'Free Health' in the Face of Healthcare Privatization in Post-1977 Sri Lanka

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The newly independent government of Ceylon adopted its 'free health' policy in the context of the post-Second World War economic boom and renewed optimism about Third World development. Anti-colonial movements had gained ground by the 1950s, and the Non-Aligned Movement, of which Ceylon was an active member, soon acquired United Nations (UN) representation as the Group of 77. As the Cold War heightened with the Soviet Union and China holding sway at the UN, in 1974, the UN adopted the 'New International Economic Order' and a more comprehensive approach to development (Kumar, Birn and McDonough 2016).

As part of the new development agenda, the World Health Organization (WHO) endorsed the 1978 Alma Ata Declaration. Alma-Ata supported a 'Health for All'[2] model that decried inequalities in health between and within "developed and developing countries" (WHO 1978). 'Health for All' was to be achieved by strengthening comprehensive primary health care, an approach that drew on the principles of the New International Economic Order. Importantly, Alma Ata emphasized a state-led health care delivery model together with intersectoral collaboration and community mobilization to address the broader determinants of health. But the Alma Ata pledge was short lived in the context of the 1970s economic recession.

The rise of inflation and unemployment in the West saw the dismantling of the Keynesian welfare state and widespread support for neoliberalism as a policy doctrine (Harvey 2005). A new constellation of actors, most prominently the World Bank, became influential in global health agenda-setting. As a result, conservative health reform agendas, entangled in the exigencies of structural adjustment, were touted for the Third World (Birn 2014). While they had drastic consequences for health systems in these contexts, this paper explores the conditions under which Sri Lanka retained the original state-centered structure of its public system, and pursued a different path to privatization.

The Beginnings of 'Free Health'

The foundations of Sri Lanka's western[3] medical system were laid under colonialism. Until the early 19th century, colonial medical administrations chiefly served military needs while 'private' practitioners attended to the European and Ceylonese elite in urban settings. The British colonial government extended western medical services to the urban poor in 1819 with the opening of the Pettah Hospital in Colombo. Missionaries played a key role in the subsequent expansion of allopathic health services; the Anglican Church's Friend-in-Need Societies set up 'pauper hospitals' in major townships while American missionaries established health facilities in the North. The 'pauper hospitals' were taken over by the colonial government in 1858, and would form the backbone of the curative arm of the public system (Jones 2009; Uragoda 1987).

Crucial to the development of preventive services was the arrival of the Rockefeller Foundation in 1914 to assist with hookworm control efforts on plantations. Confronted by an intransigent Planters' Association, the Foundation made dismal progress with sanitation, and eventually shifted its programme to non-plantation areas. A significantly restructured and more comprehensive public health programme was established in the Western Province with support from the government administrative system. This sanitation programme laid the groundwork for the health units

system, which would evolve, from its beginnings in Kalutara, into a far reaching preventive health programme spanning the entire country (Hewa 1995).

Rural expansion of healthcare accelerated after the malaria epidemic of 1934/35, which emerged in the nexus of recession, drought, and food scarcity, and made visible the desperate conditions of the rural poor. As State Councillors[4] and regional government representatives drew attention to the dire needs of their respective constituencies, the colonial government came under heavy criticism for a half-hearted response to the humanitarian crisis. In the wake of the Suriya Mal Movement,[5] a more responsive government issued free rice rations and school meals in affected areas, and took steps to strengthen rural health services (Silva 2014).

Ceylon's health sector flourished under a thriving plantation economy in the 1940s. Healthcare spending grew in absolute terms and as a proportion of national income in the first decade after independence, financed mainly through trade tariffs (Rannan-Eliya and De Mel 1997). Britain's 1946 legislation of the National Health Service prompted the government to commission Dr. J.H.L Cumpston, former Australian Director-General of Health Services, to assess Ceylon's health sector. The ensuing 1950 Cumpston Report set the direction for health reform through its recommendations (Jones 2009). The government consequently eliminated user-fees from the public system while the 1952 Health Services Act brought government health services under a centralized department.[6] As international trade slumped in the 1960s, revenue from trade tariffs became insufficient to develop the health sector. The government responded by intensifying the use of existing resources to cater to the growing population (Hsiao 2000).

