Sri Lanka's success story

Within the South Asian region, Sri Lanka stands out as a positive example of a public health system. There are several historical reasons for this outcome. The development path followed by Sri Lanka has been described as 'support-led security', in which public provision and funding of health and other social services has promoted social progress. Even before independence in 1948 there was a rapid expansion of public investment in education and health facilities in the 1930s and 1940s. Free education was introduced in 1947 and free health care, in 1953. Along with strong support for publicly funded social services, the commitment to social justice, with particular emphasis on addressing the needs of the worst-off, was a key feature of state policy for a long time.

Key health indicators

Despite having low income levels and only gradual economic growth, as well as relatively low levels of spending on health (with public healthcare expenditure equivalent to 2% of GDP), Sri Lanka has achieved remarkably good health status and a high literacy rate. Life expectancy is over 75 years old and skilled attendance at birth is as high as 96%. These achievements are testimony to the effectiveness of sustained public spending on social services and the consistent commitment to equity and social justice, which is also borne out by the relatively equitable distribution of income (with a Gini index of only 33) (McIntyre Di, 2006).

Rural access

The public health system in Sri Lanka has been particularly effective at bridging the rural-urban inequalities in access. It is now constituted by a large network of medical institutions and is divided in 258 Health Unit areas with populations ranging from 40,000 to 60,000 each (Rannan-Eliya and Sikurajapathy 2008). The Health Unit area is a clearly defined region congruent with the administrative divisions of the country. Health Units are managed by Medical Officers and are supported by a team of public health personnel comprising one or two Public Health Nursing Sisters, four to six Public Health Inspectors, one or two Supervising Public Health Midwives and 20-25 Public Health Midwives. Each Health Unit area is subdivided into Public Health Midwife areas, which constitute the smallest working unit in the public system. Each Public Health Midwife has a well-defined area consisting of a population ranging from 2,000 to 4,000 people (Perera 2007).

A creeping private sector

Today, 95% of in-patient care is still provided by the public sector, but those who can afford to can choose to use private sector services. The private health sector only began to develop in earnest during the 1960s. It focuses particularly on ambulatory care in the form of general practitioners (now 50% of services). Although there are some full-time private general practitioners, most private provision takes the form of dual practice by doctors who are employed in the public health sector and have a limited private practice outside of official working hours (Rannan-Eliya and Sikurajapathy 2008).

But Sri Lanka's system faces the threat of reforms that seek to align it with the neoliberal ethos of commercialization, despite a historically large consensus across the political spectrum on public investment in social infrastructure. In recent years, private expenditure has expanded faster than public expenditure; the entry of corporate private hospitals (often imported from India) is particularly worrying. Popular opposition has been fierce, however, and reforms have not proceeded at the pace projected by the neoliberal lobby.

Thailand: High coverage, low public expenditure

Health reforms in Thailand have drawn global attention for their rapid gains in achieving universal coverage. In 2002 Thailand's National Health Insurance Bill was enacted, creating the Universal Health Care Coverage scheme, primarily funded by the government based on a per capita calculation, and administered by the National Health Security Office. The focus has been on providing **primary healthcare services** to Thais who were left out of the healthcare system prior to 2002. Within just over a decade, coverage has increased dramatically and is now nearly universal.

Initial investment in public health infrastructure

However, there is another part of the story. The Thai reform of 2002 was preceded by the "Decade of Health Centre Development Policy (1986-1996)" that worked to establish primary health centres in rural areas. Public investment in health also increased quite dramatically towards the end of this period and the government's share of total health expenditure increased from 47% in 1995 to 55% in 1998 (Ramesh et al 2013, 8). Consequently, before the turn of the millennium there were few geographical barriers to healthcare access in the country. Thanks to massive infrastructure creation, 78% of hospital beds were in the public sector by 1999 – a trend that has remained fairly constant with 77% of hospital beds continuing to be in the public sector in 2012.

Limiting private health

The Thai reforms, thus, leveraged upon a newly built ***public* health infrastructure**. Under the UHC reforms, both public and private facilities can be providers of health services. However, in practice, private participation is low because it was made mandatory for private providers offering tertiary care to also provide primary level care. Further, while formally allowing private sector participation, the reforms delayed private sector entry pending the implementation of regulatory mechanisms.
Private practice by public sector doctors, though allowed, was minimized by providing hefty incentives to those who worked solely in the public sector. Among policy instruments to promote equitable service delivery, there is a mandatory three years of **rural service for doctors** and nurses.

