THE SRI LANKAN HEALTH SECTOR:

Policy Perspectives and Reforms

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This is a summary of a paper which will be published elsewhere. This summary was prepared by Mr T.K.Thilakeratne, Department of Economics, University of Colombo.

In many developed and developing countries health sector reform (HSR) has been on the policy agenda for some time, and in many of these countries, especially in sub-Saharan Africa, reforms are now being implemented (Cassels 1995). In contrast in Sri Lanka pressure for HSR has been less intense, from both donors and internal sources. However, the appointment of a Presidential Task Force on the Implementation of National Health Policy recently is a first sign that Sri Lankan policy-makers are seriously addressing HSR. The main purpose of this article is to explore current trends in the provision and financing of health care services in Sri Lanka with a view to assessing whether the health sector is really moving along the path of reforms and if so its progress. This would lead to the identification of issues which policy forums should address in reforming the health sector.

Forms of Health

Inefficient use of scarce resources, lack of access to health care, and services which are unresponsive to the needs of the people are problems encountered by the health sector in many developing countries. The need to achieve an equitable distribution of health care service benefits has further accentuated the challenges faced by governments in developing countries. In attempting to address these problems, largely with the assistance of donor agencies, governments have started to reform mechanisms for the provision and financing of health care services. This process has gone beyond redefinition of policy objectives and focused much on drastic changes in organisational structures and management systems to meet the challenges of the sector. These fundamental and purposive changes to promote the achievement of broad health policy objectives have formed the general framework of HSR; health sector reforms are concerned with defining priorities, refining policies and reforming the institutions through which those polices are implemented (Cassels, 1995).

HSRs could be considered an integral component of IMF-World Bank structural adjustment policies introduced in Sri Lanka in the late 1970s: in general, their purpose is to reduce the direct role of government in the provision of health service and stimulate a range of other private and NGO providers to increase competition and efficiency . Donor agencies are indeed playing a decisive role in the reform process. The World Development Report, Investing in Health, of 1993 has prescribed a series of health service financing and provision reforms (World Bank, 1993).

Zwi and Mills (1995) have categorised HSR packages into four elements (Figure 1). The first, identifying and responding to major health problems, refers to the World Bank s view for setting priorities through the application of cost-effectiveness analysis on the basis of disease burden: the newly developed cost-effectiveness indicator called disability adjusted life years (DALYs) (World Bank, 1993). The second set of reforms consists of organisational and management changes which assume that greater competition and decentralised management authority will improve incentives, efficiency and responsiveness. The third set, health financing strategies, aims to increase the financial contributions of those who are willing and able to pay more for government health services, which would also allow resources to be targeted at those who cannot afford to pay. Improvement of quality is care is categorised as the final element, and this again includes measures to reduce the role of government and promote private sector provision.

It is clear that a variety of HSRs exist and that countries have the option of choosing the most appropriate policy measures, giving due consideration to local epidemiological conditions, public and private preferences and resources (World Bank, 1993). Nevertheless these new measures pose formidable challenges to national governments. They require governments to play new but vital roles in the health sector. They envisage moving away from traditional service provision and administrative roles, and creation of new organisational and management systems which are essential for the implementation of reforms. This raises the critical question of governments' capacity to perform new roles (Russell and Attanayake 1997). For example, for the proper implementation of devolved functions under decentralisation, managerial, organisational and planning skills at provincial and divisional levels would have to be improved substantially. Or new skills would be required for administrators

Figure 1: Elements of health sector reform packages

Identifying and responding to major health problems
Changing systems of priority setting : global and national burden of disease estimation, cost effectiveness analysis
Increasing awareness of consumer preferences

Organisational and management changes
Increased privatisation of provision; broadening the mix of providers
Stimulating competition between providers
Contracting out of services
Improved planning systems throught use of burden of disease and costeffeciiveness analysis
Improving geographical coverage
Decentralisation with increased local accountability
Building capacity in the institutions through which policy is made and implemented
Increasing responsiveness to local concerns e.g. hospital boards and local government

Health financing strategies
Community financing schemes
Risk-sharing strategies including compulsory insurance
User fee
Tax finance concentrated on the poorest
Increased public sector income
Increased aid to the health sectoro

Improving quality of care
Publicly-funded care restricted to cost-effective treatments
Packages of essential health services
Accreditation and quality assurance measures
Incentives for private sector involvement in promotive and preventive care
making services providers more accountable to purchasers and consumers
Source: Zwi and Mills (1995)

Source: Zwi and Mills (1995)

both at national and regional levels for designing and managing contracts. Thus a central issue for HSR is the capacity or the ability of governments in the developing world to assume these new roles.

