita GDP of US\$870.

Many of the above-mentioned figures are estimates showing wide variations in recent years. *With the creation of the NCMH, there is a unique opportunity to review these estimates and analyze in detail the present level of financial resources invested in health in Sri Lanka, including:*

- central government health expenditures and their allocation to the provincial health budgets
- breakdown of public health expenditures for recurrent costs, capital costs, and drugs procurement (at the central, provincial and district levels)
- breakdown of public and private health expenditures for preventive and curative care
- allocation of health expenditures financed by foreign aid and their integration into the national priorities
- breakdown of private health expenditures (out-of-pocket, insurance) by broad income levels.

A clear understanding of the present level of financial resources invested in the health sector and their breakdown into the dimensions mentioned above could be very cost-effective as a basis for decisions regarding *future levels and allocations* of investments in health.

#### **Task 8: Proposals for future financial resources to be invested in health**

Conscious of the decrease in public financial resources invested in health in recent years, the Government of Sri Lanka gave a number of indications that it intends to increase again the share of health in GDP and in the overall Government budget.

The MOH/JICA Seminar on Policy Issues in Health Financing in Sri Lanka, held in July 2003, recommended increasing 'public financing of health care from 1.3% of GDP in 2002 to at least 2.0% within the next 5-year period to prevent further erosion of the quality of public sector services, especially for primary care and preventive services'.

The most recent statement in this respect was made by the Minister of Healthcare in April 2004 asking for an increase in budgetary funds allocated to health from 1.3% to 2.5% of GDP and developing proper management techniques for the utilization of the allocated resources.

Based on the analysis made by the NCMH in task 6 (proposals for improved and more cost-effective strategies for health) and task 7 (analysis of the level and allocations of the present budgetary health resources), it is a crucial function of the NCMH to make proposals regarding the desirable public investments into health in the coming years and their most cost-effective allocations with respect to:

- central, provincial and district allocations
- preventive and curative allocations
- recurrent, capital and drug allocations
- other relevant allocations.

***To be successful in the 8 tasks mentioned above, the NCMH and its Secretariat will need substantially increased human and financial resources, which will represent a very small fraction of public investments in health and will be highly cost-effective.***

## Section 4: Comparison with the ‘action agenda’ proposed in the 2001 CMH Report and conclusions

The objective of this Section is to review the 9 recommendations made by the 2001 CMH Report in its ‘action agenda’ and indicate the extent to which they have been implemented in the case of Sri Lanka.

**Recommendation 1:** *establishment of a National Commission on Macroeconomics and Health (NCMH).* The establishment of the NCMH has been detailed in Section 2 above, while Section 3 described the first steps taken by the NCMH in 2003 and 2004.

**Recommendation 2:** *increase in domestic budgetary resources for health of 1% of GNP by 2007 and 2% of GNP by 2015.* The Government of Sri Lanka has recently announced its intention to increase its budgetary resources for health from 1.3% of GDP at present to 2.5% in the coming years.

**Recommendation 3:** *adequate grant resources for health to be provided by the donor community for low-income countries to ensure universal coverage of essential interventions and scaled-up research for diseases of the poor.* It is estimated that foreign aid amounts to about 6% of Government health expenditures, mostly contributed by JICA, the World Bank (commitment of US\$ 12 million in 2002 and US\$ 60 million in 2004) and The Global Fund to Fight AIDS, Tuberculosis and Malaria. It is important that these foreign donors work closely with the NCMH in the coming year to ensure the most cost-effective use of these resources in the context of the 2005 National Health Investment Plan.

