Extending access to health care: The Sri Lankan experience

UNESCAP Asia-Pacific Regional Meeting on

"Promoting sustainable social protection strategies to improve access to health care"

Bangkok, Thailand: 23-25 July 2008

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Outline

- Sri Lanka's performance in perspective
- Evolution of the Sri Lankan system
- Resource mobilization experiences
- Key message 1 - Importance of efficiency gains
- Key message 2 - Sri Lanka (and others) as distinct model of government healthcare delivery

The two approaches that have worked in expanding access to poor

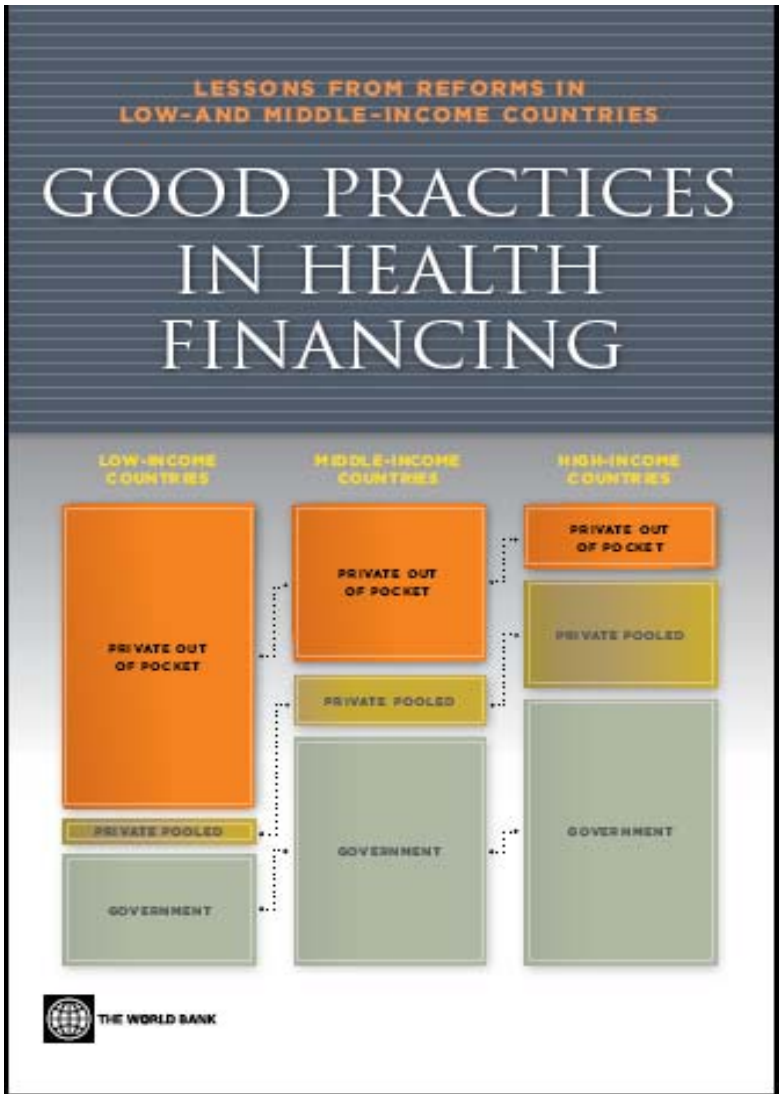
1. **Tax-funded, integrated health services *with* parallel, voluntary private provision**
   - Only approach that has worked at all levels of per capita GDP
   - Difficult to get right
   - Sri Lanka, Malaysia, Samoa, Hong Kong (China)

2. **Social health insurance *with* general revenue subsidies**
   - Worked only in middle and high income countries
   - Requires sustained government commitment and capacity
   - Japan, Korea, Taiwan (China), Thailand, Mongolia