Sri Lankan experience

The objective of government s National Health Policy is to promote the harmonious coexistence and growth of both the public and private sectors and to reduce the government s burden in the provision of free health services (Dalpatadu and Perera, 1997). However, the prospects look bleak. Few attempts have been made in Sri Lanka at the policy making level to learn from HSR experience in other developing countries. Further none of the proposals of the Task Force appointed by President Premadasa were fully implemented. In general, no HSR strategies or initiatives have been designed or implemented in Sri Lanka. However, in the past two decades, several changes similar to those highlighted in the above section are taking place in Sri Lanka. Two of the most noteworthy developments are the rapid expansion of the private sector and decentralisation. But neither can be considered as pre-designed policy strategies of the Ministry of Health (MoH). Rather they represent non-purposive directions of change in the provision and financing of health service which are the result of broader economic and political procesess.

Only very recently has the MoH shown inclination towards monitoring which would lead to encouragement and regulation of the private sector. Similarly, some discussion now seems to be taking place in health policy forums on greater decentralisation and management autonomy. In the following two sections these two issues will be examined.

Private sector involvement

A substantial increase in the involvement of the private sector in the provision of health care services is clearly evident. At present 85 private hospitals with a bed capacity of 2300 are functioning in different parts of the island (Dalpatadu and Perera, 1997): 662 retail pharmacies and a few diagnostic laboratories are additional facilities in the private health service network in which about 1000 general private practitioners along with a large number of government doctors, including specialists provide service.

Attendance figures of patients in the public health sector institutions can be considered as a basis to indicate the trends and estimate the size and growth of the private sector. During the period 1982-95, outpatient visits to the public sector recorded an annual growth rate of only 1%, while inpatient attendance grew at a rate of 1.95%. It is a common belief among policy makers that at present about half of all outpatient visits are made to the private sector. This estimate is based on the findings of few studies. For instance, in 1990, almost 40% of all types of patient visits in the Gampaha district were made to the private sector (de Silva and Attanayake, 1992). In 1993, 35% of suspected malaria patient visits in the Matale district were made to private sector facilities (Attanayake, 1994). This percentage was about 30% for the Anuradhapura district in 1996 (Attanayake forthcoming). The above figures suggest that rapid private sector expansion has absorbed a large proportion of outpatient visits (due to several reasons, which will be referred to later), while inpatient care at public hospitals still seems to remain the first choice except for those with very high income and/or those who can get reimbursed for the cost of private care through health insurance.

Many factors explain private sector expansion. A turning point was in 1977, when government doctors were allowed to engage in private practice to discourage brain drain abroad. !Channelling Centres as well as private clinics of government doctors soon became the level of first entry point in the health sector, especially, for inpatient care at public hospitals. In this con-

text, private sector has also been publicly sponsored: firstly, channelling centres and private clinics are an entry point for patients to receive better care at public hospitals. This indicates a complementarity between private practice and publicly provided services. Secondly, the cost of training of almost all doctors engaged in private practice is borne by the government.

A large number of supply side factors appear to have induced patients movement towards the private sector. In public facilities weaknesses such as overcrowding, drug shortages, lack of some essential equipment and limited service hours are clearly inducement factors of this movement. With respect to demand factors, a specific characteristic of the Sri Lankan community is a high sensitivity towards illness, and hence perceived quality of private sector care appears to be a prime reason for theprime reason for it being preferred (Caldwell et al, 1989 and Attanayake 1994): a more cordial relationship with and more attention given by the private doctor seem to be reasons for the continuous expansion of the private sector, especially for primary level care.