**Recommendation 4:** *the international community to establish new funding mechanisms, including:*

- *the Global Fund to Fight AIDS, Tuberculosis and Malaria*
- *a global health research fund*
- *country programmes should direct at least 5% of outlays to operational research.*

The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2002, committed an amount of US\$ 10.3 million over a two-year period to fighting malaria and tuberculosis in Sri Lanka. Discussions about the possible creation of a global health research fund are underway and will be continued at the Health Research Summit (and Forum 8) to be held in Mexico in November 2004. Regarding operational research, studies published by the Global Forum for Health Research<sup>10</sup> indicate that most developing countries invest less than 1% of national health expenditures in health research, while only very few invest between 1 and 2%. The 5% mark proposed by the 2001 CMH Report is therefore a distant dream. In the case of Sri Lanka, available information in this respect is limited. It will be very useful for the NCMH to gain an

overall view of health research in the country (Annex 4) and make proposals for a cost-effective health research programme. Based on the analysis presented in Section 3 above, such a research programme will contribute much to improving the level of health and economic development in

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<sup>10</sup> Reference documents:

- Global Forum for Health Research, *Monitoring Financial Flows for Health Research*, Geneva, October 2001
- Global Forum for Health Research, *The 10/90 Report on Health Research*, Geneva, May 2004

the country.

**Recommendation 5:** *additional financing (through the World Bank and IMF) for disease surveillance at the international level, analysis of global health trends (burden of disease), analysis of international best practices in disease control and health systems, technical assistance and training.* Sri Lanka is in a good position to participate in this global effort by allocating the necessary resources out of the US\$ 60 million health project recently signed with the World Bank.

**Recommendation 6:** *adapting the existing orphan drug legislation in the high-income countries to cover diseases of the poor.* This recommendation is addressed to high-income countries but is highly relevant for Sri Lanka who would be well placed to join international research consortiums on diseases of the poor.

**Recommendation 7 and 8:**

- *pharmaceutical industry to ensure access of low-income countries to essential medicines at the lowest viable commercial price and to license their production to generics producers*
- *WTO member governments to ensure sufficient safeguards for developing countries to invoke compulsory licensing for imports from third-country generics suppliers.*

These are important tasks for the NCMH in its review of the drug procurement policy.

**Recommendation 9:** *IMF and World Bank to work with recipient countries to incorporate the scaling up of health and other poverty-reduction programmes into a viable macroeconomic framework.* This is particularly relevant in the case of Sri Lanka which has faced difficult circumstances in recent years with the decline in budgetary resources and a rapid increase in the defense budget.

*In conclusion,* Sri Lanka has indeed taken important first steps in the concrete implementation of the recommendations of the 2001 CMH Report and in making the health sector a key factor for economic development and fighting poverty. In the pursuit of these efforts, the NCMH will be the central catalytic factor in the coming years.

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**Persons met during visit in Colombo, Sri Lanka  
11-17 August 2004**

**MINISTRY OF HEALTH, NUTRITION AND WELFARE**

Hon. Minister Nimal Siripala de Silva

Dr Reggie Perera, former Secretary of Health, Ministry of Health

Dr Sarath M. Samarage, Director, Organization Development

Dr H.S.B. Tennakoon, Deputy Director General, Medical Services

Dr H.R.U. Indrasiri, Director of Health Services, Western Province

**MINISTRY OF FINANCE**

Dr B. Abeygunawardena, Addl Director General, Dpt of National Budget

Dr Rukmal Abayawickrama, Deputy Director, Health Sector, Dpt National Budget

**MINISTRY OF PROVINCIAL COUNCILS AND LOCAL GOVERNANCE**

Dr Omar Mowlana, Sri Lanka Institute of Local Governance

**MARGA INSTITUTE**

Dr Godfrey Gunatilleke, Deputy Chairman, Council of Fellows

**UNIVERSITY OF COLOMBO**

Dr Nimal Attanayake, Chair Working Group Financing, National Commission on M&H

Dr Amala de Silva, Chair Working Group Budgeting, National Commission on M&H

**WORLD BANK OFFICE, COLOMBO**

Dr Daya Samarasinghe, Health Specialist

Dr Kumari Vinodhani Navaratne, Public Health Specialist

**WORLD HEALTH ORGANIZATION, COLOMBO**

Dr Kan Tun, WHO Representative to Sri Lanka

Dr Palitha Abeykoon

Dr Fernando Thushara

**OTHER**

Dr G.R. Khatri, International Union against TB and Lung Disease

## SRI LANKA MACROECONOMIC AND HEALTH PROFILE

Annex 2



### Demographics at a Glance

Area:	65,000 sq km
Population:	19 million (2002)
Population Growth Rate (annual %):	.9% (2002)
Urban Population (% total) :	23%

