Policy Study Report - 2009

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BasicNeeds Sri Lanka

Financing Mental Health Care in Sri Lanka

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SRI LANKA

FINANCING MENTAL HEALTH CARE IN

SRI LANKA

A POLICY RESEARCH STUDY

2009

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Research & Policy
BasicNeeds Sri Lanka

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List of Abbreviations and Acronyms

BN	– BasicNeeds
BNSL	- BasicNeeds Sri Lanka
CMH	- Community Mental Health
DALY	- Disability Adjusted Life Years
DMH	- Director, Mental Health
GBD	- Global Burden of Disease
G.H	- General Hospital
GoSL	- Government of Sri Lanka
INGOs	- International Non Governmental Organisations
KI	- key informant
KII	- key informant interview
LAMICs	- Low- and Middle-Income Countries
LKR	- Sri Lankan Rupees
MH&D	- Mental Health and Development
MHU	– Mental Health Unit
MoF	- Ministry of Finance
MoH	– Ministry of Health
MOMH	- Medical Officer of Mental Health
M.O.Psych	- Medical Officers of Psychiatry
NCD	- Non Communicable Diseases
NGOs	- Non Governmental Organisations
NIMH	- National Institute of Mental Health
PHI	- Public Health Inspector
RDHS	- Regional Director of Health Services
UNFPA	- United Nations Population Fund
Unicef	- United Nations Children's Fund
VSO	- Volunteer Services Organisation
WB	- World Bank
WHO	- World Health Organisation
YLD	- years of life lived with disability
YLL	- years of life lost

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Executive Summary

This study was designed and carried out in a context where global and regional burden of mental health is increasing. This burden in the context of Sri Lanka is worsened by country specific factors such as conflict, war and disasters both natural and man made. Being a low- and middle income country the economics of mental health and being able to make right policy decisions therefore is important both from a health care and economic perspectives

BasicNeeds Sri Lanka (BNSL) is part of the global BasicNeeds (BN) family registered in Sri Lanka as an International Non Governmental Organisation that works in the mental health and development sector in three provinces of the country. As part of their work in mainstreaming people with mental illnesses BNSL carry out research studies that could be used to influence policy formulations. This 2009 annual policy research study is part of its Community Mental Health Expansion Project implemented in all three districts of the Southern Province.

With this background this policy study was designed with the aim of exploring mental health financing by addressing three main study objectives, namely what are the sources of funding available for mental health in Sri Lanka, how is the funding allocated and utilized and how the current funding, allocation and utilization impact on mental health care of the country, with the broader view of influencing mental health policy and also to serve as a basis for future studies in mental health financing as a way of planning more cost effective and efficient mental health services based on evidence thus generated.

The study used a combination of qualitative and quantitative methods including reviewing of documents that was employed to collect and analyze data. To this extent key informants were interviewed from national and regional level of the country to achieve a more holistic picture as the country's governing structure makes financing for mental health a two fold mechanism. That is directly via the central government and then also by means of provincial councils. The regional level financing includes a mixture of both as revealed. The attempt to gather quantitative financial data to analyze was met with the challenge of lack of free and easy access to adequate and accurate financial information and the associated resistances encountered in divulging finance related data though analysis of such information would have been of immense benefit to the mental health services in justifying and seeking funds in order to rectify gaps in the services.

However the study yielded following key findings with regards to mental health financing in the country which would be of immense value for further studies while having many a policy and practice implications.

As the study revealed the main source of funding is the government both central and provincial while non-governmental organizations contributed substantially especially for preventive and promotional aspects as opposed to the curative aspect of mental health which are the two main mechanisms of financing both nationally and regionally as revealed by the study.

In the year 2008 as per the approximate figures quoted by one of the key informants the contribution from the non state sector for mental health prevention and promotion programs at national level is 55% where as the state funding amounted to 45%. This was found to be true

regionally as well. In addition there were organizations that directly carried out mental health services in the community in coordination with government services regionally.

The mental health financing mechanism in the country is such that the largest portion of in-patient and out-patient services of curative care extended by hospitals are only available and known to each of the hospital. Even in them not directly in their annual financial records.

The absence of actively used separate budget line/heading for mental health services at national, regional and institutional levels makes the quantification of this fund allocation, utilization and utilization rates extremely difficult indicating the lack of practice of proper use of financial information in making policy and other decisions.

Therefore this information for the whole island could not be collected by reviewing centralized budgetary documentations available with the authorities. The only way of obtaining these data is to directly review the records of each and every hospital or clinic in the country with mental health services with the presence of a person who could interpret and extract the data relevant to mental health expenditure out of the general expenditure and allocations which perhaps could be the basis for a more detailed and in depth study of financing mental health in the country.

The only exception to this is the three mental health hospitals whose allocations come directly from the national health budget. These three hospitals mainly provide long stay institutional in patient care to people with mental illnesses. The cumulative allocation for these three hospital amounts to 718,488,000 LKR in the year 2008 making it 1.32% of the national health budget.

Yet the total allocation for mental health remains to be quantified leaving room for many challenges in financing mental health of the country and making it a policy priority eventually would be reflected in the disparity between the growing burden of diseases and treatment gaps which is already of a concern at a global and regional policy levels.

Therefore in conclusion increasing the transparency of the financial information in the short and intermediate term, taking measures towards allocating funds directly to mental health services from the health budget in the long term would be considered as key policy implications and recommendations that has come out of the study.

1. Introduction

1.1 Background

BasicNeeds Sri Lanka (BNSL) is the Sri Lankan arm of BasicNeeds (BN) family which is a non-profit development oriented organisation that currently works in the mental health and development sectors of eight countries across the globe.

It implements its programs through the BasicNeeds' Mental Health and Development (MH&D) Model.

This model attempts to bring out the otherwise hidden people with mental disorders to the lime light and integrate them to the development process using the five modules of the BasicNeeds' Mental Health and Development Model. The five modules are Community Mental Health; Capacity Building; Sustainable Livelihoods; Research and Management and Administration.

One of the components of the BasicNeeds model is its research module. Hence research is part and parcel of our work in terms of improving mental health status and re-integrating people with mental disorders to the community and influencing policy formulation to facilitate the process.

With this background a research study was planned and carried out in Sri Lanka as a part of a multi country policy study on Financing Mental Health Care in Five Low and Middle-Income Countries (LAMICs).

1.2 Literature Review

1.2.1 Burden of diseases and mental disorders: global, regional and Sri Lankan context

According to the World Health Organization's 'The Global Burden of Disease (GBD) - 2004 update' (World Health Organization (WHO), 2004) almost half of the disease burden even in low and middle income countries like Sri Lanka is due to non-communicable diseases.

Even among the Non Communicable Diseases (NCDs), mental health disorders seem to be taking a quite an important place as evident by the GBD 2004 update according to which Uni-polar depressive disorder alone ranks third when considering the overall causes of the disease burden both communicable and non-communicable thus first in non communicable diseases. To further exemplify the high contribution of the mental health disorders to the burden of diseases and it's relation to the Sri Lankan context it would be worthwhile to note that in middle income countries Unipolar depressive disorder ranks right at the first place among the causes of disease burden (WHO, 2004).

In the context of South-East Asia, Unipolar depressive disorder seem to take the fourth leading cause of the overall disease burden ranking second out of the NCDs with its Disability Adjusted Life Years (DALYs) just below Ischaemic Heart Disease (WHO, 2004). Unipolar depressive disorder with a disease burden of 21.1 million DALYs as opposed to 21.6 million

DALYs of Ischaemic Heart Disease which accounts for 4.8% and 4.9% of overall disease burden of the region, making the burden of mental health disorders a substantial component of the overall burden of diseases in Sri Lanka both as a South Asian and middle income country in the world (WHO, 2004).

The burden of diseases is measured by Disability Adjusted Life Years or DALYs. DALYs is a combination of years of life lost (YLL) and years of life lived with disability (YLD) which takes into account the years of healthy future life lost due to premature mortality and disability or injury respectively, and is a measure of overall healthy future life lost due to death, disease, disability and injury (Lopez, n.d.).

