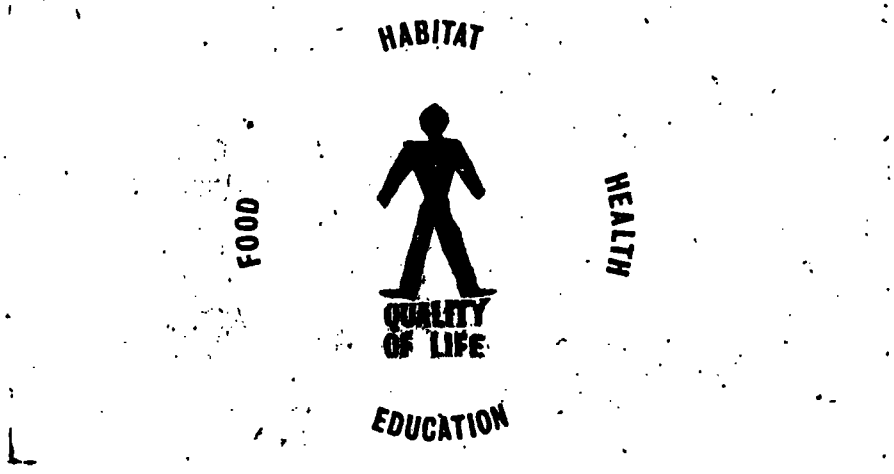

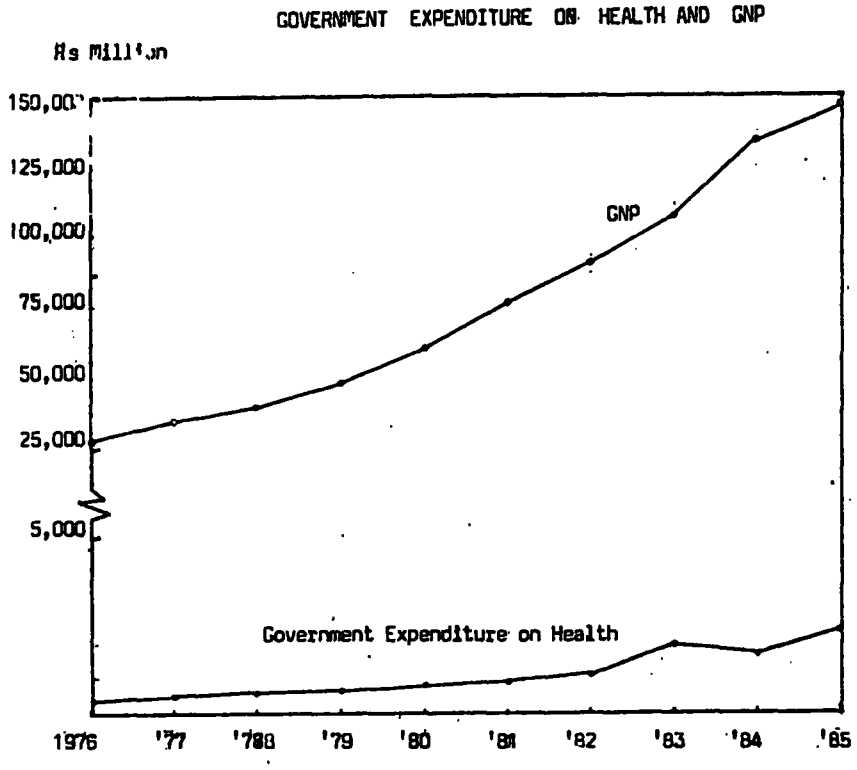

Note: There is a variation of scale for the two items illustrated

HEALTH AND MEDICAL SERVICES

Two events of importance to the Medical Services of the country occurred around the first quarter of this year when, firstly, one of the oldest professional bodies in Asia, the Sri Lanka Medical Association marked a hundred years of its existence with a Centenary Congress at the end of March; and secondly, a few weeks later the new building complex of the National Institute of Health Sciences was formally declared open. The former largely representative of the medical establishment in the country and the latter representing the new thrust in Primary Health Care. (The prevailing gulf between these two bodies was apparent from the procedings of the SLMA Congress, at which a record number of 119 free standing papers were presented by various levels of medical specialists, but less than 10 of these papers were related to the subject of Primary Health Care). The task facing health planners and policy makers is by no means an easy one. It involves not merely the redesigning of a 100 year old health service that has grown and spread through an unplanned aggregation of institutions mainly as a result of political, social, financial and other sectarian pressures; but also the undoing of some of the worst effects of a currently lopsided and commercially oriented medical system.

