NEW TRENDS IN THE HEALTH SERVICES

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From the very inception the Health Services was carried out as a welfare service in Sri Lanka. Hence, little attention was paid to its economic criteria. From an economic point of view, Health Services are planned in order to satisfy certain consumer requirements and therefore has a demand like all other commodities. If there is a demand and a supply for goods or services then there is a market for them and the prices are decided by a market process. Similarly, the marketable price and the supply position (quantity) of the Health Services are decided through a market process.

But, there is a clear distinction between the other economic commodities and the Health Services. This is due to the fact that the Health Services has characteristics of common goods or social commodities. Therefore, it has been accepted that, they should be planned and implemented as a state service for the community. Often benefits of the Health Service is not limited to a direct beneficiary, particularly, the benefits of the preventive services (eg. prevention of infectious diseases such as Malaria, Filaria, supply of clean drinking water, immunization programmes etc.) are directed at the entire society. Due to such special characteristics, and also because human worth cannot be priced it has been accepted, that planning of the Health Services should be undertaken by the state and the Local Government Institutes and that they should never be governmed by the market trends. The Health Services has been rationalized by the government. It was due to such reasons that the planning of Health Services was a state monopoly and for several decades the capacity, content and the distribution of the Health Services was based on its technical requirements. Therefore, the traditional method was to determine the physical and manpower resources required to provide for hospitals and beds, doctors and allied medical staff. Family Health nurses and Health Inspectors according to the content and concentration of the population and incur Government expenditure accordingly. For an example, one family Health nurse has been appointed for each 3000 persons. But, as pointed out earlier like all other commodities and services there is a demand and a supply for Health Services. It has been argued that allocation and distribution of resources according to technical requirements and population trends may lead to disorganized and inefficient use of resources. The current argument is that, allocation of resources for the Health Services should be based as an economic criteria such as the theory of demand and supply. But this does not mean in any way, that the Health Services should be totally governed by market trends. It only means that, the theory of demand and supply should be entered in to the planning process in order to device a logical and efficient distribution and use of economic resources. The problems emerging in the world economy and the economic and monitary constraints faced by relevant Governments has intensified the need to adopt a new approach towards the Health Services. International Lending Agencies have pointed out to the need for National Governments to explore the possibility of finding alternative ways and means with regard to logical planning of resources for the health and other services.

Planning of Health Service is two fold. (i) Clinical Service and (ii) Preventive Service.

The objective of the Preventive Service is the prevention of diseases while clinical service is aimed at cure of diseases.

As mentioned earlier, the distinct characteristic of the Health, Services which is that its benefits cannot be limited [1] to one person is more pronounced with regard to the clinical services, while the benefits of the clinical service may be united to just one patient from time to time International Agencies have stressed that attention should be accorded to both these services in order to make the welfare concept more meaningful Consequently during the past decades there has been an increase in the state expenditure with regard to Preventive Services. This new trend is clearly reflected in the expenditure patterns of the Ministry of Health. During 1977, 20% of its expenditure was incurred for Preventive Services while it show an increase of 30% at present. This is a common feature of the most countries belonging to the developing world.

One may question whether the Government has accorded low priority for clinical services by directing its expenditure or Precentive Programmes. In planning clinical services (in accordance with the general virtue that such services should be supplied) one should take into account the possible demand patterns of the beneficiaries of the programme. From an economic point of view, the demand for the clinical service is determined by possibility of contracting diseases by people and further on the economic capacity of the people. With regard to obtaining treatment for the same illness a person belonging to the higher income level may incur a higher expenditure than a persons belonging to the lower income level. Hence a common clinical service which does not pay attention to the capacity and aspirations of the people may lead to situation where the Health Service is placed outside the natural demand trend. It has been argued that peoples demand patterns should also be taken in to consideration when arriving at decisions with regard to Health Services. Clinical Services should be based on people expectations and their capacities.

This does not mean the distruption of clincial services, but to explore the possibility of planning them on a more logical basis. It is based on the argument that the benefits of the programme can be best realised when such welfare services are provided to those who actually deserve them. A practical characteristic of this new trend is the privalisation of

1. When consuming such comodities, they by their nature does not limit the benefits for individual welfare.

Clinical Services and and introduction of a Health Insurance Scheme. On the other hand International lending Agencies have repeatedly emphasised the need to introduce a new system where the partients pay for the clinical services according to their income.

The Health Service of many developing countries have been subject to reorganisation. In recent years, the African countries particularly Ghana has implemented a scheme and a fee is levied with regard to the Health Services. In Simbabwe a fee inlevied from the patients according to their income. However,in Si Lanka the current experiences relating to the Health Service can be examined in a manner that fits in to this general structure. However, the possibility of reorganising the Health Service may be particularly difficult in a country which has traditionally persued state health service for many years. But, there is a particular development with regard to privalisation and health insurance systems in Sri Lanka. In addition to the above reasons, the socio-economic chariges of the past decade have influenced the privalisation to the avove reasons, the socio-economic changes of the past decade have influenced the privalization of the clinical service. Generation and the distribution of income as a result of the Governments free economic policies have contributed towards increasing the demand for health services and the approval given for the Government doctors to carry out private practice was a complementary action. The network of hospitals show a steady growth during the past few years. On the other hand, Government and non Governmental Institutes have launched a Health Insurance Scheme for their employees. This new development is clearly seen when one examines the number of patients who seek treatment from Government hospitals. The number of out patients who showed an annual increase of 2% during 1972-78 have declined by 1% per year after 1979. However the internal patients have shown a 2% annual incease during this period.