This burden of mental health disorders in the region is further worsened and complicated in Sri Lanka by the conflict situation and terrorist activities that had been present for the past three and also by the recent Tsunami disaster that struck the island on 26th of December 2004. In addition many other adverse socio-economic and political conditions had contributed to the burden. According to the WHO Country Office for Sri Lanka's June 2008 Mental Health Update an estimated 3% of the Sri Lankan population suffer from some kind of mental disorder (WHO, 2008).

1.2.2 The treatment gap and the justification of the study

Literature shows that there's an undeniable discrepancy between the burden of disease and treatment availability when it comes to non- communicable diseases hence mental disorders as well. This treatment gap exist at least in a two fold way. On one hand the gap in financing for treatment and on the other the gap in the treatment services available which are interconnected.

In terms of financing according to analysis of year 2006-07 WHO budgets there seem to be a Large disproportion between funds allocated to communicable and non-communicable diseases. When 87% budget is allocated to infectious diseases only 12% is allocated to non-communicable diseases leaving only 1% to injuries and violence. (Stuckler et al., 2008)

Within the context of Sri Lanka according to WHO Mental Health Atals 2005, 1.6% of the total health budget expenditure is to mental health. Most of these allocations are for the mental hospitals leaving other individual hospitals to finance their mental health services out their own expenses.

This inadequate funding and many other associated reasons such as inadequate human resources with right skills in mental health care, lack of knowledge and prioritization by policy makers and leaders in mental health care delivery services, and preventing decentralization and integration of mental health services to the peripheral communities leaving them concentrated in urban areas have been identified as some key barriers of providing quality and extensive mental health care in low and middle income countries increasing the treatment gap thus the disease burden at a community level. (Saraceno et al., 2007)

Being a middle income country most if not all these may hold true in the Sri Lanka context as well. Further more specifically limitations in accessibility along with the scarcity adequate and appropriate drugs for treatment too are highlighted in many academic, professional and non

academic forums and research work in the Sri Lankan context in the recent past (BasicNeeds Sri Lanka, 2007).

Any gap in treatment and care services when compared to the burden of diseases could only be filled by allocating more resources making financing for mental health an important role and responsibility of health care administrators and policy makers of a region, country or even in an administrative entity like an institution.

With that view it is justifiable to study the sources and mechanism of financing of mental health of the country with a comparative analysis of allocation of the funds for different mental health services, and the respective rates of utilisation of these funds with the long term objective of ensuring sustained funds for mental health services as a policy priority.

1.3 Objectives

The main objective of the study was to influence mental health policy decisions made in Sri Lanka and to form a basis for more in-depth studies on financing or costing future psychiatric interventions. This was attempted to achieve by seeking answers to following main mental health financing related study questions;

1) How is mental health funding allocated and used?

2) What are the main sources of funding available for mental health in Sri Lanka?

3) How does the current funding situation (including sources, allocations and sustainability) impact mental health care?

2. Methodology

In line with the international policy study design the Sri Lanka study explored mental health financing through a combination of qualitative and quantitative methods using the same methodological principals as the basis with adaptations to suit the specific country situation and as indicated by the progress of the interviews with the key informants.

2.1 Sampling

The review of the national health budget and other related documents listed under annex 5 at the end of this report were the basis for the purposive sampling. In addition informants recommended by the respondents themselves at the KIIs too were selected where appropriate. A purposively selected sample of six key informants in the above manner to achieve a mixture of mental health, financial and general administrators along with clinicians which provided mental health care from primary health care level to referral level were interviewed. In addition to key informants that are most familiar with mental health service administration of the country, key informants who are familiar with the budgetary system, especially the health budget and the mechanism of funding for mental health of the country were also included through purposive sampling method.

In order to explore the services and the effectiveness of them and participatory nature of the budgetary and financing mechanism the opinion of clinicians involved in delivering mental health care services too was obtained. This enabled the exploration of the gap of knowledge the mental health clinicians of various levels had regarding the budgetary and financing mechanism and the degree to which they participated in the process. An attempt was made to establish how their knowledge and participation would enable them to evaluate the ways in which funding situation impact mental health care of the country, the district or the institution they worked in.

Therefore the six KI comprised of three from the national level and three from regional level to achieve the above mix. The Southern Province was purposely selected as the study is part of the BNSL Community Mental Health Expansion Project implemented in this province.

2.2 Data Collection Tools

Two pre designed interview guides targeting government officials at the national level and other key informant from regional referral hospital, districts and primary health care levels were used to conduct the key informant interviews.

As the availability of financial data was limited and difficult to collect in the manner designed by the primary study a list of quantitative data and information required to analyze finances were compiled and used to collect data. This is annexed along with other interview guides (See Annexes 1, 2 and 4)

2.3 Data Collection

Data collection process was initiated by reviewing the national health budget and related documents followed by key informant interviews and secondary document review as

explained. It included not only reviewing the financial data but other relevant documents (the list of documents attached as annex 5) to map the budget process and mechanism.

Six key informants were interviewed in total, three from national level and three from regional level. In addition supportive information was obtained over the phone from one respondent as indicated by the KIIs. The national level key informant interviews were done by the researcher and a research assistant who was briefed on the study purpose and interview guides prior to the commencement of the interviews carried out the regional interviews.

Two pre designed interview guides were used with adequate probing where and when necessary based on concerns and issues revealed by each interview. (Interview guides are annexed; annexes 1 & 2) On occasions necessary additional questions and topics had to be formulated as arisen at the previous interviews. Some of the information were later clarified and probed more when the analysis required so, by following up the respondents over the telephone and follow up visits for further clarifications if needed. Two out of six national level key informants were followed up respectively.

None of the informants declined to be interviewed and the written informed consent was obtained at all interviews and the interviews were recorded except when the interviewees did not want them to be recorded in which instances hand written notes were taken by the interviewer. One national level key informant did not want the interview to be recorded in audio. Recorded interviews were transcribed and translated when necessary and content analyzed while identifying quotes to be included in the reporting process. (Consent form is annexed – annex 3)

Some of the quantitative data was obtained from the key informants and also publicly available sources. Since the KI were reluctant to release any documents for reviewing some statistical data was collected as they quoted.

Key informant interviews were carried out in July and August 2009.

2.4 Analysis

Qualitative data were analyzed using broad pre-established themes from the study objectives in such away that provides a context in which the budgetary mechanism and the process along with financing data so gathered could be conveniently interpreted, discussed and subsequently conclusions and recommendations could be arrived at.

Direct quotations were used wherever possible in the qualitative analysis of interviews and to draw emphasis to matters. It has been taken care not to divulge the specific identity of any individual respondents while doing so.

Quantitative data whenever available analyzed summarizing them to provide meaningful interpretations. Whenever possible charts were used to re-in force these quantitative data presentation and interpretation. Flow charts were used where necessary for the same purpose.

In analyzing regional data gaps in services and resources were analyzed in an attempt to make a comparison with the fund allocation.

3. Findings

3.1 The scope of mental health services in Sri Lanka

The mental health services in Sri Lanka from a point of comprehending and explaining the financing of mental health, could be categorised mainly into curative and promotional and preventive care delivered at national and provincial level.

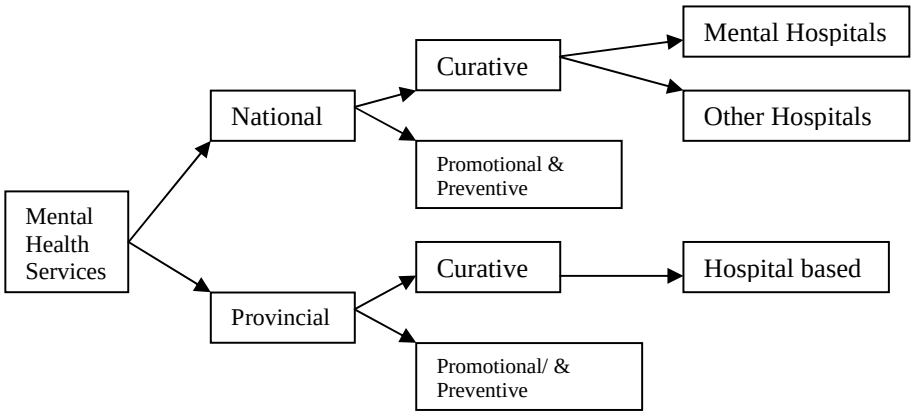


Diagram 1: An overview of mental health services in Sri Lanka

The curative aspect is mainly carried out by the institutional mental health and psychiatric services essentially delivered by various level hospitals in the Sri Lankan healthcare system including specialised mental health hospitals. These services include both inpatient and outpatient care, based in a hospital set up which usually are referral points or in out reach clinics in peripheries closer to the communities. These hospitals and clinics are either attached to the central government or provincial government according to their place in the hierarchy of the hospital systems.

