

Access to Primary Health Care within Sri Lanka's Universal Health Coverage Agenda: Current Reforms, Persistent Gaps and Priorities for Effective Coverage – A Narrative Review

Naveen D. Soysa¹

¹ Consultant Community Physician, Ministry of Health, Sri Lanka.

Article Info

Article History:

Published: 22 Sept 2026

Publication Issue:

Volume 3, Issue 9
September-2026

Page Number:

716-725

Corresponding Author:

Naveen D. Soysa

Abstract:

Sri Lanka's commitment to universal health coverage (UHC) rests on a long-standing tax-funded health system that provides public-sector services without user charges at the point of care. However, universal entitlement does not necessarily ensure effective access to timely, continuous and coordinated primary health care. This narrative review examines current developments in access to primary health care in Sri Lanka, with emphasis on reforms relevant to first-contact curative care, noncommunicable disease management, referral, continuity, and financial protection. A targeted literature search was undertaken in September 2026 using PubMed and publisher-indexed sources, supplemented by authoritative documents from the Ministry of Health, the World Health Organization and the World Bank. The evidence indicates a persistent mismatch between the formal availability of free public care and the organization of ambulatory care. Primary medical care institutions remain underused in some settings, while higher-level hospitals carry substantial outpatient demand and private providers remain important for ambulatory care. Weak referral and back-referral, incomplete longitudinal records, gaps in NCD follow-up and diagnostic access, and costs associated with private consultations, investigations, medicines and travel can reduce effective coverage. Recent reforms seek to address these constraints through shared-care clusters, population empanelment, personal health records, broader service packages, strengthened primary medical care institutions and renewed national policy attention to first-contact primary care. The central implementation challenge is to convert these reforms into trusted, accessible and continuous care at community level while preserving equity and financial protection.

Keywords: Access to health care, Health system reform, Noncommunicable diseases, Primary health care, Sri Lanka, Universal health coverage

1. Introduction

Sri Lanka has historically achieved comparatively favourable health outcomes through a predominantly tax-funded system in which public-sector preventive and curative services are provided without user charges at the point of delivery [1], [2]. This arrangement has supported broad population coverage and remains an important foundation for UHC. Yet the meaning of access has changed as the country has moved from a health profile dominated by maternal, child and communicable diseases towards one characterised increasingly by chronic disease, multimorbidity, population ageing and repeated contact with health services [1]–[3]. For these needs, access is not adequately described by the existence of a nearby facility or the absence of a consultation fee. It also depends on whether people can obtain timely first-contact care, receive appropriate investigations and medicines, maintain continuity over time, and move efficiently between primary and specialist services.

Primary curative care in Sri Lanka is delivered through Primary Medical Care Units (PMCUs), Divisional Hospitals and outpatient departments of higher-level hospitals, alongside a substantial private ambulatory sector. Patients are generally free to seek care at any public institution, and historically there has been no mandatory gatekeeping arrangement. This flexibility can be valued by patients, but it also contributes to bypassing of lower-level facilities, congestion at secondary and tertiary hospitals, fragmented clinical information and weak continuity [1], [4]. The distinction between nominal coverage and effective coverage is therefore increasingly important for Sri Lanka's UHC agenda.

The policy response has evolved substantially since the 2018 Policy on Healthcare Delivery for Universal Health Coverage. The shared-care cluster model, population empanelment, strengthened primary medical care institutions (PMCIIs), personal health records and structured referral pathways have been developed to shift the system from episodic, institution-centred care towards coordinated primary care [4], [5]. A first World Bank-supported Primary Healthcare System Strengthening Project upgraded 550 PMCIIs, and a subsequent US\$150 million Primary Healthcare System Enhancing Project approved in 2024 is intended to expand reforms to more than 1,000 PMCIIs across all districts [6]. The Ministry of Health's 2025 analysis of the UHC policy and the 2026–2035 National Policy on Health and Wellbeing document further reinforce the policy emphasis on primary care, continuity, NCD control and systematic referral [7], [8].