UNESCAP 2007, ILO 2008

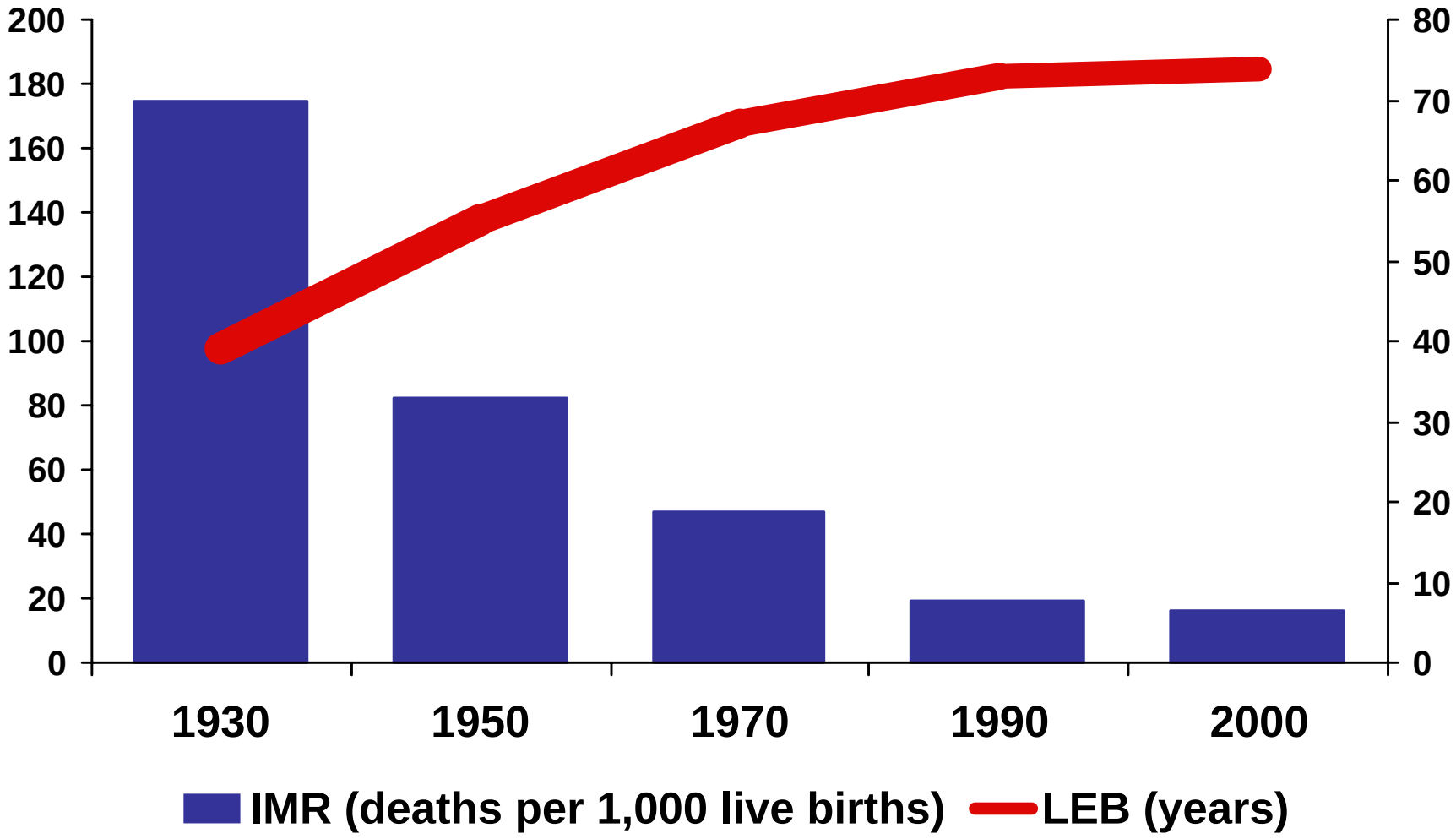
Good Practices in Health Financing

World Bank (2008)