Neoliberal trends: decreasing expenditure

However, these genuine attempts to provide access to healthcare services are taking shape in an overall neoliberal climate in Thailand, threatening to undermine their viability in the long term. Public financing (67% of which was consumed by public services in 2012) remains fairly low: **health expenditure** has increased from 1.7% of GDP in 2001 to 2.7% in 2008, but this remains lower than the global average for LMICs.

Health worker shortages

In terms of **human resource** development low expenditures have worsened the shortage of health workers in many public facilities: there are just three physicians for every 10,000 patients, compared to 9.4 in Malaysia, 11.5 in the Philippines, 12.2 in Vietnam and 18.3 in Singapore; and barely 1.5 nurses for every 1,000 people, compared to 2.3 in Malaysia and 5.9 in Singapore. This is a consequence of tough work conditions, poor job security and low pay. Better wages in private hospitals (strengthened by a burgeoning medical tourism market) draws nurses away from the public sector, as does the lucrative market in nearby Singapore.

Brazil: Comprehensive primary care, private hospital care[1]

Brazil went against the neoliberal trend in vogue in the rest of Latin America by creating the tax-funded *Sistema Único de Salud* (SUS, the Unified Health System) in 1986. The country's 1988 constitution also proclaimed the government's duty to provide **free health care for all**, despite strong opposition from a powerful and mobilized private health sector. This progressive stance was the culmination of decades of mobilization in favour of better health care that was part of the struggle to restore democracy in Brazil.

The creation of the SUS resulted in the roll out of an impressive primary care scheme, which now covers almost the entire country. But paradoxically, when in June 2013 millions came out to demonstrate on the streets of several Brazilian towns, one of the key concerns expressed was the lack of access to health care.

Costly private secondary and tertiary care

The problem is that while most primary health care is provided by a vast network of public providers and facilities, the state contracts out most of secondary and tertiary care services to the private sector. High-volume primary care clinics and emergency units remain largely public, whereas hospitals, outpatient clinics and other profitable services such as diagnostic and therapeutic services are in private hands.

This places several kinds of strains on the system. The private sector continues to ratchet up the cost of care it provides, and with **health expenditure** standing at 9% of GDP, Brazil now has one the most expensive health systems in the world. No less than 57% of public funding goes to private care (one of the highest in the Latin American region in terms of percentage of total health expenditure, even higher than in the United States). Such dominance of the private sector introduces **inequity in access** and is further reinforced by the fact that most Brazilians who can afford it (including an influential and growing middle class) purchase private insurance to 'top-up' services that they can access through the public system.

1 Amit Sengupta (2013) Universal health coverage: Beyond rhetoric. MSP Occasional Paper No. 20. Cape Town: Municipal Services Project. http://www.municipalservicesproject.org/publication/universal-health-coverage-beyond-rhetoric

Chile and Costa Rica: Different Paths to Universal Health

A comparative study of health outcomes in Chile, where private and public insurance companies and providers co-exist in the healthcare sector as part of a national policy, and in Costa Rica, where the public sector is dominant, convincingly debunks the myth that the private sector is inherently more efficient than the public sector and should therefore participate in health services.

Access to health services

In terms of access to basic services, both Costa Rica and Chile have made major advances. Today, they have the lowest infant mortality and highest life expectancy in the Latin American region. However, availability of basic services is not the same as having access to comprehensive care to resolve most health problems, which may explain why, over the last decade, people in Costa Rica have consistently perceived their **access to health services** to be better than people in Chile have (66.4% vs 35.0%). This difference has been maintained even after 2005 when Chile sought to remedy the situation by imposing more stringent regulation of insurance companies (Plan AUGE).

Financial protection

With respect to **financial protection**, although the lack of access to health services for economic reasons has been reduced substantially in Chile since 2005 (from 11.7% to 4.2% in 2011), the figure remains much lower in Costa Rica (0.8%). And in comparison with Costa Rica, out-of-pocket expenditure by families and the proportion of households facing catastrophic health expenditure are all substantially higher in Chile. This situation is produced in part by the fact that Chileans pay for services or products that are not covered by their insurance (e.g. drugs or consultations).

Health system efficiency and affordability

The relative efficiency and affordability of the Costa Rican health system is all the more impressive given the fact that total **per capita health expenditure** is lower than in Chile (US$811 vs US$947). The higher cost of the Chilean health system can be attributed in part to the inefficiency of the private sector in that country, where the use of unjustified medical procedures is more frequent and administrative costs are higher.