Advocates of the growth of the private sector argue that it enables the financial burden of health care provision to be shifted from the government to those who are willing and able to pay for the care. In this context the question whether the rapid expansion of the private sector has indeed reduced the financial burden on the government merits consideration. Firstly, government expenditure on health has increased at a rate of 4% during the period from 1987 to 1996 in real terms whilst this rate was 15.5% in monetary terms. On the other hand, during the past decade, the share of government expenditure on health as a percentage of GDP and total government expenditure remained at around 5% and 1.5%, respectively. Whilst 55 new hospitals and 50 central dispensaries and maternity homes (CD&MHs) were added to the health service network (except Northeast Province), the health workforce expanded substantially during the period from 1988 to 1995 the number of doctors (2,316 to 4,627), nurses (8,317 to 13,403) and public health midwives (3,209 to 4,383) increased at annual average rates of 12.2%, 8.3% and 5.3%, respectively. Nothwithstanding such an expansion of the public sector, absorption of about half of patient load by the private sector, especially in primary care, could be considered as positive evidence that the financial burden on the government has been reduced. Nevertheless, in any judgement from a societal point of view, the complementarity between private and private care and hence the cost borne by patients for private care in conjunction with the utilisation of public health services should also be taken into account.

It is worth mentioning that the growth of the private sector has not been confined to clinical services. Contractual arrangements with the private sector, particularly for non-clinical services such as provision of raw or cooked food for hospitals, laundry services, cleaning and security services appear to have expanded substantially during the past decade. But these developments too have been non-purposive. For instance, closure of the Marketing Department led to more involvement of the private sector in the provision of food to hospitals on a contractual basis. And following the general trends in the country, security services in large medical institutions and administrative offices have been given to the private sector. At present, involvement of the private sector is being sought on a contractual basis for sophisticated surgery, but only in a few cases.

The MoH seems to have deliberately played a very limited role in both regulating and encouraging the private sector (Russell and Attanayake 1997).

The rapid growth of the private sector in the 1980s was not monitored, co-ordinated or regulated. The slow response of the MoH in the past has made it more difficult now to regulate or promote the private sector. It has grown large and complex, and provider and user interests have become more established and diverse. Only now is the MoH formulating new legislation to regulate private medical institutions. However, the capacity of the MoH to implement the new law in an effective manner still remains unproven, and what it can do may be too little, too late (Russell and Attanayake 1997).

Decentralisation

Decentralisation can be defined as the transfer of responsibility for planning, management and resource mobilisation and allocation from the central government and its agencies to sub- national agencies including non-governmental, private or voluntary organisations (Rondinelli 1981). Thus, a common aim of decentralisation is to bring government nearer the people and to encourage community involvement (Mills 1994). It could take several forms such as deconcentration, delegation, devolution and privatisation. In principle, the potential benefits of decentralisation include greater management authority and flexibility to respond to local needs and weaknesses, greater responsiveness to service users, and therefore more efficient and accountable use of resources (Mills et al 1990). However, the requirement of management skills in a large number of small units, difficulties for the higher levels to interact with a large number of local units and difficulties in organising services that can be provided efficiently only for a reasonably large population could be considered as some drawbacks of decentralisation (Mills 1994).

Therefore before implementation, the levels to which authority is decentralised have to be determined very carefully.

In Sri Lanka, decentralisation of management and administration of public health services was initiated in 1987 following the 13th amendment to the constitution. Responsibility for a set of functions including health was granted to the Provincial Councils which were set up in 1987. Subsequently, in 1992, all the administrative bodies in each province were brought under a formal organisational framework with the setting up of Divisional Secretariats: administration and management of health services were assigned to Divisional Directors of Health Services (DDHS). Vertical programmes such as the Anti-Malaria Campaign were abolished in the late 80s and both curative and preventive services were brought under the direct control of DDHSs.