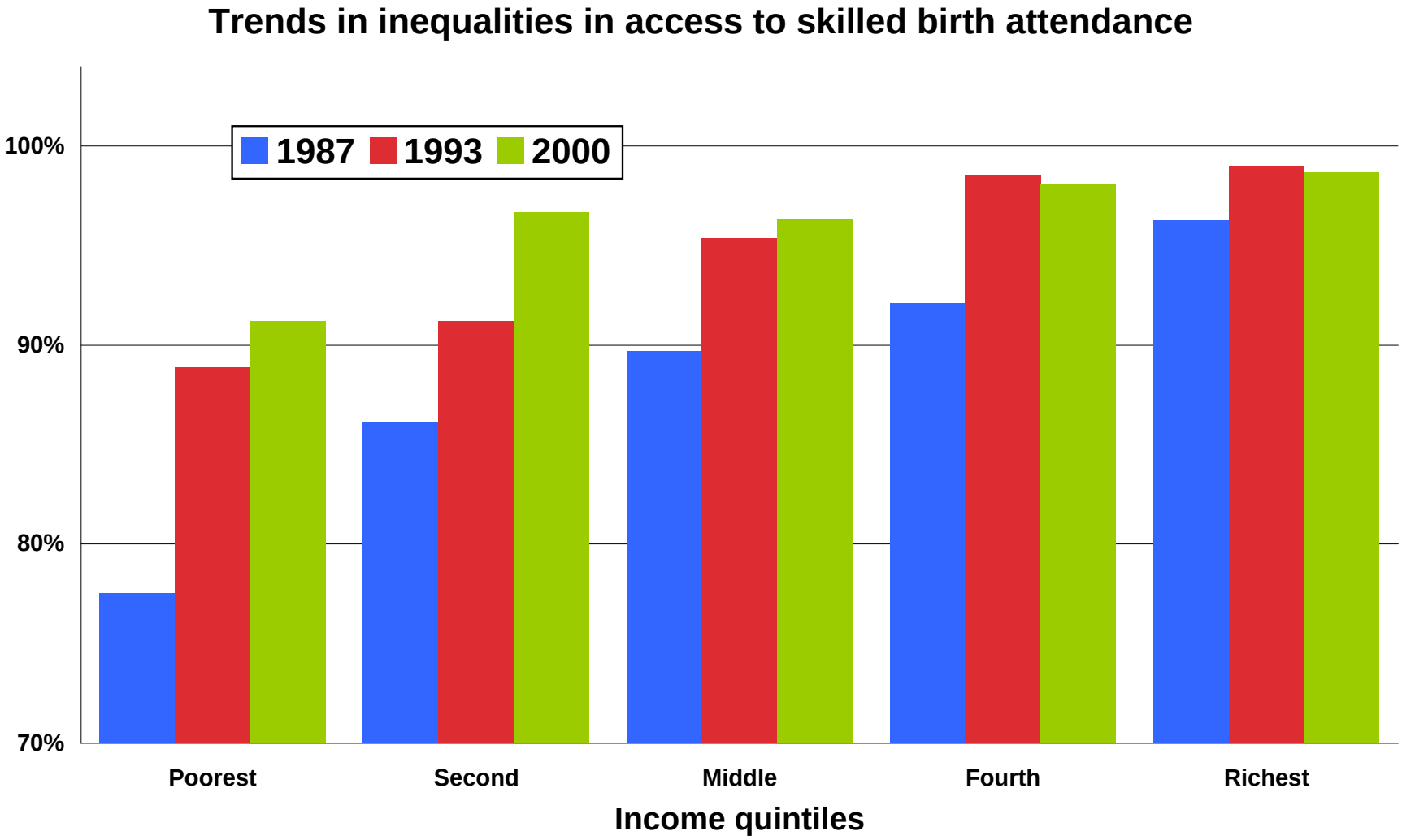


- Countries chosen: Chile, Colombia, Costa Rica, Estonia, Kyrgyz Republic, Sri Lanka, Thailand, Tunisia, and Vietnam
- 'Good Practice' defined in terms of large increases in the breadth and depth of coverage and financial protection
- Selected countries generally have:
  - significantly expanded coverage (i.e., depth, breadth, and catastrophic protection) through NHS, SHI, and private health insurance systems
  - average or below average health spending and little, if any, external aid
  - better than average health outcomes for spending and income levels