TABLE A 2 **HEALTH EXPENDITURE BY TYPE AND SOURCE, SRI LANKA 1978-87**

Item	Year 1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
1. Modern Health Care Services										
Government	589.0	736.1	861.3	931.2	1273.6	1989.7	1789.5	1966.3	2159.2	3606.7
Private	318.0	364.0	466.0	508.0	670 0	898.4	1204.6	1615.2	2165.8	2904.0
TOTAL	907.0	1100.1	1327.3	1439.2	1943.6	2888.1	2994.1	3581.5	4325.0	6510.7
2. Indigenous Health Care Services										
Government	14.1	16.4	22.7.	22.5	28.9	34.4	50.2	63.6	78.7	104.4
Private	90.0	106.0	125.0	143.0	162.0	186.3	214.2	246.4	283.3	325.8
TOTAL	104.1	122.4	147:7	165.5	190.9	220.7	264.4	310.0	362.0	430.2
3. Other										
Ceremonial & other	38.0	43.0	55.0	66.0	78,0	95.1	116.0	141.5	172.5	210.4
4. Total Health Expenditure										
1. Government:										
(a) Percentage	57.5	59.5	57.8	57.1	58.9	63.2	54.5	50.3	46.1	51.9
(b) at current prices	603.1	752.5	884.0	953.7	1302.5	2024.1	1839.7	2029.9	2237.9	3711.1
(c) at constant prices (1982=100)	603.1	649.4	645.3	578.6	717.4	971.2	751.7	823.4	860.2	1336.0
(d) Per Capita (Rs.)	42.5	52.0	59.9	63.5	85.7	131.3	117.9	128.2	138.9	226.8
(e) Per Capita (real) [Rs.]	42.5	44.9	43.8	38.5	47.2	63.0	48.2	52.0	53.4	81.7
2. Private:										
(a) Percentage	42.5	40.5	42.2	42.9	41.1	36.8	45.5	49.7	53.9	48.1
(b) at current prices	446.0	513.0	646.0	717.0	910.0	1179.8	1534.8	2003.1	2621.6	3440.2
(c) at constant prices (1982=100)	446.0	442.7	471.6	435.0	501.2	566.1	627.1	812.5	1007.7	1238.5
(d) Per Capita [Rs.]	31.4	35.5	43.8	47.8	59.9	76.5	98.4	126.5	162.7	210.3
(e) Per Capita (real) [Rs.]	31.4	30.6	32.0	29.0	33.0	36.7	40.2	51.3	62.5	75.7
3. Total (4.1+4.2):										
(a) at current prices	1049.1	1265.5	1530.0	1670.7	2212.5	3203.9	3374.5	4033.0	4859.5	7151.3
(b) at constant prices (1982=100)	1049.1	1092.2	1116.9	1013.7	1218.7	1537.2	1378.9	1635.8	1867.9	2574.5
(c) Per Capita [Rs.]	73.9	87.5	103.7	111.3	145.6	207.8	216.3	254.7	301.5	437.1
(d) Per Capita (real) [Rs.]	73.9	75.5	75.7	67.5	80.2	99.7	88.4	103.3	115.9	157.4
5. Govt. Health Exp. as a % of Total Govt. Expenditure	3.2	3.5	2.9	3.1	3.4	4.3	3.4	3.1	3.2	5.1
6. Govt. Health Exp. as a % of GDP	1.5	1.5	1.4	1.2	1.4	1.8	1.3	1.4	1.4	2.1
7. Total Private Health Exp. as a % of GDP	1.1	1.0	1.0	0.9	1.0	1.0	1.1	1.4	1.6	1.9
8. Total Health Exp. as a % of GNP	2.5	2.6	2.5	2.2	2.4	2.9	2.5	2.8	3.0	4.1

Sources: Government Expenditure - (1) Annual Health Bulletin, Medical Statistics Division, Ministry of Health, (2) Annual Report, Central Bank of Sri Lanka, and (3) Budget Estimates,Government of Sri Lanka.
Private Expenditure - for 1978-82- Health Sector Resource Flows, Alaiima, P. (1984)
for 1983-87 - estimated from (1) Consumer finance and Socio Economic Survey 1981/82, Central Bank of Sri Lanka (1984) and (2) Health Sector Resource Flows, Attanayake & Silva-(1987)

Notes: 1. (a) In estimating private expenditure on MHCS for 1983-87, Health Sector Resource Fows (Attanayake & Silva-1987) was used to estimate the terminal year (1987) figure. Initial year figure was estimated from Consumer Finance & Socio Economic Survey 1981/82 (Central Bank of Sri Lanka) and intermediate year figures here intrapolated. As the former source confines to a particular district, the aggregates may be upward bias. However, once the report of the CFS 1987/88 is available, these figures can be reestimated with more precision.(b) In estimating private expenditure on indigenous health care services and other health care services for 1988/87, extrapolation was done based on the figures pertaining to past five years (i.e. 1978-82). (c) The procedure adopted to estimate private expenditure on MHCS is based on the assumption that the growth rate pertaining to this expenditure category significantly increased in early 80's. The procedure adopted to estimate private expenditure on other health care services is based on the assumption that the growth rates pertaining to this expenditure category remained the same through out the period concerned.

2. Implicit GNP deflator in the Central Bank Annual Report was used to estimate real expenditure.
3. Government expenditure includes expenditures of Ministry of Health, Ministry of Teaching Hospitals and Ministry of Indigenous Medicine. Expensditures on health care services by local government bodies (including District Development Councils) are not included.