The national level preventive and promotional offered by the mental health program of the Mental Health Unit of Ministry of Health includes the cross cutting services such as: human resources development that includes capacity building; supervision and assessment of Curative facilities; Promotion of Mental Well Being; an information system on mental health (which is being developed) and interventions by carrying out various pilot projects. These services cut across a spectrum of diagnoses and/or disease categories such as severe mental disorders, common mental disorders, substance abuse, suicide prevention, mental health promotion, mental health in children and the elderly. In addition to these there will be some preventive and promotional programs in mental health funded and carried out by the provincial level ministries of respective provincial councils of the country, which in total are nine.

3.2 Regional mental health services (Southern Province - Matara District)

Matara is one of the three main districts of the southern province and some analysis of mental health services of the region would provide a general understanding of the mental health care services available provincially. The main bulks of these services have started after the Tsunami in the year 2006 and have been developing since then.

These services and resources available in Matara region include both hospital based services and resources as well as community based services and resources by the RHDS.

General Hospital (G.H.) Matara managed by the central government has a mental health clinic. In addition the staff of the hospital also provides services to the out reach clinics done by RDHS peripherally and home visits when necessary. The hospital has one consultant psychiatrist who looks after the entire Matara district; three Medical Officers of Mental Health (MOMH); three Medical Officers of Psychiatry (M.O. Psych). In addition an Occupational Therapist, a Social Worker, a Public Health Inspector and a Speech Therapist to carry out the ancillary services.

The RDHS Matara conducts thirteen other out-reach clinics in rural areas of the district in peripheral hospitals; four Community Support Centres; a Rehabilitation Centre; two Day Care Centres: Deniyaya and Akurassa; a detoxification Centre, a half way home in Weligama, Community Projects with NGOs, training of Counsellors. The RDHS has four MOMH, two nurses trained in rehabilitation in the two day care centres, RDHS, MOMH focal point (included in the four MOMHs), MO Planning, Statistical Officer, to carry out these services.

There are number of gaps identified in terms of services offered, human resources, infrastructure and supply of drugs. A main shortcoming in the region is the absence of functioning acute in patient care in G.H. Matara, construction is underway but there are delays. In addition the absence of ancillary mental health services such as counselling, in both out reach clinics and the hospital clinic and absence of facilities such as monitoring drug concentrations are some of the shortcomings.

> ***"Only problem we have is we do not have the acute care unit in Matara …. If the patients really need acute treatment they will go to the near by hospital in Galle about 40 to 50 kilometres from here"*** *- A key informant in the region*

Absence of adequate and appropriate basic infrastructure is another shortcoming that was highlighted, especially to see patients with mental illnesses in a confidential manner ensuring their privacy.

> ***"No I am not talking about the building, but the space, absolutely no privacy. What to do, we have to work with the available resources..."***
>
> - *A key informants providing clinical care*

There is only one consultant Psychiatrist for the whole region of 800,000 populations and no adequate numbers of allied health care professionals such as trained counsellors, occupational therapists, speech therapists and psychiatric social workers. Additionally drug shortages are experienced at times due to various reasons and impact the treatment process greatly.

> ***"I would like to have a multidisciplinary team … We are not completely out of resources... We need psychiatric occupational therapists… and few social workers for the clinics… at least for a few clinics."***
>
> - *A key informant providing clinical care*

3.3 The main sources of funding for mental health services in Sri Lanka

Primarily the Government of Sri Lanka (GoSL) and other donor agencies fund mental health services in the country.

The World Bank (WB), World Health Organisation (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (Unicef), Volunteer Services Organisation (VSO) etc, are the current main donor agencies to the Ministry of Health (MoH), national level mental health prevention and promotion program funds. These donor funds obtained for a particular year varies according to the need, the situation, the programs and proposals submitted by administrators and their enthusiasm to work to find their own funding as emphasised by one of the key informant of the study and could be as high as the government funds received.

> ***"… therefore some of these funds received depend and vary year by year based on the person who is in charge and that person's interest to work and finding funds for his or her work"***
>
> - *A key mental health administrator*

Table 01:
Funding for mental health prevention and promotion programs of MoH in 2008 by the source

The source of funding for mental health	**Amount in LKR** (only an approximation)	**%**
State		
From the government treasury department	100,000,000	44.84
Non-State		
World Bank (WB)	100,000,000	44.84
United Nations Population Fund (UNFPA)	15,000,000	6.73
World Health Organisation (WHO)	8,000,000	3.59
Other Donor Agencies	Vary	
Total for the program	**223,000,000**	**100.00**

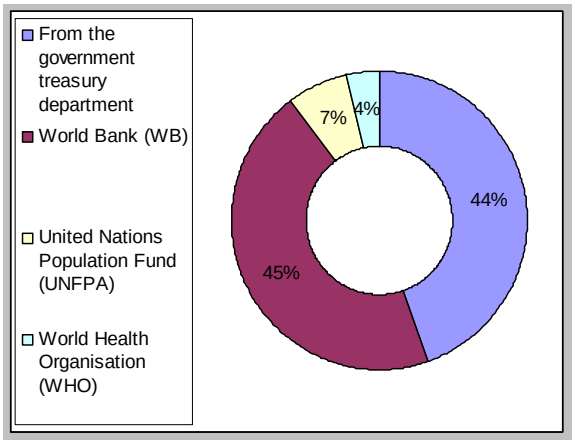
Source: As quoted by MoH, key informants[5]

In terms of utilisation the more than 90% of these funds are usually utilised according to one of the mental health administrator who took part in the study.

> ***"Yes in most of programmes about 92% to 93% funds are utilised so it is like that in the mental health as well"***
>
> - *The key informant said*

[5] These quoted figures are not fact-checked

Chart 01:
Funding for mental health prevention and promotion programs of MoH in 2008 by the source



Source: as quoted by MoH, key informants

"Last year (2008) the government funds exceeded a little more than 100,000,000 Sri Lankan Rupees (LKR) to this program and the World Bank has given another 100,000,000 too"

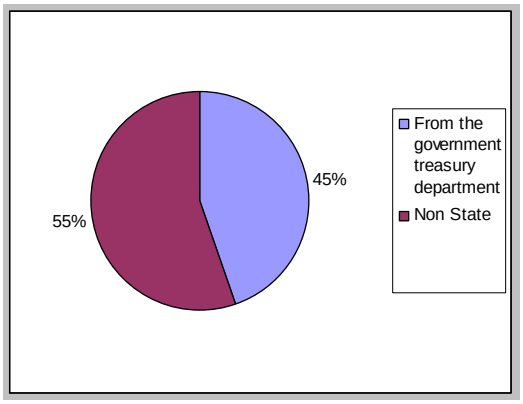
- A key informant

Table 02:
Summary of funding for mental health prevention and promotion programs of MoH in 2008

The source of funding for mental health	**Amount in LKR (Approximations only)**	**%**
State Total	100,000,000	44.84
Non State Total	123,000,000	55.16
Total for the program	**223,000,000**	**100.00**

Source: As quoted by MoH, key informants

Chart 02:
Summary of funding for mental health prevention and promotion programs of MoH in 2008



Source: As quoted by MoH, key informants

Similarly the provincial ministries receive funds directly from the government and other donors directly except for the institutional services funded directly by the line ministry but located regionally. In addition there are organisations that directly carry out mental health services on their own in coordination with the regional directors without funding the government work directly. However sustainability of the funds and services that are provided by NGOs were thought to be low an unreliable at provincial level compared to government services. In addition there may be small private grants and funds from well wishers and charitable individuals on specific tasks and activities.

