Research Studies: Working Paper Series No.18
June 2013

Private Hospital Health Care Delivery in Sri Lanka

Some Issues on Equity, Fairness, and Regulation

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National Library of Sri Lanka-Cataloguing-In-Publication Data

Dayaratne, G. D.,
Private Hospital Health Care Delivery in Sri Lanka : Some Issues on Equity, Fairness and Regulation / G. D. Dayaratne .- Colombo : Institute of Policy Studies of Sri Lanka, 2013
55p. ; 28cm. .- (Working Paper Series ; No.18)

ISBN 978-955-870-876-7

i. 362.11095493 DDC 23 ii. Title
iii. Series

1. Health Services – Sri Lanka

ISBN 978-955-870-876-7

Price

Please address orders to:
Institute of Policy Studies of Sri Lanka
100/20, Independence Avenue, Colombo 7, Sri Lanka
Tel: +94 11 2143100 Fax: +94 11 2665065
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List of Abbreviations

CABG	Coronary Artery Bypass Graft
CCU	Cornoary Care Unit
CSE	Colombo Stock Exchange
CT	Computed Tomography
ENT	Ear, Nose and Throat
EPI	Expanded Programme on immunization
FMCG	Fast Moving Consumer Goods
GMOA	Government Medical Officers Association
ICU	Intensive Care Unit
IPS	Institute of Policy Studies
JDCSI	Jaffna Diocese of the Chruch of South India
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
NHSL	National Hospital of Sri Lanka
NMDP	National Medical Drug Policy
OPD	Out-Patient Department
PHA	Private Hospital Association
PHSRC	Private Health Services Regulatory Council
SLMC	Sri Lanka Medical Council
WHO	World Health Organization

Acknowledgements

At the outset, the author wishes to thank Saman Kelegama (Executive Director, IPS) and Malathy Knight (Research Fellow, IPS) for overall guidance and support provided during various stages of preparing this paper.

The author wishes to acknowledge the valuable contribution by Wimal Hettiarachchi (Senior Visiting Fellow, IPS) and D.D.M. Waidyasekera (Editor, IPS and Former Commissioner, Department of Inland Revenue and Secretary, Presidential Commission on Taxation 1990) for their substantive inputs as well as editorial support.

The author also thank Asuntha Paul for her assistance in formatting the paper for publication.

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Executive Summary

Private Hospitals were in existence prior to the World War Two period, and the growth of this sub-sector coincided with the emergence of a market economy in the country, along with the entry into the market of the pharmaceutical industry, medical equipment industry and private insurance. This review attempts to document, understand, and offer suggestions concerning the Private Hospitals in some specific areas such as characteristics, distribution, incentive mechanism for the private health sector, involvement of government and foreign doctors in the private sector, user fees charged , medical negligence and the role of the regulatory regime.This review has utilised published and unpublished empirical studies, reports in electronic and print media on the private health sector, findings of survey results, interviews with professional associations, and respective hospital authorities.

Sri Lanka's health sector is complex. It is characterised by a mixed ownership pattern, many types of providers and different systems of medicine. In absolute terms, the size of the health care sector is reasonably large enough but unfortunately, the distribution is lopsided with the bulk of services (public and private) skewed toward the Western Province and main urban areas. In Sri Lanka, it is clearly seen that there is an absence of a holistic approach in the provision of services to the population with 13 per cent in the poverty bracket in the year 2010. The issues related to the private health sector have not been addressed substantially by any of the Task Force Reports nor in the Health Master Plan in 2006. This has led to successive governments focusing on delivery of public health care services, while the growth of the private sector is not planned or promoted as part of an overall health care system. The power acquired by Private Hospitals in curative care has now reached a new height since the end of the North/ East war and unless a strategy for public health reforms combined with the private sector is formulated, desired results in equity in delivery of health care will become a red herring. The government has given land at subsidized rates for setting up private hospitals, in addition to duty waivers for the import of medical equipment. Also, it is to be noted that land offered so far has been mainly in urban areas.

Private hospital providers utilize the best experience of the public health sector by absorbing government doctors to work part-time in their hospitals. Most of these doctors have undertaken their medical studies through the universal free education system that prevails in the country.

It is well known that the rural population rely on the public health facilities available with unsatisfactory equitable service provision than the urban population, which indicates that private hospital facilities have not penetrated much to these areas. The private sector is driven by the desire to maximize profit, and hence concentrate their operations in densely populated urban areas. As a result, it is reasonable to say that current medical costs for treatment at

private hospitals have contributed towards plunging those that cannot afford it, into an adverse situation when they seek treatment which is not accessible in public facilities on an urgent basis.

According to World Health Organisation (WHO, 2011) estimates, each year 100 million people slide into poverty as a result of medical care payments. Another 150 million people are forced to spend nearly half their incomes on medical expenses. That is because in many countries people have no access to social health protection - affordable health insurance or government-funded health services. However, in Sri Lanka, both these facilities exist, yet people are plunged into poverty and untold misery in the face of the enormous medical bills they encounter when they are forced to seek treatment from private providers due to the shortfalls in delivery of public health facilities.

While over-priced medical bills remain one area that needs to be addressed, how medical mishaps (and unforeseen complications) associated with medical procedures in private hospitals need to be handled, is another area needing due attention by the authorities. The patients who seek treatment from the private sector are not necessarily the rich and well-to-do. Many of them do so despite the issues of affordability they are faced with. They come to private hospitals for various reasons that include the perception of better care being available in the private hospital vis-à-vis the state sector hospitals, and non-availability of specialist out-patient care at government hospitals in the evenings.

In this context, a review of the existing regulations under Private Hospital Regulation Act No. 21 of 2006 and Private Health Regulatory Council (2008), find that regulations have mainly focused on the registration, licensing and issuing of registration certificates. So far, there has been no action implemented with regard to exorbitant user fees, medical negligence or the behaviour of private providers. Also, the government efforts to regulate were in many instances opposed by the powerful trade union lobby of the doctors (GMOA).Secondly, even though the regulatory body is adequately resourced they are more often reluctant to operate against their own membership and self-interest. This situation has been seen in most Asian countries including in India and Thailand.

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පුද්ගලික රෝහල් අංශය දෙවන ලෝක යුද්ධය කාල සීමාවට පෙර පටන් පැවති අතර මෙම අංශයේ වර්ධනය ඖෂධ කර්මාන්තය, වෛද්‍ය උපකරණ කර්මාන්තය සහ පුද්ගලික රක්ෂණය වෙළඳපලට ඇතුළුවීම ඔස්සේ රටතුළ වෙළඳපල ආර්ථිකයක් මතුවීමත් සමගම එකවිට සිදුවිය. මෙම සමාලෝචනය මගින් ලිපි ලේඛන අවබෝධකර ගැනීමට උත්සාහ ගැනීමත් පුද්ගලික රෝහල්වල ලක්ෂණ, බෙදාහැරීම, පුද්ගලික රෝහල් අංශය සඳහා දිරි දීමනා යාන්ත්‍රණය, පුද්ගලික රෝහල් තුළ රාජ්‍ය සහ විදේශීය වෛද්‍යවරුන්ගේ මැදිහත්වීම, අයකරන ගාස්තු, රෝගී සත්කාර පිළිබඳ නොසැලකිල්ල සහ නියාමික පරිශ්‍රය ආශ්‍රිත භූමිකාවන් සම්බන්ධ යෝජනාවන් ඉදිරිපත් කරයි. මෙම සමාලෝචනය මගින් ප්‍රකාශිත හා අප්‍රකාශිත ප්‍රත්‍යක්ෂ මූලික අධ්‍යයනයන්, පුද්ගලික වෛද්‍ය අංශය පිළිබඳව විද්‍යුත් සහ මුද්‍රිත මාධ්‍යයන් ඉදිරිපත්කළ වාර්තාවන්, සමීක්ෂණ ප්‍රතිඵල සෙවීම්, වෘත්තීමය සංවිධානයන් සමග සම්මුඛ සාකච්ඡාවන් පැවැත්වීම සහ අදාළ රෝහල් අධිකාරීන් සමග සාකච්ඡාවන් පැවැත්වීම වැනි දෑ භාවිතා කර ඇත.

ශ්‍රී ලංකාවේ සෞඛ්‍ය අංශය සංකීර්ණ එකකි. එය හවුල් අයිතිකාර රටාවන්, විවිධ වර්ගයේ සැපයුම්කරුවන් සහ බෙහෙත් පිළිබඳ විවිධ ක්‍රමයන්ගෙන් සමන්විත වේ. සෞඛ්‍ය සේවා අංශයේ ව්‍යාප්තිය පිළිබඳව සැබෑ නියමයන් සෑහෙන තරම් දුරට විශාල වුවද අවාසනාවකට බෙදාහැරීම පිළිබඳ සේවාවන් රාශියක් (රාජ්‍ය සහ පුද්ගලික) බස්නාහිර පලාත සහ ප්‍රධාන නාගරික ප්‍රදේශයන් දෙසට ඇලවී පැත්තකට බරවී පවතී. වර්ෂ 2010 යේ ලංකාව තුළ, දිළිඳු කොටසේ ජනගහනයෙන් සියයට 13 කට සෞඛ්‍ය සේවාවන් ලබාදීමේදී සාකල්‍ය ප්‍රවේශයකට පැමිණ නොමැති බව පැහැදිළිව දක්නට ඇත. පුද්ගලික සෞඛ්‍ය අංශයට සම්බන්ධ ගැටළු සඳහා කාර්යය සාධන වාර්තාවන් සහ 2006 සෞඛ්‍ය ප්‍රධාන සැලැස්ම මගින් සැලකිය යුතු තරමින් ආමන්ත්‍රණය කර නොමැත. පැවති රජයන් සෞඛ්‍ය සේවාවන් ලබාදීම පිළිබඳව අවධානය යොමු කරමින් සමස්ථ සෞඛ්‍ය ආරක්ෂණ ක්‍රමයක කොටසක් වශයෙන් පුද්ගලික අංශයේ වර්ධනය සැලසුම් නොකිරීමත් හා එය වර්ධනය නොකිරීමත් පෙනෙන්නට ඇත. රෝග නිවාරණ කාර්යයේදී පුද්ගලික රෝහල් විසින් මේ වෙනතුරු අත්කරගෙන ඇති ශක්තියල උතුරු නැගෙණහිර යුද්ධය අවසානයේ සිට පුද්ගලික අංශය සමග සම්බන්ධිත පුද්ගලික සෞඛ්‍ය ප්‍රතිසංස්කරණ සඳහා උපක්‍රමයක් සහ සෞඛ්‍ය සේවා ලබාදීමේදී හිමිකම තුළ අපේක්ෂිත ප්‍රතිඵල පිළියම් යෙදීමක් කළයුතු අග්‍රස්ථානයකට ලගා වී ඇත. රජය විසින් පුද්ගලික රෝහල් පිහිටුවීම සඳහා සහන මිලකට ඉඩම් ලබා දී ඇත. ඊට අමතරව, වෛද්‍ය උපකරණ ආනයනය කිරීමේදී රේගු බදු සහන ලබා දී ඇත. එමෙන්ම, මෙසේ ලබාදුන් ඉඩම් ප්‍රධාන වශයෙන්ම පිහිටා ඇත්තේ නාගරික ප්‍රදේශ තුළ බව සඳහන් කළ යුතුය.

පුද්ගලික රෝහල් විසින් රජයේ වෛද්‍යවරුන් ඔවුන්ගේ රෝහල්වල අමතර කාල වේලාවල්වලදී සේවය කිරීමට යෙදවීම මගින් රජයේ වෛද්‍ය අංශයේ ප්‍රශස්ත අත්දැකීම පුද්ගලික රෝහල් විසින් භාවිතා කරනු ලබයි. මෙවැනි වෛද්‍යවරුන්ගෙන් බහුතරයක් රටතුල පවත්නා සමස්ථ නිදහස් අධ්‍යාපනය තුළින් ඔවුන්ගේ සෞඛ්‍ය අධ්‍යයනයන් ලබාගෙන ඇත.

පුද්ගලික අංශය විසින් උපරිම ලාභය ලබා ගැනීමේ අරමුණින් කටයුතු කරන බැවින් තම ප්‍රදේශයන් තුළ අවශ්‍ය තරමින් පුද්ගලික රෝහල් පහසුකම් පැතිරී නොමැති බැවින් සහ මේනිසාම ඔවුන්ගේ මෙහෙයුම් අධික ජනගහනය සහිත ප්‍රදේශවලට කේන්ද්‍ර ගත වී ඇති බැවින් ග්‍රාමීය ජනගහනය විසින් නාගරික ජනගහනයට වඩා අසතුටුදායක සමානාත්මක සේවා සැපයීම් සහිතවූ රාජ්‍ය සෞඛ්‍ය සේවාව කෙරෙහි විශ්වාසය තබන බව ප්‍රකට කරුණකි. මෙහි ප්‍රතිඵලයක් වශයෙන්, ඔවුන් හදිසි අවශ්‍යතා සඳහා රජයේ පහසුකම් තුළින් ලබාගත නොහැකි වන

ප්‍රතිකාර පුද්ගලික රෝහල්වලින් ලබා ගැනීමට යාමේදී පුද්ගලික රෝහල්වලන් ප්‍රතිකාර සඳහා වන සෞඛ්‍ය පිරිවැය හේතුවෙන් ව්‍යාසනයක තත්වයන් දක්වා ඇද දැමීමට පුළුවන් බව පැවසීම යුක්ති සහගතය.

ලෝක සෞඛ්‍ය සංවිධානයේ (WHO, 2011) ඇස්තමේන්තු අනුව, සෑම වසරකම මිලියන 100ක ජනතාව සෞඛ්‍ය රක්ෂණ ගෙවීම්වල ප්‍රතිඵලයක් වශයෙන් දිළින්දන් බවට පත්වේ. තවත් මිලියන 1500ක ජනතාවට වෛද්‍ය වියදම් සඳහා තම ආදායමෙන් භාගයකට ආසන්නව වියදම් කිරීමට බලකරනු ලැබේ. මේ නිසා බොහෝ රටවල්වල, ජනතාවට සමාජ සෞඛ්‍ය ආරක්ෂාව, සුභදායක සෞඛ්‍ය රක්ෂණය හෝ රජයේ අරමුදලින් ලබාදෙන සෞඛ්‍ය සේවාවන්ට ප්‍රවේශ විය නොහැක. කෙසේවෙතත්, ශ්‍රී ලංකාව තුළ, මෙම පහසුකම් දෙවර්ගයම පැවතියද, තවමත් ජනතාව රාජ්‍ය අංශයේ සෞඛ්‍ය සේවාවේ ඇති අඩුපාඩුකම් හේතු කොට ගෙන පුද්ගලික අංශයෙන් ප්‍රතිකාර ලබාගැනීමට උනන්දු කරවනු ලබන අතර ඔවුනට ලැබෙන අති විශාල වෛද්‍ය බිල්පත්වලට මුහණදීම මගින් දිළිඳුකමට සහ අප්‍රමාන දුක්ඛිත තත්ත්වයට පත් වීම නොවැලැක්විය හැක.

පුද්ගලික අංශයෙන් ප්‍රතිකාර සොයන රෝගීන් අවශ්‍යයෙන්ම පොහොසත් සහ ධනවත් අය නොවේ. ඔවුන් බොහෝමයක් එසේ කරන්නේ ඔවුන් මුහුණ දෙනු ලබන සාධාරණ මිල පිළිබඳව ගෙවීම්ගැටළුව සහිතවය. ඔවුන් පුද්ගලික රෝහල් වෙත පැමිනෙන්නේ රාජ්‍ය අංශයේ රෝහල්වලට වඩා පුද්ගලික රෝහල් තුළදී ලබා ගත හැකිවන වඩා ආරක්ෂාව පිළිබඳ අවබෝධය ඇතුළුව විවිධ හේතූන් සහ සවස් වරුව තුළ රජයේ රෝහල්වලදී විශේෂඥ වෛද්‍යවරුන් හමුවීමේ නොහැකියාව නිසාය.