Critically, in Sri Lanka, decentralisation can be largely considered a political manoeuvre under external

pressure, to devolve power to the provinces as a remedial measure to the ethnic conflict, rather than a deliberate attempt to reform the organisational structure of public services (Russell et al 1996). In the health sector, as in any other public service, changes in the organisational structure of the MoH were imposed from elsewhere. Before implementation, the technical, management and organisational feasibility of decentralisation was not properly examined. In fact the MoH appeared to be quite resistant to such changes (Russell et al 1996). For example, allocation as well as administration of some vital resources such as manpower is still in the hands of central agencies. In other words, decentralisation was not a purposive attempt to reform the health sector and delegation and devolution have not been operationalised to an adequate extent for the sub-national agencies to carry out their functions smoothly.

Although the decentralisation process has been ongoing for a decade, it still seems to be in its infancy: apart from formal deconcentration (e.g., DDHSs) and devolution (e.g., Provincial Councils), no concrete measures have so far been adequately taken to delegate responsibility for defined functions to relatively autonomous entities. At the divisional level, political and administrative bodies are still apart. Even though the provinces have shown some improvements in upgrading their capacities, with the assistance from the centre, particularly in planning and management, they still have a long way to go in successfully carrying out their devolved functions. This is largely explained by central level administrators as well as politicians lack of motivation to accelerate the decentralisation process. Moreover, there seems to be a centralisation tendency at the provincial level as well, due to lack of capacity at divisional and secondary hospital levels. With all these weaknesses, in general, health sector decentralisation in Sri Lanka has taken a form which looks more like a deconcentrated structure than a devolved one (Russell et al 1996). An assessment whether decentralisation has achieved its objectives is therefore rendered difficult. Therefore the following section, brings out the trends of some indicators related to the provision of services across provinces, for the purpose of illustration.

Table 1
Share of public health expenditure in GDP and government expenditure, 1978-95

Year	Public health expenditure as a % of total government expenditure	Public health expenditure as a % of GDP
1978	3.2	1.5
1979	3.5	1.5
1980	2.9	1.4
1981	3.1	1.2
1982	3.4	1.4
1983	4.3	1.8
1984	3.4	1.3
1985	3.1	1.4
1986	3.2	1.4
1987	5.1	1.7
1988	5.3	1.8
1989	5.6	1.8
1990	5.1	1.5
1991	4.5	1.4
1992	5.5	1.5
1993	4.9	1.4
1994	5.5	1.6
1995	5.3	1.6

Source: Annual Reports, Central Bank of Sri Lanka

With respect to resource allocations, in 1995 the North Central Province received the highest per capita allocation (Rs.439). When recurrent expenditure of hospitals managed by the MoH is added to provincial totals, except Central and North Central Provinces, others appear to have received substantially low per capita allocations compared to the Western Province. The high allocation to the North Central province is primarily due to the large amounts of additional inputs to its provincial hospital (Anuradhapura), which serves injured armed services personnel as it is the tertiary level public hospital closest to the war zone. In 1995, total recurrent expenditure of this hospital stood at about Rs 135 million, which was indeed the highest total for any hospital outside the Western Province (Uni Quest, 1996). Trends in provincial disparities were further examined with respect to the availability of and hence access to services (Table 3). During the period concerned, whilst the number of beds per 1,000 population (BPOP) increased slightly from 2.81 to 2.84, the number of beds per 1,000 inpatients (BINP) decreased from 16.58 in 1987 to 16.42 in 1995. The low annual growth rate of estimated population (1.3%) compared to inpatient load (1.6%) is one important reason for the different changing patterns of these two indicators. Even though BINP at national level has recorded a decline, a highly irregular pattern can be observed in the changes of its annual average growth rates across provinces. An increase in BINP associated with an increase inpatient load was recorded only in three provinces and the combination of Matale and Polonnaruwa districts.

The national level averages of both the number of doctors per 10,000 outpatients (DOP) and the number of doctors per 1,000 inpatients (DINP) have increased from 0.62 and 0.07 to 1.12 and 0.13, respectively. However, both of them have changed in a highly irregular pattern across provinces. For

Table 2
Resource allocation patterns on health across provinces in 1995(Rs.)