From around the time of the Alma Ata decleration in 1978, the realisation has grown stronger that health is basically a human condition and no lasting improvements in the health care system could be achieved only through the development of medical services. In short, medicine could no longer be regarded as one of the most fundamental causes of good health. A change of emphasis and perspectives in health policies was therefore urgently needed. It had to be accepted that the determinants of good health in the community are controlled by the social order and the political economy. Changes in the approaches to health servicing are necessary but these could come about only through fundamental social and economic changes. It is this realisation, that fulfilment of man's need for better health can be a stronger force in social development than satisfaction of any other needs, which is the motive force behind the attempt to restructure the country's health services.

The new goals that have been set for the improvement of health services is a recognition of the part these services could play in the overall improvement in people's political, economic and social status. The rationale behind this policy is that people have felt needs for both curative and preventive services. Meeting of such felt needs for the eleviating of suffering caused by disease is more likely to contribute to the generation of self confidence within a community and lead to people's participation in changes in other social

and economic spheres than any other force. The personnel engaged in health care are confronted with this challenge. The ideal situation it appears is one where training could be re-organised and professional attitudes changed so that subservience to people's needs are realised. A strong supporting argument in this regard is that if the health services are to be re-structed to serve the broad mass of the people, the existing health-service system which has a potential for creating dependence and resulting in exploitation of people by a category of health professionals and also for promoting commercial interests will have to be changed. This view maintains that health has for a long time been the exclusive preserve of a particualr professional class and with increasing economic and social competition and consumerist tendencies this trend has had certain unfortunate consequences. The 'establishment' has generally not been in a position to view this problem from a perspective other than that of the professionals and therefore the community has not had the opportunity to be actively concerned about health issues. Furthermore, the low priority usually assigned to health ministries by governments and the absence of health issues in national debates is, in fact, a result of the rigid norms and isolation in which the medical profession has preferred to perform its work. One of the practical problems has been to breakdown the barriers created by the medical profession and to put 'health' in the centre of the development debate.

The most basic of the issues raised in this debate has been the current concept of health. In terms of this concept health appears to have meaning for most people only as the negation of a state of illness; it has become just a state of "no disease". This issue is provocatively summed up in the words of the Swedish Professor of Health Care Research, Göran Sterky who remarked "the health-service system which is so often turned into a medical supermarket, displays the disease problem so predominantly that we are incapable of seeing the health problem. What exists then in our perception is the disease-episode of the individual and not the state of health of the community..... The Western doctor basically diagnoses and treats an isolated individual. He or she habitually makes individualistic assumptions about the 'case' and society. Patients and human beings are mostly viewed as inherently separated from one another and from surrondings".

Professor Sterky raises the question whether it is possible to apply the definition of health, as laid down in the constitution of WHO * in its general formulation. In practice, he says, this definition which is widely used, transfers to the physician the right to determine what constitutes sickness and lets medical technology and professional satisfaction erode people's self-confidence. Sterky asserts that there is a glaring contradiction in WHO's policy when at the same time it promotes the notion of Primary Health Care, based on community involvement and people's own capabilities to cope with their health problems. A socio-cultural redefinition of the basic health concept is needed if health is to become the very lever for development. The problem, as he sees it, is to turn health care from a professionalized service into a self-reliant care, exercised in collective forms. And this has to be done, he says, in a situation where major health development institutions are still obsessively promoting in their recommendations and declarations the notion of distributing, delivering, providing or boosting health services.

A more serious question raised is whether our present health development institutions are suitable tools for the tasks ahead. "In other words, will the technicalities of the professional bodies kill what primary health care is all about? The hospitals are isolated from the people's health problems. Ivan Illich may be right: the system has to a certain extent become counter-productive. The delivery of more cures and more medicines tend to make people more sick. And even worse: 'the medical service ideology' has deprived the people of their creative potential, their precious ability to act as a competent community upon solvable health problems".

Of what relavance are these issues to the state of Health and Medical Services in this country.

During the 1950's and 1960's, clinical and curative medicine was developing rapidly, while new drugs and other tools for treatment were becoming widely available. Many billions of dollars were going into research and experimentation aimed at relief of suffering and pushing the profits of the big pharmaceutical firms. These developments helped to overshadow the importance of preventive and public health measures and also resulted in health professionals, politicians and the public becoming more pre-occupied with the life-saving medical possibilities. Meanwhile, over these years it was being realised that human behaviour and life-styles were major determining factors in health and disease. In the affluent countries degenerative and non-communicable diseases were increasing, while, in the less affluent countries, poverty and ignorance often predetermined attitudes and behaviour patterns and tended to multiply the causes of ill-health. In both the developed and developing countries it was found that social, economic and political factors were all reasons for disease. The incapability of the health service system alone to meet the most felt health needs of the mass of the people was growing more apparent. This led to the search for an approach that would relate the important aspects of social and community life with the existing health services infrastructure. It was against this background that Primary Health Care (PHC) came to be developed.