Health trends in Sri Lanka since 1930

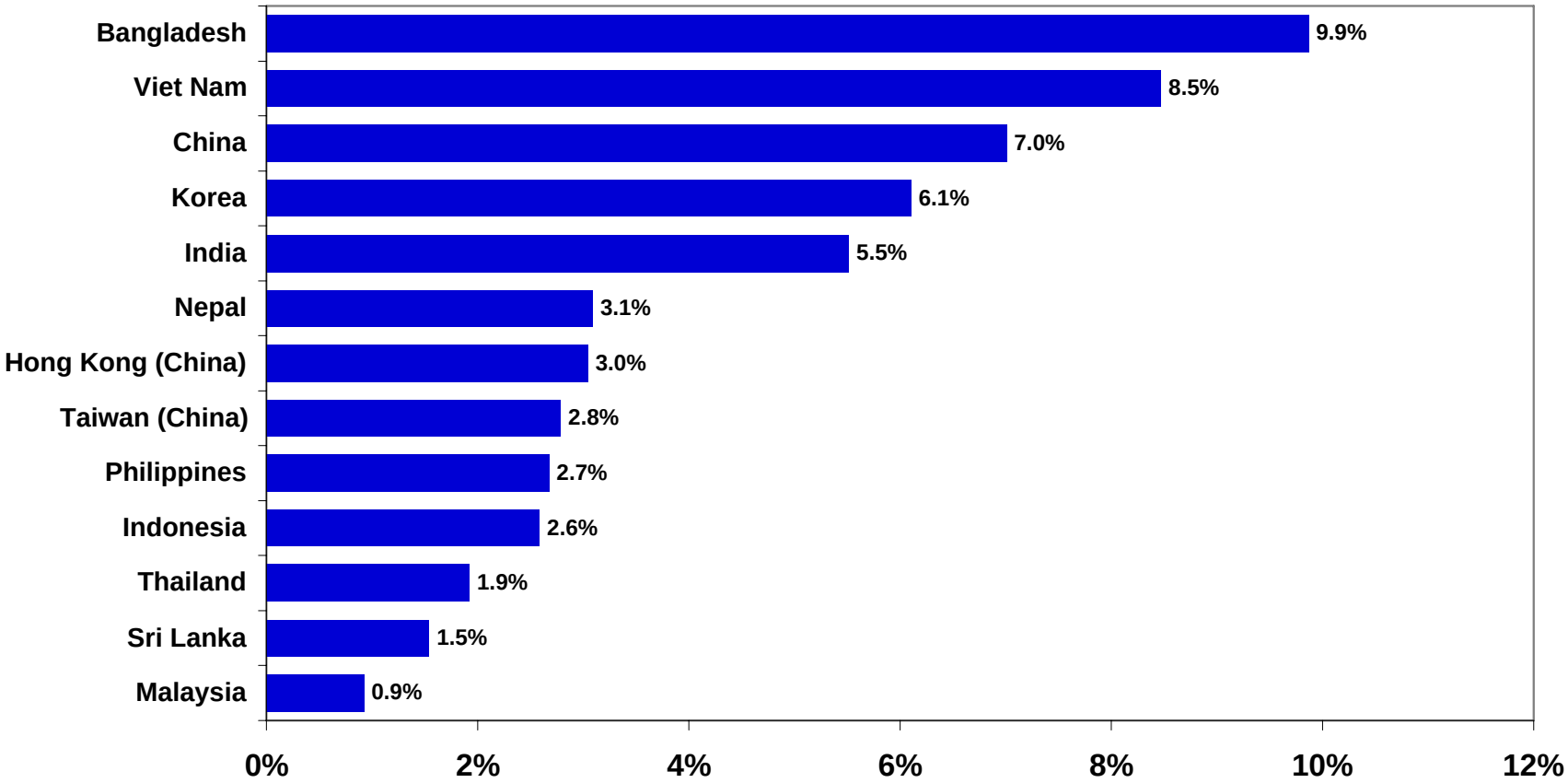


Low inequalities in access to healthcare services

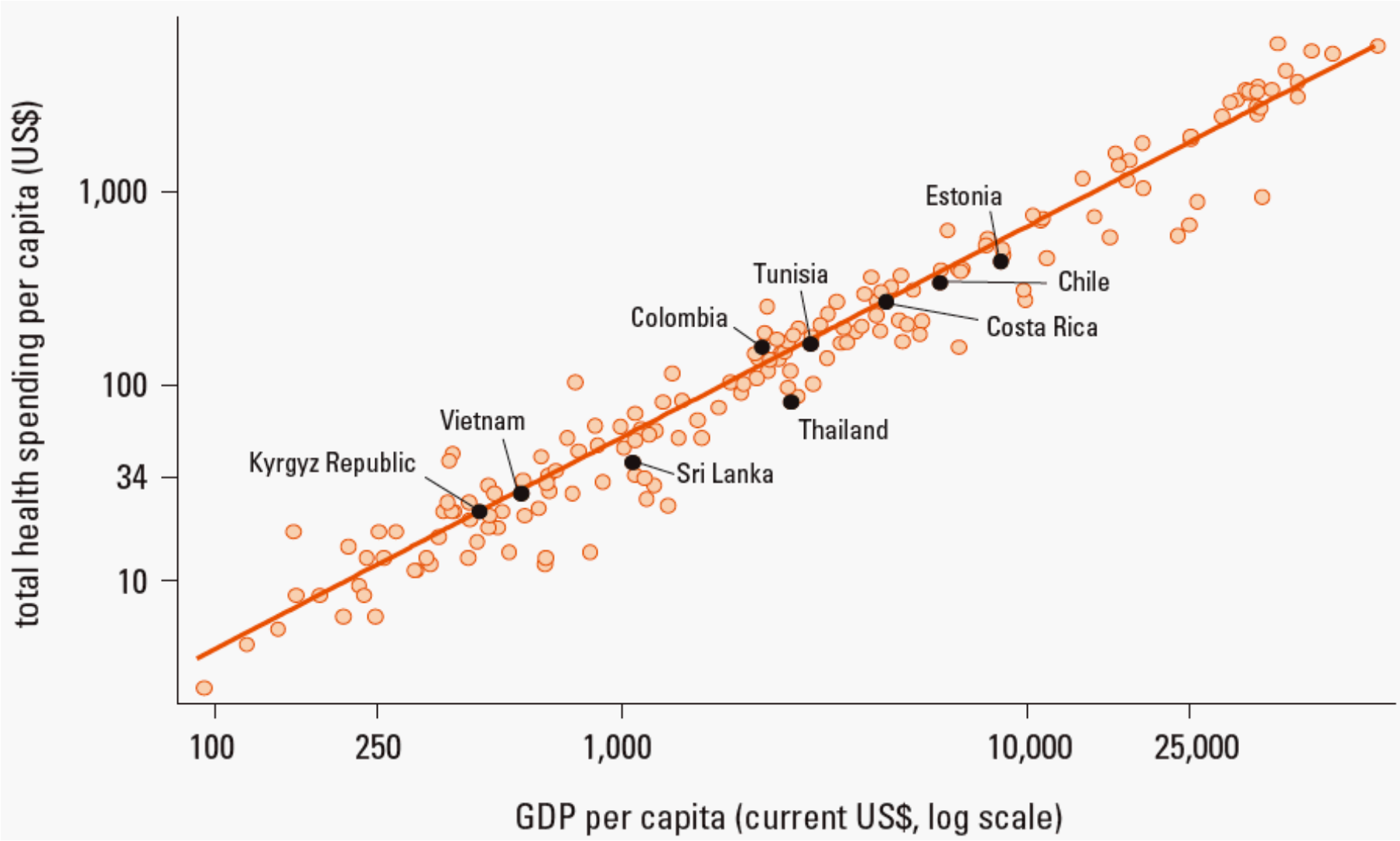


Effective risk protection at low per capita income

Households forced to spend more than 15% of income on healthcare



Low health spending as a share of GDP relative to income



Evolution of the Sri Lankan healthcare system

Historical expansion of access in Sri Lanka

1858	Establishment of colonial medical department
1931	Introduction of universal suffrage (& income taxation)
1934-35	Great Malaria Epidemic impoverishes rural areas
1936-37	Expansion of health facilities into rural areas
1948	Social health insurance considered and rejected
1951	Government user fees abolished
1950s	Health budget increased
1960s	Health budget cut and efficiency gains predominate
1980s	Public sector model retained alongside market economy

Key features of expanding access to poor in Sri Lanka

- Recognition in 1930s of importance of risk protection as core function of health system
  - Adequate financing of hospitals and inpatient care
- Political pressures drove expansion of infrastructure in rural areas to ensure close physical access to services (from 1940s)
  - High levels of physical supply
- Prioritization of access to the poor over clinicians' concerns for quality
- Constant emphasis on effective public sector management to control costs and improve productivity
- Pragmatic attitude to private sector given limits of public financing
  - Government doctors permitted private practice since 1860s
  - Opting out of wealthy into private sector implicitly encouraged
  - Self-purchase of out-of-stock medicines used to shift cost-burden

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
  - Effective mechanisms to post doctors
- Accessible tertiary care
  - Large budgetary allocation to secondary hospital care - poor patients entitled to “expensive” care
  - Referral system not enforced