Province	Provincial health expenditure		Provincial health expenditure and recurrent expenditure of the hospitals handled by the line ministry	
	Total (millions)	Per capita	Total (millions)	Per capita
North Central	467	439	467	439
Uva	336	298	336	298
North Western	554	263	554	263
Central	513	217	890	377
South	461	199	690	299
North Eastern	466	177	645	245
Western	687	148	2695	579
Total	3483	214	6277	386

Source: Finance Commission, Offices of the Provincial Directors of Health Services, Ministry of Health and Uni Quest (1996)

Table 3
Some indicators of variations in the distribution of doctors and hospital beds with respect to population and patients' attendance at public hospitals across provinces from 1987 to 1995

Province/District	BPOP			BINP			DPOP			DINP			DOP		
	1987	1995	GR* 87-95	1987	1995	GR 87-95	1987	1995	GR 87-95	1987	1995	GR 87-95	1987	1995	GR 87-95
Western	3.69	3.75	0.2	21.24	18.73	-1.5	2.27	4.25	10.9	1.30	2.12	7.8	1.87	2.45	3.9
Central	3.16	3.38	0.8	17.67	19.11	1.0	1.27	2.47	11.8	0.07	0.14	12.1	0.68	1.25	10 5
South	2.17	2.35	1.0	14.79	14.48	-0.3	0.84	1.91	16.0	0.06	0.12	13.3	0.57	1.12	12.2
Northeast	2.39	2.04	-1.8	20.72	16.95	-2.3	0.80	0.86	0.8	0.07	0.07	0 3	0.31	0 38	2 6
Northwest	2.29	2.37	0.4	12.46	14.66	2.2	0.64	1.15	9.8	0.03	0.07	12.9	0.27	0 61	16 3
Northcentral	2.97	3.11	0.6	11.93	13.73	1.9	0.69	1.44	13.7	0.03	0.06	16.4	0.27	0.46	8.7
Uva	2.52	2.65	0.6	12.83	15.26	2.4	0.60	1.18	12.2	0.03	0.07	15.4	0.29	0 48	8 5
Sabaragamuwa	2.42	2.38	-0.2	13.70	13.88	0.2	0.70	1.41	12.9	0.04	0.08	13.6	0.39	0.86	14.9
Matale & Polonnaruwa	2.47	2.76	1.4	12.35	13.82	1.5	0.73	1.72	16.8	0.04	0.09	16.9	0.22	0.74	29 1
Average	2.81	2.84	0.2	16.58	16.42	-0.1	1.19	2.20	10.7	0.07	0.13	10.2	0.62	1.12	9.9

BPOP = number of beds per 1,000 population
BINP = number of beds per 1,000 inpatients
DPOP = number of doctors per 10,000 population
DINP = number of doctors per 1,000 inpatients
DOP = number of doctors per 10,000 outpatients
* Growth rate
Source: Medical Statistics Unit, Ministry of Health

outpatient attendance, whilst a positive annual average growth rate of 7.1% was reported for the Western Province, the Northeast and the Northwest Provinces, and the combination of Matale and Polonnaruwa districts had negative rates of 0.01%, 1.7% and 2.6%, respectively. Similarly, whilst the very high growth rate of inpatient attendance in the Western Province (3.3%) has brought down the annual average growth rate of its DINP, low or negative growth rates of inpatient attendance in most of the other provinces have moved up the growth rates of their DINPs.

The disparities demonstrated by the indicators related to population are, however, somewhat different. For instance, although the national average of the number of doctors per 10,000 population (DPOP) has almost doubled from 1.19 in 1987 to 2.20 in 1995 with an annual average growth rate of 10.7, an irregular pattern can be observed across provinces. Except the lowest value of 0.8% in Northeast Province, it varies from 9.8% (Northwest) to 16.8% (Polonnaruwa).

Concluding Remarks

The Sri Lankan health sector has not undergone any significant or purposive changes to overcome inefficiency, low quality and inequity in the delivery of its services. Whilst the expansion of the private sector can be largely attributed to private practice by public service doctors, the roots of decentralisation were political. The expansion of some forms of public-private mix such as contracting out non-clinical services to the private sector, is also due to a more general shrinking of the size of public sector as part of the liberalisation process. However, none of these changes was well designed or even piloted before implementation. Thus, in general, most changes in health service provision and financing have occurred in a haphazard manner. Even though provincial disparities in resource allocation, access to health care, quality of care etc., appear to have eased out to some extent during the decentralisation period, there is still a continuation of trends which had prevailed before decentralisation (Attanayake and de Silva 1989).

