OCTOBER 2015
Health Economic Series No. 02

Transforming Health Care Delivery in Sri Lanka - Public Private Partnership

G. D. DAYARATNE

INSTITUTE OF POLICY STUDIES OF SRI LANKA

ISBN 978-955-8708-91-0

Cataloguing-In-Publication Data Approved by
National Library and Documentation Services Board

Dayaratne, G. D.

Transforming Health Care Delivery In Sri Lanka - Public Private Partnership (PPP) / G. D. Dayaratne. - Colombo : Institute of Policy Studies of Sri Lanka, 2015. - (Health economic series ; No. 02)

34 p. ; 21cm.

ISBN 978-955-8708-91-0

i. 362.1095493 DDC 23 ii.Title

iii. Series

1. Public health - Sri Lanka

2. Medical care - Sri Lanka

G. D. Dayaratne is Manager of the Health Economic Policy Unit, and his research interests are in the areas of Health financing, health economics and public policy.

He received his BA in Economics from the University of Peradeniya, a Postgraduate Diploma in Statistics from the Statistical Institute for Asia and the Pacific in Tokyo, and a Postgraduate Diploma in Population Studies from the University of Colombo.

G.D. Dayaratne is also a Hubert H Humphrey Fellow.
(dayaratne@ips.lk)

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
Email: ips@ips.lk
Website: www.ips.lk
Blog 'Talking Economics': www.ips.lk/talkingeconomics
Twitter: @TalkEconomicsSL
Facebook: www.facebook.com/instituteofpolicystudies

INSTITUTE OF POLICY STUDIES OF SRI LANKA

Health Economic Series

Transforming Health Care Delivery In Sri Lanka Public Private Partnership (PPP)

G. D. DAYARATNE

Table of Contents

List of Tables

List of Figures

Abbreviations

CABG	Coronary Artery Bypass Graft
BME	Bio Medical Equipment
GDP	Gross Domestic Product
IPS	Institute of Policy Studies of Sri Lanka
MOH	Ministry of Healthcare and Nutrition
MOs	Medical Officers
NCD	Non Communicable Diseases
NGOs	Non Governmental Organizations
OOP	Out-of-Pocket Payments
OPD	Out Patients Department
PPP	Public-Private Partnership
THE	Total Health Expenditure
WHO	World Health Organizatio

Foreword

The increasing needs of health care delivery of a larger section of the population have triggered health sector reforms in the state sector. This has resulted in a substantial increase in public investment in general health services which have in turn created a burden to the state to generate more revenue. In order to bridge the gap between the insufficiency of services and unmet revenue, the policy that is being advocated the world over is a public-private mix of services.

The key questions surrounding health care systems around the world are: (a) how to raise revenues to pay for health care; (b) how to pool risks and resources; and (c) how to organize and deliver health care in the most efficient and cost-effective manner. Whether the strategies adopted rely on public sources like taxes and social insurance, or private sources like private insurance and out-of-pocket payment are other relevant factors that need consideration.

Public-private partnership in health services provision entails government encouragement of private sector participation in the delivery of public services. Prudent health care policies that encourage public-private participation in health care financing and provisioning have conferred in many countries the advantage of flexible response as they face potentially conflicting challenges in providing access to affordable health care.

The United States relies heavily on the private sector to finance health care. A study[1] found marked gains in the number of people with insurance—as other research has repeatedly confirmed—as well as improved access to doctors and medications, affordable health care, and good health status after implementation of the Affordable Care Act. Although the British enjoy free health care under the National Health Service, 10 per cent of the population have purchased private health insurance, with one-fifth of all elective surgery being performed in the private sector.

Malaysia's two tier health system, of a heavily subsidized public sector and a user charged private sector, has produced a progressive health financing system. The case of Malaysia exemplifies that policy makers can gain an in-depth understanding of the equity impact, in order to help shape health financing strategies for the nation.

In the Sri Lanka context, the public health service is burdened with maintaining over 1000 health facilities and a health workforce of around 60,000 to meet the demand for health care for over 50 million OPD visits and 5.8 million in-patient admission to government hospital facilities. [2]

Further, as a result of demographic transition, the pressures to increase government health spending that are primarily the result of rising spending in the free health care coverage, are likely to persist further. This is due to several factors such as rising incidence of chronic diseases, population ageing, and continuing pressure from over 60,000 of health workforce for greater compensation, and demands for expanded benefits under the respective schemes. Ever increasing Household Out-of-Pocket (OOP) spending amounting to 47 per cent of Total Health Expenditure[3] indicates that health care delivery is not entirely free, mainly due to increasing demand for health care delivery which cannot be met by under-funded public facilities alone.

[1] The Journal of the American Medical Association (JAMA), July 28,2015, Vol 314, No.4.
[2] MOH Annual Health Bulletin 2012.
[3] IPS National Health Account 2010-2011.

There is no question of the achievement of the public stewardship toward the community health services which is unique. However, that Sri Lanka confronts a potential health crisis of overwhelming proportions is widely understood. Increasingly, so-called lifestyle ailments of non-communicable diseases such as cancer, diabetes, heart disease and chronic kidney diseases in the North Central Province are afflicting the Sri Lankan population and compounding the country's health crisis, reflecting the poor state of its health system in the public sector. Further, with the increasing tourism potential after the conclusion of the war in the year 2009, the spread of HIV-Aids cannot be ruled out in addition to persisting parasitic diseases such as Dengue which are all well documented.

Public expenditure on health in this country remains less than 2 per cent of the GDP (increased to 3 per cent in the Interim Budget of 2015), though private expenditure has also been increasing. While allocation of more resources coupled with institutional improvements can go a long way in improving health care services, it needs to be recognized that the future trajectory of public health issues in Sri Lanka need to deviate from the known path.

In this context, the statement of His Excellency the President on Private-Public partnership at the Sri Lanka Economic Summit in early August 2015 is timely. "The Public and Private sectors - including small and medium entrepreneurs should form an interwoven bond based on trust and transparency."[4] This should be the way forward for the health sector also.

Saman Kelegama
Executive Director,
Institute of Policy Studies of Sri Lanka
August 2015

[4] H.E. The President at the Sri Lanka Economic Summit, 6th August, Colombo.

Acknowledgement

At the outset, the author wishes to express sincere thanks to Saman Kelegama, Executive Director IPS for overall guidance and support provided during various stages of preparing this paper.

The author wishes to acknowledge the valuable comments made by Dr. Paltha Abeykoon, Chairman NATA and by other experts for their substantive inputs.

Author also thanks D. D. M. Waidyasekara (Editor, IPS and Former Commisioner,Department of Inland Revenue and Secretay , Presidential Commission on Taxation 1990) for editorial support and Nayomi Jayakody for assistance in formatting the paper for publication.

Executive Summary

Historically, the pendulum in the health care debate world over has swung back and forth between the state and the private sector.

Sri Lanka remains a moderate performer in health status and is on par with its South Asian counterparts. Successive governments' welfare orientated policies coupled with continued state obligation to address health needs of the population have exerted pressure on state health care providers to increase the public expenditure ratio to Gross Domestic Product (GDP). The continuous decline in growth of investment in the health sector has impacted on the efficiency and effectiveness of the public health system. With a dual health system in operation, its equity and effectiveness has become a challenging task in the context of protection for the poor in respect of access to basic medical services.

The primary public provider is the Ministry of Healthcare and Nutrition (MOH) which serves primary, secondary and tertiary care. MOH approach directly benefits the entire population by means of direct health subsidies. It is assumed that the poor have a worse health status compared with the rich and therefore have more health care needs. In this context, the size of the private household Out-of-Pocket Expenditure (OOP) provides a picture of the process in which increasing demand for health care delivery cannot be met by underfunded public facilities alone. It underscores the existing inequity of income distribution of the households, which has widened the gap in access to health service delivery while the affluent section of the community had the privilege to utilize private health care facilities through voluntary private health insurance schemes.

As per income distribution statistics, approximately 80 per cent of employed persons earn less than the average monthly per capita income of US$ 283.Official data depicts that the lowest 40 per cent of the income earners secure 13 per cent of the income whereas the share of the income of the richest 20 per cent is over 54 per cent. This disparity is reflected in every sphere of socio-economic activities in the country. Further, the data shows that only about a quarter of the population is covered by social protection schemes such as EPF (Employees' Provident Fund) and government pensions. Social protection schemes introduced in the recent past targeting the self-employed, farmers and fishermen are functioning ineffectively due to underfunding by the state. In addition, Sri Lanka is facing the challenge of an ageing population with life expectancy rates increasing, while the birth rates are slowing.

The provision of basic health care to citizens by the state free of charge has ensured almost universal access to at least basic health facilities in all parts of Sri Lanka. Yet, inadequate public investments in the health sector in a context of increasing cost of manpower, equipment and drugs have resulted in a decline in the quality of health care, such as overcrowding of hospitals coupled with inadequate services and shortage in life saving drugs. The situation changed often for the worse when more private health care providers emerged following the introduction of liberal economic reforms in 1977 and the conclusion of the 30 year of separatist war with Tamil rebels in 2009. The rise of the private health sector relegated the poor to public health services which is becoming deficient in strength to deliver as before. These issues have become highly contentious and the answers are not clear-cut. While consulting a doctor is a very personal matter, the thought of denying a fellow human being access to the same level of health care because of his or her inability to pay, or due to weaknesses in the system, stirs deep emotions.

This situation creates a window of opportunity to policy makers and Ministry of Health to revisit the existing health policy to accommodate a selective Public Private Partnership (PPP) to clear the gaps in health care delivery to the people. Given the opportunity, private sector organizations too could spread out their facilities to enable access of to a wider section of the patient population at a reasonable and affordable cost.

The term "public-private partnership" in health care delivery refers to the situation where the government mobilises private sector sources to deliver health care services by arrangement. Correspondingly, public-private partnership in health services provision entails government encouragement of private sector participation in the delivery of public services when there are shortfalls in public facilities.

විධායක සාරාංශය

ඓතිහාසිකව සෞඛ්‍ය රැකවරණය පිළිබඳ විවාදය රාජ්‍ය සහ පෞද්ගලික අංශ අතර දෝලනය වෙමින් පවතී.

