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POLITICAL COMMITMENT AND ECONOMIC SUSTAINABILITY: EARLY ACHIEVEMENTS AND LATER STRAINS IN SOCIAL DEVELOPMENT

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Scope and Objectives

Sri Lanka's high attainments in social indicators at a relatively low per capita income are often cited as evidence of the possibility of achieving social progress even at early stages of economic development. Other countries in this league of good social indicators at low levels of per capita income include, Barbados, the State of Kerala in India, Costa Rica, Jamaica, Mauritius and Cuba.

Sri Lanka's early political commitment to social development was due to a number of reasons which are discussed in this paper. But the initial political commitment was effective owing to the availability of an extractive surplus in the economy. The deterioration in economic conditions particularly the fall in international prices, and the increasing cost of the welfare package as population increased, resulted in serious strains in continuing the social development agenda. Despite these economic difficulties the broad thrust of social policies continued, but some of the cut-backs in expenditure resulted in a slowing down of the pace and momentum of the initial successes.

Some have argued that the excessive spending on the social sector was responsible for retarding economic growth and thereby ultimately impacting on social progress itself. This approach points out that the Sri Lankan experience is not illustrative of social development indicators being high inspite of a low per capita income, but that her low per capita income and slower rate of economic growth was a consequence of the excessive social expenditure.

The Sri Lankan social development experience, as well as its economic growth are so exceedingly complex as to permit very diverse but inconclusive interpretations. The paper does not pretend to address itself to these various hypotheses but to capture some of the factors which contributed to the initial success and the subsequent strains in social development. In analysing the reasons for the success of the primary health care programme in particular, micro level and institutional factors are also discussed.

The next section of the paper gives an overview of the social attainments over time and in comparison with other South Asian countries. Section three is an interpretation of the factors responsible for the initial success and the current strains and deficiencies. The central theme of the paper is elaborated in this section. The concluding section focuses on the needed new directions for social policy.

Social Attainments

Sri Lanka's contemporary social indicators are considerably better than those of her neighbouring South Asian countries. The comparative social indicators in Table 1 demonstrate Sri Lanka's higher attainments compared to those of India, Pakistan, Bangladesh and Nepal. Sri Lanka's adult literacy rate of 89 per cent compares with 50 per cent for India, 36 per cent for Pakistan and Bangladesh and 27 per cent for Nepal. Sri Lanka's life expectancy at birth is 71 years, compared to less than 60 years for these four South Asian neighbours. The contrast is much greater for infant mortality (IMR), under 5 years mortality, maternal mortality (MMR), death rates, birth rates and the total fertility rate. There is no doubt that Sri Lanka's social attainments are of a higher order than those of our neighbours. The only exception is the State of Kerala in India, which has comparable social indicators.

Table 1: Sri Lanka's social indicators - compared to other South Asian countries.

	Sri Lanka	India	Pakistan	Bangladesh	Nepal
Life Expectancy years	71.2	59.7	58.3	52.2	52.7
Infant mortality rate	24.0	89.0	99.0	109.0	100.0
Under 5 mortality rate	19.0	124.0	137.0	127.0	128.0
Maternal mortality rate	80.0	460.0	500.0	600.0	830.0
Crude birth rate	21.0	30.0	42.0	39.0	39.0
Crude death rate	06.0	10.0	11.0	14.0	14.0
Total fertility rate	2.5	3.9	6.2	4.8	5.5
Adult literacy rate	89.1	49.8	36.4	36.6	27.0
Gross enrolment rate	107.0	99.0	42.0	77.0	82.0
Primary completion rate	95.0	62.0	37.0	46.0	-

Sources: *UNDP, Human Development Report 1994*
UNICEF, Progress of Nations 1994
The World Bank Atlas 1995

Even more significant than the current indicators is the fact that Sri Lanka achieved considerable social progress by the 1960s. Life expectancy reached 64 years in 1963, compared to the current 71 years. The Infant Mortality Rate was 57 per thousand in 1960, much lower than the current rates in other South Asian countries (89-109 per thousand). The maternal mortality rate was 30 per thousand live births in 1960. The progress of key health indicators over time is given in Table 2.

Statistical Tables

Table 2: Key health indicators 1960-90.

	1960	1965	1970	1975	1980	1985	1990
Life Expectancy	-	64 (1963)	66 (1971)	-	70 (1981)	-	71
IMR	57	53	48	45	34	24	19.3
MMR	30	24	15	10	06	05	04

Source: Department of Census and Statistics.

Adult literacy was 65.4 per cent by 1953 and 71.6 per cent by 1963. Significantly female literacy was as high as 53.6 per cent in 1953 and 63.2 by 1963 (Table 3). These attainments are higher than those of other South Asian countries today, as can be seen by comparing the indicators in Table 2 and 3 with those in Table 1.

