The Role of Sri Lanka's Health System in Reaching the Poor

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DFID China – Sri Lanka Maternal Health Study Tour 2006

Outline

- Background
  - Sri Lanka and China comparison
  - Pro-poor achievements
- Sri Lanka's health system
  - History
  - Key features
- How does Sri Lanka's system work?
  - Health policy
  - Health care use patterns
  - Lessons

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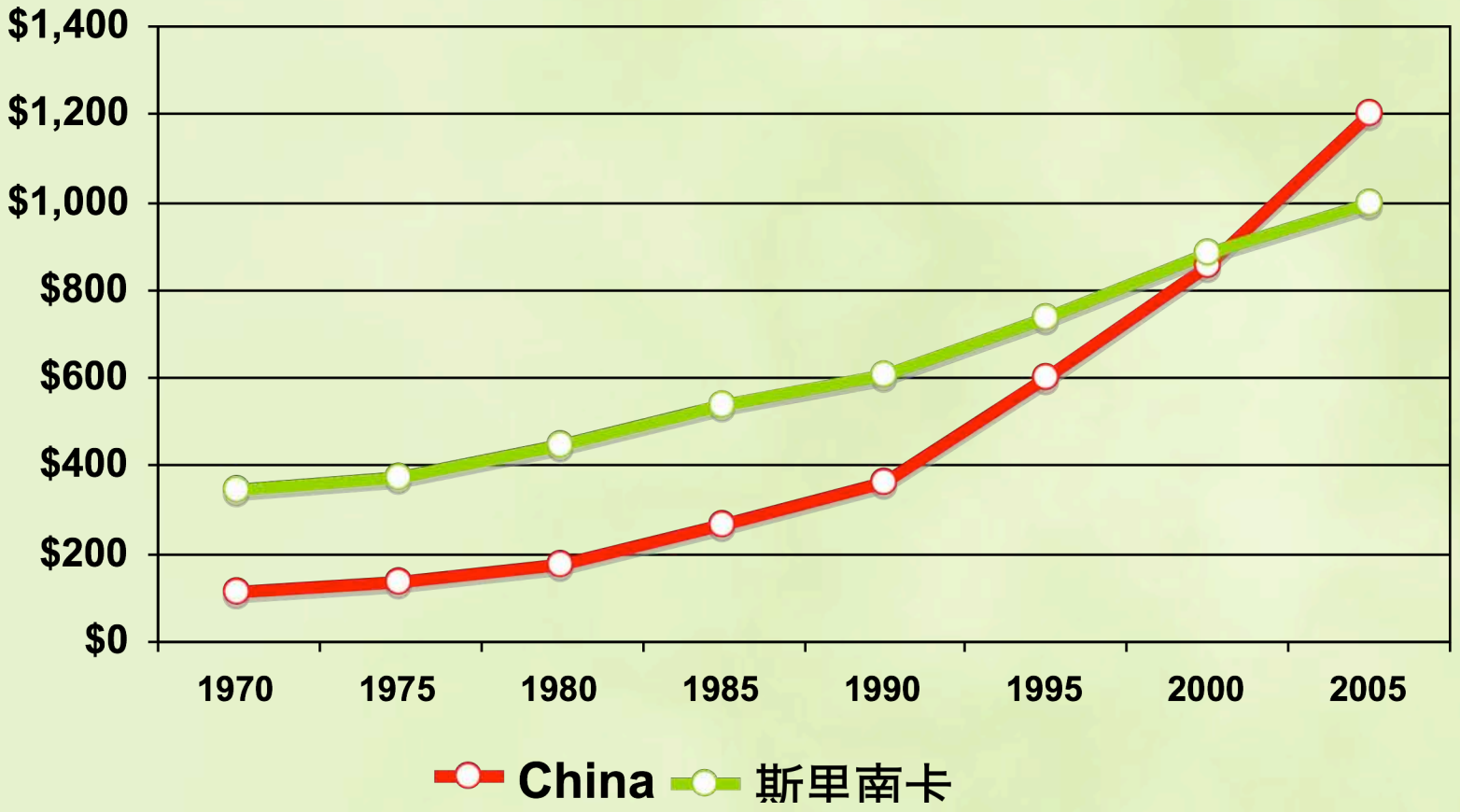
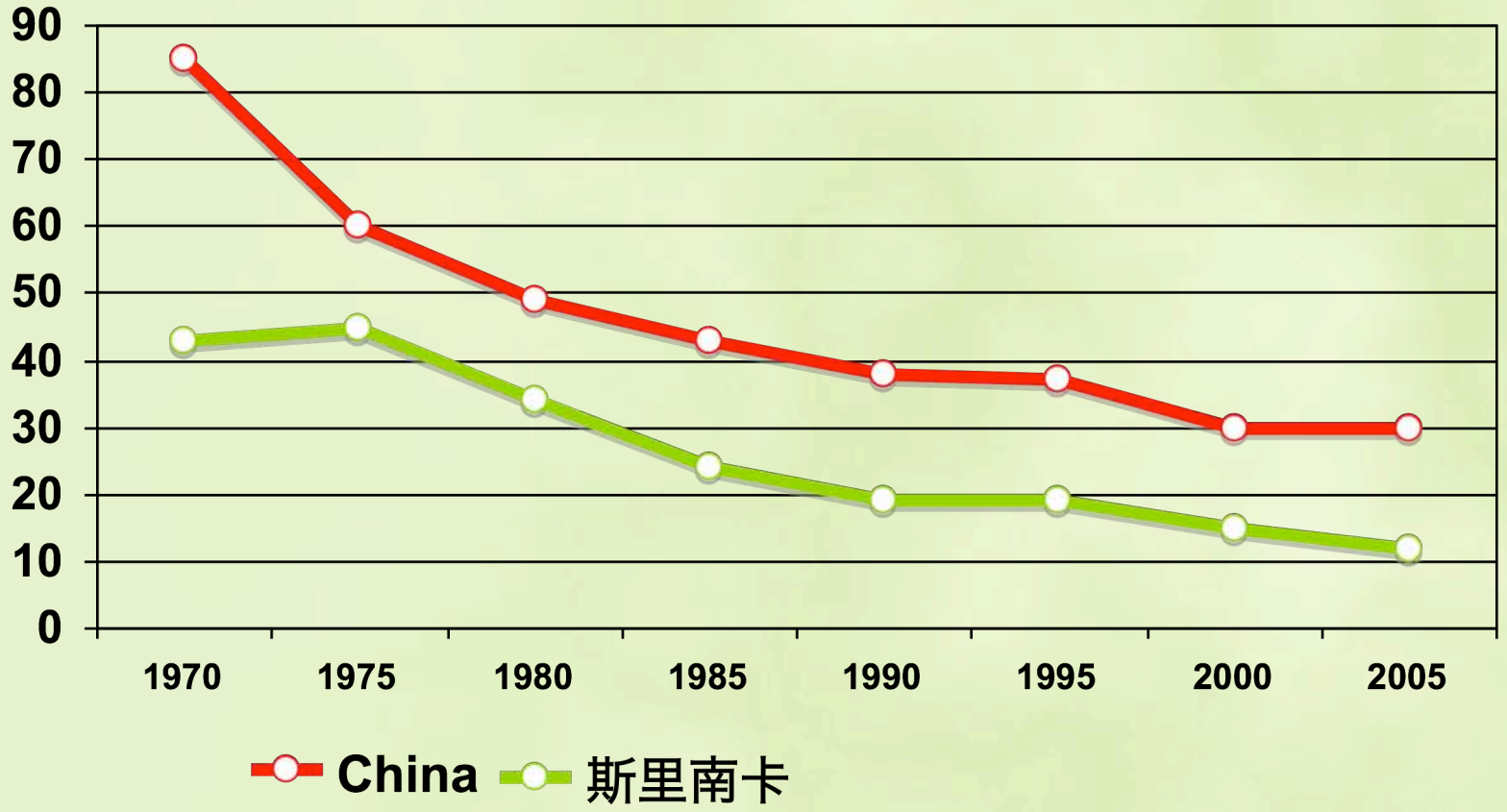
Background