The private sector ran in parallel throughout this period, serving a wealthy minority. The colonial government encouraged medical practitioners serving in public hospitals to engage in private practice after hours to maintain low wages in the state sector. This form of dual practice created a channel through which private patients gained entry to government hospitals (Jones 2009). For this reason, the 1950 Cumpston Report recommended banning dual practice to ease the congestion in state hospitals. This recommendation was resisted by the medical establishment, and only implemented in 1956 by the incoming Sri Lanka Freedom Party (SLFP) government (Jayasuriya 2010). Subsequent trade union action by the Government Medical Officers Association (GMOA) led to the granting of some private practice privileges for specialists.

Faced by a balance of payment crisis exacerbated by surging world oil prices, the leftist United Front government, elected into power in 1970, introduced a series of reforms that impacted the health sector. It cut welfare subsidies in the 1971 budget, and introduced a user-fee in the form of a stamp duty for out-patient services (Herring 1987; Rannan-Eliya and de Mel 1997). A centralized purchasing system to rationalize pharmaceutical imports, introduced in the early 1960s, was, in 1972, extended to the private sector (Lall and Bibile 1977).[7] The Left alliance also banned public sector health professionals from engaging in private practice (Jayasuriya 2010). By 1977, when the newly elected United National Party (UNP) government adopted an 'open economy,' 'free health' was fairly well established and enjoyed widespread popularity.

'Free Health' under Early Economic Liberalization: 1977 to the Late 1980s

The incoming UNP government embarked upon a donor-driven programme of economic liberalization. Paradoxically, despite a widening trade deficit, the government continued to expand the public sector while cutting welfare spending (Herring 1987). Budgetary allocations to the social sector plummeted from about 40 per cent between 1970 and 1977 to 11 per cent in 1981 (Jayasuriya 2010). The government turned to indirect taxation to finance public services even as revenue from trade tariffs fell steeply following trade liberalization (Hsiao 2000).

This policy shift in Sri Lanka took place in the context of the Third World debt crisis. The World Bank and International Monetary Fund (IMF) negotiated debt relief and issued loans to Third World governments to finance repayment. Widely known as structural adjustment programmes, these loans entailed conditions that promoted economic liberalization, including the removal of trade barriers, financial deregulation, privatization of state-owned enterprises, regressive forms of taxation, and cuts to social spending (Harvey 2005). Implemented to varying degrees in Third World contexts, sweeping reforms were also negotiated for the health sector, including cuts to public health spending, privatization of public services, and introduction of user-fees and/or health insurance (Birn, Pillay, and Holtz 2017).

The World Bank had commenced activities in Sri Lanka by the 1950s, long before the advent of s tructural adjustment (Lakshman 1985). On its recommendation, the government attempted to remove the rice subsidy in 1953, a move that was met with the 'Great Hartal'

led by the trade union movement. Although the government substantially cut food subsidies in 1977, it displayed some reluctance to dismantle the 'free health' policy, which, together with 'free education,' was viewed as sources of national pride (Herring 1987). Instead, the government abolished user-charges from the public health system, a step viewed by many as a populist gesture since the government simultaneously incentivized private healthcare expansion by removing the ban on dual practice; providing loans for the establishment of private healthcare facilities and; deregulating the pharmaceutical and insurance industries (Baru 2003; Jayasuriya 2010).

Paradoxically, the government also endorsed the 1978 Alma Ata Declaration and adopted a national strategy to achieve 'Health for All by the Year 2000.' This strategy aimed to build capacity at the national level, decentralize health services, strengthen rural structures for advocacy and community mobilization, and invest in rural infrastructure to support comprehensive primary healthcare (Economic Review 1987). Decentralization was further legislated through the 13th Amendment to the Constitution introduced in 1987, which sought to address the national question. Although the administration of (most) regional healthcare facilities was transferred to nine provincial departments of health under the 13th amendment, financial decentralization remained unsuccessful as the taxes devolved to the provinces were not substantial (Hsiao 2000). Taken together, the 1980s health reforms differed substantially from the World Bank's policy prescriptions, which included user-fees for government health services, health insurance, 'effective' use of private sector resources, and decentralization (World Bank 1987, p. 5).