3.4 The basic mechanism of funding for mental health services in Sri Lanka

There are two main mechanisms of financing health thus mental health in the country. That is either from the central government directly or through the provincial councils. However a notable finding is, in any of the above two mechanisms currently there is no active separate budget line or a heading dedicated to mental health used to allocate funds.

At the national level the central government funds are allocated by the treasury itself. The Ministry if Finance coordinates the fund allocation to the MoH through the department of finance in the MoH. Director Mental Health of the Mental Health Unit manages the national level mental health budget allocated for the prevention and promotion of mental health where as the other budgets are managed by respective institutional heads including separate budgets for three mental hospitals in the western province funded directly from the national health budget. Some of these institutions/hospitals come under the line ministry where as there are others that come under the provincial councils. The institutions that come under the line ministry gets their budgets allocated though the central government directly. The special hospitals that cater to mental health and psychiatric services are directly funded by the national health budget they include; Mental Hospital Angoda (NIMH), Mental Hospital Mulleriyawa, Mental Hospital Handala[6]

The funds from donor agencies for preventive and promotional activities are obtained by preparation and submission of special project proposals to the respective donor agencies and are carried out by the Director, Mental Health of the MHU in coordination with the finance department of the ministry as stated above. The funds so received are allocated and utilised directly by the MHU to carry out its planned activities under the MHU and some times the MHU may fund provincial ministries on carrying out special programs that are of relevance to mental health in respective provinces.

Similarly the individual institutes that come under provincial councils submit the budget proposals to the respective provincial ministries'. Provincial council budgets are allocated by en-block by the Finance Commission in coordination with the relevant department of the Ministry of Finance of the central government with the involvement of the Ministry of Local government and Provincial Councils. The allocation for health budget takes place at the provincial levels through their provincial health ministries. In addition provincial councils have their own income which finances their budgets apart from the money received from central sources and non-governmental sources.

These funding mechanisms at times become arbitrary as there could be many over-laps among the two mechanisms, with funding of other projects and even with funding from other ministries that provides similar services. These will depend on the situation and need in the country from time to time, during which health care professional and staff take collective decisions prioritizing the objectives, therefore many overlaps could occur and provincial activities may be funded by central ministry if the need arises. This overlapping and lack of demarcation could change further from year to year if there are any changes to the management structure of the hospitals. For example a hospital that belonged to a provincial council in one year could be taken over by the central government and vice versa.

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[6] *Source: Budget Estimates 2009, Ministry of Healthcare and Nutrition*

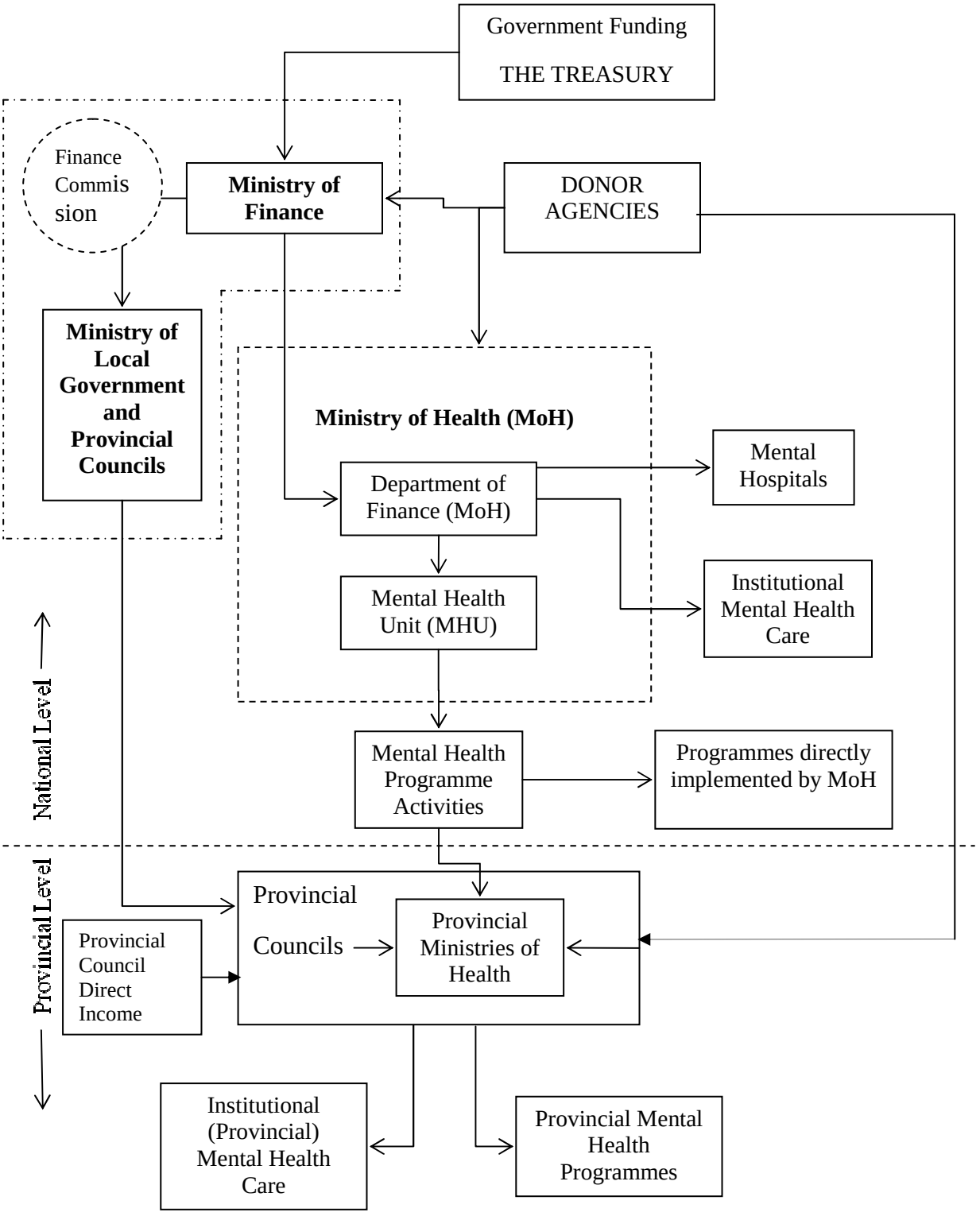


Diagram 2 –The basic mechanism of funding for mental health services in Sri Lanka, national and provincial levels

3.5 The process of budget formulation – The Budget Cycle

Department of National Budget of Ministry of Finance (MoF) prepares the National Budget of the country. The National Health Budget is prepared by MoF in coordination with MoH and the Treasury. They prepare the budgets for curative and prevention services including both recurrent and capital expenditure for the national budget while provincial budgets are prepared separately in coordination with the Finance commission and the ministry of local government and provincial councils. The Department of Planning (the capital budgets), the Fiscal Policy Department (projections of government income and funds available) and the government state accounts department (records and maintains the actual monthly expenditures) are the other departments of MoF that are involved in the process.

The process involves sending a budget call to heads of all the relevant bodies and obtaining estimations. The budget call is released in the month of July of the current year and includes the guidelines and formats, steps and the timeline for estimation of budgets for the coming year. Then the National Budget Department of MoF internally prepares a dummy budget depending on the government income against which the respective budget estimates are compared with at a series of internal discussions. Tentative allocations are made within the limits of the income for each ministry. Then takes place the budget discussion at which each ministry and the MoF negotiate their budgets and come to an agreement which then becomes the health *budget estimat*e for the coming year. This is then submitted to the parliament and approved which is the *approved budget*. Finally the Minister of Finance (in the current context the president of Sri Lanka) authorizes the budget by releasing the authorization circular on the 31st of December. Only after this circular is being issued that cash could be issued from the 1st of January. The actual cash is released from the treasury operations department of the MoF. Some times due to various reasons within the financial year the approved budget might be revised by issuing circulars, and then it is known as the *revised budget* for the year. Finally when the actual expenditure is incurred the *actual budgets* are prepared. Which are used in future budget estimation processes. This is the budget cycle in brief from estimations to actual budgets.