A recent Sri Lankan narrative review examined the sustainability of preventive-health achievements and broader challenges of governance, information systems and mixed public–private care [9]. The present review addresses a distinct question: how current UHC reforms relate specifically to access to first-contact curative primary care, continuity and effective coverage. It aims to synthesize the available evidence on current access patterns, identify persistent barriers, describe reforms now being implemented, and outline priorities for translating structural change into meaningful access for patients.

2. Method

A targeted narrative literature review was conducted in September 2026. PubMed and publisher-indexed web sources were searched using combinations of the terms “Sri Lanka”, “universal health coverage”, “primary health care”, “primary care”, “access”, “ambulatory care”, “outpatient”, “referral”, “noncommunicable disease”, “private sector”, “health-seeking”, “financial protection”, “out-of-pocket expenditure”, “economic crisis”, “shared care cluster”, and “primary medical care institution”. Peer-reviewed studies directly examining health-care utilization, primary care quality, NCD care, financial access and public–private care in Sri Lanka were prioritised. Authoritative policy and programme documents from the Ministry of Health of Sri Lanka, the World Health Organization (WHO) and the World Bank were used to describe current reforms, national policy directions and UHC indicators. Because the objective was interpretive and policy-oriented rather than to estimate a pooled effect, no meta-analysis or formal risk-of-bias synthesis was undertaken. No numerical search-flow counts are reported because the search was iterative and purposive rather than a systematic review conducted under PRISMA. Evidence was organised around five themes: the meaning of access within Sri Lanka's UHC model; patterns of first-contact care; continuity and NCD management; financial and geographic barriers; and the implementation of current PHC reforms.

3. Results and Discussion

3.1 From universal entitlement to effective primary-care access

Sri Lanka's public system offers a strong form of population entitlement: citizens can seek care in government facilities without paying consultation or inpatient fees at the point of service. This has contributed to financial protection and broad use of public hospitals. Nevertheless, UHC requires more than legal or financial entitlement.

Service coverage must be sufficiently comprehensive and of adequate quality, and needed care must be usable without unreasonable financial or practical barriers. WHO's 2021 UHC Service Coverage Index for Sri Lanka was 67; within its component scores, the NCD sub-index was lower than several other domains [10]. The Ministry of Health's 2025 UHC policy analysis identified hypertension treatment as a particularly weak tracer and prioritised several areas requiring accelerated policy action, including hypertension, diabetes-related care, tuberculosis, acute respiratory infection care-seeking and health workforce capacity [7].

This pattern is consistent with the changing nature of health need. Acute episodic access can be achieved by allowing patients to attend any outpatient department, whereas chronic disease requires repeated contact with a provider or team that knows the patient, monitors risk, adjusts treatment, arranges investigations and coordinates referral. The quality of access therefore becomes inseparable from continuity. For UHC in contemporary Sri Lanka, the relevant policy question is no longer simply whether care is available, but whether the system reliably connects each person to an appropriate first-contact service and maintains that connection over time.

3.2 First-contact care remains distributed across multiple levels and sectors

Sri Lanka's ambulatory-care pathway remains plural. Public primary-level facilities, outpatient departments of large hospitals and private practitioners can all function as first-contact providers. This offers choice but weakens the development of a clearly identifiable primary-care home. Evidence from a community-based study in Gampaha District illustrates the mixed pattern: among participants seeking allopathic care, private ambulatory visits were common, whereas hospital admissions occurred predominantly in public hospitals [11]. The study was conducted in 2018 and should not be interpreted as a national 2026 utilization estimate, but it provides recent empirical evidence of the continuing division between private outpatient care and public hospital care.

Earlier national and facility-level research also shows that patients' sector choices reflect income, convenience, waiting time, interpersonal experience and perceived quality. Household-level analysis found that higher-income groups were more likely to use private care despite the availability of free public services, and that access patterns differed geographically and among people with chronic disease [12]. Direct observation of outpatient encounters found that patient satisfaction and technical quality do not necessarily move together across public and private primary care; this cautions against assuming that patients' choice of provider is explained by a single measure of quality [13].