ශ්‍රී ලංකාව සෞඛ්‍ය තත්වය අතින් මධ්‍යම මට්ටමේ පවතින අතර අනෙකුත් දකුණු ආසියානු රටවල් සමග සම මට්ටමේ සිටී. ජනතාවගේ සෞඛ්‍ය අවශ්‍යතා සපුරාලීම රාජ්‍ය යුතුකමක් සේ සැලකෙන සුභ සාධනය කෙරේ නැඹුරු වූ ප්‍රතිපත්ති පැවති සෑම රජයකටම දළ දේශීය නිෂ්පාදිතයේ අනුපාතයක් ලෙස රාජ්‍ය වියදම් වැඩි කිරීමට රාජ්‍ය සෞඛ්‍ය රැකවරණ සලසන්නන් කෙරේ බලපෑමක් ඇති කරවීය. සෞඛ්‍ය අංශයේ ආයෝජන වර්ධනය දිගටම පහත වැටීම රාජ්‍ය සෞඛ්‍ය පද්ධතියේ කාර්යක්ෂමතාවය සහ බලපෑම කෙරේ බලපෑවේය. ද්විත්ව සෞඛ්‍ය පද්ධතියක් ක්‍රියාත්මක වීමත් සමග එහි සමානාත්මතාවය සහ බලපෑම මූලික සෞඛ්‍ය සේවාවන් ලබා ගැනීම සම්බන්ධයෙන් දුප්පතුන්ට ඇති ආරක්ෂාව අනියෝගාත්මක කාර්යක් බවට පත් කෙරිණ.

මූලික රාජ්‍ය සම්පාදකයා වන්නේ ප්‍රාථමික, ද්විතීයික සහ තෘතීයික රැකවරණය සලසන, සෞඛ්‍ය සහ පෝෂණ අමාත්‍යාංශය ය. (MOH) අමාත්‍යාංශයේ වැඩ පිළිවෙළ ඇති සෘජු සෞඛ්‍ය සහනාධාර මාර්ගයෙන් මුළු මහත් ජනතාවටම ප්‍රතිලාභ අත්වේ. ධනවතුන් හා සසඳන විට දුප්පතුන්ගේ සෞඛ්‍ය තත්වය වඩාත් නරක බවට පිළිගැනීමක් පවතින නිසා ඔවුන්ගේ සෞඛ්‍ය රැකවරණ අවශ්‍යතා වැඩිය. මෙවැනි සන්දර්භයක දී ගෘහස්ථයක් විසින් කරන වියදමේ (Out of Pocket Expenditure OOP) ප්‍රමාණය අරමුදල් අඩුවෙන් ඇති රාජ්‍ය පහසුකම්වලට පමණක් සෞඛ්‍ය රැකවරණය සැලසීමේ අපහසුතාවය වැඩි වෙමින් පවතින ඉල්ලුමේ ක්‍රියාමාර්ගය පිලිබඳ චිත්‍රය පැහැදිලි කරයි. ඉන් පෞද්ගලික ස්වේච්ඡා රක්ෂණ යෝජනාක්‍රම තුළින් පෞද්ගලික සෞඛ්‍ය රැකවරණ පහසුකම් ලබා ගැනීමේ වරප්‍රසාදය ප්‍රජාවේ ධනවත් කොටස්වලට ඇති අතර ගෘහස්ථ ආදායම් බෙදී යෑමේ පවතින විෂමතාවය සෞඛ්‍ය සේවා ලබා ගැනීමේ පරතරය පුළුල් කළ බව ඉස්මතු කරයි.

ආදායම් බෙදීයෑමේ සංඛ්‍යාන අනුව සේවයේ නියුතු පුද්ගලයන්ගෙන් ආසන්න වශයෙන් සියයට 80 ක සාමාන්‍ය මාසික ඒක පුද්ගල ආදායම ඇ. ඩො. 283 ට වඩා අඩුය. නිල දත්ත අනුව අඩුම ආදායම් උපයන සියයට 40 ලැබෙන්නේ ආදායමෙන් සියයට 13 කි ඒ අතර ධනවත්ම සියයට 20 ට හිමි වන ආදායම් ප්‍රමාණය සියයට 54 කට වඩා වැඩිය. මෙම අසමානතාවය රටේ සමාජ ආර්ථික ක්‍රියාකාරකම් සෑම ක්ෂේත්‍රයකම කැපී පෙනෙන ලක්ෂණයකි. වැඩි දුරටත් එම දත්ත අනුව සේවක අර්ථ සාධක අරමුදල (EPF) සහ රජයේ විශ්‍රාම වැටුප් වැනි සමාජ ආරක්ෂණ යෝජනා ක්‍රම වලින් ආවරණය වන්නේ ජන සංඛ්‍යාවෙන් හතරෙන් එකකටත් වඩා ප්‍රමාණයකි. ස්වයං සේවා නියුක්තිකයන්, ගොවීන් සහ ධීවරයන් ඉලක්ක කර ගත් මෑතකදී හඳුන්වා දුන් සමාජ ආරක්ෂණ යෝජනා ක්‍රම රජයෙන් ප්‍රමාණවත් අරමුදල් ලබා නොදීමෙන් ක්‍රියාත්මක න්නේ ආකාර්යක්ෂමවයි. ඊට අමතරව ශ්‍රී ලංකාව උපත් අනුපාතය පහත වැටෙන අතර ආයු කාලය වැඩි වීමෙන් වයස්ගත වන ජන සංඛ්‍යා අභියෝගයටකටද මුහුණ දෙමින් සිටී.

රජයෙන් සියලුම පුරවැසියන්ට නොමිලයේ මූලික සෞඛ්‍ය රැකවරණය ලබා දීමෙන් ශ්‍රී ලංකාවේ සෑම ප්‍රදේශයකම ජනතාවට අඩුම වශයෙන් මූලික සෞඛ්‍ය පහසුකම් ලබා ගැනීමට අවස්ථාවක් හිමි වේ. එහෙත් මිනිස් ශ්‍රමය, උපකරණ සහ ඖෂධ පිරිවැය ඉහළ යන සන්දර්භයක් තුළ සෞඛ්‍ය අංශයේ රාජ්‍ය ආයෝජන ප්‍රමාණවත් නොවීමේ ප්‍රතිඵලයක් ලෙස අත්‍යාවශ්‍ය ඖෂධ නිඟකම සහ සේවා ප්‍රමාණවත් නොවීමෙන් රෝහල් පිරියෑම වැනි තත්වයන් නිසා සෞඛ්‍ය රැකවරණයේ ගුණාත්මක භාවය පහත වැටී ඇත. 1977 දී ලිබරල් ආර්ථික ප්‍රතිසංස්කරණ හඳුන්වා දීමෙන් පසුව සහ 2009 දී දෙමළ කැරලිකරුවන් සමග වසර 30 ක් පැවති යුද්ධය අවසන්වීමෙන් පසුව පෞද්ගලික සෞඛ්‍ය රැකවරණ සපයන්නන් වැඩි වීමත් සමග තත්වය වඩාත් නරක් විය. පෞද්ගලික සෞඛ්‍ය අංශයේ වර්ධනයත් සමග දුප්පතුන් කලින් මෙන් සේවා ලබා දීමේ ශක්තිය පිරිහෙමින් පවතින රාජ්‍ය සෞඛ්‍ය සේවා අංශයට වඩාත් තල්ලු කරනු ලැබිණ. මෙම ගැටලු වඩාත් විවාදකාරී වුවත් පැහැදිලි පිළිතුරු නොවීය. වෛද්‍යවරයෙකු හමුවී උපදෙස් ලබා ගැනීම බෙහෙවින් පෞද්ගලික කාර්යයක් වුවද ඔහුට හෝ ඇයට මුදල් ගෙවීමට නොහැකි වූ නිසාම හෝ පද්ධතියේ දුර්වලකම නිසා ඒ මට්ටමේම සෞඛ්‍ය රැකවරණය ලබා නොහැකිවීම සිත් සසල කරවන්නකි.

මෙම තත්වය ප්‍රතිපත්ති සම්පාදකයන්ට සහ සෞඛ්‍ය අමාත්‍යාංශයට ජනතාවට සෞඛ්‍ය රැකවරණය ලබා දීමේ දී පවතින හිඩැස් පියවීම සඳහා තෝරා ගත් ක්ෂේත්‍රවල රාජ්‍ය හා පෞද්ගලික හවුල්කාරිත්වයට ඉඩ සැලසීම සඳහා සෞඛ්‍ය ප්‍රතිපත්තිය නැවත විමසා බැලීමට අවස්ථාවක් උදා කරවයි. එවැනි අවස්ථාවක් ලබා දීමෙන් පෞද්ගලික අංශයේ සංවිධානවලටද සාධාරණ සහ පහසු මිලකට රෝගී ජනතාවගෙන් පුළුල් කොටසකට ඔවුන්ගේ පහසුකම් ලබා දීමට ව්‍යාප්ත විය හැකිය.

සෞඛ්‍ය රැකවරණය සැලසීමේ දී ''රාජ්‍ය පෞද්ගලික හවුල්කාරිත්වය'' යන්නේ අදහස් වන්නේ ඇති කර ගත් එකඟතා අනුව, රජය සෞඛ්‍ය රැකවරණය ලබා දීමට පෞද්ගලික අංශයේ සම්පත් මෙහෙයවන තත්වයකි. එසේම සෞඛ්‍ය සේවා සැපයීමේ රාජ්‍ය පෞද්ගලික හවුල්කාරිත්වයෙන් රාජ්‍ය පහසුකම්වල අඩුවක් පවතින ක්ෂේත්‍රවල රාජ්‍ය සෞඛ්‍ය සේවා සැපයීමේ දී පෞද්ගලික අංශයේ සහභාගිත්වය දිරි ගැන්වීම යි.

நிறைவேற்றுச் சுருக்கம்

வரலாற்று ரீதியாக, அரசாங்கம் மற்றும் தனியார் துறைகளுக்கிடையில் சுகாதாரப் பராமரிப்பு பற்றிய விடயம் தொடர்பான விவாதம் உலகம் பூராகவும் நிதமும் நடைபெற்றுவரும் ஒருவிடயமாக காணப்படுகின்றது.

