Commodification of Health in Sri Lanka: The rise of Out-of-Pocket Expenditure and the Push for Voluntary Private Health Insurance under Neoliberal Health Reforms

Colombo Economic Journal (CEJ)
Volume 3 Issue 2, December 2025: PP 45-68
ISSN 2950-7480 (Print)
ISSN 2961-5437 (Online)

Published by Department of Economics, University of Colombo, Sri Lanka
Website: https://arts.cmb.ac.lk/econ/colombo-economic-journal-cej/

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Received: 28 February 2025, **Revised:** 02 July, 2025, **Accepted:** 06 December 2025.

Abstract

This study critically examines the commodification of healthcare in Sri Lanka by analyzing the rise in out-of-pocket expenditures (OOPE) and the growing emphasis on Voluntary Private Health Insurance (VPHI) within the context of neoliberal policy reforms. Employing a mixed-methods approach, the study combines quantitative trend analysis (2000–2022) using Sri Lanka's health expenditure data from the World Health Organization's Global Health Expenditure Database (GHED) with qualitative thematic analysis of health policy documents and reports from international financial institutions (IFIs). The findings indicate a consistent increase in OOPE, driven by limited public health investment, expanding privatization, and the indirect influence of international financial policies on national budgets and healthcare frameworks. The study highlights a shift from a universal public health model to a market-driven system, where individuals are increasingly treated as consumers rather than citizens. While proponents of VPHI argue that it enhances efficiency and financial sustainability, the study questions whether these reforms genuinely improve healthcare access or lead to structural inequalities. The findings underscore the need for stronger government regulation of VPHI, increased public awareness of health rights, greater transparency in healthcare financing, and policies that prioritize public welfare over market efficiency.

Keywords: *Commodification of Healthcare, Out-of-Pocket Expenditure (OOPE), Voluntary Private Health Insurance (VPHI), Neoliberal Health Reforms, International Financial Institutions (IFIs)*

JEL Codes: I13, I18, H51, P16, O19

Introduction

Neoliberalism, a dominant political and economic paradigm in the Global South, fundamentally redefines individuals as consumers rather than citizens by extending market logic to all areas of life and shaping human beings primarily as economic actors (Brown, 2015; Peck, 2010). It consistently emphasizes market-driven policies as primary solutions to all social, economic, and political issues (Herring, 1987). Neoliberal reforms enable corporations to prioritize profit over public welfare, especially by discouraging government involvement in providing essential services, promoting market conditions, and protecting private property rights. Where markets do not exist for essential services such as life-preserving healthcare, governments create space for private intervention by commodifying these services (Harvey, 2005; McDonald & Ruiters, 2012).

Neoliberalism discourages the idea of a collective social good; instead, individuals are framed as solely responsible for their own survival. This ideology was famously captured by Margaret Thatcher, who stated in a 1987 interview, "…*they are casting their problems on society and who is society? There is no such thing! There are individual men and women and there are families and no government can do anything except through people and people look to themselves first*." (Thatcher, 1987, pp. 29-30). This view reflects the neoliberal shift away from state responsibility toward individual accountability (Mirowski & Plehwe, 2009; Herring, 1987). This places larger vulnerable populations at risk of severe financial and social hardships. The rise in out-of-pocket expenditure (OOPE) reflects the growing economic burden of accessing healthcare worldwide. OOPE refers to the costs borne directly by households for healthcare goods and services not covered by national healthcare systems or private insurance providers (Dayaratne, 2012). Typically, OOPE includes doctors' consultation fees, medication, laboratory services, and hospital bills (Govindaraj *et al.*, 2014). Such expenditures place a significant burden on low- and middle-income households, often limiting their access to healthcare or forcing them to postpone treatment.

Health is a critical factor in poverty reduction, but high health expenditures push vulnerable populations deeper into poverty (Frenk, 2006; Benatar, 2016). In 2019, according to the Sustainable Development Goals Report, 4.9% of the global population was pushed into extreme poverty due to OOPE (United Nations, Department of Economic and Social Affairs, 2023). Sri Lanka has long been recognized for its robust public healthcare system, but in recent decades, it has faced increasing challenges due to rising OOPE. According to the Sri Lanka Health Accounts (SLHA) health expenditure estimates (Amarasinghe *et al.*, 2021), OOPE increased from Rs. 5.1 billion in 1990 to Rs. 197.2 billion in 2019. Catastrophic health spending, defined as healthcare costs exceeding a significant share of household

income, is increasingly recognized as a major driver of financial vulnerability (Wagstaff *et al.*, 2018). Rajapaksa *et al.* (2021) note that when 10% or more of a household's income is spent on healthcare, the financial impact is considered catastrophic.

Against this backdrop, international financial institutions (IFIs), notably the International Monetary Fund (IMF) and the World Bank (WB), have played a significant yet subtle role in shaping the direction of health sector reforms in Sri Lanka. While they have not been directly involved in policy design, their influence has been exercised through conditionalities attached to structural adjustment loans, technical assistance, and fiscal policy recommendations (Stiglitz, 2002; Kentikelenis, 2017). These mechanisms have encouraged successive governments to adopt cost-recovery models, reduce public sector subsidies, and expand space for private sector engagement. Though positioned as strategies to improve efficiency, such approaches have contributed to the commodification of healthcare and a transfer of risk from the state to individuals.

One of the most promoted mechanisms in this regard is voluntary private health insurance (VPHI), often presented by IFIs and global health policy scholars as a viable remedy for rising OOPE (Goursat & Rannan-Eliya, 2021). However, these proposals frequently overlook the deeper structural issues driving health inequities (Mukhopadhyay, 2013; Benatar, 2016). While marketed as a "voluntary" choice that empowers consumers, VPHI operates within a constrained environment where the public health sector is underfunded, limited in capacity, and often inefficient (Benatar, 2016). This raises critical questions about whether privatization truly addresses inefficiencies or merely reproduces and intensifies inequalities that benefit selected segments of the population.