Insurance drives costs up

Health insurance schemes are often promoted on the assumption that competition among different providers should produce higher levels of service quality at lower costs ("active purchasing" [WHO 2010] and "management competition" arguments [World Bank 1993]). To the contrary, the Chilean health system is an example of how segmentation produced by the coexistence of private and public insurances is detrimental to efficiency; **collusion** among private providers and **oligopolies** are realities that are ignored in these arguments.

This comparative study demonstrates widespread and consistent financial and health outcome advantages of a strong, single public system rather than a fragmented public-private, insurance-driven model. Insurance schemes are neither the only, nor the best policy option.

Cuba: Universal Health Coverage through Free Primary Health Care

Health situation

Cuba's achievements in the area of **public health** are impressive. The Caribbean island-nation of 11,27 million people is classified as an upper middle-income country. Life expectancy is 78 years, just below the US average even though it is eight times more affluent. Even more telling, the infant mortality rate in Cuba is lower than in the US (4.7 vs 5.8/1,000 live births).

Access to health care

After 50 years of offering universal health care services, experts agree that most Cubans have access to quality health care. There is a much higher health worker density than the Latin America and Caribbean regional average and utilization rates of health services are also higher in Cuba. This demonstrates high health system efficiency given that the country's total health expenditure per capita is also much lower than the regional average[i].

These results are directly related to the political choices Cuba is making, placing **the population's well being at the center**. Progress in health indicators came with the economic and social change in Cuban society after the 1959 revolution. An improvement in general living conditions and a number of important social achievements (a private home per family, guaranteed income, improved education, etc.) have been fundamental to the population's better health. Campaigns were launched to eradicate illiteracy and an adult education program encouraged people to at least obtain a high school degree. Special attention was also given to **women's rights**. Since 1991, every woman has the option to stay at home up to six months after giving birth, while keeping 60% of her salary. A land reform was carried out. Arts, sports and science were promoted and special attention was given to women's rights and prosperity. **People's organizations** (neighborhood committees, women's organizations, trade unions, youth organizations, etc…) played an important part in these change processes.

The right to free quality health care for all was written into the Cuban Constitution. This priority has survived despite all the problems the country has had to face. Straight after the 1959 revolution, the US imposed the first **economic embargo** measures. The beginning of the 1990s saw the implosion of the Soviet bloc, which had maintained privileged trade relations with Cuba up to then. The country sank into economic crisis, but the Cuban government kept health care as a priority. During these crisis years, the budget for public health was 10% of the national budget. In the same period, other Latin American countries saw drastic reforms and health care privatizations as encouraged by the IMF and the World Bank.

Comprehensive primary health care:

The Cuban Ministry of Public Health sets up the global health strategy in coordination with provincial and local health councils. After the 1959 revolution, private clinics and the pharmaceutical industry were nationalized and integrated into one single system, managed by the Ministry of Public Health. The country was divided into health zones, each with its own polyclinic. Health care was decentralized to the community level.

The system shows excellent transfer procedures for patients and communication between health workers at different levels of the healthcare system are efficient. General practitioners have access to all their patients' medical information, allowing them to adapt care to their patients' needs. Doctors have a central role in the system, are very close to their patients and know their social situation. This allows for large

scale prevention.
José Luis Fabio, representative of the Pan-American Health Organization (PAHO) in Havana, reported in The Lancet (25 January 2014) that focus on basic health care was essential to achieving good health outcomes. Also, **health care is free for all**. All medical examinations and operations are carried out free of charge, and Cubans pay a symbolic price for their medication at the doctor's.

Human resources:

While many developing countries face a "health worker crisis", with serious shortages of health workers severely limiting their health systems' development, the Cuban doctor-patient ratio is at 6,7 doctors per 1,000 inhabitants, far above the WHO minimum set at 2,28 doctors, midwives and nurses. Cuba emphasizes the importance of education for health workers. Even in times of economic crisis, the medical education's quality has been improved and the number of medical facilities increased. Medical training for international students is available at the Latin American Medical School in Havana. Cuba also engages in international medical support through the "Integrated Health Program" and showed an example to the world with the impressive response to the West-African Ebola epidemic[ii] with massive deployment of human resources.