### 1. Socioeconomic Context

#### Selected Economic and Social Indicators<sup>1</sup>

GDP (US\$)	16.6 billion (2002)
GDP per capita (US\$)	873 (2002)
GDP per capita annual growth rate	3.4% (1990-2002)
Total Debt Service	
% GDP	4.3% (2002)
% exports of goods and services	9.8% (2002)
Gini Index*	34.4 (1995)
Poverty (% below national poverty line**)	25% (1990-2001)
Population below \$1 a day	6.6% (1990-2002)
Human Development Index***	.740 (2002)
Adult Literacy Rate	92.1% (2002)
Female	89.6% (2002)
With access to improved water source (% pop.)	77% (2000)
With access to improved sanitation (% pop.)	94% (2000)

<sup>1</sup> UNDP Human Development Report, 2004

\* Gini index measures the degree of inequality in the distribution of family income in a country. Perfect equality = 0; perfect inequality = 100.

\*\* National poverty line—the poverty line deemed appropriate for a country by its authorities

\*\*\* Human Development Index is a composite index measuring average achievement in three basic dimensions of human development—health, education and standard of living.

Beginning in 1977, Sri Lanka has seen economic liberalization and a move towards market-oriented policies, including privatization of state-owned industries and opening the economy to international competition. Though serious ethnic disturbances have caused periodic slowdowns in economic reforms and times of political and economic uncertainty, Sri Lanka's economy has grown steadily over the past 25 years at an average rate of about 4 to 5% per annum. GDP was estimated at US\$ 16.6 billion in 2002. The first contraction of the economy in 2001 was caused by a variety of global economic and domestic budgetary,

political and security factors. Since that time there has been a marked recovery of the economy due to growth in the service industries (fueled by telecom and tourism), increased foreign investment and the furthering of the peace process that began in early 2002.

Despite significant poverty levels and decades of ethnic conflict, Sri Lanka has been able to attain high overall and female literacy levels, improved water and sanitation access, and strong health achievements, a testimony to Sri Lanka's pro-poor policies and social safety net over the past decades.

Although the economy continues to expand, Sri Lanka faces many challenges to maintain the economic growth and social achievements of the past 40 years. In 2002, Sri Lanka's external debt amounted to 105% of GDP and debt service accounted for 4.3% of GDP and 10% of exports of goods and service. One quarter of Sri Lanka's population live below the national poverty line, the unemployment rate reaches 10% and there are significant social and economic disparities due to decades of civil conflict with approximately 64,000 deaths and 800,000 people displaced. According to the World Bank, inequalities are highlighted among the poor and in the rural areas where 77% of the population lives.

## 2. Health Situation

<b>Selected Health Indicators<sup>2</sup> (2002)</b>	
Life Expectancy (years; 1996-2001) <sup>1</sup>	
Male	70.7
Female	75.4
Probability of Dying (per 1000, between 15-60 years)	
Male	238
Female	131
Infant Mortality Rate (per 1000)	15.7 (2000)
Under-5 Mortality Rate (per 1000)	19.8 (2000)
Maternal Mortality Rate [per 100'000]	60
Total Fertility Rate	2.0
Children underweight for age	
(% under 5, 1995-2000)	29%
% births attended by trained staff	95%
% children fully immunized	94%
Malaria cases [per 100'000]	1110

