B3 | HEALTH FINANCING MODELS THAT MAKE HEALTH SYSTEMS WORK: CASE STUDIES FROM COSTA RICA, SRI LANKA AND THAILAND

In Chapter B2 we have discussed different options available for health financing, in order to secure equity and universal coverage by health systems. In order to deepen our analysis we analyse in this chapter three case studies that examine systems in place in Costa Rica, Sri Lanka and Thailand. Each of them has been proclaimed an exemplar of a 'well-performing' health system. They are, by no means, the *only* three such examples (others such as Brazil, Cuba, etc., have also been part of such discussions). Nor are the three cases entirely similar. However, the three cases are a good starting point for visualising the contours of health systems that have the best potential for ensuring both access and equity.

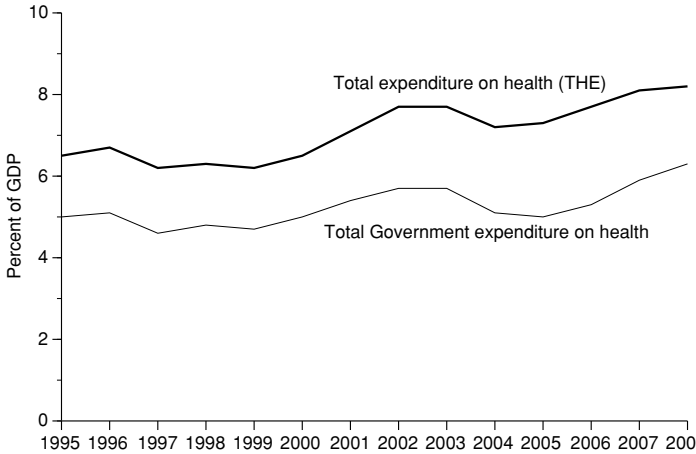
Costa Rica: integrating health financing with service provision

The Costa Rican health system is characterised by strong integration between health financing (through a compulsory social health insurance programme) and service provisioning by the public sector. This has been a cause of contention, over the years, between the Costa Rican government and the IMF/World Bank combine (as we shall see later).

The impact of such a system on health indicators has been almost spectacular. In the Americas, Costa Rica's life expectancy (78 years) is second only to that of Canada (Unger et al. 2008). It has been argued that Costa Rica's health achievements are a function of income growth in the country.[1] This is not, however, borne out by evidence. Rosero-Bixby (1986) has shown that only one-fifth of the country's spectacular infant mortality reduction in the 1970s can be accounted for by economic growth, whereas three-fourths can be attributed to improvements in public health service.

Since the 1970s, Costa Rica's economic growth rate has been less than one-third that of Chile and similar to that of Colombia and Mexico. But, in the same period, Costa Rica achieved reductions in infant mortality similar to those achieved in Chile and twice those achieved in Colombia and Mexico (Homedesa and Ugalde 2002). The country's infant mortality rate was 10 per 1,000 in 2008, representing a sixfold reduction over a four-decade span.

Health sector development in Costa Rica A social security system for wage-earning workers in Costa Rica was instituted through the creation of the



B3.1 Total expenditure and general government expenditure on health as a percentage of GDP (*source*: World Health Organisation (n.d.)

Social Security Administration (CCSS – *Caja Costarricense de Seguro Social*) in 1941. Several progressive measures were adopted during the 1970s. CCSS extended its coverage and expanded the delivery of hospital-based health services. In addition the Rural Health Programme (*Programa de Salud Rural*) and Community Health Programme (*Programa de Salud Comunitaria*) were launched to provide comprehensive primary care services in rural and semi-urban areas (Unger et al. 2010).

The CCSS is the sole provider of public hospital care (23.9 per cent of total health expenditures is targeted at public hospitals and 2 per cent at private hospitals). The CCSS both purchases and provides care services. This unified health care system has helped Costa Rica avoid the social insurance stratification typical of other Latin American countries (ibid.). By 2000 the CCSS covered about 82 per cent of the population.