	China	斯里南卡
Income per capita (US$ per capita)	$1,200	$1,000
Rural population (%)	64%	78%
Literacy (%)	91%	91%

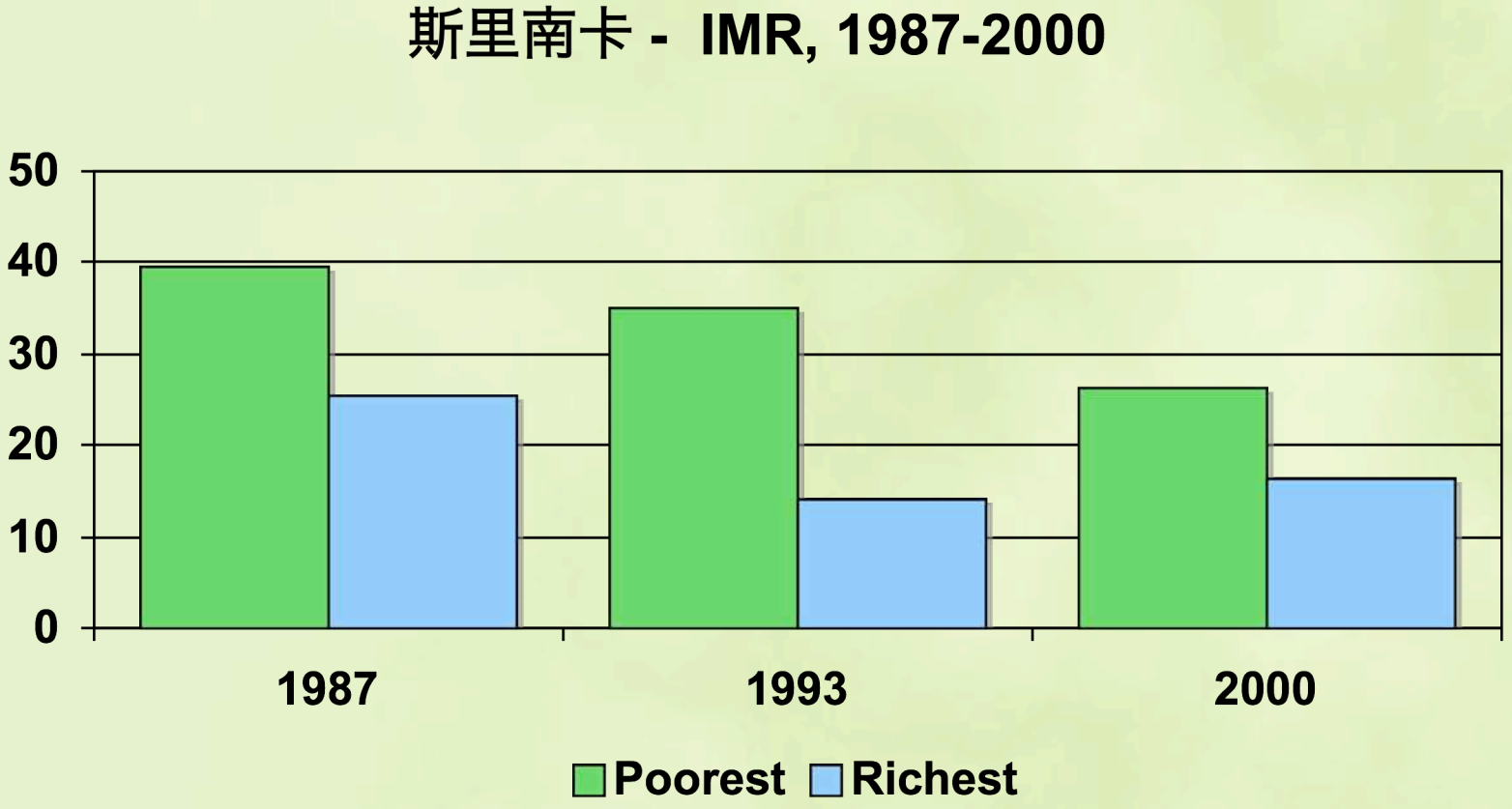
Economic growth



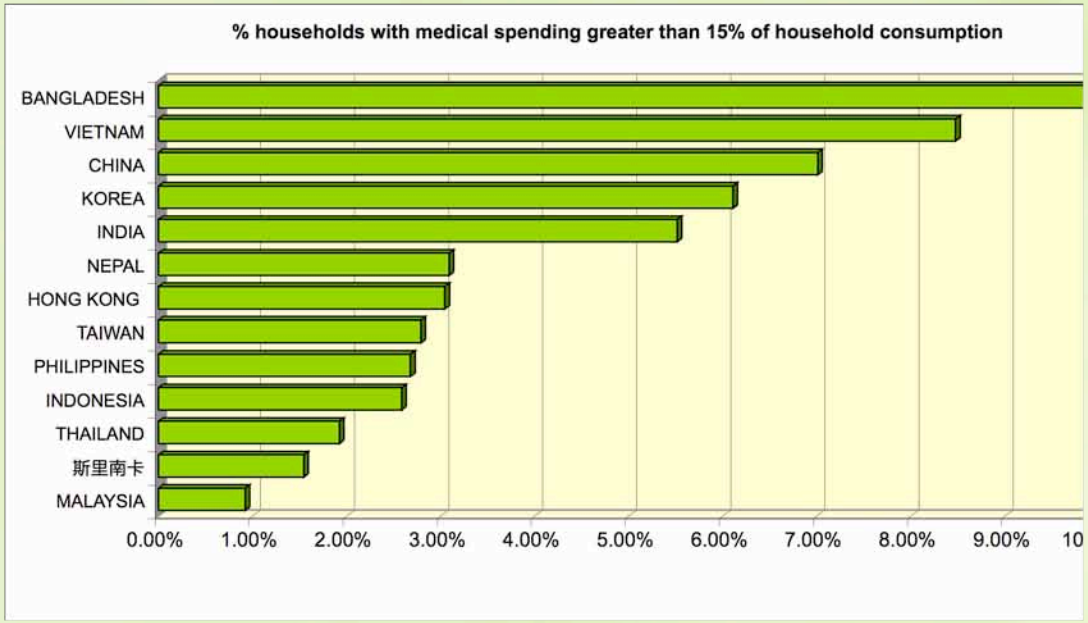
Infant mortality rates



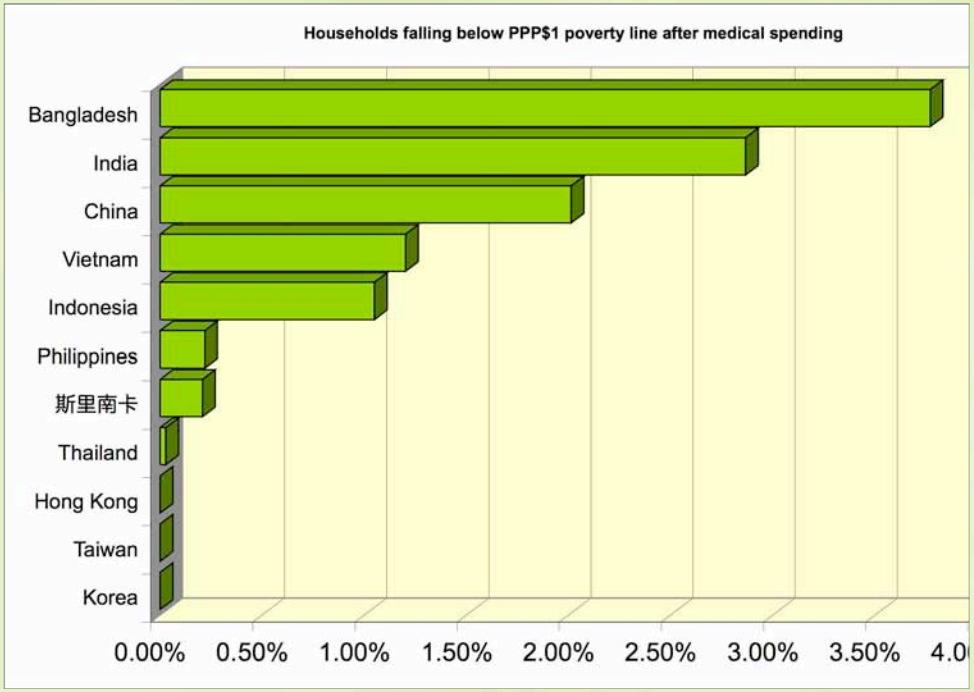
Reductions in mortality



Catastrophic impact



Poverty impact



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History

- 1926 First health unit
  - But health services concentrated in towns
- 1930s
  - Self-rule, democracy (1931)
  - Great Malaria Epidemic (1934-5)
    - -> A problem of rural suffering and poverty
  - Expansion of rural public hospital infrastructure
- 1950s
  - Abolition of user fees in government hospitals
  - Decentralisation
- 1980s - 2005
  - Encouragement of private sector

Key features of Sri Lanka health system

- Objectives of health sector are (1) to improve health and (2) prevent poverty
- Government pays for most inpatient care
- Dual system