<sup>2</sup> WHO World Health Report 2004

Sri Lanka has long been recognized for its significant achievements in the area of health, reflected in population health indicators which approach those of some developed countries. These achievements have been attributed to the country's emphasis on social development and a social service network established in the late 1940s<sup>11</sup>. Over the past three decades, life expectancy at birth has exhibited a dramatic improvement with males averaging 70.7 years and females 75.4 years (1996-2001).<sup>1</sup> Fertility rates have declined to replacement levels and infant mortality rates have seen a significant decline from 35 (1980) to 15.7 (2000) deaths per 1000 live births. Under-5 mortality rates likewise have decreased from 48 per 1000 live births in 1980 to less than 20 in 2000. The decrease in infant and under-5 mortality rates can be attributed to a combination of high percentage of attended deliveries, improved antenatal care, high immunization levels, nutrition programmes, and other health interventions.

A number of health challenges persist in Sri Lanka including malnutrition in children resulting in anemia, and continuing threat of infectious diseases such as

malaria. Sri Lanka, like many developing countries, is experiencing a double burden of disease with the growing prevalence of noncommunicable diseases due to lifestyle changes and an aging population. Additionally, significant health inequities exist in the conflict areas in the north and east of Sri Lanka, including 58% of all malaria cases and high levels of chronic malnutrition due to a lack of access to care and high level of internally displaced peoples<sup>12</sup>.

## 3. Health Expenditures

Sri Lanka's total health expenditures amounted to 3.6% of GDP in the late 1990s, about 50% of which financed by the public sector (or 1.8% of GDP) but may have decreased to perhaps 1.3%<sup>13</sup> in the past two years (under the pressure of the defense budget and lower overall Government revenues as a share of GDP).

<sup>11</sup> Department of Census and Statistics, Sri Lanka.

<sup>12</sup> UNICEF. At a Glance: Sri Lanka. <http://www.unicef.org/infobycountry/srilanka.html>.

<sup>13</sup> MacroHealth Sri Lanka, Newsletter No. 1, April 2004 (published by the NCMH Secretariat).

Financing of public health expenditures comes primarily from government general revenues, external aid, and a small amount from employment-based or provincially generated funds.<sup>14</sup> Private financing is mainly from out-of-pocket payments of patients and families. External resources for health have increased over the years to an estimated 3.1% of total health expenditures (or 6% of Government health expenditures).

In the coming years, the main challenges for Sri Lanka will be maintain the health status of the population and extend these health achievements to the poorest segment of the population and to the displaced persons. This may prove difficult in view of the growing importance of noncommunicable diseases (involving higher costs) and the current low level of Government health spending (including in preventive health care services). To this end, the Minister of Health recently has pledged to increase government funds allocated to the health sector to 2.5% of GDP in 2005 and introduce measures to efficiently and equitably utilize the increased allocations.

