# Redistributive impacts of financing and delivery in Sri Lanka's healthcare system

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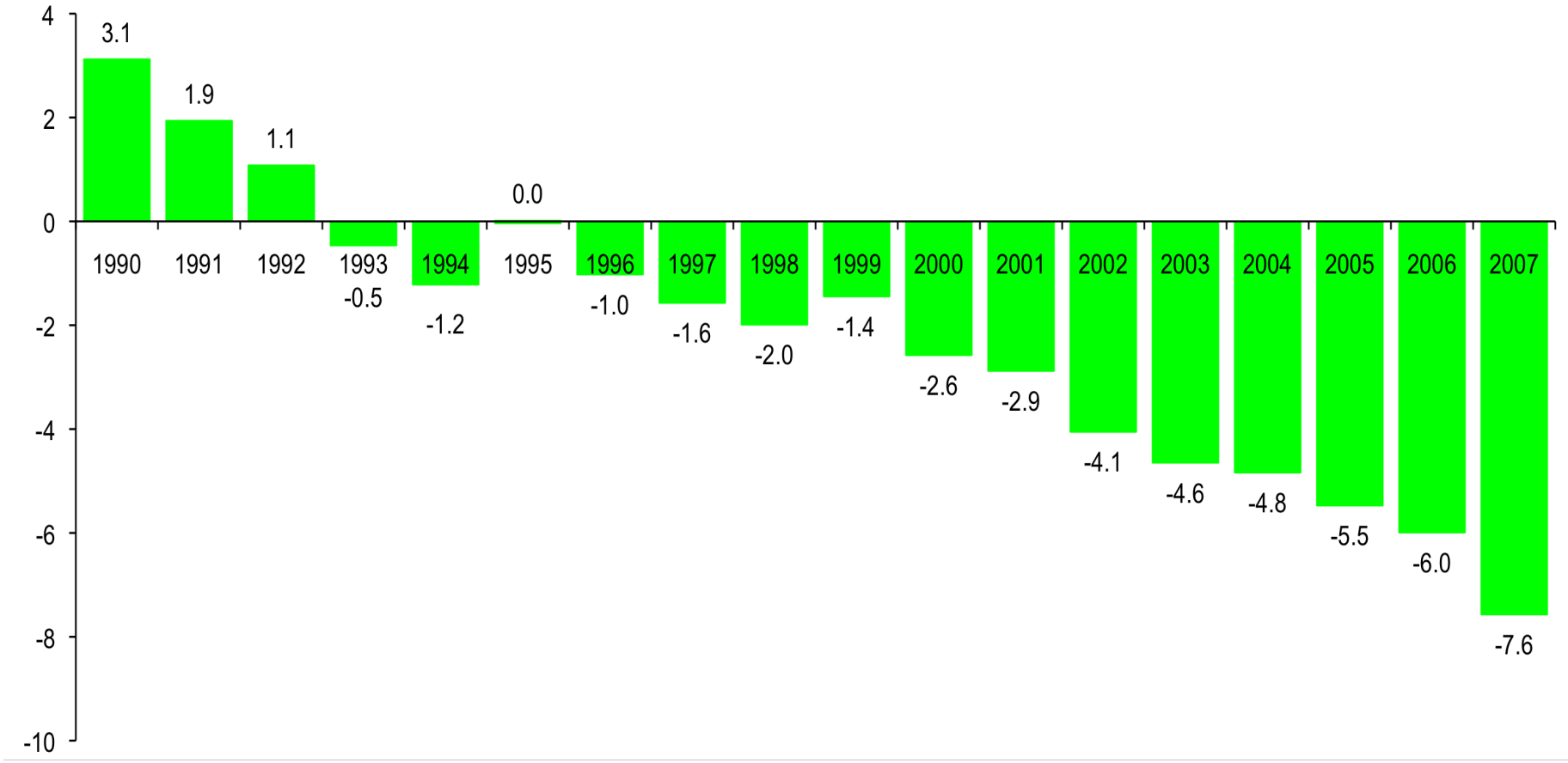
# Outline

- Healthcare financing debate in Sri Lanka
- Sri Lanka healthcare system
  - Profile of financing
  - Profile of delivery
- Analysis of financing and benefits in current system
- Simulation of substitution of public provision for private provision

# Fiscal pressures and financing debates

- <1930s
  - Healthcare seen largely as private good, and left to market
- 1931-51
  - Income taxation introduced and government tax-financing accepted as insurance mechanism
  - User fees abolished
- 1951-60s
  - Increase in government expenditure peaked with fiscal constraints
- 1980s –
  - Large fiscal deficits owing to tax cuts. Constant calls to either to reduce tax financing of government services or introduce user fees or insurance
  - Repeated failure to sustain cuts in tax-financing or to introduce alternative financing mechanisms (1972, 1980, 1997, 2004, 2009?)