  - Public sector hospitals and preventive services
    - Free of charge, no user fees
  - Private sector doctors and hospitals
    - Not free - patients pay fees
- Government doctors can work in private practice
    - Do not charge fees in public sector, but can do private practice outside government hospitals

Dual system

	Public	Private
Expenditure	45%	55%
Financing	National budget	User fees
Preventive care	95%	5%
Outpatient care	50%	50%
Inpatient care	97%	3%
Beds	55,000	2,500
Location	All areas	Mostly urban

Taxation versus social insurance

- Original financing was taxation
  - Social insurance considered many times
- Reasons for not changing
  - Main reason for insurance is to pay for expensive health care - In Sri Lanka this is provided by free hospital system
  - Only small formal sector - rural farmers cannot pay for insurance - only central taxation can finance services for rural people, poor
  - Taxation allows government to transfer money from wealthy and urban areas to poor and rural areas
  - Difficult to design payment system

User fees

- **<1951**
  - User fees charged in government hospitals with means-tested exemption
  - Fees ~5% of hospital budgets
  - Difficult to identify rich and poor
- **1971-1977**
  - Small user fees introduced
    - Poor people discouraged from visiting government hospitals
- **>1978**
  - Still difficult to identify rich and poor
  - To protect poor, user fees abolished
  - …But rich can voluntarily choose to pay for private care
  - Private financing: 35% -> 55% of total

Private practice by government doctors

- First introduced in 1850s
  - Problem: How to pay for government doctors when government cannot afford
- Benefits
  - Doctors can supplement low wages, but don't leave public sector
  - Poor people can still see the doctors in public clinics for free, and rich people can pay to see them outside
- Problems
  - Doctors can break rules - needs strict enforcement

