A Critical look at Our Health Services

Professor Colvin Goonaratna

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Economic Review: How would you describe the state of the health services provided by the Ministry of Health in Sri Lanka?

Colvin Goonaratna: I would describe them as quite unsatisfactory. Mind you, in saying so, I am not necessarily casting aspersions on those administrators who are doing their best under extremely trying circumstances in which most of us would have simply thrown in the towel. Nor am I unaware that the continuing war in the north and the east is sapping the nation's lifeblood, and that the JVP inspired violence in 1988 and 1989 was a serious setback. I must also emphasize that when I describe the health service offerred by the Ministry of Health as "quite unsatisfactory" I am not making an unrealistic comparison of it with the health services of developed industrialized countries such as Britain.

E.R: Are you absolving the administrators of the Ministry from all blame?

C.G: I am not trying to absolve them of ALL blame. But senior administrators should be given sufficient time and freedom to think, and plan, and manage. I do not believe they have that kind of freedom. Most of their time seems to be spent on attending to day-to-day trivia of administration which should never reach them, following politicians all over the country, or listening to lengthy speeches made by them with great ostentation and TV coverage. There seems to be too much political meddling. Political direction regarding policy making is permissible. But what is happening seems to be quite different.

E.R: What evidence have you to say that the services provided by the Ministry of Health are "quite unsatisfactory"?

C.G: What would be immediately obvious to even a casual observer are the dearth of equipment, facilities and staff, the unconscionable overcrowding and the squalor of most major hospitals in the country. That is only the easily visible part. Perhaps the visibility is deliberate – to compel people to seek the services of a thriving and very expensive private hospitals industry.

E.R: Is there any other evidence for your assertion?

C.G: Yes, the statistics. Malnutrition is on the increase, particularly among under-fives and pregnant mothers. Malaria is on rampage, and the rates for tuberculosis, leprosy and filariasis do not show a decreasing trend. The rates for suicide and poisoning appear to be increasing. The rates for the top five causes of hospital admissions are increasing or not significantly decreasing.

E.R: But what about the reported decrease in infant mortality, maternal mortality and crude death rates?

C.G: With so much malnutrition and malaria, and so many refugees huddled in miserable camps, for at least the last five years, I find the statistics you refer to very hard to believe. I do not say that anybody has deliberately set out to deceive. The data reporting and collection processes are likely to be unreliable in the present circumstances. For instance, how much credence can be placed on data reporting and analysis when 5 to 12 per cent of the entire population are in refugee camps? For the Northern and Eastern Provinces we have practically no statistics available for so many years.

The Health Ministry is of course not directly responsible for the civil wars, refugees and malnutrition. But whatever their causes might be, I want to point out that the health of the nation is very much worse than what any profferred statistics might suggest, and that it is likely to steadily decline if present circumstances prevail.

E.R: What are your views on the quality of the state health care services?

C.G: The quality (ie. effectiveness), the efficiency (ie. cost–benefit), and 'client satisfaction' of our health care services have not been reliably estimated. It is unlikely that they are at a level which could be described as even barely adequate – particularly the first and the last of these.

E.R: What do you see as the principal shortcoming in the Ministry?

C.G: The first is allocation of financial resources. Over the last two decades the Ministries of Health and Indigenous Medicine together have

only received between 3% and 4.5% of actual total government expenditure. This is nowhere near adequate. I believe that over the next five years this should be increased from 6% to 9%, with an increase upto 10% or 12% in the following five. Good health care cannot be provided at low cost, relative to the total economy.

E.R: Is there any discrepancy in distribution of resources?

C.G: Yes, of course there are discrepancies. The most glaring ones are a disproportionate concentration of services, resources and persónnel in Colombo and other major towns like Kandy, at the expense of semi-urban and rural areas; and an over-emphasis on hospital based services at the expense of preventive, promotive and rehabilitative services.

E.R: What specifically do you mean when you say preventive, promotive and rehabilitative services?

C.G: The most important factors which influence the nation's health are food, safe dinking water, and housing (with sanitation) – and not the number of heart specialists or neurosurgeons or sophisticated units. I admit that if I get a heart attack or a brain tumour, I would be grateful for their help. But if we had none of them available in Sri Lanka. I would be quite happy to have whatever treatment is available, and live and die within my means. Be that as it may, it is absolutely certain that in our stage of development, a massive investment in sophisticated units is unlikely to be rewarded by a commensurate improvement in the nation's health as judged by infant mortality, neonatal mortality, preschool mortality, maternal mortality, the death rate, nutritional and educational status and the incidence of common diseases and conditions such as malaria, respiratory and intestinal infections, tuberculosis, anaemia, abortions and high blood pressure. Indeed even in the case of high blood pressure and coronary heart disease, the national incidence and mortality can be significantly reduced only by prevention, and not by sophisticated units, as many people seem to suppose.

Anyway, to get back to your question, what I mean by preventive, promotive and rehabilitative interventions include, for example, eradication of malaria, childhood and maternal immunizations, antenatal and child-care, health education, counselling, rehabilitation for the mentally and physically disabled and the old, clean drinking water and food.

E.R: What are the other major shortcomings of the state health service?

C.G: Equity in health is the most crucial issue of all in the strategies related to health. We need to examine dispassionately and carefully whether the present system of health care in Sri Lanka is equitable. A strong case can be made that it is quite inequitous.