# Tax/GDP ratio compared to countries at similar income level, Sri Lanka 1990-2007



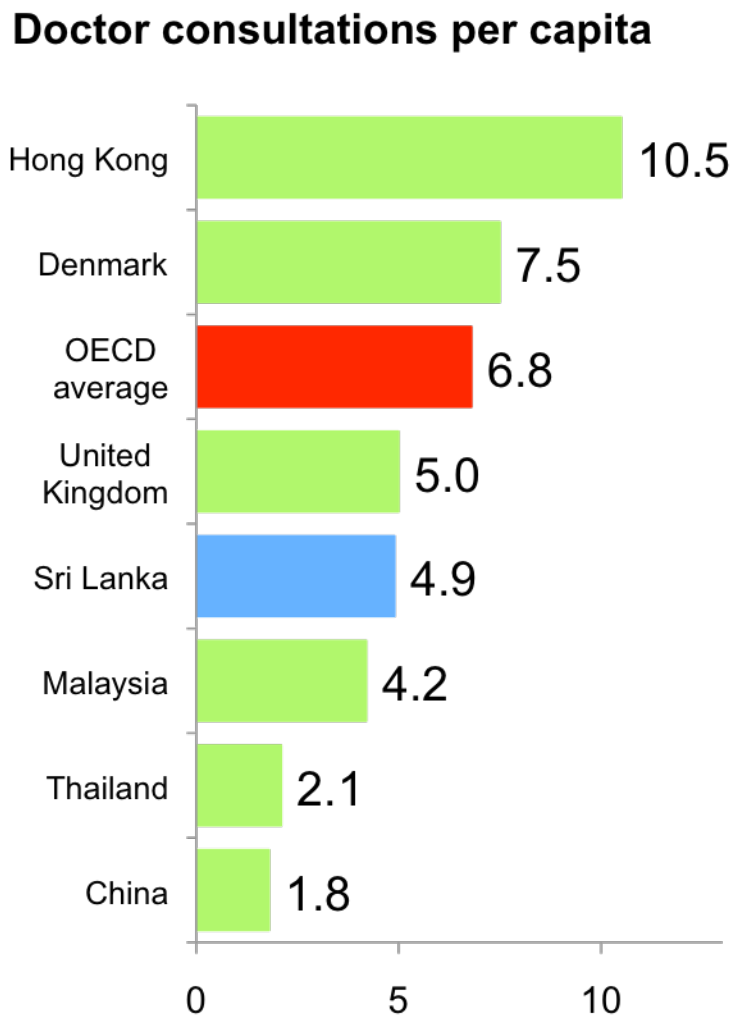
# Country background

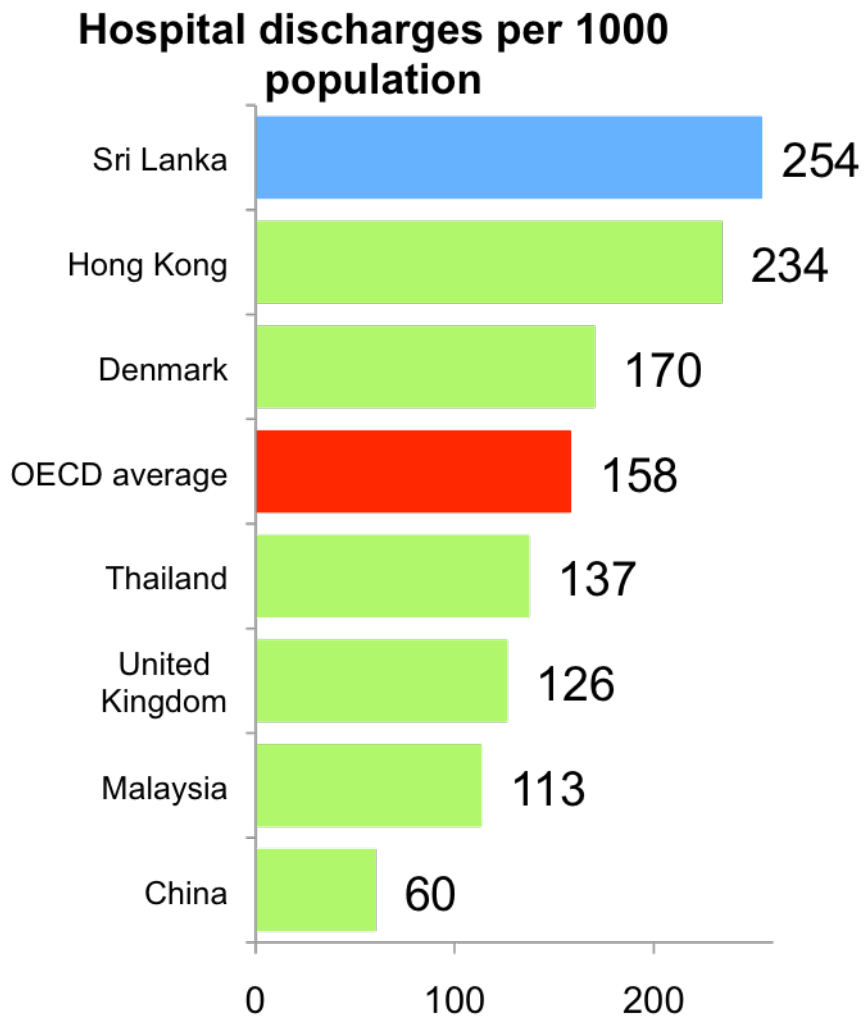
- LIC/LMIC economy
  - GDP per capita US$ 2,000 (2009)
  - GDP per capita growth 4% (1990-2009)
  - Tax revenues 15% of GDP
- Population
  - 20 million (2009)
- Health outcomes
  - IMR 11.2 deaths/1,000 live births
  - LEB (women) 76.4 years
  - LEB (men) 71.7 years
- Disease pattern
  - Dominated by NCDs, with CVD leading cause of death

# Health system

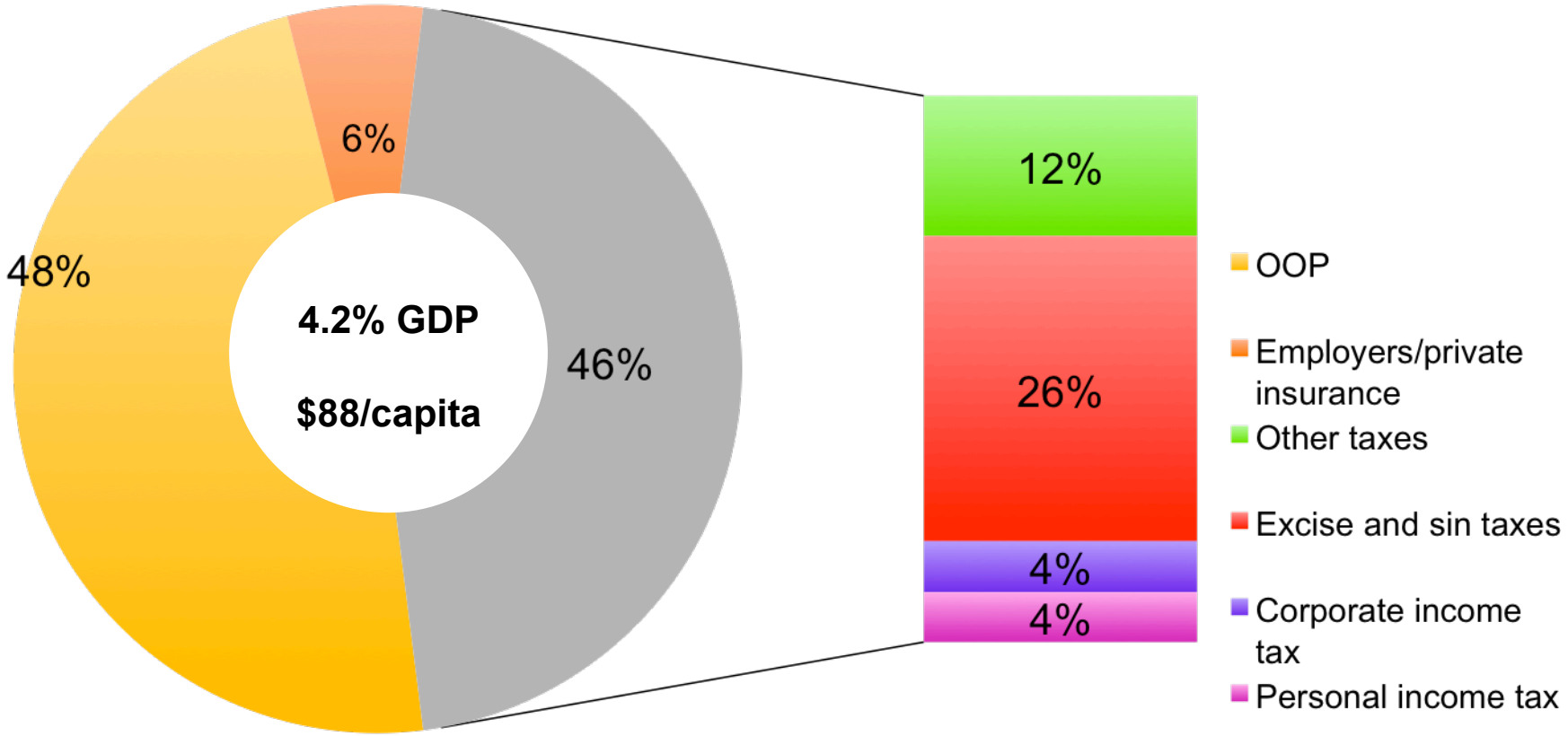
- Public sector
  - Universal coverage through tax-financed, free public services, dominated by extensive government hospital system
    - 96% of inpatient care
    - 45% of outpatient care
- Private sector
  - Fee-for-service based private provision. Mostly staffed by government doctors doing dual practice
    - 4% of inpatient care
    - 55% of outpatient care
    - Limited financing by insurance (2%) and employer schemes (5% of total financing)