By the 1970's there was evidence indicating that a number of low income countries had succeeded in significantly reducing diseases, using simple low cost methods of health care. Health care for all thus appeared to be

(continued on page 6)

* Health is a state of complete physical, mental and social well-being and not merely absence of disease and illness

a practical proposition since these methods were within the economic resources of even the poorest countries. By 1978 broad international political support emerged for increasing access to basic health services, and the International Conference on Primary Health Care, at Alma - Ata in September that year, gave political and professional legitimacy to this new consensus on health priorities. This concept of improving access to essential health care services for the poor was pursued with greater vigour in the 1980's. Recent studies have shown that in the developing countries, improvements in housing, sanitation and hygiene have made a significant contri-

bution to improvements in health. The need to broaden access to the most cost-effective elements of modern health care therefore became a priority in the health sector.

Primary Health Care thus became the essential health care provided in the community by relying upon comunity resources; with such care being generally technically appropriate and acceptable to the beneficiaries. The areas covered by primary health care include maternal and child health care, immunization, care of injuries, and promotion of nutrition and sanitation.

Eventually, the impluse towards health for all through Primary Health Care (PCH) became central to the search for better health and enhanced human welfare. The logical end-product of the PCH approach was therefoe the goal of Health For All (HFA) by the year 2000; or the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life.

In Sri Lanka the national strategies fore Health For All by the year 2000 were formulated, adopted and presented to the world community through the WHO in 1980. The corner-stone of these strategies were as follows:

(a) The establishment of a Natinal Health Development Network to ensure intra-sectoral and inter-sectoral coordination for health development activities;
(b) Decentralization of health administration;
(c) Identification and prioriszation of PHC components for implementation; and
(d) The development of an implementation model for subsequent application on a national scale.

Plans were formulated for establishing a more rationally organised health care system, with the aim of improving the access of the entire population to essential health care. The main practical steps taken towards the achievement of the HFA goal was the establishment of a National Health Development Network. This network consists of the following mechanisms:

1. National Health Council.
2. National Health Development Committee,
3. Six Standing Committees,
4. District Health Development Committee,
   (Health Sector of District Development Council)
5. Mechanisms at Sub-Divisional and Village level.

The Public Health Programme covers all basic requirements of health of the people and if all the components identified could be fully provided achieving the goal of Health for All could be made possible. There is, however, far more ground to be covered before this goal is reached, as an examination of some aspects of the existing health services and systems will show.

For instance, about 3 percent of the Government's budgeted expenditure is spent on health services. Over the last 10 years Government's direct health expenditure has doubled (in constant terms) going up from about Rs 225 mn to Rs 450 mn during this period. What is significant in this expenditure pattern is that nearly two-thirds of the health budget has been expended on patient care services. In 1983 this aspect of expenditure took up nearly 79 percent of total expenditure although by 1986 it accounted for about 53 percent. Meanwhile, allocations for Community Health Services took up about 17 percent of total expenditure in 1983, although this increased to about 31 percent by 1986. What is clear is that a major part of Government funds are being channelled into the curative services (More details are discussed in the Box).

The curative services are provided by the Government through about 825 institutions comprising 14 major hospitals located in the main cities and categorised as Provincial Hospitals, of which 7 are also used as hospitals for teaching medical students; 19 Base Hospitals; 115 District Hospitals; and 109 Provincial Units. In addition there are 128 rural Hospitals, 87 Maternity Homes and 328 Central Dispensaries and about 25 other specialised institutions. In 1985 there were a total of 1,914 Government Medical Officers directly engaged in the curative services.

The preventive services are offered through specialised campaigns and disease control programmes under the charge of almost 100 Government Medical Officers, assisted by about 3,500 health support personnel. About 37 other Medical officers were more engaged in administrative functions; while about another 99 function as M.O.H.s.

The maintenance of even minimum services in many instances has been difficult due to the serious problems and deficiencies in the public sector health servicing facilities. Among them are severe shortages of trained personnel, maldistribution of available staff between different geographical areas; underutilisation of peripheral hospitals and over crowding of provincial and district hospitals; inadequate and inappropriate distribution of medical supplies, including drugs, to different institutions; lack of supervision and a lack of motivation of the staff.

Such deficiencies in the management of the health systems appear to be the underlying causes behind many of these problems.