Table 3: Literacy 1953-1981.

	1953	1963	1971	1981
Adult literacy rate	65.4	71.6	78.5	87.2
Male	75.3	79.6	85.6	91.1
Female	53.6	63.2	70.9	83.2

Source: Department of Census and Statistics.

While the primary health care policies have been successful in curtailing deaths and the food subsidy programme has ensured minimal nutrition, these have not been complemented with adequate economic development to improve living standards. The rate of economic growth has been inadequate to provide needed employment opportunities, increase incomes and eradicate poverty. Consequently about one million persons or 11 per cent of the labour force are estimated to be unemployed; about 25 per cent of the population is estimated to be below the poverty line; more than half the population do not have latrines; a large proportion of households have poor housing conditions and over 40 per cent use unprotected water supplies. (UNICEF 1991, Department of Census and Statistics & UNICEF 1988, Gunatilleke 1989). Consequently, although Sri Lanka made considerable progress in reducing mortality and increasing life expectancy, the morbidity pattern discloses a high incidence of diseases associated with poverty, malnutrition and poor living conditions. Gastro-intestinal infections, parasitic and communicable diseases and respiratory illnesses account for the highest incidence of morbidity. While the food intervention programmes appear to have ensured an overall adequate calorie intake, except in the crisis years of the 1970's, yet, about one fourth of the population appears to fall below nutritional requirements. (Gunatilleke 1989: 11-15).

While the initial thrust in education enabled impressive gains in literacy and basic education, economic conditions and resource constrains have impeded a better distribution of education and an improvement in the quality of education. Those with a secondary and even tertiary education are considered unemployable as they lack specific skills, a good general education and a knowledge of English. The failure to shift educational facilities from basic requirement to more sophisticated needs, socio economic conditions which deter poor children from attending school and school children requiring supplementary private tuition are among the glaring deficiencies in education.

Factors Responsible for Social Attainments

An early political commitment to a welfare policy consisting of subsidized food, free health services and education are undoubtedly the underlying reason for Sri Lanka's impressive record of social indicators. The early grant of adult franchise in 1931 has been "the most explicitly and directly relevant factor accounting for the commitment of social welfare...." (Snodgrass 1966: 194-5). Furthermore, the early grant of universal adult franchise in 1931 and the consequent development of a competitive democratic political system in which political parties tended to woo the voter by promises of better subsidies and improved health and educational services, were undoubtedly responsible for the policies which gave a high priority for social expenditure. This political commitment was sustained and re-inforced by the competitive political system. Any curtailment of welfare expenditure could have serious repercussions for an incumbent government, as the political opposition would seize the opportunity to discredit the government.

The significance of the franchise in improving social conditions is illustrated by the health and education experience among estate workers of Indian origin. Prior to 1930 health indicators were better on the estates than in the rural areas owing to the requirement that the estates must provide medical facilities to the immigrant indentured Indian labour. With the expansion of health facilities rural areas caught up. Soon after independence, with the disenfranchisement of Indian labour in 1949, health facilities on the estates deteriorated and health indicators did not improve in the same manner as in the rest of the country. Government were not interested in improving health facilities on the estates as Indian Tamils did not count at elections. Consequent on their enfranchisement in the 1960s their living conditions have been progressively improved even at a time when their labour productivity declined owing to unfavourable international prices and mismanagement of the estates. Educational facilities remain poor partly due to these reasons, but also owing to the lesser demand of the Tamil estate workers for better schooling facilities.

Political commitment has been most conspicuous with respect to the food subsidies, where despite the enormous burden on the public finances, there was a reluctance to curtail this expenditure. When the government attempted to reduce the subsidy in 1953 it led to political turmoil and the resignation of the Prime Minister. This sealed the fate of food subsidies which became a legacy of

subsequent governments for several decades later. Proposals to modify the food subsidy 1962 and 1972 were also dropped owing to opposition within the government itself. The rice subsidy was ultimately removed only in 1979 when the rice ration, which had dominated the political and economic scene for nearly half a century, was substituted with a food stamp scheme. Although this scheme was intended to reduce the food subsidy drastically by targeting it to the poorest sections, in fact the expenditure increased progressively as the number entitled to the food stamps increased over time and over 40% of the population became entitled to it. Even this seemed politically inadequate and consequently in 1989 the government promised the extravagant Janasaviya poverty alleviation programme which entitled food stamp holders to Rs. 2,500 per month. However, by phasing the implementation of the programme and not releasing some of the promised funds, the scale of this programme was modified. The People's Alliance government which came into power in 1994 has also committed itself to an extensive welfare package including a wheat flour, bread and other food subsidies as well as the Samurdi programme of income support. This experience with respect to food subsidies is illustrative of the strong political commitment to welfare policies. Welfarism is a cornerstone of the country's political culture and economic policies.