இலங்கை சுகாதார நிலைமைகளில் சற்று முன்னேற்றமடைந்த நாடாக தன்னை தக்கவைத்துக் கொண்டிருப்பதுடன் தென் ஆசிய நாடுகளில் அதன் தோழமை நாடுகளுடன் சமமான சுகாதார பராமரிப்புத் தரத்தினை கொண்டுள்ளது. சனத்தொகையின் சுகாதாரத் தேவைகளை நிறைவு செய்யும் நோக்கில் நாட்டின் கடமைகளை முன்னெடுக்கும் செயற்பாட்டில் தொடர்ந்து வந்த அரசாங்கங்கள் நலன்புரி நோக்கம் கொண்ட கொள்கைகளினை இரட்டிப்பாக்கி செயற்படுத்தி வருகின்றதுடன் இந்த சனத்தொகையானது அரச சுகாதார சேவைகளை வழங்குகின்றவர்கள் தங்களுடைய சுகாதாரச் சேவைகளை அதிகரிக்கும் பொருட்டு மொத்த உள்நாட்டு உற்பத்தியில் அரச செலவீனங்களின் சதவீதத்தை அதகரிக்கும் வகையில் அரச சுகாதார சேவைகளை வழங்குகின்றவர்களுக்கு அழுத்தம் கொடுத்து வருகின்றது. சுகாதாரத் துறைசார்ந்த துறைகளில் முதலீடுகளின் தொடர்ச்சியான வீழ்ச்சியானது பொது சுகாதார முறைமையில் வினைத்திறனிலும் செயற்திறனிலும் தடையொன்றினை ஏற்படுத்தியுள்ளது. இரட்டை சுகாதாரச் செயற்பாட்டு முறைமையின் கீழ், அடிப்படை சுகாதாரச் சேவைகளை அடைந்து கொண்டு வறிவர்களை பாதுகாத்துக் கொள்ளும் செயற்பாட்டில் சுகாதார சேவைகளின் வினைத்திறன் மற்றும் செயற்திறன் தொடர்பாக சவால்மிகு இலக்குகளாக சுகாதாரத்துறை உருவெடுத்துள்ளது.

ஆரம்ப நிலை சுகாதார சேவை வழங்குனராக சுகாதார மற்றும் போசாக்குப் பராமரிப்பு அமைச்சு காணப்படுவதுடன் இது ஆரம்ப நிலை, இடை நிலை மற்றும் மூன்றாம் நிலை சுகாதாரப் பராமரிப்பு சேவைகளை வழங்கிவருகின்றன. நேரடி சுகாதார உதவிகள் என்ற வகையில் முழுமையான மக்கள் சமுகம், சுகாதாரம் மற்றும் பராமரிப்பு அமைச்சின் நேரடி நன்மைகளினை அனுபவிக்கின்றன. செல்வந்தர்களுடன் ஒப்பீடு செய்யும் போது வறியவர்கள் மிகக் குறைவானதும் மோசமானதுமான சுகாதாரப் பராமரிப்பைப் பெற்றுக் கொள்வதாக ஊகிக்கப்படுவதுடன் அவர்கள் தொடர்பாக சிரத்தையான சுகாதாரப் பராமரிப்பு தேவையானது. இந்த பின்னணியில், வீட்டுத்துறையினரின் நாளாந்த செலவீன அளவானது அவர்களின் சுகாதாரம் தொடர்பான செலவீனங்கள் தொடர்பான உண்மை நிலைமையினை வெளிப்படுத்துவதுடன் அதிகரித்து வரும் சுகாதாரப் பராமரிப்பு சேவைகளினை அடைந்து கொள்வதானது குறைவான அரச வசதிகளின் கீழ் மாத்திரம் அவர்களுடைய மருத்துவத் தேவைகளை அடைந்து கொள்வது மிகக் கடினமாகும். வீட்டுத் துறையினரின் நியாயமற்ற வருமானப் பங்கீட்டின் தற்பொழுதைய நிலைமையானது இந் நிலைமையினை மேலும் தெளிவுபடுத்துவதுடன் இந் நிலைமையானது வறியவர்களுக்கு வழங்கப்படுகின்ற சுகாதாரச் சேவைகளை பெற்றுக் கொள்வதில் அல்லது அடைந்து கொள்வதற்கு வாய்ப்புக்கான இடைவெளியினை அதிகரிக்கின்றது. அதே வேளை சமூகத்தில் செல்வந்தர்கள் சுயமான சுகாதாரக் காப்புறுதி திட்டங்களின் ஊடாக தனியார் சுகாதார பராமரிப்பு வசதிகளை பயன்படுத்திக் கொள்வதற்கான வரப்பிரசாதங்களை பெற்றுக் கொள்கின்றனர்.

வருமானப் பங்கீட்டு புள்ளிவபரங்களுக்கு ஏற்ப, ஏறக்குறைய 80 சதவீதமான ஊழியர்கள் சராசரி தனியாள் வருமானமான ஐ.அ.டொ.283 தொகையிலும் குறைந்த வருமானத்தினையே உழைக்கின்றனர். குறைந்த வருமானத்தை உழைக்கின்ற 40 சதவீதமானவர்கள் நாட்டின் வருமானத்தில் 13 சதவீதத்தினை அனுபவிப்பதுடன் அதே வேளை நாட்டின் சனத்தொகையில் 20 சதவீதத்தினை பிரதிநிதித்துவப்படுத்துகின்ற செல்வந்தர்கள் நாட்டின் வருமானத்தில் 54 சதவீதத்தினை அனுபவிக்கின்றனர் என உத்தியோக பூர்வமான தரவுகள் வெளிக்காட்டுகின்றன. இந்த சமநிலையற்ற தன்மையானது, நாட்டின் சமூக - பொருளாதார செயற்பாடுகளின் ஒவ்வொரு இலக்கிலும் வருமான சமமின்மையினை வெளிப்படுத்துகின்றது. மேலும், நாட்டின் சனத்தொகையில் நான்கில் ஒரு பகுதியினரே சமூக பாதுகாப்பு திட்டத்தினை பெற்றுள்ளனர், அதாவது, (ஊழியர் சேமலாப நிதி) மற்றும் அரச ஓய்வூதிய நன்மையினை அனுபவிக்கின்றனர். அரசாங்கத்தின் குறைவான நிதியளிப்பின் காரணமாக, சுய தொழிலாளர்கள், விவசாயிகள் மற்றும் மீன்பிடித் தொழிலாளர்களை இலக்கு வைத்து அண்மைக் காலத்தில் அறிமுகம் செய்யப்பட்ட சமூக பாதுகாப்பு திட்டமானது வினைத்திறனின்றி செயற்பட்டு வருகின்றது. மேலும், ஆயுள் எதிர்பார்க்கை வயது அதிகரிப்பு மற்றும் பிறப்பு வீத வீழ்ச்சி ஆகிய காரணிகள் காரணமாக இலங்கை வயோதிபமடையும் சனத்தொகை அதிகரிக்கும் அச்சுறுத்தலுக்கு முகங்கொடுத்து வருகின்றது.

இலங்கையின் சகல பாகங்களிலும் வாழ்கின்ற மக்கள் அரசாங்கத்தினால் மக்களுக்கு இலவசமாக வழங்கப்படுகின்ற அடிப்படை சுகாதார வசதிகளில் ஆகக் குறைந்த அளவான சுகாதார வசதிகளை அடைந்து கொள்வதற்கான பூகோள பிரவேசம் முழுமையாக உறுதிப்படுத்தப்படுதல் வேண்டும். இருந்த போதும், மனித வளம், உபகரணங்கள் மற்றும் மருந்துகளுக்கான செலவீனம் அதிகரித்து வரும் நிலையில் சுகாதாரத் துறை சார்பாக அரச முதலீடுகள் போதியளவற்றதாக இருப்பதனால் சுகாதாரச் சேவைகளின் தரத்தில் வீழ்ச்சி ஏற்படுத்தப்பட்டுள்ளது. அதாவது, கட்டுக்கடங்காத நோயாளர்களின் எண்ணிக்கை இரட்டிப்படைதல் மற்றும் அவர்களுக்கான போதியளவற்ற சுகாதாரப் பராமரிப்பு மற்றும் உயிர் காப்பு மருந்துகளின் பற்றாக்குறை போன்றன. தமிழ் போராளிகளின் 30 வருட நீண்ட கால யுத்தம் 2009 ஆம் ஆண்டில் முடிவுற்றமை மற்றும் 1977 ஆம் ஆண்டின் சுதந்திர பொருளாதார மறுசீரமைப்பு முறைமையின் அறிமுகத்தை பின்பற்றல் போன்ற காரணத்தினால் அதிகமான தனியார் துறை சுகாதாரப் பராமரிப்புச் சேவைகளை வழங்குபவர்கள் முன்வரும் போது இந்த நிலைமை அடிக்கடி மாற்றமடைந்துள்ளன. முன்னர் போலல்லாது அரச சுகாதார பராமரிப்பு சேவையின் வினைத்திறனின்மை காரணமாகவும் தனியார் துறை சுகாதார பராமரிப்பு சேவையின் அதிகரிப்பும் வறியவர்கள் அரச சுகாதார சேவைகளை நாடுவதை குறைத்துள்ளன. இந்தப பிரச்சினை விவாத்துக்கு உட்பட்ட முக்கிய விடயமாக இருப்பதுடன் இதற்கான தீர்வுகள் தெளிவின்றியும் உள்ளன. வைத்தியர் ஒருவரின் ஆலோசனையினைப் பெற்றுக் கொள்வது தனிப்பட்ட ஒரு விடயமாக இருக்கும் அதே வேளை, ஒருவர் தன்னுடைய வறுமை, முறைமையில் காணப்படும் குறைபாடு, காரணமாக அதே தன்மையான மருத்துவ ஆலோசனையினை பெற்றுக் கொள்வதற்கு மறுக்கப்படுதல் பாரதூரமான மன உழைச்சலுக்கு குறிப்பிட்ட நபருக்கு உட்படுத்துகின்றது.