In sum, having adopted an 'open economy' amidst a world recession, the government sustained its 'free heath' policy while promoting private sector expansion. Perhaps fearing electoral repercussions, the World Bank health sector reforms were not adopted in Sri Lanka. As opposition to neoliberal capitalism weakened after the dissolution of the Soviet Union in 1991, Sri Lanka duly accelerated healthcare privatization together with other poorer countries.

'Investing in Health' in the Second Phase of Liberalization: 1990s to 2009

A major shift occurred in private health sector development after the establishment of the Board of Investment of Sri Lanka (BOI) in 1992. Having its origins in the Greater Colombo Economic Commission set up in 1978 to 'develop' the outskirts of Colombo, the BOI's mandate covered the entire country. The BOI offered a range of fiscal incentives to expand private healthcare, including tax holidays, concessionary rates on corporate income tax, import duty exemptions, and concessionary lease terms on state lands (Rannan-Eliya and Kalyanaratne 2005). Several large-scale private hospital projects subsequently took off, changing the landscape of private healthcare in Colombo (Dayaratne 2013).

These developments in Sri Lanka coincided with the collapse of the 'socialist bloc' and the entrenchment of neoliberal ideology within structures of global governance. The 1990s saw the creation of the World Trade Organization and the adoption of numerous free trade agreements. A new economic regime supported by multilateral agencies acknowledged market failures and institutional constraints, and recommended state intervention to overcome them. Although purportedly seeking to address the disastrous impact of structural adjustment, the new framework still endorsed a market order and intensified integration to global financial markets (Saad-Filho 2005).

The health reform platform supported under the new framework manifested in the 1993 World Development Report, *Investing in Health*. Framing health as an investment opportunity to further economic development, the report recommended public provision of an essential 'basket' of health services with the remainder to be offered within a competitive market where "suppliers (both public and private) … [would] compete both to deliver clinical services and to provide inputs … to publicly and privately financed health services" in a context where "[d]omestic suppliers [would] not be protected from international competition" (World Bank 1993, p. 6). The dominance of the market order remained unchallenged in the 2000 United Nations Millennium Project. The 2001 WHO Commission on Macroeconomics and Health undertook to examine the role of health in economic development, and reaffirmed the 1990s commitment to public provisioning of 'essential' health services. Notably, at the turn of the millennium, the influence of corporate actors in global health agenda-setting had visibly grown through numerous global 'public-private partnerships' (Kumar, Birn and McDonough 2016).

The new healthcare financing strategies supported by multilateral agencies were not adopted in Sri Lanka, although a series of national health policy documents contained plans to increase or formalize the role of the private sector in service delivery in Sri Lanka (Haniffa 2006; Hsiao 2000; Government of Sri Lanka 2002). While most of these policy initiatives supported the

introduction of health insurance, the UNP's *Regaining Sri Lanka* explicitly outlined proposals to dismantle the 'free health' policy by targeting the 'free' public system to the poor (Government of Sri Lanka 2002). However, public and private health sectors remained administratively distinct while the private sector expanded under state patronage.

The BOI granted massive subsidies to the private healthcare industry through the 1990s, intensified under the brief UNP government between 2001 and 2004, and continued unabated under the tenure of President Rajapaksa. Reflecting this subsidization, the number of private hospitals rose from 66 to 123 between 1990 and 2009 (Amarasinghe et al. 2015). In 2002, the private share of capital expenditure reached an all-time high of 29 per cent (Institute for Health Policy 2015). However, the fiscal incentives (e.g. tax exemptions for imports, corporate income tax reductions, subsidized rates on state lands, etc.) provided by the state were not offset by savings as anticipated by the government. Rather the government incurred losses (Rannan-Eliya and Kalyanaratne 2005).