# Relative levels of service delivery



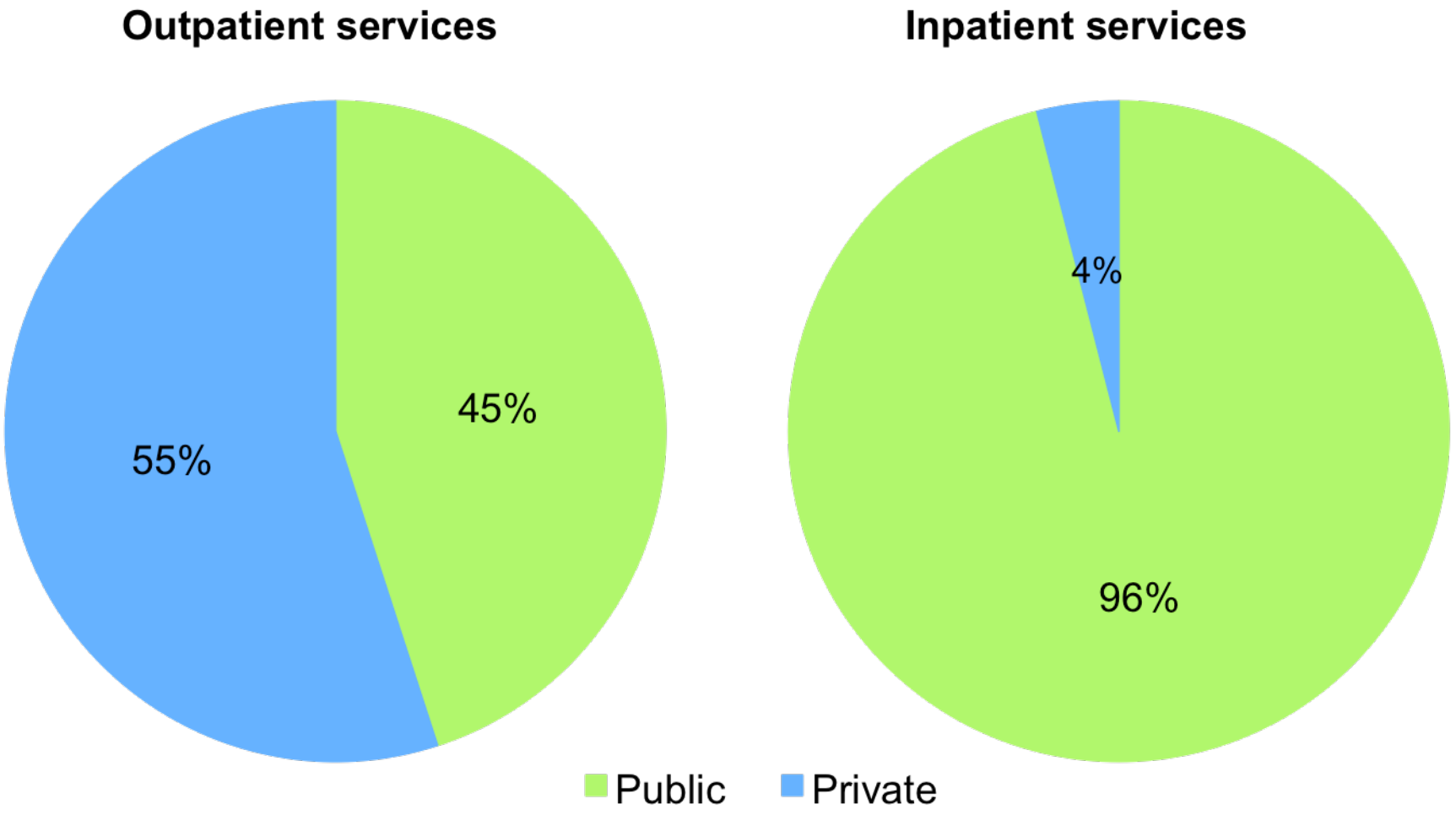
# Sri Lanka healthcare financing (2006)