Information such as the carder requirement; salary, over time and other allowances structures; expenditure on utilities such as electricity, water and telephone are mainly required to estimate recurrent expenditure accurately. Similarly for capital projects; whether the project planning is done properly, whether tender procedures have adhered to in estimation of budgets, if the plans and time lines are realistic, are the necessary information to prepare the budget estimates.

Financial and resource constraints are the main challenges faced in budget estimation and preparation. In addition lack of capacity especially of the provincial councils and institutions to prepare budgets too adds to the burden. Provincial councils are still in the process of developing thus sometimes lack the adequate capacity to carry out these administrative tasks. Politicization of the process, undue priorities in budgetary allocations such as for over time allowances etc, lack of knowledge and capacity of the heads of the institutions regarding financial matters and lack of knowledge about mental health or health care matters of the accountants who mainly prepare the budgets, lack of personnel with capacity to manage mental health issues, lack of prioritization of mental health in government policy priorities are some of the challenges as revealed by the study informants.

"Provincial councils lack the capacity… no personnel with good education and even the ones that are there are politicized… provincial councils are still in the process of development, and it's a difficult and slow process …"

- A national level key informant

The national health budget directly allocates money to specialized hospitals for mental health such as the National Institute for Mental Health in Angoda and total budgets of other hospitals attached to the central ministry that may located in various provinces of the country. Allocations for mental health take place from these latter budgets at the level of the institutions. These are the main budgets for curative services. Similarly some institutions are funded by the provincial health budgets by provincial councils. The main shortcoming in the process as revealed by one respondent is that the budgets' are prepared and funds are allocated based on the requests made by the respective heads of the institutions, units or programs and there is no evaluation of performance or results involved in the process.

In terms of preventive and promotional services the sole responsibility of preparation of the mental health budget for the mental health unit of the MoH on behalf of the ministry lies on the director of mental health which is facilitated and coordinated by the finance division of the ministry. The director decides what amounts to be allocated for what purposes based on the analysis of the existing situation and the future needs. The information that needs to come to these decisions is usually obtained at the district review meetings the director attends periodically throughout the year. During these review meetings the gaps and needs are identified in each locality. Based on these the annual planning is done. In addition she consults the expert consultants on technical matters and entertains other requests that are made by the regional and provincial staff.

Similarly at the provincial and regional level Finance Commission allocates money to the Provincial Councils. This is a block allocation for the entire province. At the provincial level these funds are allocated to different services and ministries of the provincial council including health out of which mental health funding takes place. NGOs, other private donors and provincial council income are other sources of funds to the province.

Each province has several regions. Southern Province which is the province under this study has three regions or districts; Galle, Matara and Hambantota with their own regional health administrative system lead by Regional Directors of Health Services (RDHS). There are regular meetings called by the RDHS for which all the stakeholders from administrators, clinicians, community workers to other NGOS representatives are invited. The needs and gaps that require financing are identified at these meetings. Then funds are sought, if there are no funds from government sources, then the assistance of NGOs are sought. For this project proposals are prepared and submitted which would be perused by the respective NGO and decided on the funding and the amount. These are in addition to the annual fund allocation they receive from the provincial councils' health budgets for the expenses estimated in their annual budget plans. If a clinician identifies a need that requires financing he or she could go to the RDHS who then take up the matter for funding. The clinician's involvement with financial matters in this manner though present, is minimal they do not have access to financial data in their day to day activities as emphasized by the following quotations.

"We have regular meetings once in three four months… We identify deficits and deficiencies and then ask for financial assistance from the ministry as well as from various NGOs. Most of the time NGOs help us."

- *A regional key informant*

"I have no duty there. May by the regional directors have the budgetary meeting or something like that? They attend that. I do not know. I am only a technical leader. I have no administrative powers."

- *Clinicians' comments on financial and statistical information*

3.6 Allocation and utilisation of funds for mental health services in Sri Lanka

3.6.1 National budget and the total health budget

The total national expenditure including expenditure of the provincial councils as well for the year 2008 revised budget is 1,555,099,740,000 LKR[7] and out of that the total allocation for health both national and provincial council allocations is 4.87%. 3.51% of which is the national health budget and 1.36% is the provincial health budget.

Table 03:
National, Provincial and Total health budgets as a percentage of Total National Budget in the year 2008 revised budgets

Budget	Amount in LKR	%
National Health Budget [a]	54,518,428,000	3.51
Provincial Health Budget [a]	21,101,000,000	1.36
Total Health Budget (National + Provincial)	**75,619,428,000**	**4.87**
National Budget [b]	**1,552,099,740,000**	**100.00**

Sources: a. Budget estimates 2009, ministry of Healthcare and Nutrition b. Budget estimates for the Fiscal Year 2009 of Democratic Socialist Republic of Sri Lanka

The total health budget compromise of two main parts, that is the national part and the provincial council part which are funded as described in preceding sections. No data is available to make a complete assessment of the total mental health budget either provincially or nationally.

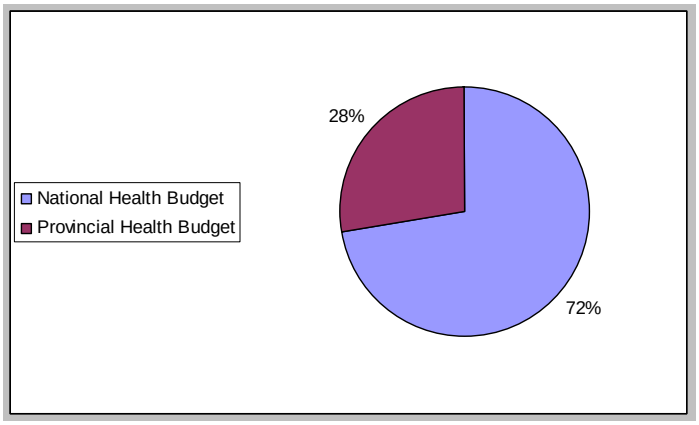
[7] Source: Budget estimates for the Fiscal Year 2009 of Democratic Socialist Republic of Sri Lanka

Table 04: Total Health Budget in 2008 revised budget

	Amount in LKR	%
National Health Budget	54,518,000,000	72
Provincial Health Budget	21,101,000,000	28
Total Health Budget of the Country	**75,619,000,000**	**100**

Source: Budget estimates 2009, ministry of Healthcare and Nutrition

Chart 03: Total Health Budget in 2008 revised budget



Source: Budget estimates 2009, ministry of Healthcare and Nutrition

3.6.2 Mental health budget

There is no direct fund allocation or budget line that encompasses all the mental health services both provincially and nationally, therefore this could not be quantified in an accurate manner. But as explained in above sections this budget is the cumulative total of the both institutional and preventive budgets of provincial and national mental health services including mental hospitals.

Mental health preventive and promotional services budget: As explained by the section 3.3 above there has been approximately 100,000,000 LKR allocated for preventive and promotional mental health services in year 2008 from the national health budget from government funds. This fund is a part of the health promotion and disease prevention project, where funds for specific prevention and promotional programs but mental health promotion have not identified as a separate budget line in the budget. These funds are mainly allocated from the subproject identified as "Other community health services". The total budget allocation for other community mental health services in 2008 revised budget is 160,646,000 LKR[8]. It is noteworthy to mention that some sub-projects like STD/AIDS prevention to which allocations are lesser than (62,351,000 LKR in 2008 revised budget[3]) has its own budget line where as there is no separate line for mental health services. In addition as a recent development since 2009 there is an estimate of 75,000,000 LKR under a specific sub-project heading allocated for 'strengthening and rehabilitation of provincial mental health'. This amount is projected to be increased up to 120,000,000 LKR by 2011[3], which is a noteworthy improvement. These budgets would be supplemented by the allocations for preventive and promotional work provincially and regionally.