මේ අනුව, 2006 පුද්ගලික රෝහල් නියාමන පනත් අංක 21 සහ පුද්ගලික සෞඛ්‍ය නියාමන සභාව (2008) යටතේ පවත්නා රෙගුලාසි සලකා බැලීමේදී පෙනී යන්නේ එවැනි රෙගුලාසි ප්‍රධාන වශයෙන්ම අවධානය යොමු කර තිබෙන්නේ පුද්ගලික රෝහල් ලියාපදිංචි කිරීම, බලපත්‍ර ලබාදීම සහ ලියාපදිංචි සහතික නිකුත් කිරීම සඳහා වන බවයි. මේ දක්වා, එම රෝහල් භාවිතා කරන්නන්ගේ ඉතා අධික ගාස්තු, වෛද්‍ය නොසැලකිලිමත්කම හෝ පුද්ගලික රෝහල් හිමිකරුවන්ගේ අවධානය සම්බන්ධයෙන් ක්‍රියාත්මක කිරීම සඳහා කිසිදු ක්‍රියා මාර්ගයත් ගෙන නොමැත. එමෙන්ම, රජය විසින් බොහෝ අවස්ථාවලදී නොයෙකුත් නියාමනයන් කිරීමට උත්සාහ ගත්තද වෛද්‍යවරුන්ගේ වෘත්තීය සමිතිය (GMOA) මගින් නොයෙක් අවස්ථාවලදී එයට විරුද්ධත්වය ප්‍රකාශ කරන ලදී. දෙවනුව, නියාමන ආයතනයට පමාණවත් අයුරින් බලය තිබුනද ඔවුන් නිතරම ඔවුන්ගේ සාමාජිකත්වයට සහ ආත්මාර්තයට විරුද්ධව කටයුතු කිරීමට ක්‍රියාකාරී නොවේ. මෙම තත්ත්වය ඉන්දියාව සහ තායිලන්තය ඇතුළත්ව බොහෝ ආසියානු රටවල දැකිය හැකිය.

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நிறைவேற்றுச் சுருக்கம்

தனியார் துறை வைத்தியப் பிரிவானது இரண்டாம் உலக மகா யுத்தக் காலத்திற்கு முற்பட்ட காலம் தொடக்கம் செயற்பட்டு வந்துள்ளதுடன் இத் துறையின் அபிவிருத்தியானது மருந்து உற்பத்திக் கைத்தொழில், மருத்துவ உபகரணக் கைத்தொழில் மற்றும் தனியார் துறை காப்புறுதித் துறைபால் பிரவேசித்தமையும் நாட்டில் சந்தைப் பொருளாதாரத்துடன் இணைந்தமையும் ஒருங்கே நிகழ்ந்தது. இந்த ஆய்வின் ஊடாக ஆவணங்களை புரிந்து கொள்வதற்கு முயற்சி எடுப்பதும் தனியார் துறை வைத்தியசாலைகளின் பண்புகள், விநியோகப் பண்புகள், தனியார் துறை வைத்தியசாலைகள் தொடர்பாக ஊக்கக் கொடுப்பனவு முறைமை, தனியார் துறை வைத்திய சாலைகளில் அரச மற்றும் வெளிநாட்டு வைத்தியர்களின் பங்களிப்பு, அறவிடப்படுகின்ற கட்டணங்கள், மருந்துகள் பற்றிய கவனயீனம் மற்றும் விதி முறைகளுக்கு உட்பட்ட செயற்பாட்டுப் போக்கு என்பன தொடர்பாக ஆலோசனைகள் முன்வைக்கப்பட்டன. இந்த மீளாய்வின் ஊடாக வெளியிடப்பட்ட மற்றும் வெளியிடப்படாத ஆரம்ப ஆய்வுகள், தனியார் துறை வைத்திய சாலைகள் தொடர்பான இலத்திரனியல் மற்றும் அச்சு ஊடகங்களில் வெளியிடப்பட்ட அறிக்கைகள், ஆய்வுப் பெறுபேறுகளைக் கண்டறிதல், தொழில்சார் அமைப்புக்களுடன் நேர்முக கலந்துரையாடல்களை நடாத்துதல் மற்றும் உரிய வைத்தியசாலை அதிகாரிகளுடன் கலந்துரையாடல்களை நாடாத்துதல் போன்ற செயற்பாடுகள் மேற்கொள்ளப்பட்டுள்ளன.

இலங்கையின் சுகாதாரத்துறை சிக்கல் நிறைந்த ஒரு அலகாகும். அதன் கூட்டு உரிமைப் போக்கு, பலதரப்பட்ட விநியோகத்தர்கள் மற்றும் மருந்துகள் பற்றிய பலதரப்பட்ட முறைமைகளை இவை உள்ளடக்குகின்றன. சுகாதாரப் பாதுகாப்புப் பிரிவின் பண்பு பற்றிய உண்மையான ஒழுங்குவிதிகள் பெரும்பாலும் பரந்து காணப்பட்ட போதும் துரதிஷ்டவசமாக விநியோகம் பற்றிய பல சேவைகள் (அரச மற்றும் தனியார்) மேல் மாகாணம் மற்றும் பிரதான நகரப் பிரதேசங்கள் நோக்கி சார்ந்து ஒரு பக்கம் சார்ந்ததாகக் காணப்படுகின்றன. இலங்கையில், வறிய மக்களின் தொகை மொத்த சனத்தொகையில் 13 % சதவீதத்தினருக்கு சுகாதார வசதிகளை வழங்கும் போது சாத்தியமானதும் வினைத்திறனானதுமான பிரவேசத்தை அடைய முடியாமை தெளிவாக காணப்படும் நிலைமையாக உள்ளது. துனியார் துறை சுகாதாரப் பிரிவுடன் தொடர்புடைய பிரச்சினைகளுக்கு செயலாற்றுகை அறிக்கை மூலம் மற்றும் 2006 ஆம் ஆண்டின் சுகாதாரம் தொடர்பான பிரதான திட்டத்தின் ஊடாக கருதத்தகு அளவில் கவனம் செலுத்தப்பட வில்லை. இந் நிலைமையானது நடைமுறையில் உள்ள அரசுகள் சுகாதாரப் பாதுகாப்புச் சேவையினை வழங்குவது தொடர்பாக கவனம் செலுத்தி மொத்த சுகாதாரப் பாதுகாப்பு முறைமையின் பகுதியொன்றாக தனியார் துறை வைத்திய சாலைகளின் அபிவிருத்தி தொடர்பாக திட்டமிடாமை மற்றும் அவற்றினை அபிவிருத்தி செய்யாமை போன்ற செயற்பாடுகள் நிகழ்ந்துள்ளமை கருதத்தகு விடயங்களாகும். தற்பொழுது நோய்களைத் தடுக்கும் செயற்பாடுகளின் போது தனியார் துறை வைத்தியசாலைகளினால் கைப்பற்றப்பட்டுள்ள அதிகாரம் யுத்தம் நிறைவடைந்ததைத் தொடர்ந்து தனியார் துறையுடன் ஒருங்கிணைந்து தனியார் சுகாதார மறுசீரமைப்பு தொடர்பாக உபாய வழிகளை மேற்கொள்ளும் வரை மற்றும் சுகாதாரப் பாதுகாப்பினை வழங்கும் போது தமது உரிமைப் பங்கில் எதிர்பார்த்த பெறுபேற்று தீர்வுகளை மேற்கொள்ளும் வகையில் அமையும் வரை புதிய கட்டத்தினை அண்மித்துள்ளது. அரசாங்கத்தினால் தனியார் துறை வைத்தியசாலைகளை நிறுவுவது தொடர்பாக அனுசரணை விலையில் காணிகள்

வழங்கப்பட்டுள்ளன. மேலும், வைத்திய உபகரணங்களை இறக்குமதி செய்யும் போது சுங்க வரிகள் நீக்கப்பட்டுள்ளன. அதேபோன்று, இவ்வாறு வழங்கப்பட்டுள்ள காணிகள் பிரதானமாக நகரப் பிரதேசங்களில் அமைந்துள்ளமையினைக் குறிப்பிடப்படுதல் வேண்டும்.

தனியார் துறை வைத்தியசாலைச் சேவை வழங்குனர்களினால் அரச வைத்தியர்களை தனியார் துறை வைத்திய சாலைகளில் மேலதிக கால நேரங்களில் சேவையில் ஈடுபடுத்துவதன் ஊடாக அரச வைத்தியத் துறையின் பரந்த அனுபவத்தினை தனியார் துறை வைத்தியசாலைகளிலும் பயன்படுத்த வாய்ப்பாக அமைந்துள்ளது. இது போன்ற வைத்தியர்களில் பெரும்பாலானோர் நாட்டில் நடைமுறையில் உள்ள இலவசக் கல்வியின் ஊடாக அவர்களின் சுகாதார கற்கைகளை பெற்றுள்ளனர்.

தனியார் துறையினர் உச்ச இலாபத்தை அடையும் நோக்கில் செயற்படும் அதே வேளை தமது பிரதேசங்களில் தேவையான அளவு தனியார் துறை வைத்தியசாலைகள் பரந்து காணப்படாமை போன்ற காரணங்களினால் அவர்களுடைய செயற்பாடுகள் அதிக மக்கள் தொகையினர் வசிக்கின்ற பிரதேசங்கள் தொடர்பாக மையப்படுத்தப் பட்டிருக்கின்றமையினால் கிராமிய மக்கள் திருப்திகரமற்றதும் பக்கச் சார்பானதுமான சேவைகளை பெற்றுக் கொள்ளக் கூடிய அரச சுகாதாரச் சேவைகள் தொடர்பாக நம்பிக்கை வைத்திருக்கின்றமை பிரபல்யமான விடயமாகும். இதன் பிரதிபலிப்பாக, அவர்கள் அவசர நிலைமைகளை அடிப்படையாகக் கொண்டு அரச வசதிகளின் ஊடாக பெற்றுக் கொள்ள முடியாத சிகிச்சைகளை தனியார் துறை மருத்துவ மனைகளிலிருந்து பெற்றுக் கொள்வதற்கு முயற்சிப்பதன் காரணமாக சுகாதாரம் தொடர்பாக செலுத்த வேண்டிய நியாயமான விலையிலும் பார்க்க பாரிய செலவினங்களுக்கு வறிய மக்கள் தள்ளப்படுவதற்கும் இந் நிலைமை வழிவகை செய்துள்ளது என்று குறிப்பிடுவது சாலச் சிறந்தது.

உலக சுகாதார அமைப்பின் (WHO) மதிப்பீட்டின் பிரகாரம், ஒவ்வொரு வருடமும் 100 மில்லியன் மக்கள் சுகாதாரப் பாதுகாப்புக் கொடுப்பனவுகளின் பெறுபேறாக வறியவர்களின் தொகுதிக்குத் தள்ளப்படுகின்றனர். மேலும், 1500 மில்லியன் மக்களுக்கு மருத்துவச் செலவீனங்கள் தொடர்பாக தமது வருமானத்தில் அரை வாசிக்கு அண்மித்த அளவில் செலவு செய்வதற்கு அழுத்தம் செலுத்தப்பட்டுள்ளது. இதன் காரணமாக அனேக நாடுகளில், மக்களுக்கு சமுக சுகாதாரப் பாதுகாப்புத் தேவையான சுகாதாரப் பாதுகாப்பு அல்லது அரசாங்கத்தினால் நிதியளிப்புச் செய்கின்ற சுகாதாரச் சேவைகளுக்கு பிரவேசிக்க முடியாது உள்ளது. எனினும், இலங்கையில், இந்த இரு வகையான வசதிகளும் காணப்பட்ட போதும், இன்னும் மக்கள் அரச துறையில் சுகாதாரச் சேவையினை வழங்குவதில் உள்ள குறைபாடுகளின் காரணமாகக் தனியார் துறையின் ஊடாக சிகிச்சை பெற்றுக் கொள்வதற்கு உந்தப்படுவதுடன் வறியவர்கள் அதிகப்படியான கட்டணங்களுக்கு முகங் கொடுப்பதன் ஊடாக வறுமை நிலை மற்றும் பாரிய அல்லல்களுக்கும் ஆழாகி உள்ளனர். அதிகப்படியான மருத்துவ கட்டணங்கள் காணப்படுவதுடன் அவை நிறுத்தப்பட வேண்டிய ஒரு பரப்பிற்குள் கட்டுப்படுத்தல், தேவையான தனியார் துறை மருத்துவ மனைகளில் மருத்துவ செயற்பாட்டு முறைகளுக்கு உதவி புரிகின்ற சுகாதார முறைகேடுகள் (மற்றும் காணப்பட முடியதா சிக்கல்கள்) எவை என அதிகாரிகள் உரிய கவனம் செலுத்த வேண்டிய தேவை காணப்படுகின்ற இன்னுமொரு துறையாகவும் காணப்படுகின்றது. தனியார் வைத்தியத் துறையின் ஊடாக சிகிச்சையை வேண்டுகின்ற நோயாளர்கள் உண்மையில் செல்வந்தர்களோ தேவை

உள்ளவர்களோ அல்ல. அவர்களில் அனேகமானவர்கள் அவ்வாறு செய்வது அவர்கள் முகங் கொடுக்கின்ற நியாயமான விலைகள் தொடர்பான சிக்கல்களை கவனத்திற் கொள்ளாமையின் காரணமாகும். அவர்கள் தனியார் துறை வைத்திய சாலைகளுக்கு சமுகமளிப்பது அரச துறை வைத்திய சாலைகளிலும் பார்க்க தனியார் துறை வைத்திய சாலைகளின் ஊடாக பெற்றுக் கொள்ளக் கூடிய உச்ச பாதுகாப்பு பற்றிய புரிந்துணர்வு உள்ளடங்கலாக பலதரப்பட்ட காரணங்கள் மற்றும் மாலை வேளைகளில் அரச வைத்தியசாலைகளில் விசேட சத்திர சிகிச்சை வைத்தியர்களின் சேவைகளைப் பெற்றுக் கொள்ளும் இயலுமை இன்மை போன்ற காரணங்களின் அடிப்படையிலாகும்.