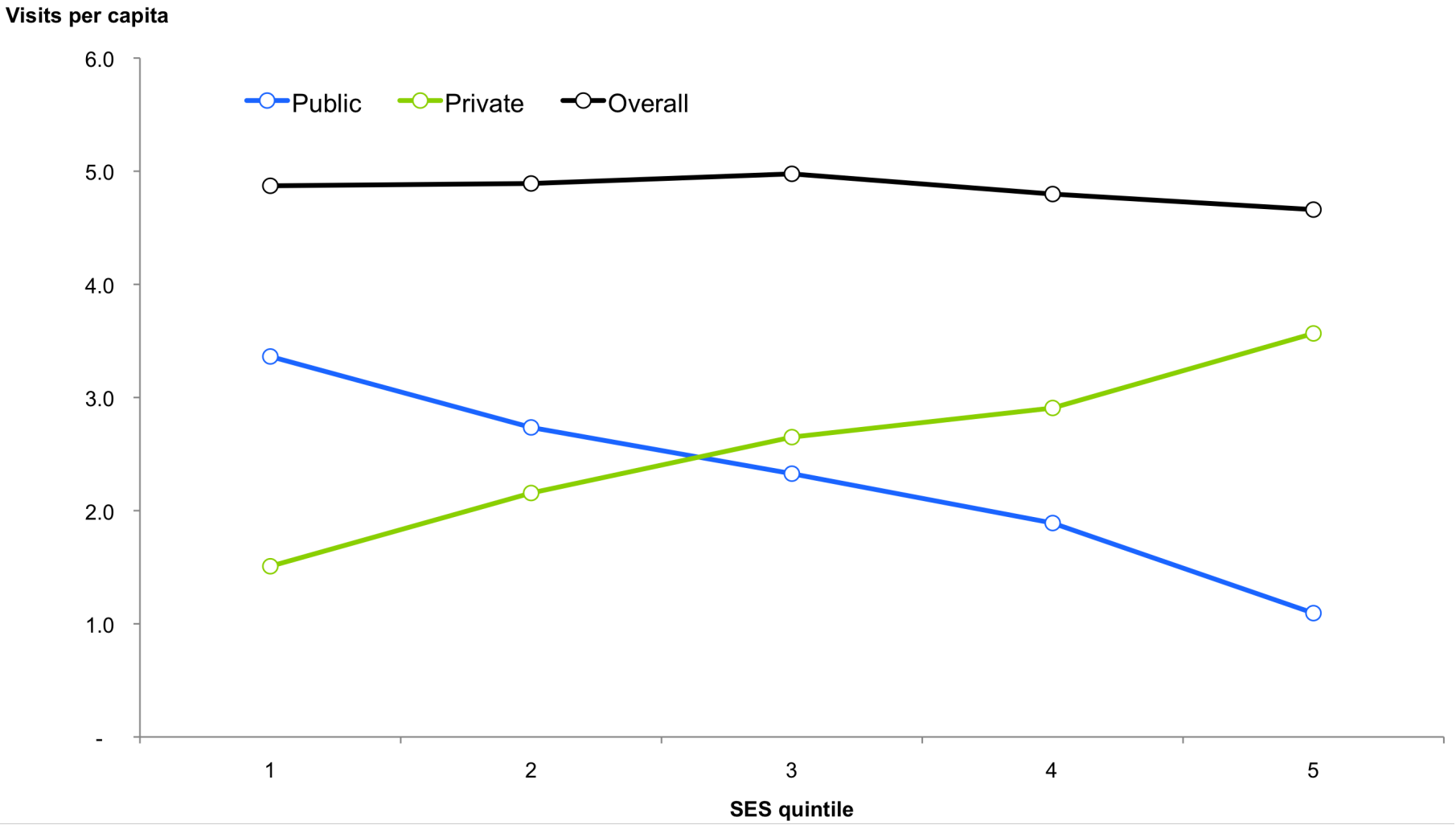
# Public sector user charges

- Official charges for inpatient/outpatient services:
  - zero
- User charges only for private pay-beds and family planning services:
  - ~1% of total MOH costs
- Informal payments
  - Not common
  - Patients expected to self-purchase medicines/ supplies from private sector if out of stock

# Service delivery by public/private sectors



## Distribution of outpatient visits by source by SES quintile, Sri Lanka 2004



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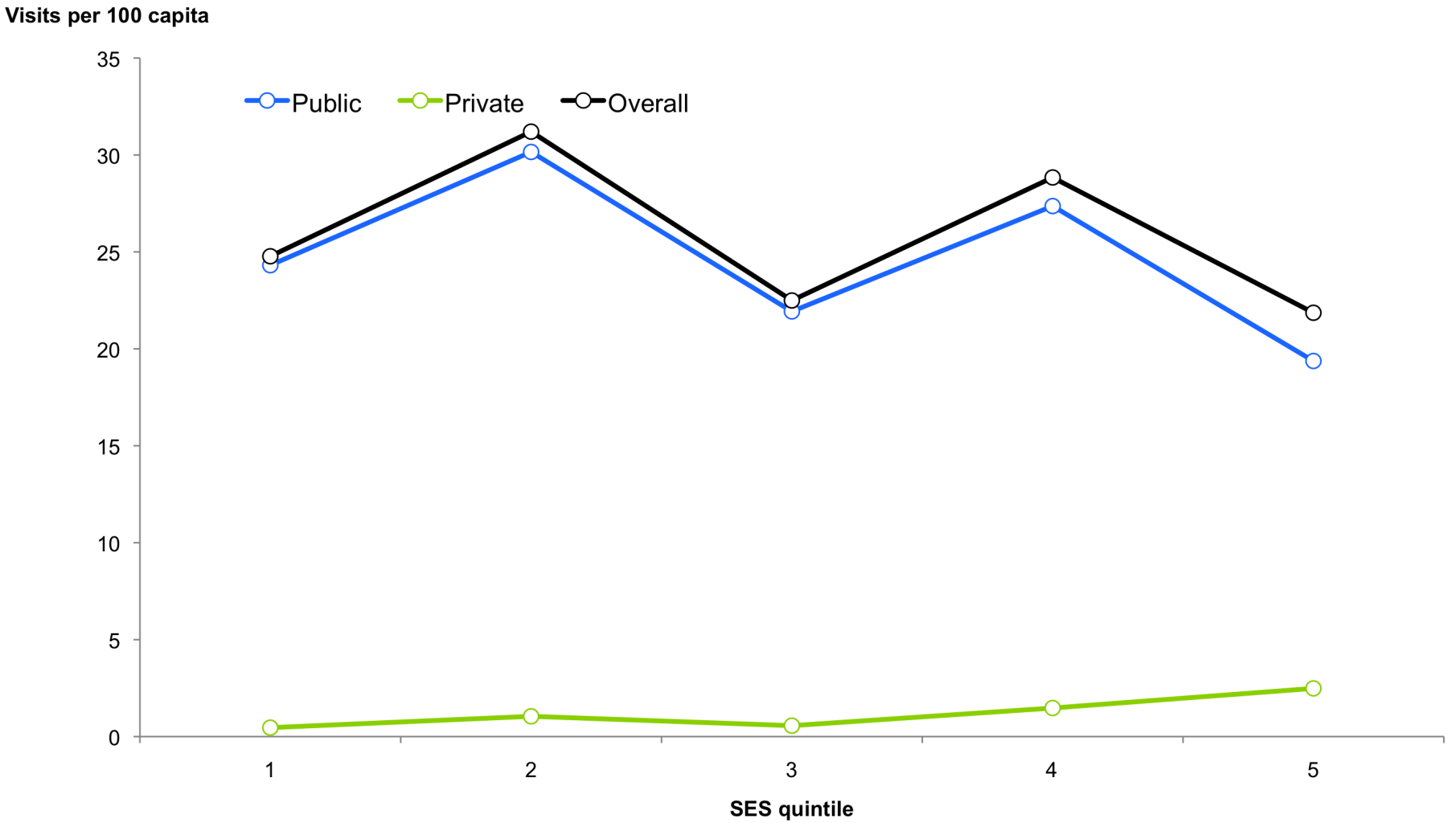
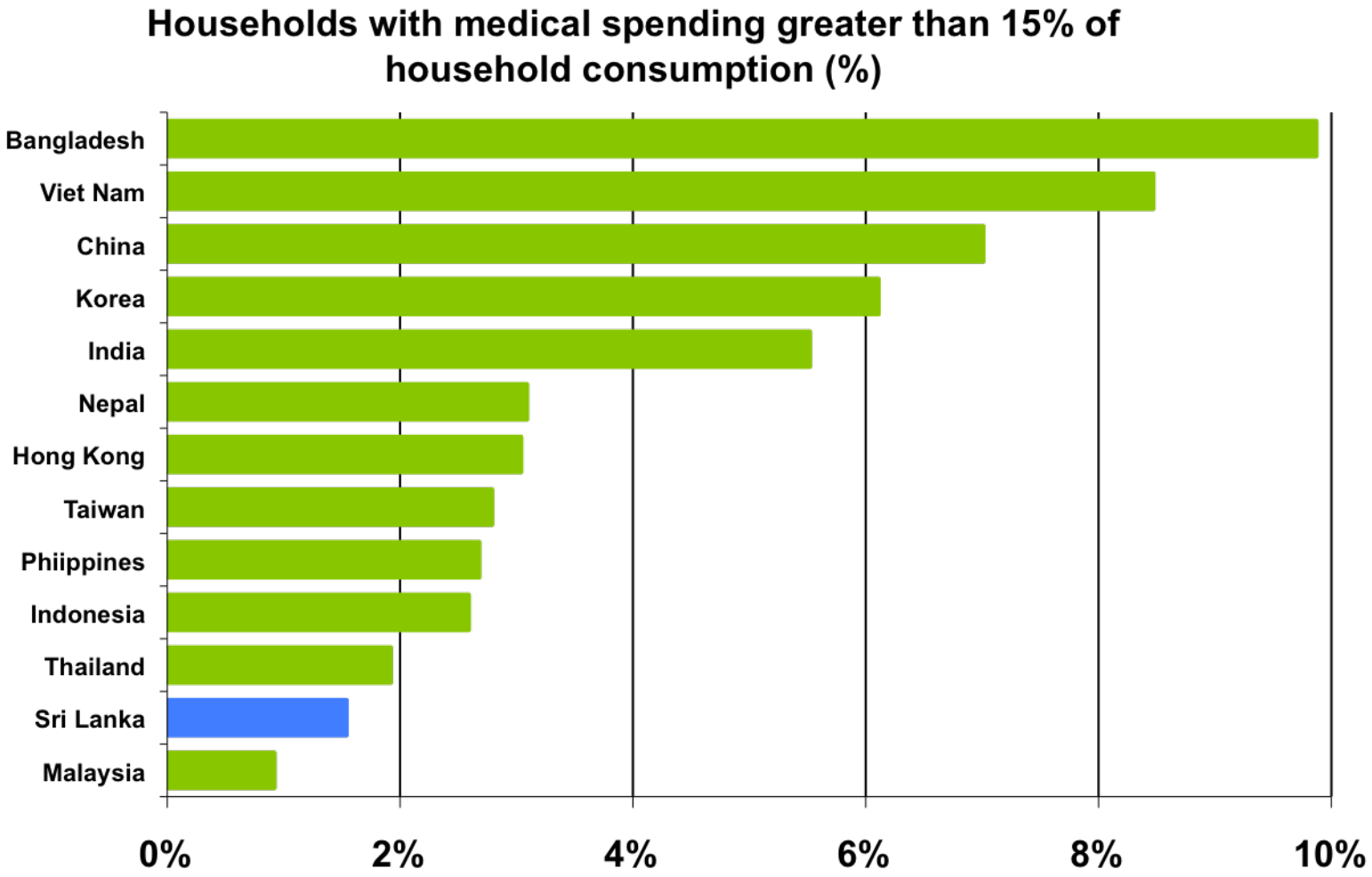