The government of Rodrigo Carazo (1978–82) introduced major elements of community participation into the health system. Health committees were activated in rural health posts under the aegis of the Unit for People's Participation (*Unidad de Participación Popular*), a newly created division of the Ministry of Health. The focus on primary health care received a setback during the regime of Luis Alberto Monge. However, a major expansion of primary health care clinics (EBAIS; *Equipos Básicos de Atención Integral en Salud*) commenced in the mid-1990s.[2] Health committees occasionally co-manage these clinics. While, as part of a World Bank project, the CCSS started contracting out some services to the private sector, this was done only to a limited extent (ibid.).

The health system ensures wide coverage for most services – 90 per cent of women access antenatal care; 94 per cent of deliveries are attended by a trained professional; measles immunisation coverage is above 90 per cent (data for 2008) (World Health Statistics 2010).

Health financing The government is the main source of finance for health care. During the mid 1990s, around 5 per cent of GDP was allocated to health, and this rose to 6.3 per cent in 2008. (See Chart B3.1.) Of the total expenditure on health care, public funding accounts for over 70 per cent (World Health Organisation n.d.). Interestingly, over the years, private expenditure has fluctuated in an almost identical manner to public spending.

To understand better the experience of Costa Rica, let us examine the relative situation in health financing, in selected Latin American countries (see Table B3.1)

Clearly, Costa Rica is one of the best performers – both in terms of high public spending and in terms of low out-of-pocket expenditure. If we leave Cuba out of the discussion (because the Cuban system is so different), Colombia is the only other country that matches Costa Rica's performance. There is, however, an interesting difference. While only 0.12 per cent of Costa Rican households report an impact of catastrophic health expenditure (Unger et al. 2010), the corresponding percentage of households in Colombia is 6.26 (Xu et al. 2003). As the CCSS is both a purchaser and a provider of care services, no purchaser–provider split is evident in the dominant (public) part of the Costa Rican health system. In contrast, Colombia suffers from the consequences of transferring care provision to several private providers, or combinations of private and public providers. The unified system in Costa Rica also ensures better efficiency – the administrative cost has varied been between 3 and 4 per cent since 1990, in contrast to double-digit numbers among competing private insurers in Chile and Colombia (Rodríguez Herrera 2006). The health system in Costa Rica also actively promotes equity through progressive targeting of expenditure – 29 per cent of expenditure is targeted at the poorest income quintile and 11 per cent at the richest (figures for 2000) (Unger et al. 2010).

The trajectory chosen by Costa Rica goes against the core recommendations of the World Bank, which has consistently argued in favour of a purchaser–provider split. This dissonance has been a cause for strained relations between Costa Rica and international agencies. When José María Figueres Olsen became president in 1994, he opposed recommendations of the IMF that called for privatisation of public services, and instead favoured greater government intervention in the economy. The World Bank subsequently withheld $100 million in financing from the country. More recently, in 2003, Costa Rica temporarily abandoned the Central American Free Market Agreement (CAFTA) discussions and hesitated in accepting the US condition of opening up the insurance market (ibid.).

Some concerns do exist about the Costa Rican health system. One relates to the sustainability of the system in the face of rising costs of health care. There is also concern that out-of-pocket expenses still constitute almost a quarter of total health expenditure. While this is lower than in most low- and middle-income countries, it still means that vulnerable sections may still not

TABLE B3.1 Expenditure on health: comparison with some Latin American countries (as % of GDP)

	General government expenditure on health			Prepaid and risk-pooling plans			Private households' out-of-pocket payment		
	1995	2000	2007	1995	2000	2007	1995	2000	2007
Argentina	5.0	5.0	4.6	0.9	1.3	2.7	2.3	2.5	2.1
Brazil	2.9	2.9	4.9	1.2	1.5	1.2	2.6	2.7	2.4
Chile	2.5	3.0	3.0	1.5	1.6	1.2	1.6	1.5	1.4
Colombia	4.3	6.2	6.4	0.5	0.6	0.6	2.6	0.9	0.4
Costa Rica	5.0	5.0	5.9	0.0	0.0	0.2	1.3	1.3	1.9
Cuba	5.2	6.1	9.9	0.0	0.0	0.0	0.5	0.6	0.6
Mexico	2.4	2.6	3.0	0.1	0.1	0.2	3.2	2.8	3.3
Panama	4.8	5.3	5.7	0.4	0.5	0.4	1.9	2.0	1.7
Venezuela	2.3	3.2	2.7	0.1	0.1	0.1	2.0	2.5	2.4
Latin American average	3.3	3.6	4.1	0.5	0.8	0.7	2.3	2.4	2.3

Source: Data from WHO (2009), cited in Hernández, L. O. et al., *Progressive Alternatives of Primary Health Care in Latin America*

be adequately secured. A final concern relates to the method of computing budgets for health facilities. These are based on the previous year's expenses, thus providing an advantage to facilities in the capital regions and in big cities.

