1. Key development issues and rationale for Bank involvement

Having emerged from nearly three decades of civil war, Sri Lanka is aspiring to re-establish a peaceful and prosperous nation with the participation of all segments of the population. The realization of this aspiration will depend on the management of four inter-linked transitions: (a) from conflict to lasting peace; (b) from low-income to middle-income (estimated GDP per capita in 2009: USD 2,053); (c) demographic i.e., aging population; and (d) epidemiological, i.e., from a predominance of communicable diseases (CDs), maternal and child health to a growing burden of non-communicable diseases (NCDs). With a stable government in place, it is opportune for policy actions to shape these transitions positively.

*Sri Lanka’s remarkable progress in improving the population’s health status* over the past several decades is internationally acknowledged. Increased life expectancy at birth (40 yrs. in 1930 to 65 yrs. in 1970 and to 72 yrs. by 1990, continuing at this level at present), and declines in infant mortality rate from 82/1,000 in 1950 to 47 in 1970 and 15 in 2006 and in total fertility rate (from 4.7 in 1970 to 1.9 in 2000, and 2.3 in 2006) have been achieved largely by effective public health services covering almost the entire population, even in war-affected areas.

*The demographic and epidemiological transitions will have a significant impact on the health sector and warrant a reorientation of the health system.* Driven by higher life expectancy and lower fertility levels, Sri Lanka has been going through a demographic transition, at a very rapid pace: the proportion of people 60 years and older increased from 5.4% in 1945 to 9.2% in 2000 and to 12.1% in 2010. This is projected to double from current the level to 24.4% by 2040. Side by side, the epidemiological transition has also been under way: approximately 85% of the disability-adjusted life years lost in Sri Lanka are now attributable NCDs (including injuries).
Urbanization and life-style changes have also increased the incidence of acute NCDs (mainly injuries) and mental health problems. When we examine mortality alone, infectious diseases and maternal and child health (MCH) conditions accounted for only 20.2% of deaths in 2003, compared with 46.6% in 1945. However, malnutrition (21% under-five children underweight and 16% women below body mass index of 18.5) continues to be a lagging indicator in the otherwise impressive Sri Lankan story, when it comes to MCH.

**NCDs and diseases of the elderly are more expensive to prevent and treat; the transition to middle income status is resulting in higher expectations of the citizenry for health care quality. All this will raise health care costs, and put pressure on an already constrained fiscal space.** Total health expenditures at 4.2% of the Gross Domestic Product (GDP) is at the lower end of the spectrum of countries with similar national income; this spending is roughly equally divided between public and private sources. About 50% of ambulatory care, 90-95% of inpatient care and almost 100% of preventive services are financed publicly, and provided through health facilities owned and operated by the government. The remainder is in the private sector, largely financed by out-of-pocket payments with a small contribution from insurance mechanisms. Apart from providing expensive hospital care for the richer segments of the population, the private sector is mainly providing ambulatory care (largely by government-employed providers doing private practice), certain pharmaceuticals and laboratory services (lacking in the public sector due to a combination of resource shortage and inadequate planning / management). In the public sector, the central level manages pharmaceutical procurement, human resource development and deployment, tertiary care, and stewardship functions (policy, planning, guidelines, monitoring, information provision, and financing); provincial and district levels handle the delivery of preventive services, primary and secondary levels of curative care and local level planning. The public sector’s increasing inability to pay for all the health care costs is reflected in the high share of out-of-pocket expenditures, with a potential for financial strain on the poor and the borderline poor. There is a need to explore alternative health financing options, provider payment mechanisms and ways to extract more efficiencies.

Currently, the Bank is financing a Health Sector Development Project (HSDP), which has been helping strengthen district and provincial level planning, improve quality of care, and enhance efficiency and equity of access. The proposed project would build on the achievements of HSDP and lessons learned from it. An independent assessment of the project is planned for the second half of 2010, and will therefore be timely input into the preparation of the follow-on project.

The project design will be significantly informed by recent study on NCDs, which recommended policy options such as: (a) increasing financial resources for NCD prevention and control; (b) increasing access to NCD drugs, especially for the poor; (c) addressing social determinants of NCDs by multi-sectoral population-based actions; (d) being selective about NCDs to address; (e) addressing under-nutrition and over-nutrition; (f) creating an intensified national NCD program; (g) strengthening and reorganizing NCD preventive and curative services; (h) moving services closer to clients and improving efficiency; (i) further decentralizing and devolving service delivery; (j) human resource development for NCD prevention and control; (k) creating a national NCD surveillance system; and (l) public-private partnerships (PPP) and aligning service delivery. Earlier studies on nutrition and ageing would also inform project design.