The health and education programmes had a similar strong commitment but its political sensitivity was much less. This was due to the essential difference between a food subsidy, which is a continuous benefit, and health benefits which are utilised only at times when persons require the particular services. This has enabled governments to curtail health expenditure, at least in real terms though the system of public health-care and free medical services has continued. Similarly, the basic principle of free education has continued, but when economic conditions made it difficult to expand and improve educational facilities, there has been a curtailment of such expenditure -- both current and capital -- without a shift in the basic policy. Consequently the quality of the educational services has suffered.

The expansion of health services to cover the entire country and its sustainability over the last six decades a political commitment arising from the expansion of political responsibility and competitive politics. The initial impetus to expanding the health service throughout the country arose from the introduction in 1931 of limited self government by representatives elected on the basis of universal franchise. The elected representatives became concerned with their voter's health, education and other basic needs.

The expansion of health facilities to remote areas was also inextricably connected with the country's agricultural development strategy based on land settlement, which was considered essential for food security, provision of employment opportunities, economic growth and preservation of democracy. The need to improve health conditions in the newly settled areas was part of this programme. This gave primary health care a degree of importance beyond the direct needs of improving health to one which could have an impact on the economy itself.

The extensive network of hospitals and maternal and child health clinics, which enabled easy access to medical facilities, special maternal and child health services with field public health midwives, school medical services and subsidised basic foods and a high rate of literacy, especially female literacy, are among the vital ingredients which contributed to the country's health attainments.

The health care delivery system consisted of a three-tiered network of institutions spanning the entire country. At the primary level are Central Dispensaries, Maternity Homes and Rural Hospitals. The Central Dispensaries and Rural Hospitals, which provide outpatient services, except for limited inpatient facilities for minor illnesses at Rural Hospitals, are in charge of Registered or Assistant Medical Practitioners. Mid-wives provide the maternity services. At the intermediate level, Peripheral Units and District Hospitals which are better equipped and served by Medical Officers provide both in-patient and out-patient services. Provincial and Base Hospitals have specialised units covering a wide range of services. (Vidyasagara & De Silva 1985:3).

The early break-through in MMR and IMR is directly related to the fact that by 1945 a little less than half the total number of births was cared for by either field mid-wives or in hospitals and nursing homes. The traditional home child-delivery system, generally of poor hygiene and incapable of coping with complicated deliveries, was already on its way out.

The key elements which accounted for the decline in these mortality rates were the comprehensive and widespread maternal and child health services at primary level linked to the intermediate institutional level, the training of the Public Health Midwife (PHM) and the relatively manageable area serving 3000-5000. A programme of maternal and child health education and nutritional supplements were also important contributory factors for this success.

In Vidyasagara's assessment:

> The basic corner stone of this system rested on the Public Health Midwife who not only provided services at domiciliary level but also linked the mother and child to the next level of health care namely that provided at health centres and medical institutions. The PHM serves a population within a clearly defined area which comprises the smallest working unit within the health system and is the first point of contact between the health system and the household. Having an intimate knowledge of her area and the families she serves, the PHM, through a systematic scheme of home-visits, provides the necessary domiciliary contact and care to mothers and children. This activity is supported by a system of record keeping that helps her to plan and monitor her activities, as well as report on her performance and the vital events that have occurred in her area, to the Medical Officer of Health. (*Ibid.* 1985: 3-4).

An important factor bearing on the efficacy of the maternal and childcare services is the 18 months intensive training of the midwife comprising one year in a school of nursing and six months of work experience in a health unit working within the community. *(Ibid: loc.cit)*. The PHM in uniform and resident in the local area has had a reputation for a strong commitment to serve the community, which in turn held the PHM in high respect and esteem.

An effective social innovation of the PHC system is the honorary voluntary health worker (VHW) who performs the function of communicating basic health concepts and advice on simple health problems to the family cluster. "Through these links with the health personnel they help to bridge the gap between health personnel and the community". (Vidyasagara 1985a: 3). Typically the VHW in and out and school job seeker in the early twenties, more likely a female with close links in the village and selected by the people and health staff. As to be expected there is a high turnover of VHWs but their informal training is a community investment in health. The VHW has been a significant influence in enhancing public awareness and hygiene and in building community confidence in new community health practices like immunization.

