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Case study on Provincial Specific Development Grant allocation for Regional Directorate of Health Services, in Western Province, Sri Lanka

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Abstract

Background: The case study delves into the Provincial Specific Development Grant (PSDG) allocation for the Regional Directorate of Health Services (RDHS) in the Western Province of Sri Lanka. The Western Province, being the smallest and most densely populated, comprises three RDHS divisions: Colombo, Gampaha, and Kalutara. This study assesses the methodology used for PSDG apportionment, considering factors such as demography, epidemiology, health status, and annual regional performance.

Objective: To assess the methodology used for the apportionment of PSDG to RDHS regions of Colombo, Gampaha and Kalutara by PDHS, WP.

Methods: Examining health sector expenditure, demographic and health status indicators, and regional performance, the study highlights the need for a clear system to generate, collect, and interpret performance data.

Results: The study identifies "Annual Regional Performance" as the prioritized problem. Lack of a clear system for data management, inadequate performance information, and traditional monitoring practices contribute to this issue. The study recommends implementing Result-Based Management (RBM) approaches at the provincial level, to conduct workshops on RBM to build awareness among regional officers, to develop Key Performance Indicators (KPI) for measuring medium-term results and ensure fair PSDG allocation through scientific criteria and a scoring system.

Conclusion: This study underscores the importance of a systematic and scientific approach to PSDG allocation, aiming for efficient and equitable distribution to address the unique needs of each RDHS region.

Keywords: Capital allocation, PSDG, Western Province

Introduction

Western province is the smallest and the most densely populated province out of nine provinces in Sri Lanka. Provincial Directorate of Health Services (PDHS), western province is entrusted with delivery of preventive and primary, secondary and a certain extent of tertiary health care services to the estimated population of 5,382,952 out of total provincial population of 6,219,000, rest of the population obtain services from line ministry tertiary care hospitals and hospitals governed by Colombo MC and the private sector. Western province includes three RDHS divisions, Colombo, Gampaha and Kalutara [1].

Considering all three regional directorates, Colombo RDHS has the highest urban population while Gampaha and Kalutara

RDHS areas consist of majority of rural population. The highest estate population resides in Kalutara RDHS area. Records reveal that, 25% of total population in western province is migrant population, this is due to the presence of the Katunayake and Biyagama free trade zones, garment factories, international airport and the Colombo port, warehouses, and highway entries [1].

13th Amendment

Thirteenth Amendment to the Constitution created a provincial setup of devolved governance by demarcating the areas of legislative, executive and financial authority which has to be exercised by provincial councils [2].

The subject content of powers between the centre and the provinces is specified in the three lists given in the Thirteenth Amendment as,

1. Reserved List (powers of the centre)
2. Provincial List (powers devolved to the provinces)
3. Concurrent List (area of shared responsibilities).

Line ministry has authority over policy-making and strategic planning, financial management, providing policy guidance to relevant state ministries, and health sector monitoring and evaluation and it is responsible for regulating both public and private provision of healthcare [2].

Provincial Councils and local government entities are entrusted with the delivery of preventative and primary curative health services and a significant share of secondary health services. These services are provided by nine provincial ministries under their respective PCs. While the central government, line ministry, oversees policy and manages large, specialised hospital services, the provincial ministries manage regional access to healthcare [2].

Public health is a partially devolved subject under the 13th amendment to the Sri Lankan Constitution and the public health sector consists of institutions that are funded by national and sub-national government budgets [2].