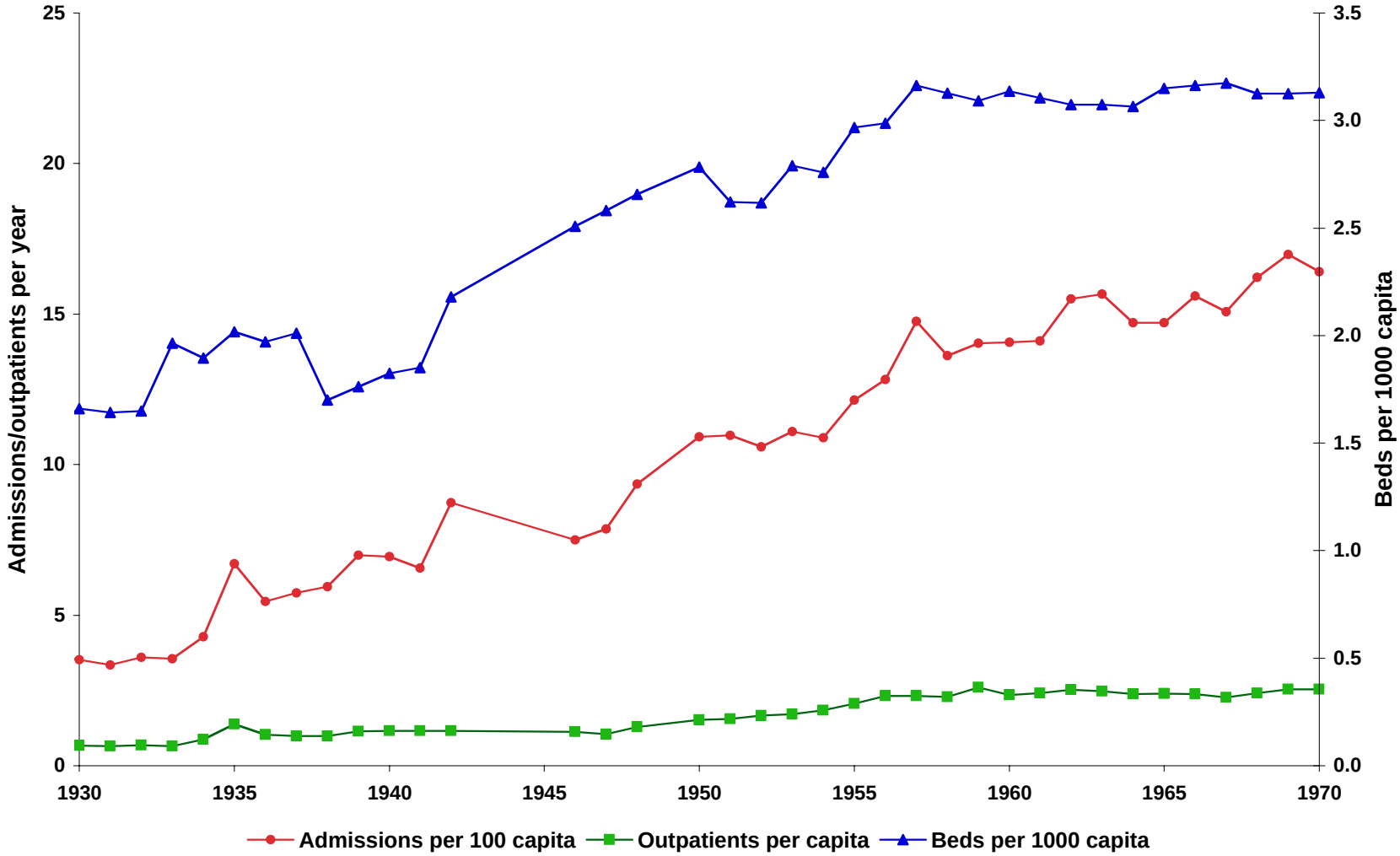
Resource mobilization experience in Sri Lanka