# High levels of financial risk protection by regional standards

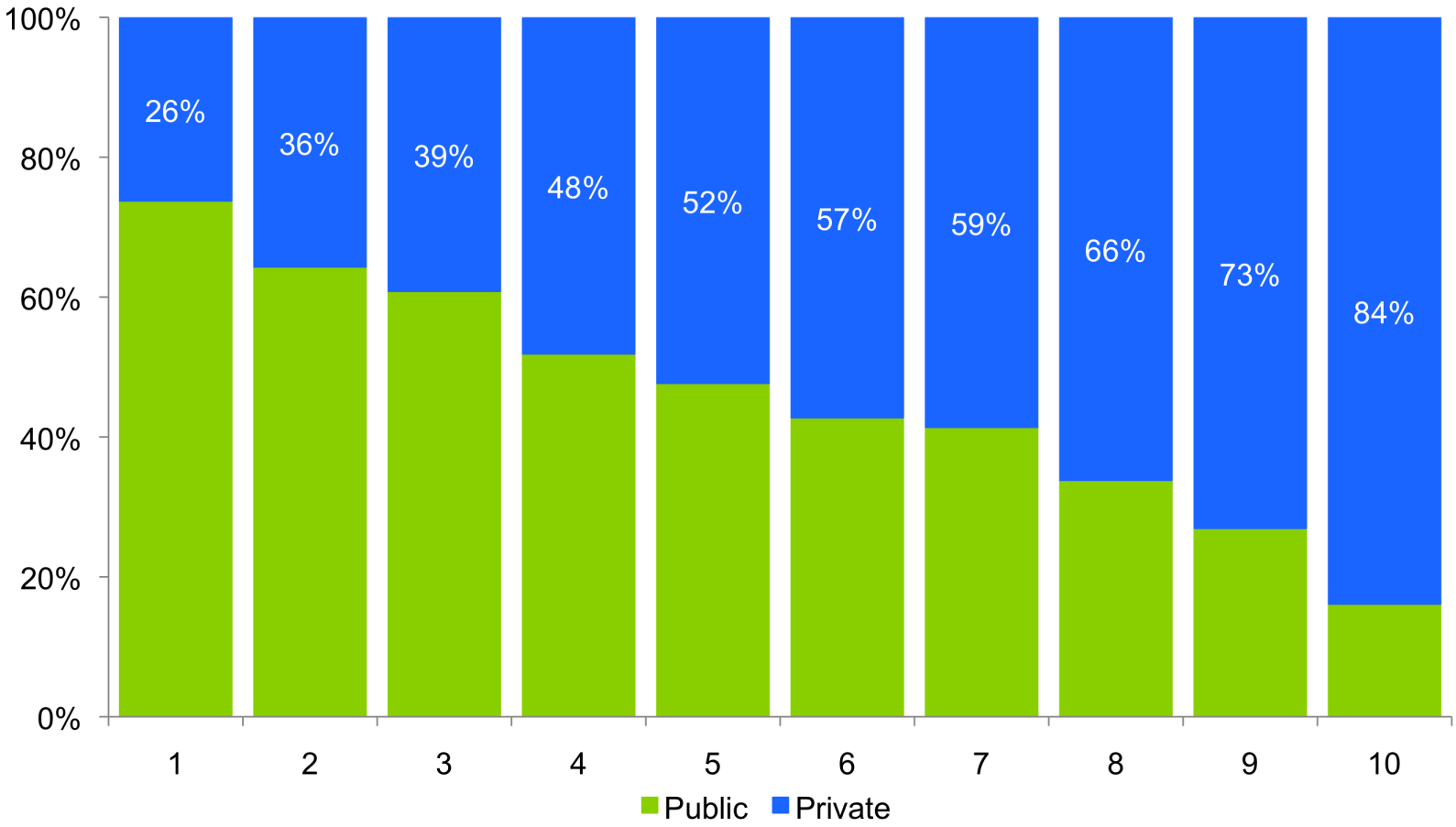


# Health system performance

- Excellent health outcome indicators, with high levels of healthcare use
- Close to universal coverage with good financial risk protection
- Equality in healthcare use (if not true equity)
- Low levels of government expenditure on health
  - **But high frequency of dissatisfaction targeted at policy makers**