Health sector expenditure by central and provincial authorities

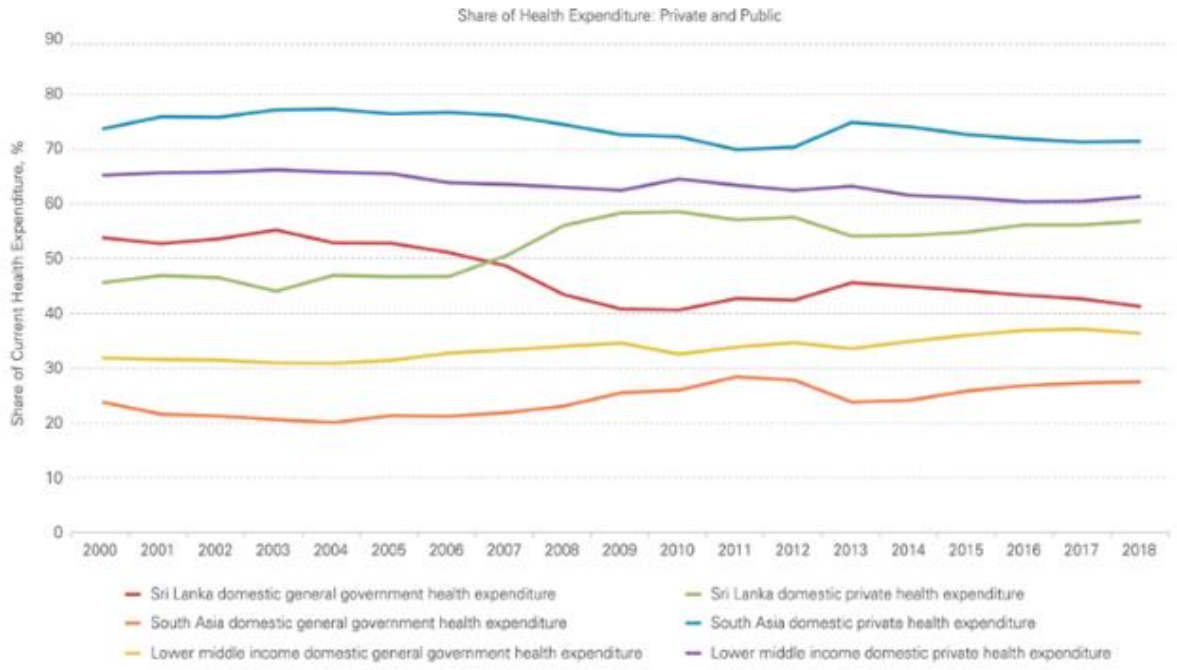
Sri Lanka's total expenditure on health both public and private healthcare is 3.8% of GDP. Even though it is higher than the average health expenditure (3.5%) of South Asian countries, lower than average health expenditure (4.1%) of lower middle-income countries [3].

Provincial Specific development Grant (PSDG) is the main funding source to health sector received by PDHS, western province for financing capital nature development projects paying special attention to infrastructure development. Upon the receipt of regional development plans, provincial and regional authorities discussed and agreed to ensure that such plans would address the regional needs.

The need for cooperation, to bring the national and provincial authorities together to synergize the provincial investment plans with National Development Policy Framework has been recognized by authorities.

Objective

To assess the methodology used for the apportionment of PSDG to RDHS regions of Colombo, Gampaha and Kalutara by PDHS, WP.



Source: WB, World Development Indicator database[27]

Figure 1: Share of Public and Private Health Expenditure in Sri Lanka

Situation Analysis

Sri Lanka's public health expenditure amounts to 1.5% of GDP which is similar to public health expenditure of lower middle-income countries. Sri Lanka's public health expenditure as a share of GDP has dropped over time because it was accounted for 1.5% of GDP in year 2018 and 2.3% in year 2000.

Public health spending in Sri Lanka is divided into recurrent and capital expenditure. Recurrent expenditure refers to spending on salaries/remunerations, goods and services, operating costs, transfers and financial operations. Capital expenditure refers to spending aimed at improving access to health services and quality care (e.g., construction of clinics and hospitals, training of doctors and nurses, etc [4].

As a share of Sri Lanka's total health expenditure, domestic public health expenditure decreased while domestic private health, external public health and out-of-pocket health expenditures increased.

Share of Public and Private Health expenditure

Districts should align their development plans with nationally funded regional development programs outlined in the National Development Policy Framework. PSDG allocation aims to achieve balanced regional development by considering factors such as total population, per capita income, and reducing disparities. Indicators like Provincial Gross Domestic Product, Poverty Head Count Index, and Per Capita Income are used to measure disparities among provinces.

Allocation depends on population, service provision, quality of care, and healthcare performance. Proper need assessment is crucial to avoid mismatches between required and allocated amounts, ensuring effective fund utilization. Various factors,

including regional economic and social disparities, influence the developmental requirements in the Western Province regions.

Demography and Population

When considering the population of the regions, Colombo and Gampaha consists of nearly 2.3M population, while nearly 1.2M population resides in Kalutara district. Population density is high in Colombo region, and it followed by Gampaha and Kalutara, whereas land area showed reverse in order [5].

Table 1: Population Distribution of Western Province of Sri Lanka

District	Colombo	Gampaha	Kalutara
Population	2,310,136	2,294,806	1,217,566
Population density (Persons/Km^2)	3417	1711	773
Land area (Km^2)	699	1,387	1,598

Health status

Table 2: Health Status Indicators of Western Province of Sri Lanka

District	Colombo	Gampaha	Kalutara
Crude Birth rate	11.6	10.3	10.8
Crude Death rate	6.3	5.8	6.7
Maternal Mortality Ratio	16.5	51.9	42.8
Neonatal Mortality Rate	5.1	5.5	6.2
Infant Mortality Rate	6.4	7.3	8.5
Under five mortality Rate	7.2	8.1	9.8
% of Underweight infants	4.4	3.6	4.5

In western province regions, Crude birth rate was higher in Colombo district and was lower in Gampaha district. Crude death rate was lower in Gampaha district in comparison of other two districts. But maternal mortality ratio was higher in Gampaha district and was lower in Colombo district [5].