The primary health care programme was strongly supported by several other measures. A school medical service functioned in over one thousand of the schools as early as the 1940s. Free mid-day meals for school children, free milk in some schools, the food ration scheme and subsidies on basic food items introduced during the second world war ensured a certain minimum nutrition at a time when widespread poverty, food shortages and otherwise poor distributional systems would have created severe nutritional deficiencies. The entire Island was served with a network of cooperatives which ensured that at least minimal quantities of essential food was available during the world war period of domestic food shortages and food import disruptions. (Gunatilleke 1985). This system of food subsidies continued till 1979 when a food stamps scheme replaced it. Whatever the implications of this subsidy was for the country's public finances there is no doubt that it ensured a basic minimum nutrition for the poor.

One of the significant achievements of the public health services has been the immunization of around 90 percent of children from Tuberculosis, Polio, Diptheria and Tetanus. In 1962 the oral Polio Vaccination was introduced and in the next year BCG vaccination commenced and achieved quick widespread coverage.

The experience of the immunization programme illustrates both the problems and difficulties of implementing such a programme in a poor country, as well as the ingredients for the success of the programme. The initial efforts at immunization was beset with numerous problems such as inadequate trained personnel, breakdowns in the cold chain and the lack of adequate transport and breakdowns in vaccine supplies. At first, the programme also faced a degree of scepticism and resistance from the people. (Vidyasagara 1985a: 5-6).

In order to overcome these problems an Expanded Programme of Immunization (EPI) was begun in 1978. Supplies of vaccines were ensured and the

immunization facility was made readily available at all medical institutions and Health centres. The ingredients of the success has been described by Vidyasagara as follows:

> The Expanded Programme also created a greater awareness about immunization and increased public acceptance of immunization offered. Needless to say the availability of a strong service infrastructure that can operate without interruption and provide a high quality of service is a *sine qua non* towards improving public acceptance. This has been amply demonstrated in the Sri Lanka Programme, where the strengthening of deficiencies regarding equipment, supplies and vaccine logistics combined with training has contributed in no small measure to enhancing public confidence and acceptance. In addition, the provision of immunization as part of a package of MCH services not only fosters public support and enhances public confidence, but also provides for intensive follow up at the immunization needs of pregnant mothers, infants and preschool children. The latter is made possible at the family level through contact with the PHM who is responsible for the health care of all pregnant mothers, infants and pre-school children within her area. Through a scheme of routine home-visits the PHM is able to register early all pregnant mothers ("Pregnant Mothers' Register") and infants ("Birth and Immunization Register"), thereby ensuring a systematic follow up. This intensive approach has made it possible to achieve a satisfactory coverage of "age appropriate immunization", in keeping with the recommended schedule of immunization. (Vidyasagara 1985: 6).

There has been a deep commitment to the provision of primary, secondary and tertiary education by the state. One of the fundamental reasons for this is the esteemed value attached to learning by the two main communities, the Sinhalese and Tamils. The most significant reasons for the high literacy and high school enrolment were the scheme of free education, the expansion of schools, the adoption of the mother tongue as the media of instruction, increased school enrolment, and the provision of a mid-day meal for children in schools and free text books since 1990.

The main reasons for the achievements in literacy and education have been succinctly summarised by Jayaweera:

> In the decades that followed, particularly till the mid 1960s, education participation rates increased and urban-rural and gender disparities declined to an extent that was unique in South Asia. The major policies that contributed to this situation were the allocation of educational expenditure amounting to over 4% of GNP by the 1960s; provision of an island-wide network of schools, increasing in number from 4537 in 1945 to 9494 in 1971 and to 10,209 in 1988, of which around 95% were co-educational schools by 1971; establishment of Central Schools between 1940 and 1947 chiefly in rural locations to

> extend secondary education facilities to children from the lowest economic strata; provision of an island-wide scheme of scholarships for post-primary education; and the change in the medium of instruction to the mother language in the whole school system by 1959 and in some university courses in the 1960s. (Jayaweera 1991: 14).

The most far reaching educational policy was the introduction of free education in 1945. Free education for primary, secondary and university education was mainly responsible for the increased enrolment of students and accessibility to education irrespective of the financial conditions of parents. This policy, coupled with a continuous expansion in schools, resulted in primary schools being at reasonable distances from the homes of most children and thereby ensuring at least a primary education. The school system was expanded throughout the country from the 1930s. By 1946 nearly 5000 schools had been established. By 1992 the number had reached 10,000. About 97% of children attend these government schools in addition to which there are private schools, mainly in the cities and towns, catering to the remaining 3% of children.

The free education system was further reinforced by several other policies which enabled poor children to participate in education. A free text books scheme has operated for most of the period since the 1950s. A free-mid-day meal operated from the 1950s till 1964 and was again reintroduced in 1990. There is some evidence that school enrolment and school attendance have been greater during periods when a mid-day meal has been provided. In 1991 a free school uniform was also provided. The parental costs for education has been minimal owing to free tuition, the close proximity of schools to most homes, subsidised cost of transport, as well as the provision of free text books and the mid-day meal.