இந்த நிலைமையானது கொள்கை உருவாக்குனர்களுக்கான வாய்ப்பொன்றினை உருவாக்கிக் கொடுப்பதுடன் மக்களுக்கு சுகாதாரப் பராமரிப்பு சேவைகளை வழங்குவதில் காணப்படும் இடைவெளியினை குறைக்கும் பொருட்டு தெரிவு செய்யப்பட்ட அரச மற்றும் தனியார் துறை மருத்துவ சேவையினை பெற்று வழங்கும் வகையில் தற்பொழுதுள்ள பொருளாதார முறைமை பற்றி சிந்திப்பதற்கு சுகாதார மற்றும் பராமரிப்பு அமைச்சு கவனம் செலுத்த வேண்டியுள்ளது. நியாயமானதும் தாங்கிக் கொள்ளக் கூடிய விலையிலும் பாரிய அளவான பொது மக்கள் தொடர்பாக தனியார் துறை சுகாதார பராமரிப்பு வசதிகளை வழங்குகின்ற நிறுவனங்கள் தமது சேவையினை வழங்கும் வகையில் வாய்ப்பொன்றை வழங்கும் போது அவர்களும் பெருந் தொகையான நோயாளர்களுக்கு சேவை வழங்குவதற்கான வாய்ப்பொன்று கிடைக்கின்றது.

சுகாதார பராமரிப்புச் சேவை வழங்கலில் "அரச மற்றும் தனியார்துறை பங்காண்மை" என்ற சொற்றொடர் ஏற்பாடொன்றின் கீழ் சுகாதாரப் பராமரிப்புச் சேவைகளை வழங்கும் பொருட்டு தனியார் துறையினரை அரசாங்கம் ஈடுபடுத்தல் என்ற பொருள் படும். மேலும், பொது மக்களுக்கான சுகாதாரப் பராமரிப்பு சேவைகளை வழங்குவதில் அரசாங்கமானது தனித்து வழங்க முடியாத நிலைமை காணப்படும் போது அரச மற்றும் தனியார் துறை பங்காண்மையின் ஊடாக பொது மக்களுக்கு தனியார் துறையினர் சுகாதார பராமரிப்புச் சேவையினை வழங்குவதற்கான தேவையினை அரசாங்கம் ஊக்கப்படுத்த வேண்டிய தேவை காணப்படுகின்றது.

1. Introduction

The desired goals of health systems are the improvement of health status, financial protection, and responsiveness to the expectations of the population.[1]

By virtue of the definitions and the characteristics of the *public* and *private* sectors, it can be stated that public-private arrangements are fostered when government agencies interface with the *for-profit* private sector by arrangement to tap into resources when the need arises. Public Private Partnership has emerged as a new trend in public sector management to improve the efficiency and responsive to the users.

Public-Private Partnerships (PPP) are being increasingly encouraged world over as a part of the comprehensive development framework. The need to foster such arrangements is supported by a clear understanding of the public sector's inability to provide public goods entirely on their own, in an efficient, effective and equitable manner because of lack of resources and management issues. These considerations have necessitated the development of different interface arrangements, which involve the interfacing of organizations that have the mandate to offer public good on one hand, and those that could facilitate this goal on the other.

Most high income countries, and a growing number of middle income countries, have policy mechanisms to operate in both public and private sectors. They have private markets for health care, but they have avoided many of the potential negative outcomes because their governments engage in stewardship of the whole health system, including the part not under direct government control.

This paper focuses on PPP that are intended to address broad questions of providing sustainable health outcomes to the population rather than on the day-to-day interaction that occurs when the government buys a health service from a private supplier or where it leaves the entire matter of health service supply to the private sector.

The *public* sector in this paper refers to national, provincial and all other government and inter-governmental agencies with the mandate of delivering 'public goods'. The word *private* denotes two sets of structures; the *for-profit* private sector encompassing commercial enterprises of any size, and the *non-profit* private sector referring to Non-Governmental Organizations (NGOs). The word *partnership* in this paper refers to long-term, task oriented, and formal relationships. Further, it also needs to be differentiated from *privatization*, which involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe. A distinction also needs to be made between partnerships and *contractual arrangements*, particularly with regard to the relationship between the public sector and private partners. Although such arrangements can be used for strategic purposes, they are inherently distinct from *partnerships*.

This report is about the role of the public and private sector in mixed health systems which are imperative for the health well-being of the population in Sri Lanka in time to come. Mixed health systems have centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services. In such mixed systems, the private sector encompasses a vast diversity of providers and other actors apart from those owned or operated by government entities, and thus includes everything from NGO health clinics to local pharmacy shops, to traditional healers, to high-end for-profit hospitals and to a plethora of other types between the extremes. Some observers refer to all this as "the non-state sector". One key theme emerging from this analysis is the importance of public stewardship of the non- state sector (that is, the private sector, broadly defined). Effective government stewardship is crucial for achieving broader health objectives, given the reality that many countries already have large, complex markets for health care, presenting major challenges and significant opportunities.

[1] WHO Report 2000. *Health Systems: Improving Performance.*

Those in the public sector who should be overseeing the entire health system—state and non-state—are not monitoring what is happening in the non-state sector and have imperfect understanding of the forces at work in the health system in its entirety. Nor is there adequate recognition of the fact that private Out-of-Pocket Payments (OOP) by households account for a large proportion of total health spending. Compounding these problems are severe limitations in the data available on the non-state sector. Basic information on what kinds of services the private sector provides, to whom, and with what results is not readily at hand for policy makers. Sri Lanka is an example in this respect.

Over the years, the demand for health care has increased in tandem with the key drivers of health care costs, such as the rapid ageing of the population, Chronic Kidney disease, advancing medical technology resulting in the increased range and number of possible interventions, and rising public expectations. In recent years, the trend in both the developed and developing worlds has been towards greater private sector involvement in health care provision and financing. Reasons for this include insufficient government resources which led to under-performance on the part of the public sector as state-run institutions which are somewhat bureaucratic. Also, there is a growing realisation that involving the private sector in health services provision could lead to improved systems efficiency.

When it comes to improved system efficiency, key questions surrounding health care systems around the world are: (a) how to raise revenues to pay for health care; (b) how to pool risks and resources; and (c) how to organise and deliver health care in the most efficient and cost-effective manner . In this context, the strategies adopted rely on public sources like taxes and social insurance, or private sources like private insurance and out-of-pocket payment.

This report pays particular attention to how governments can improve their stewardship of the non-state components of the health systems they oversee. The report is not about how the private sector can enhance delivery of a specific intervention or a single national priority health program. Nor is it about whether an ideal health system should be predominantly public or pre-dominately private. Instead, it recognizes the reality that many countries already have large private markets for health care (as demonstrated by their large numbers of private providers and by the high degree of out-of-pocket spending as a percentage of total health expenditure). It also recognizes that these large private health care markets are unlikely to go away in the short-term. So, it concentrates on the barriers to stewardship of public and the private sector and on the options for reform. The aim is not to advocate for a larger or smaller private sector in any setting but to argue that existing institutional arrangements can be improved to achieve health system goals through step-wise reform to enhance the public sector's stewardship of the private sector. In this context, the author wishes to emphasise that around 45 per cent of Sri Lanka's total health expenditures are private out-of-pocket transactions which provide impetus to access private health care delivery as an alternative when the need arises.

The aim of this paper is threefold. First, is an analysis of Sri Lanka's status quo in depth. Second, the existing issues and challenges in health care financing are examined and finally, the public and private partnership as an imperative followed by necessary steps forward are discussed.

While not seeking to detract the dominant role of national governments in delivering health care, this report aims to demonstrate that the health of the population could be catered to in a more equitable level. This could be achieved through a more formalized, integrated, regulated, and better capitalized private sector in an environment where revenue funded public health care is under stress to deliver the health needs of the people free of charge, and where in the world over, health has been transformed as a commodity to be purchased.

2. Sri Lanka's Status Quo

Sri Lanka has placed high priority on equity since its independence in 1948.Even during the periods of the closed economy, successive governments spent close to 10 per cent of its GDP on social welfare compared with 6 per cent in Thailand and 3 per cent in the Philippines (World Bank, 1981). Sri Lanka is one of the oldest democratic states in the developing and developed world. Health care and health continue to have high priority, as is evidenced by its relative protection in the annual budget negotiations, and the substantive role that health services have played in stabilizing the health of the population at critical moments such as the Malaria epidemic[2]. Health policy has remained an area decided by bipartisan consensus.

Sri Lanka is one of the very few countries in the world fortunate enough to have a comprehensive system of health care delivery, which covers all segments of society, irrespective of purchasing power. Sri Lanka's health system evolved gradually over a period of more than three decades since independence, to acquire the features that we see today.

The present system deserves praise for maintaining high standards of preventive and public health services, although the emphasis and the share of expenditure has declined. The percentage of expenditure on those services has decreased from 9 per cent in 1990 to 6 per cent in 2011[3]. Yet, 99 per cent of mothers receive regular antenatal care and 98 per cent of them deliver their babies in Government health facilities. Also, 97 per cent of children below 2 years are fully vaccinated. The secret behind these commendable achievements despite the fund cuts, is the argument that it is also attributed to the educational and social development that has taken place in parallel to the development of the health system.

Accordingly, Sri Lanka remains a moderate performer in health status and is on par with its South Asian counterparts. Successive governments' welfare orientated policies coupled with a continued state obligation to address the growing health needs of the population have exerted pressure on health care providers to increase the public expenditure ratio to Gross Domestic Product (GDP). Growing demand and stagnating investment has negatively impacted on the efficiency and effectiveness recorded in the early days of the public health system. With a dual health system in operation, in the background of market oriented policies, equity and effectiveness of health care delivery has become a challenging task in the context of protection of the poor in relation to access to basic medical services. As an example, increasing Household Out-of-Pocket (OOP) spending indicates that health care delivery is not entirely free mainly due to increasing demand for health care delivery which cannot be met by under-funded public facilities alone. Also, it indicates that inequity of income distribution of the population has widened the gap in access to health service delivery while the affluent community rely on voluntary private health insurance (which is around 1 per cent of total health expenditure) schemes to utilise private facilities.