இந்த உண்மைகள், 2006 ஆம் ஆண்டின் தனியார் துறை வைத்தியசாலைச் சட்டம் மற்றும் தனியார் துறை மருத்துவ ஒழுங்குமுறைப்படுத்தல் சபையின் (2008) கீழ் காணப்படுகின்ற ஒழுங்குவிதிகள் பற்றிய மீளாய்வின் ஊடாக தெளிவாகின்றது. அவ்வாறான ஒழுங்குவிதிகள் தொடர்பாக பிரதானமாக கவனம் செலுத்தப்பட்டிருப்பது தனியார் துறை வைத்திய சாலைகளைப் பதிவு செய்தல், அனுமதிப் பத்திரங்களை வழங்குதல் மற்றும் பதிவுச் சான்றிதழ் வழங்குதல் போன்றன தொடர்பாகவாகும். இது வரை, அவ்வாறான வைத்திய சாலைகளை பயன்படுத்துகின்றவர்களின் அதிக கட்டணங்கள், வைத்திய கவனயீனங்கள் அல்லது தனியார் துறை மருந்து விநியோத்தர்களின் நடத்தை தொடர்பாக கடைப்பிடிக்க வேண்டிய ஒழுங்கு முறைகள் தொடர்பாக எந்தவித முன்னெடுப்புக்களும் எடுக்கப்பட வில்லை. அதே போன்று, அரசாங்கத்தினால், அனேக சந்தர்ப்பங்களில் இவற்றை ஒழுங்குமுறைப்படுத்துவதற்கு முயற்சிகள் எடுத்த போதும் வைத்தியர்களின் வலுவான தொழிற்சங்கங்கள் (GMOA) ஊடாக அவ்வாறான முயற்சிகளுக்கு எதிர்ப்புக்கள் வெளிப்படுத்தப்பட்டுள்ளன. இரண்டாவதாக, ஒழுங்குமுறைப்படுத்தல் நிறுவனத்திற்கு போதியளவான அதிகாரம் இருந்த போதும் அவர்கள் நிதமும் அவர்களுடைய பிரத்தியேக செயற்பாடுகள் மற்றும் சுயநலத்திற்கு எதிராக நடவடிக்கைகளை மேற்கொள்வதற்கு விரும்புவதில்லை. இந்த நிலைமை இந்தியா மற்றும் தாய்லாந்து உள்ளடங்கலாக அனேக ஆசிய நாடுகளில் காணக் கூடியதாக உள்ளன. தாய்லாந்தில் சுகாதாரத் துறைபால் செல்வாக்குச் செலுத்துகின்ற பரந்த சட்டங்களை உருவாக்குதல் அவர்கள் அச் சட்டத்தினைப் பயன்படுத்தும் போது ஒழுங்கு முறையான விதிமுறைகள் மற்றும் வலுவூட்டல்கள் தொடர்பாக செயற்படுகின்ற சிறிய அளவான பதவியணியினால் அச் செயற்பாடுகள் தடைப்பட்டுள்ளன.[2]

1. Introduction

While there are numerous studies available on the Public Health Programme, there is a dearth of studies on the private health sector, and it is only in the recent past that an interest has been shown in the media about this most important crucial health sub-sector. For this study, the author had to mostly depend on data collected by the Health Economic Policy Unit of the Institute of Policy Studies of Sri Lanka, which is engaged in conducting a "Census of Private, Co-operative and Estate Hospitals" once in every two years to elicit vital information in this regard, and which is not documented in its news bulletin "Health Statistics" mainly for preserving respondent confidentiality.

The socio-political context and commitment to welfare provisioning in the early post-independence period led to health status indicators of the country being on par with developed countries.

From the time of independence, the successive governments provided universal and free welfare services which included free education and health services, and subsidized food. From 1948 through to the 1960s, there was a considerable growth of welfare services supported by maternal and child health services and expansion of health services at the primary, secondary and tertiary level. With the restructuring of the economy in 1977, food subsidies were largely withdrawn while other welfare programmes such as free education and free health care continued to remain in force. During the same year, there was a shift in government policy on health and it allowed medical officers and other technical officers within the state health sector to practise privately, outside their official working hours. This was the first instance that boosted the privatization of the health sector in the country.

While Sri Lanka completed its demographic transition from high mortality and fertility rates to low mortality and low fertility in a period of sixty years, it maintained total national health expenditures at a level of US $ 50 per capita per annum, on average, during 2004 to 2009.

During the last decade, there have been an increasing number of diseases such as ischemic heart disease, cerebrovascular conditions, lung cancer and diabetes which belong to the category of non-communicable diseases, mainly among the ageing population of the country, whereas most EPI (Expanded Programme on Immunization) diseases are almost eradicated (e.g., polio,TB, tetanus, diphtheria, etc.). The only notable exceptions to these trends in recent years have been infections for which there had been a dearth of effective vaccines available, and for which environmental or socially complex interventions are critical, e.g., dengue viral fever. With demographic ageing, it is expected that morbidity and mortality from age-related diseases such as ischemic heart disease, cerebrovascular disease, diabetes, osteoporosis, etc., will increase substantially, as mentioned before.

At present, Sri Lanka's two tier health system - comprised of a heavily subsidized public sector and a user charged private sector - has produced a progressive health care delivery system to face the health challenges indicated above. Expansion of publicly-financed medical services in the early stages provided the whole population with ready access to modern medical services. Over time, the household demand for modern Western medical services increased, and demand for traditional forms declined or remained unchanged. Household preferences having shifted to Western or allopathic medicine, once again began to shift to preference being shared with public health services and private Western services. Although demand for

Western medical services rose dramatically, it was not accompanied by an increase in the ability of the public sector to meet the health needs of the whole population, which paved the way for sections of the population to seek treatment from the private sector, determined by their ability to pay for the service. This situation led to the establishment of a private hospitals network in Sri Lanka, which spread island-wide during a period of around 150 years since the inception of the first private hospital. From 1980, there was a continuing shift toward private medical services, which appears to have stabilized during the 1990s.

In 1990 there were 44 private hospitals in operation, which increased to 87 hospitals in 2008, and further to 145 actively operating hospitals in 2013 out of 200 registered private health institutions in the Private Health Regulatory Council. With the waves of liberalization measures introduced since 1977, Sri Lanka's health sector has seen the beginning of the growth of private hospital capacity assisted by State sponsored investment incentives, and was boosted further with the ending of the North/East war situation in 2009. Their investment in cutting edge technologies and the modernization of medical facilities has certainly contributed to the expansion of health facilities for the affordable income earning segment of the society.

In this context, it is imperative to identify the key processes that influence the shaping of the private health sector. Among these processes are the growth of the middle class and their influence on both the supply and demand side of private health services; role and effectiveness of the government and the Ministry of Health (MOH) especially in terms of investment in uplifting, expansion and modernizing public health facilities; and the role and influence of medical equipment and pharmaceutical industries as major contributors in this process.

In the case of the private hospital industry, it remains highly concentrated in densely populated areas where the rich and urban middle class are congregated. Distribution of private hospitals are mainly seen in the cities. It is important to point out that both the suppliers and consumers of private health services are largely drawn from the upper and middle classes. Data have revealed that there is an abundance of bio-medical equipment and technology in urban areas, as compared to rural areas, leading to excess capacities. Between 1990 and 2013, over 100 private hospital centres entered the market with an investment of over Rs.50 billion.

Although the private health insurance has gradually improved, it lacks the potential to expand beyond the small affluent sector as it is still voluntary by nature. Insurance plays a major source of finance in many countries in which private health is the key provider. In Sri Lanka, the private health insurance covers only around 1 per cent of the total health expenditure, and as a result remains totally out of the reach of the majority of households. This suggests that the utilization of the private sector is related to income levels. While there is a marked preference for allopathic medicine, choice of medical facilities utilization shows variations across classes.[1] The IPS survey reveals that the urban middle class used private facilities more than the government facilities, while the urban poor utilize the facilities of government hospitals depending on the accessibility. Greater availability of general private practitioners in rural areas is filling the void of private hospitals.

[1] Pieris, I.(1999), *Treatment and Health Behaviour in Sri Lanka*. Oxford University Press, New Delhi.

As per IPS Sri Lanka National Health Account 2009 estimates, the private sector provides 6 per cent of overall in-patient admissions, and around 50 per cent of total out-patient treatments which includes OPD treatment by General Practitioners.

Private health care services are largely ambulatory. Approximately,5,000 full-time private general practitioners provide out-patient care from private clinics on a fee-for-service basis in addition to private hospitals. The major portion, however, is delivered by government doctors in their private capacity, who work from home, clinics or private hospitals. The operations of private GPs who dispense out-patient treatment are faced with competition from private hospitals through the networks of channelling services, and would gradually decline over time, as this is not so profitable for the doctors concerned.

The emergence of private hospitals is driven by the demand of affluent members of the population, who expect high quality health services.As a result, the standard of care at private facilities was perceived to be of high quality. Consequently,newly built private hospitals are equipped with large, ultramodern and high quality bio-medical technology. By doing this, fee levying private hospital providers are attracting customers by taking advantage of the gaps that prevail in the free medical services provided by the government.

Private health providers who focus on curative services, exist in a variety of sizes (with the number of beds ranging from 5 to 500). In 2012, there were 145 private hospitals in the country (with a total capacity of 4,500 beds), and an estimated 5,000 private general practitioner clinics (providing a range of primary health services).

According to the IPS survey, demand for curative care has been growing rapidly and reached a new height after the end of the war. As a result, new private hospitals have come up in war ravaged areas, and many existing hospitals in the rest of the country, especially in Colombo and suburbs, engaged in expansion and modernization of the infrastructure to meet the challenge of intense competition among providers.

Private hospital providers have rightly identified the health needs of the new upper middle class and their quality of life that is rising along with emerging growth in the development process. They have embarked on introducing new bio-medical technologies at a high cost, alongside newly built hospital infrastructure characterized by utmost cleanliness and adequate car parking facilities. Nevertheless, the reality is that it is not only the rich and the middle classes in urban cities that visit Private Hospitals for treatment, but the poor households too are forced to seek treatment from private facilities as a last resort at an unaffordable cost to the family budget.

On the demand side, the out-of-pocket expenditure of households clearly indicates an increasing financial burden of health care on the population. As per IPS National Health Account 2009, private Household Out- of-Pocket payments account for 45 per cent of Total Health Expenditure and 83 per cent of Total Private Health Expenditure.These expenditures are not confined to medicine alone. Currently, the households are experiencing a very high increase in Consultation fees, Hospital Charges, laboratory and investigation fees, therapeutic charges and other systems of medication by private providers.

2. History of Private Hospitals

The history of the establishment of private hospitals in Sri Lanka goes back to the 19th century when missionaries from the West arrived in Asian countries, including Sri Lanka, to propagate their religious doctrines. Hence, they focused their missionary activities mainly in the field of education and health. In 1819, several American missionaries came to Ceylon and started several schools, religious organizations and medical activities.

The Green Memorial Hospital (1847) which is located in Manipay, was founded in 1847 by Dr. Samuel Fiske Green, a young medical graduate from New York, United States.

This mission hospital was the first medical school in Sri Lanka, taking in the first batch of students in 1848. Manipay hospital has already completed more than 165 years and its main objective is to provide medical services to the surrounding communities. When the American Missionaries left Sri Lanka (Ceylon), the Jaffna Diocese of the Church of South India (JDCSI) was set up, and it took control of the running of this hospital. It is run by a Board of Governors.

Following the establishment of the Green Memorial Hospital, another hospital by the name of Mclord Hospital was established in 1898. When IPS Health Policy Programme launched the Private hospital survey in 2000, it was reported that the hospital was not in operation. Since the end of the war this hospital has been renovated, and is now back in operation.

The oldest hospital in Colombo is the Ratnam Hospital established in 1904 in Slave Island, and which has completed more than 109 years in operation. It had 74 beds in 1990 with 8 permanent physicians and 50 nurses.

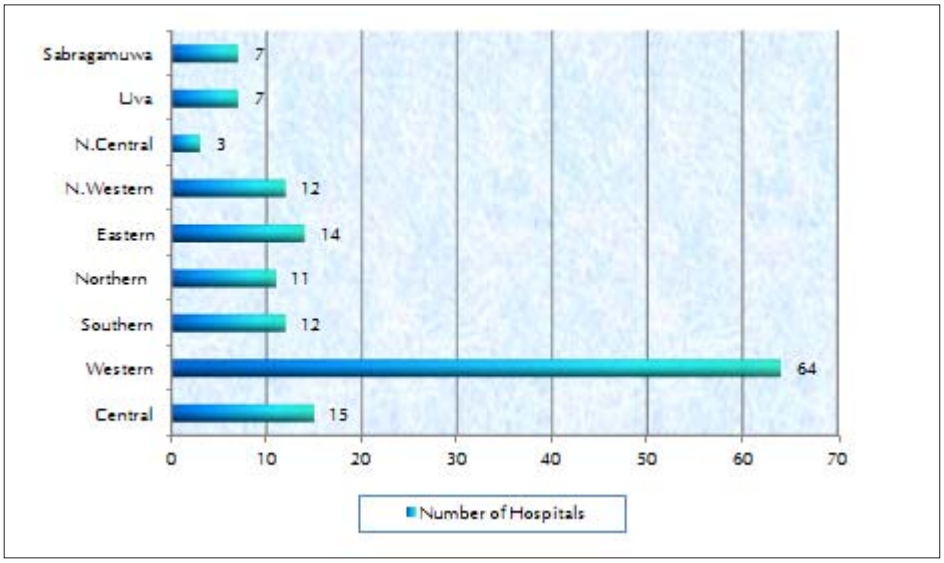
Joseph Fraser Memorial Hospital (1923) in Colombo has a history of 90 years, and was operating with 4 physicians, 24 consultants and 11 nurses. This hospital is located in an isolated area away from the crowded environment, and is unique in maintaining its status as an aristocratic hospital. From the very inception, this hospital has been patronized by Judges, the Diplomatic Corps, and the elites of plantation companies under Agency Houses.

Grand Pass Maternity and Nursing Home, popularly known as the Sulaiman Hospital is over 70 years old, having been established in 1942. In 1990 the hospital was operating with 87 beds, 6 physicians, 12 consultants and 45 nurses.According to the owners, this hospital was primarily opened to care to the needs of the Muslim community, and it was the reason that the hospital was built on Moors Street in Colombo 10.

Durdans Hospital which was established in 1945, was a converted army hospital (1939) serving British Army personnel during the Second World War period. In 1990 the hospital was operating with 92 beds, 20 physicians and 98 nurses.

Asha Central Hospital established in 1947, is another pioneer hospital in Colombo city. In the year 1990, this hospital maintained a bed strength of 112 with 7584 admissions and 18,200 out-patient visits which increased to 190,732 in 1997. In 1997 the hospital was served by 19 physicians and 150 nurses. Asha

Figure 2.1
Number of Active Private Hospitals by Province - 2012



Central ceased operations in 2008 due to transfer of ownership to SoftLogic Holding PLc, and in turn SoftLogic Holding Plc sold the properties to reinvest in the construction of The Central Hospital at Norris Canal Road.

Almost all the other hospitals in the island have been established in the late nineties with a history of less than 20 years. Among these hospitals, Oasis Hospital at Narahenpita (2000) operates with a 170 bed capacity, 45 visiting consultants, and 150 nurses. This hospital has joined hands with Forties Malar in Chennai, and opened a dedicated heart centre managed by Forties. However, its location has become an impediment to the growth of the hospital, as three other popular private hospitals are operating in the same location.

Apart from the location of many hospitals in the Western Province, the most noteworthy feature among other provinces is the expansion of the number of hospitals in the Northern and Eastern Provinces, which can be identified as dividends of post-war developments. In 2009, the Nothern Province had only 2 partially operating hospitals while the Eastern Province had 4 hospitals. In 2012, the number of Northern Province Hospitals increased to 11, and the Eastern Province to 14. Among these new hospitals is the renovation and opening of a state of the art 80 bed hospital in Jaffna named, Northern Central Hospital, at Palaly Road, Thirunaveli. It is the largest fully equipped private secondary health care centre in Northern Sri Lanka with 21 Medical Personnel including surgeons, specialists and physicians. Figure 2.1 above shows the distribution of private hospitals by Province in 2012.

3. Key Players

It is noteworthy to mention that a few hospitals in Colombo have become the key players or a dominant force in the private hospital network in the country. These hospitals are namely, Nawaloka Hospital, Durdans Hospital, Asiri Hospitals, Lanka Hospitals and Hemas Hospital located in Wattala. These five hospitals are reported to have a bed facility strength of over 1,500, which is 42 per cent of total private

hospital bed facilities in the island. Out of the total reported 8.2 million laboratory tests performed in 2011, IPS Survey data revealed that 65 per cent of all laboratory tests have been performed by these five hospitals. Also, 50 per cent of them have been performed by two players namely, Asiri Group of hospitals and Durdans hospital. Salient features of these five key players are given below.

Medical Directors or representatives of these key institutions serve as members of the Private Health Regulatory Committee, established under the Private Hospital Regulatory Act No.21 of 2006.