For the public system, the consequence is not merely competition with private providers. When patients move between providers without shared records or explicit care coordination, tests may be repeated, treatment plans may diverge and follow-up responsibility may be unclear. The 2025 UHC policy analysis and current PHC reform documents therefore place increasing emphasis on organised primary care rather than relying on unrestricted facility attendance alone [5], [7].

3.3 Underuse of PMCIs and bypassing of lower levels

A central rationale for primary-care reorganisation is the coexistence of underused lower-level facilities and high outpatient demand at larger hospitals. The World Bank's 2024 project documentation identifies capacity constraints and the absence of a formal referral mechanism as contributors to underutilization of primary facilities and crowding at tertiary institutions [6]. The reform response has therefore combined physical strengthening of PMCIs with changes in service organisation.

Investment in buildings or equipment alone, however, is unlikely to change care-seeking. Patients will continue to bypass a local facility if opening hours, medicines, diagnostics, staff availability, perceived competence or communication do not meet their expectations. Primary care must become a credible source of comprehensive care, not simply a location to which patients are administratively assigned. This distinction is especially important for chronic conditions, where confidence in the availability of medicines and investigations influences whether patients remain in primary care or seek services elsewhere.

The current reform model attempts to address both supply and relationships. Ministry guidance describes PMCIs as part of shared-care clusters linked to an apex secondary or tertiary hospital. A defined population is to be attached to primary-care providers, with a Personal Health Number and Personal Health Record supporting longitudinal care and referral [5]. In principle, this can make first-contact care more predictable and reduce unnecessary hospital-level attendance. Its effectiveness will depend on whether empanelment is operational rather than nominal, and whether patients experience tangible advantages from using their designated primary facility.

3.4 NCD care exposes the gap between contact and continuity

NCD management provides some of the clearest evidence of why access must be assessed beyond a single consultation. Healthy Lifestyle Centres created an important platform for risk-factor screening through primary-level institutions, but earlier evaluations identified underutilization, particularly among men, and challenges related to integration and human resources [14]. More recent evidence from PMCIs supported by the Primary Healthcare System Strengthening Project found gaps after screening: incomplete documentation, loss between screening and clinic registration, weak tracking and limited access to recommended biochemical investigations were among the reported problems [15]. Patients sometimes had to obtain investigations privately when they were unavailable at the PMCI, creating out-of-pocket costs [15].

These findings do not imply that the reform has failed; rather, they show that screening coverage is only one step in an effective-care pathway. For hypertension, diabetes and other long-term conditions, primary care must provide reliable medicines, periodic investigations, adherence support, complication surveillance, referral when required and feedback after specialist review. The Ministry's 2025 UHC policy analysis gives particular attention to hypertension treatment, reinforcing the need to move from detection towards sustained control [7].

The PHC reform agenda has begun to respond to this wider requirement. The 2024 reform framework and the subsequent PHSEP include more comprehensive service packages, strengthening of NCD care and referral pathways, and additional attention to geriatric and palliative services [6], [16]. World Bank implementation reporting from late 2025 noted progress in developing service packages and guidelines, alongside implementation delays in infrastructure and procurement [17]. Thus, by 2026 the direction of reform is clear, but many anticipated benefits should still be regarded as implementation goals rather than established population-level outcomes.

3.5 Referral and back-referral are essential access functions

A referral system is sometimes interpreted mainly as a mechanism for restricting entry to specialists. In Sri Lanka, its more important function may be coordination. A patient with a condition that exceeds the capacity of a PMCI should be able to reach the appropriate higher-level service without unnecessary delay, while a patient whose specialist assessment is complete should be able to return to primary care with a clear plan. Without back-referral, specialist hospitals accumulate routine follow-up work and primary care loses opportunities to build continuity.