Conclusions The 2010 *World Health Report* remains ambiguous about direct public provisioning, while emphasising social insurance mechanisms in ensuring universal access to health services (WHO 2010). The experience of Costa Rica, and the contrast with other countries in the region, is clear evidence that health systems that promote equity and universal access are best served by a combination of public financing and provisioning.

Sri Lanka: welfare state under strain

A quarter of a century back, Sri Lanka's remarkable experience in promoting equity in social development was summarized as follows (Herring 1987: 326):

> The basic needs performance of Sri Lanka, in the face of classical and severe structural dependency, raises a profound developmental point: extreme national poverty need not entail mass destitution, just as national wealth is no guarantee of well-being for the bottom of the income pyramid. The relative effective mediation between national poverty and individual well-being in Sri Lanka was sustained by extensive public investment in economic processes, with specific politically driven priorities.

The Sri Lankan story has been a subject of considerable discussion. One of the poorest Asian countries with a dependent economy (on export of plantations produce and tourism), it has sustained human development indicators that rival or surpass those of many developing countries. Sri Lanka's paradigm of development, however, has not been linear, and the last two decades have also witnessed the tension between its earlier 'welfare' model of development and the later introduction of neoliberal policies. In the following section we examine the effect of this tension, especially in the health sector.

Welfare state under strain After independence from British colonial rule in 1948, Sri Lanka engaged in developing a welfare state. It was characterised by universal public distribution of food at a very low price, free education and health, labour legislation, pensions, etc. By the 1950s such measures accounted for almost a quarter of the country's gross national product (GNP) (Lakshman 1987). These measures were complemented by extensive land reforms, carried out to alleviate the acute problem of landlessness among peasants (Bjorkman 1987). The results were fairly spectacular (see Table B3.2).

The first three decades after independence from colonial rule witnessed a huge expansion of health units and hospital, directly financed by the government. By 1997, government spending on health was 5.5 per cent of total government expenditure (Fernando 2001).

TABLE B3.2 Comparison of development indicators (by the late 1970s)

	Low-income countries	Lower-middle-income countries	Upper-middle-income countries	High-income countries	Sri Lanka
Life expectancy	51	52	62	72	64
IMR	138	98	83	21	42
Death rate per 1,000 population	16	14	10	9	7
Literacy (%)	36	57	67	97	85
GNP per capita ($)	225	566	1800	8222	270

Source: Hansen et al. (1982), cited in Bjorkman (1987)

A worsening balance of payments situation in the 1970s was the trigger for imposition of a structural adjustment policy in Sri Lanka in 1977, on the dictates of the World Bank and the IMF, with an emphasis on economic 'growth' over measures to promote social well-being (Herring 1987). Social welfare programmes, instead of the earlier universal character, changed to targeted programmes. There were cuts, for example in food subsidy, and food coupons replaced direct provisioning.

A key change in the health sector was the permission granted to medical officers in the public sector to work as private practitioners outside office hours. This was a major factor in triggering an expansion of the private medical sector. In the 1990s, foreign medical service providers and insurance providers were allowed to operate in the country, government facilities were leased out for private operation, and concessional loans were provided to private investors to set up medical facilities in rural areas. In recent years,

B3.2 Public expenditure on health as a percentage of GDP, 1977–2009 (*source*: Institute for Health Policy (2009) and Fernando (2001)

the clinical and non-clinical services of public facilities have been contracted out to the private sector. This has resulted in a substantial expansion of the private sector (Baru 2003).

However public spending on health stabilised at earlier levels, after initial cuts. By 1989 health expenditure as a proportion of the total health budget had increased to 6.5 per cent (Fernando 2001). (See Chart B3.2.)