To elaborate more on income equity, approximately 80 per cent of employed persons earn less than the average monthly per capita income of US$283[4]. This could be further illustrated by examining the income distribution among households. Mean incomes of the lowest 4 deciles of households are convergent with all ranging below Rs. 17,833 per month. Further, more than 30 per cent of households' monthly incomes are less than half the national average. At the other end of the income distribution scale, the highest decile of households' mean income range over Rs. 140,000 per month. While the lowest 4 deciles of households together account for just 13 per cent of total household income, the highest decile of households alone, accounts for a staggering 39.5 per cent of total household income.

Inequality places the poor in permanent poverty, and rising

[2] Saman Kelegama, 2013, Review of *Famine, Fevers and Fear: The State and Disease in British Colonial Sri Lanka* by Dr. S. A. Meegama, 2012.

[3] IPS Sri Lanka National Health Account 2011.

[4] Official Exchange rate Rs.127=1 USD at the time of writing.

inequality in income slows down the poverty reduction efforts by government. This is because when a smaller percentage of income goes into the hands of the poor, their status cannot be upgraded at the desired rate. As a result, poverty becomes a permanent feature. Rapid increases in public and household/individual debt is partly a reflection of the widening gap between money supply and the actual production of goods and services. Hence, the distribution of financial resources within the country is highly unequal and the demand for goods and services is also highly uneven within the country.

This situation has reflected in a vacuum in access to health care among other social services all over the country. Access in health care may be defined as a measure of potential and actual entry for a given population into the health system. It is the outcome of a process that is determined by the interplay between the characteristics of the health care system and the characteristics of the potential user. In this interplay between providers and populations at risk, there had been identified five dimensions of access: availability, accessibility, accommodation, affordability, and acceptability. From the Sri Lanka context, it is seen that all the above dimensions have been negatively affected.

Although Sri Lanka has seen significant improvements in health outcomes and succeeded in expanding the coverage of health protection schemes over the last decades, this paper highlights three key challenges:

(i) Inequalities in utilization and spending under different health financing schemes (Public and Private) and across geographic areas;

(ii) Mounting cost pressures; and

(iii) Fragmentation of financing and unresolved issues concerning the role of central governments.

In addition, the pressures to increase government health spending that are primarily the result of rising spending in the free health care coverage, are likely to persist further. This is due to several factors such as rising incidence of chronic diseases, population ageing, and continuing pressure from over 75,000 of health workforce for greater compensation, and demands for expanded benefits under the respective schemes. Other factors include increasing overhead cost of maintenance of over 600 hospital facilities, and ever increasing cost of medical supplies to meet the rising expectations of patients for better health care.

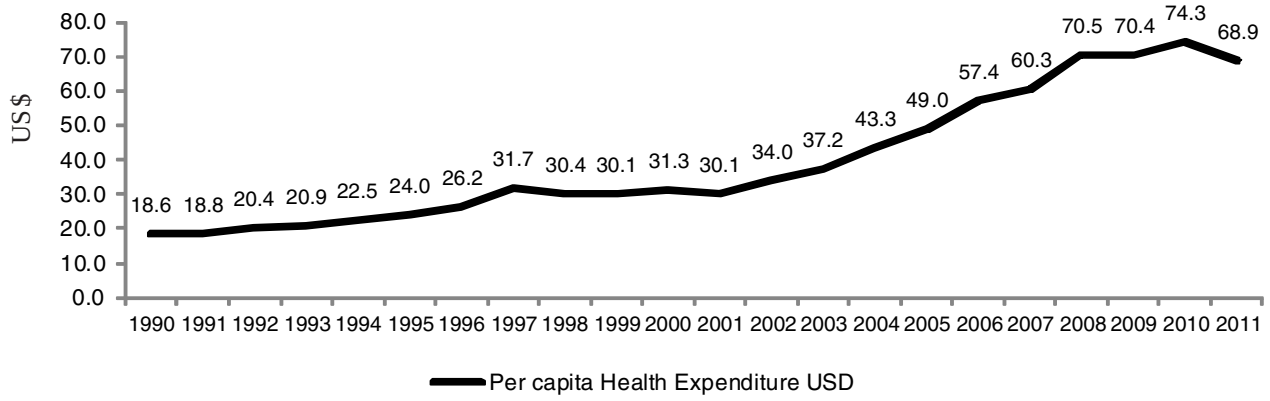
3. Cost Pressures and Their Consequences

Sri Lanka has achieved a great deal with relatively low levels of GDP spending on health. Share by government has remained the same amounting to around of 50 per cent of total health spending from the year 1990 onward from which health spending data are available. The negative side of this trend is that patients are spending more on health (OOP) jeopardizing family savings and assets to pay for health care, while there is also a significant inequity in access to the same. This situation implies a growing fiscal burden to the household. In a context of limited buoyancy of government revenues, the share of the government budget allocated to health has increased at a slow pace over the years, a trend that is unlikely to be sustainable over the longer term. There is also growing concern that cost-pressures not accommodated by increased government spending are having adverse consequences which are followed by hospital deficits, increased waiting times, and other forms of rationing, deferral of facility maintenance, and risks of deterioration in quality of health care delivery.

The public and private sectors are two major funding sources for Sri Lanka's health system. Figure 1 below provides the per capita health expenditure in US Dollar terms from 1990 to 2011 based on the IPS Sri Lanka National Health Account.

Private household out-of-Pocket Expenditure (OOP) plays a central role in this process. The primary public provider is the Ministry of Healthcare and Nutrition (MOH) which serves primary, secondary and tertiary care. The MOH approach directly benefits the entire population by means of direct health subsidies. It is assumed that the poor have a worse health status compared

Figure 1
Per Capita Health Expenditure USD



Source: National Health Account 1990-2011, IPS.

with the rich and therefore, have more health care needs. In this context, the flow of public health expenditure is similar to vertical equity where more resources have been targeted predominantly towards the low income segment. This distribution therefore covers the middle and the lower middle class income categories including the urban slums and the rural areas where the marginalised tend to cluster. In this context, insufficient financing is a major overarching constraint of the Ministry of Health (MOH) to effectively regulate the health care sector to meet the growing health needs of the population, especially of the low income segment.

On the other hand, private health care services are largely ambulatory. Full time private general practitioners provide out-patient care from private clinics on a fee-for-service basis in addition to private hospitals. According to IPS Sri Lanka National Health Accounts 2011 estimate, the private sector provides 6 per cent of overall in-patient admissions and approximately 50 per cent of total out-patient treatment which includes OPD treatment by general practitioners. In-patient care by private providers are limited and restricted to 200 hospitals with a bed strength of 5,000 against 76,000 bed strength in government hospitals. On the demand side, the Out-of-Pocket (OOP) expenditure of households clearly indicates the deficit in facilities by provider of free health care while aggravating the health burdens in the household budget due to forced pressure on increasing health spending. These include over-the-counter payments for medicines and fees for consultation and procedures.

4. Disparities in Health Spending

An effective system of financial provision is necessary in the country for sustainable development with environmental care and minimum regional/ provincial disparities to redress the health needs of the people which are imperative. Table 1 below depicts the regional disparities as a share of the GDP for the period 2005-2011.

In this context, the sharp difference between the level of prosperity of the Western Province and that of the others is a worrying concern. While the poverty headcount in the Western Province is a mere 4.2 per cent, it is more than 10 per cent in the Northern, Eastern, North Western, Uva and Sabaragamuwa Provinces.

Again, if the sole responsibility of addressing this is left to the government, then a widening budget deficit due to direct and indirect subsidies for poverty alleviation, rising inflation along with interest rates, and depreciating currency will persist further.

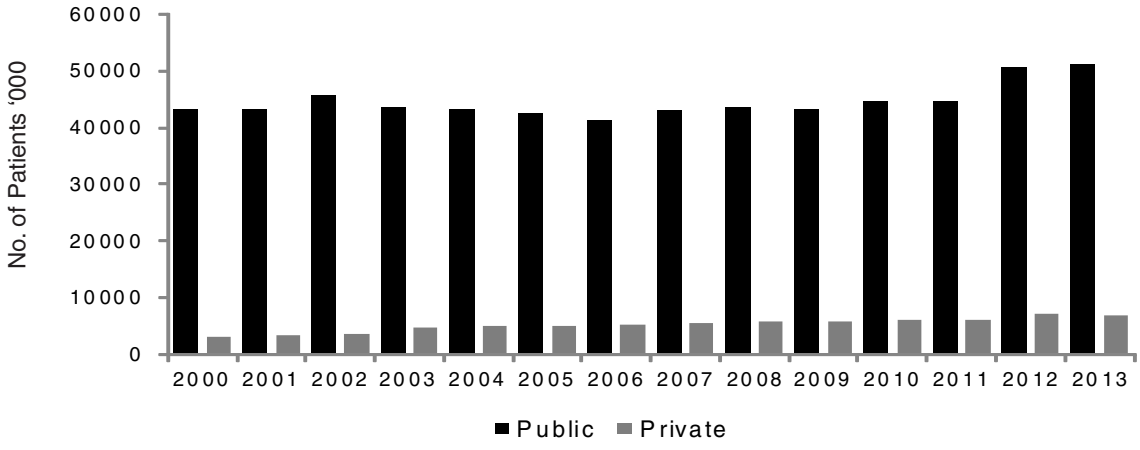
Table 1
GDP Share (%) by Province 2005-2011

Province	2005	2006	2007	2008	2009	2010	2011
Western	50.8	50.1	46.5	45.4	45.1	44.8	44.4
Central	8.5	8.8	9.6	9.8	9.6	10	9.8
Southern	8.9	10	10.5	10.5	10.2	10.7	11.1
North Western	8.9	9.1	9.6	9.9	10.3	9.5	10
North Central	4,3	4	4	4.7	4.8	4.8	4.6
Uva	4.5	4.3	4.9	4.5	4.6	4.5	4.5
Sabaragamuwa	6.4	6.1	6.4	6.4	6.3	6.3	6.2
Eastern	4.7	4.9	5.2	5.6	5.8	6	5.7
Northern	3	2.8	2.9	3.2	3.3	3.4	3.7

Source: Central Bank Report various years.