Studies specific to the Sri Lankan context, often commissioned or supported by institutions aligned with neoliberal agendas, tend to justify privatization as a rational, technocratic solution to inefficiencies in public healthcare delivery (Govindaraj *et al.*, 2014). These narratives frequently highlight how the private sector delivers services that are "quicker," "cleaner," and more "flexible" (Salgado, 2012), while also arguing that privatization helps reduce corruption in public administration (Sobhani, 2019). However, such studies rarely address the long-term political and structural transformations introduced through financing reforms. They typically focus on isolated service delivery outcomes, while neglecting how broader market-driven frameworks exacerbate systemic inequalities and further commodify healthcare (Safaei, 2020).

This study aims to critically examine how neoliberal economic frameworks, particularly as promoted by IFIs, have shaped the evolution of healthcare reform in Sri Lanka, focusing on the indirect influence of conditionalities, the rise of OOPE, and the institutional promotion of VPHI. It argues that while reforms have shifted in discourse, from the aggressive cost-containment strategies of the 1990s to the post-2015 emphasis on human capital as a development strategy, the underlying logic remains consistent: health is framed increasingly as an individual responsibility rather than a collective right. By analyzing these trends historically and structurally, this study aims to contribute to a more nuanced understanding of how global economic governance intersects with national health systems, often in ways that deepen rather than resolve existing inequities.

Literature Review

Theoretical Background of Neoliberalism

Neoliberalism is broadly defined as an economic and political ideology that emphasizes the primacy of free markets, deregulation, and a reduced role for the state in economic affairs, often summarized as the "magic of the market" and skepticism toward government intervention (Herring, 1987; Harvey, 2005; Peck, 2010). Emerging as a reaction against the post-World War II Keynesian consensus, neoliberalism champions laissez-faire economics grounded in neoclassical theory and individual entrepreneurialism, promoted by intellectuals such as Friedrich Hayek and Milton Friedman through institutions like the Mont Pelerin Society (Mirowski & Plehwe, 2009; Brown, 2015).

IFIs such as the IMF and WB have operationalized neoliberalism globally through Structural Adjustment Programs (SAPs), which enforce macroeconomic reforms including fiscal austerity, trade liberalization, and privatization in developing countries (Harvey, 2005; Kentikelenis, 2017). The Washington Consensus, first articulated by Williamson (1990) and later critiqued and augmented (Rodrik, 2006), encapsulates this neoliberal blueprint prioritizing market liberalization, fiscal discipline, and the shrinking of public sectors (Stiglitz, 2002). Despite recognition of its limitations, especially its adverse social effects, no comprehensive alternative framework has been widely adopted by IFIs (Rodrik, 2006). A landmark publication illustrating neoliberal influence on health policy is the WB's Investing in Health report (1993), which critiqued inefficiencies in public healthcare systems in developing nations and advocated reducing state roles in healthcare provision and insurance (World Bank, 1993; Fisk, 2000).

This report rejected healthcare as a public good and reframed it as an individual and family responsibility, promoting privatization and the expansion of private health insurance markets (Biehl & Petryna, 2013).

Table 1: *Washington Consensus*

Original Washington Consensus	**"Augmented" Washington Consensus the previous 10 items, plus:**
1. Fiscal discipline	11. Corporate governance
2. Reorientation of public expenditures	12. Anti-corruption
3. Tax reform	13. Flexible labor markets
4. Financial liberalization	14. WTO agreements
5. Unified and competitive exchange rates	15. Financial codes and standards
6. Trade liberalization	16. "Prudent" capital-account opening
7. Openness to DFI	17. Non-intermediate exchange rate regimes
8. Privatization	18. Independent central banks/inflation targeting
9. Deregulation	19. Social safety nets
10. Secure Property Rights	20. Targeted poverty reduction

Source: Rodrik (2006), p. 978

The IMF's fiscal policies emphasize low inflation and budgetary restraint, often resulting in decreased government expenditure on public health infrastructure (Sobhani, 2019; Kentikelenis, 2017). This reflects the "equity-growth trade-off" perspective, loosely connected to Kuznets' hypothesis of inevitable early-stage inequality (Herring, 1987, p.327). However, empirical research challenges this trade-off, showing that austerity and SAPs exacerbate healthcare access disparities and social inequities (Kentikelenis, 2017; Labonté & Stuckler, 2016).

Overall, neoliberalism reshapes health systems by commodifying care, promoting individual responsibility over collective rights, and structurally marginalizing vulnerable populations (Harvey, 2005; Benatar, 2016). These processes are deeply embedded in the governance strategies of IFIs, affecting policy trajectories in countries like Sri Lanka.

Empirical Evidence

Chile provides a key case study in this debate. Following the 1973 military coup that overthrew socialist president and physician Dr. Salvador Allende, who had promoted 'socialized medicine', Chile became the first experimental laboratory for neoliberal reforms (Unger *et al.*, 2008) and was called an "economic miracle" (Rotarou & Sakellariou, 2017). Under the neoliberal Chicago Boys' guidance, dictator Augusto Pinochet focused on three reforms in the healthcare system: cutting public health expenditures, decentralizing the healthcare system, and introducing private health insurance funds (ISAPREs) alongside the public insurance plan (FONASA) (Bruce, 2000). Unofficial estimates show that in the 1980s, ISAPREs consumed

approximately 70% of salary withholding but provided healthcare to less than 10% of the population (Scarpaci, 1988). By 1998, revenue from health insurance as a percentage of GDP skyrocketed to 3% (Bruce, 2000).