An important policy which had an effect on dispersing quality education even to remote areas was the establishment of Central Schools with boarding facilities in many districts. These Central Schools, which were established in rural areas between 1940-47, were purposely located somewhat away from even rural towns. Through a system of scholarships the brighter students were selected to the Central Schools for their post primary education. (Jayaweera 1991: 23-25). By drawing the brighter and cleverer students in rural schools into these schools, which had better facilities, and by providing them with a quality education, they were able to enter the universities. Many of those presently holding the highest positions in the public service have come from rural areas, being beneficiaries of this scheme of education. However, this scheme deteriorated in the 1970s apparently due to a lesser concern with reducing disparities and providing equality of opportunity for children in disadvantaged areas. In place of this scheme, the government introduced a fifth grade scholarship examination on the basis of which the best students obtain scholarships to enter the bigger National Schools in the country particularly in Colombo. This scheme has had mixed results.

On the one hand, students have no doubt benefited from the better facilities of the national schools and gone on to achieve distinctions in higher education.

On the other hand, research studies have pointed out that many children have found the dislocation from their homes, poor housing and boarding conditions in the vicinity of the school or transport from a long distance to these schools, a traumatic experience and a high rate of drop outs has been noted.

Another significant element of the educational system which contributed to quality education was the denominational schools, mainly Christian, in various parts of the country. The history of these schools go back to over one hundred years. Until 1961 these schools were operated by religious denominations and provided a good educational environment to children of that particular religion and also to others. These denominational schools were however taken over by the government in 1964 when they became either government schools or continued to operate without government assistance. In 1978 the government once again began to pay the salaries of teachers of these schools and reduced their financial burdens. These denominational schools provided a good quality education in many parts of the country.

The high rate of school enrolment in Sri Lanka is not due to compulsory primary education. Although it is generally believed that the country has legislated for compulsory primary education, there is no such legislative provision. The 1939 Education Ordinance provided for enabling legislation to enforce compulsory attendance at school, but such regulations were not implemented. The high rate of school enrolment is due to the value orientation of most people who recognise education as a very important and valued attribute and most parents have been keen on children receiving an education, except in the case of a few communities like the Moors, who have refrained from sending their girls to school.

However, more recently with an increasing incidence of child employment and child prostitution, the need for legislation for compulsory education has become apparent. Despite the high rate of school enrolment a residual small proportion of children, with or without the connivance of parents have been lured away into informal employment or vice.

Another factor which has had an important impact on extending education has been the adoption of the mother tongue as the medium of education in schools. This has had two impacts: one is the equalisation of education throughout the country, and the second is, that it has made children more willing and able to participate in the educational system unlike when the school system operated in the English medium. Though this policy has resulted in the quality of the knowledge of English deteriorating there is little doubt that it has been one of the instruments which encouraged the larger participation rate in education at primary, secondary and tertiary levels.

The educational programme has failed in several ways. One is the enormous disparity that exists in the schools around the country. There are wide differences among districts and within districts, the quality of estate schools is poor and there is a lack of basic facilities in many schools. A large number of

schools are one or two teacher schools. Although general science is compulsory in Grades 6 to 11, only about 5% of schools have science classes at Advanced Level (Grades 12-13). In over half the districts in the country, less than 5% of schools have science facilities. This implies that higher education in science is inaccessible to a very large proportion of students outside the more developed centres. (Jayaweera 1991; 15-17).

The lower expenditure on education in the 1970s and early 1980s, a lesser concern for redressing inequalities in educational opportunities, and deteriorating economic conditions of the poor, appeared to have slowed down if not reversed slightly the attainments in literacy and primary education. In 1991, the UNICEF study, Children and Women in Sri Lanka - A Situation Analysis pointed out:

> Despite the rapid expansion of educational opportunity in the mid-century and the provision of incentives, universal primary education has yet to be achieved in Sri Lanka, contrary to the expectations of the sixties. The eighties appear to have been a lost decade in this respect as large scale surveys have reported a mild reversal in the earlier positive trends in educational participation and literacy." (UNICEF 1991: 85).

This experience is illustrative of the fact that literacy and educational indicators, like other social indicators cannot be presumed to be irreversible. Even if the evidence of a reversal of these indicators is scanty, there is little doubt that the march of progress in educational development has been slowed down. The need to fund education adequately as well as to intervene directly in redressing inequalities of opportunities is quite clear.