An annual budgetary allocation of more than 90 billion rupees is made to the Health Ministry in 2014 to run more than 600 public hospitals and medical clinics, pay the salaries of some 17,000 medical officers, 36,000 nurses and thousands of other para-medical and health administration officials. Government finances health improvements both directly, through investment in the health sector and indirectly, through spending on social determinants by reducing poverty. Since Sri Lanka has gained Middle Income status, external financing to health sector development by international donors dried up and the tax revenue ratio to the GDP became stagnated over the years. As a result, the cost pressures on the national budget, made non-fee levying public health sector a non-priority. It has been found that the annual allocation of funds is not sufficient to meet the demand for the health needs of the public as in-patient and out-patient numbers are growing rapidly with emerging of new diseases. Figure 2 below provides the trend of Out-Patient visits in public and private health facilities from 2000 to 2013. Accordingly, it has been recorded that in the year 2013, there were around 50 million OPD visits in public hospitals while private hospitals have recorded 6.7 million visits.

Figure 2
OPD Treatment by Public and Private Facilities 2000-2013



Source: Census of Private, Co-operative and Estate Hospitals 2013, IPS.

The present public finances in the country do not permit strengthening the social sectors like health and education unless there is a major reallocation of public resources across different sectors of public investment. Public expenditure on health in the country remains less than 2 per cent of the GDP, though private expenditure is continuously increasing more toward infrastructure development. Given such a low level of public expenditure, the achievements received in the past decades in terms of positive health indicators are noteworthy. But it was not the same in recent years. Yet, the day-to-day experience of ordinary citizens with respect to availability, accessibility, affordability and quality of health care is much to be desired.

The result is a widening gap between private and public institutions in terms of the availability and quality of health facilities. This has encouraged even non-affluent patients to rely on private providers, at least for out-patient treatment and routine medical tests. Eventually, rural families confronted with non-communicable diseases such as cardiovascular, diabetes, cancer, etc., which needs expensive treatment from hospitals far away from the area of dwelling, might be forced to avoid regular long distance travelling due to economic reasons. This would create a deficit in drug usage by continuing out-dated prescriptions to purchase medicine from the nearest unregulated pharmacies as state funded rural dispensaries have become dysfunctional due to shortage of drugs and manpower. Long-term residential care for elderly patients is out of reach for poor households. This situation is further aggravated by the non-availability of medical personnel for routine supervision in government hospitals in distant areas. Also, most of the physicians in government hospitals do not have confidence in the reliability of laboratory investigation reports of government hospital laboratories, and as such, tend to order a second investigation to be performed by a private sector laboratory adding more burdens to the purse of the poor.

On the other hand, in Sri Lanka private providers of health care play an important part in the health care delivery today. Though they make use of many medical specialists attached to public institutions, private health care institutions are run entirely as private enterprises. Patients usually have to pay fees upfront and often do not get such expenses reimbursed as they are not covered by health insurance. This situation restricts private residential care to a small minority of affluent patients or those who are covered by limited private health insurance available in the country. In this context, the absence of private but non-profit health care institutions in the country is a case in point despite the existence of Co-operative hospitals of around 10 in number.

As it is well known, Sri Lanka does not have a systematic referral system although it is in the blueprint stage in the state health sector (Health Master Plan). The referral system is not functioning well as the government doctors have been allowed to work in private facilities after completion of an allotted number of hours per day in the public facilities. In the private sector, it is not mandatory for a GP to refer a patient seeking out-patient treatment to a specialist, in public or private facilities. Instead, most patients go direct to specialists in private hospitals and thereby creating long waiting lines at private consultation rooms. Moreover, patients are not well distributed among GPs as the spatial distribution of GPs are not regulated. Many patients do not go to the same GP on a regular basis and, as a result, the management of case loads is not done in a systematic fashion. GPs provide a critical link between the community and the health care institution. If the patients first go to a GP, the number of patients turning up at specialist consultation rooms will be drastically reduced, allowing specialists to allocate more time for patients. Yet, such a system can work only if realistic fee structures are worked out and patients are covered by health insurance that reimburses most of their out-of-pocket expenses.

5. Health Expenditure

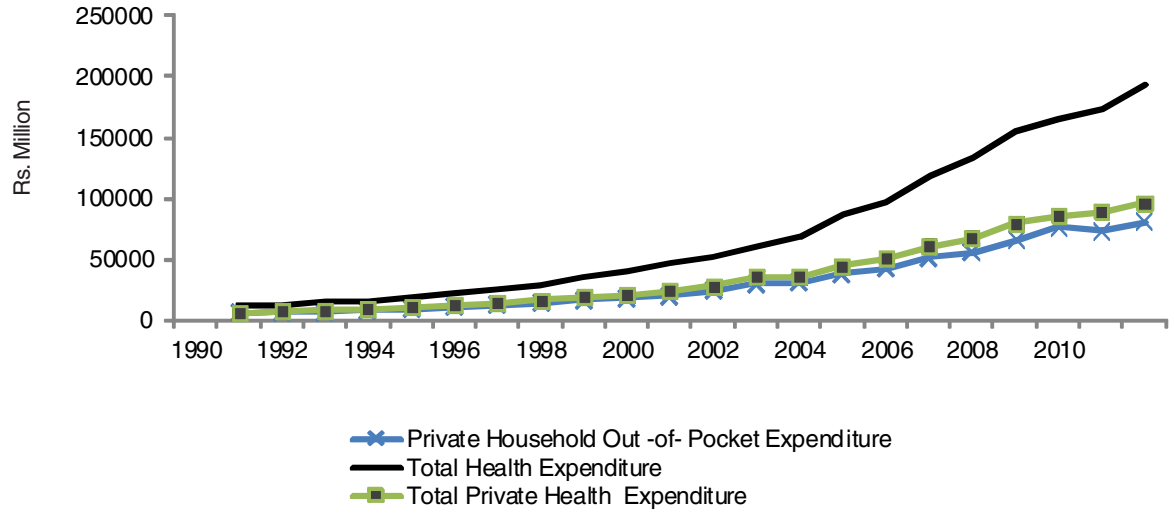
Total Health Expenditure (THE) as depicted in Figure 3 increased to Rs.183.4 billion in 2011 from Rs.11.4 billion in 1990. While expenditure has soared over the years, a large proportion of health expenditure is incurred on recurrent costs rather than on investments to enhance the quality of health care facilities. Health expenditure as a percentage of GDP expenditure has declined to 2.8 per cent in 2011 from 4.0 per cent in 2004. This statistic reiterates the issue of under-funding in the health sector mainly in the public sector, at present which is a critical concern for the health of the population. In the meantime, the government comes under immense pressure to reduce social expenditure with resultant adverse consequences on vulnerable groups.

Escalating household debts aggravates the situation further, especially on these groups due to the absence of adequate availability of social assistance and protection. Household income plays a major role in determining nutrition levels of under-fives, with those among the country's poorest 20 per cent three times more likely to be malnourished as those in the richest quintile. Families working on tea estates are among the nation's poorest in terms of earnings as well as nutrition. One in every five children younger than five is malnourished nation-wide and one in six newborns has a low birth weight, one cause of infant deaths, according to a recent study.

As observed from Figure 3, private expenditure has steadily risen over the years. Private sector spending share has exceeded 50 per cent for the period between 1990-2011. Private sector sources consist mainly of OOP expenditure, voluntary insurance, NGOs and private employers' own arrangements for health. OOP dominates by an average of 87 per cent of the total private expenditure. Private voluntary insurance and employers contributed to 4.8 per cent in 2009 and 6 per cent in 2011. Private voluntary health insurance share in total expenditure accounted for Rs.65.7 million in 1990 and rapidly rose to Rs. 6.2 billion in 2011[5].

OOP payments have many drawbacks: they are the most inequitable form of health care financing, the poor pay a disproportionate share of their income, and there is no opportunity for cross-subsidization between rich and poor or between the healthy and the unhealthy.

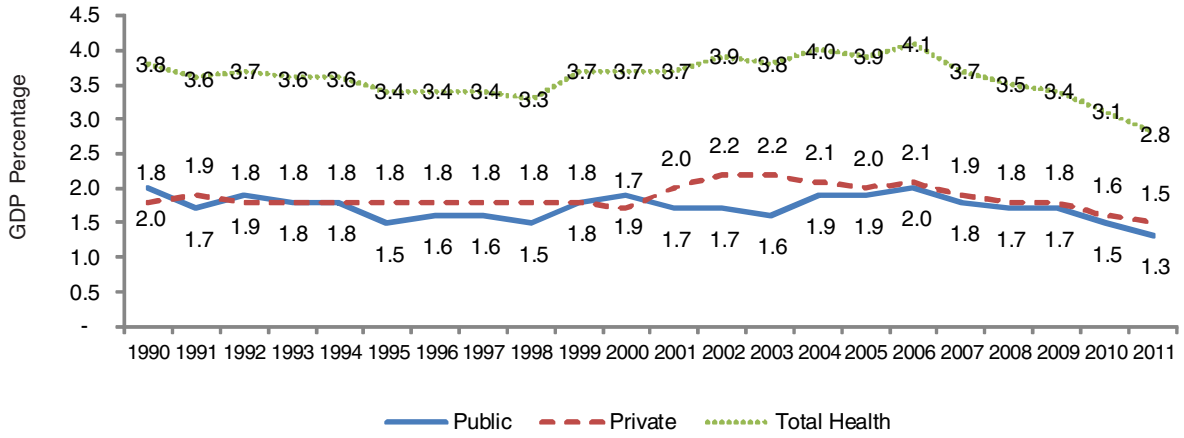
Figure 3
Private Household Out-of-Pocket Expendtiture, Total Private Expenditure and Total Health Expenditure 1990-2011



Source: IPS National Health Account Database 1990-2011.

[5] IPS National Health Account 2010-2011.

Figure 4
Trend in Expenditure on Health as a Percentage of GDP 1990-2011



Source: National Health Account Database (IPS).