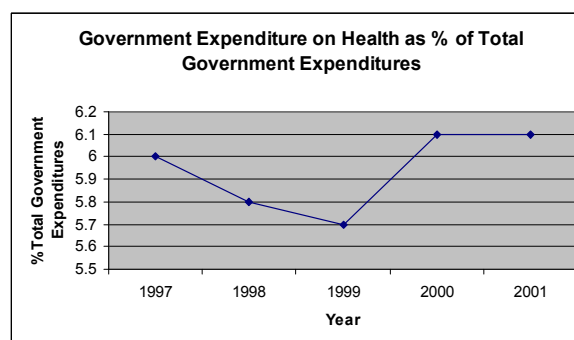
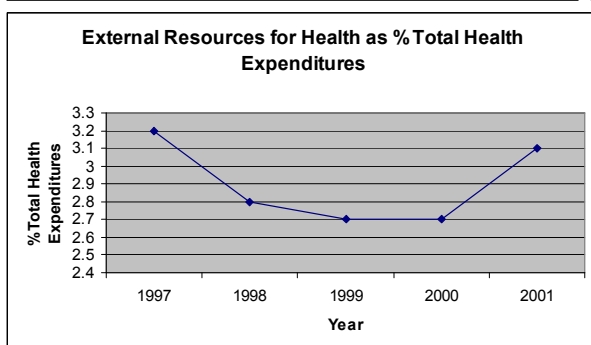
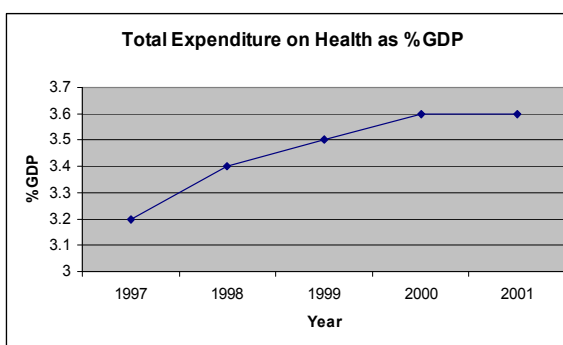
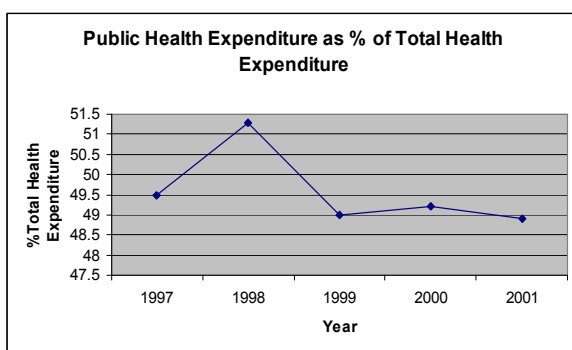
### Health Expenditures (2001)<sup>1</sup>

Total Expenditures on Health (%GDP)	3.6%
Public Expenditures on Health (%GDP)	1.8%
Per Capita Expenditures on Health	\$30
Government Expenditures on Health as % Total Government Expenditures	6.1%
<b>% of Total Health Expenditures</b>	
Public	48.9%
External (included in the total Public Health Expenditures)	3.1%
Private	51.1%
% of Private Health Expenditures that are Out-of-Pocket	95%
% of Private Health Expenditures that are Pre-Paid Plans	1.1%
<b>Government Sector Expenditures as % of Total Government Budget<sup>2</sup> (2002)</b>	
Health	6.1%
Education	9.2%
Defense	12.2%
Social Security and Welfare	11.9%

<sup>1</sup> WHO, World Health Report, 2004

<sup>2</sup> IMF Country Reports 2004

<sup>14</sup> WHO, Sri Lanka. Macroeconomics and Health Initiatives Sri Lanka: Investing for Health, April 2002.



#### 4. Health System Profile

Physicians per 100,000 pop	40.0 (2001)
Nurses per 100,000 pop	76.0 (2000)
Hospital beds per 100,000 pop	270 (1990)
Immunization, measles (% children under 12 months)	99% (2001)
Immunization, DPT	99% (2001)

Government Health Expenditures <sup>3</sup>		
	1990	1999
Curative Services	45%	56%
In-patient Care	29%	37%
Ambulatory Care	16%	19%
Rehabilitative Care	0%	0%
Ancillary Services	0%	0%
Outpatient Medical Goods	1%	2%
Preventive and Public Health Services	20%	11%
Health Programme Administration and Insurance	4%	4%
Capital Expenditures	30%	27%
Total	100%	100%

**Health system structure.** Sri Lanka's achievements in strengthening infrastructure and access to health care can be exemplified by 95% of births attended by trained staff and 94% of children in 2000 reported to be fully immunized. Health care in Sri Lanka is managed centrally by the Line Ministry and by 8 provincial ministries. The Line Ministry traditionally has the role of regulation and coordination but also maintains a role in direct delivery of health services. The provision of care can be categorized into curative and preventive services

within a multi-tiered system of smaller outpatient facilities and larger secondary and tertiary care hospitals. The larger secondary and tertiary care hospitals have witnessed overcrowding while the smaller, primary care facilities have seen underutilization due to the preference of patients for institutions with better facilities and perceived higher quality of care. Preventive services are provided by 280 health units around the country run by Medical Officers of Health. An important component of the preventive health system is the Public Health Midwife who provides a wide variety of maternal and child health care and ensures a link between the family and the clinics.<sup>15</sup>

The private sector also plays an important role in health care delivery by providing an estimated 50% of outpatient care and 5% of inpatient care.<sup>5</sup> In addition, the traditional medicine systems, armed forces and prisons represent a segment of health care provision.