The shared-care cluster is designed to create this clinical relationship between a group of primary institutions and an apex hospital [4], [5]. Its potential advantage is that referral becomes a managed pathway within a defined network rather than an isolated decision by a single provider. Yet the effectiveness of the model will depend on practical details: referral criteria, appointment mechanisms, transport and distance, communication between clinicians, access to investigation results, responsibility for medicine continuation and a workable back-referral process. These elements need to be measured as access indicators in their own right.

Importantly, introducing stronger referral should not create new barriers. Patients with emergencies or conditions that require specialist care must retain timely access. Reform therefore needs to distinguish rational care coordination from rigid gatekeeping. The aim should be to make primary care the preferred first contact because it is useful and trusted, not because patients are administratively prevented from seeking necessary higher-level care.

3.6 Financial protection is incomplete when ambulatory care is fragmented

The absence of user fees in government facilities is a major protective feature of Sri Lanka's health system, but households can still incur health expenditure through private consultations, diagnostics, medicines, transport and other associated costs. Historical analysis has shown growth in out-of-pocket spending alongside increased use of supplementary private services [18]. Research on private-sector demand similarly indicates that ability to pay shapes provider choice [12]. These patterns are relevant to PHC because outpatient care is recurrent and can generate cumulative expenditure even when catastrophic inpatient costs are avoided.

The mixed system also produces indirect financial pathways. A patient may obtain a free public consultation but pay privately for a laboratory test that is unavailable locally; alternatively, a patient may use a private doctor for faster access while relying on a public hospital for medicines, specialist review or admission. Qualitative research among women in Kandy described such hybrid public-private routes and highlighted their unequal implications for people with different resources [19].

Financial protection should therefore be evaluated across the whole care pathway. A strengthened PMCI that can provide a consultation, essential medicines and basic investigations close to home may reduce both direct and indirect costs. Conversely, empanelment that still requires repeated travel, private testing or frequent specialist attendance will have limited effect on effective UHC. Current PHC reforms have the potential to improve financial protection, but this benefit should be explicitly monitored rather than assumed.

3.7 Economic shocks have made resilient access a UHC priority

The 2022 economic crisis demonstrated how quickly nominally universal access can be weakened by shortages of medicines, consumables, fuel and household purchasing power. WHO reported critically low stocks of essential medicines and constraints on health-service continuity during the crisis [20]. More recent research comparing public perceptions in the Western and Uva Provinces found changes in care-seeking and chronic-disease management during the crisis, with greater reported difficulties in the less-resourced Uva setting, including medication omission and access problems related to medicines and travel costs [21].

These observations reinforce two lessons for PHC reform. First, geographic proximity is not sufficient if facilities cannot maintain core supplies and services. Second, primary care can contribute to resilience by decentralising essential chronic-care functions and reducing the need for repeated long-distance hospital visits. The 2026–2035 health and wellbeing policy document explicitly frames primary care as the first point of contact and links UHC with resilience, continuity and systematic referral [8]. Because the document was posted through the Ministry's policy-development process in 2026, its implementation and operational translation should be followed separately from its policy intent.

3.8 The present phase: moving from pilots and infrastructure to system-wide implementation

The current phase of reform is broader than the initial strengthening of selected PMCIs. The PHSEP approved in 2024 aims to extend comprehensive PHC services across all districts and to cover the full network of more than 1,000 PMCIs, while strengthening clinical quality, person-centred care, community engagement and monitoring [6], [22]. Ministry documents similarly describe integrated, innovative and quality primary health care as a core route to UHC [16].

However, recent implementation reporting indicates that the programme remains in a transition from design to full execution. A World Bank status report in November 2025 described delays related to project-management arrangements, civil works and procurement, while noting progress in protocols, NCD referral pathways, the essential medicines list and training [17]. The PHSEP website in 2026 reports active implementation activity but also indicates that some project components remain pending [22]. These sources support a cautious interpretation: Sri Lanka has established a coherent reform architecture, but national evidence of improved access, continuity or health outcomes from the new project is not yet mature.