Sustaining the early momentum Much of the spectacular health improvement in Sri Lanka had taken place by the mid 1970s. In 1977 its life expectancy at birth (65 years) was comparable to some of the European countries, far better than that of its neighbours in the South Asian subcontinent (India, Pakistan and Bangladesh) and even China (Herring 1987). With very low levels of per capita income ($200), it could achieve an Infant Mortality Rate (42 per 1,000 live births) lower than in countries with five to ten times higher per capita income. Maternal Mortality Rate (Bjorkman 1987) was also significantly lower than in countries with comparable income.

Health indicators have continued to improve since then, though the improvement slowed down in the last two decades of the twentieth century (Fernando 2001). Clearly, the early momentum provided by expansion of public services still has an impact on health outcomes – which continue to be much better than those of most low- and middle-income countries (LMICs) (see Table B3.3).

TABLE B3.3 Sri Lanka: key health indicators

Indicator	Year	Data
Life expectancy at birth (years)	2001–06	
Female		76.4
Male		71.7
Neonatal mortality rate (per 1,000 live births)	2002	8.4
Infant Mortality Rate (per 1,000 live births)	2003	11.17
Under-five mortality rate (per 1,000 live births)	2002	13.39
Total fertility rate (per woman)	2000	1.9
Maternal mortality rate (per 100,000 live births)	2002	14.3

Source: Ministry of Health (2007)

Health financing The total expenditure on health (as a percentage of GDP) rose marginally between 1990 and 2006 – from 3.8 to 4.2 per cent. This is almost equally shared by public and private expenditures – 1.7 and 1.8 per cent respectively in 1990 and 2.1 per cent each in 2006. The estimated health expenditure per person was Rs5,926 (US$57) in 2006 (Institute for Health Policy 2009).

The public sector is financed from general tax revenue. Within this (in 2006),

the share of the central, provincial and local governments was 65, 33 and 1.4 per cent respectively. The private sector is mainly financed by out-of-pocket expenditure. Out-of-pocket expenditure accounted for 86 per cent of total private financing, followed by 6 per cent through employers' contributions and 3 per cent through private health insurance (ibid.).

Interestingly, while private and public spending are almost equal, there is a large divergence in terms of where this money is spent. Public spending covers 90 per cent of people accessing inpatient care and 40 per cent of those accessing outpatient care, while private spending accounts for only 10 per cent of inpatient care and 60 per cent of outpatient care (see Table B3.4) (Central Bank of Sri Lanka 2008).

TABLE B3.4 Sri Lanka: share of health expenditure by function and source in 2006

Function	Expenditure (Rs million)	Source (%)	
		Public	Private
Inpatient care	39,864	72	28
Outpatient care	24,869	35	65
Medical goods dispensed for outpatients	26,139	10	90
Prevention and public health aervices	6,476	86	14

Note: 90 Sri Lankan Rs = US$1 approx.

Source: Institute for Health Policy (2009)

Owing to the higher costs in the private sector, actual expenditure on inpatient and outpatient care is shared differently among the actual number of patients covered (see Table B3.4). The private sector accounts for 28 per cent of costs for inpatient care (while treating about 10 per cent of the patients) and 65 per cent of outpatient care (while treating about 60 per cent of patients).

While the government continues to be the main source of finance for new infrastructure creation, the private sector has steadily increased investment in this area. Thus, overall private spending on capital investments in the health sector has grown faster in recent years than public spending (Institute for Health Policy 2009).

The government offers free inpatient care through an elaborate network of hospitals.[3] The cost per patient treated in the private sector is over three times that of the public sector (Rs22,504 (US$240) as against Rs6,431 (US$70)). It is important to underline that the cost of treatment in the private sector does not include the direct and indirect subsidies that it receives from the government. Such subsidies, for example, include the services of government doctors who are now allowed to practise in the private sector; and fiscal incentives for setting up tertiary care hospitals. These subsidies were estimated to be Rs7,230 (US$80) per inpatient (during 1990–2003) (Kalyanaratne and

Rannan-Eliya 2005). In other words, government subsidy to the private sector (per inpatient treated) is higher than what the government spends to treat one inpatient! This constitutes direct evidence of how public money is being spent to strengthen the private sector.