3.1 Nawaloka Hospital

It was established in September 1985, with the objective of serving as a centre of excellence in high technology diagnostic and curative facilities. Located at Union Place, Colombo 02, it is in very close proximity to the business centre and within easy reach of the National Hospital and many other commercial establishments. Nawaloka Hospitals have many "firsts" to their credit, the introduction of Intensive Care Units, Coronary Care Units, Laparoscopic Surgery and Thoracic Surgery being some of them. Nawaloka Hospital has been at the forefront of bringing the latest in medical technology to Sri Lanka. Further, the hospital was the first to locally operate a dedicated Intensive Care Unit (ICU) in 1985, and Coronary Care Unit (CCU) in 1994, as well as being the first to introduce Laparoscopic Surgery (1993) and Thoracic Surgery among private hospitals. Starting with 175 beds, it reached 430 beds in 2011. In respect of In-patient admissions, the hospital reported 11,054 admissions in 1990 which reached 33,200 in 2011. As for the Out-patients treated,the number has increased from 234,100 in 1990 to reach1,141,937 in 2011.

During the last few years, Nawaloka hospital has reached a zenith in sophistication of health service delivery. At present, 30 types of service delivery and medical packages are offered to health seekers. Nawaloka hospitals has a network of branches in Battaramulla, Kandana,Kiribathgoda, Kottawa and Mount Lavinia. With more than 400 beds and 600 visiting medical consultants, Nawaloka Hospital is one of the largest local private hospitals in a single location and the country's first fully fledged private healthcare institution. The hospital was responsible for the well-being of over 1.5 million patients during the 2011/ 2012 period, during which it also carried out close to 15,000 surgeries. The hospital currently features 14 operating theatres, including dedicated operating theatres for Orthopaedic, Neurosurgery, Cardiac Surgery, Maternity and Gynaecology. The hospital has also established a Transplant Centre, which has already carried out live donor liver and live donor lung transplants locally. This makes it the first and only private sector healthcare centre to carry out live donor liver and live donor lung transplants in Sri Lanka. Nawaloka Hospital has launched a new home medical service making it possible for anyone to access a doctor from their own home with the launch of the Home Ambulance Service.

The Nawaloka Hospital Nursing School currently comprises about 200 trainee nurses, all in either their first, second or third year of study. The nursing school, which was also inaugurated in 1985, admits about 50 students twice a year. The hospital recently opened a 15 floor new wing with a multi-storey car park with the lake in view.Nawaloka is listed in the Colombo Stock Exchange.

3.2 Durdans Hospital

A military hospital serving British military personnel, eventually became Durdans Hospital, situated where

the present hospital now stands under the name of Ceylon Hospitals Limited. A special focus was given to maternity care from 1968 when Durdans opened its first maternity care facility, as well as an Out-patient facility.

The hospital gradually offered more services and a modernisation and remodelling programme was initiated. In 1997 a strategic alliance was formed with a regional centre of excellence in cardiology. The Durdans Heart Centre was opened in 1999, bringing unmatched and dedicated cardiac care to patients for the first time in Sri Lanka. Ceylon Hospitals Limited was listed in the Colombo Stock Exchange in 2003, followed by a phased expansion programme which commenced in 2004 with the second phase commencing in 2007.

3.3 Lanka Hospitals

Lanka Hospitals Corporation Limited commenced operations in Sri Lanka on 7th June 2002, under the brand name Apollo Hospitals, a part of the chain of Apollo Hospitals founded by the renowned Dr. Pratap C. Reddy in India. Apollo is a 350-bed multi-specialty tertiary care hospital spread over 350,000 square feet, with 7 acres of landscaped gardens, which is a unique feature among private hospitals. Apollo is a 11-storey structure complete with a helipad, and is the only private medical facility in Sri Lanka equipped for air-ambulance services. Apollo Colombo revolutionised Sri Lanka's healthcare service offer, and was the benchmark in introducing latest bio-medico technology based treatments, which were followed by other leading hospitals mainly located in Colombo. In 2007 Apollo Hospital Limited transferred it ownership to Sri Lankan entrepreneurs led by Sri Lanka Insurance Corporation Limited through a share transaction. As a result, Lanka Hospitals Limited was formed. Over the past decade, Lanka Hospitals has revolutionized the healthcare industry in Sri Lanka through infrastructure development and advancement of its products and services, through sizeable investments, with a view to deliver healthcare that is on par with global developments in bio-medical technology. In 2003 there were 1.9 million Out-patient visits which grew to 2.8 million in 2011. As for in-patient treatment, there were 45,000 admissions in 2003 which reached 58,000 in 2011.[2]

World renowned Forties Global Healthcare Holdings Pvt. Limited holds a 29 per cent stake of Lanka Hospitals PLC (Apollo Hospital), with an investment amounting to Rs.4 billion. The major share of the 350 bed hospital is owned by Sri Lanka Insurance Corporation Limited, with a stake of 55 per cent.

3.4 Asiri Group of Hospitals

Asiri Hospitals Group is the largest private medical care provider/largest Private Hospital Operator within Sri Lanka. It has 5 hospitals including 3 in Colombo and 2 in Matara, with a total bed strength of approximately 700 beds, and 25 Operating Theatres.

The Group caters to 75,000 out-patients per month and carries out approximately 450,000 laboratory tests per month, which is approximately 45 per cent of the market share of the private sector laboratory testing within the country.

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[2] IPS Census of Private, Co-operative and Estate Hospitals 2012 - October 2012.

The Group which commenced in 1980, has expanded rapidly over the last 5 years and has plans to begin construction of another regional hospital in Kandy shortly.

Asiri Hospitals Group is a subsidiary of Softlogic Holdings PLC. Softlogic Holdings PLC is a diversified conglomerate listed in the Colombo Stock Exchange (CSE) with interests in Retail, Information and Communication Technology, Travel & Leisure, Automobile, Finance and Healthcare.

Asiri Group of Hospitals consists of five hospitals. Three are Asiri Hospital PLC , Aisri Surgical Hospital and Central Hospital situated in the City of Colombo, while the fourth, and fifth are located in Matara.

3.4.1 Asiri Hospital

Located in Colombo and widely recognized as having the best equipped and most reliable laboratory in Sri Lanka, it has 110 beds and 3 operating theatres, along with CT scan diagnostic facilities and a state-of-the-art Neonatal unit for infants with special requirements. It has become a hub for OPD and channelling services. Asiri Hospital boasts of an average occupancy rate of over 90 per cent, and has become one of the cornerstones of the Group's revenue-generating services, with approximately 7,000 - 8,000 laboratory tests performed daily.

3.4.2 Asiri Surgical

A 14-storey specialized surgical hospital located in Colombo, Asiri Surgical has 156 beds and 9 operating theatres. It also offers a comprehensive cardiac care programme, encompassing all areas of cardiology, vascular medicine, acute heart attack services, invasive and interventional cardiology, as well as all forms of adult cardiac and thoracic surgeries.

3.4.3 The Central Hospital

Considered to be the most modern multi-specialty general hospital in Colombo, the Central Hospital has 272 beds, and 12 operating theatres. It has the most technologically advanced neurosurgical unit in the country.The hospital has more than 250 Consultants consisting of all specialties and super specialties in medicine and surgery. The Central Hospital Laboratory functions together with the Asiri Hospital Laboratory chains.

In the first year of operation, the Central Hospital treated over 450,000 patients and the estimated turnover for the year was Rs. 1.7 billion.

3.4.4 Asiri Hospital, Matara

Asiri Hospital, Matara has 50 beds and a modern laboratory. The hospital is equipped with an emergency treatment unit, a 24-hour pharmacy, and X-ray, mammography, and ultrasound facilities.

3.4.5 Matara Medi House

The Asiri Group acquired the Matara Medi House in 2010. After undergoing significant development, this hospital has some of the most modern facilities outside Colombo. Situated in the heart of the town of Matara, it has 80 beds and a flourishing channel practice.

Asiri Group of Hospitals is the first in devolving laboratory services outside Colombo mainly in Kandy, Kurunegala and Matara.

3.5 Hemas Hospital

The Hemas Hospital, Wattala which opened in 2008, is equipped with state-of-the-art facilities, has 100 beds, over 100 Specialist Consultants, 05 operating theatres, MRI and CT Scanning, 24/7 lab, and an ICU. Hemas Hospital Thalawatugoda with 50 beds was completed by March 2013 and became the 3rd Multi-specialty Hospital of the Group.

In 2009, Hemas group opened its second hospital in Galle with 50 beds, two operation theatres, two labour rooms, an Endoscopy unit, an ICU, a modern medical laboratory and a modern radiology unit. This hospital is strategically located within 45 minutes of the Hikkaduwa tourist resort.

Hemas Hospital is owned by the Hemas Group, a leading conglomerate in Sri Lanka with a focus on five key sectors - FMCG, Healthcare, Transportation, Leisure and Strategic Investment.

Figures 3.1 & 3.2 below, provide market share as a percentage of revenue of major players in private health care providers. It is noteworthy that within a period of 1 year, Hemas Group of hospitals increased its share of revenue from 1 per cent to 4 per cent.

The private sector industry size is estimated to be about US$ 200 million, consisting of 5 hospital chains amounting to 1500 beds capacity and enjoys 75 per cent market share.

Figure 3.1
Market Share as a Percentage of Revenue 2008/2009

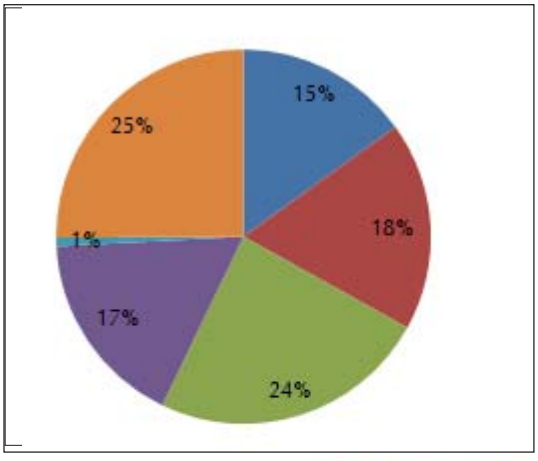
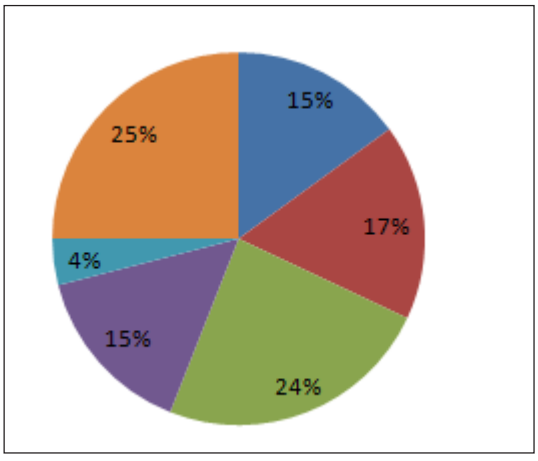
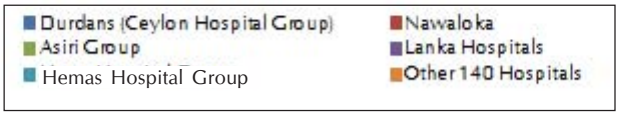


Figure 3.2
Market Share as a Percentage of Revenue 2009/2010





Source: Company Annual Reports, Durdans, Nawaloka, Asiri Group, Hemas Group, Lanka Hospitals and IPS Private Health Data Base.
Murtaza Esufally, Presentation at Economic Summit: Ceylon Chamber of Commerce 2011.

4. Government Doctors Working in the Private Sector

Private Health Care providers , as part of their competitive behaviour, indulged in the use of public sector resources, particularly the experience of physicians in public hospitals. According to the National Census of Health Manpower 2006 conducted by the Ministry of Health (MOH), it was estimated that 1,200 government doctors were engaged in working part time at private hospitals.

There are around 17,000 government doctors working in government hospitals today. The large percentage of these doctors employed in the public sector, practise privately as GPs or in private hospitals after their official duty hours. This number is complemented by a further 1,000 retired doctors. Most of the doctors practising in private hospitals are engaged as specialists or non- specialists, and they work mostly in urban areas. Privately practising government medical officers are independent with no formal organization structure, but most of them are affiliated to the Government Medical Officers Association (GMOA) trade union as they are employed permanently in Government Hospitals.

Also at present, there is a 'cold war' between MBBS doctors in government hospitals and the specialist doctors practising in private hospitals with regard to purported changes to the Medical Ordinance by the Sri Lanka Medical Council (SLMC). The Government Medical Officers' Forum accused the SLMC of manipulating to introduce lesser duties to the medical officers who have been well-trained to treat any patient. The proposed amendments to the Sri Lanka Medical Ordinance were based on making all the MBBS qualified doctors, assistant medical practitioners by reducing their responsibilities to handle patients. It claimed that the SLMC has decided to remove surgery and midwifery components from the MBBS degree, because the practising Consultant would have more opportunities than the general practitioners, to engage in channel practice in the private sector.

The involvement of government doctors working in private sector hospitals blurs the distinction between the public and private sector, since the same individuals operate in both. There are various problems associated with this form of dual practice. It is believed that the physician seeing the patient privately would provide more time and better care for a patient, than in the public sector. The public health care services are further affected as one finds that the care provided by the doctors are hurried and impersonal. It is assumed that there are wide differences in pay for government doctors, and the amounts doctors could make while engaged in the private sector depending on the hospitals they are practising in. Although there are no documentary evidence available, it is well known that all surgeons and specialists in teaching hospitals are engaged in private practice after official duty hours in government hospitals, and some are engaged as part time consultants. There have been many complaints that many specialist doctors pave the way for their patients in government hospitals, to opt for private hospitals care. While these arrangements work well with those can afford private care, it is much to the detriment of the poor who approach government hospitals for free health care. Amidst this situation, it was reported that three of the 12 specialist Heart Surgeons currently working in government hospitals have left government service and are working in private hospitals full-time. This situation has aggravated the already serious condition of the dearth of specialist heart surgeons in government hospitals, and also it is felt that specialists in other fields too may be poised to leave for employment abroad, or in private hospitals.

The private sector charges user fees for patients for utilizing health services in order to operate and maintain their facilities, while offering lucrative remuneration packages to medical practitioners for their services. Access to private health services is inevitably limited to the richer segments of the population that can afford to pay high user fees as out-of-pocket payments or co-payments (with coverage of private insurance).

5. Foreign Doctors Working in Private Sector Hospitals

There had been various news items related to foreign doctors, mainly those of Indian origin, practising in Sri Lankan private hospitals. When Apollo Hospital began operations in Colombo in 2003, it was reported that Indian doctors, nurses and paramedic staff were employed in the hospital as it was an Indian Investment and was agreed upon by the Board of Investment (BOI). When the hospital management changed in 2007 the situation changed, but the precedent was established for other major hospitals to utilize services of Indian doctors, including those doctors who served at the Apollo Hospital earlier. At present, all major hospitals in Colombo have employed Indian doctors as specialists in Cardio Vascular and Hip Transplant procedures. According to the GMOA, the Indian qualified doctors are registered in the Sri Lanka Medial Council as medical officers and later change the title to consultants or surgeons. In 2007 the MOH suspended the registration procedure of foreign doctors because those doctors do not have the required qualifications to perform surgeries. The GMOA had strongly objected to the registration process of foreign doctors by SLMC because several patients that underwent cardiac surgery at private hospitals, were admitted to the Colombo National Hospital as they had developed post-surgery complications. Also, it was reported that if patients died due to the medical negligence of foreign doctors, the relatives of patients and the government blame Sri Lankan doctors, thereby making Sri Lankan doctors scapegoats for the errors and omissions of foreign doctors. At present, about 184 Indian registered medical practitioners have become consultants in private hospitals although they do not possess the required qualifications, and is a flagrant violation of the Sri Lanka Medical Ordinance, according to the GMOA.