It was therefore not surprising that many people did not seek in-patient treatment at hospitals in their own areas. They generally imagine that treatment would be much better in a big hospital, whatever the illness. In the big General, Provincial and Base hospitals bed occupancy is 100 percent and over, while in Central Dispensaries it is 18 percent and Rural hospitals 72 percent. And this happens despite the fact that average duration of stay of patients in big hospitals has been cut over the last 20 years. (See table below). The Health authorities were therefore compelled to report: "Bypassing of medical institutions is one of the major problems as it leads to over utilization of some medical institutions and under utilization of others".

The morbidity pattern in official hospital statistics also indicates clearly that preventible diseases constitute a large proportion of hospital admissions and many of these conditions could be dealt with at the periphery through simple interventions, thereby avoiding revisits and reducing overcrowding in central institutions as well as having an impact on disease incidence itself.

Inadequate drugs, dressings, equipment and similar basic facilities is a common deficiency in all levels of government health institutions. Apart from other factors, one reason for the short supply of these essential items is the existing pilferage. Losses, pilferage and wastage is a common complaint from these hospitals. A general cause, the health authorities have found, is

TABLE I AVERAGE DURATION OF STAY PER PATIENT IN SELECTED TYPES OF HOSPITALS 1965-1985

	Average Duration of Stay		
	1965	1975	1985
General Hospital,Colombo	9.1	8.3	6.8
Provincial Hospitals	8.3	7.0	6.2
Base Hospitals	6.3	6.2	5.0
District Hospitals	5.9	4.6	3.8
Peripheral Units	-	4.0	3.6
Rural Hospitals	-	4.2	4.6

Source: *Medical Statistics Division, Ministry of Health*

(It has been suggested that this reduction in duration of inpatient treatment in all hospitals, except Rural, was due to higher pressure on hospital admissions resulting in a quicker turnover of patients, or to changes in the diseases and their severity, or to the adoption of more effective methods of treatment, or more likely to a combination of these factors).

due to apathy and lack of supervision on the part of the responsible staff. A deterioration or breakdown in the supervision of all categories of health personnel has been officially reported in several of these institutions.

The inadequacy of trained manpower in the health services has continued to be a major problem, and according to the Ministry of Health "the number of medical doctors and assistant medical practitioners required for 1985 was 2,416 and 1,443 respectively, while the respective availability was 2,151 and 957 during the year. As a result the number of persons per doctor increased from 5,528 in 1984 to 7,363 in 1985. The number of nurses available was 8,091 as against a requirement of 12,550 in 1985", according to the Central Bank's annual report which also gives the details in the table below.

An important problem therefore is the lack of sufficient staff at various levels. Most serious is the shortage of Grade Medical Officers particularly in the bigger Provincial and Base hospitals. The main reasons, it has been found, are due to the exodus to other countries of Medical Officers who leave mainly for higher emoluments; and also the fact that many Officers prefer to work in the periphery areas, specially in one-man stations, due to the ease with which they could do private practice and earn extra income. Although the medical profession as a whole is noted for its high norms and standing in the community there are a few officers who tend to bring the profession into disrepute by taking undue advantage of the illness and suffering of their fellow beings. It is perhaps attitudes such as this that widen the gap between those who give medical attention and those who need it, an attitude that runs counter to the concept of Health for All through Primary Health Care which is basically a needs based concept.

This attitude also comes out strongly, in Sri Lanka, in the manner in which some medical personnel conduct their consultation and private practice, and also have direct financial interests in private medical institutions and marketing of pharmaceuticals. Charges of unprofessional conduct have been made against such personnel in Government and private practice alike. One aspect of these practices is the manner in which some medical practioners establish conncections with representatives of big drug firms. In a paper published recently (Economic Review Nov/Dec 1986) Professor K.Jayasena, Head of the Department of Pharmacology at Peradeniya Medical School, commented as follows on his experience of marketing of drugs in Third World countries:"It is common practice, indeed the rule, in these countries for general practitioners not only to examine and prescribe for the patient, but also to sell the drugs to the patient. The income of the doctor is therefore more dependent on his earnings from the sale of drugs than on consultation fees. It follows, therefore, that in these Third World countries where the number of general practitioners is nearly as great as in the state sector, they account for the sale of a large volume of drugs. The drug representatives of all manufacturers are, not surprisingly, constant visitors to GPs. The latter are first supplied with free 'samples', together with other gifts. Once doctors are convinced that they have a profitable line of drugs, i.e. where the margin of profits is significant, they place their order directly with the drug representatives. Obviously, this type of marketing practice does not protect consumer interests".