Private outpatient care services are the fastest growing segment of health services. The relative shares of total patients treated in private clinics by different providers include: government medical officers and specialists (59 per cent), private general practitioners (26 per cent) and traditional medical practitioners (15 per cent) (Institute of Policy Studies 2000). Again we note the substantial role played by the public sector in strengthening the private sector – through the large presence of government doctors in private sector facilities.

Expenditure per outpatient treated in the private sector (Rs817) is three times that in the public sector. An explanation for the growth of the private sector also lies in evidence that there has been a decline in the standard of outpatient care in the public sector and a rise in indirect expenditures borne by patients accessing the public sector.[4]

During the early post-independence years 20–25 per cent of total health expenditure was allocated for preventive and promotional services. However, by 2003 this figure had come down to barely 5 per cent. The number of persons using primary care facilities has also declined. In 1991 primary-care-level facilities obtained between 30 and 35 per cent of total recurrent patient care expenditures. In 2003 primary care expenditures declined to 25 per cent of total patient care expenditures

Conclusion The Sri Lankan story carries messages that are both good and bad. The good news is that the health system has managed to withstand the onslaught of neoliberal economics and continues to be the major provider of health services in Sri Lanka. The momentum created in the first three decades after Sri Lanka's independence is not entirely lost. The bad news is that structural measures, introduced in the health system, serve to strengthen the private sector – often through government subsidy. The private sector is growing faster than the public sector today and is also responsible for a deterioration in standards of care. Continued vigilance, advocacy and action by health activists, civil society organisations and people's movements is necessary to defend and expand what has been a model of a public-sector-run health system in a low-income country.

Thailand: good practice in expanding health coverage

In recent decades the health system in Thailand has been proclaimed one of the better-performing health systems in the region, as well as at a global level. In this section we examine the evolution of the Thai health system.

Major reforms in the Thai health system commenced around the turn of the present millennium, but these were shaped by several initiatives that date

back to the 1970s. The first major social health insurance (SHI) scheme – the Medical Welfare Scheme (MWS) – was initiated in 1975. It was funded through general taxation and covered those with monthly incomes of less than 1,000 Thai baht (NESDB 2005). Under the scheme, medical services were provided through public health facilities. This scheme was later expanded to cover the elderly, children, veterans, the disabled, monks, and priests (Pannarunothai 2002). This was followed by three other social health insurance schemes. The 'Health Card Scheme', a voluntary scheme that required co-payment from beneficiaries, had elements of selection bias (Srithamrongsawat and Torwatanakitkul 2004). Two other schemes covered employees – the compulsory Social Security Scheme, started in 1992, for all private sector employees and civil servants, and the Civil Servant Medical Benefit Scheme (CSMBS), which covered public sector employees and their family members. The former was funded through mandatory co-payment by employers and employees while the latter was fully funded from general tax revenue.

In 2000, the four social health insurance schemes (along with a marginal presence of private health insurance) covered around 75 per cent of the population (Wibulpolprasert 2004). The Thai-Rak-Thai party, after being

TABLE B3.5 Progress in health insurance coverage (%)

Scheme	1991	1996	1998	2001	2003	2006	2007
Universal Coverage	–	–	–	–	74.7	74.3	74.6
Social welfare	12.7	12.6	45.1	32.4	–	–	–
Civil servants	15.3	10.2	10.8	8.5	8.9	8	8.01
Social security	–	5.6	8.5	7.2	9.6	11.4	12.9
Voluntary health	1.4	15.3	13.9	20.8	–	–	–
Private health	4	1.8	2	2.1	1.7	2.3	2.16
Total insured	33.4	45.5	80.3	71	94.9	96	97.7
Uninsured	66.6	54.5	19.7	29	5.1	4	2.3

Source: National Statistical Office (2006); NHSO (2007)

TABLE B3.6 Catastrophic expenditure by households, 2000–06 (%)

Year	Quintile 1	Quintile 5	All quintiles
2000	4	5.6	5.4
2002	1.7	5	3.3
2004	1.6	4.3	2.8
2006	0.9	3.3	2

Source: Tangcharoensathien (2007)