Medicines and technology:

Scientific research and production in function of needs for medicine and their rational usage are key factors of the Cuban pharmaceutical policy. Every newly developed and tested product is immediately made available free of charge to the Cuban population. The current Cuban biotechnological industry, the 'Western Havana Scientific Pole', includes various institutes with a total of 12,000 staff, of which 7,000 are scientists and engineers. They provide the Cuban health system with 12 regular vaccines, over 40 drugs for common conditions (including recombinant interferon and erythropoietin) and diagnostic tests for screening on 30 diseases. Recent challenges have been non-communicable diseases. Cuba's pharmaceutical industry has been working on technology for a number of years to counter this situation . Cuba's example shows the potential of adjusting innovative pharmaceutical production to the population's needs, at low cost. Cuba produces around 90% of its basic medication. Dr José Luis Fernández Yero, director of the Immunoassay Center in Havana, says sustainable health is primarily built on prevention and health promotion, rather than on the latest technologies advertised by market-driven transnational manufacturers. According to Dr Yero, technology is useful only when it's available to the people needing it. "The adequate technology," he says, "contains a higher degree of fairness than cost efficiency". He adds that policy-makers should meet the population's right to health with the available means as well as they possibly can.

Conclusion

Boasting excellent achievements in the field of health, Cuba demonstrates universal health care is achievable. Putting the population's well being first and creating general living conditions favourable to health are the basic requirements. In Cuba, public spending on healthcare has always remained priority even in times of crisis. Health care is still entirely public and free, with a sustained focus on preventive medicine, giving the majority of the population access to quality health care.

However, Cuba is still struggling with **structural issues**. Since April 1960 the US have been imposing ever stricter sanctions on Cuba. Despite the weakening international support for this embargo, the US were until recently maintaining these sanctions. Over the years, they had a significant impact on health care. For instance, Cuba only has

limited access to specialized medical equipment (kidney dialysis units for example) and the country also misses out on important sources of income as it is not allowed to sell its pharmaceuticals on the North American market. The US embargo also limits the import possibilities of technology, materials and active ingredients needed for medication production.

After the recent exchange of prisoners between the US and Cuba, diplomatic relations may change significantly[iii]. According to Gail Reed, founding director of Medical Education Co-operation with Cuba (MEDICC), both the US and Cuba could benefit enormously in terms of health by the lifting of the embargo. It is in this evolving context that the Cuban authorities tried to develop new sources of funding for the health system. This resulted for example to the creation in 2011 of the "Empresa Comercializadora de Servicios Medicos Cubanos" (Company for cuban medical services commercialization), which ensures the comercialization by the state of some high quality and competitive prices health services for strangers. Although the initiative was set up by the state and aims to improve the health system and preserve its accessibility for cuban people, current experiments should be closely monitored as different forms of commercialization and trade in services, such as medical tourism risk to have a negative impact on access to health care.

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i WHO country health profile 2012

ii *Cuba's extraordinary global medical record shames the US blockade.* Seumus Milne,The Guardian Comment is free, December 3rd, 2014. From: http://www.theguardian.com/commentisfree/2014/dec/03/cuba-global-medical-record-shames-us-blockade-ebola (accessed on June 16th, 2015)

iii http://edition.cnn.com/2014/12/17/politics/cuban-embargo-questions-answers/

India: Public financing for whom?[1]

Health financing.

In the past six years there has been an impressive roll out of **government-funded insurance schemes** in India that are meant to improve the country's public health system. In theory, treatment covered under these schemes can be provided by any accredited facility. But in practice the majority of providers are found in the largely unregulated private sector which already accounts for 80% of outpatient and 60% of in-patient care according to the National Sample Survey Organisation (NSSO), making India one of the most privatized systems in the world and one with an infamous track record of expensive private health services and unethical practices.

As a result, **health insurance schemes mostly channel public monies for private profit**. For example, from 2007 to 2013 the state of Andhra Pradesh allocated a total Rs.47.23 billion to facilities accredited under the Arogyasri scheme, of which Rs.36.52 billion went to private facilities.

Limited coverage

What the majority of Indians lack is comprehensive primary care, but current health insurance "packages" only insure beneficiaries for ailments that require hospitalization. They **cover a very small portion of the burden of disease**, excluding out-patient treatments for tuberculosis, diabetes, hypertension, heart conditions, and cancer among others. Evidence from the first such scheme in India – Arogyasri – suggests that it consumed 25% of the state's health budget but addressed only 2% of the burden of disease.