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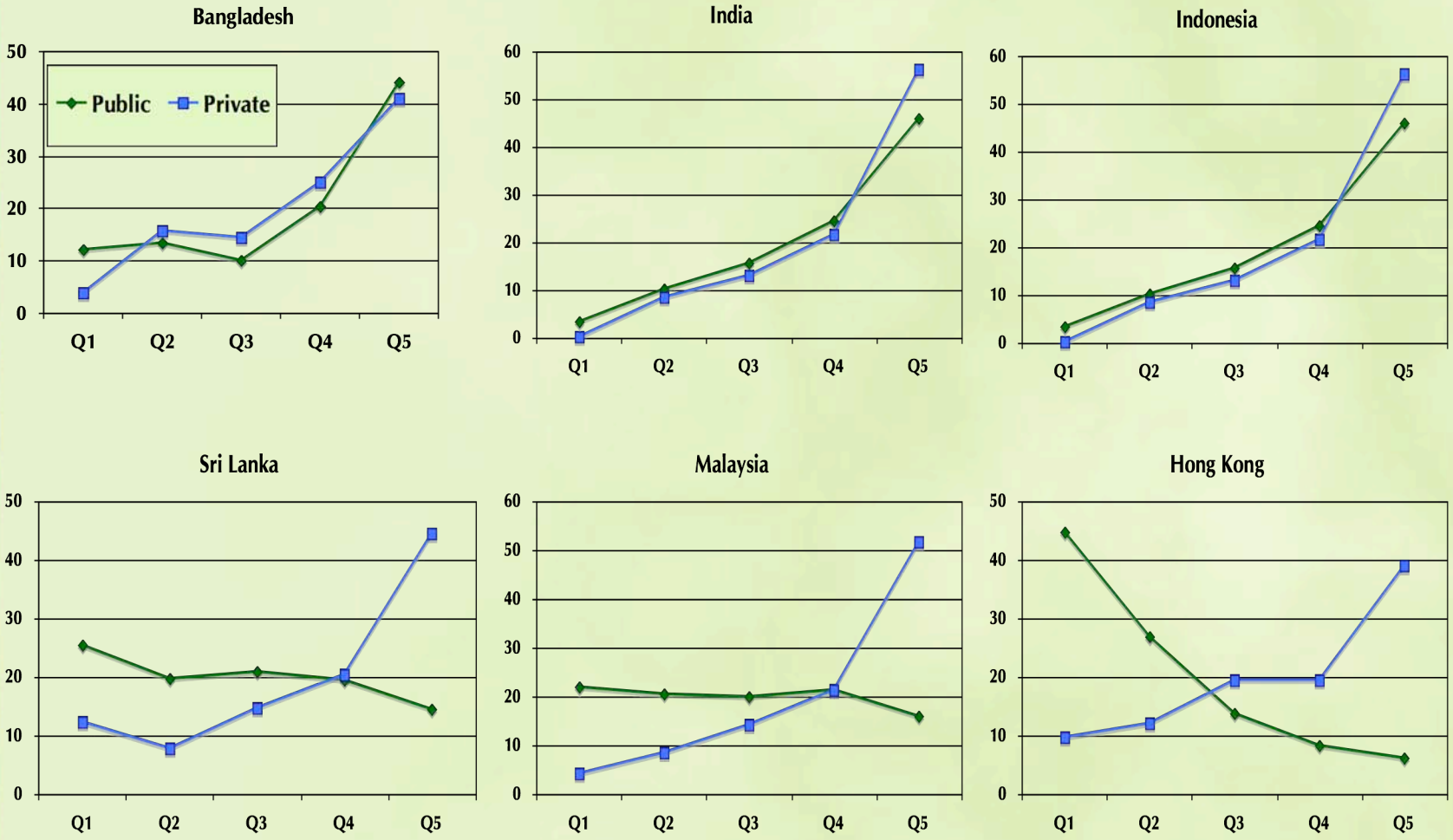
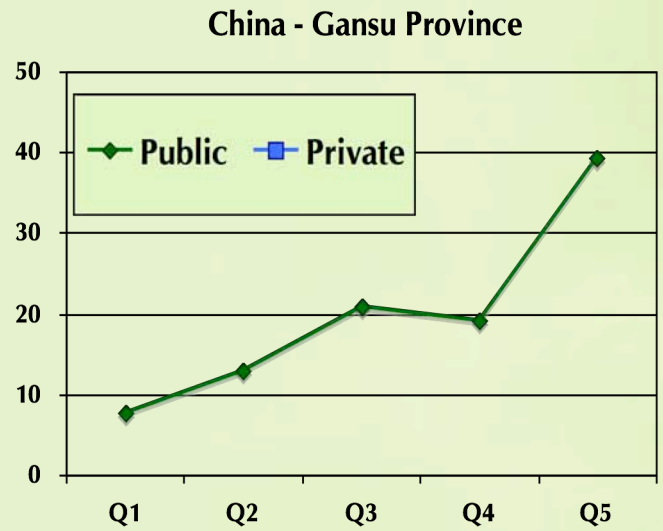
Making Sri Lanka public hospitals accessible to the poor