There were serious health issues that had emerged with reports of surgeries that had been carried out by unqualified Indian doctors resulting in six patients being transferred to and treated at the National Hospital of Sri Lanka (NHSL) and the Lady Ridgeway Children's Hospital in Colombo, post-surgery.[3] These patients were admitted to hospital for heart surgery, the costs of which was Rs.600,000 per operation. However, these surgeries were failures and the doctors in question have reportedly fled the country. One such patient was forced to get himself discharged from the hospital in which he underwent surgery as he could not continue to pay the bills, which were mounting. He had to therefore seek admission at the National Hospital, and has since incurred a further Rs.1.5 million for treatment.

In another case, a child who had a heart ailment and whose heart surgery was not successful, was transferred for treatment to the Lady Ridgeway Hospital. At the private hospital when the child's parents were advised that she would need a heart transplant, they had sought the services of an Indian doctor. When the outcome of the surgery was not successful, the Indian doctor who had operated on her had left the country. It therefore poses the question, how such a large number of foreign doctors, without the requisite qualifications, have been able to serve in these hospitals. What is also cause for concern is that the majority of them have obtained registration with the SLMC. What is more aggravating is that none of these Indian

[3] Ibid.

doctors are even registered with the Indian Medical Board. There are no links between any of the Indian state medical bodies and any Sri Lankan medical body. It is therefore a mystery as to how these doctors obtain appointments in Sri Lanka. However, it was learnt that if the registration of such specialist doctors are rejected – these doctors could still seek registration as general practitioners (GPs). This would enable them to continue to treat innocent patients who unknowingly will seek treatment, and maybe even surgery.

According to the SLMC, opportunities have been granted to these Indian doctors to serve in private hospitals, as there was a shortage of such doctors to treat heart patients in the country. As per medical norms, no surgery can be performed by a single doctor. It has to be performed by a group of specialist doctors, systematically and methodically. Furthermore, performing a surgery is a very serious job. It is in this light that the SLMC has given them registrations, and absorbed them as assistant surgeons.

Private Hospital Association (PHA)which defends the service of foreign doctors in private hospitals claims, that it is the accepted norm as per the recommendations of the Ministry of Health, that a foreign Specialist can be contracted in the event that the post cannot be successfully filled by a local Specialist. Section 67A of the Medical Ordinance stipulates that a temporary registration of such a foreign medical practitioner can be made for a period of 1 year. This procedure was followed strictly and the Private Hospitals successfully infused the know-how of an international medical team to uplift their medical services.

Also, they argue that the local specialist does not favour the "resident-doctor" service model and does not join a hospital on full-time basis. For hospitals having dedicated centres in super specialist core disciplines such as Neurology, Nephrology, ENT, Eye, Surgical Care and for cardiac surgical procedures, especially for open heart surgery and other invasive and interventional cardiac procedures, it is imperative to have full-time competent dedicated teams of specialists for 24 hour coverage.

To meet the challenge of working full-time in private hospitals by government doctors, GMOA has requested that government medical officers and consultants be allowed to provide round-the-clock health care services at private hospitals, instead of allowing unscreened Indian doctors to do so. If the proposed concurrent practice is allowed, it is bound to affect the quality and productivity of services offered at state hospitals, resulting in a gradual erosion of free health services the public are entitled to at state hospitals. It would also give rise to a plethora of similar requests from other grades in the health service and elsewhere which the authorities would be hard put to resist. Also among demands, GMOA requested that the government allow government doctors to work in private hospitals, utilizing their earned annual leave, and also to utilize the services of Sri Lankan consultants between 8:00 a.m. and 4:00 p.m. in private hospitals if they have earned leave. At present, government doctors are eligible to utilize earned leave for educational purposes or to go overseas.

6. Payment Method to Doctors

Typically in payment methods three parties are involved: Patient, physicians and hospitals.

In general,the fees for physicians are fixed by the hospital to the satisfaction of the doctors. The fees are fixed for consultations, and the patient pays first directly to the hospital. As a result, data of total fees collected against individual physicians are available with hospital authorities. At the end of every month, by arrangement a fixed percentage of this total is paid to the concerned physician. In addition, he or she

may get some incentive amount based on the volume of patients. The remainder goes to the hospital account. A special payment method is applicable for surgeries, which depend on the nature of the surgery, and the time spent on the surgery.

It was evident recently that most of the hospitals in Urban areas, mainly in Colombo, do not include the doctor's fee in the main treatment bill, and insist payment of the doctor's fee separately in cash. Under these circumstances, the patient pays the physician's fee directly, while the hospitals also charge the patients directly. When discharging patients from rooms or wards, doctor's fees are excluded from the bill but they insist on patients paying doctor's fees in cash, with no receipts being provided.

7. User Fees and Other Charges and the Regulatory Regime

The private sector charges user fees on patients for utilizing health services in order to operate and maintain their facilities.Capital investment in large private hospitals in Colombo reveals that investment in bio-medical equipment can be viewed as a competitive strategy for increasing market share. Under these circumstances,one would expect large private providers to have competitive charges for services they offer. According to the IPS survey, charges for comparable services among key players in private hospitals in Colombo city showed that although there are different pricing systems involved, there were no significant differences among them but there is a marked difference in the charges between Colombo and Outside Colombo facilities. Access to private facilities is inevitably limited to the richer segments of the population that can afford to pay high user fees as out-of-pocket expenses if not reimbursed by private insurance facilities. As there is no proper mechanism or caps to control the user fees charged, the competitive atmosphere has led to over-use and misuse of techno based facilities for over-charging. Also, it was reported that there were some variances between charged fees reimbursed by Insurance, and those directly paid by Out-of-Pocket.

The private facilities are not monitored although regulation has been enacted by the government to ensure quality service and cost control. The regulatory environment has not been strengthened due to the inactive implementation of the Private Hospital Regulatory Act No.21 of 2006 enforced on the private sector. The Act expresses specific requirements for facility standards and the assurance of quality services and rates and charges .

Although the Private Hospital Registration Act was passed in Parliament in 2006 it appears that the law is not being implemented for obvious reasons, and most private hospitals have become big business operations with some of them imposing unreasonable charges.

Clause 18 of the Regulatory Act says (See Annexure).

(1) The Minister may make regulations in respect of all matters required by this Act to be prescribed or in respect of which regulations are authorised to be made.

(2) Without prejudice to the powers conferred by subsection (1), the Minister may on the advice of the Council make regulations in respect of all or any of the following:

(b) the rates, charges and any other expenses, which shall be recorded or received for any services rendered or performed in terms of the Act;

(h) charges for accommodation, drugs and services rendered by Private Medical Institutions.

The above regulations have specifically mentioned that the Act has provided provision for the Minister to make necessary regulation with regard to the rates and charges to be levied by private medical institutions.

User fees and charges in Private Hospitals are classified information that are not available in the public domain. Time to time, the information appeared and was highlighted in the media, which was never denied by Private Hospital providers. Some of the relevant and reliable information which were conspicuous and which appeared in the media with regard to user fees and medical negligence as compiled by the author, are given below.

Today, medical bills are exorbitant and surpass even the affordable limits of the upper middle-class. The privatisation of the health sector began in a small way about 40 years ago, when the Government allowed doctors to engage in private practice. At that time, when a patient wished to channel a doctor at a private hospital, the charge was Rs.20 - Rs.25 for the doctor and Rs.5 for the hospital. Today the fee has swelled to between Rs.1000 and Rs.2000 for a consultant and at least Rs.600 as the hospital fee.

In major Colombo hospitals, normal charges for one day's stay is a minimum of Rs.100,000 inclusive of medicine and nursing care, and exclusive of surgical or other procedures.

Also, there had been various reports regarding the charges for blood transfusion for patients in these hospitals. Medical Bill for a patient for blood transfusion is Rs.50,000 per pint of blood, while the private sector purchases 450 ml blood packs from the National Blood Bank at a price of Rs. 1,500 a pack.

In recent years, a couple of hospitals have introduced In Vitro Fertilization for couples looking to conceive. Those who are seeking conception through the In-Vitro fertilization process needs to spend around Rs.500,000 as a non-refundable deposit, while the success rate is 20 per cent.

One leading hospital runs a dedicated ward for eye surgeries conducted by a renowned eye surgeon in the country, at a cost of Rs. 56,000 per eye surgery lasting only 15 minutes using laser technology. On Saturdays this particular surgeon conducts a minimum of 20 such surgeries.

In another instance, according to family members, a patient having walked into the hospital for an endoscopic test as an out-patient procedure, has been subjected to an emergency operation in which the patient did not recover consciousness, necessitating artificial ventilation in the ICU for the next few remaining hours of his life. This whole scenario, which took barely 26 hours to unfold, culminated in the dead patient's family getting a bill amounting to Rs. 2 million. However, with some internal influence within the hospital, the bill was slashed by Rs. 800,000. Finally, a Rs.1.2 million bill had to be settled before the body was released. For a private hospital to waive off no less than Rs. 800,000, amounting to 40 per cent of the original bill, speaks volumes for the margins of profits they make.

Another incident reported was that of an old patient who while undergoing a simple investigative procedure at a private hospital suffered cardiac arrest, for which emergency cardiac surgery was performed. The

surgical intervention was futile as the patient died, but it left a thumping bill amounting to over a million rupees which left the kith and kin at a loss of how to generate such a huge amount in a matter of hours. Refusal to release the body by the hospital authorities without the due payment, made settling of the bill to the last cent a necessity for the dead body to be released from the hospital morgue.

While over-priced medical bills remain one area that needs to be highlighted, how medical mishaps (and unforeseen complications) associated with medical procedures in private hospitals need to be handled is another area needing due attention by the authorities.

One example is when on 6 Feb 2013, a five-year-old admitted to a private hospital with symptoms similar to epilepsy died due to alleged medical negligence, caused by the explosion of an oxygen tube in a Magnetic Resonance Imaging (MRI) Scanner at a private hospital in Colombo. In this instance, the hospital management vehemently denied the allegation that the child died inside the scanner, but insisted that she died at the Scanning Intensive Care Unit.

In another incident, the death of a 38-year-old female patient due to alleged medical negligence at a private hospital in Colombo,resulted in her 13-year-old daughter being detained under hospital custody until the bill was settled. The deceased had been transferred from the private hospital to a government hospital in a critical condition while her 13-year-old daughter was detained inside a hospital room until the hospital bill amounting to Rs.1 million was settled. The patient had died due to medical negligence of the gynaecologist and obstetrician who performed a surgery into an ovarian cyst, in April 2012. The condition of the patient had started to deteriorate even after the second operation was performed. The doctors in the hospital have accepted the fact that her intestines had been damaged due to the surgery and that it would have taken a long time to heal.

According to the national body in charge of regulating private sector health services The Private Health Regulatory Council (PHRC), it was advisable for those who visit private sector health service institutions to make sure the establishments were registered with the Council before going for treatment. Although there is a Complaint Committee, there was hardly any evidence to support any verifications related to User Fees and medical negligence. At the same time, SLMC's concern on negligence by medical professionals in government hospitals are not the same with private hospitals. According to SLMC, they are not provisioned to take action against institutions, they are only able to take action if complaints are filed against individuals who violate the standards of the medical profession.

Although the patients are willing to pay for the services they seek, they may not be prepared or resourceful to pay for the mishaps and complications that may arise in the process of attending to their needs. Furthermore, it is really unfair for the patients to be charged for the medical mishaps that occur due to the negligence of doctors and complications that occur due to no fault of theirs; despite that the small print on the agreement prior to the medical procedure that the patient signs in haste and without reading, may mention otherwise.

If the medical bills remain exorbitant then the MOH needs to intervene through the powers vested in it through the Private Medical Institutions (Registration) Act No. 21 of 2006 mentioned above. In areas where the existing regulation needs more teeth, Section 18 of the Act provides for the Minister bringing in

further regulations and sub-section 2 (h) specifically identifies charges for accommodation, drugs and services, etc.

But the issue here is that the Ministry of Health's slow response to rapid private sector growth has made the applicability of regulations more difficult as the private sector is larger and more complex, and the user interest is more established and diverse. Although there is a Director for Private Sector Health Services, apart from the existence of the Private Health Regulatory Council, insufficient administrative resources is a constraint when carrying out his functions of overlooking the private sector. After the enactment of the Private Hospital Registration Act, MOH made an initiative by requesting doctors doing private practice to register with the Regulatory Council, but faced a vehement protest made by the GMOA, the initiative ended in failure. The fact was that most private providers are government doctors, and being members of the GMOA, reduced the perceived need and pressure for registration. Even at present, MOH doesn't have an overall strategy, or clear objectives directed at the private sector.

8. Functions of Private Health Regulatory Council (PHRC)[4]

The Private Health Regulatory Council (PHRC) is a Council established to exercise, perform and discharge its powers, duties and functions under the Private Medical Institutions (Registration) Act No.21 of 2006, which was certified on 14th July 2006 by the Parliament.

PHRC, which was established in 2008, meets once a month and is Chaired by the Director General of Health Services. The committee is constituted by the Provincial Directors of Health of all Provincial Councils, and Medical Directors or their representatives of major private hospitals in Colombo i.e. Nawaloka,Asiri,Durdans, Lanka Hospitals, Central and Hemas Hospitals. Further, PHRC has a separate Complaint Committee to look into various complaints made against the private sector.

PHSRC, is aimed at the development and monitoring of standards to be maintained by the registered Private Medical Institutions, and acts as a method of evaluation of standards maintained by such Private Medical Institutions. It is further aimed at achieving the objectives of ensuring that the minimum qualifications for recruitment, and minimum standards of training of personnel are adopted by all Private Medical Institutions and to ensure the quality of patient care services rendered or provided by such Private Medical Institutions.

The Council is empowered to exercise, perform and discharge certain specified powers, duties and functions in the formulation of quality assurance programmes for patient care in Private Medical Institutions. It is also empowered to monitor the same and to ensure the maintenance of minimum standards for recruitment of all staff engaged or employed in such Private Medical Institutions. It is responsible for the collection and publication of relevant health information and statistics and the implementation of a method of grading, according to the facilities offered by the respective Private Medical Institutions. Additionally,it has the responsibility of performing any other functions as may be necessary to achieve its objectives.

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[4] Source: Private Health Regulatory Council.

9. Private Hospital Curative Care

Curative care or curative medicine is the kind of health care directed towards seeking a cure for an existent disease or medical condition. Curative care differs from preventive care, which aims at preventing the appearance of diseases through immunization or exercise. Sri Lanka's private hospitals concentrate and engage in curative care by providing treatment and therapies to patients with an intent to alleviate symptoms and cure the patients' medical problem for a fee.

The treatment constitues mainly of Nursing Care, Medication, investigations, laboratory tests and surgical procedures when necessary for In-patients, and laboratory tests, investigations and medication for Out-patients through medical consultation.

In this process, the key players have opened up dedicated operating theatres for Orthopaedic, Neurosurgery, Cardiac Surgery, Maternity and Gynaecology.

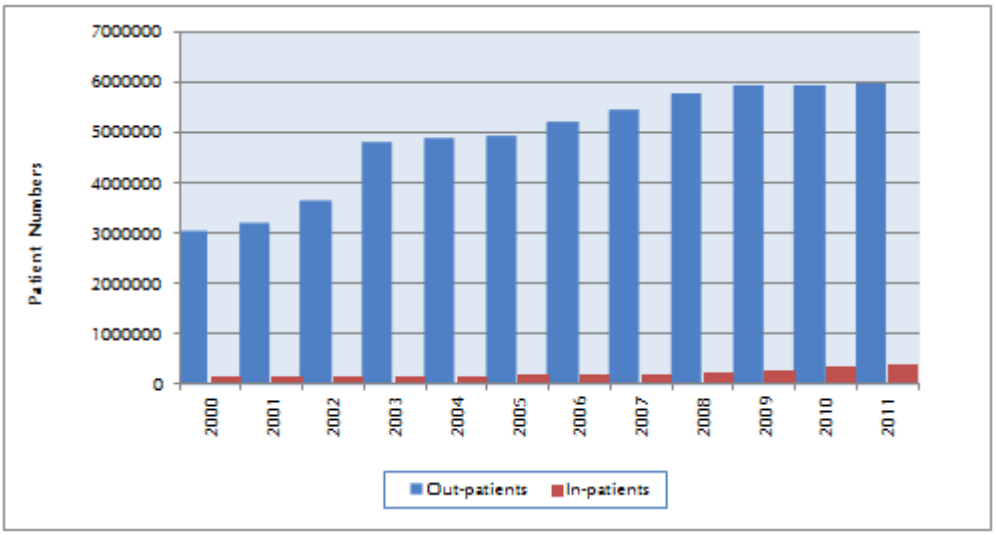
With regard to Out-patient treatment, consultancy services and laboratory tests have become the major revenue sources among other services.