This distinction is important for scientific reporting. Current reforms should be described as policy and programme developments, not as demonstrated outcomes. Future evaluation should measure whether strengthened PMCIs actually change where people seek first-contact care, reduce avoidable use of higher-level outpatient departments, improve NCD control and continuity, and reduce household spending and travel burden.

Table 1. Current developments relevant to primary-care access and UHC in Sri Lanka

Development	Access problem addressed	Expected contribution	Current caution
Shared-care clusters	Fragmented movement between primary and specialist care	Defined referral network, specialist support and back-referral	Effectiveness depends on operational referral and communication, not structure alone
Population empanelment and personal health records	Weak continuity and unclear provider responsibility	Longitudinal care for a defined population and portable clinical information	Requires data quality, interoperability, privacy safeguards and actual patient use
Expansion and strengthening of PMCIs	Bypassing of lower-level facilities and hospital OPD congestion	More comprehensive first-contact care closer to communities	Infrastructure without medicines, diagnostics and trusted staff may not change utilization
Expanded NCD, geriatric and palliative services	Health system designed around episodic and acute care	Broader PHC service package for ageing and chronic disease	National outcomes remain to be demonstrated
PHSEP 2024–2028	Uneven primary-care capacity and quality	System-wide scale-up, quality improvement and community engagement	Implementation reporting shows progress alongside delays; outcome evidence is still emerging
2025 UHC policy analysis and 2026 policy agenda	Need to align reform priorities with UHC gaps	Greater emphasis on hypertension, NCDs, first contact, referral and resilience	Policy intent requires operational indicators and sustained financing

4. Priorities for Achieving Effective UHC through Primary Care

4.1 Make comprehensive primary care reliably available

Access reform should begin with a service guarantee that is visible to patients. Each PMCI needs a clearly defined package of services supported by essential medicines, basic diagnostics, functioning equipment and appropriate staffing. Service availability should be monitored routinely, including opening times, stock continuity and whether common NCD investigations can be completed without forcing patients into private care. Variation between districts and facilities should be treated as an equity issue.

4.2 Build continuity around empanelment rather than attendance alone

Empanelment should create an accountable relationship between a population and a primary-care team. Its success should be assessed by continuity indicators: the proportion of patients with a usual source of care, follow-up after abnormal screening, treatment retention for hypertension and diabetes, medication continuity, and successful return after referral. A Personal Health Number or electronic record is useful only if it improves clinical continuity and can be accessed appropriately across relevant levels of care.

4.3 Strengthen referral and back-referral as a two-way clinical process

Referral standards should specify which conditions can be managed at primary level, when escalation is required and how feedback returns to the referring team. Digital referral tools may help, but basic processes, named receiving services, appointment mechanisms, clear documentation and clinical responsibility, remain essential. Indicators should include completed referrals, waiting time, back-referral and avoidable repeat attendance at apex hospitals.

4.4 Protect access from hidden out-of-pocket costs

UHC monitoring should capture costs incurred outside the consultation itself. Particular attention is needed to medicines, diagnostics and transport for chronic care. Where patients are routinely required to obtain tests privately because they are unavailable in PMCIs, the resulting expenditure represents a gap in effective public coverage. Strengthening primary diagnostics and medicine availability is therefore both a service-delivery and financial-protection intervention.

4.5 Use the private ambulatory sector as part of the access landscape without weakening public stewardship

Private providers will remain an important source of first-contact care for many Sri Lankans. Policy should therefore focus on interoperability, quality standards, rational referral and information exchange rather than assuming that all ambulatory care can be shifted into the public sector. At the same time, public financing should continue to protect equitable access, and private-sector engagement should not create a two-tier pathway in which timely coordinated care depends on ability to pay.

4.6 Measure effective access, not infrastructure completed

Evaluation of PHC reform should move beyond counts of renovated facilities, equipment supplied or staff trained. Core outcomes should include first-contact use, continuity, control of common NCDs, patient-reported experience, referral completion, medicine and diagnostic availability, waiting and travel burden, and household expenditure. Disaggregating these indicators by geography, income, sex, age and vulnerability will be important to determine whether reform is narrowing or reproducing inequities.