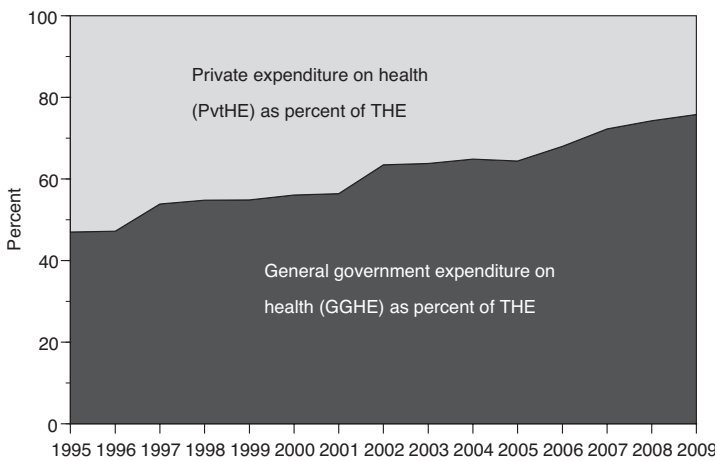
elected in 2000, introduced a universal health coverage scheme (UCS) – the '30 Baht treat all diseases' scheme. Initiated in 2002, the scheme combined the previous Medical Welfare Scheme and the Voluntary Health Card Schemes and expanded coverage to an additional 18 million people. The 30 Baht scheme achieved nearly universal coverage (NHSO 2007) and included a comprehensive package of care, both curative and preventive. After a new government assumed office in 2006, the 30 Baht co-payment was abolished.

Financed entirely from general tax revenue, the main health care providers are public hospitals (covering more than 95 per cent of the beneficiaries). About 60 private hospitals are part of the scheme and cover about 4 per cent of the beneficiaries – mainly from the highest-income groups.

The depth of coverage has increased over the years and services not previously covered have been included, such as antiretroviral treatment (included in 2003) and renal transplantation (included in 2006). Owing to these policies there was a rapid increase in utilization of public health services by all sections of society, especially the poor.

While near universal in coverage, the UCS still leaves out about 4.5 per cent of the Thai population (2.8 million people) (Hughes and Leethongdee 2007). Those not covered are largely migrants and people from indigenous communities, and this is an area of concern that the UCS needs to address.

Evidence of success Several studies point to the success of the UCS in increasing coverage (see Table B3.5), and in reducing catastrophic health expenditures (see Table B3.6). It is estimated that the UCS, by reducing catastrophic expenses for health care, has rescued an estimated one million people from the effects of extreme poverty. Surveys show that a majority are satisfied with the quality of the care provided. (NHSO and ABAC Poll Research Centre 2007). Civil society's participation has been actively sought in designing and sustaining



B3.3 Share of government and private health expenditure in Thailand, 1995–2009 (*source*: World Health Organisation (n.d.)

the UCS, reflected also in the large popular participation in the process of drafting of the National Health Security Bill.

Final evidence about the impact of the UCS is provided by data on public and private health expenditures. There is a secular trend of a rise in the former and a decline in the latter (see Chart B3.3).

Challenges before the UCS The increase in demand for health services, as a consequence of the success of the UCS, has implications for the workload of health workers. More than 70 per cent of health workers surveyed claimed that their workload has increased as a result of the UCS (NHSO and ABAC Poll Research Centre 2007). Increased workload, along with relatively poor remuneration in the public sector, have led to a huge exodus of public sector doctors to the private sector. The growth in the private sector has also been fuelled by the growth of medical tourism, with Thailand having emerged as one of the most preferred destinations for medical tourism.

During the initial years of implementation, the UCS was criticised by health care providers for being underfinanced, particularly for inpatient care. Almost a third of the public hospitals, mostly rural community hospitals in the north and north-east, were severely indebted. Such experiences have now prompted the government to increase their budgets significantly. The financial situation of most hospitals has thus greatly improved.

Lessons from the Thai reforms While countries such as Sri Lanka and Costa Rica have a much longer history of health systems based on principles of universal coverage, public sector provisioning and financing, what is remarkable about the Thai reforms is that they have been initiated in a period when neoliberal policies have led to health sector reforms, in many parts of the world, based on increased private sector participation and a decreased role for governments in both care provision and financing.