Same as neonatal mortality also was lower in Colombo district but was higher in Kalutara district. Further, both infant mortality rate and under five mortality rates were lower in Colombo district when compared to other two districts in western province. While the percentage of underweight infants were higher in Kalutara district, it was lower in Gampaha region. MMR was 16.5 in Colombo district, where 417 well women clinics were established, which is four times higher than Gampaha, where the population near similar to Colombo and MMR was 51.9, highest in the province [5].

Number and Type of Curative and Preventive health facilities in the regions

Curative institutions

Table 3: Curatives Institutions of Western Province of Sri Lanka

Health Institutions	Colombo	Gampaha	Kalutara
District General Hospital	1	1	0
Base Hospital Type A	1	1	3
Base Hospital Type B	0	3	1
Divisional Hospital Type A	1	2	2
Divisional Hospital Type B	6	1	6
Divisional Hospital Type C	2	7	7
Primary Medical Care Unit	28	45	8
Total	39	60	27

Preventive institutions

Table 4: Preventive Institutions of Western Province of Sri Lanka

Preventive care institutions	Colombo	Gampaha	Kalutara
Medical Officer of Health Office	18	16	13
Maternal and child health clinics	142	190	161
Family planning clinics	32	132	96
Well women clinics	417	102	70
Regional NCD unit	01	1	1
Regional STD/AIDS control unit	01	4	1
Regional Malaria control unit	0	1	0
Regional chest clinic	0	1	1
Regional Leprosy unit	01	1	1
Regional Rabies control unit	01	1	1
Regional Filariasis unit	01	1	1
Health education/promotion unit	01	1	1
Mental health unit	10	1	14
Total	627	452	361

Annual regional Performance

Physical Progression.

Financial progression.

Clinical performance.

Disease control and prevention.

When assessing the performance, the followings must be considered,

- Maintaining the existing services productively
- Improving the efficiency of services
- Achieving intended results effectively
- Avoiding duplication and wastage
- Focusing on priority needs

Epidemiology of the region

The surge in Non-Communicable Diseases (NCDs), coupled with an aging population and lifestyle shifts, has reshaped Sri Lanka's healthcare demands. In 2019, a substantial 82.5% of deaths in the country were attributed to NCDs, with the Western province following this trend. Monitoring and enhancing the performance of Health and Local Councils (HLCs) are imperative to meet the Sustainable Development Goal (SDG) 3.4, aiming to reduce premature mortality from NCDs by one third by 2030.

While provincial councils align with the Development Policy Framework in their planning processes, stronger coordination with Central Government agencies is needed. Despite provinces overseeing key sectors like education and health, the absence of a unified platform hinders collaboration with central ministries. Furthermore, the Provincial Department of Health Services (PDHS) in the Western Province lacks a transparent protocol for rational Public Sector Development Grant (PSDG) allocation, relying on stakeholder meetings and negotiations.

Methodology

Problem identification and prioritization

Methodology used to gather information on apportionment of PSDG to regions and the problems faced was direct observations, key informant interviews, discussions with the staff and evaluation of the records. Key informant interviews were held with