Limited availability and quality of health services

This situation ends up distorting the very structure of the health system by **starving primary care facilities** to the benefit of more profitable secondary and tertiary care. In 2009-2010, direct national government expenditure on tertiary care was slightly over 20% of total health expenditure, but if one adds spending on the insurance schemes the total would be closer to 37%. In Andhra Pradesh, following the implementation of Arogyasri, the proportion of funds allocated for primary care fell by 14%.

Current public health services are marked by poor access, low quality and limited choice. Besides rampant corruption, poor management results in mismatches between demand and supply of services: facilities aren't distributed optimally; equipment and funds fall short of requirements and don't flow efficiently. Labour shortages can be partly explained by disinvestment in medical education and flawed deployment mechanisms. Although programs such as the National Rural Health Mission have made some inroads to improve services, much remains to be done. The problem is largely one of unresponsiveness to citizens coupled with unreliable technical estimates of costs and disease burden, leading to ill-informed prioritization.

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1 Amit Sengupta (2013) Universal healthcare in India: Making it public, making it a reality. MSP Occasional Paper No. 19. Cape Town: Municipal Services Project. http://www.municipalservicesproject.org/publication/universal-health-care-india-making-it-public-making-it-reality

Philippines: civil society opposes Public-Private Partnership approach

According to local organizations - IBON, Gabriela, Council for Health and Development (CHD) and Advocates for Community Health – the current privatization policies of the Philippine government do not provide an answer to the enormous health needs. Despite the name of the Filipino "Universal Health Care" program that claims to "bring equity and access to critical health services to poor Filipinos", commercialization of health services will do exactly the opposite and leave the poor behind. Civil society organizations in the Philippines insist that providing health services to the people, especially the poor and vulnerable is one of the fundamental functions of government. This function should not be subject to the profit motive and other influences but should remain a core public function. They insist that health services for Filipinos should be free. People should not be paying for health services because it is an obligation of the government to provide accessible and affordable health services. Instead of spending public money on health insurance, the government should provide government hospitals with budgets for capital outlay, maintenance and expand on key demands.

IBON, Gabriela, Advocates for Community Health and CHD are active members of the Network Opposed to Privatization of Health; a platform composed of groups and organizations of hospital workers, community health workers, students, professionals and individuals belonging to the health sector and from other sectors who oppose the policy of privatization.Together with other progressive health groups: Alliance of Health Workers and the Health Alliance for Democracy, the network leads the forces opposed to privatization of health in nationally-coordinated mass campaigns and mobilizations. The Alliance of Health Workers (AHW) recalls: "it is the government, and not the private sector, that has the primordial constitutional mandate to deliver health services, to move toward social justice and equity. Our health system should be managed as a social service, and not as a business that focuses on the extraction of profit", says a trade union representative of the AHW.

Because it is the first hospital to be corporatized, the campaign is focused on stopping the privatization of the POC. Following actions have been undertaken:

- A Mass walkout of health workers of the POC has been organized simultaneously with actions in 3 other government hospitals.
- Alternative media have been used to report on the campaign against the privatization of the POC.
- Education forums are organized in hospitals, health sciences schools and communities.
- Dialogue with the Secretary of the Department of Health regarding the POC privatization.
- There have been protest actions at the Department Of Health against the privatization with mass distribution of leaflets and reading materials.
- A petition has been organized to demand a prohibition of the privatization or a Temporary Restraining Order for the privatization of the POC.

In October 2014, the civil society campaign successfully managed to have a court ruling a Temporary Restraining Order for the privatization of the Philippine Orthopedic Center, on the basis of provisions in the constitution of the Philippines on the right to health, such as state responsibility in protecting and promoting the right to health and the adoption of an integrated and comprehensive approach to health development and access to essential goods, health and other social services, with priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. Next to that, the

campaign enabled to sensitize the health sector and the general public about the negative effects of privatization of public hospitals on universal access to health care.

Within the Philippine government Health secretary Enrique Ona is under fierce opposition for the privatization plan of 72 government hospitals, with Abakada party representative Jonathan de la Cruz filing a resolution asking Enrique Ona to attend the house inquiry. He said: “We have been giving the Department of Health huge amounts of money to improve the delivery of medical assistance through government hospitals and now Enrique Ona is coming out with statements on privatization, I don't think that is a responsible way of handling the budget his department receives.” Also representatives 'Gabriela' denounced the privatization plans, affirming that “it would make medical help more inaccessible to the majority of people” and filed a resolution compelling the Departments of Health, Finance, Budget and Management and the National Economic Development Authority to disclose the blueprint of the modernization plan for public hospitals.