The patients who seek treatment from the private sector are not necessarily the rich and well-to-do. Many of them do so despite the issues of affordability they are faced with. Patients come to private hospitals for various reasons that include, the perception of better care being available in the private hospital vis-à-vis the state sector hospitals, availability of insurance cover to a few and non-availability of specialist out-door care at government hospitals in the evenings. Private hospital industry has exploited this situation to such a level that they have created hundreds of employment opportunities, with more than 45,000 servicing the sector directly and over 100,000 indirectly. According to the National Census of Health Manpower 2006 conducted by the MOH, it was estimated that 1,200 government doctors are working part-time in private hospitals. IPS Census of Private Hospitals conducted in 2006 estimated that 4,700,000 patients (out-patients and in-patients) had been treated in 2006, amounting to 0.226 physicians per 1000 patient population in private hospitals, compared to 0.682[5] physicians per 1000 patients in government hospitals. Also, IPS survey carried out in 2012 estimated that private hospital in-patient admission for 1000 population was 11.05, as opposed to 230 per 1000 population in government hospitals. Similarly, out-patient visits in private hospitals were 255 per 1000 population, as against 2,152 per 1000 population in government hospitals. In 2007 out of a total of 43.5 million out-patients treated in public and private hospitals, 12 per cent had received treatment in private hospitals; while out of a total of 4.8 million in-patient admissions, private hospitals accounted for around 5 per cent of admissions.

Figure 9.1 below, depicts the growth of curative care by private hospitals over the years 2000-2011. Out of the total out-patient care, around 75 per cent have been treated in Western Province hospitals, mainly in Colombo. The main reason for this situation is that out of 145 private hospitals in active operation, 64 are located in the Western Province mainly, Colombo City as the hub. Also, the effectiveness in channelling doctors in Colombo could be seen as the major reason for the influx of in-patients to Colombo hospitals. With regard to In-patient admissions, Colombo hospitals monopolized the intake of patients, mainly because of the availability of specialist consultations and the modern facilities offered. In addition, the

[5] De Silva , N. R. 2008, *Impact of Migration of Medical Workforce In Sri Lanka.*

Figure 9.1
Private Hospital Curative Care, In-Patients and Out-Patients 2000-2011



Source: IPS Private Hospitals Data Base.

Colombo hospitals maintain around 65 per cent of total bed strength (of 4200) in all private hospitals in the country.

9.1 Laboratory Tests and Investigations

Table 9.1 and Table 9.2 below provides the growth of major services and laboratory investigations in private hospitals between 2000 to 2010. All these services, mainly Coronary Artery Bypass Graft,Renal Transplant,Knee replacements are being attended to by Colombo based, major private hospital players. Growth of these curative procedural areas are an indication of the demands that were growing over the years, which could be attributed mostly to the illnesses of old aged patients.

In Sri Lanka, CT scans were first introduced in 1987, Mammograms in 1992, Cardiac Catheterisation in 1994, MRI scans in 1995, laser eye surgery in 2005, and 3.0 Tesla MRI Scanner in 2010.

Table 9.1
Growth of the Selected Major Services in Private Hospitals 2000-2010

	No. of Hospitals					
Services/ Year	**2000**	**2002**	**2004**	**2006**	**2008**	**2010**
Coronary Artery Bypass Graft (CABG)	4	4	5	6	6	7
Renal Transplant	4	4	4	5	6	6
In Vitro Fertilization	1	1	2	3	4	4
Laparoscopic surgery	2	2	4	4	5	5
Chronic Haemodyalisis	4	4	6	8	10	10
Total knee and hip Replacement	2	3	3	5	6	6

Source: IPS Private Hospitals Data Base.

Table 9.2
Selected Major Laboratory Investigations in Private Hospitals 2000-2010

	No. of Hospitals					
Investigation/ Year	**2000**	**2002**	**2004**	**2006**	**2008**	**2010**
Sophisticated hematology, urine and biochemical tests(bone marrow tests,24 hour urinary proteins)	3	5	6	7	8	10
MRI scanner	2	3	5	6	6	7
CT scanner	3	3	20	20	21	22
Endoscopy: Upper gastro intestinal tract	2	5	9	9	10	10
Colonoscopy	2	4	6	6	7	7
Lung Function Tests	3	5	8	8	8	10
Autonomic Function Tests	2	4	5	7	7	9
Bone density	2	3	6	6	8	12

Source: IPS Private Hospitals Data Base.

The Radiology and Imaging departments of healthcare have recorded a significant increase in Radiology investigations during recent years.One of the leading hospitals in Colombo has recorded an increase in Radiology investigations, to 100,000, for the twelve months ending in August 2012. This has led to many major hospitals introducing Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners, as there is a growing demand coupled with increased earning potential to providers.

Among private hospitals, there is a division in the range of services and quality of care offered between small and large hospitals in terms of investment, equipment and facilities and the user fees charged. In the case of Coronary Bypass surgeries (CABG), it is the Colombo major hospitals that conduct CABG and have been maintaining a lower mortality level that has attracted the group affected with heart ailments, who are in need of open heart surgery and other invasive and interventional cardiac procedures. According to the Private Hospital Association, at any given time, there are approximately 50 patients admitted to the Heart Centres as in-patients and are awaiting surgical procedures to be performed. This is in addition to the monthly schedules in the waiting list which may run to well over 160. A fair number of patients belong to the high risk category. On an annual average, the Centres referred to above, perform 2,800 open heart surgical procedures and approximately 10,000 invasive and interventional procedures, in addition to the hundreds of different surgeries and procedures performed in non-cardiac speciality areas. Yet, quite a number of patients travel overseas, especially to seek heart related medical care and support. According to hospital sources there is a dearth of cardiothoracic surgeons to meet the demand. Accordingly,there are less than ten cardiothoracic surgeons and only 38 cardiologists in Colombo. There are at least 600 Sri Lankans travelling to India, annually, for surgical treatment.

Intense competition among private hospitals to increase their market share in curative care delivery is seen among major hospitals located in Colombo and suburbs. To meet the challenges among competitors, hospitals indulge in three main strategies as given below.

- Improve and expand the existing infrastructure with modified spacious facilities, multiple operating theatres, and with at least two car parks;
- Introduction of state-of-the-art medical technologies;

- Opening of networks of Chanelling centres for appointments with specialist doctors; and
- Establishment of networks of laboratory test sample collection centres.

Among these strategies, are those related to upgrading their standard of delivery by introducing state-of-the-art technology into the interventions of Neurology, Gastroenterology, Neurosurgery, laparoscopic surgery and Plastic and Reconstructive Surgery. The latest addition is the Capsule Endoscopy technique, that allows non-invasive endoscopic examination without sedation. On the government's part , it has granted 100 per cent tariff concessions to private hospitals on the import of life saving equipment under BOI facility.

As a section of curative care,most private hospitals in Colombo have their own medical laboratories and sample collection centres opened all over the island. Laboratory tests had become the second major source of revenue for key players of Private Hospitals, because these hospitals dominate the laboratory tests all-island through a network of collecting centres. Some hospitals have samples bar-coded throughout the entire process from collection to issuing results. IPS survey revealed that there had been 8.2 million laboratory tests carried out by private hospitals in 2011 and around 65 per cent of these tests had been performed by the hospitals in Colombo. Of these tests, 45 per cent has been accounted for by Durdans, Asiri, Nawaloka and Hemas Hospitals.It was reported that the bulk of tests were related to Urine and blood count samples for prior testing, for continuous diagnostic procedures. In most government hospitals, doctors recommend that patients obtain prescribed medical tests from private laboratories for accuracy and to expedite the treatment process. On the supply side, private medical laboratories offer 10 per cent discount to the original bill if the prescription for tests has come from government hospitals. Further, it could be seen that most of the private hospitals have opened medical labs in the close vicinity of government hospitals such as the Colombo National Hospital, Castle Street Children Hospital, De Soyza Maternity Hospital, and Lady Ridgeway Hospital for children, to facilitate the laboratory tests for patients. Charges levied for medical tests range from a minimum of Rs.600 depending on prescriptions.

Out of all hospitals in Colombo, Durdans Hospitals is on record by maintaining an extensive all-island coverage of laboratory test facilities with 16 satellite Labs, 4 Medical Centres and 263 collecting centres spread island-wide.

10. Health Tourism Initiative by Private Hospitals

Unlike general tourists needing medical attention, medical tourists are people who cross international borders for the exclusive purpose of obtaining medical services. Medical tourism has increased in part because of rising health-care costs in developed countries, cross-border medical training and widespread air travel. The medical tourism industry has been growing worldwide. It involves about 50 countries in all continents and several Asian countries are clearly in the lead. In Asia, medical tourism is highest in India, Singapore and Thailand. These three countries combined comprised about 90 per cent of the medical tourism market share in Asia in 2008, and have invested heavily in their health-care infrastructure to meet the increased demand for accredited medical care, through first-class treatment process.[6]

[6] *The Effects of Medical Tourism: Thailand's Experience*, WHO.

Medical tourism is not without its critics. Many professional organizations in the West advise against the idea of travelling abroad for surgery, due to concerns about long-term follow-up and the development of possible complications during the travel home.

In Sri Lanka over the last decade more than 60 per cent of tourist arrivals have come for pleasure, with India (19 per cent) and UK (18 per cent) taking the lead.[7]

Along with the peaceful environment that prevails in the country after the end of the conflict, the hospitality trade has targeted 2.5 million tourist arrivals in Sri Lanka by 2016. Already, it has recorded 1 million tourist arrivals by the end of 2012. While development of necessary infrastructure has been at a rapid rate, it is not only the infrastructure but the availability of trained human resources to meet the above target, that has become the concern of the tourist trade.

According to the Private Hospital Association, private hospitals have targeted a 20,000 medical tourists by 2015, and to increase it to 100,000 by 2020. Already, many hospitals in Colombo have initiated programmes to promote medical tourism, taking advantage of the growth of tourism in the country. As an example, Durdans has joined hands with the world renowned Healing Journey programme and Ceylon Tours to promote medical tourism. The Healing Journey is a programme for people who want to learn how to help themselves when they have cancer, or other serious chronic diseases.Durdans has already appointed an International Patient Coordinator, and arrangements have been made for on-line payment in advance for potential medical tourists. Healing Journey says that for individuals without insurance or those needing medical procedures that insurance may not cover, medical tourism offers an attractive alternative to rising healthcare costs. Medical tourism has been traditionally associated with selective procedures such as cosmetic, dental and plastic surgery. The Company works with Sri Lanka's world-class hospitals to offer international patients the best of medical care. Though the medical tourism industry in Sri Lanka is still in its early days, major private hospitals in Colombo are well geared to provide services to international clients.All of these are equipped with state-of-the-art technology and equipment.

When analyzing Sri Lanka's geographical location and the rates charged from medical tourists, there appears some comparative advantage against Thailand , Malaysia and other neighbouring countries.Table 10.1 provide comparative rates for medical tourism without taking into account air fares and cost of accommodation or room charges.

The economic benefits of health tourism could be outweighed when limited resources are drawn away from national health priorities, towards serving foreigners. As an example, in Sri Lanka there is now a two tier health system: the public sector where services are provided free at the point of delivery, and a private sector, particularly in Colombo and a few capital cities in the provinces. In the private sector, the services are provided for a fee by medical personnel (consultants) from the public sector. There is a general perception among the public that this system, in which consultants who are full-time public sector officials, divide their time between the two sectors, has a negative impact on the public sector services. If health tourism increased, it would lead to a three tier health system by creating a third segment which caters to wealthy foreigners, and services of all three tiers will be provided by the same medical professionals, many of whom are full-time employees in the public sector. This will naturally have a further negative impact on the public sector services.

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[7] Sri Lanka Tourism Development Authority, *Annual Statistic Report* 2010.

Table 10.1
Rates in Health Tourism in the Region and US in 2010 (US$)

Surgery	India	Korea	Thailand	Vietnam	Malaysia	Sri Lanka	USA
Heart Bypass	5,200	28,900	15,121		11,430	6,220	144,000
Angioplasty	3,300	15,200	3,788		5,430	3,110	57,000
Heart Valve replacement	5,500	43,500	21,212		10,580	6,220	170,000
Hip replacement	7,000	14,120	7,879	8,250	7,500	4,440	50,000
Hip resurfacing	7,000	15,600	15,152		12,350	4,440	50,000
Knee replacement	6,200	19,800	12,297	8,500	7,000	3,550	50,000
Spinal Fusion	6,500	15,400	9,091	6,150	6,000	2,665	100,000
Dental Implant	1,000	4,200	3,636		354	1,330	2,800
Gastric Sleeve	5,000		13,636				28,700
Gastric bypass	5,000		16,667		9,540		32,927
Lap Band	3,000		11,515			3,200	30,000
Liposuction	2,800		2,303	2,850	2,299	2,220	9,000
Tummy tuck	3,000		5,000	3,850			9,750
Breast implants	3,500	12,500	2,727	3,850		2,220	10,000
Rhinoplast	4,000	5,000	3,091	2,100	1,293		8,000
Face lift	4,000	15,300	3,697	4,150	3,440		15,000
Hysterectomy	2,500	11,000	2,727		5,250	1,155	15,000
Lasik (both eyes)	500	6,000	1,818	1,640	477	1,155	4,400
Cornea (both eyes)		7,000	1,800			530	
Retina	850	10,200	4,242		3,000	530	
IVF Treatments	3,250	2,180	9,091		3,819	3,530	14,500

Note: *The above prices except Sri Lanka are taken from the Medical Tourism Association 2010 Survey and are not inclusive of airfare or hotel accommodation for the patient or companion.*

Source: Murtaza Esufally: Economic Summit : Ceylon Chamber of Commerce 2011.

There is a possibility that the medical and paramedical personnel who have been trained using the tax payers' money may be tempted to leave the public sector for higher paid positions in private hospitals serving foreign patients, leading to an acute shortage of health personnel in the public sector.

It is also very unlikely that by promoting health tourism, the additional incomes from foreign patients could be harnessed to benefit the national health system, since all the profits will go to the private sector which serves the foreign patients.

11. Some Weaknesses Highlighted in Private Hospitals Health Care Delivery

In fairness to the private healthcare institutions, it needs to be said that they too make huge investments in installing and upgrading facilities. All the state-of-the-art facilities now most of the private hospitals are equipped with, are not second to the facilities found elsewhere in the world despite, of course, being

expensive. On the government's part too, it has done its bit by granting 100 per cent tariff concessions to private hospitals on the import of life saving equipment, with the expectation that it would ease the cost factor to be borne by the patients. Yet the medical bills remains exorbitant. Today, medical bills are exorbitant and surpass even the affordability limits of the upper middle-class.