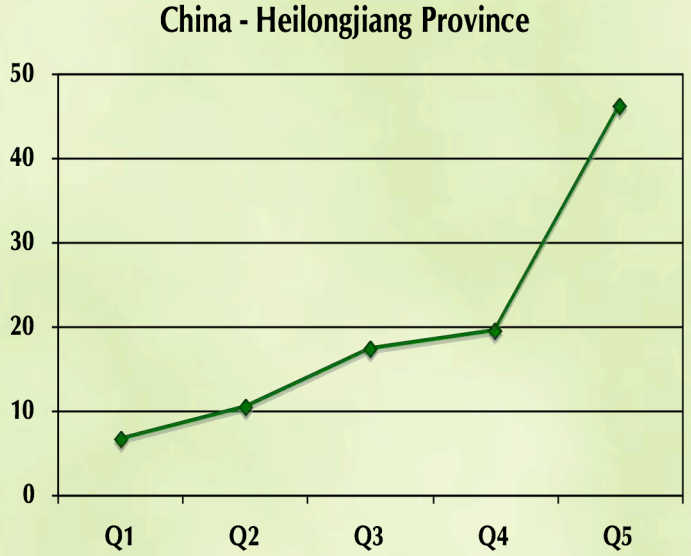
- Zero user fees
  - Patients may have to buy drugs, but poor are often protected
- High density of facilities in rural areas
  - Health facility within 2 km of most villages
- Rural facilities are staffed by qualified doctors supported by nurses
- Accessible tertiary care
  - Large budgetary allocation to secondary hospital care - poor patients entitled to “expensive” care
- Affordability to government
  - Hospitals are low technology, crowded

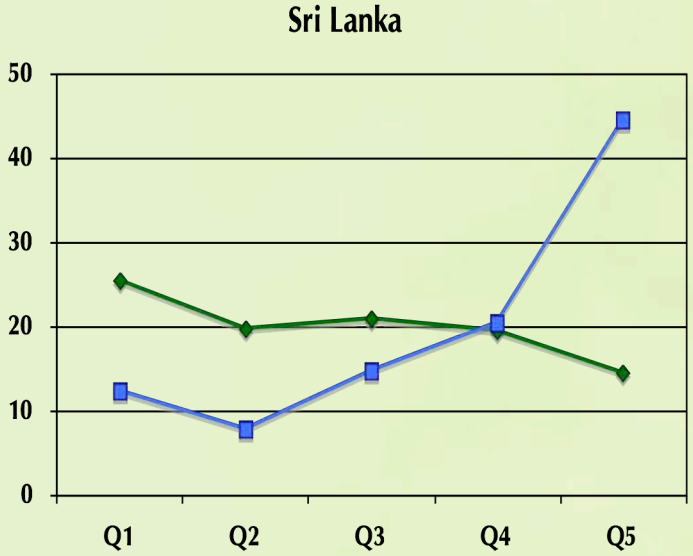
Distribution of use of public and private inpatient care by quintiles in Asia