5. Limitations

This review is narrative and policy-oriented rather than systematic. The literature on Sri Lankan primary care is uneven, and several influential utilization studies pre-date the current reform programme. Some newer studies report data collected before or during the economic crisis and therefore should not be interpreted as direct measurements of service performance in 2026. Current policy and project documents describe intended structures and activities, but many reforms are still being implemented; consequently, evidence of population-level effects remains limited. The review has therefore separated documented problems and empirical findings from anticipated benefits of current reforms. No unpublished programme data were used, and no quantitative estimate was included unless it could be traced to a cited source.

6. Conclusion

Sri Lanka enters the final years before the 2030 UHC target with a substantial asset: universal public entitlement to care and a dense national health-service network. The principal access challenge is now to make primary care the dependable point at which people can enter, remain within and navigate the health system. Current reforms address important structural weaknesses through stronger PMCIs, shared-care clusters, empanelment, personal health records, expanded NCD services and renewed policy emphasis on referral and continuity. Yet these developments should not be equated with achieved effective coverage. Their value will depend on whether local facilities consistently provide medicines, diagnostics and trusted clinical care; whether referrals work in both directions; whether chronic patients remain connected to care; and whether households can obtain needed services without resorting to burdensome private spending or travel. For Sri Lanka, the next phase of UHC is therefore not simply expansion of coverage, but conversion of universal entitlement into effective, continuous and equitable primary health care.

Acknowledgments

None.

Author Contributions

Naveen D. Soysa conceived the review, conducted the literature search and narrative synthesis, drafted the manuscript, critically revised it and approved the final version.

Funding

No funding was received for this work.

Conflicts of Interest

The author declares no conflict of interest.

Ethics Statement

This article is a narrative review based exclusively on published literature and publicly available institutional documents. It did not involve recruitment of human participants, collection of identifiable personal data or animal research; therefore, ethics committee approval was not required.

Data Availability

No primary dataset was generated or analysed for this article.

References

- [1] L. Rajapaksa, P. De Silva, A. Abeykoon, L. Somatunga, S. Sathasivam, S. Perera, et al., Sri Lanka Health System Review. New Delhi, India: World Health Organization Regional Office for South-East Asia, 2021.
- [2] A. R. Chapman and S. D. Dharmaratne, "Sri Lanka and the possibilities of achieving universal health coverage in a poor country," *Global Public Health*, vol. 14, no. 2, pp. 271–283, 2019, doi: 10.1080/17441692.2018.1501080.
- [3] World Health Organization Regional Office for South-East Asia, Monitoring Progress on Universal Health Coverage and the Health-related Sustainable Development Goals in the WHO South-East Asia Region: 2023 Update. New Delhi, India: WHO SEARO, 2023.
- [4] S. Perera, S. Nieveras, P. de Silva, S. Wijesundara, and A. Pendse, "Accelerating reforms of primary health care towards universal health coverage in Sri Lanka," *WHO South-East Asia Journal of Public Health*, vol. 8, no. 1, pp. 21–25, 2019, PMID: 30950426.