Experiences with resource mobilization for expanding access

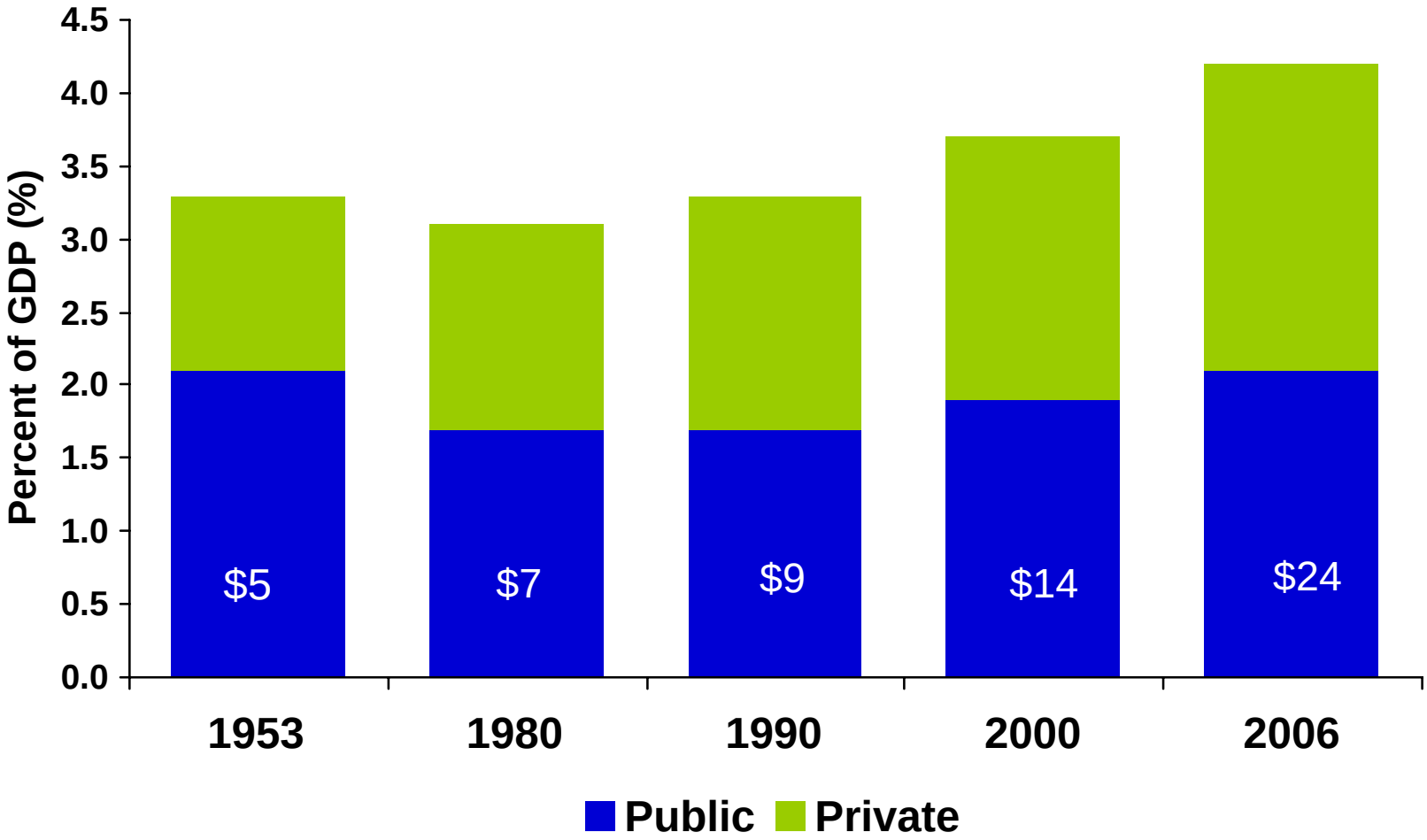
- Tax financing most efficient resource mobilization mechanism
  - Only proven mechanism to ensure coverage for poor, and for building rural infrastructure
- User fees
  - Act as financial barrier to poor
  - Limits to means testing recognized early
  - Limited revenues raised
- Social health insurance
  - Rejected in 1948 recognizing that free hospital care is a form of insurance
  - Impossible to extend contributory schemes to rural, informal pops
- Private health insurance
  - Thirty years of experience showed that it will not cover poor, rural sector, informal workers, old

Key message 1 – Importance of efficiency gains

Expansion on public sector supply and utilization, Sri Lanka 1930-70



Financing levels since 1930
(%GDP and $ per capita public)



*Per capita values in constant 2000 US dollars

Technical efficiency gains during scaling-up: Sri Lanka

Year	GDP (US$ 1995 per capita)	IMR	Government spending (US$ 1995 per capita)	Outputs (Out-patients per capita)	Outputs (In-patients per capita)
1948	255	92	4.3	1.1	0.09
1960	279	57	5.4	2.3	0.14
12 yrs	+9%	-38%	+ 25%	+110%	+55%

Contribution of increased spending = <25%
Contribution of technical efficiency gain = >75%

Key message 2 – Sri Lankan system as distinct approach (and Malaysia, Hong Kong SAR, Jamaica, …..)

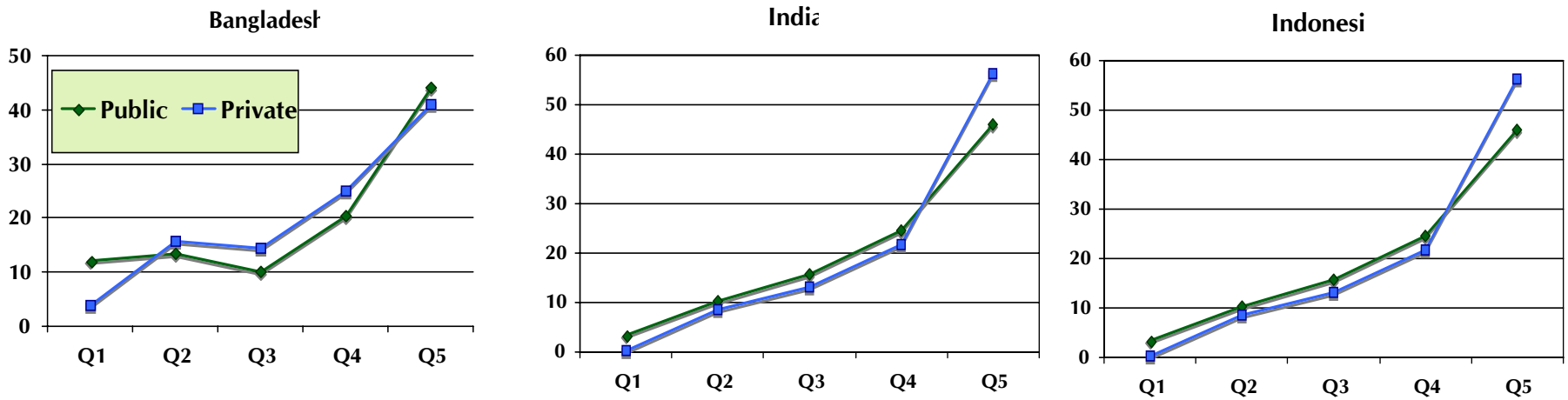
Tax-funded, integrated government health services