[8] Source: Budget Estimates 2009, Ministry of Health Care and Nutrition

Allocation and distribution of funds for special mental hospitals: There are three special mental health hospitals located in the western province Angoda (aka National Institute of Mental Health (NIMH), Mulleriyawa and Handala. In the year 2008 a total of 718,488,000 million LKR has been allocated to these three hospitals. As shown below out of this allocation 67% is for the NIMH as where as 24% and 9% are respectively for Mulleriyawa and Handala mental hospitals, making National Institute for Mental Health the single largest hospital that the largest portion of mental health funds are allocated directly from the national health budget. The total amount of funds allocated to mental hospitals in the western province is 1.32% of the national health budget.

Table 05:
Budgetary Allocations for Mental Hospitals in 2008 revised budgets

Mental Hospital	Amount in LKR	%
Angoda	482,238,000	67.12
Mulleriyawa	174,270,000	24.26
Handala	61,980,000	8.63
Total	**718,488,000**	**100.00**

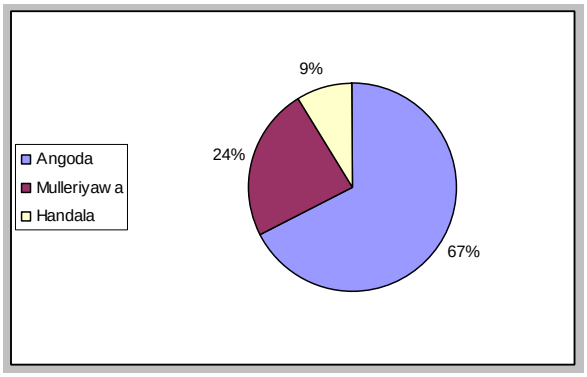
Source: Budget Estimates 2009, Ministry of Health Care and Nutrition

Table 06:
Allocations for special mental health hospitals as a percentage of national Health Budget in the 2008 revised budget

	Amount in LKR	%
Total Funds Allocated to Mental Hospitals	718,488,000	1.32
National Health Budget	54,518,000,000	100.00

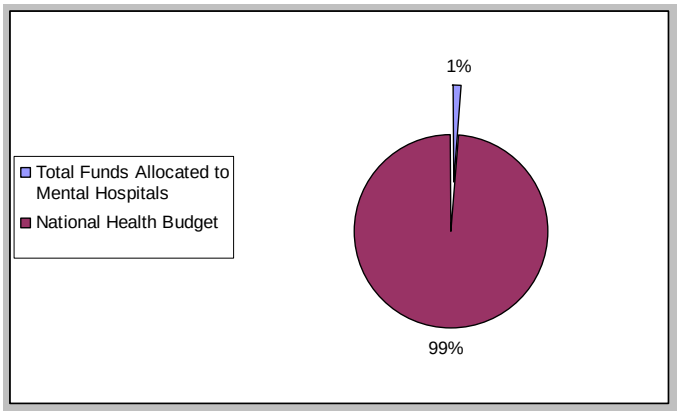
Source: Budget Estimates 2009, Ministry of Health Care and Nutrition

Chart 04:
Distribution of funds for Specialized Mental Health Hospitals in the year 2008 revised budget



Source: Budget Estimates 2009, Ministry of Health Care and Nutrition

Chart 05:
Allocations for special mental health hospitals as a percentage of national Health Budget in the 2008 revised budget



Source: Budget estimates 2009, Ministry of Health Care and Nutrition.

Other institutional budgetary allocations for mental health services: This is the most difficult part to quantify in order to arrive at the total mental health expenditure for a given year. This would require a list of health care institutions which provides mental health service other than that is covered by preventive and promotional programs both at provincial and national level and quantifying the expenditure for mental health in their budgets by going through all the budget items and would be an extensive exercise. The alternative option being selection of sample institutions and quantify this data and make a projection in future studies or analyses. In addition to these budgets there's another direct allocation from the national mental health budget to three special mental hospitals in the country which are all located in the western province.

3.7 Key findings in brief

- Government is the main source of funding for mental health with additional funding from NGO's. Some of whom carry out work directly in coordination with government services. Government funds are thought to be more sustainable than funding from non-governmental organization.

- There are two main mechanisms of financing health thus mental health i.e. through the health budgets of the national and provincial levels that encompass both curative and preventive/promotional aspects. There are overlaps in these funding especially in preventive and promotional services.

- Currently there is no active separate budget line or a heading dedicated to mental health. The only direct fund allocation for mental health from the national health budget is for the three main mental hospitals in the western province. Allocations for the other curative mental health care are through respective institutional health budgets which come either from national or provincial health budgets managed by respective institutional heads.

- Director Mental Health of the Mental Health Unit manages the national level mental health budget allocated for the prevention and promotion of mental health where as the other budgets are managed by respective institutional heads.

- There is no system in place to evaluate the performance and results in budgetary allocation but it is done based on the requests made by the institutional and program heads. At regional level there are gaps in terms of knowledge and access to financial information by clinical care providers

- Financial information in relation to mental health are difficult to obtain, informants would not quote information at KIIs without referring to documents and they are not available in an easily accessible and transparent manner.

- In order to gather detailed financial resource allocation and utilization in mental health it requires studying of the budgets of each and every institute that has a mental health service as there are no direct budget allocations for mental health.

4. Study Limitations

The study encountered the following limitations which affected quantitative findings more than qualitative findings which affected the overall quality and the extent of findings.

The starting point of the study was revision of National Health Budget following which the KII to be interviewed and documents to be reviewed was to be identified by the initial KIIs, which left room for researcher biases in sampling initially and subsequently interviewee biases adding to the overall sampling biases as the key informants (KI) referred to by other KIs was influenced either by the people they came closely in contact in their day to day work or their personal preferences and/or their informal networks which potentially could skew the overall findings and outcome of the study by increasing the overall interviewee bias of the research.

Identification of the documents to be reviewed through KII too had limitations as sometimes most of the documents were referred to and used out of habit rather than referring to their technical names thus affecting the accuracy of information.

Sometimes it was evident that the KI were newly appointed to the position he or she holds thus the understanding of the intricacies of the information system and flow in order to provide the relevant information was limited.

Furthermore there were instances KI were resistant to divulge information in a one to one interview and seemed to prefer group discussion where their seniors and other individuals in the process are collectively consulted for information. Absence of subordinates of KI, who could successfully give relevant data at the time of the interview who could interpret data limited the quality and quantity of the overall findings.

Therefore there was a high degree of recall bias that affected the overall outcome of the study, mainly in identifying the relevant documents to be reviewed and gathering quantitative data.

Key informants at times would quote the data off their records during which approximations were made which again left room for an increased interviewee bias of findings.

Another limitation is the scope of the study, the study has collected data from national level and one out of three districts in the southern province, therefore a generalization could not be achieved as there are 24 districts in nine provinces in the country. Therefore making some of the regional findings such as scope of the services and treatment gaps descriptive in nature and not absolute in terms their application to the whole country yet the key findings pertaining to financial mechanism, fund allocation and utilization remains valid.

5. Discussion

The global burden of mental health disorders is increasing a trend which is valid to the South East Asian region as well as Sri Lanka. Specifically in the context of Sri Lanka this burden was further worsened by the Tsunami devastation and also by the conflict and war situation that prevailed in the country for nearly three decades. This study was carried out at national level and in the Southern Province of the country which is one the provinces that was affected by the Tsunami , but did not include any locality where the conflict and war prevailed to major part of the last two to three decades.

To initiate the discussion on the findings revealed, on a positive note it could be stated that there is an increased tendency to concentrate and pay more attention to mental health services, especially in terms of preventive and promotional aspects. This is evident by the presence of a mental health directorate in the ministry of health, a mental health policy and the newly started mental health programs which mainly caters to community mental health services in provinces and smaller regions such as the Matara district of the Southern Province, which had been initiated periods following Tsunami. Further more there has been an influx of human resource though not ideal to carry out these services. The availability of MOMHs at newly established out reach mental health clinics and MOMH focal points in the RDHS office attest to this. The community awareness, the policy makers and health administrators' awareness on mental health have increased over the years.