6. Existing Challenges

Sri Lanka is challenged by a number of factors in the health system:

(1) The demographic and epidemiological transition combined with the residual non-communicable disease burden;

(2) Insufficient health budget afflicted by shrinking government revenues with rising costs; and

(3) The poor management procedures in the public health system, all of which pose threats to the safeguard and improvements of the health status.

Apart from the above, the country also faces several major problems in its health sector. They include:

(i) Confused macro-organization of health care financing and delivery resulting from devolution (devolving power through Provincial Councils);

(ii) A lack of an overall health sector policy;

(iii) A severe shortage of human resources including nurses and specialists. At present, public hospitals are experiencing a shortage of around 15,000 nurses while 700 doctors are awaiting to get recruited to government hospitals.

Amidst all these challenges, providing free health care to its population through the public health care system prevents catastrophic situations in poor households.

The public health system is over-stretched. There are fewer resources available (human and financial) to improve the quality of patient services. It will require infusions of additional funding and human resources to reduce pressure on overworked staff, to reduce overcrowding and improve quality, and to reduce the waiting time. New resources are also needed for management capacity building, access to new medico technology which is a necessary precondition in order to improve the current system to maintain the quality and strength and continue the existing system. Constraints in funding for public health services has also kept physician salaries very low compared to what other equivalent professionally trained persons can earn in the private sector. As a result, the chances of a large exodus of the best doctors and specialists to the private sector have always been great.

6.1 Ageing Population

The demographic profile of the country influences health care demand. Sri Lanka's population is rapidly ageing. The population is projected to reach its peak of 21.9 million people in 2031 and start declining after 2046. By 2041, one out of every four persons is expected to be an elderly person, making Sri

Lankans the oldest population in South Asia. Increasing urban population is also another factor that determines how services should be made available. The shift of families to urban towns has left elders to care for themselves in rural areas. Thus, there is a growing need to improve health care facilities for elders and health cadres that are trained in caring for elders in the community.

Gains made by the health sector long before have been challenged by the demographic transition triggered by the gradual ageing population and a declining fertility rate resulting in a constrictive population pyramid. The eventual decline in the working age population has concurrently increased the dependency ratio creating an epidemiological transition from maternal and child health to non–communicable diseases.

Despite predictions and forecasts that the percentage of aged population will double in the next 20 years, the response by the public health sector seems to be slow. Formal linkages between health and social services in this regard have not been implemented as yet. Thus, there is an absence of an organisational structure to support caregivers in the families with elderly persons. Support services such as day care centres are sparse and elders' homes continue to require funding from Non-Government Organisations or from the private sector. Already a few private organizations including "Help Age", have initiated elderly home programmes.

It is clearly visible that impending challenges therefore lie more with the state capacity to join hands with the private providers to provide health need to the population mainly to the elderly with NCD.

The present health care delivery system, budget and infrastructure, both human resource and physical, was designed to cater for a growing young population, whose main health concerns were mother and childcare, nutrition and communicable diseases. However, with the population ageing, geriatric medical care has become a priority and illness patterns have moved from infectious diseases such as malaria, filaria, influenza and chicken pox to lifetime diseases such as diabetes, high blood pressure, cancer and kidney disease, etc., which require lifetime expensive treatment.

Neither the present health budget nor the health human resources plan of the health care delivery system nor the physical infrastructure presently in operation can cope with these new challenges. The National Health Plan needs to be completely revised in all aspects: human resources, physical infrastructure and equipment, to meet the new challenges of providing first class health care to geriatrics and an ageing population.

6.2 Insufficient Medical Supplies

The government has not been able to increase funding sufficiently to keep pace with changing epidemiology and medical progress. New technology and costly medication raise expectations of patients indicating the need for additional funds to manage the health system. Medical supplies are a major element of hospital costs borne by the state in the context of free health care provided through public hospitals. The rise in the costs of drugs is attributed to the inefficiencies in the estimation of drug needs, procurement, storage and distribution which further contributes towards the costs.

6.3 Overcrowding of Hospitals

Approximately three-fourth of the government health budget for recurrent expenses go to public hospitals overheads. Sri Lanka achieved historically low levels of public health expenditures when medical technology was not so costly, along with low salaries for health professionals and centralized purchasing of essential drugs and supplies. With trade liberalization policies adopted in 1977, and new expensive medical technology developed world over, the government has found that it cannot provide sufficient funds to sustain to be in line with the new development. Meanwhile, overcrowding and long waiting lines has forced patients to seek health care from the private sector whenever they can afford to pay. Eventually this situation has paved the way for 50 per cent of the out-patients to visit private facilities. However, since most of the population cannot afford to pay the fee levied by private hospitals, they continue to rely on public hospitals for in-patient services whatever available.

6.4 Human Resources

Compared with many developing countries, the majority of the health institutions in Sri Lanka are resourced by different categories of trained health care workers. The primary difficulty relating to human resources were:

(i) Shortages of nursing and paramedical staff,
(ii) Severe geographic misdistribution, and,
(iii) Insufficient facilities for basic and in-service training.

The total number of Medical Officers (MOs) increased to 15,910 in 2012. MOs per 100,000 population also increased and in 2012 it was 78 as compared to 71 in 2010. Similarly, the number of nurses was 36,486 in 2012 which was an increase from 171 per 100,000 population in 2010 to 180 in 2012. Although the island value is 180 nurses per 100,000 population, more than 50 per cent of all districts are less than 180 nurses and 5 districts are less than even 100 nurses per 100,000 population.[6]

Sri Lanka achieved enviable results in its health sector and is now facing difficulty of maintaining its record, because it is challenged by its epidemiological transition while the world over, health has become a commodity to purchase. With the conclusion of war, the rapid economic development that took place was accompanied by a high incidence of mental disorder, drug addiction and suicides. Raising the standard of health care delivery needs the raising of per capita income to meet the cost of better quality of health care and new expensive medical services. On the other hand, the government's budget is stretched beyond its limits partly due to envisaged infrastructure development which lagged behind the civil war which was ended in 2009.

7. Prepayment and Risk Pooling

Avoiding (over)reliance on direct payments is a central issue in disparity in access to health care that is prevailing. Direct or Out-of-Pocket (OOP) expenditures can constitute a major barrier to access and are often an important source of financial hardship and inequity to eliminate, or at least reduce, direct payments are two characteristics that need to be advocated in promoting universal health coverage which will reduce the disparity in health delivery.

Sri Lanka's publicly dominated health care provision and financing has been not so effective in providing effective and equitable health care services to the whole population at low cost to both the economy as a whole as well as the public treasury. National health expenditures have been low, and have not inflated with time or with economic development and market liberalization post-1977. The empirical evidence demonstrates whether the Sri Lankan public hospital system manages available resources efficiently, and achieves productivity and efficiency levels on par with the private sector.

The principal reason for the lack of this appears to be insufficiency of resources at the margin to fund additional management capacity or to increase human and financial resources in the delivery of services. While Sri Lanka's public health system is still a centrally managed command and control system despite devolved functions, it lacks the resources to shift to a more effective or responsive management structure. This constraint requires significant new financial resources to resolve and deal with existing issues. A decade of experience with devolution has not resolved many of the real implementation and design issues. Political commitment to decentralization has also been lacking, and has manifested itself in all areas contributing to continued confusion and ambiguity.

It is unrealistic to expect any significant increase in public expenditure in real terms in the coming years amidst the debt trap looming in the country's economy. Given the current development thinking and political priorities, it is unrealistic to expect any major shift in a way the public resources are allocated across different sectors. In other words, socially important sectors such as health, education and social protection are unlikely get priority treatment. The result is a widening gap

[6] Annual Health Bulletin (2012).

between private and public institutions in terms of the availability and quality of health facilities. This has encouraged even non-affluent patients to rely on private providers, at least for out-patient treatment and routine medical tests. In the absence of affordable private or public health insurance, OOP expenses incurred by patients have become a severe burden on households. Yet, many people do not see an alternative to publicly provided health services due to financial constraints.

Given this situation, it is necessary to determine what sort of reforms are feasible in order to improve the performance of the health sector. In this context, the vital issues include, the optimal use of existing resources within the health sector, mix of health care institutions, and relationship between public and private institutions. The role of health insurance and inter-sectoral action to deal with health issues are the areas that can be strengthened to improve the financing and access to health care.

Availability of data and study resources provide an assessment of the technical inefficiency of taxation funded health services in Sri Lanka. The predominance of hospital services in the public sector means that efficiency in the hospital system is a reflective of overall system efficiency. At present, from an international perspective, the Sri Lankan health system needs a more proactive approach to make efficient use of the physical and human resources. The government spends a relatively small amount of its resources and produces a not so impressive health status for its people. Hence, Sri Lanka has difficulty in maintaining a better health status record, because it is completing its epidemiological transition. The population now suffers increasingly from chronic diseases. Chronic Kidney Diseases that prevails in the most part of the North Central Province is a case in point.

This challenge is significant but not insurmountable. There is a tremendous opportunity to leverage the private sector in ways that improve access and increase the financing and quality of health care goods and services in the public facilities throughout the country. In a country where public resources are under pressure, the private sector is already a significant player. Around 50 per cent of health care financing in Sri Lanka comes from private sources, and about 50 per cent of total health expenditure goes to private providers. Just as important, the vast majority of the country's poor people, both urban and rural, rely more on public health care but reaching to private health care as a last resort.

In this regard, risk pooling is widely regarded as a better and more equitable method for financing health care rather than the out-of-pocket payments on which most of the population currently depends. Further, risk pooling arrangements and their ability to contract with provider organizations for the provision of care are a powerful force to encourage the development of higher-quality, more organized more proactive public and private sector providers.

8. Private Health Care Providers

Though the private health sector in Sri Lanka largely provides out-patient services, they make important contributions to the health care service in the country, but have no formal associations with the state sector. Provision of in-patient services is much more limited in the private sector with only 5,000 beds compared to the 75,000 beds in the public sector health care facilities .The private sector services are mainly limited to the main urban areas in and around Colombo. Private health expenditure has drastically increased within the last few years with investments being mainly on capital investments, expanding the bed capacity, expanding the technology and soon. In Health Master Plan 2005-2016 Sri Lanka, it is mentioned that the investments will be forecasted on IT and technology expansion in the government sector as well.