The Thai UCS was a result of a bold political decision, and its current state shows that the scheme is sustainable – thereby belying the negative expectations of several international agencies.

Learning from the country case studies

The three case studies in this chapter raise very interesting issues. What is common among them is the clear attempt, in all three countries, to minimise the split between provisioning and financing of care. All three countries also put reliance on public financing, largely raised through general taxation. The examples thus might appear to be out of sync with the recommendations of international agencies which today argue forcefully in favour of a split between financing and provisioning of health services. But the evidence from the three case studies appears quite overwhelming, and suggests that it is the international agencies that are out of sync with reality.

The countries operate in a global environment where their endeavours are seen as 'swimming against the current'. At least two of them – Sri Lanka and Costa Rica – have faced or continue to face strains because the neoliberal trajectory of global policy-making stands in contradiction to the trajectory of the health system in the country. Sri Lanka shows the most clear signs of this contradiction actually starting to fundamentally change the contours of its health system – for the worse.

Clearly there is a need to defend these systems, learn from them (and also from their mistakes!) and make this a basis for the articulation of equitable and accessible health systems in other situations across the globe. This requires, apart from national action, global solidarity.

Notes

1 The *World Development Report* of 2004, while showcasing Costa Rica's achievements, credits economic growth for the health improvements (World Bank 2004).

2 EBAIS comprises health centres with a general practitioner, an assistant nurse, a clerk, a pharmacy assistant, and a primary health technician, and second-line clinics (clinics providing first-referral care in the context of a multi-tiered health care system) located in proximity to the CCSS's area headquarters.

3 A survey on public hospital inpatient discharge reported that the rate of hospital admissions per 100 population is relatively high in comparison with other countries, and comparable with those seen in the Organisation for Economic Co-operation and Development (OECD) economies with the highest rates of hospitalisation. The average length of stay in Sri Lanka (4.2 days) is relatively short, and lower than in most developed countries, but when examined in relation to specific diagnoses the lengths of stay are actually comparable to those in many developed countries (Institute for Health Policy 2009).

4 A study of 158,699 outpatients visiting 12 primary care institutions in three districts in 1988 revealed that prescribing officers were able to use standard treatment schedules based on essential drugs almost exclusively to meet the drug requirements of patients (Ministry of Health 1988). A study done in 2005 on a sample randomly selected from outpatient clinics of public medical facilities reported that at least 30 per cent of the direct cost of treatment is borne by the patient. Depending on the type and level of illness, the patient had to bear at least 57 per cent of the total cost with a maximum of 98 per cent including indirect cost (Attanayake 2005).

References

Attanayake, N. (2005). *The Economic Cost of Five Common Diseases in Sri Lanka*. Ratmalana, Sri Lanka, Vishva Lekha Printers, December.

Baru, R. (2003). 'Privatisation of health services: a South Asian perspective'. *Economic and Political Weekly*, 38(42): 4433–7.

Bjorkman, J. W. (1987). 'Health policy and politics in Sri Lanka: developments in the South Asian welfare state'. *Asian Survey*, 25(5): 537–52.

Central Bank of Sri Lanka (2008). *Annual Report 2008*. Colombo.

Fernando, D. N. (2001). 'Structural adjustment programs and health care services in Sri Lanka – an overview'. In Qadeer, I., K. Sen and K. R. Nayar (eds), *Public Health and Poverty of Reforms: The South Asian predicament*. New Delhi, Sage.

Herring, R. J. (1987). 'Economic liberalization policies in Sri Lanka: international pressures, constraints and supports'. *Economic and Political Weekly*, 22(8): 325–33.

Homedes, N. and A. Ugalde (2002). 'Privatización de los servicios de salud: las experiencias de Chile y Costa Rica'. *GAC Sanit*, 16(1): 54–62. In Unger et al. (2008).

Homedesa, N. and A. Ugalde (2005). 'Why neoliberal health reforms have failed in Latin America'. *Health Policy*, 71: 83–96.

Hughes, D. and S. Leethongdee (2007). 'Universal coverage in the land of smiles:

lessons from Thailand's 30 baht health reforms'. *Health Affairs*, 26(4): 999–1008.