The provision of health services at zero price (not "free" – as I explain below) to all users is not equitable, although it may seem so at first. The description "free health service" is inaccurate and misleading for the simple reason that everyone, including the poor, have indirectly paid for the health services they receive through taxes on sales, and consumption of goods and services. Therefore the present system compels the poor to pay a large proportion, relative to their incomes, of the cost of the so-called "free" health service, whereas middle-income groups and the rich derive most of the benefits from it. In other words, a health service which uses very scarce resources to provide services, including the most expensive ones, to the non-poor at zero price cannot be described as equitable. To the more affluent these services are not only zero priced but also have cost them (ie. have value) only slightly greater than zero. That such an inequitous system also provides services at zero price (but not zero tax-cost) to the poor is a rather weak reason for continuing to subsidize these services for the non-poor. The results of such a system are evident in Sri Lanka as a serious decline in efficiency.

The time has come to review the issue of equity in relation to the so-called "free" health service we have. A system which would provide zero priced or nearly zero priced services for the indigent, while collecting revenue from the middle-income groups and the rich, each according to their ability to pay, would vastly improve both efficiency and fairness of the system, while relieving a considerable burden from the national budget.

E.R: How can this be done?

C.G: Numerous systems of cost-sharing, community-financing and medical-savings schemes, which generate vitally needed funds for health care, and make the system fairer at the same time, are already functioning very satisfactorily in rich countries as well as in the poorer ones. The emphasis in such systems should be on two aspects; levying a fee for curative services rather than those which benefit many people in the community (eg. immunization against poliomyelitis) or where the beneficiary cannot even be identified (eg. spraying against malaria), and secondly on providing adequate protection for the poor, the aged, and the disabled from the need to pay for health services. The advantages and disadvantages of such systems are now well known and it ought to be a simple matter to formulate a fair system appropriate to our economic, social and cultural background.

Of two things we may be sure. The first is that our genuflectory and servile dependence on the largesse of foreign donors may not be rewarded as well in the future as it

has been in the past, and that we have to generate funds nationally to sustain the health services. The second is no money, no Health for All or even 50% of All.

I have pressed the issue of costs only from two perspectives: they are, a more egalitarian and efficient state health service.

E.R: What about management in the state health sector?

C.G: There is no doubt that serious deficiencies exist in management processes, although several initial steps have been taken. I would list the priorities as follows: a single comprehensive document detailing national health policy and a prospective plan for total health development, improvements to the national health information and monitoring systems, clear operational guidelines for converting policy into action, and reliable, objective and valid evaluation philosophy and procedures.

E.R: What are your views on high technology in health care?

C.G: One of most formidable dilemmas faced by poor countries concerns the technological "advances" mushrooming in the affluent countries, which are aggressively promoted in all countries rich, middling and poor. The dilemma is unlikely to be solved by voluntary action on the part of specialists and hospital doctors because it is simply not in their interest to do so, particularly when fee-for-service is the dominating influence in clinical practice. Indeed the experience in most affluent countries is that the expenditure on increasingly sophisticated technology has risen, and will continue to rise as the number of specialists increases. They are not noted for their interest in the allocation of resources for health care except of course, for their own unit, speciality or hospital in that order; and it has been claimed that they rarely have the time to reflect on such matters.

The public are almost entirely guided by the attitudes and views of those who treat them when they are ill and the media when making up their minds about priorities in the allocation of resources. One heart transplant performed on an old man captured the imagination of many millions of people all over the world thanks to the media, and enabled the surgeon, incidentally, to love practically any woman be wished, if we are to believe newspaper accounts of interviews with him. Oral rehydration therapy, in contrast, has already saved millions of lives without being glamourized at all by the media, and I doubt whether any of us even know the names of the people who pioneered it, or whether these scientists have had any added luck with the ladies which they did not enjoy before their monumental discovery. A heart transplant costing about a million rupees will, if it is successful, save one life, which is unlikely to be of much use to the patient or the community for any length of time. Oral rehydration therapy worth a million rupees will, at a guesstimate, save at least 25,000 children from death. Such are the harsh realities of allocating resources, and the fickle affections of the public and media.

E.R: Are all modern technologies expensive and useless?

C.G: There are some instruments and technological advances which have unquestionably left their imprint upon health care delivery in poor countries at affordable prices: eg. oral rehydration therapy, cold-chain technology for vaccines, dip-stick and blotting-paper tests, battery-powered Xray machines, micro-computers etc. Others probably occupy the "grey area" in which decision-making is so difficult: eg. the extent to which dialysis, critical care units (coronary, medical, accident and emergency or neurological) should be available, autoanalyzer technology etc.

The problems of health care in poor countries like ours are not caused by the lack of technology; they are problems principally of maldistribution, lop-sided priorities and lack of equity and access.

E.R: How should decisions be made regarding these matters?

C.G: Decisions regarding which aspects of technology to accept, and when, are always hard to take. They are too important to be left entirely to clinicians, the media, the public and politicians who have no interest and even less insight about such matters. One must listen to everybody carefully of course, but decision-making should come from a small panel comprising the Minister for Health, a team of expert health economists and planners, and an evenly-balanced quartet of "curative", "preventive" medicine specialists, who have no financial interests in promoting particular instruments. Any other course of action is likely to lead us to disaster, and limiting the importation of technology to what is essential today, balanced against what may be necessary as a base for tomorrow, will be a key determinant of containing health care costs in the next 15 to 20 years.

E.R: What are the major areas to which you would like to divert more resources?

C.G: Now that is a difficult question to answer. Diverting funds should be done within the context of an overall health plan and strategies. However, I would like to see increased resources directed within the next year or two to psychiatric and adolescent health problems and the problems of substance abuse, poisoning, and old age. In the area of planning and management, I would channel more resources to medical audit (of medicines, and laboratory and imaging services), maintenance of equipment and buildings and developing an effective referral system. Overall, community health and preventive and promotive services deserve more funds than they receive now■