It was argued that the WB, the Inter-American Development Bank, the North American Free Trade Agreement, and neoliberal governments undermined public health sectors in Latin American countries (Rotarou & Sakellariou, 2017; Fisk, 2000). Mexico privatized its social security health system after receiving loans from the WB in 1997, and in 2003 introduced a new reform, Popular Health Insurance (Seguro Popular), aimed at protecting the poor (Frenk, 2006). A study by Hooda (2016) in India shows that neoliberal policies shifted tax-funded healthcare financing toward tax-funded insurance without empirical evidence supporting this under the third National Health Policy (2017). Structural adjustment programs tightened government expenditure on health, and from 1987-1992, no Indian state increased its funding for health (Hooda, 2016). The WB report 'Better Health Systems for India's Poor' further justified public sector underfunding and privatization (Peters *et al.*, 2002).

Sri Lanka updated its National Health Policy 2016–2025, addressing Sustainable Development Goals with the tagline "leave no one behind" (UNICEF Sri Lanka, 2021). A detailed overview of major changes in Sri Lanka's healthcare system since 1858 is provided in Appendix A. In the pre-liberalization phase, the WB was highly critical of Sri Lanka's high expenditure on education, health, and nutrition but later acknowledged the social benefits of such investments (Herring, 1987). After liberalization in 1977, Sri Lanka was acclaimed as an "IMF Success" with high growth rates (Herring, 1987). Sri Lanka's government healthcare expenditure relies solely on a tax-based healthcare financing mechanism (Goursat & Rannan-Eliya, 2021). The country does not have a formal social health insurance scheme. Existing social health insurance coverage consists of the Agrahara insurance scheme for government sector employees, the Suraksha free health insurance policy for school children (introduced in 2017, paused in 2022, and relaunched in 2024), the President's Fund (financed through the Niroga lottery), and limited insurance schemes in large private companies (Rajapaksa *et al.*, 2021; Ministry of Education, 2024).

Social health insurance has been seen as problematic in Sri Lanka because most of the labor force is informal (Institute of Policy Studies of Sri Lanka, 2015). The Agrahara scheme is also inefficient; in 2018, there were 14.6 million Employees' Trust Fund accounts, but 12 million were inactive, leaving only 2.6 million active members (Goursat & Rannan-Eliya, 2021). Consequently, the Institute of Policy Studies of Sri Lanka (2015) suggests that public-private collaborations could alleviate capacity constraints and improve equity and efficiency by pooling resources such as funds and technology.

Sri Lanka's private sector is becoming increasingly prominent in healthcare expenditure (Institute of Policy Studies of Sri Lanka, 2015; UNICEF Sri Lanka, 2021). From 1981 to 2000, private health sector facilities in Sri Lanka grew rapidly (Govindaraj *et al.*, 2014). In 1991, the government privatized all state-owned commercial organizations under pressure from the WB and donor countries (Rannan-Eliya, 1997). OOPE accounts for the highest share of private health expenditure in Sri Lanka. A study by Pallegedara and Grimm (2018) found that OOPE rose faster than household income between 1990 and 2012, per capita household consumption expenditures increased by about 50%, while OOPE increased by about 150%. The rise in Non-Communicable Diseases is a main factor driving increasing OOPE in Sri Lanka (Institute of Policy Studies of Sri Lanka, 2015) and the fees paid to medical practitioners represent the largest component of higher OOPE (Govindaraj *et al.*, 2014; Wang *et al.*, 2018).

To increase health sector financing, in 1993 the Presidential Task Force on National Health Policy identified VPHI as a key mechanism (Rannan-Eliya, 1997). It was expected that VPHI would reduce demand on the public sector from higher-income groups and bring additional financial resources to the private health sector (Rannan-Eliya, 1997). VPHI is sharply increasing in Sri Lanka; the Insurance Industry Act no. 43 of 2000 facilitated this growth. Over 100 private hospitals, with investments exceeding Rs. 50 billion, entered the healthcare sector between 1990 and 2013 (Institute of Policy Studies of Sri Lanka, 2015). Rannan-Eliya's (1997) report Analysis of Private Health Insurance in Sri Lanka: Findings and Policy Implications showed that between 1988 and 1995, private corporations increased their share of the life insurance market from 7% to 54%. Existing literature on Sri Lanka's health system has extensively documented the rise in OOPE and related challenges. Many studies argue that privatization enhances efficiency by addressing public sector inefficiencies. However, significant gaps remain in understanding how health policies have actively commodified healthcare in Sri Lanka. Most existing studies focus on surface-level economic trends, statistical analyses, and efficiency arguments rather than critically examining systemic inequalities exacerbated by these reforms. Furthermore, limited research exists on the role of the IMF and WB in shaping these policy shifts. This study addresses these gaps by critically analyzing how neoliberal policies have transformed Sri Lanka's healthcare landscape. It traces the historical trajectory of OOPE, explores the policy shifts leading to the expansion of VPHI, and assesses the broader implications of these changes for equitable healthcare access. By challenging the underlying neoliberal logic, this research questions whether these reforms genuinely serve the public interest or further entrench systemic disparities.

Methodology

This study adopts a mixed-methods approach that integrates qualitative thematic analysis with quantitative trend analysis to examine how neoliberal policy frameworks have influenced healthcare financing in Sri Lanka. While economic liberalization began in the late 1970s, it has been noted that the fragmented availability of data across time periods and institutions along with the ideologically charged nature of health policy reforms requires an approach that goes beyond conventional causal or econometric modeling. This research therefore combines empirical analysis of expenditure trends with critical interpretation of policy texts to produce a more layered understanding of reform processes.