The government's strategy was essentially to withdraw from healthcare provision while supporting private health sector development. Government expenditure on health as a percentage of general government expenditure dropped from 6.8 to 5.9 per cent between 2000 and 2009 (WHO 2012) as the government invested heavily on a military offensive against the Tamil Tigers. Although the public share of health expenditure remained fairly constant at just over 40 per cent, admissions per public hospital bed rose from 50 to 80 per year between 2000 and 2009, reflecting insufficient capital investment in the public health sector (Amarasinghe et al. 2015). In the absence of health insurance, the government began to directly finance private sector provision. The President's Fund, a populist humanitarian initiative to provide assistance to needy citizens, expanded its mandate in 1995 to cover a portion of the costs of private healthcare for a set of pre-defined conditions. In 1997, the government introduced a contributory health insurance scheme for public sector employees, which offset the costs of private healthcare.

The World Bank's involvement in health sector development increased with its support of the first leg of Sri Lanka's Health Sector Development Project, which aimed to make the health sector "adapt to the challenges resulting from the double burden of disease by improving equity, quality and efficiency of the health system by 2010" (World Bank 2004, p. 3). Notably, the project proposal contained plans to assess the feasibility of alternative healthcare financing options, although there was no reference to such an assessment in the project's completion report (World Bank 2017a).

In sum, despite weakened opposition to neoliberalism at the global level, the 'free health' policy remained in place during the 1990s, struggling under putative resource constraints. With the aim of attracting foreign capital, the government opened the health sector for investment through the BOI, which led to the spread of private hospitals, primarily in Colombo. Numerous national health policy initiatives attempted to formalize the role of the private sector in healthcare delivery, but were not implemented by the Ministry of Health. Instead, the government supported private healthcare expansion while underinvesting in the public system.

Post-Civil War Development in the Age of 'Universal Health Coverage': 2009 to the Present

As the civil war came to an end in 2009, the Rajapaksa regime embarked on a massive wave of liberalization taking advantage of the inflow of foreign capital. Embracing the rhetoric of post-war development, the government spearheaded a programme that sought to make Sri Lanka the "Wonder of Asia" under the *Mahinda Chinthana Vision for the Future*. For the health sector, *Mahinda Chinthana* outlined plans to expand hotel-style state-of-the-art facilities through 'public-private partnerships'. These services, to be covered by health insurance, were expected to support the burgeoning medical tourism industry (Department of National Planning 2010, p. 150-153).

The National Health Development Plan 2013-2017 (NHDP), designed when President Sirisena was Minister of Health, included several strategies that targeted the private sector. Among them stand out, "promoting and regulating the private sector to deliver affordable and quality services; improving public-private partnerships in providing healthcare services;…promoting medical tourism; [and] …promoting alternative financing options for healthcare" (Ministry of Health n.d., p. 9). A few proposals contained in the NHDP's action plan also spelled out danger: outsourcing cleaning, laundry, security, ambulance, and other transport services (p. 306); developing sections dedicated to medical tourism in government and private sector hospitals (p. 338) and; introducing social insurance and fee-for-services (p. 344), all by 2017 (Ministry of Health n.d.). Although some facility services have already been out-sourced to the private sector, the government has still not moved forward with the other strategies contained therein.

The second phase of the World Bank-supported Health Sector Development Project, launched in 2013 in conjunction with NHDP and valued at USD 5 billion, aimed to "upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases" (World Bank 2013, p. 17). Notably, a second component of the project addressed "innovation, results and capacity building" (World Bank 2013, p. 18-22). A private sector review was undertaken before the commencement of the second phase to address "the significant knowledge gaps on the private health sector … and foster a dialogue on opportunities for collaboration between the government and the private sector" (Govindaraj et al. 2014, p. ii). Yet, the Second Health Sector Development Project did not allude to health insurance, and all loan disbursement indicators associated with the project remained linked to interventions targeting the public sector (World Bank 2017b).