- UK Beveridge NHS model not feasible in Sri Lanka in 1948
  - » Depends on sufficient financing for public services that most healthcare demands are met by public sector
  - » Costs 5-8% of GDP in tax subsidies
- Sri Lanka lacks sufficient budgetary resources to replicate UK
  - » Can afford only 1-2% of GDP in tax subsidies
  - » So only able to provide 40-60% of overall needs through public services
  - » Typical outcome is that limited public services are captured mostly by rich, leaving poor without services
- Sri Lanka solved this through the management of public and private provision and reliance on voluntary opting out to private sector

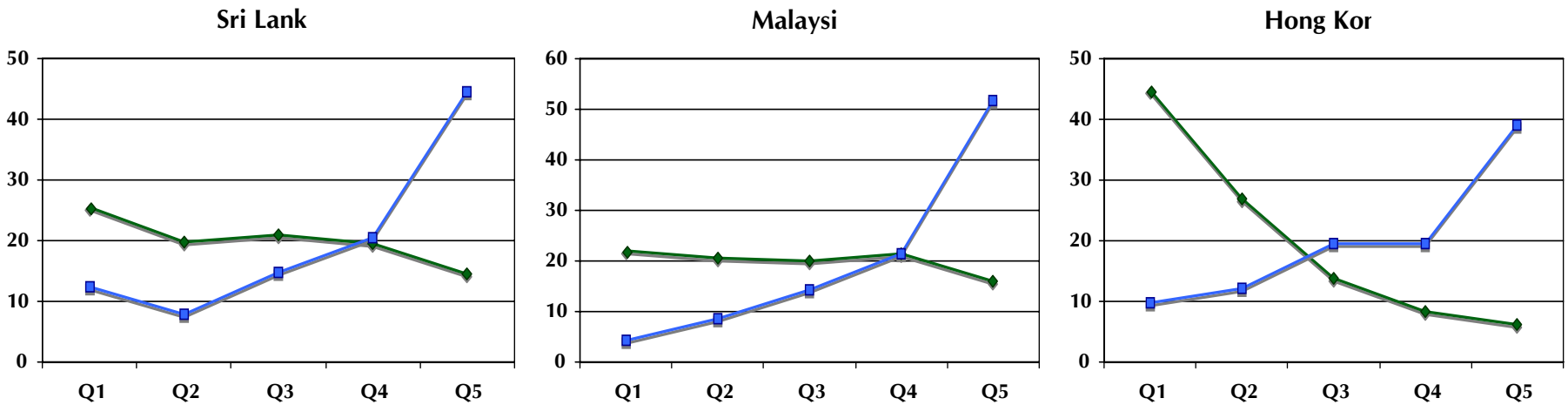
Sri Lanka's dual system

	Public	Private
Expenditure	47%	53%
Financing	Government budget	User fees
Provision		
Preventive care	95%	5%
Outpatient care	50%	50%
Inpatient care	97%	3%
Beds	55,000	2,500
Location	All areas	Mostly urban

Differences in public-private mix in government delivery systems



Use of public and private inpatient services by income quintiles



Key points from Sri Lanka health system

- Dual objectives of health system
  - (1) Improve health
  - (2) Prevent poverty through effective risk protection
- Dual system used to target limited government spending
  - Government pays for most inpatient care
    - Most people cannot access insurance
  - Public sector hospitals and preventive services
    - Free of charge, no user fees
    - Access to poor emphasized
  - Private sector doctors and hospitals
    - Not free - patients pay fees
    - Non-poor voluntary choose private sector
- Efficiency gains key to expanding coverage with limited resources

Thank You