The qualitative component is based on an interpretive analysis of 40 policy documents (see Appendix B), grouped into four categories: 16 national policy reports published by Sri Lankan institutions such as the Ministry of Health (MOH), the Institute for Health Policy (IHP), and the Institute of Policy Studies (IPS); 5 Sri Lanka-specific reports produced in collaboration with or funded by IFIs), such as the WB and IMF; 5 policy documents authored independently by IFIs; and 4 policy reports from other countries used for comparative context. In addition to this dataset, a separate collection of 10 IMF Country Reports on Sri Lanka, published between 1999 and 2024, was analyzed to trace changes in macroeconomic policy narratives and their influence on the health sector.

These documents were examined using Braun and Clarke's thematic analysis framework, with coding and synthesis supported by MAXQDA 24 software. The analysis focused on identifying dominant policy narratives and institutional logics related to privatization, fiscal consolidation, the commodification of healthcare, the expansion of private insurance, and shifts in how individuals are represented in health systems (e.g., as patients, clients, or consumers). The study also pays close attention to language and terminology as markers of deeper ideological shifts, particularly those aligned with neoliberal thought. Comparative references to other IMF-influenced countries, including India and Chile, help situate Sri Lanka's trajectory within broader global policy trends.

The quantitative component analyzes health expenditure trends from 2000 to 2022. Data were primarily drawn from two sources: the Global Health Expenditure Database (GHED) maintained by the World Health Organization (WHO), and the Sri Lanka Health Expenditure Accounts (SLHEA) 2021 Report published by the Institute for Health Policy (IHP). While certain inconsistencies between international and national datasets are observed, GHED data are prioritized for their alignment with cross-country benchmarking standards and IMF evaluation frameworks. Key indicators examined include OOPE as a percentage of Current Health Expenditure

(CHE), Per Capita GDP, government health spending as a percentage of GDP, and VPHI as a share of CHE. The analysis places particular emphasis on trends since 2000, including the implementation of major national health strategies and recurring IMF interventions, to identify structural shifts in the logic and composition of health financing.

Rather than seeking to isolate causal relationships or generate predictive models, this study adopts an interpretive stance grounded in critical policy analysis. It approaches healthcare reform as a process shaped not only by technical considerations, but also by contested political, institutional, and ideological forces. By integrating expenditure trends with document-based thematic insights, the study aims to provide a comprehensive and contextually grounded account of how neoliberal reforms have reshaped the financing and governance of healthcare in Sri Lanka.

Results and Discussion

The findings of this study are organized into five key themes identified through a systematic thematic analysis of policy documents using MAXQDA 24. These themes illuminate the multifaceted impact of neoliberal policy frameworks on Sri Lanka's healthcare system, revealing how shifts in policy language, institutional priorities, and financing strategies interact to reshape healthcare roles, responsibilities, and structures. Each theme is supported by specific codes and illustrated with representative excerpts from the documents, highlighting changes such as the commodification of healthcare, underfunding of the public sector, increased out-of-pocket spending, expansion of VPHI, and the influential role of international institutions. Together, these themes demonstrate a gradual but significant shift from a state-centered, universal model toward one that emphasizes market mechanisms, individual responsibility, and public-private partnerships.

Table 2: Summary of Key Themes from Thematic Analysis of Policy Documents

Key Themes	Codes	Significant Statement Example
1. Commodification of Healthcare	Healthcare role and identity (consumer, patient, client, user, citizen), neoliberal terminology (private demand, rationale, competition, cost-effectiveness)	*"Patients who do not receive certain types of services 'on demand' in a public hospital tend to buy those services in the private sector if they can pay for them."* (Govindaraj *et al.*, 2014, p. 30, funded by WB)
2. Underfunded Healthcare Sector	Fiscal consolidation, Structural reforms, State/Public Sector	*"..... the program will focus on reforms that help to accelerate growth with the private sector as its main*

	dominance, ineffective public sector	*engine. The main areas of the agenda will be to reduce state dominance in the economy."* (IMF Country Report 03-107, 2003 SL, p. 19)
3. The rise of OOPE	Individual preference (choice, privacy, human dignity), Household and community actions	*"Strengthen individual, household and community actions for health."* (Japan International Cooperation Agency [JICA], 2003, p. 12)
4. The Expansion of VPHI	Market failure, Justification of VPHI, Knowledge gap	*"It [VPHI] can be the primary means of financing health care, an alternative to a public program, or a mechanism for individuals to finance what is not covered under a public program."* (World Bank, 2012, p. 4)
5. The Role of International Institutions	Deregulation, Privatization, Subsidy, public-private partnership (contract, mandate)	*"To increase market penetration and efficiency in the insurance sector, the State Insurance Corporation (SLIC) is being privatized."* (IMF Country Report 03-107, 2003, p. 71)

Source: Author's thematic analysis using MAXQDA 24

Theme 1: Commodification of Healthcare

Commodification refers to the process by which healthcare, traditionally considered a public good or fundamental right, is redefined as a market commodity. This shift is reflected in the language policy documents use to describe individuals, employing terms such as "user," "citizen," "consumer," "client," and "patient." These terms reveal how different institutions construct identities and roles within the healthcare system. For this analysis of identity-related terms, the IMF Country Reports on Sri Lanka (10) were excluded to focus specifically on health policy documents from Sri Lankan institutions, international financial organizations, and comparative country reports.

Table 3 presents the relative frequency (percentage of total references) of these identity-related terms within each report type (vertical analysis), showing how often each term appears in that category. For example, Sri Lankan policy reports most frequently use the terms "patient" (61.01%) and "client" (56.74%), while "citizen" also appears prominently (45.07%). This suggests a persistent state-centered framing of healthcare, where individuals are entitled recipients of care. However, the frequent use of "client" indicates a growing emphasis on personal responsibility for accessing services, consistent with neoliberal shifts that transfer financial and logistical burdens to individuals. In IFI reports, the term "consumer" appears most frequently (55.78%) reflecting a strong focus on individuals as market actors.