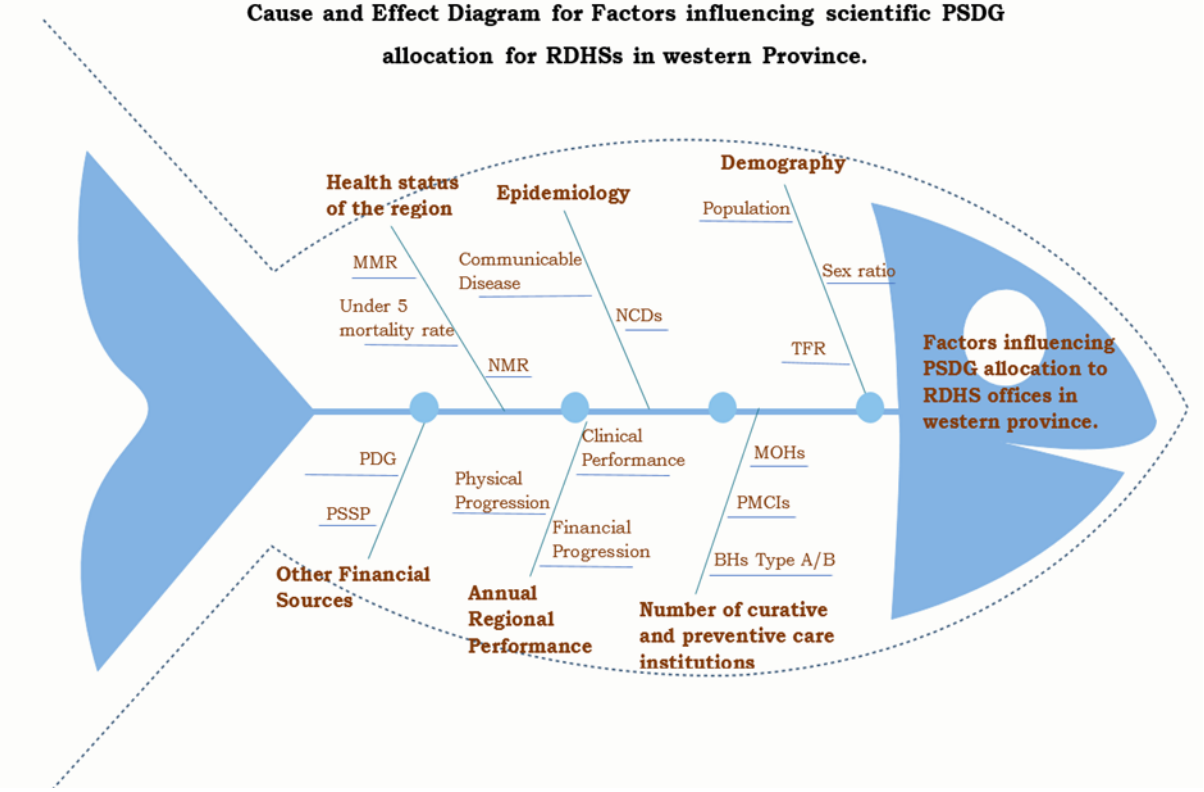


Figure 2: Ishikawa Diagram of the Factors Influencing PSDG allocation in Western Province

CCP/Planning and MO-planning. Discussions were conducted with the selected staff from planning unit in PD office western province.

The records pertaining to fund allocation activities and its outcome were evaluated. Based on the information gathered by these methods problems were identified. Identified problems were prioritized using nominal group technique. Underlying root causes were identified using Isikawa/Cause and effect diagram.

Major Factors / Problems identified

Identified factors categorized as follows

1. Demography and Population of the region
2. Epidemiology of the region.
3. Health status
4. Annual regional Performance
5. Number and types of curative and preventive care institutions
6. Other financial sources

Prioritization of the highly influential factor/problem

The prioritization of problems in Sri Lanka, particularly in the western province, is determined using the nominal group technique, considering input from various stakeholders like RDHS-Colombo, CCP-Planning, MO-Planning, technical experts, and end users. The country faces socio-economic challenges, including a nutritional 'triple burden' of undernutrition, high levels of overweight and obesity, and vitamin and mineral deficiencies.

Despite budgetary constraints, Sri Lanka has consistently invested in nutrition interventions. The identified major problem, "Annual regional performance," is prioritized due to its impact on financial allocation for the province. Limited health budget necessitates efficient financial management, and addressing this problem

is crucial for implementing Result Based Management (RBM) in healthcare institutions, considered a vital strategy in the industry.

Ishikawa diagram for Factors influencing scientific PSDG allocation for RDHSs in Western Province

Underlying causes for prioritized problem

- There is no clear system to generate, collect, store, interpret and disseminate the required performance data.
- Physical progression of the region influenced by many factors in many stages, which requires close regular monitoring and commitment from supervising authority.
- Traditional progress monitoring system focuses mainly on looking at physical and financial input and output with less attention on the anticipated results.
- Lack of revisiting and reviewing clinical standards based on the clinical performance of the region, on a regular basis, for advancement and achievement of highest clinical standards in future.
- Inadequate indicators and traditionally followed up indicators without getting updated and revisited.
- Lack of performance information of many regions of the western province.

Recommendations

The provincial adoption of the Results-Based Management (RBM) approach aims to enhance the efficient use of public funds, aligning with international development planning practices. Some line ministries also embrace RBM to ensure planned benefits reach target groups. Recognizing the importance of fair fund allocation between regions, workshops on RBM at the regional level are crucial to raise awareness among senior officers involved in planning and implementation.

Addressing inter-regional and intra-regional disparities in socio-economic development guidelines is imperative, with a focus on sustaining the minimum well-being of people in isolated pockets. Additionally, regional authorities should prioritize developing Key Performance Indicators (KPIs) to measure medium-term results and outcomes effectively.

Action plan

Provincial Health authority – Western Province has committed on ensuring an effective PSDG allocation for the regions, based on scientific criteria and scoring system. A protocol with set criteria needs to be tabled with relevant stakeholders for discussion. Special focus must be given on identified highly influential factors, which has discussed above, to get it incorporated in the final document.

A technical committee must be in place for ensuring the scoring system with measurable scale, such as indicators, for each criteria mentioned. PSDG apportionment will be made for each region based on the scoring. Further, the criteria and scoring system with relevant indicators will be revisited and revised time to time by the technical committee, based on the regional priorities and latest trends of the regions, province and the country, in the context of health and development.

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