The donor funding too is at a considerably high level as revealed by the findings. In preventive and promotional care the donor funding equals government funding according to both national and regional key informants.

Yet many treatment gaps are available in the mental health services as revealed by this short study. Some crucial and essential services such as acute in-patient care; suitable infrastructure; adequate ancillary and supportive services like counseling, occupational therapy, psychiatric nursing services; adequate laboratory facilities; seamless flow of medication are missing especially regionally as indicated by analysis of services and gaps in the district of Matara in the Southern province of the country despite a very active newly initiated mental health programs and activities in the post Tsunami period with the contribution of many government and non – governmental stakeholders.

The most important of these gaps according to the findings is the non availability of a dedicated financing mechanism for mental health in the country in general, which has added insult to injury and left whatever the existing and newly established mental health services out on a limb without a system of proper monitoring and evaluation in terms of their efficiency and cost effectiveness. This not only hampers the effective delivery of existing care, but also makes it difficult to manage and plan any further interventions in the future based on any sound financial information and reason.

This lack of dedicated financing mechanism and the complexity of the existing financing process essentially makes it more difficult to quantify mental health fund allocation and utilization even by way of an external analysis or research.
In this context the financing of mental health care based on a system of evidence seem still a distant concept to administrators, clinicians and financial managers of the process of delivering

mental health care. This lack of awareness increases as you go down to the lower levels of financing hierarchy adding to the treatment gaps already prevailing.

The only item of mental health service that direct fund allocation is present form the national health budget is the three large traditional mental hospitals in the western province which were present from the long gone colonial era of the country.

The milieu of mental health services though has changed ever since both in practice and policy level to a recognizable degree accompanying appropriate prioritization of financing in terms of direct allocations from the national health budget of these services do not have taken place putting such newly initiated programs in jeopardy, in terms of their efficiency as well as their sustainability. This is especially true as some of the services seem to heavily depend on the non- state sources of funds in the prevention and promotion of mental health care.

This situation is complicated by lack of adequate and accurate knowledge on financial information by clinicians at the practice level and administrators and policy makers at the policy level creating a knowledge gap between the clinicians and practitioners and policy makers affecting formulation of healthy policies in mental health financing.

Some of the specific information is only available to the administrators (which are somewhat redundant in their contribution and efficacy in influencing policy) and there is a considerable portion of fund allocation for mental health that may not be directly available for even for administrators without detailed analysis of their institutional budgets.

How ever studies of this nature could be effectively used to shed light on these concerns and drawbacks but the lack of access to adequate accurate financial data makes carrying out the same challenging and findings thus gained limited.

It would be useful if further in depth studies with greater scope could be carried out in order to quantify the actual financing of the overall mental health services of the country. The bulk of the financing may remain in the curative services provided by institutions scattered around the island that delivers mental health and psychiatric services which had not been captured by this study. A more comprehensive understanding of health and mental health administrative and financing process and the mental health services available nationally and regionally by institution would lay a good foundation to such an in depth study. Furthermore social costs such as accessibility cost which may not be revealed by examining and analyzing the financial information of the health administrative system but only by collecting personal expenditure from consumers and carers and their respective families. This will enable to establish a holistic picture and quantification of the cost of mental health thus financing mental health of the country in a more practical way.

Such measures surely could lay a solid foundation for future psychiatric and mental health interventions based on sound analysis and projections which could be the corner stone of effective administration of mental health and a powerful tool to face the challenges imposed by the growing burden of diseases, increasing cost of health care and turbulent global financial climate.

6. Recommendations

Recognition the importance of mental health by introduction and use of a separate budget heading/line for mental health financing allocation and utilization at all levels including national, provincial, regional and primary health care level as a strategy to reduce the increasing disease burden of mental disorders and reducing the gap in treatment and other ancillary services to counter the same.

Recognition the importance of mental health promotion and prevention by assigning the work of mental health unit of Ministry of Health new sub–project number in budget allocation instead of current common budget allocation that it shares titled 'other community health services' as a strategy of ensuring sustainable funds for the purpose.

Increase transparency of financing and budgetary information and process at all levels of the health care administration and management structure. This is truer especially in regional levels where transparency seem to be particularly low.

To make the allocation and utilization and expenditure of public funds and other relevant statistics readily available in an easily accessible manner to all stakeholders concerned including beneficiaries, carers, health officials, clinicians and general public including concerned analysts and researchers as a measure of ensuring their right to have access to information that would affect their needs.

Increase the internal communication between health administrators and clinicians in such a way their decisions are based on information made available in such manner and build their capacity to make management and other decisions according to the information available.

Increase the use of information technology such as web based solutions which would make this financial information available freely and easily accessible manner on the web in a cost effective manner.

To this extent, the initiative of the Director, Mental Health, Mental Health Unit of Ministry of Health to develop a strong centralized information management system on mental health related information to include information pertaining to mental health financing, allocation and utilization in the country.

Allow the provincial, regional and primary health care level personnel to freely access this information system and use the information, including financial information in their planning and decision making processes.

Encourage and cultivate evidence based planning and decision making processes including preparing budgetary estimates, plans and proposals in the mental health service delivery using this information made available.

Develop the capacity of the provincial, regional and primary health care level officials in budget estimation, planning and preparing proposals and timely submission of the same to the Ministry of Finance in preparing annual budgets.

Make aware of the importance of analyzing conducting research on financial data for future decision making process as measure of establishing sustainability and planning activities appropriately

Build and develop the capacity of these officials to use above financial data to negotiate budgets at annual budget discussions with the ministry of finance and this way to minimize deductions.

In this manner develop and increase the capacity of the relevant officials to take independent decisions at regional level by establishing an ongoing communication process with the central authorities in budget finance related matters.

Increase the communication between administrators and clinicians as a way of increasing their knowledge and understanding the roles of each other as a strategy to develop better financial allocation and utilization.

Increase the participatory nature of the health care delivery staff in the administrative process of budget preparation and allocation.

Finally to carry out above mentioned recommendations as policy measures and revise the section 1.2.1 of The Mental Health Policy of Sri Lanka 2005 – 2015 to ensure inclusion of the recommendations as a measure of ensuring good governance in mental health financing and build the capacity of relevant local level officials to implement these measures.

7. Conclusion

In conclusion when the global, regional and country mental health burden is increasing and the overall financial climate of the world is in a state of crisis and the cost of overall health care increasing due to various factors, if the needs of the communities and populations with regards to mental health services, in which there seem many gaps when it comes to treatment available and finances available, are to be prioritized it seems that the correct thing to do is sound knowledge of cost of mental health care to be made available to the policy makers, health care managers and administrators as well as to the beneficiaries of services.

But as per the findings of this study there seem to be many policy level, procedural, technical level issues that prevents achieving this state, including the lack of awareness of the conceptual importance of engaging in evidence based policy, administrative and clinical practices in mental health care.

Therefore it would be prudent to take necessary and immediate steps to rectify these gaps in the search of cost effective mental health care services.

To this extent much empirical evidence has to be generated with in-depth studies with wider scope that explore both micro and macro economics of financing mental health care. The processes involved needs to be mapped and analyzed in detail, in order to find cost effective yet efficient solutions and processes of financing. Yet it would be hard to envision that this along would make a sufficient impact on mental health financing.

Due recognition of the importance of conceptually engaging in such strategic financial management mechanisms, especially in a sector that deals with mental health is of utmost importance and should be an immediate step that the relevant policy makers should take as it takes somewhat effort and time for the benefits of such initiatives to be trickled down to the bottom tier of beneficiaries. It is only through the acceptance of such strategic concepts at a macro level, this process could be effectively initiated and implemented, the neglect of which may result in the delay of the development of better mental health care services adding to the ever growing burden of diseases.