Table 3: Distribution of Identity-Related Terms Across Report Types (Vertical Analysis)

	User	Citizen	Consumer	Client	Patient
SL Policy Reports	42.15%	45.07%	24.49%	56.74%	61.01%
IFI-funded SL Reports	16.14%	19.72%	5.90%	3.37%	13.34%
IFI Reports	31.84%	21.83%	55.78%	24.16%	18.72%
Other Countries Reports	9.87%	13.38%	13.83%	15.73%	6.94%

Source: Derived from MAXQDA 24

In contrast, Table 4 compares the overall use of these identity-related terms across report categories (horizontal analysis), showing the proportion of total references in the entire dataset attributed to each report type. This horizontal comparison reveals that IFIs favor the term "consumer" (36.62%) over "citizen" (14.33%), reflecting an ideological framing of individuals as autonomous market actors rather than rights-bearing citizens. This language shift corresponds to a reconceptualization of healthcare from a collective state obligation to a market service requiring individual choice and payment.

Table 4: *Distribution of Identity-Related Terms Across Report Types (Horizontal Analysis)*

	User	Citizen	Consumer	Client	Patient
SL Policy Reports	18.37%	19.64%	10.67%	24.73%	26.59%
IFI-funded SL Reports	27.61%	33.73%	10.8%	5.77%	22.81%
IFI Reports	20.9%	14.33%	36.62%	15.86%	12.29%
Other Countries Reports	16.51%	22.40%	23.15%	26.33%	11.61%

Source: Derived from MAXQDA 24

The contrast between nationally grounded terms like "patient" and globally favored terms like "consumer" signals more than just linguistic variation. It reflects fundamental ideological differences influencing who is seen as responsible for healthcare and how services are expected to be accessed and financed. This distinction has critical implications for the structuring and experience of health systems in Sri Lanka and internationally.

Theme 2: Underfunded Public Healthcare Sector

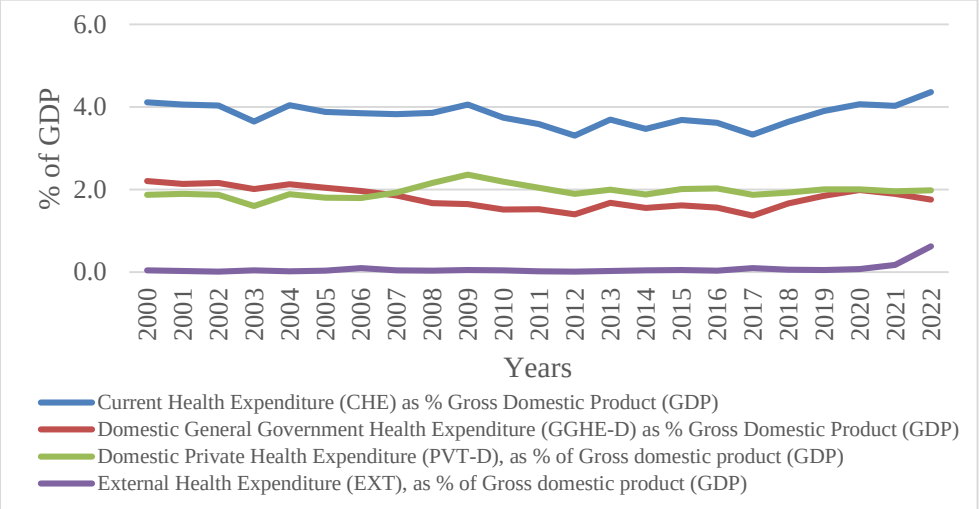


Figure 1: ***Health Expenditure as % of GDP***
Source: Global Health Expenditure Data (2023)

While the increase in CHE suggests overall growth in health spending, a closer examination reveals persistent underfunding of the public health sector. Specifically, Domestic General Government Health Expenditure (GGHE-D) as a share of GDP stagnated and even declined between 2006 and 2017, whereas Domestic Private Health Expenditure (PVT-D) matched or exceeded it during much of this period. This trend indicates a structural shift away from public provision toward private sector dominance.

The apparent rise in GGHE-D after 2017 reflects a policy shift rather than a sustained increase in public investment. The longer-term decline in public health expenditure, particularly after 2003, aligns with structural adjustment policies. The 2003 IMF Country Report No. 03/107 explicitly states that *"the program will focus on reforms that help to accelerate growth with the private sector as its main engine... [by] reducing state dominance in the economy"* (p. 19). This policy orientation corresponds with a decline in the government's share of health spending (see Figure 4) and an associated rise in private health expenditure and OOPE.

Thematic analysis of IMF reports further supports this pattern, showing a strong emphasis on "Private Sector" expansion and minimal focus on strengthening the public health system. Thus, underfunding of public healthcare is evidenced not only by expenditure data but also by policy directives. This shift has increased reliance on private providers, contributing to higher OOPE and widening inequities in healthcare access.