**Decentralization.** Since 1987, the health sector has been evolving into a decentralized system. Many of the areas of delivery and management of health services has been delegated to the Provincial Ministries but several central functions have been kept by the Line Ministry, including health worker training and delivery of services through teaching hospitals.

**Health financing.** Government health expenditures are mainly financed by central government general revenues and by external aid. A small amount is also contributed by job-based funds and provincial sources. Private financing is almost exclusively from household out-of-pocket expenditures (95% in 2001)<sup>5</sup> and smaller contributions in the form of pre-paid insurance plans and NGOs.

**Human resources.** 10% of all government workers work in the health care sector. The number of doctors and nurses has been increasing over the past two decades. There is in fact a surplus of doctors currently, particularly in the capital city, due to measures taken in the 1980s and 1990s to combat physician shortages. Graduating physicians until 2009 have been guaranteed recruitment by the government.<sup>5</sup> Government physicians are allowed to have a private practice when off-duty.

In contrast there is a shortage of nurses, especially in the rural areas and smaller facilities. Skilled health staff is found to be concentrated around the capital city and relatively limited in rural districts and conflict areas, namely in the Northern and Eastern Provinces.

## 5. Current Health and Development Planning/Reforms

**Health sector plans.** Sri Lanka has undertaken a series of efforts over the years to define the national health strategy for providing efficient, effective and accessible care to the population. In 1992, the Ministry of health, for the first time since Sri Lanka's independence, developed a comprehensive National Health Policy. The draft policy focused on the needs of the underprivileged and vulnerable with major strategic directions on human resource development, decentralization of health administration and improving quality and efficiency of services. The plan also emphasized the importance of community involvement in the "planning, implementing, and evaluating all health and health-related activities".<sup>5</sup> With a change in administration, a new health policy document was developed in 1996. The broad aim of this policy was to further increase life expectancy through the reduction of preventable diseases and health promotion. The plan identified key disease areas to target and addressed the allocation of more resources for priority health needs and the financing of health care for the poor. The implementation of the 1996 National Health Policy however resulted in the targeting of tertiary and secondary hospitals as opposed to a broader disease control strategy or district level primary care services. In 2001, following-up on the Health Sector Reform Unit's work, an 18-point health programme was developed that focused on "upstream policy development, strengthening primary health care, and improving equity and quality of health services".

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<sup>15</sup> WHO, Sri Lanka. Macroeconomics and Health Initiatives Sri Lanka: Investing for Health, April 2002.

Over the last few years emphasis has been placed on the integration of health and economic development goals and on the interaction between the two. The following two documents have highlighted the challenges facing the health system and the importance of investing in health for overall poverty reduction :

***Vision 2010.*** In 2001, the Government of Sri Lanka launched *Vision 2010*, a new plan for accelerating the economic development of the country with ambitious macroeconomic and sectoral goals. In the field of health, objectives were set with respect to the elimination of malnutrition for children under 5, reduction of iron deficiency anaemia among pregnant women, reduction of the incidence of NCDs, special programmes in TB and malaria, and development of comprehensive health services with particular emphasis on the disadvantaged populations.<sup>16</sup>

***PRSP and Regaining Sri Lanka Report.*** In 2002, the Government of Sri Lanka, in broad consultation with all stakeholders, outlined its poverty reduction strategy in the *Regaining Sri Lanka Report*. The priority areas of this strategy are a significant increase in economic growth, a greater role by the private sector in economic growth and poverty reduction, development of the rural sector, and promotion of human and economic development.<sup>17</sup> In the field of health, the same concerns and objectives were expressed as in previous global planning documents of the Government.