One result is the overuse of drugs or prescriptions whether patients need them or not; as Professor Jayasena states"The axiom that, 'Medicines should be prescribed only when they are essential, is often overlooked by doctors in the Third World as much as their counterparts in the industrialized countries. In countries such as Sri Lanka, where there are restricted drug lists for use at the various levels of health care (peripheral, district, base/ provincial, and teaching hospital and

TABLE II HEALTH SERVICES 1981-1985

Item	1981	1982	1983	1984	1985
1. Hospitals (a) (Practising Western medicine)	488	479	483	484	490
2. Beds	44,082	44,389	44,016	44,919	45,211
3. Central dispensaries	340	338	334	338	338
4. Total No.of doctors	2,233	2,038	1,951	2,822	2,151*
5. Total No.of asst. medical practitioners	925	911	933	992	957
6. Total No.of ayurvedic physicians	10,685	11,531	12,043	12,277	12,277
7. Total No.of nurses	6,805	6,931	7,112	7,216	8,091
8. Total No.of attendants	4,883	4,932	4,690	4,705	4,881
9. No.of in-patients ('000)	2,283	2,445	2,524	2,524	2,497
10. No.of out-patients('000)	30,439	31,696	30,720	31,907	29,570
11. Currency expenditure (Rs Mn)	857	999	1,308	1,621	1,783
12. Total health expenditure (Rs Mn)	999	1,188	2,024	1,751	2,031

Source: *Ministry of Health, Ministry of Indigenous Medicine*

(a) Includes maternity homes

* (This figure of Govt. doctors had gone upto about 2,300 in 1986. In addition, there were about 550 private medical practitioners).

specialist institutions), the drugs used are on the whole rational although there is still a tendency for over-perscription of certain agents. However, in the private sector there is no control. Sometimes the physician uses the prescription as a substitute for counselling or to satisfy the expectation of the patients".There is another aspect of drug perscribing nullifying the Health for All concept on which he faults these medical personnel:"The strategy of Health for All by the year 2000 envisages that the people will become full partners both in the decision-making process as well as in the provision of health care. However, in the matter of prescription of drugs, the decision-making is usually done solely by the doctor. The patient is given little or no information, even on such basic issues as the type of drug used, how it could help the patients, possible adverse effe :cts and precautions to be observed.

In the Third World doctors often defend themselves for such noncommunication on the basis that the patient is illiterate. This overlooks the fact that they fail to give information even to literate patients, and that even illiterate patients are quite capable of comprehending basic facts if presented in simple language".Another useful study on the dispensing of drugs, presented recently at the SLMA Centenary Congress sessions, by a team of Colombo doctors, titled the "Analysis of Prescriptions Dispensed at a Pharmacy in Central Colombo", * showed that only 48 percent of the drugs were prescribed by generic name. The average cost per prescription in this study was Rs 41.22, but had the prescription been by generic name the cost of each prescription would have decreased by Rs 15.00. It is apparent that prescriptions by generic name could reduce costs for the patient by nearly 40 percent, but less than half the prescriptions of medical personnel carried generic names. This study also drew attention to the fact that the majority of the prescriptions lacked the minimum details; and it appeared that nutritional products are over prescribed.

Another useful study presented at the SLMA sessions, by a team of Peradeniya doctors was on "Utilization of Health Facilities in Sri Lanka: A Consumer Viewpoint"** where the views of school teachers, belonging to a comparatively high income group (Rs 1,500 per month), were sought. These were considered generally well informed views, since school teachers are widely distributed and constitute a knowledgeable group in society. Conforming to the general pattern in Sri Lanka, where the higher the income group the larger the proportion seeking Western Medicine, nearly 77 percent of this group sought Western medicine regularly (and 21% occasionally) and only 13 percent received ayurvedic treatment regularly (though 64% contacted an ayurvedic practi tioner occassionally). As many as 73 percent of them had a family doctor. In the case of this particular group as many as 71 percent generally first go to a private practioner, while the others would go to either the nearest Government Hospital, the General Hospital in the city or to a specialist. (The pattern is different for the lower income groups, according to other surveys).

Routine care during pregnancy, and immunization was carried out more in hospitals (73%), while advice of General Practioners was sought on family planning, treatment of minor injuries and ailments and paediatric diseases. It was only in the case of specific diseases like heart attacks and other serious complications that General Hospital or Specialist treatment was sought.

Commenting on the country's health programmes, as manyas 80 percent considered the general public health programme very poor to fair. On the other hand as many as 76 percent rated the Immunisation programmes at good or excellent. A majo rity considered the family planning, maternity care and dental care programmes as fair or below fair. Less than 15 percent were satisfied with the services at the local hospital. In their local hospitals, the major problem was the non-availability of drugs, with as many as 69 percent rating 'availability' as fair to very poor. The other main problem listed by between 66 and 63 percent were the quality of meals, courtesy of staff and promptness of service. Availability of doctors was considered a problem by 59 percent.