As the NHDP neared the end of its timeframe, the Ministry of Health unveiled the *National Strategic Framework for Development of Health Services 2016-2025* (Ministry of Health 2016). Evidently not associated with a World Bank credit facility, this framework has been developed following multi-stakeholder consultations at the national level. It includes a number of initiatives that seek to harness the private sector's contribution to service delivery, particularly in relation to primary healthcare. As with previous policy initiatives, the section on health financing contains plans to introduce a national health insurance scheme to provide financial security for "certain healthcare problems" (Ministry of Health 2016, p. 71).

Although these national health policies seem inconsistent and even contradictory, there appears to be wide consensus on the need to introduce national health insurance. Both the United People's Freedom Alliance (UPFA) and the UNP underscored the need for health insurance in their respective 2015 election manifestos (Deshodaya Movement 2015). Moreover, the incumbent UNP-dominant government's 2017 budget proposals included a health insurance scheme for all school-going children alongside a series of other proposals that promoted private health sector expansion (Ministry of Finance 2016). Although the GMOA objected to these budget proposals, they have remained silent on the privatizing health reforms contained in national health policy documents.

The widespread support for health insurance draws on the 'universal health coverage' (UHC) framework embraced by international health and development agencies in recent years. UHC was formally introduced to the global health agenda in the *2010 World Health Report* where its definition underscored 'financial risk protection' (WHO 2010). The United Nations endorsed UHC by including it as target 8 of the third Sustainable Development Goal (*Ensure healthy lives and promote well-being for all at all ages*). Notwithstanding the broader approach envisioned by the United Nations, recent interventions that have their basis in the UHC framework have focused rather singularly on expanding health insurance and diversifying provision through private sector 'collaboration.' The emphasis on 'financial risk protection' has diverted attention from the fact that rising out-of-pocket expenditures are a manifestation of weakening public systems (Sengupta 2015). Indeed, the experiences of countries with publicly financed and delivered health systems, such as Cuba and Sri Lanka, receive little attention in these deliberations. Rather than investing in the 'free' public system, policymakers in Sri Lanka have uncritically accepted the UHC framework touted by global health gurus with little consideration for the implications of healthcare privatization for equity.

The Future of 'Free Health'?

The growing dominance of the private health sector is evident in its rapid expansion in Colombo, its suburbs, and other urban settings. Unlike a couple of decades ago when state-of-the-art facilities were introduced to the health sector by the Ministry of Health, today, the country's most advanced biomedical technologies are housed at private hospitals. While the merits of medicalization and commercialization of healthcare may be questionable, the government's policy of supporting private healthcare expansion while investing inadequately in the public system has wide-ranging implications for equity in healthcare.

State policies have supported the creation of a two tiered health system with growing stratification of services between the wealthy and poor. For one, commercial hospitals are used by a wealthy minority and remain virtually inaccessible to the rest of the population. Even wealthier users generally access private (out-patient) services while exploiting the government's 'open door' policy at public facilities to enter the public system for in-patient care and other resource-intensive procedures. Dual practice allows private healthcare users to essentially pay to receive priority within public facilities, compromising service for disadvantaged users who cannot afford private healthcare. On the other hand, large sections of poorer users pay out-of-pocket to access the private sector for out-patient care owing to

gaps in public services. This situation is compounded by deficits in medicines, diagnostics, and medical supplies at public facilities, which compel even the poorest to access the private sector.

The present situation perhaps reflects a health system in limbo. Fee-levying sections have already been opened in some tertiary care centers and a number of facility services, most recently ambulance services, are outsourced to private companies. The incumbent government proposes to worsen this situation by providing health insurance to some sections of the population, perhaps to diminish reliance on the public health sector. Other proposals to privatize the health sector contained in the 2017 Budget Proposals include upgrading public facilities through 'public-private partnerships,' establishing (more) paying wards together with the private sector in state hospitals, and inviting the private sector to establish laboratories in state hospitals (Ministry of Finance 2016). As the private sector grows, public sector health professionals are increasingly opting out of government employment to take up fulltime positions in the private sector, causing a dearth of human resources for health in remote, disadvantaged areas (Dayaratne 2013).