The poor wages for teachers have resulted in poor quality teachers and the development of an alternate private tuition system in which the government teachers themselves provide tuition at a fee. Owing to these reasons, the present quality of education is questionable. The educational system has failed to upgrade itself to provide the skills needed for an industrialising society. The system of vocational education too has not met with much success owing to the lack of teachers, appropriate facilities and a perception among parents and children that vocational education is an inferior channel.

The efficacy of each social sector was enhanced by the other welfare policies. Health was improved by food subsidies and free education. Food subsidies played an important role in ensuring minimal nutritional levels of the poor and this in turn contributed significantly to improved health conditions. Similarly improved health conditions would have enhanced educational abilities. The food subsidy and the free mid-day meal contributed to school enrolment and educational attainments. The expansion of primary education and the high rate of literacy improved the awareness for public hygiene, the ability to communicate health instructions, the effectiveness of immunization programmes, the improvement of pre-natal conditions, and the widespread use of maternity hospitals and

midwives at childbirth. The equality of access to education for most women was another important factor in ensuring the success of health programmes.

The poorer health indicators among the immigrant Indian labour and the Muslims, compared with those of other communities, underscore the significant interdependence between, health, education and nutrition. Health indicators were impressive not merely because of the policies in the health sector itself, but owing to the complementary policies in food and education. This is illustrated by the experience of the Indian Tamils and Moors. The lower health indicators of estate labour is partly due to the poor educational facilities and lower literacy among them. Moors, comprising 7% of the population, also have poorer indicators owing to their cultural values not encouraging education among females.

Sri Lanka's social development was quite forcefully influenced by cultural factors. Buddhist religious values which emphasized egalitarianism and the responsibility of a ruler for providing basic needs of food, shelter and medicine may have been significant underlying forces for the political commitment to social development policies. (Abeysekera 1985: 291-92; Bruton 1992: 26). The Buddhist temple was a place of learning from time immemorial and the levels of basic male literacy appears to have been significant even in ancient times. Similarly Buddhist priests practised medicine and though this function has been largely transferred to lay people, the indigenous system of medicine, known as Ayurveda is a part of the social medicine of the country even today and a large proportion of the population resort to it for the treatment of very many ailments.

Therefore, Sri Lanka's social development policy in the 20th century was based on a strong underlying traditional set of values committed to welfarism, a prestigious place for learning and a traditional system of medicine. These were further strengthened by socialist ideologies and by over six decades of intense competitive democratic politics. The high value placed by the Sinhalese and Sri Lankan Tamils on literacy and education and the much lesser gender discriminations among them, compared with the Moors, resulted in a lesser performance in literacy, maternal mortality, infant mortality and higher birth rates among the Moors. This illustrates that a transformation of cultural values is basic to the efficacy of educational and health programmes, particularly for females.

The efficacy of the health and educational programmes was enhanced by the small size of the country. The compact 62,000 square kms. makes most places easily accessible. Persons in the remotest areas, if not reached by the public services, could commute to a nearby location where such services are provided. The compact nature of the country undoubtedly enables, particularly the health programmes, to penetrate into the remotest parts of the country. The efficacy of preventive and curative measures, and, in particular, the Malaria eradication programme, can be attributed to this. In the case of Malaria eradication the disease was epidemic only in the Dry Zone which comprises two-thirds of the country. The ten thousand government schools, which span the country mean

that at least primary schools are available at a relatively short distance form most homes. This fact of compactness also perhaps explains the similar achievements recorded in small countries like Jamaica and Mauritius.

Sri Lanka's experience brings out the conflict between political commitment and economic capacity. It is one thing to be committed to providing welfare services and quite another for an economy to have the capacity to provide the needed resources. The structure of the economy which emerged from colonial rule enabled the government to tap resources from the developed and more productive plantation agriculture to finance the welfare package. The availability of an extractive surplus at an early stage of development enabled the country to expend as much as 8 per cent of GDP on social expenditures in the 1950s. This is particularly so in the initial years when the food subsidy was introduced and health and educational services were provided free. By resorting to a high rate of taxation of the export plantation crops, tea, rubber and coconut, the government was able to find the resources to finance the welfare programmes. When international prices of plantation crops declined in the late 'fifties and 'sixties and the country's balance of payments deteriorated social expenditures became a strain and arguably a constraint on other investment for economic growth. Decreased revenue from export taxes required governments to revise the large expenditure on food subsidies, in particular, and also in health and education. Yet the political context was such that governments were extremely reluctant to curtail these welfare programmes and expenditures. Instead they continued to resort to high levels of taxation, which in fact jeopardized the plantation industry.