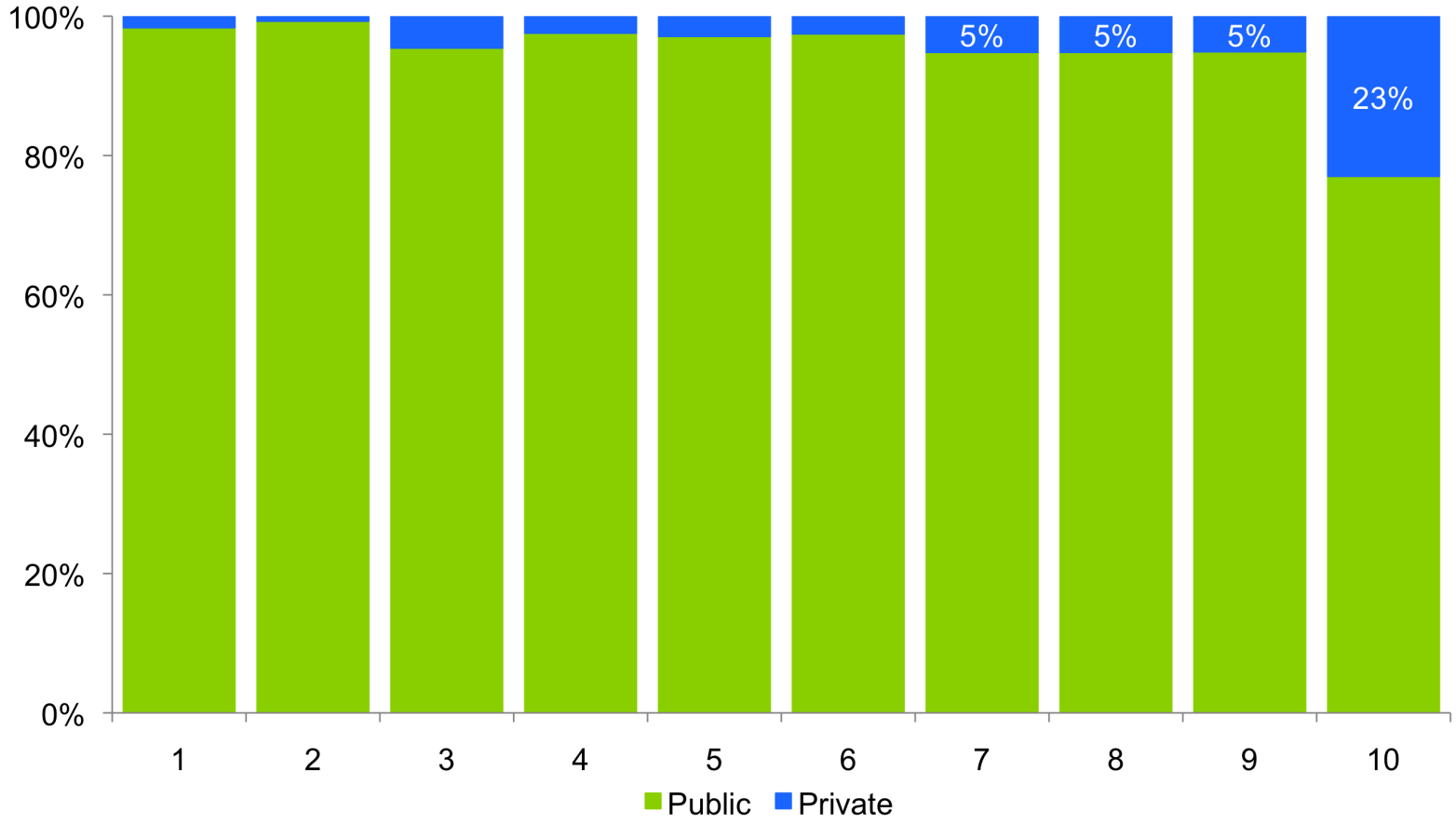
# Unhappiness of middle income groups over use of private doctors