In the General Hospitals in the city a major problem (considered fair to very poor by 82%) was the availability of drugs. The other major problems in these big hospitals is the courtesy of the staff and the quality of meals, with only 7 percent considering these aspects good.

The main suggestions made by this group for improving the health services was to develop the peripheral hospitals in preference to general hospitals; and more specialised units in Colombo (84%); and to increase the intake of medical students in order to supply more doctors (87%). What they disagreeed on most was to employ foreign doctors to meat the existing shortage (88%), to charge a fee for treatment at Government hospitals (59%), and to encourage more doctors to become private practioners or family physicians(55%).

An overall picture of the utilisation of health services in the country and the patterns of expenditure of various income groups could be drawn from the data collected in the Central Bank's Socio-Economic Surveys of a representative sample of the population. All island, it was found that for about 80 percent. of the population their source of treatment was Western Medicine and about 14 percent Ayurvedic treatment. This 1981/82 survey showed that of a sample of 4,300 who had fallen ill a total of 1,959 (46%) sought Western Government treatment and 1,471 (34%) Western Private; with 519 (12%) seeking Ayurvedic Private and 94 (2%) Ayurvedic Government

* M.Ganesan, R.C.Fernandopulle, Deepthi Galappathy, W.P. St D. Fernandopulle, W.R.I.Fernando, K.Weerasooriya comprised the team on this study of 'An Analysis of Prescriptions Dispensed at a Pharmacy in Central Colombo'.

** Lakshman Karalliedde, Nimal Senanayake and Jayampathy Udurawana were the medical academics who conducted this study

TABLE II.I AVERAGE EXPENDITURE FOR ONE MONTH ON SELECTED NON DURABLE ITEMS PER SPENDING UNIT ALL ISLAND

Item	All Island	
	Rupees	%
Housing	90.27	16.3
Clothing	109.29	19.8
Fuel and Light	80.06	14.5
Transport & Communication	60.56	11.0
Education	24.22	4.4
Medical	24.77	4.5
Other non Food	163.10	29.5
	552.27	100.0

Source: *Consumer Finance and Socio-Economic Survey 1981/82, Central Bank of Ceylon*

There were also 15 (.3%) who resorted to Homeopathy and 6 (.1%) to Acupuncture and 236 (5.5%) to other forms of treatment.

This survey showed that in 1981/82 the average expenditure of a spending unit, generally a single family of five, (all isalnd) for one month on selected non-durable items (excluding food) was Rs 552.27 of which Rs 24.77 or 4.5 percent was medical expenses.(See table below).

In terms of average medical expenditure per person, it was found that 74 percent of overall expenditure was for Western medical treatment; 18 percent for Ayuervedic treatment; and 8 percent for ceremonies, charms, and other connected expenses. The average amount spent, per person, for one month was Rs 5.01. As would be expected the average expenditure per person was highest in the Urban areas (Rs 9.05) and lowest in the Estate sector (Rs 2.03); while in the Rural sector monthly expenses averaged Rs 4.24 per person. Also, expenses on Ayurveda were highest in the rural sector.

TABLE IV AVERAGE MEDICAL EXPENDITURE FOR ONE MONTH PER PERSON URBAN, RURAL, ESTATE AND ALL ISLAND

Medical Expenses	Urban		Rural		Estate		All Island	
	Rs	%	Rs	%	Rs	%	Rs	%
Ayurveda	1.39	15	0.83	20	0.18	9	0.89	17.7
Western	7.13	79	2.99	70	1.72	85	3.70	73.8
Charms etc. & other	0.53	6	0.42	10	0.13	6	0.43	8.5
Total	9.05	100	4.24	100	2.03	100	5.01	100

Source: *Consumer Finance and Socio-Economic Survey 1981/82 Central Bank of Ceylon*

Expenses in the Estate sector were mostly for Western medical treatment. The highest monthly expenditure per person for Western medical treatment was found to be in the Urban sector; averaging Rs 7.13 per person. For further details see Table 4.

The survey which recorded the number of sampled persons who had fallen ill during the reference period of 14 days, also reveals that the most common category of illness was fevers. As many as 40 percent complained of fevers, of which about 3 percent included fevers with skin manifestations or with neurological problems. Another 32 percent were down with coughs, upper respiratory infections and breathing problems; while 11 percent had complaints of diarrhoeas, vomitting and other abdominal problems; while about 9 percent had general problems.