Theme 3: The Rise of OOPE

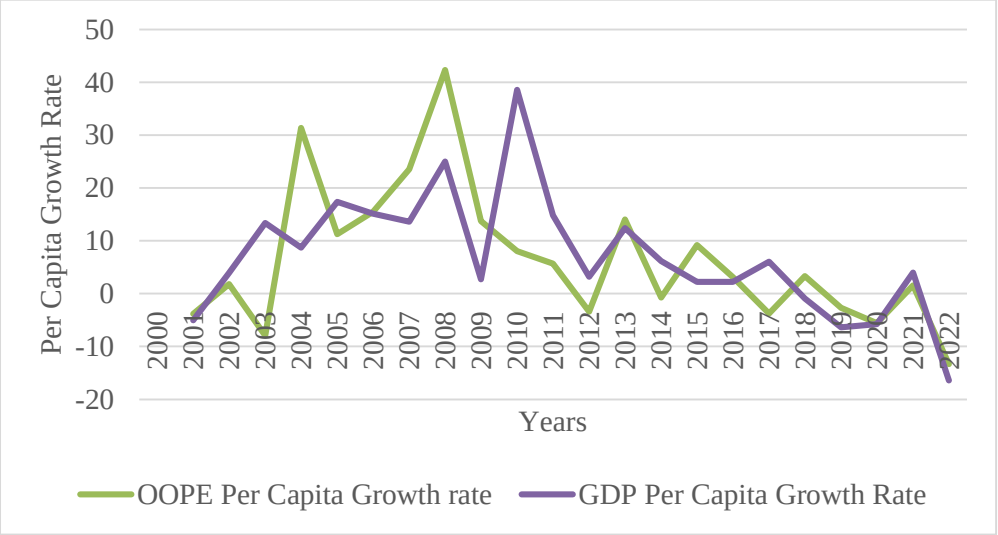


Figure 2: ***OOPE vs GDP per Capita growth***

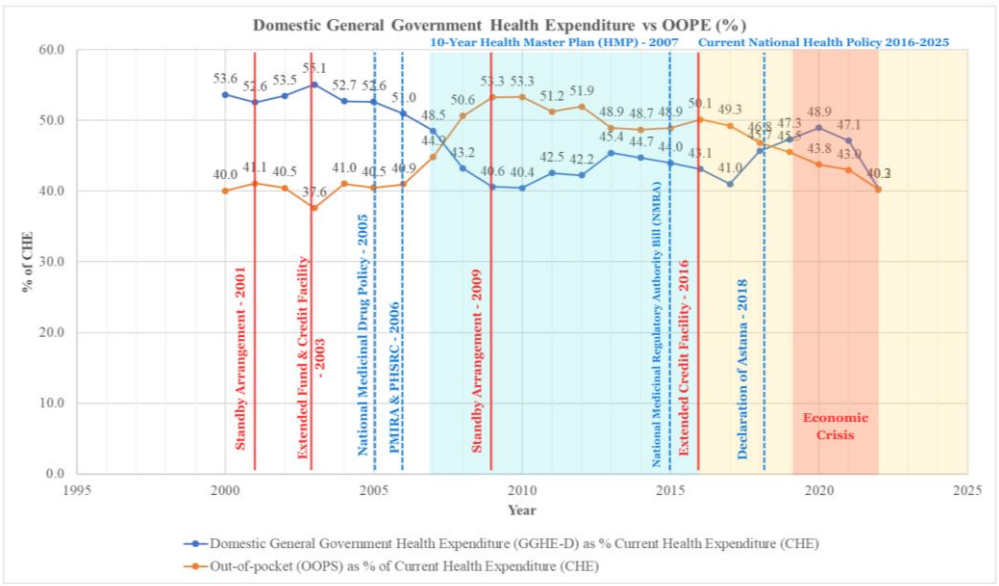
Source: Global Health Expenditure Data (Calculated by the author)

Pallegedara and Grimm (2018) suggest that economic growth often increases dissatisfaction with public healthcare quality, driving up OOPE. In Sri Lanka, the relationship between OOPE growth and GDP growth is inconsistent, indicating that factors beyond income, particularly policy changes play a significant role. Notably, OOPE per capita growth rate peaked in years when GDP per capita growth rate fell (2003, 2007, 2015), underscoring the influence of policy over economic performance alone.

This study's trend analysis examines GGHE-D and OOPE as shares of CHE, highlighting two key policy phases: the 10-Year Health Master Plan (HMP, 2006–2015) and the Current National Health Policy (2016–2025). IMF arrangements and other policy shifts are marked for reference. Following the 2003 MOH-JICA report that informed the HMP, OOPE steadily increased, surpassing General Health Expenditure (GHE) around 2007–2008. With the implementation of the Current National Health Policy, GHE again exceeded OOPE by 2017–2018. These shifts, alongside IMF interventions, appear critical in shaping expenditure patterns.

Thematic analysis reveals that the HMP emphasized strengthening individual, household, and community responsibility for health, which contributed to rising OOPE. The 2005 National Medicinal Drug Policy, aiming to "safeguard the rights of patients/consumers" (Ministry of Health Care and Nutrition, 2005, p. 14), signaled a transfer of responsibility from the state to households, increasing OOPE. Conversely, the 2016–2025 policy explicitly seeks to "fight the exploitation of people's health needs for purposes of profit" (Ministry of Health, Sri Lanka, 2016, Vol. IV, p. 2),

reflecting a growing awareness of market-driven healthcare's adverse effects. This change coincides with a declining OOPE trend before the economic challenges of 2020, which led to reductions in both government and OOPE health spending. Importantly, government health expenditure had already begun to outpace OOPE prior to this crisis.



PMIRA - Private Medical Institutions Registration Act &
PHSRC - Private Health Services Regulatory Council

Figure 3: ***Domestic General Government Health Expenditure vs OOPE (%)***
Source: Global Health Expenditure Database (2023); policy timeline derived from author's compilation (see Appendix A)

Theme 4: The expansion of VPHI

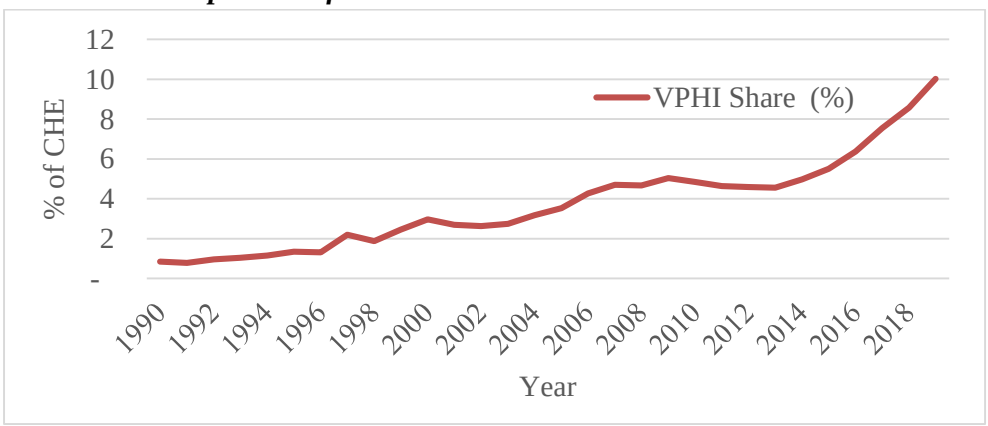


Figure 4: ***Volunteer Private Health Insurance as a % of Current Health Expenditure***
Source: Sri Lanka Health Expenditure Data 1990-2019