It has been observed that the doctors have a financial interest in continuing treatment and to exploit the situation as long as the patient is ignorant. IPS Private Hospital Surveys have shown that there is an abundance of bio-medical equipment and modern technology in Colombo hospitals, as compared to areas outside the Colombo District. In many hospitals, doctors are under pressure to see that the beds are occupied all the time and the equipment utilized fully. Many hospitals have fixed the minimum amount of business a physician or surgeon has to bring over a certain period , to qualify for performance based ex gratia payments. The above statement cannot be backed by empirical data ,since the IPS limited study has not covered these issues. However, discussion with key persons both in the public and private sector revealed the prevalence of such practices.

Often the media reports that beside high consultation fees and the prescription of expensive drugs, many specialists are also encouraged or persuaded by hospital authorities to prescribe non-essential tests for patients. The media also reported that one big hospital did something outrageous, when it wrote to cardiologists saying they would get a commission of 10 per cent if they recommended a patient for heart-bypass surgery at that hospital. Fortunately,the matter was exposed to the media, and the unethical practice was stopped. The same hospital, some years ago, installed an expensive scanning machine and the specialists were told that about 50 scans would have to be done each day for the hospital to regain the money it had spent to buy the scanning machine. So the specialists had no option but to prescribe scans, and a hospital official admitted that about 50 per cent of those scans were not essential and were intended to increase the profits of the hospital instead of ensuring the well-being of the patient.[8]

It was also revealed that in order to save costs patients were discharged early in order to ensure quick turnover. According to industry sources, improved facilities and new technology contributed towards shorter patient stays in hospital. Actual findings were that private hospitals often discharge patients even before they are ready for it, in order to maximize patient turnover and increase intervention. It is only during the first few days of hospitalization that a hospital makes profits on beds,after which profit margins tend to fall. It is during the first few days of hospitalization that all procedures, both surgical and non-surgical are completed. There is little scope thereafter for charging patients more than bed and routine check up charges.The only charges that the hospital is likely to derive profit from during the recovery phase are on drugs and nursing care. Early release of mothers after the caesarian procedure is a case in point in this regard.

Apart from routine curative treatment, they are also opted for communities during an epidemic situation. During the dengue epidemic in late 2011 in urban areas mainly in Colombo, the private hospitals have been unable to respond to crisis situations and were found to be ill-equipped to meet the challenge. Running back and forth between private hospitals and public hospitals led to the loss of valuable time and the unnecessary death of children. Finally,it was public hospitals and doctors who treated the patients.

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[8] http://www.dailymirror.lk/opinion/172-opinion/22548-deadly-rates-in-private-health-sector-editorial.html.

Also in the Sri Lanka private hospital system, there is no specific separation of primary care, secondary care and tertiary level care, as in government hospitals.It is to be noted that in Sri Lanka there is only very small presence of private institutions at the secondary and tertiary level.

There have been many incidents in small private hospitals where treatment offered for common ailments are often irrational, ineffective, and sometimes harmful. Apart from routine treatment, the private sector has been unable to respond positively to a crisis situation during an epidemic and is ill-equipped to avert death. Also,there is a variability in the cost of services provided by these institutions. Very often the patients or consumers have no information regarding the costs he or she is likely to incur when they seek care.

12. Foreign Investment

Apollo Hospital Chain in India invested a sum of USD equivalent of Rs.400 million to put up a 350 bed multi-facility hospital, and was the first major foreign investment made in the country's private health care sector.

Fortis Healthcare, which entered Sri Lanka acquiring 29 per cent of Lanka Hospitals Plc (Apollo), established a joint a collaboration with Oasis Hospital in Colombo to set up a state-of-the art cardiac section. Oasis Hospital, entered into an agreement with Fortis Malar Hospital in Chennai, to set up a 24/7 cardiac centre. Subsquently, Fortis Malar Hospitals Limited has taken over the operations and management of the Cardiac Centre at the Oasis Hospitals Limited. Oasis Hospital is a 170 bed facility which provides tertiary level treatment and care in Cardiology and Cardiac Surgery . The total network of Fortis Healthcare consists of 55 hospitals in 13 states in India.

13. Conclusion

The hallmark of the Sri Lankan private sector is its strong dependence on the state sector for medical personnel. Apart from the decision in 1977 to permit private practice for state medical officers, the growth of the private healthcare sector has occurred by and large, within a policy vacuum. In general,the policy towards the private sector has been passive, encouraging private hospital growth through financial incentives. The major government policy intervention with respect to the private medical sector was a programme of incentives in 1990s which offered to private hospital providers tax holidays, and exemptions for qualifying investments through the Board of Investment (BOI). Although medical services were not originally identified as an area needing support, investment incentives were later offered and modified, by extending the criteria for eligibility, generally making it easier to qualify.

The private hospitals in allopathic medicine have expanded in number and size during the last two decades and are mainly located in urban areas. Around 145 hospitals are in active operation with a total bed strength of around 4,500.[9]

In a dual health system, equity and fairness in delivery of health care cannot be seen when society is highly iniquitous. Therefore the State policy towards the private sector has to be addressed within a system of inclusive perspective, covering not just providers of health care services but also beneficiaries and other

[9] IPS. Private.Co-operative and Estate Hospitals data base.

related components in the health care system. This integrated approach is necessary for evolving a policy towards private hospitals, because the piecemeal effort now being proposed[10] by the Minister of Health (New Regulation for Private Health Sector) might lead to a fragmented, ineffective and adverse outcome. This has been amply demonstrated by the American experience, where there was initially an effort to only regulate provisioning but, during the seventies, the growth of bio-medical technology and corporate hospitals gave rise to an increase in medical cost. Subsequently, the federal government had to set up offices for technology assessment and boards for regulating technology in order to prevent its over-use or even misuse. Also, regulatory authorities set up ceilings for the number of high technology equipment per given population.[11]

It is common knowledge that the utilization of the Private Hospital facilities is related to the income level.There is a higher utilization of the private sector among the urban upper middle class and above, while the urban and rural poor utilize government facilities. The richer group voluntarily chooses to use insurance or direct payment for private providers while the poorer section uses out-of-pocket payments by households to purchase medical care from the private providers.This imbalance in mode of payment through household out-of-pocket, creates a void among the poorer section to access higher facilities offered by private providers for serious illnesses. Seeking the same medicare from public facilities is a long journey on a waiting list. At present, over 5,000 patients needing heart surgery are on the waiting lists of the State-run hospitals.[12]

It is imperative that the government intervenes through various means in the private health sector.While the private sector has created a permanent space in the country's health care system, it needs to be defined by the State where the principles of equity and fairness stand. It must be kept in mind that efforts at regulation were considered in 2006 after the private sector has grown over the last 100 years, only after the foreign funded Apollo Hospital came into operation in 2003. The State has a responsibility to ensure that health services are available to the whole population. The State aims towards equitable service provision, and the private sector is driven by the desire to maximize profit. The challenge therefore is to develop and evolve partnerships that serve the public health goal. Such arrangements could help to overcome the current situation where the private health sector should get involved in preventive care and community health because comprehensive health care includes not only curative services, but also preventive and community health services.

The regulation of the private sector needs revisiting, and needs to be articulated within the fundamental reforms strengthening existing universally accessible health care with high quality, and which is financially fair and responsive to people's interest. Growth of the private health sector has already penetrated the public sector by absorbing its experiences. Unregulated or weak regulatory mechanisms will enhance the growth of the private sector that could dissipate public health programmes by disrupting curative inputs. Inactivation of referral system in government hospitals is the best example.

Further,the government offers subsidies to private hospitals for the import of high tech bio-medical equipment, but there is no information on initiatives to regulate the flow of medical technology. As a result,

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[10] http://www.dailymirror.lk/news/26296-new-regulations-for-private-hospitals.html.

[11] Iglehart, John K. (1977), The Cost and Regulation of Medical Technology. Health and Society.

[12] http://www.island.lk/index.php?page_cat=article-details&page=article-details&code_title=74821.

there is an abundance of medical equipment and technology in metropolitan areas, mainly in Colombo city. It is important for the state to provide guidelines and structures for licensing the use of equipment. The danger is that higher the demand for modernized hi-tech medical establishments, the lesser equipped might be closed down. It was reported that many hospitals in sub-urban areas are faced with this predicament.

The influx in technology may well have led to the irrational use of bio-medical equipment services. Yet unnecessary investigation, and hospitalization inevitably occurs in settings where profit making is the primary concern. In this context, it needs to be highlighted that very often, private providers are not in a position to do justice to patients because the cost is inaccessible, and that makes a larger number of users seek transfers to public facilities.

Historically, government has given lands at subsidized rates for setting up private hospitals. These lands offered were mainly in urban locations.[13] It is ironic that governments were providing incentives to set up institutions in urban areas instead of rural areas where the provision of services to the poor in government facilities are weak.

In areas where the existing regulation needs more teeth, Section 18 of the Act provides for the Minister bringing in further regulations and sub-section 2 (h) specifically identifies charges for accommodation, drugs and services and such areas. The Ministry of Health having established a separate directorate on private health sector development, now needs to act proactively to redress the grievances of the public with regard to rip-off charges made by private hospitals. Further, it can make a case that it is on the side of the general public and not on that of business.

At the time of conclusion of this study,the media announced that the Ministry of Health (MOH) intended to introduce far-reaching amendments to the Private Health Services Regulatory Council Act of 2006 including the introduction of a fixed price formula for medical care, drugs, medical equipment and tests. Further, it has identified the main weakness of the current Act, such as that the MOH has no power to enter a private hospital and conduct an inquiry. It also does not have power to put a ceiling on the exorbitant prices charged through channel practices and private hospitals/nursing homes. The amendments are expected to bring the prices charged for drugs, medical equipment, inward patient care, surgeries and medical tests, to an affordable level; but it would vary on the rankings of the hospital, based on the facilities provided by each private hospital. The amendments are expected to give more legal teeth to the PHSRC Act, enabling the Director General of Health Services or his deputy to entertain public complaints against private hospitals, nursing homes and private medical practitioners /specialists and take legal action against them.

In this instance, it is reasonable to remember that a similar attempt was made to introduce a National Medicinal Drug Policy (NMDP). In October 2005, the MOH succeeded in getting the approval of the Cabinet with an undertaking to present the NMDP for ratification by Parliament. For the past eight

[13] Ravi Rannaneliya, Ajantha Kalyanaratne, G. D. Dayaratne, Tharanga Fernando -Report of the Study on Fiscal Incentives for the Development of Health Sector in Sri Lanka 2004. National Commission on Macroeconomics and Health, Institute of Policy Studies of Sri Lanka.

years,various excuses have been given, but for various reasons including pressure from vested interests, the legislation has not been brought before Parliament yet.

With growing demand for health by the people, amidst an ageing population,increased lifestyle related illnesses, growth of the private sector, constraints in financial provisioning to maintain and improve the public health sector, it is imperative that policy makers focus attention on a far reaching policy drive to introduce a public private partnership to maintain reasonable equity and fairness in health care delivery to the whole population.

As concluding remarks, it is suggested that the following areas need immediate attention of policy makers:

- Abolish incentives given to private hospital providers to purchase lands in metropolitan areas especially in Colombo, as Private hospitals have reached an over crowded level in the city. Private providers are not interested in moving out to rural areas because the main criteria such as Population Density, close proximity to Teaching Hospitals and a growing middle class are absent.
- BOI should introduce some rationale when allowing a 100 per cent duty free facility for the import of bio- medical equipment. Already the Secretary MOH has released a statement in this regard.[14]
- "The government has allocated over Rs.2,000 million for bio-medical equipment (BME) required by government hospitals. He said the government might have to form a partnership with the private sector when acquiring BME. A committee, headed by Director General Health Services, Dr. Palitha Mahipala,was appointed to formulate a BME policy for Sri Lanka. He said the policy would have to assess the feasibility and demand of BME in various parts of the country prior to acquiring it for government hospitals."
- Government doctors' request for more working hours in private hospitals needs to be viewed carefully. They are wholly opposed to Indian Doctors working in these hospitals despite the fact that there is a dearth of heart specialists in the country. At the time when the now abandoned Comprehensive Economic Partnership Agreement (CEPA) with India was in the discussion stage, GMOA managed to get the health sector out of the CEPA agreement mainly to safeguard the interests of the local doctors, and in fear of the influx of Indian doctors to work in private hospitals. Now the pressure is mounted to increase their working hours, while opposing Indian doctors working in private hospitals, indicating their business interests are placed higher than the health needs of the people.
- It is imperative that policy makers look into a comprehensive public and private partnership with private sector providers. At present there is an unofficial partnership existing in laboratory test procedures, between government hospitals and private laboratories. Evaluation of the current situation where 5,000 patients are in the waiting list for heart surgeries in government hospitals, ring the alarm for urgent government action in this direction.

[14] http://www.island.lk/index.php?page_cat=article-details&page=article-details&code_title=74821.

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Annexure : Private Health Regulatory Act No. 21 of 2006

PARLIAMENT OF THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

PRIVATE MEDICAL INSTITUTIONS (REGISTRATION) ACT, No. 21 OF 2006

[Certified on 14th July 2006]

Printed on the Order of Government

Published as a Supplement to Part II of the Gazette of the Democratic Socialist Republic of Sri Lanka of July 14, 2006

PRINTED AT THE DEPARTMENT OF GOVERNMENT PRINTING, SRI LANKA

TO BE PURCHASED AT THE GOVERNMENT PUBLICATION BUREAU, COLOMBO 1

Private Medical Institutions (Registration)
Act No.21 of 2006

L.D. — O. 37/2003

AN ACT TO PROVIDE FOR THE REGISTRATION, REGULATION MONITORINGAND INSPECTION OF PRIVATE MEDICAL INSTITUTIONS; TO PROVIDE THE NECESSARY INFRASTRUCTURE FOR, AND FOSTER THE DEVELOPMENT OF, PRIVATE MEDICAL INSTITUTIONS; AND TO PROVIDE FOR MATTERS CONNECTED THERE WITH OR INCIDENTAL THERETO.

Preamble.

WHEREAS it has become necessary for the government, in the interest of providing a safe and efficient medical service to the public, to set out a national policy in relation to the provision of medical services through private medical institutions and to identify the manner in which such services are to be so provided in order to achieve its objectives :

NOW THEREFORE BE it enacted by the Parliament of the Democratic Socialist Republic of Sri Lanka as follows :—

Short title and date of operation.

1. This Act may be cited as the Private Medical Institutions (Registration) Act, No of 2006 and shall come into operation on such date as the Minister may appoint by Order published in the Gazette (hereinafter referred to as the "appointed date")

Private Medical Institutions and persons operating them to be registered.

2. (1) No person shall—

(a) establish or maintain on any specified premises; or

(b) operate or permit any other person to operate,

a Private Medical Institution, except under the authority of a Certificate of Registration issued in that behalf in term of the provisions of section 4 of this Act.

(2) Any person who contravenes the provisions of subsection (1) shall be guilty of an offence.

Application for registration.

3. (1) Every application for a Certificate of Registration shall be made to the Private Health Services Regulatory Council through the respective provincial Director of Health Services in the prescribed form and shall be accompanied by the prescribed fee, and all other relevant documents.

(2) On receipt of the applications under subsection (1), the Private Health Services Regulatory Council shall where the Private Medical Institution and premises to which the relevant application relates satisfies the criteria as may be prescribed, inform the Provincial Director of Health Services of the respective Province that it has no objection to the registration of such Institution and premises and direct the respective Provincial Director of Health Services to—

(*a*) register the Private Medical Institution (hereinafter referred to as an "Institution") and its premises with the Private Health Services Regulatory Council and register the applicant as the person registered to maintain such Institution; and

(b) forward to the applicant the Certificate of Registration in the prescribed form.

(3) A Certificate of Registration granted under this section shall be valid for such period as shall be specified therein.

(4) A Certificate of Registration shall be renewed on application being made in that behalf in the manner specified in subsection (1), prior to one month of the date of expiry of such Registration, and on payment of the prescribed renewal fee.