Sri Lanka's experience demonstrates that when surpluses generated in a part of the economy are used to support a social programme of the magnitude Sri Lanka adopted it could result in lower growth subsequently. The resultant economic strains lead to the curtailment of the welfare expenditures ultimately. This explains why Sri Lanka's impressive attainments in several indicators upto the "sixties lost some of the momentum and failed to achieve still better indicators in 1980s and 1990s. This is particularly pertinent with respect to achieving an improved quality in educational and health services.

The capacity to pursue broad based social development programmes was facilitated by the lesser demands of other large expenditures, particularly defence. In the initial years and till the 'seventies Sri Lanka had a very low defence budget and debt servicing costs. Revenues, which otherwise may have been spent on them were used to enhance the welfare programme. But since the 'seventies these expenditures have grown and made the financing of the welfare programmes ever so difficult. In 1993 debt servicing absorbed 29 percent of revenue and defence around 12 percent. It is arguable that the vast expenditures on these two items deprive higher resource allocations to health and education.

The slow rate of economic growth and the persistence of poverty and unemployment have created conditions, where despite the improvements in the CDR, CBR, IMR, MMR, literacy and school enrolment, high rates of morbidity

associated with poverty and poor living conditions persist; the quality of health and educational services leaves much to be desired and regional disparities are conspicuous. Consequently further gains in social indicators are tardy. But whether economic growth could have been better with lesser expenditure on welfare is a moot question. More pertinent is the issue whether a better targeted welfare system could have achieved the same measure of social progress, as well as higher rates of economic growth which may have sustained a qualitatively superior educational and health system. These questions of vital significance for social development policies emerge as the issues which must be considered in the evolution of social policy in the next decade.

Overall economic conditions had not only a direct, but an indirect role as well, in social development. When resources were inadequate for the expansion of the educational and health systems, the numbers of professionals and technicians to serve these sectors became inadequate to cope with the growing demands of an increasing population. This was brought about partly by an exodus of doctors and medical personnel who have sought greener pastures when the country's overall economic conditions deteriorated. On the other hand, owing to financial difficulties it was not possible to expand facilities for training an increased number of trained medical personnel. The output of medical personnel from the local institutes has not been able to expand adequately to make up for the loss of such persons through migration. Consequently, notwithstanding the higher health standards achieved by the country, it has one of the lowest doctor to population ratios. In Sri Lanka a doctor serves 7140 persons compared to only 2440 in India and 2940 in Pakistan. The persons per nurse at 1400 has however been the best in South Asia.

At times of difficult economic conditions there has been no conspicuous change in health policy, but capital and recurrent expenditure on health has been curtailment of public expenditure. During 1970's, the deteriorating economic conditions resulted in a curtailment of public expenditure. During 1970-77, a government which was strongly committed to welfarism and socialist policies had to limit resources unwillingly owing to the severe financial stringency. This period also coincided with food shortages and consequent deterioration in nutrition standards and the exodus of medical personnel owing to their deteriorating living standards.

The post 1977 government committed to liberalization and open market policies pursued a package of policies which directly and indirectly affected the public health delivery system adversely. Although at the beginning, the per capita expenditure increased, the severe erosion in the value of money, the high cost of drugs, the commitment of large expenditures for capital budgets in health, and the greater emphasis on sophisticated medical equipment, resulted in the deterioration of primary health facilities. The shift in policies to encourage private practice of government medical personnel as a device of preventing the brain drain has had an adverse effect on services in government hospitals.

Economic performance has influenced social development policies since 1977 by the adoption of the IMF's Structural Adjustment Programme. The slow growth of the economy and the severe balance of payments difficulties made it necessary for the country to embark on a Structural Adjustment Programme in 1977. These policies resulted in conditionalities being imposed by the multilateral agencies to curtail the welfare expenditure in order to divert resources for investment and growth. The impact of the structural adjustment policies since 1977 has not only led to a curtailment of the overall expenditures, but by changing the price structures by the removal of administered pricing and the depreciation of the currency, the price of food, drugs and medical supplies increased significantly. With their incomes not rising as fast as prices, there has been an erosion in the ability of the poorer sections of the people to obtain their basic needs. (UNICEF 1985).

The general thrust of economic policies since 1977 has also resulted in the well to do sections of the population shifting their demand for health and educational services from the public service to the private sector. The deteriorating quality of public health and education has made the affluent sections of the population to rely more and more on private hospitals, fee based medical consultants' services, private schools and private tuition. This shift away from public health and educational services may resolve the problem of the affluent, but to the extent of their opting out of the public health and educational services, an important and influential body of opinion would be less concerned about the nature and quality of these services. This could affect the standards of health and educational services available to the bulk of the population.

Although the government continues to be committed to the provision of health cares, the general thrust of policies pursued by the government has had an effect of depriving the poorer sections of the people of adequate medical facilities. The main impact has been on the quality of services though some of the health indicators have reflected these conditions.