Institute for Health Policy (2009). *Sri Lanka Health Accounts. National Health Expenditures 1990–2006. Colombo – Public Hospital Inpatient Discharge Survey 2005, Health Statistics Report Number 1*. October.

Institute of Policy Studies (2000). *The Private Clinic Market in Sri Lanka 2000*. Colombo.

Kalyanaratne, A. and P. R. Rannan-Eliya (2005). *Fiscal Incentives for the Development of Health Services in Sri Lanka*. Ratmalana, Sri Lanka, Vishva Lekha Printers, October.

Lakshman, W. D. (1987). 'Active state control vs. market guidance in a dependent capitalist economy: the case of Sri Lanka, 1970–84'. *Social Scientist*, 15(4/5): 10–44.

Ministry of Health (1988). *A Survey on Morbidity Patterns and Drug Requirements of Primary Health Care Level in Sri Lanka*. Colombo.

Ministry of Health (2007). *Annual Health Statistics*. Colombo, Government of Sri Lanka.

Ministry of Public Health (2006). *Village Health Volunteer Database* [in Thai]. Department of Health Service Support. phc.moph.go.th/phc/.

National Statistical Office (2006). *Key Statistics of Thailand 2006*. Database and Statistics Division, National Statistical Office.

NESDB (National Economic and Social Development Board) (2005). *Thailand's Official Poverty Lines*. www.nscb.gov.ph/poverty/conference/papers /7_Thai%official%20 poverty.pdf.

NHSO (National Health Security Office) 2007. *The Success of the UCS Implementation* [in Thai]. Paper presented at the National Health Security Board meeting, National Health Security Office, Nonthaburi, Thailand, 29 August.

NHSO (National Health Security Office) and ABAC Poll Research Centre (2007). *The Perspectives of UC Members and Health Care Providers to UC Program* [in Thai]. Nonthaburi, Thailand, National Health Security Office.

Pannarunothai, S. (2002). 'Medical welfare scheme: financing and targeting the poor'. In Pramualratana, P. and S. Wibulpolprasert (eds), *Health insurance systems in Thailand*. Nonthaburi, Thailand, pp. 62–78.

Rodríguez Herrera, A. (2006). *La reforma de salud en Costa Rica*. Report no. 173, Santiago de Chile, Naciones Unidas, Comisión Económica para América Latina y el Caribe (CEPAL), Unidad de Estudios Especiales. In Unger et al. (2010).

Rosero-Bixby, L. (1986). 'Infant mortality in Costa Rica: explaining the recent decline'. *Stud Fam Plann*, 17(2): 57–65, March. www.unicef.org/infobycountry/costarica_statistics.html.

Srithamrongsawat, S. and S. Torwatanakitkul (2004). 'Implications of the universal coverage scheme on health service delivery system in Thailand'. In Tangcharoensathien, V. and P. Jongudomsak (eds), *From policy to implementation: historical events during 2001–2004 of universal coverage in Thailand*. Nonthaburi, Thailand, National Health Security Office, pp. 51–60.

Tangcharoensathien, V. (2007). *What Do We Expect on Health Care Financing?* Presentation at an International Labour Organization–World Bank–Ministry of Public Health workshop on Model Development for Sustainable Health Care Financing, Bangkok, 11 June.

Unger, J. P. et al. (2008). 'Costa Rica: achievements of a heterodox health policy'. *American Journal of Public Health*, 98(4).

Unger, J. P. et al. (eds) (2010). *International health and aid policy*. Antwerp, Institute of Tropical Medicine.

Wibulpolprasert, S. (2004). *Thailand Health Profile 2001–2004*. Nonthaburi, Thailand, Ministry of Public Health.

World Bank (2004). 'Spotlight on Costa Rica and Cuba'. *World Development Report*.

World Bank (2010). *World Development Report*.

World Health Organisation (n.d.). *National Health Accounts, Costa Rica*. www.who.int/nha/country/cri.pdf.

World Health Organisation (2010). 'Health system financing: the path to universal coverage'. *World Health Report*. Geneva.

World Health Statistics (2010). WHO.

Xu, K. et al. (2003). 'Household catastrophic health expenditure: a multicountry analysis'. *The Lancet*, 362(9378): 111–17.