This steady expansion of VPHI, particularly after 2016, may have contributed to the observed decline in OOPE. However, this trend also coincides with increased government spending, making it difficult to isolate VPHI's impact. A comparison between Figure 2 and Figure 5 suggests that while VPHI rose, the overall share of private expenditure in CHE remained relatively stable, indicating that the structure of financing became more diversified rather than more privatized.

Despite this upward trend, Sri Lankan policy documents have historically expressed caution toward the role of private insurance in healthcare financing. The 2003 HMP prepared by JICA explicitly warned against the unchecked growth of private health insurance, recommending the withdrawal of subsidies and stronger regulatory oversight. It proposed key safeguards such as minimum benefit packages, guaranteed renewals, coverage for pre-existing conditions, dispute resolution mechanisms, and transparent plan comparisons (JICA, 2003, Vol. 1, pp. 40–42)

Yet, the sustained growth of VPHI implies that these recommendations were either not enforced or not sufficient. The post-2016 acceleration in VPHI uptake, alongside limited regulatory enforcement, raises concerns about potential inequities in access. Vulnerable populations, particularly those without employer-based insurance or financial literacy, may face challenges in navigating or affording private coverage. This expansion therefore signals not only a structural shift in health financing but also a potential risk to the equity goals of Sri Lanka's public health system.

Theme 5: The Role of International Institutions

International institutions such as the IMF, WB, WHO, and International Labour Organization (ILO) have played a significant role in shaping health policy frameworks in developing countries, including Sri Lanka. Their influence has been exercised through financial assistance, technical expertise, and policy recommendations, which have at times promoted market-based reforms in the health sector.

Historically, key milestones such as the Alma-Ata Declaration of 1978, endorsed by WHO and United Nations Children's Fund (UNICEF), emphasized health as a human right and promoted universal access to primary healthcare (WHO & UNICEF, 1978). Over the decades, however, the nature of institutional influence has diversified. While organizations such as WHO have continued to advocate for universal health coverage (UHC) with an emphasis on affordability, pooled financing, and equity, other institutions have at times encouraged reforms more aligned with market-oriented mechanisms.

For instance, the WB (2012) has published documents in support of VPHI in specific contexts. The report, Private Voluntary Health Insurance: Consumer Protection and

Prudential Regulation, outlined potential benefits of VPHI such as expanding healthcare access, enhancing efficiency, attracting private investment, and offering financial protection against catastrophic health costs, particularly when public health systems are underfunded or overstretched. However, this position remains contested in public health discourse, particularly in relation to equity and access for vulnerable populations. It is important to differentiate between institutional mandates. WHO, for example, does not endorse VPHI as a primary financing strategy and has been critical of models such as the U.S. insurance-based system. Instead, WHO's recent health financing guidance encourages publicly financed pooled resources, either through taxation or social health insurance, to achieve UHC.

Moreover, it is worth noting the positive institutional engagement with strengthening public health systems. For instance, in World Bank (2018), the WB supported the development of a cluster system in Sri Lanka to strengthen primary healthcare and manage non-communicable diseases (NCDs), with one of its explicit objectives being to reduce OOPE. This reflects a shift in international health financing discourse, recognizing the risks of excessive reliance on private spending and reinforcing support for equitable public service delivery.

Conclusion

The analysis of Sri Lanka's healthcare system, through the interconnected themes of underfunding, OOPE, and the expansion of VPHI, reveals a complex interplay between public and private healthcare financing. While privatization and market-oriented policies have in some cases increased access and alleviated short-term pressures on the public system, they fall short of offering a sustainable solution to the country's long-term healthcare challenges.

The growing commercialization of healthcare where services are increasingly treated as market goods rather than as public entitlements has contributed to widening disparities in access, particularly for low-income and marginalized populations. Although economic growth is generally associated with improved health status over time, trends in OOPE indicate rising financial burdens or increased reliance on private care due to gaps in the public sector. The increase in VPHI coverage may offer short-term relief for some individuals seeking better-quality care; however, without adequate regulation and equity safeguards, it risks deepening inequalities.

The persistent underinvestment in public healthcare further compounds these challenges, leaving many individuals with no choice but to pay out-of-pocket for services. This trend raises serious concerns about affordability and access for vulnerable groups who may not be able to afford private insurance or care. Addressing these systemic issues requires not only increased investment in the public

health sector but also robust regulation of private financing mechanisms, such as VPHI, to ensure universal and equitable healthcare access.

Policy Recommendations

1. Strengthening Public Healthcare Funding: The current National Health Policy should focus on increasing government funding and improving the efficiency of the public sector. Gaining people's trust in the public sector will also help reduce OOPE over time.
2. Regulating the Expansion of VPHI: The government should regulate the expansion of VPHI to ensure it does not compromise the goals of population-level health protection and equitable access to care. VPHI should remain a supplementary option rather than a substitute for public healthcare.
3. Increasing Public Awareness on Health Rights: A public education campaign should be launched to emphasize healthcare as a human right rather than a commodity. This would help shift the mindset from seeing healthcare as a consumer product to viewing it as a service that should be accessible to all citizens, regardless of their economic status. Policymakers should take the lead in this shift.
4. Ensuring Health Sector Autonomy and Transparency: The health sector should have the freedom to regulate and operate independently, without undue influence from external parties. Policies should be transparent, and policy shifts should prioritize citizens' human rights rather than favoring any particular group or interest.

