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Editorial

Deconstructing the "Free Health Service" in Sri Lanka

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Sri Lanka is renowned for its free health services, which cover all citizens (and sometimes even non-citizens), irrespective of their ability to afford healthcare. Sri Lanka has reported impressive health indicators in the past few decades: the lowest maternal mortality ratio in the South East Asian region, the eradication of poliomyelitis along with the elimination of malaria, measles [1], lymphatic filariasis [2], and Congenital Rubella Syndrome [3] from the country. The "free health" model was first adopted in the early 1950s to cover all citizens with state funded healthcare facilities and provide health services free of charge at the point of use. Even though it is called "free", in reality, health services cost money and someone has to pay [4]. Moreover, there is no limitation on the amount of money spent on one person in this model [1,5]. However, the free health model has reduced health inequalities and the burden of many diseases in the country [6] by increasing service utilization and improving financial protection.

Free healthcare demand is based on the assumption that healthcare is a human right that should not be denied to anyone [7]. In that way, as it is like right to life, liberty, and the pursuit of happiness, it should be taken care of by the government. However, this right to free healthcare can be considered a self-defeating argument [7], and some argue that for many reasons, healthcare should not be considered a human right [8].

Despite its many benefits and achievements, the free health model faces many challenges. While free healthcare (FHC) policies may trigger an increase in the use of services, the evidence of improved financial protection is mixed. People may still have to make direct payments for other services (high transport costs of seeking healthcare during after-hours, paid bystanders, or opportunity costs such as lost wages in seeking healthcare during normal work hours), leading to high out-of-pocket expenditure [9]. Moreover, if not properly anticipated and backed by increased supplies and medicines, FHC may have negative unintended consequences, such as patients having to pay for this scarce supply informally or in the private sector. Since there are no direct incentives for health workers in this system, the long-term staff motivation needed to maintain this service can deteriorate [9].

Welfare state models face common challenges such as increased social spending, growing inequality, and the need for severe budget savings [10]. Moreover, without proper targeting and monitoring, better-off population groups will benefit more from FHC policies than vulnerable population groups [9]. Even in post-growth welfare systems, five core dilemmas have been identified: how to maintain funding for the welfare system in a non-growing economy, how to manage the increasing relative costs of welfare, how to overcome structural and behavioural growth dependencies within the welfare system, how to manage the increasing need on a finite planet, and how to overcome political barriers to the transformation of the welfare state [11].

At the time of political independence, Sri Lanka has enjoyed the third-highest per capita income in Asia after Japan and Malaysia [12]. Furthermore, Sri Lanka has enjoyed economic

prosperity during the early years of independence with a trade surplus [13]. At that time, Sri Lanka had the finest chances for a rapid economic take-off; by and large, the economy performed poorly during the five decades of the post-independence period [13]. Now Sri Lanka is classified as a lower-middle-income country by the World Bank [14] when many countries in Asia have surpassed us in the economic front after independence [15]. Independent Sri Lanka's failure to live up to its initial promise in the area of economic development could be attributed inter alia to: (a) a foreign-exchange crisis which persisted till 1977 because the exigencies of electoral politics bound the country to welfare-oriented, inward-looking policies; and (b) the eruption of conflict between the two main communities as of 1983 [16]. Indisputably, Sri Lankan free healthcare model including the free medical education model need urgent reforms [17] and the avenues need to be explored where the health sector can generate revenue to the government.

The lack of resources in the health system in Sri Lanka has reached its zenith in the present economic crisis. The country is struggling to provide adequate resources to the health sector, with a lack of investment in medical technology and equipment. This has led to a shortage of drugs and outdated facilities, which have impacted patient care [18]. Health services rationing or restricting the access of some people to useful or potentially useful health services due to budgetary limitation [19] needs careful consideration in this context. Financial and resource constraints worsened by the current economic crisis put enormous pressure on policymakers and health authorities to consider explicit rationing [20] of healthcare services as well as other sustainable financing options besides traditional funding through general taxation.

Explicit rationing occurs when society enacts precise and transparent rules that determine the circumstances under which certain persons can claim certain medical services [21]. When implemented based on well-defined, transparent and data driven criteria, explicit rationing has the potential to maximize nations' health, improve cost effectiveness and efficiency in health services and reduce health inequities [20,21]. Supplementary financing methods on the other hand, can increase state-owned health resources, incentivize the health workforce and minimize financial risk (especially among the poor). Ultimately, both will help to sustain the FHC model. However, a public outcry may be unavoidable if the existing information asymmetry is not addressed by increasing public awareness of such initiatives [22]. In contrast, implicit rationing of health services at the bedside or physicians' level may come in the form of prioritization of the neediest (due to scarcity) when ideally a larger group would have been benefited from the same health expenditure by explicit rationing. Implicit rationing can have more negative effects on health outcomes and financial protection of the poor, even in an FHC model.

Considering other available options, private financing initiatives (PFIs), which are a form of public-private partnership, include the private sector providing funding for public projects such as construction and operation of health infrastructure, sometimes, in exchange for long-term contracts with governments or public health providers. However, it is important to note that PFIs are criticized for their high public budgetary costs compared to other forms of financing. Furthermore, escalating costs associated with PFIs have been documented in the long term. Despite these criticisms, some governments and development agencies have promoted the use of private financial capital in healthcare as a means of promoting development [22]. Apart from these, donations and various charity provisions such as drug donations, constructions and renovations of the government health facilities by the private sector are some examples where private sector

provides financing while the public sector provides health services.

The other common mode of public-private partnership occurs when public sector undertakes financing and the private sector provides services [23]. Some examples include public financial assistance to patients undergoing predefined procedures in the private sector, outsourcing various facility services to private companies and not-for-profit contractual agreements for ambulance services [24].

Additionally, health insurance has been explored in the country over the past two decades. The majority of the health insurance sector is dominated by the growing private insurance industry owing to the lapse of the national health insurance scheme. Evidence suggests that private health insurance schemes have limited usefulness in providing financial protection and achieving universal health coverage [25]. Social health insurance (SHI) is another beneficial pathway explored by many countries. When different health risk groups and health resources are pooled in one (risk and resource pooling) without fragmentation in a SHI model, the desired population and service coverage can be achieved adequately. To successfully implement SHI, a country must have good socio-economic development, a large proportion of well-developed formal sector organizations, and a well-developed financial sector, including banks [26]. As informal sector accounts for two-thirds of the total employees in Sri Lanka [27], it requires a comprehensive feasibility assessment if SHI is selected as a health financing option, without forgetting the costs involved in such efforts. Although a publicly financed school health insurance scheme and a contributory insurance scheme (covering a specified set of benefits) for some public sector employees have been introduced [1], they are still largely yet to be explored.

In conclusion, we need to carefully re-envision the universal health coverage through "free health" model, exploring many health financing options that can meet people's aspirations for health and social justice. First, complementary measures are needed for FHC policies to be successful, and sufficient financial resources generated through various means need to be provided at the facility level to compensate for both the loss of revenue at the provider level and the desired increase in the use of services. Second, policymakers should look for synergies between different sectors and ensure that FHC policies lead to a coherent health-financing architecture. Finally, all health services must be available to the most distant, needy, and vulnerable populations.

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