In conclusion it could be considered that the study has achieved its primary purpose if this study serve as a an indicator of the need to initiate such strategic health care measures in the future and also to initiate more detailed, comprehensive and in-depth studies that assess and analyze the multi faceted financing of mental health, including the mental health disease burden and its relationship to financing in Sri Lanka. The first step towards achieving this somewhat intermediate term purpose would be for all policy makers to ensure that financial decisions and information are more transparent to the public, service recipients and other stake holders at all levels and enable the practice of using these information in decision making by the stakeholders thus healthy financing of mental health could be achieved which perhaps is the need of the hour in many spheres of not only in mental health but also subsequently in development at a larger level.

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Annexes

Annex 1

Topic Guide for Key Informant Interviews with Government Officials

Introduction to the interview

Thank you for agreeing to participate in this interview. The purpose of the interview (state duration – 1 hour) I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable. There are no right or wrong answers to the questions; we are interested in your opinions based on your experiences or the experiences of others you know.

Participation in the interview is voluntary, so if you don't want to answer a particular question you don't have to, and you are free to leave at any stage. (Remind participants that the discussion will be recorded.)

Obtain consent now

1) Describe your role in MH funding allocation.
2) Who are the other people/departments involved in this process?
3) How are mental health services defined by the country? Which diagnoses are included under the umbrella of mental health services?
4) What are the current sources of mental health funding?
5) What records or information systems exist with data on MH public funding allocation?
6) Please explain the steps involved in MH funding allocation from the source to the recipient services.
7) How are mental health funding decisions made? (Probe for what sources are consulted to make these decisions)
8) What specific challenges do you encounter in this process?
9) What information is required to make well-informed MH budget decisions?
10) Do you think the current sources of MH funding are sustainable? Why or why not?

If necessary, ask:

11) Do you know of any documents identifying sources and amounts of MH funding for previous years? If yes, which document(s)?
12) Do you know of any documents which identify NGO contributions to public MH funding? If yes, which document(s)?
13) Do you know of any documents that break down funding allocation amounts by specific MH services? If yes, which document(s)?
14) Do you know of any documents that identify utilization rates for these services? If yes, which document(s)?

Annex 2

Topic Guide for KII at Referral Hospitals, Districts, and PHCs

Introduction to the interview
Thank you for agreeing to participate in this interview
The purpose of the interview (state duration – 1 hour)
I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable. There are no rights or wrong answers to the questions; we are interested in your opinions based on your experiences or the experiences of others you know.

Participation in the interview is voluntary, so if you don't want to answer a particular question you don't have to and you are free to leave at any stage.
Remind participants that the discussion will be recorded.

Obtain consent now

1) What mental health services are offered at your hospital/clinic?

2) How is mental health funding allocated in your hospital/clinic?

3) What records or information systems exist for recording MH service utilization information?

4) What records or information systems exist for hospital expenditures?

5) **If necessary, ask:** Do you have a method for recording each individual patient diagnosis? If so, how is the diagnosis determined and how is the record maintained?

6) **If necessary, ask:** Is usage for dispensed psychiatric medications recorded? If so, how is that information collected/recorded?

7) **If necessary, ask:** Is every patient visit recorded? If so, what information is collected and how is it recorded?

8) **If necessary, ask:** Is payroll information recorded for the hospital/clinic? Is that information accessible to us?

9) Do you have adequate resources for providing mental health services? If not, which areas are lacking?

Annex 3

Informed Consent Form

A research project being undertaken by BasicNeeds

Key information to be communicated to each participant BEFORE commencing the Focus Group Discussion or Interview.

Information	**Understood?**
We are looking at mental health financing	
This group discussion/interview will take 1 hour of your time	
Everything said will be confidential. The discussion may be recorded, but this will be protected from others. Please keep what is discussed in this group to yourself.	
You do not have to be a part of this discussion. You may leave when you choose. Your choices will not affect your relationship with us.	
Will you participate? **YES** **NO**	

I have communicated the above information to _____ and he/she has agreed to be involved in the Focus Group Discussion/Interview.

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Before we begin, do you have any questions you would like to ask?

Annex 4

BasicNeeds Finance Study 2009 - Information requirement for quantitative analysis

Documents needed:

The documents that could provide the following information are needed;

- Information on sources of funding of mental health services
    - Government – National Budget, Central government budget for provincial councils , provincial council income
    - Non – Government – by donor
    - Private if any

- Information on allocation of budgets for mental health services (total amounts by service)
    - For Curative care
    - For preventive and promotional care

        By

        - In-patient care
        - Outpatient care
        - Infrastructure
        - Maintenance and administrative
        - Salaries
        - Medication
        - Travelling
        - Other

- Information on utilisation of allocated funding for mental health services (above) (Expenditure sheets)

Above data for the previous year and (three to five years before if possible) and estimates for 2009.

Names of the documents in which these data is available

Additionally:
Summaries of mental health patient records
Summaries of mental health drug records
Summaries of mental health staff pay roll information

Annex 5

A List of additional documents reviewed for the study design and information

1. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Budget Estimates 2009 – National Summary of Expenditure - Summary of Expenditure by Program* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/1expenditurebyprogramme.pdf

   Budget Estimates 2009 - National Summary of Expenditure – Summary of Financing [PDF] available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/2-summaryoffinancing.pdf

   Budget Estimates 2009 – National Summary of Expenditure – Government Expenditure by Ministries and Institutions [PDF] available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/3-governmentexpenditurebyministriesandinstitutions.pdf

   Budget Estimates 2009 – National Summary of Expenditure – Summary of Expenditure by Category and Code [PDF] available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/4-summaryofexpenditurebyobjectcode_gov.pdf

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2. Ministry of Finance and Planning, Sri Lanka, Department of National Budget. *Budget Estimates 2009, Ministry of Healthcare and Nutrition* [PDF] Ministry of Finance, Colombo, Sri Lanka, Available at: http://www.treasury.gov.lk/BOM/nbd/nbdheadseven/111/Head_111E_2009.pdf [Accessed on 4.06.2009]

3. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Budget Estimates 2009 – Summary of the Budget* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/summaryofbudget2009.pdf

   Budget Estimates 2009 – National Summary Revenue – Revenue Classification [PDF] available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/revenue2009/RevenueClassification.pdf

Budget Estimates 2009 – National Summary Revenue – Government Revenue 2009 [PDF] Available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/nationalsum2009/revenue2009/GovernmentRevenue2009.pdf [Accessed on 5.06.2009]

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5. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Estimate 2006, Ministry of Health Care and Nutrition* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/pdfdocs/expenditure2006.pdf [Accessed on 4.06.2009]

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7. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Estimate 2008, Ministry of Health Care and Nutrition* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/nbdheadseven/111/Head_111E_2008.pdf [Accessed on 4.06.2009]

8. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Estimate 2009, Ministry of Health Care and Nutrition* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/nbdheadseven/111/Head_111E_2009.pdf [Accessed on 4.06.2009]

9. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Fiscal Management Report -2009* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka. Available at: http://www.treasury.gov.lk/docs/budget2009/FMRPEnglish.pdf [Accessed on 5.06.2009]

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11. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Public Investment 2008 – 2011* [PDF] Ministry of Finance and Planning, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/docs/budget2009/publicinvest-eng.pdf [Accessed on 5.06.2009]

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13. Ministry of Finance and Planning, Sri Lanka, Department of National Budget: *Vision,Mission and Functions of the Department of National Budget* [PDF] Ministry of Finance, Colombo, Sri Lanka, available at: http://www.treasury.gov.lk/BOM/nbd/ [Accessed on 04.06.2009]

14. Ministry of Healthcare and Nutrition, Sri Lanka n.d. *The National Mental Health Policy of Sri Lanka 2005 – 2015.* Mental Health Directorate, Ministry of Healthcare & Nutrition, Colombo, Sri Lanka

15. Ministry of Health Care and Nutrition, Sri Lanka: *Organizational Chart of Ministry of Health Care and Nutrition* [PDF] Ministry of Healthcare and Nutrition, Colombo, Sri Lanka, available at: http://www.health.gov.lk/OC-2008%201st.pdf [Accessed on 2.06.2009]

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