Comparisons with similar Central Bank surveys carried out earlier show that there has been a general increase in all sectors, in the percentage seeking western medical treatment. At the earlier stages the demand for Western medicine was concentrated mainly in the urban areas, while indigeneous medicine was dominant in the peripheral areas of the country. But from around the 1950's and 1960's new developments were occuring in medical science, with new drugs and other advances in methods of treatment becoming rapidly available. These developments in Western medicine caught on in the urban areas and began to spread, and its more immediate curative effects than those of the indigenous system resulted in its growing popularity among rural areas as well. As shown in th e table below, average expenditure on Western medicine among the lowest income groups (more widespread in rural areas) has been steadily increasing during the last two decades. It is evident that the poorest continue to suffer a significantly greater burden of disease that the higher income groups.

Table V

EXPENDITURE BY INCOME LEVELS FOR ONE MONTH ON WESTERN MEDICINE AS A PERCENTAGE OF TOTAL EXPENDITURE - ALL ISLAND

Income Groups	1963	1973	1982
0 - 200	0.53	0.42	----
201 - 400	0.16	0.55	0.81
401 - 800	0.13	0.44	0.41
801 -1500	0.63	0.44	0.31
1501 - 3000	1.46	1.11	0.29
3000 and over	1.65	0.89	0.08

Source: *Socio Economic Surveys - Central Bank 1963,1973,1981/82*

In 1963 those households earning less than Rs 400 per month spent 0.16 percent of their income on Western medicine. In 1973 this proportion had increased to about 0.55 percent and in 1983 it was about 0.83 percent. Between 1963 and 1973 their share of income spent on Western medicine had increased more than three fold and by 1982 it had increased further. The increasing dependency of low income groups on Western medicines could be due to several factors.

a) The major developments (such as the Mahaweli)undertaken in the country has involved destruction of forests and natural vegetation reducing access to indigenous medicine.

b) Provision of more Western based medical facilities to the lower income groups, particularly in rural areas, has become a major aspect of rural development schemes.

c) As a result of irrigation development, which has compounded problems of drainage and wastewater management, water related diseases have become more widespread in rural areas. The expansion of Western oriented curative medical services from the centre has been considered necessary to solve these new problems.

d) As a consequence of increasing commercialization and cash crop farming the low income groups have not been able to afford their earlier nutritionally balanced diets and the frequency of illness among those groups has been on the increase.

e) The attitude towards a free western medical system was also changing among the rural poor.

Another important implication that could be observed in the table is the decreasing expenditure on Western medicine by the higher income groups. The higher the income lower the proportion has been spent on Western medicine. Households earning more than Rs 3,000/- per month spent about 1.65 percent of their incomes on Western medicines in 1963; while in 1982 this figure had dropped sharply to 0.8 percent. The income group between Rs 1,500 - Rs 3,000 per month spent only 10.29 percent in 1982 for the same purpose compared to a higher percentage of 1.46 in 1963.

Improved health conditions, better preventive health care practices, easy access to highly advanced health technology and specialist services are important factors in the trend towards the lower frequency of illness among the higher income groups. Furthermore, most of the high income groups are well protected by various health insurance and security schemes and a part of expenditure on Western medicine could be covereed under such programmes.

However, the overall pattern of changes between 1963 and 1982 indicate that the low income groups are spending a higher percentage of their income on Western medicine than the higher income groups. Despite the free medical facilities made available to these low income groups they remain major buyers of Western medicines.

Sri Lanka's health services have been regarded as unique in many ways for a low income developing country. The basic committment of governments over the past 5 decades has been the provision of freee health services to every citizen and this has in a way contributed to the exceptionally high health status of the overall population of Sri Lanka. Often quoted indicators are Sri Lanka's Infant Mortality Rate of 29.5 per 1,000 live births and a Crude Death Rtae of 5.9 per 1000 of the population (in 1981) providing a life expectancy of about 68 years in that year. Other indicators however have shown the need for improvement in the health status of particular sectors. For instance, Maternal Mortality was 0.6 per 1000 live births, with a neo-natal mortality rate of 19.1 per 1000 live births in 1981. More significant was the variation in the mortality rates among the districts of the island. In Nuwara Eliya the Infant Mortality Rate (IMR) reached 53.0 per 1000 live births, while in Gampaha the IMR was only 16.0 per 1000. Again, Maternal Mortality was 2.7 per 1000 live births in Mannar while in Colombo and Gampaha the rate was only 0.2 per 1000. So too with the Crude Death Rate (in 1985) which was 9.0 per 1,000 in Nuwara Eliya as against 4.4 in Jaffna. On the whole indicators from the Registrar General's data show that districts such as Mullaitivu and Moneragala have a comparatively high health status compared to those of Nuwara Eliya and Kandy. These indicators may point to an extensive network of public health facilities but more significant is that there is also a need for a more equitable distribution of resources.