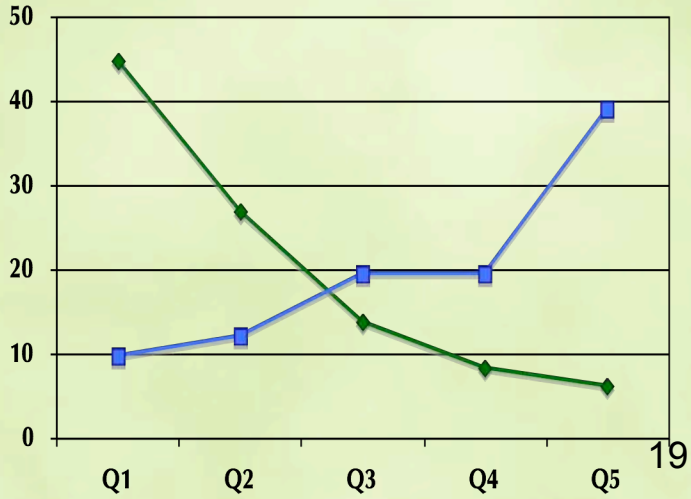


Public inpatient use in China, Sri Lanka





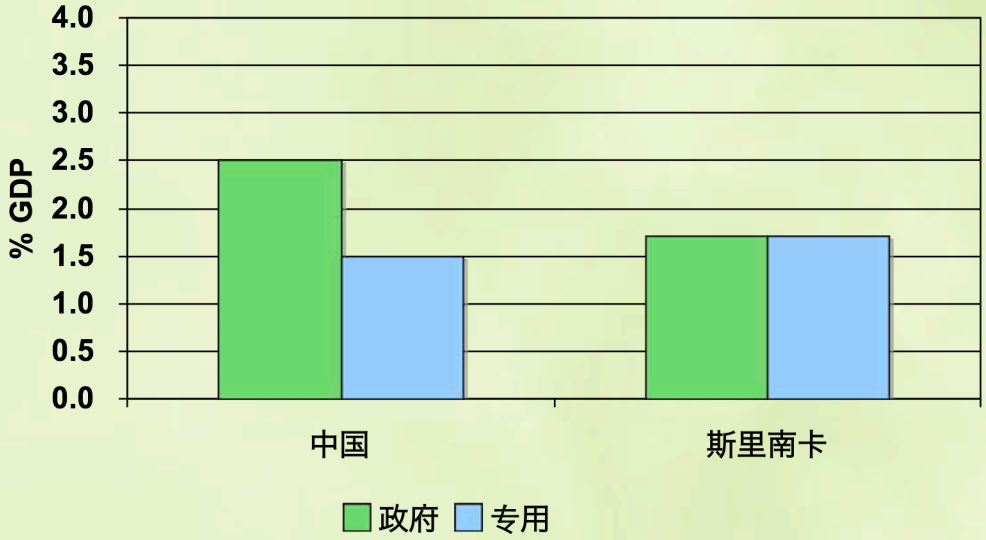




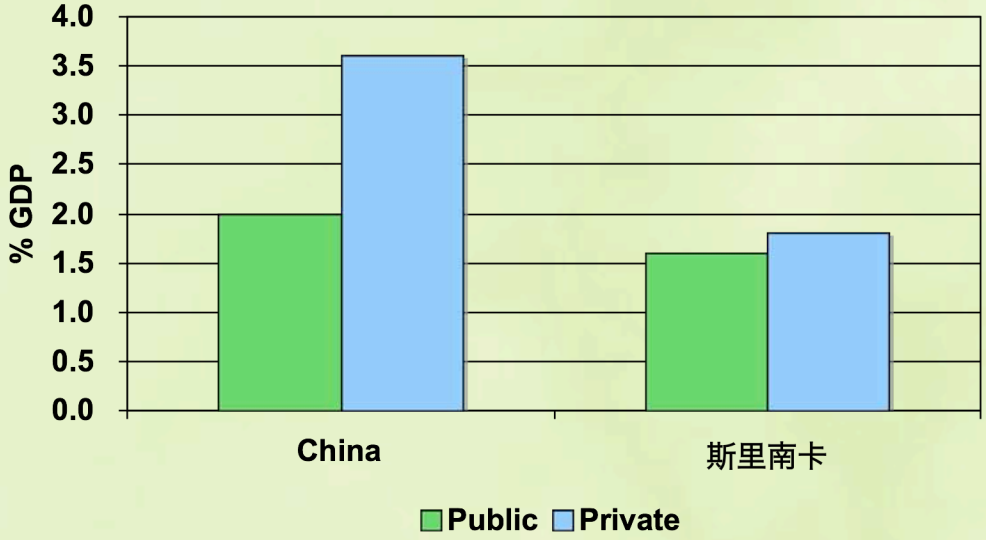
Adapting to a market economy

- 1977-78
  - Introduction of free market economy
  - Growth in private sector, privatisation
- Health services
  - Public sector not privatised
    - Hospitals remained government owned, and funded from government budget - user fees removed
  - Private sector
    - Encouraged for those who can afford it
    - Government doctors allowed to supplement salaries by working in private sector - mostly in outpatient clinics
    - Growth of private sector allows government to target spending for poor

Is it affordable?



1990



2003

General Lessons

- To reach the poor, government must finance services for them
- Accessibility requires removing user fees, and easy physical access
- Rich people are willing to pay for more luxury care - difficult to provide this in public facilities without undermining access of poor -> Use private sector
- Easier to control costs through global budgets
- Market economy = public financing of health care