(5) Fifty *per centum* of the fees collected by each Provincial Director of Health Services under this section shall be remitted to the respective Provincial Council.

(6) The Provincial Director of Health Services of the Province shall in carrying out his duties, action in compliance with such guidelines as are prescribed under this Act, relating to the registration of Private Medical Institutions.

Effects of registering.

4. (1) Where any Private Medical Institution is being operated or maintained by any person on any premises without being registered as required by section 2, the Provincial Director of Health Services shall inform the Private Health Services Regulatory Council of such fact and the Regulatory Council shall thereupon issue a directive to such Institution to forthwith register such Institution with the Regulatory Council within such period as shall be specified in such directive.

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(2) Non-compliance with a directive issued by the Regulatory Council under subsection (1), shall be an offence under this Act.

(3) Where any person or institution convicted of an offence under subsection (2) continues to commit such offence after a period of one month from the date of such conviction , the Magistrate Court may upon application for a closure order being made by the Regulatory Council, order the closure of such Private Medical Institution being maintained in such premises, until the institution or person convicted complies with the directive issued by the Council under subsection (1).

Registration of existing Private Medical Institutions.

5. (1) Any person or body of persons who is on the appointed date, operating or maintaining a private medical institution at any premises shall, within three months from the appointed date, take such steps as are necessary to register himself and the premises concerned with the Private Health Services Regulatory Council.

(2) In giving effect the provisions of subsection (1), the provisions of section 2, section 3 and section 4 of this Act shall, *mutatis mutandis,* apply to and in relation thereto.

Private Health Services Regulatory Council.

6. (1) There shall for the purposes of this Act be established a Private Health Services Regulatory Council (in this Act referred to as "the Council"), which shall consist of—

(a) the following members appointed by the Minister (hereinafter referred to as "appointed members") :–

(i) a representative each to represent each of the associations hereinafter set out, nominated by the respective association;

(a) the Independent Medical Practitioners Association;

(*b*) the Sri Lanka Dental Association; and

(c) the society of General Medical Practitioners;

(i) one person each to represent the fields of Accountancy, Management and Nursing provided such person is a person who has rendered distinguished service in his respective field;

(ii) nine representatives from the Association of Private Hospitals and Nursing Homes; and

(b) the following *ex-officio* members :—

(i) the Director General of Health Services;

(ii) the Director in-charge of development of the Private Health Sector;

(iii) the Registrar of the Sri Lanka Medical Council; and

(iv) the Provincial Director of Health Services of each Province.

(2) The Director-General of Health Services shall be the Chairman of the Council, and the Director of Private Health Sector Development shall be its Secretary.

(3) An appointed member of Council shall, unless he vacates office earlier by death, resignation and removal or otherwise, hold officer for a period of three years.

(4) An appointed member shall be deemed to have vacated office if he absents himself from three consecutive meetings of the Council without any reason, which the council considers as being an acceptable excuse.

(5) (*a*) The quorum for any meeting of the Council shall be seven members.

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(*b*) The Chairman shall preside at all meetings of the Council and on the absence of the Chairman, the members present shall elect one from amongst them to preside at the meetings.

(6) The Minister may at any time after assigning reasons therefore, remove an appointed member of the Council from office.

(7) An appointed member of the Council may at anytime resign from his office by letter to that effect addressed to the Minister.

(8) In the event of the vacation of office by an appointed member by death, resignation, removal, the Minister shall, having regard to the provisions of paragraph (a) of subsection (1), appoint another person to succeed such member. The member appointed to fill the vacancy shall hold office during the unexpired period of the term of office of the member whom he succeeds.

Council to be a body corporate.

7. The Council shall, by name assigned to it under section 6, be a body corporate and shall have perpetual succession and a common seal and may sue and be sued in such name.

Seal of the Council.

8. (1) The Seal of the Council shall be in the custody of the Secretary of the Council or any other member authorised by the Council.

(2) The Seal of the Council may be altered in such manner as may be determined by the Council.

(3) The Seal of the Council shall not be affixed to any instrument or document except in the presence of the Chairman of the Council, and one other member, both of whom shall sign the instrument or document in token of their presence:

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Provided that where the Chairman is unable to be present at the time when the seal of the Council is affixed to any instrument or document, any other member authorized in writing by the Chairman in that behalf, shall be competent to sign such instrument or document in accordance with the preceding provisions of this subsection.

(4) The Council shall maintain a register of the instruments or documents to which the seal of the Council is affixed.

Objects of the Council.

9. The Council shall exercise, perform and discharge its powers, duties and functions under this Act in such manner, as the Council considers best calculated to achieve the following objects :—

(a) the development and monitoring of standards to be maintained by the registered Private Medical Institutions;

(b) the method of evaluation of standards maintained by such Private Medical Institutions;

(c) to ensure that minimum qualifications for recruitment and minimum standards of training of personnel, are adopted by all Private medical Institutions;

(d) to ensure the quality of patient care services rendered or provided by such Private Medical Institutions.

Duties and functions of the Council.

10. The Council shall exercise, perform and discharge the following powers, duties and functions:—

(a) the formulation of quality assurance programmes for patient care in Private Medical Institutions and monitoring of the same;

(b) the maintenance of minimum standards for recruitment of all staff engaged or employed in such Private Medical Institutions;

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(c) the collection and publication of relevant health information and statistics;

(d) the implementation of a method of grading according to the facilities offered by the respective

Private Medical Institutions; and

(e) such other functions as may be necessary to achieve the objects as referred to in section 9.

Council to delegate its duties and functions.

11. The Council may where it considers it necessary, delegate the performance and discharge of its duties and functions under this Act to any member or members of the Council or a Committee consisting of members of the Council who shall perform and discharge such duty or function, subject to the general direction and control of the Council.

Fund of the Council.

12. (1) The Council shall have its own Fund.

(2) There shall be paid into Fund of the Council—

(a) all such sums of money as may be voted from time to time by Parliament for the use of the Council;

(b) all such sums of money as may be received by the Council by way of fees, rates, charges or otherwise in the discharge of its functions;

(c) all such sums of money as may be made available to it by way of grants or donations.

(3) There shall be paid out of the Fund such sums of money as may be required to defray the expenses incurred by the Council in the exercise, discharge and performance of its powers, duties and functions under this Act.

Accreditation of Private Medical Institutions.

13. (1) The Minister may on the advice of the Council, by Order published in the Gazette, formulate and enforce schemes of accreditation for private medical institutions. Such Order should carry

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all the details specifying the facilities, services and any other factors constituting the criteria for accreditation :

Provided however, that period of nine moths shall be given to concerned interests, before the implementation of such schemes of accreditation or subsequent changes that may be made thereto.

(2) Notwithstanding the Order published under subsection (1), a Private Medical Institution shall continue to offer its services until such time, the final decision of the Council on accreditation shall be made known to such Institution:

Provided however, in the event of a Private Medical Institution not qualifying for accreditation, sufficient time shall be given in writing to such institution, to achieve the standards specified by the Ministry of the Minister in charge of the subject of Health to qualify for accreditation.

(3) The Council shall where necessary, call upon a panel of persons who in their opinion possess the necessary knowledge, expertise, skill or learning to assist and advice the Council in working out the details in the schemes of accreditation and to help, examine and evaluate the applications made in terms of such schemes.

(4) The Council may implement the schemes of accreditation in stages or in such other manner as the Minister may determine.

(5) An accreditation of a Private Medical Institution under this section shall not restrict such institution from attending to life saving emergencies.

Power to enter and inspect.

14. (1) It shall be lawful for any authorized officer, without prior notice, at any time by day or night, to enter any Private Medical Institution, or any premises appertaining thereto, and do all such acts as may be reasonably necessary for the purpose of carrying out any inspection, examination, investigation or survey, for the purposes of this Act.

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(2) Nothing in the preceding provisions of this section shall be deemed or construed to authorize any person to inspect any medical record relating to any patient in an institution unless there is a special authorization by the Council to inspect any records, other than confidential information which requires the sanction of Court.

(3) Every person who resists or obstructs such authorized officer by the Council in the exercise of the powers conferred by the preceding provisions of this section shall be guilty of an offence under this Act.

(4) For the purpose of this section "authorised officer" means the Provincial Director of Deputy Provincial Director of Health Services of the respective Provincial Council or any other officer, as may on the recommendation of the Council be appointed by the Minister by Order published in the Gazette.

Offences.

15. (1) Any registered person or body of persons who—

(a) contravenes or fails to comply with the provisions of this Act or any regulation or rule made there under, or any order or direction lawfully given;

(b) contravenes or fails to comply with any condition or provision contained in any Certificate of Registration, issued under this Act, shall be guilty of an offence under this Act.

(2) Any person who—

(a) attempts to commit an offence under this Act; or

(b) aids or abets another person to commit an offence under this Act,

shall be guilty of an offence under this Act.

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(3) No prosecution for an offence under subsection (1) or (2) shall be instituted except with the written sanction of the Council.

Penalties.

16. (1) Any person who is convictes after summary trial before a Magistrate, of an offence under this Act, shall be liable on such conviction—

(a) where such offence involves the causing of injury to human life or seriously jeopardizing public health or public safety, to a fine not exceeding fifty thousand rupees;

(b) for any other offence —

(i) in the case of a first offence, to fine not exceeding ten thousand rupees;

(ii) in the case of second or subsequent offence, to a fine not exceeding twenty thousand rupees; and

(iii) in the case of continuing offence, to a further fine not exceeding one thousand rupees for each day on which the commission of the offence is continued after conviction or to imprisonment of either description for a term not exceeding six months or to both such fine and imprisonment.

(2) Where a person convicted of an offence under this Act is convicted for a second offence of like or similar nature, the Magistrate's Court convicting him for the second offence shall cancel any certificate, authorization or permit granted or issued to such person or body of persons under this Act, or any regulation made thereunder and shall cause notice of such cancellation to be notified to the Council.

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Offences committed by a body of persons.

17. Where an offence under this Act or any regulation or rule made thereunder is committed by a body of persons, then—

(a) if that body is a body corporate, every person who at the time of the commission of such offence was the Director, General Manager, Secretary or other similar executive officer of that body;

(b) if that body is not a body corporate, every person who at the time of the commission of the offence was the Chairman, General Manager, Secretary or other similar executive officer of that body;

shall be deemed to be guilty of that offence, unless he proves that the offence was committed without his knowledge or that he exercised all due diligence to prevent the commission of that offence.

Regulations.

18. (1) The Minister may make regulations in respect of all matters required by this Act to be prescribed or in respect of which regulations are authorised to be made.

(2) Without prejudice to the powers conferred by subsection (1), the Minister may on the advice of the Council make regulations in respect of all or any of the following matters:—

(a) the guidelines to be complied with by Provincial Directors of Health Services in the registration or renewal of registration of Private Medical Institutions;

(b) the rates, charges and any other expenses, which shall be recovered or received for any services rendered or performed in terms of the Act;

(c) the layout, construction, illumination, additionsand improvements and the maintenance of cleanliness of all the buildings and premises of registered Private Medical Institutions;

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(d) the circumstances in which cases of infectious diseases may be admitted for treatment and the precautions to be taken in such event;

(e) the adoption of universally recognized precautions for the prevention and control of infections;

(f) the classification of Private Medical Institutions into categories, depending upon services being rendered or functions discharged by such institutions;

(g) the procedure or practice to be followed in entertaining any complaint against any Private Medical Institution or person attached thereto from any interested or aggrieved person, and the final disposal thereof;

(h) charges for accommodation, drugs and services rendered by Private Medical Institutions ;

(i) the appointment of competent officers to prosecute actions instituted under this Act.

(3) Every regulation made by the Minister shall be published in the Gazette and shall come into operation on the date of such publication, or on such later date as may be specified in the regulation.

(4) Every regulation made by the Minister shall as soon as convenient after its publication in the Gazette be brought before Parliament for approval. Any regulation, which it is not so approved, shall be deemed to be rescinded from the date of it's disapproval, but without prejudice to anything previously done thereunder.

(5) Notification of the date on which any regulation made by the Minister is so deemed to be rescinded shall be published in the Gazette.

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Rules.

19. (1) The Council may make rules in respect of all or any of the following matters :—

(a) the maintenance of records, books, registers, bills, receipts, returns, statements, forms and other documents by a Private Medical Institution;

(b) the reports, returns, statements and other information required to be furnished periodically by a Private Medical Institution to the Ministry of the Minister;

(c) the minimum size of wards or rooms and the minimum floor space, which should be allotted for each patient;

(d) the provisions of adequate latrine and bathing facilities for in-patients and personnel employed in Private Medical Institutions;

(e) the machinery, equipment, devices, utensils, apparatus, crockery, fittings, furniture and other requisites of a general or special nature ;

(f) the immunization of personnel employed in Private Medical Institutions against specified diseases;

(g) the prohibition or restriction of admission of midwifery cases, except to a maternity home or to such other Private Medical Institution having separate and exclusive facilities for the reception and treatment of such cases;

(h) the prohibition or restriction of the admission of cases other than midwifery cases to a maternity home or to such other Private Medical Institution having separate and exclusive facilities for the reception and treatment of maternity cases;

(i) defining staffing patterns including minimum qualification, induction and in-service training and refresher courses that should be followed by such personnel;

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(j) the definition of the specialized departments and ancillary services that should be maintained in terms of special fields of treatment;

(k) the disposal of refuse and waste matter;

(l) the provision of sinks, taps and outlets in wards, kitchens, bathrooms and latrines in proportion to the ratio of patients and personnel employed therein;

(m) the provision of housing, residential quarters or transport facilities required for maintaining the health of patients; and

(n) the provision of adequate expertise for the maintenance of all institutional assets, machinery and equipment.

(2) No rule made by the Council shall have effect unless it has been approved by the Minister and published in the Gazette.

Interpretation.

20. In this Act, unless the context otherwise requires —

"accreditation" means a process that is adopted for the purpose of certification of the technical competence and quality of service and facilities of a Private Medical Institutions; and

"Private Medical Institution" means any Institution orestablishment used or intended to be used for the reception of, and the providing of medical and nursing care and treatment for persons suffering from any sickness, injury or infirmity, a Hospital, Nursing Home, Maternity Home, Medical Laboratory, Blood Bank, Dental Surgery, Dispensary and Surgery, Consultation Room, and any establishment providing health screening or health promotion service, but does not include a house of observation, Mental hospital, Hospital, Nursing Home, dispensary, Medical Centre

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or any other premises maintained or controlled by the State, any private dispensary or Pharmacy or drug stores exclusively used or intended to be used for dispensing and selling any drug, medical preparation or pharmaceutical product, or any Institution or premises registered for any purpose under the provisions of Ayurveda Act, No. 31 of 1961 and the Homeopathy Act, No. 7 of 1970.

Repeals.

21. (1) The Nursing Homes (Regulation) Act (Chapter 220) is herby repealed.

(2) Notwithstanding the repeal of the Nursing Homes (Regulation) Act, the registration of any Private Medical Institution registered thereunder shall be deemed to be valid and effectual and shall continue to be so valid and effectual for a period of three months from the appointed date, within which period such medical institution is required to apply for registration in terms of the provisions of this Act.

(3) Where any Private Medical Institution referred to in subsection (2), fails to obtain a registration under this Act as required by that subsection within the period specified therein, the registration obtained under the repealed Act shall cease to be valid and effectual from and after the expiry of such specified period.

Sinhala text to prevail in case of inconsistency.

22. In the event of any inconsistency between the Sinhala and Tamil texts of this Act, the Sinhala text shall prevail.

Annual subscription of English Bills and Acts of the Parliament Rs. 885 (Local), Rs. 1,180 (Foreign), payable to the SUPERINTENDENT, GOVERNMENT PUBLICATIONS BUREAU, NO. 32, TRANSWORKS HOUSE, LOTUS ROAD, COLOMBO 01 before 15th December each year in respect of the year following