Acknowledgments: I wish to acknowledge Dr. Kalpa Rajapaksha for introducing me to the critical study of political economy. This paper is a direct result of the intellectual curiosity he fostered regarding neoliberal policy shifts in the Global South. I also thank the editorial team and anonymous reviewers for their constructive feedback. This research received no external funding.

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Appendix A: Major Changes in Sri Lanka's Healthcare System (1858 - 2025)
(Detailed overview of key developments in Sri Lanka's healthcare system.)

No	Period	Key Healthcare Developments
1	Early Foundations: Pre-Independence & Early Post-Independence (1858-1947)	1858: Government health services established (Civil Medical Department). 1870: Colombo Medical School founded – Start of modern medical education. 1913: Sanitary Branch established – Focus on public health. 1926: Health Unit system introduced in Kalutara – First preventive care reorganization. 1931: Universal Franchise granted – Increased demand for healthcare. 1934-35: Malaria epidemic leads to rural health expansion.
2	Post-Independence & Public Health Expansion (1948-1978)	1949: Free healthcare policy institutionalized. 1950-1980: Central Health Department oversees services. 1950: Control of Prices Act No. 29 regulates medicine costs. 1952 & 1953: Health Services Act formalizes public healthcare structure. 1957: National Formulary Committee (NFC) established – Drug regulation begins. 1961: Insurance Corporation Act No. 2 – Nationalization of life insurance. 1971: Bibile Report leads to the creation of the State Pharmaceutical Corporation (SPC). 1977: Economic liberalization introduces private pharmacies.
3	Decentralization & Market Reforms (1979-1991)	1979: Insurance (Special Provision) Act allows new state-owned insurers (NIC). 1980: Cosmetics, Devices, and Drugs Act No. 27 – Medicine regulation introduced. 1986: Insurance sector liberalized – Private companies enter market. 1987: 13th Amendment decentralizes health to Provincial Councils. 1988: Provincial Council Act formalizes local health governance. 1989: Fair Trading Commission Act – Introduces retail drug price regulations. 1991 & 1996: National Medicinal Drug Policies proposed but not approved. 1991: Medical Service Minute regulates healthcare employment.

4	Strengthening National Health Policy (1992-2006)	1992: National Health Policy (Primary Health Care Model). 1993: Presidential Task Force explores Voluntary Health Insurance (VHI). 1996: Health policy revised – Focus on elderly care & fair resource allocation. 1997: Agrahara Insurance Scheme introduced for government employees. 2005: National Medicinal Drug Policy (NMDP) approved – Access to affordable medicines. 2006: Private Medical Institutions (Registration) Act – Regulatory council created.
5	Long-Term Strategic Health Planning (2007-2025)	2007: 10-Year Health Master Plan (HMP) launched. 2014-2016: Universal Health Coverage (UHC) strengthened. 2015: National Medicinal Regulatory Authority Bill (NMRA) – Ensuring drug quality. 2016-2025: Current National Health Policy – Equity, modernization, prevention focus. 2018: Declaration of Astana – Moves towards market-driven healthcare models.

Note: The timeline and information provided in this appendix are primarily drawn from the following sources

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Appendix B: Groups of Policy Documents/ Reports

Group	No. of Docs	Title
Sri Lanka Policy Reports	16	National Health Policy (1992) National Health Policy (1996) Results of Private Health Insurance Study (1996) Analysis of Private Health Insurance in Sri Lanka: Findings and Policy Implications (1997) National Medicinal Drug Policy for Sri Lanka 2005 (2005) Health Master Plan - Volume 1 (2007) Health Master Plan - Volume 2 (2007) National Health Policy 2007–2015 (2007) Health Sector Reforms (2015) National Health Strategies Master Plan 2016–2025 (2016) IPS Sri Lanka Public-Private Determinants (2016) Budget Brief - Health Sector (2019) Sri Lanka Health Accounts 1990–2019 (2021) Review of the National Health Policy 2016–2025 (2022) Budget Brief – Health Sector 2021 (2022) Annual Performance Report 2022 (2023)
IFI-funded Sri Lanka Reports	5	Achieving Pro-poor Universal Health Coverage Without Health Financing Reforms (2009) Social Health Protection in Sri Lanka (ILO) -2018 Sri Lanka: Good Practice in Expanding Health Coverage (2019) Health Care in Sri Lanka: What the Private Sector Offers (World Bank) - 2020 Sri Lanka Health System Review (WHO) - 2021
International Financial Institution (IFI) Reports	5	World Development Report (1993) Private Participation in Health Services – World Bank (2003) Private Voluntary Health Insurance – World Bank (2012) IMF: Future of Public–Private Health Insurance (2012) Declaration of Astana (2018)
Other Countries' Reports	4	National Health Policy (India) - 2017 Better Health Systems for India's Poor: Findings, Analysis, and Options (2002) Explicit Health Guarantees for Chileans – AUGE Benefits Package (2013) At a Tipping Point: Chilean Private Healthcare Insurers Owe Chileans USD 1.4 Billion (2023)
IMF Country Reports – Sri Lanka	10	IMF Country Report No. 99/136 (1999) IMF Country Report No. 02/208 (2002) 2001 IMF Article IV 2002 IMF Article IV IMF Country Report No. 03/106 (2003) IMF Country Report No. 03/107 (2003) IMF Country Report No. 06/446 (2006) IMF Country Report No. 23/340 (2023) 2024 IMF Article IV Consultation IMF Country Report No. 24/2162 (2024)