**Public/private mix in outpatient use by SES decile, Sri Lanka 2006**

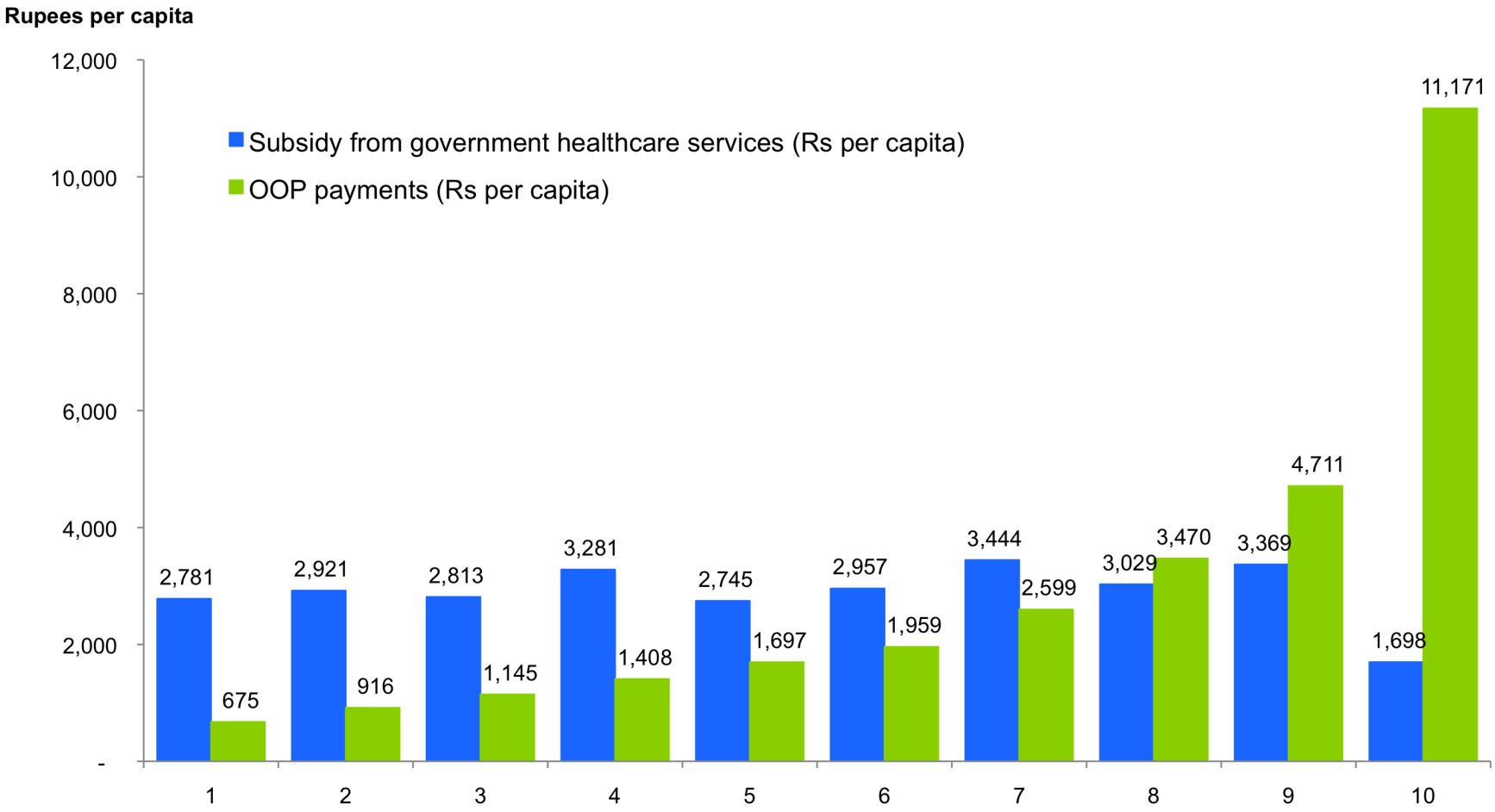


# Unhappiness of upper-middle income groups over cost of private inpatient care

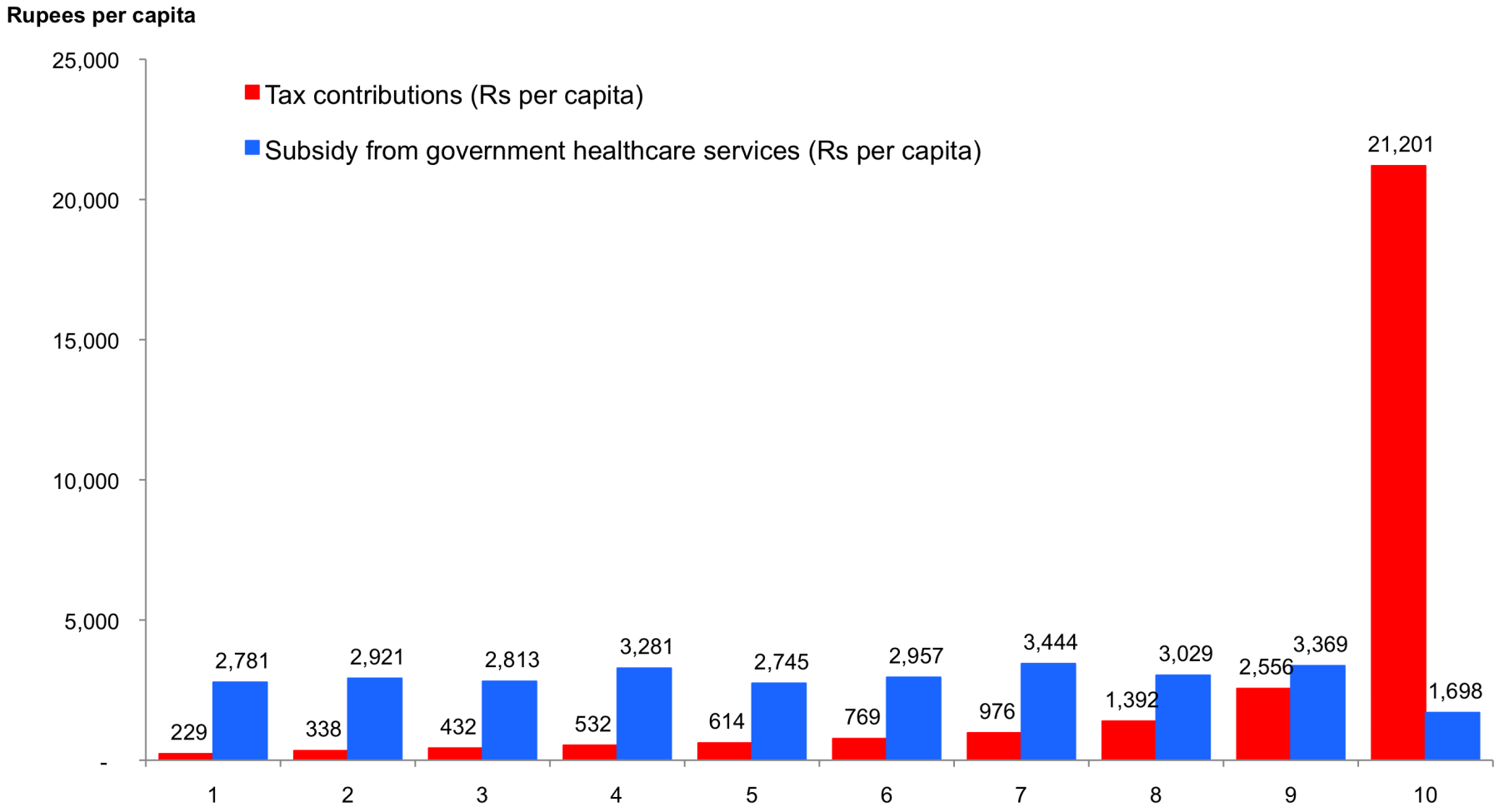
**Public/private mix in inpatient use by SES decile, Sri Lanka 2006**