- [5] Ministry of Health, Sri Lanka, Manual on Management of Divisional Hospitals, rev. ed. Colombo, Sri Lanka: Ministry of Health, 2025.
- [6] World Bank, “World Bank approves \$150 million to improve primary healthcare services in Sri Lanka,” Washington, DC, Jun. 24, 2024.
- [7] Ministry of Health, Sri Lanka, Analysis of Sri Lanka’s Policy on Healthcare Delivery for Universal Health Coverage. Colombo, Sri Lanka: Ministry of Health, 2025.
- [8] Ministry of Health, Sri Lanka, National Policy on Health and Wellbeing Sri Lanka 2026–2035. Colombo, Sri Lanka: Ministry of Health, 2026.
- [9] U. Gunawardana, “Sustaining Sri Lanka’s preventive health achievements: Emerging system challenges and policy directions – A narrative review,” *International Journal of Sciences and Innovation Engineering*, vol. 3, no. 9, pp. 155–163, 2026, doi: 10.70849/ijsci03092683730.
- [10] World Health Organization, “UHC Service Coverage Index (SDG 3.8.1): Sri Lanka, 2021,” Global Health Observatory, Geneva, Switzerland.
- [11] S. S. Withana, K. Mendis, U. P. Liyanage, S. Nandasena, and A. R. Wickremasinghe, “Ecology of healthcare in an urban and rural area of Gampaha district of Sri Lanka: a community-based prospective study on symptom prevalence and healthcare utilization,” *BMC Health Services Research*, vol. 25, art. 1123, 2025, doi: 10.1186/s12913-025-13337-w.
- [12] A. Pallegedara and M. Grimm, “Demand for private healthcare in a universal public healthcare system: empirical evidence from Sri Lanka,” *Health Policy and Planning*, vol. 32, no. 9, pp. 1267–1284, 2017, doi: 10.1093/heapol/czx085.
- [13] R. P. Rannan-Eliya, N. Wijemanne, I. K. Liyanage, J. Jayanthan, S. Dalpatadu, S. Amarasinghe, and C. Anuranga, “The quality of outpatient primary care in public and private sectors in Sri Lanka—how well do patient perceptions match reality and what are the implications?,” *Health Policy and Planning*, vol. 30, suppl. 1, pp. i59–i74, 2015, doi: 10.1093/heapol/czu115.
- [14] D. S. V. Mallawaarachchi, S. C. Wickremasinghe, L. C. Somatunga, V. T. S. K. Siriwardena, and N. S. Gunawardana, “Healthy Lifestyle Centres: a service for screening noncommunicable diseases through primary health-care institutions in Sri Lanka,” *WHO South-East Asia Journal of Public Health*, vol. 5, no. 2, pp. 89–95, 2016, doi: 10.4103/2224-3151.206258.
- [15] D. Nair, P. Thekkur, M. Fernando, et al., “Outcomes and challenges in noncommunicable disease care provision in health facilities supported by Primary Health Care System Strengthening Project in Sri Lanka: A mixed-methods study,” *Healthcare*, vol. 11, no. 2, art. 202, 2023, doi: 10.3390/healthcare11020202.
- [16] Ministry of Health, Sri Lanka, Integrated, Innovative & Quality Primary Healthcare Reforms 2024. Colombo, Sri Lanka: Ministry of Health, 2024.
- [17] World Bank, Sri Lanka: Primary Healthcare System Enhancing Project (P181564), Implementation Status & Results Report. Washington, DC: World Bank, Nov. 14, 2025.
- [18] A. Pallegedara and M. Grimm, “Have out-of-pocket health care payments risen under free health care policy? The case of Sri Lanka,” *International Journal of Health Planning and Management*, vol. 33, no. 3, pp. e781–e797, 2018, doi: 10.1002/hpm.2535.
- [19] R. Kumar, A.-E. Birn, R. Bhuyan, and J. P.-H. Wong, “Universal health coverage and public-private arrangements within Sri Lanka’s mixed health system: Perspectives from women seeking healthcare,” *Social Science & Medicine*, vol. 296, art. 114777, 2022, doi: 10.1016/j.socscimed.2022.114777.

- [20] World Health Organization Sri Lanka, “WHO delivers essential medicines and supplies to help sustain vital health services for crisis response and beyond,” Jan. 24, 2023.
- [21] A. I. Nilaweera, D. R. Fernando, P. R. Adikaranayake, et al., “Impact of the economic crisis on general health-seeking behavior and chronic disease management: a comparative study of public perceptions in the Western and Uva Provinces of Sri Lanka,” *BMC Health Services Research*, vol. 26, art. 830, 2026, doi: 10.1186/s12913-026-14599-8.
- [22] Primary Healthcare System Enhancing Project, Ministry of Health, Sri Lanka, “Primary Healthcare System Enhancing Project: objectives, components and implementation updates,” 2026. [Online]. Available: <https://phsep.lk/>. Accessed: Sep. 20, 2026.