***The National Commission on Macroeconomics and Health.*** While remaining general in their formulation, the above-mentioned policy documents gradually opened the door to a number of economic concepts in the field of health, which facilitated much the discussion of the recommendations of the international Commission on Macroeconomics and Health when its Report was published in December 2001. As a result, the decision was made by the National Health Council (presided over by the Prime Minister) in August 2002 to create the National Commission on Macroeconomics and Health (NCMH), to be co-chaired by the Minister of Health and the Minister of Finance. The Commission was formally established in November 2002. Its overall responsibility is to advise the Government and the Minister of Health on all aspects related to increasing investments in health and ensuring the optimal contribution of the health sector to economic development and fighting poverty. In 2005, the NCMH plans to finalize the National Health Investment Plan on the basis of the documents mentioned above and submit it for approval by the Government and Parliament.

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<sup>16</sup> WHO, Sri Lanka. Macroeconomics and Health Initiatives Sri Lanka: Investing for Health, April 2002.

<sup>17</sup> Sri Lanka PRSP, 2002. Regaining Sri Lanka: Vision and Strategy for Accelerated Development

## **National Commission on Macroeconomics and Health**

### **Composition of Working Groups**

#### **WORKING GROUP I (BUDGETING)**

- Senior Lecturer in Economics, University of Colombo (Chair)
- Ministry of Finance
  - Secretary, Finance Commission
  - Director Human Resources, National Planning
  - Director General, National Budgeting
- Ministry of Healthcare, Nutrition and Welfare
  - Deputy Director General, Planning
  - Deputy Director General, Chief Accountant
  - Director, Finance estimates
- Provincial Ministries of Health
  - Provincial Director Health, Western Province
  - Provincial Director Health, Southern Province
  - Provincial Director Health, North Central Province
- District level health services
  - Director Health Services, Ratnapura District
  - Accountant, Ratnapura District
- Representative Institute of Policy Studies (under Ministry of Finance)
- President, Independent College of General Practitioners (private sector)

#### **WORKING GROUP II (FINANCING)**

- Senior Lecturer in Economics, University of Colombo (Chair)
- Ministry of Finance
  - Director General, National Planning
  - Director General, External Resources
  - Additional Director General, Budget
- Ministry of Healthcare, Nutrition and Welfare
  - Deputy Director General, Finance
  - Deputy Director General, Planning
  - Director, Children's Hospital (tertiary care), Colombo
- Central Bank
  - Senior Economist, Research Department
- Representative, Institute of Policy Studies (under Ministry of Finance)
- President, Independent College of General Practitioners (private sector)
- Representative, Marga Institute (Research NGO)

Further members may be asked to join, depending on the subject matter.

**Sri Lanka Health Research Map: A Practical Framework for Organizing Information**

		ACTORS AND FACTORS DETERMINING THE HEALTH LEVEL OF A POPULATION (INTERVENTION LEVELS)			
	Global level	(a) Individual and community level	(b) Level of health ministry, health and health research systems	(c) Level of sectors other than health	(d) Level of central government and macroecon. policies
<b>1. BURDEN OF DISEASE (present level and future objective)</b>	<u>Study 4:</u> Econ cost of five common diseases <u>Study 5:</u> Occupational health study among working pop.				
<b>2. WHY DOES BURDEN PERSIST? (analysis of causes)</b>					
<b>3. PRESENT STRATEGIES (and programmes)</b>			<b>Study 1:</b> Review of cost studies of health services  <b>Study 3:</b> Review of current basis for allocation of health resources by the central government to the provinces		<b>Study 2:</b> Evaluation of taxation and fiscal incentives to support health sector development
<b>4. FUTURE STRATEGIES (and programmes)</b>		<b>Study 6:</b> Cost implications of a community nursing service			
<b>5. PRESENT FINANCIAL RESOURCES</b>					
<b>6. NEEDED FINANCIAL RESOURCES</b>					