One might ask why this longwinded approach to privatization? Why was the 'free health' policy not dismantled in Sri Lanka under structural adjustment along with public health systems of other poorer countries? The reality is that 'free health' is etched in the public imaginary. As Hsiao (2000, p. 57) pointed out over a decade ago, healthcare is a highly contentious political issue "so much so that [user-fees] will not be debated in public". In other words, the notion of paying for healthcare remains unacceptable among a fairly literate population.

The widespread appeal of the 'free health' policy manifests in its endorsement by high-ranking politicians. The incumbent President's 2014 Election Manifesto articulated a commitment to strengthen "free health," and promised a "unified state service" that would "coordinate Western, Eastern and indigenous systems of medicine" and provide "all medical drugs and tests" through "appropriate state institutions" (Sirisena 2014, p. 35). Moreover, any pronouncements on health insurance made by the present government have been couched in the language of public financing. In the 2017 Budget, for example, the government proposed a *government-financed* health insurance scheme for all school-goers (Ministry of Finance 2016).

Although plenty of evidence supports the assertion that publicly-financed and -delivered health systems are more equitable and economical in the long-term, they are presumed unfeasible for poorer countries. Health insurance with its basis in 'risk sharing' is the recommended model. It is presumed to improve 'efficiency' of service delivery through the separation of the purchasing and providing functions of a health system (or the 'purchaser-provider split'). While inefficiency has not been identified as a major concern in Sri Lanka's health sector (Hsiao 2000), the experiences of other poorer countries suggest that expanding insurance increases healthcare costs for governments (while ensuring a fixed and lucrative market for private health insurers and providers), and widens inequity. Health insurance schemes rolled out in poorer settings are generally not single-payer models, but consist of several pooled funds that differ in their comprehensiveness. They often cover a pre-defined package of 'essential' services for the low-income bracket while the wealthy enjoy superior coverage (Birn, Nervi, and Siqueira 2016).

The national health policy documents formulated by successive governments in Sri Lanka suggest that the future of 'free health' is bleak. However, the reluctance on the part of the government to move forward with privatization strategies prescribed by multilateral agencies is evidence of the potential electoral implications of dismantling the 'free health' policy. The public system still provides healthcare without user-charges and covers a large section of the population's healthcare needs. Changing the structure of financing and delivery of healthcare in Sri Lanka would necessarily lead to widespread protests and social unrest. As the incumbent government attempts to rollout market-based health reforms to revamp the health sector, the fate of 'free health' remains in the hands of the people.

Notes

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2 "A healthcare delivery system that provides equal services for the entire population regardless of an individual's or family's financial resources" (Waitzkin 2015, p. 93).

3 Ayurveda, Unani and Sidda medical systems functioned in pre-colonial times and ran parallel to Western medical services under colonialism and after independence (Uragoda 1987). Indigenous medicine still constitutes an important component of the health system. While privatization has encroached upon the indigenous medical system and merits attention, in this paper, I focus on the allopathic medical system.

4 The 1931 Donoughmore Constitution granted universal franchise and established the State Council, a unicameral legislature, comprising fifty elected state councilors (Wickramasinghe 2006).

5 Initiated in 1932 to protest the sale of poppies on Remembrance Day, the Suriya Mal Movement evolved into the Trotskyite Lanka Sama Samaja Party, launched in 1935 (Wickramasinghe 2006).
6 Extant work on health policy in Sri Lanka does not clearly map out a timeline or provide an analysis of the actors and forces behind the adoption of the 'free health' policy. Some sources indicate that user-fees were removed from the system in 1950 (Perera 1985; Haniffa 2006) and others 1951 (Rannan-Eliya and de Mel 1997).
7 The Bibile and Wickramasinghe pharmaceutical reforms, later endorsed by the World Health Organization as a model for poor countries, faced the wrath of transnational pharmaceutical companies, and were abandoned by the government in 1976 (Lall and Bibile 1977).

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SSA's Outreach

The SSA periodically organizes discussions with university students on democracy, justice, and citizenship. To follow our work with university students visit www.ssalanka.org