Initial stakeholder consultations for the project preparation identified key sector issues that must be addressed to modernize the health system and deal with the double burden of CDs and NCDs and also to reduce the fiscal space constraints include: (a) improving the quality of services
within the current public sector system, especially at the lower levels; (b) reducing inefficiencies in the current system (e.g., unnecessary inpatient admissions, lack of an effective referral system, unplanned infrastructure development resulting in under-utilization); (c) addressing imbalances in the human resources for health and updating skills to match the changing disease burden; (d) strengthening stewardship functions at the center, i.e., improved monitoring and evaluation capacity, stronger regulatory function including quality enhancement in the public and private sectors; (e) strengthening the decentralization of service delivery; (f) establishing a robust and integrated health management information system; (g) promotion of PPP – to explore policies to leverage the private sector towards public health goals, (h) better cooperation with non-health sectors such as water, roads, education, social welfare, agriculture, environment, and urban development; and last but not least (i) exploring options for a more sustainable mechanism of health financing, to promote better risk-pooling and mitigate the potential impoverishing effect of out-of-pocket payments. It is noteworthy that this list has considerable overlap with the policy options listed by the NCD study (vide previous paragraph).

Subsequently, the team from the Sri Lankan Government (representing the Central Ministry of Health, the Ministry of Finance, the Finance Commission and two Provincial Ministries of Health), which participated in the Regional High Level Forum on Health Financing, presented a proposal to pilot-test alternative risk-pooling mechanisms. Though these discussions are at an early stage, there is sufficient interest to explore options in this area.

The Country Assistance Strategy (May 7, 2008) acknowledges the importance of strengthening service delivery as a strategic objective and improved health services as CAS outcome 3.2. The mid-term review of the CAS is currently under way, which may change the project size and scope; however, the critical role of the health sector in the CAS is not expected to change.

2. Proposed objective(s)

To contribute to improvements in quality, efficiency, and equity of health services and a reduction in out-of-pocket expenditures by the poor for health care.

3. Preliminary description

The proposed project would help address systemic issues needed to enable Sri Lanka’s health sector to continually improve health outcomes. It is part of a package of Bank assistance to the sector that includes technical support, analytical work and other knowledge products to contribute to sector goals. A Sector Policy Letter from the Government would outline the policy actions envisaged to address the issues identified in section I B. The Government already has a 5-year Health Master Plan, which is in fact a strategic, rather than an operational document. A Medium Term Expenditure Framework, currently under preparation (building on the master plan), would set out the resource envelope needed to achieve the intended results over the next 4-5 years. The project is expected to support the following:

- **Enhancing capacity to address the growing NCD burden:** strengthening community-based and clinic-based preventive and curative interventions, targeting individuals and population, through reoriented health services, and coordination with non-health sectors.

- **Reducing under-nutrition, especially among the plantation workers:** through scaled-up community-based and inter-sectoral interventions with a life-cycle approach and targeting the right age groups and addressing the gender dimensions. A special focus on developing an appropriate institutional framework for the plantation sector services would be needed.
• **Reorientation of health services, especially at the primary health care level:** analytical work and pilot implementation of new model(s) of delivering primary care, improving the referral system, emergency care and overall quality, deepening decentralization of health services delivery, while strengthening the central level stewardship, and exploring PPP.

• **System development:** improved planning, procurement, quality assurance, inventory management of pharmaceuticals; modernization, automation, consolidation and better utilization of health management information systems; and further capacity-building for planning, economic analysis, and monitoring.

• **More sustainable health care financing:** To address the potentially impoverishing effect of out-of-pocket spending, and to mitigate the fiscal space constraints, support would be provided to analytical work, training and for the design and pilot-testing of new risk-pooling mechanisms. One way to increase fiscal space would be to get efficiency gains from system improvements; another option to improve efficiency might be to explore alternative provider payment mechanisms and PPPs.

IDA financing would be: (a) driven by policies and plans of central and provincial ministries of health; (b) focused on results more than on inputs; (c) coordinated with other partners’ support to the sector; (d) mainstreamed into existing government structures without the creation of a separate project management unit or other parallel structures; and (e) using country systems wherever feasible and appropriate. At present we are not proposing disbursement against a share of the government health budget. The team is in dialogue with the Government on such a mechanism, and if successful, disbursement would be designed accordingly. Otherwise, disbursement would follow the same pattern as the current project, except that central level disbursements also would be report-based. The team is in early stages of discussion with the Government on the possibility of introducing results-based financing approach, perhaps for a part of the project funds. Details need to be worked out as preparation progresses.

4. **Safeguard policies that might apply**

The project will fall into Environment category B, in view of the need to address Health Care Waste Management (HCWM) in a safe manner. A HCWM Plan had been developed and initiated under the HIV/AIDS Prevention Project, which was completed in 2008, and continued under HSDP. This HCWM Plan has been implemented satisfactorily so far, and is expected to be fully operational by the time HSDP ends in December 2010. However, it needs to be evaluated / reviewed and new HCWM plan should be developed to incorporate lessons learned and also to scale up implementation nationwide. Sri Lanka has also enacted an Environment Act, which includes the necessary regulations on HCWM, but this needs to be enforced at all health facilities, public and private. Such legal enforcement needs to be accompanied by appropriate technical support and financial resources needed to implement the provisions of the Act. The Second Health Systems Development Project will include a strong focus on this.

5. **Tentative financing**

Source: ($m.)

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<td><strong>Total</strong></td>
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