Lack of purposive reform in the past has given rise to many obstacles in their tasks to policy makers as well as health managers. Moreover, expansion of private practice and lack of sufficient legislative power to regulate the private health sector has led to the formation of a deformed private health care market the passive sponsor of which has been the government and it has emerged as an entry point for some services provided by public medical institutions.

The key challenges to reforms in the health sector in Sri Lanka now centre around the expansion of the private sector and decentralisation. Even if the very meaning of HSR is fundamental change, the highly segregated health system which is still under a traditional administrative framework means that Sri Lanka may have to adopt a package of incremental changes for the reform of the system. Gradual restructuring of the whole health system, with due recognition given to provincial autonomy, and formulation and implementation of a strategy for strengthening capacity at provincial, divisional, institutional and programme levels, critical issue in decentralisation. And with respect to the private sector, better regulatory and co-ordination mechanisms, supported by a health information system, are essential. All the changes require gradual increase in MoH capacity at all levels if policy design and implementation are to be effective.

References:

Attanayake, N.(1994). Cost-effectiveness of Anti-malaria Activities in Sri Lanka, PhD thesis, University of London.

Attanayake, N. (forthcoming). An Analysis of Willingness to Pay for Curative and Preventive Care for Malaria, A WHO/ TDR funded study.

Attanayake, N. and de Silva, U.H.S. (1989). An Inquiry into Equity and Efficiency Issues Related to Allocation and Utilization of Human Resources for Health in Sri Lanka, WHO/ HMD/HPA/89.C23.

Caldwell, J. Gajanayake, I. Caldwell, P. and Peiris, I. (1989), Sensitization to illness and the risk of death: an explanation for Sri Lanka s approach to good health for all , Social Science and Medicine, 37(9), 1137-1145.

Cassels, A. (1995). Health sector reform: key issues in less developed countries , Journal of International Development, 7(3), 329-348.

Dalpatadu, K.C.S. and Perera, MA.L.R. (1997). Health sector reform initiatives in Sri Lanka , Informing and Reforming, ICHSRI, Jan-Mar. No.1,8-9.

de Silva U.H.S. and Attanayake, N. (1992). Utilization Patterns of Resources at Peripheral Level Health Care Institutions in Sri Lanka, Health Systems Research Project, Ministry of Health, Colombo.

Mills, A. (1994). Decentralization and accountability in the health sector from an international perspective: what are the choices? , Public Administration and Development, 14, 281-292.

Mills, A., Vaughan, J.P. Smith, D.L. and Tabibazadeh, I. (1990). Health System Decentralisation: Concepts, Issues and Country Experience. World Health Organisation, Geneva.

Rondinelli, D.A. (1981). Government decentralization in comparative theory and practice in developing countries , International Review of Administrative Sciences, 47(2), 133-145.

Russell S., Wijeratne, K. Abayaselera, G. and Perera, M.A.L.R. (1996). Sri Lanka: Decentralization and Health Systems Change, Ministry of Health, Sri Lanka, Division of Strengthening of Health Services, World Health Organization, Geneva.

Russell, S. and Attanayake, N. (1997). The Role of the Government in Adgusting Economies, Paper 14: Sri Lanka- reforming the health sector: does government have the capacity? Development Administration Group, The University of Bermingham.

Uni Quest (1996). A Study on Financing of Social Services Project, Sri Lanka: Health & Population Sector, A study undertaken for the Asian Development Bank.

World Bank (1993), World Development Report 1993, Investing in Health, Oxford University Press, Oxford.

Zwi, A.B. and Mills, A (1995). Health policy in less developed countries: past trends and future directions', Journal of International Development, 7 (3), 299-328.

The author thanks Mr Steven Russell of the Health Policy Unit, London School of Hygiene and Tropical Medicine, for his valuable comments on an earlier draft of the original article. Mr Steven Russell is now a Visiting Research Associate at the Department of Economics, University of Colombo.