## Distribution of health expenditures by source by SES decile, Sri Lanka 2006

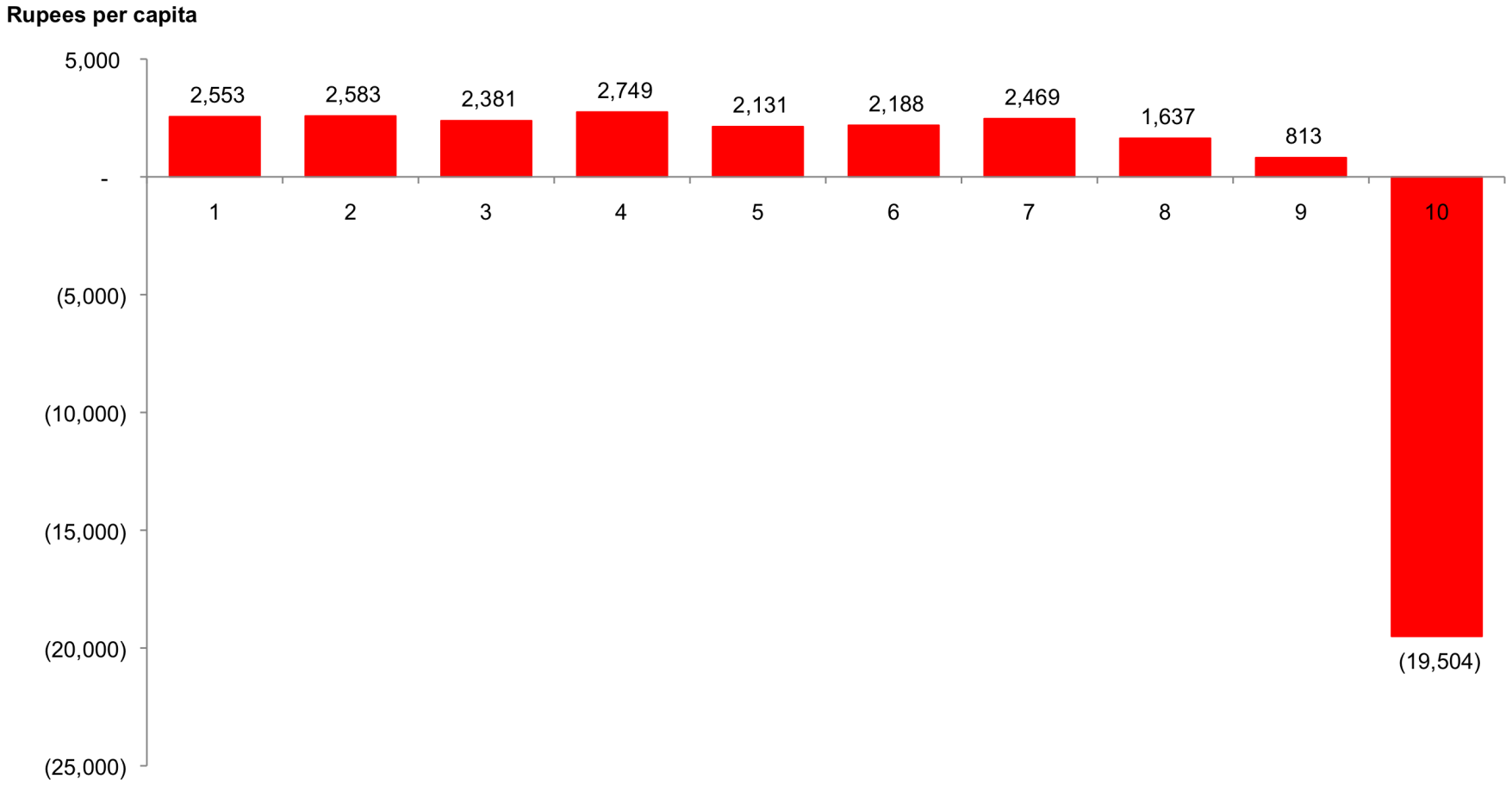


# Distribution of tax payments and healthcare subsidies, Sri Lanka 2006



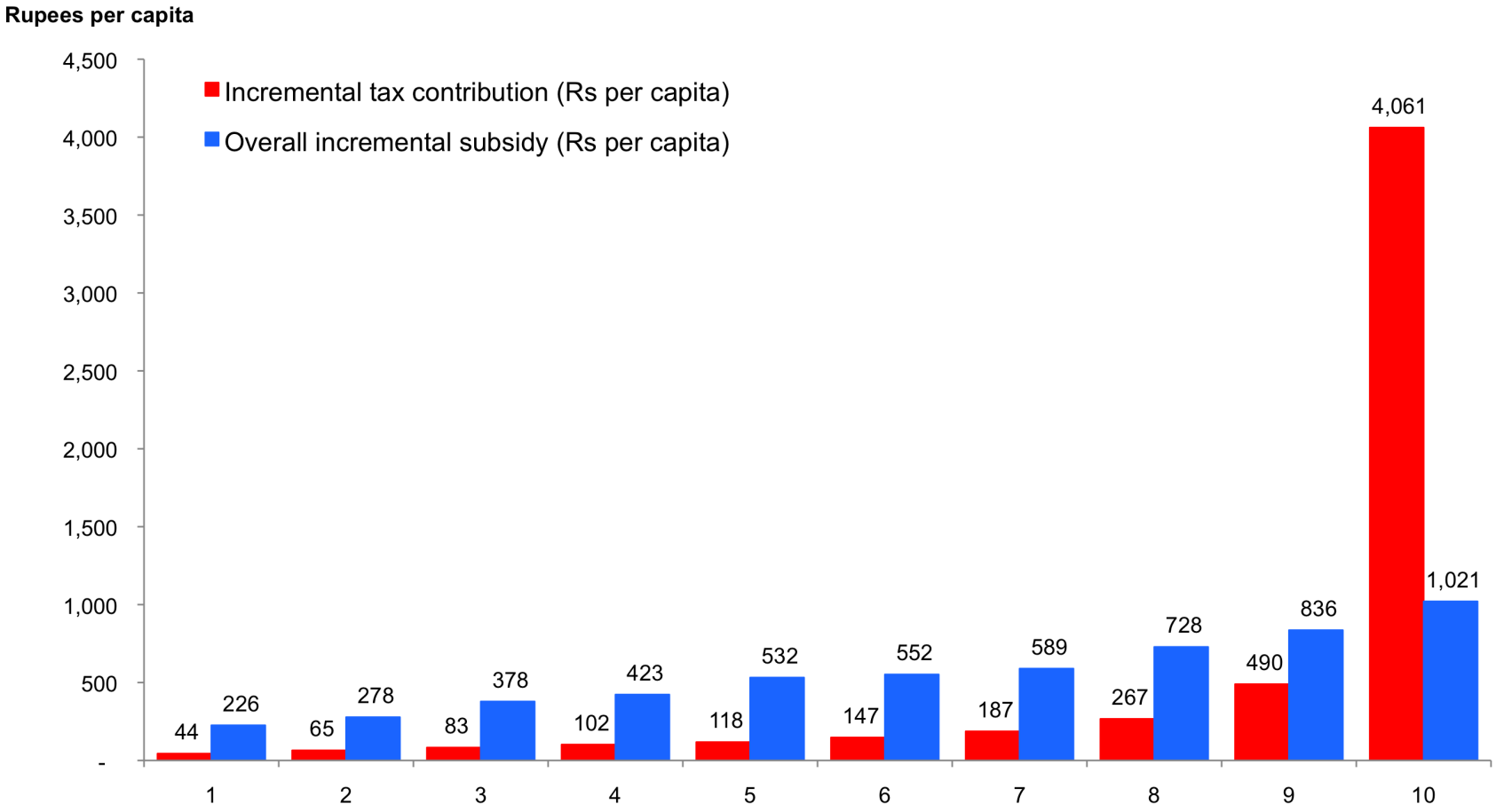
# Redistribution in financing

**Net subsidy/payments from government healthcare, Sri Lanka 2006**



# Simulation: Impact of increasing public spending

**Distribution of incremental tax payments and healthcare subsidies (Sri Lanka 2006 simulation)**



# Summary

- Electoral balance in favour of status quo
  - Healthcare financing system is least expensive solution for 75-85% of population
  - 15-20% unhappy about having to pay for private option and paying taxation
- Social insurance option unlikely to be favored by most voters
  - Insurance contributions will largely fall on upper 2 quintiles, but at current costs could not extend coverage to private provision without substantial premiums
  - Insurance coverage limited to formal sector unlikely to be supported by majority of voters