The health service has also been weakened by the dual system of a free medical service and private practice. Alailima observed that:

> "Permitting two systems to function simultaneously within the health service-one with a profit motive and the other with a service objective has led to preferential access and utilization of government facilities by the former. Other categories of health workers in the curative services want the same privilege of private practice and an unofficial system of "fee-levying" came into being whereby patients had to pay individual hospital staff to obtain services which the state was providing free. Pilfering of drugs and consumables also became widespread, leading to recurrent shortages of essential items." (Alailima 1985: 32).

The morale and motivation of health staff outside the curative services and those of paramedical cadres have also been affected by the lure of more lucrative

jobs abroad and the cadres of laboratory technicians, radiographers, pharmacists and midwives remain vacant. As Alailima pointed out:

> "Weaknesses in management and supervision within the health services, aggravated by the exodus of medical and paramedical manpower and the introduction of private practice within the context of a restriction of recurrent expenditure, has led to a deterioration in the quality of the health services. The preventive services have been particularly affected, ironically, at a time when there is increasing publicity on the need for primary health care and growing support for the provision of such services by donors." (Alailima 1985: 32).

Despite impressive achievements in health indicators especially in the 'forties and 'fifties, the slow growth of the economy in the 'sixties and most of the 'seventies resulted in the unsustainability of the free medical services at levels which would have pushed Sri Lanka's health to even better levels of achievement. The financial stringency, the shift away from welfarism since 1977 the deterioration in morale and the exodus of medical personnel have resulted in a poor quality of public health services. Both political accountability and administrative accountability, which were good in the mid sixties, appear to have deteriorated since then.

Since 1973, and particularly since 1981/82, the highest decile of income receivers received an increased share of incomes, while the lowest deciles have decreased their proportion of income. In 1985/86, the latest year for which data are available, the top most decile obtained 39 percent of incomes, while the bottom 40 percent received only 11 percent. There are indications that these trends, which are consistent with Kuznets curve, have accentuated further. (Kelegama 1993).

An interesting parallel paradoxical development in the morbidity pattern is its bi-polar distribution of increased illnesses associated with high incomes and stress conditions, together with a simultaneous increase in morbidity conditions associated with low incomes and poor nutrition. This bi-polar modality is consistent with recent developments of income distribution, removal of food subsidies, high cost of basic food, and a continued high rate of unemployment.

This experience provides several insights. The development process based on market-forces could bring out a phenomenon of a small proportion of the population with high incomes being subject to a morbidity pattern similar to high income societies. Yet the gamut of economic policies which generate this development process, could leave behind a section of the population whose basic needs are inadequately met. This could result in the persistence of illnesses associated with poverty, malnutrition and poor hygienic conditions of living. These developments have important policy implications for health policy. There would be a tendency for health expenditures to be directed to higher cost technologies to meet the needs of the affluent minority and thereby resulting in the lesser availability of funds for the prevention and treatment of the common ailments.

Conclusions

While Sri Lanka succeeded in attaining good basic social indicators early, the slow rate of economic growth did not enable her to achieve better health and educational standards in recent years. Sri Lanka's experience illustrates, on the one hand, the possibility of improving basic literacy and education and achieving low mortality figures with relatively low incomes given a priority for these, and on the other hand, it demonstrates the difficulty of providing better quality health and education with low per capita incomes.

Although social development has a self sustaining capacity, reversals are not impossible. The initial attainments of Sri Lankan education in particular was itself an important factor in inducing subsequent improvements. Literate and educated parents are the best launching pad for a more educated, as well as for a healthier, next generation. While this has happened during most of the country's post-independent period, there is evidence that there is some slippage in recent years. Having attained a literacy level of 87 percent in 1981, more recent sample survey data disclose literacy rates still below 90 percent. Similarly there is some evidence that nutritional levels among the poorest have deteriorated. The reasons for this possible retrogressions are the economic difficulties of the poorest sections amidst overall economic growth, the reduction or withdrawal of subsidies, neglect of institutions catering to the poorer sections and in remote areas, and the deterioration in the quality of services, partly due to inadequate funding. Illustrative of these setbacks are the deterioration of the central School systems, inadequate funding and personnel for small schools, the withdrawal of the food subsidy, rising real costs of basic needs and inadequate facilities in government hospitals, particularly the shortage of drugs.

A political commitment to social development, the availability of resources for the development of health and education infrastructure throughout the country and the interaction of the different sectoral programmes account for the initial successes in social indicators. Changed economic conditions and the extensive welfare package have in recent years cast shadows on the sustainability of the attainments. Inadequate economic growth appears to be the biggest stumbling block to Sri Lanka's achievement of still higher health and educational attainments.

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