Another unique feature of the existing status of health services in Sri Lanka is the "disease pattern" of the country which is a mix between those of developing and developed countries. For instance, diseases such as Hypertensive and Ischaemic Heart diseases or accidents and suicides have emrged as leading causes of hospitalization and death; while diseases more common to developing countries such as infectious diseases, diseases of the respiratory system, intestinal infection and malnutrition still persist as major cause for hospitalization. In recent years diseases where control is comparatively simple and cheap such as diarrhoeal diseases have been a major cause of illness and death. Again, the resurgence of Malaria and growing incidence of Sexually Transmissible Diseases has been the cause of concern for the health authorities.

The question arises how deficiencies in the system have been allowed to grow while the overall health status of the population has appeared to be improving. This is a basic issue now facing the authorities. A noticeable trend among developing countries is that till recently many had not undertaken comprehensive programmes to provide for the health of their populations. Public expenditures on health were often limited and even here the bulk of the outlays have been concentrated in the urban areas and on expensive hospital facilities, with rural populations having limited access to these facilities. In Sri Lanka's case clear illustrations of this situation are the widely differing nutritional status in different districts (shown in the illustration on inside cover), and the wide variations and the uneven distribution of doctors to the population in various districts. As the table below shows the ratio of Government doctors to the population in Colombo is as much as 15 times more than that of Moneragala. Colombo district has in its curative services a ratio of 36.1 Government Medical Officers to every 100,000 of the population followed by Kandy 17.8 and Jaffna 15.50. At the other end of the scale is Vavuniya, Mannar and Mullaitivu with 2.3, Moneragala 2.4 and Amparai 3.8. Another significant feature in these statistics is that while there are 12 Medical Officers per 100,000 people in the Curative Services, in the Preventive Services the rate is less than *1 for every 100,000.

TABLE VI GOVERNMENT MEDICAL OFFICERS BY HEALTH DISTRICT 1985

Health Districts	Curative Services		Administrative & Preventive Services		Medical Officers of Health	
	No	Rate*	No	Rate*	No	Rate*
Colombo	659	36.1	13	0.7	10	0.5
Kandy	200	17.8	7	0.6	6	0.5
Jaffna/ Kilinochchi	138	15.5	6	0.7	7	0.8
Batticaloa	43	12.1	3	0.8	3	0.8
Galle	92	10.5	2	0.2	6	0.7
Kalutara	86	9.6	11	1.2	8	0.9
Gampaha	125	8.4	3	0.2	9	0.6
Badulla	53	7.7	4	0.6	2	0.3
Ratnapura	65	7.6	5	0.6	4	0.5
Trincomalee	20	7.3	1	0.4	1	0.4
Kurunegala	80	6.1	3	0.2	9	0.7
Puttalam	32	6.0	2	0.4	4	0.7
Matale/Polonnaruwa	37	5.6	3	0.4	2	0.3
Anuradhapura	35	5.5	1	0.1	3	0.5
Kegalle	39	5.3	-	-	6	0.8
Matara/Hambantota	53	4.6	1	0.1	11	0.9
Nuwara Eliya	30	4.6	1	0.1	2	0.3
Amparai	16	3.8	1	0.2	2	0.5
Moneragala	7	2.4	-	-	2	0.7
Vavuniya/Mannar Mullaitivu	7	2.3	2	0.7	2	0.7
Special Campigns & Others	97	0.6	69	0.4	-	-
TOTAL	1,914	12.0	137	0.8	99	0.6

Source: *Medical Statistics Division*

Food and nutrition, medicines and treatment, and disease patterns are major connected issues in the current health situation in Sri Lanka. Some of these have been discussed earlier in Special Reports of the 'Economic Review'. However one such relevant issue, namely, disease patterns, connected with the socio economic changes that have occured in Sri Lanka in recent decades is discussed in the following paper on "Primordial Prevention of Cardiovascular Diseases in Sri Lanka."

Sri Lanka is committed to achieving the goal of Health for All by the year 2000 through Primary Health Care (PHC) which means a reversal of the existing System of Health. The existing System as we have seen is heavily doctor and treatment oriented and all decisions on the system today are largely influenced by those who have a strong interest in it. On the other side is the patient/consumer/people for whom the system is intended but who have no say at all in it. If this situation is allowed to continue it will not require much hindsight to forecast that Health for All will remain a distant goal as long as the community is not actively integrated into the system and preventive measures not given their due place in practice.

C.G.
L.S.
S.L.T.
K.G & S.F.