Rapid ageing of the population and rising non-communicable diseases including cardiac diseases, mental health, accidents and injuries have created a demand for health care services than before. Ageing population in the country is forecasted to be increased by 25 per cent in 2025. According to WHO, 65.4 per cent of deaths has been reported due to non-communicable diseases in Sri Lanka in 2009. Taking note of this

situation, private sector providers have timely forecasted the future demand for the health care in the country and are rapidly increasing their investment on necessary health resources.

The formal element of the private sector consists of non-public entities that include for-profit commercial companies, non-profit organizations, and social enterprises. Individual public sector health workers also provide private sector services, both formally and informally, and an informal health sector of healers, midwives, and individual medicine sellers also provide care.

The private sector consists of technologically advanced machinery and equipment and public hospitals also refer patients to such facilities to get the services done. Maintenance of the machines are also not up to standard in the public sector and it was found that the machine breakdowns that occur in the public hospitals are due to poor maintenance. Regular breakdown of thermo therapy equipment at the cancer hospital and referring serious patients to private hospitals are a case in a point in this regard.

The private sector is often perceived as serving only the rich, but often the opposite is the case. In fact, private sector providers, including for-profit and social enterprises, fill an important medical need for the poor and rural population under-served by the public sector. In addition, the private sector frequently provides services or products that might not otherwise be available, such as advanced medical equipment and procedures. In many cases, the private sector can also provide higher-quality services. Together, these benefits are likely to lead to improved health outcomes across the country if properly regulated.

From interviews with stakeholders which include health care givers and recipients, five main imperatives emerged that together create an agenda that can mobilize the responsible development of private sector health care in the country. These include developing and enforcing quality standards and fostering risk pooling programs.

Weaknesses in public health care, among other reasons, has seen a rise in demand for private health care services in Sri Lanka. As a multitude of factors point towards increasing demand for private healthcare, the shortage of skilled professionals in the industry act as a constraining factor in exploiting such demand. The number of medical professionals in Sri Lanka, although progressively higher over the past several decades, is still relatively lower than the number in regional countries. The shortage of medical personnel is more pronounced in private hospitals which are dependent on visiting specialists to attract patients, given the doctor-centric nature of the Sri Lankan health care industry. The recently debated burning question as to whether foreign medical specialists have a right to work in the private hospitals in Sri Lanka leaves an open-ended question. According to the Private Hospitals' Association (PHA), this burning issue is now adversely affecting the private health sector by disrupting the clinical activities of the specialist centres of their hospitals.

In the last fifteen years, the major private hospitals invested over Rs.50 billion by way of total expenditure to increase capacity-building within the private health care sector by investing in necessary infrastructure, cutting edge technology and continuous development in human capital in the clinical discipline. The centres have created several hundreds of employment opportunities with more than 45,000 servicing the sector directly and over 100,000 indirectly. The centres were set up under Section 17 of the BOI Law of Sri Lanka, and even then, the agreements signed with BOI had no restrictions imposed on the hospitals on the number of foreign nationals being employed, if the hospital management considered recruitment of such personnel as necessary for the proper and efficient functioning of the business enterprises.

The private service providers have not widely spread their services all over the country as it not very attractive to set up health care facilities in rural areas from a business point of view. Private sector providers have accepted that the investment and the risk to set up a health facility in rural areas are higher than setting up a facility in main cities due to the unavailability of human resources, transport cost, infrastructure constraints, management difficulties and demand for services. The private sector is of the view, that if the government facilitates them to diverge their business to the rural areas by providing lands, infrastructure and tax exemptions, they will be able to expand the services for a wider coverage in the country.

The limitations of public health care, particularly inadequate capacity, limited availability of specialty treatment and disparities in service quality, have provided an impetus for the growth of the private health care

sector. In spite of intensive investment for health resources, government could not make any major impact in developing the health sector during the past few years. Whilst demand for private health care is expected to be robust over the short to medium term, intensifying competitive pressures has signalled a negative effect on the profitability of players. This is particularly true for the capital Colombo, in which most private health care sector operators have consistently expanded room capacity in recent years. IPS survey estimates indicate that the 4 listed operators increased their collective room capacity by around 55 per cent over the last 5 years while maintaining the bed occupancy rate at around 80 per cent. On the other hand, larger more established players have in recent times sought to strengthen their geographical presence by venturing outside the capital. Operators have also attempted to diversify their revenue sources by providing additional services such as laboratory and pharmaceutical services.

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. Household preferences having shifted to western or allopathic, the focus has shifted to sharing 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 a section of the population to seek treatment from the private sector as decided by their ability to pay for the service. This situation has led to the establishment of the private hospitals network in Sri Lanka and which spread island-wide during the period of around 150 years from the inception of the first hospital. The year 1980 saw a continuing shift which appears to have stabilized during the 1990s.

In 1990 there had been 44 private hospitals in operation which increased to 87 hospitals in 2008, and further increased to 145 hospitals in 2013[7].With the wave of liberalization introduced in 1977, the Sri Lanka 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 end of the war situation in 2009 in recent years, based on in and out-patient numbers and revenue. Their investment in cutting edge technologies and the modernization of medical facilities has certainly contributed to the expansion of health facilities of the affordable income earning segment of the society.

In this context, it is imperative to identify the key process that influence the shaping of the private health sector. The growth of the middle class and their influence on both the supply and demand side of private health service, role of the government and 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 are the major contributors in this process.

In the case of the private hospital industry, it remains concentrated in highly populated areas where the rich and urban middle class are congregated. It is important to point out that both the suppliers and consumers of private services are largely drawn from the middle class and above.

Although private health insurance has improved, it lacks the potential to expand beyond the small affluent sector. It still remains unable to directly address the major issues of the OOP expenditure in the household. There is a higher utilization of the private sector among the urban middle class.[8] There is a marked preference for allopathic medicine but the choice of medical facilities utilization shows variations across classes. IPS survey reveals that the urban middle class used the private facilities more than the government facilities while the urban poor utilize the facilities of government hospitals depending on the accessibility. The greater availability of private practitioners in rural areas fills the void of private hospitals.

Private health care services are largely ambulatory. Approximately, 2000 full-time private general practitioners provide out-patient care from private clinics on a fee-for-service basis. The major portion, however, is delivered by government doctors in their private practice, 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

[7] IPS Census of Private,Co-operative and Estate Hospitals 2013.

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

through the networks of channelling services and would gradually decline over time, when private hospital centres spread across the country in time to come.

The emergence of a private health sector is driven by demand. Affluent members of the population expect high quality health services and create the demand for a private sector. The quality of care at private facilities was perceived to be of high quality. Newly built private hospitals are equipped with large, ultramodern and lavish medical technology. The prompt services at the private general practitioners' clinics also offer convenient medical services in particular to the nearby population.

Private health providers complement the medical services provided by the government. Private health providers mainly focused on curative services and include general practitioner clinics, and medical centres servicing private hospitals. Private hospitals exist in a variety of sizes (with the number of beds ranging from 5 to 500). There are 200 private hospitals registered with the Private Hospital Regulatory Commission in which 145 Hospitals are actively operational (with a total of 5,000 beds), and an estimate of about 2,000 private general practitioner clinics (providing a range of primary health services). A rapid increase in bed numbers could be seen after the end of the war in 2009 as more private hospitals came into operation in the Northern and Eastern area.

Out-patient care by the private hospital sector are limited, and restricted to over a hundred nursing homes and hospitals in urban areas, which were staffed by both full-time private doctors and government doctors working in their off duty-hours. However, in the last two decades, there has been an increase in their number and the level of sophistication of their services.

The private sector often provides services or products that might not otherwise be available. For example, the Ministry of Health only recently attempted to purchase bio–medical equipment for heart surgeries. Although heart surgeries are conducted in a few government hospitals, the number of patients that are waiting for heart operations have to be in the waiting list for a longer period. Previously, the only available machines were in private facilities. In metropolitan areas mainly in Colombo City, the private sector frequently operates specialized facilities that predominantly serve the middle and upper classes. In Colombo City alone there are five such private tertiary hospitals with modern equipment that serve upper-middle-class patients who might otherwise travel abroad for care. Such entities can serve as a national benchmark for public and private sector providers, raising expectations and benefiting the broader population.

9. Public Private Partnership (PPP) in the Health Sector is not a New Trend

It is important to acknowledge at the outset that many in the public health community oppose in principle a role for the private sector in health care. Indeed, there are legitimate concerns about the role of private providers. In this context, the government needs to play a key role in the PPP process by creating the political environment to win the trust of the general public, trade unions and private sector investors. Partnership is commonly used to describe the relationships and collaborations between two organizations or institutes. As per the WHO, the PPP is a tool to bring together some common goals and objectives of improving the health care service to benefit the society. Blagescu and Young in 2005 described that PPP means the government and the private party have agreed to work together in order to implement a program, in which each party had clearly defined roles.

Public-private partnership is the contractual agreements between public and private sectors in order to provide product or service to its nation. Partnerships help to improve the infrastructure to deliver the quality services as well as enable the public sector to benefit from efficiencies, innovations along with the capital, skills and experiences of the private sector institutions. By collaborating with each other, both sectors can deliver better service with available resources providing

better value for money which would have not been feasible if done individually. (Bennett, 1991).

The need for public-private partnerships in health care is required due to the inadequacies of the public sector in addressing the total health care demands. Although the public-private partnerships generate a powerful tool for providing solutions to the difficult problems by leveraging on the strengths of two different partners, PPP also answers the challenges of the changes in the processes (WHO, 1999).

By virtue of the definitions and the characteristics of the public and private sectors, it can be stated that public-private arrangements are fostered when government agencies interface with the for-profit private sector by arrangement to tap into resources when the need arises. Public-Private partnership has emerged as a new trend in public sector management to improve the efficiency and responsive to the users. It is government responsibility to provide basic health care services to the people as the majority of the population mainly the poor are dependent on it. In areas where it is not able to provide services, it should collaborate with the private sector to meet the objective of fairness in health delivery.

In Sri Lanka, PPP was in existence unofficially for a longer period of time. With the restructuring of the economy in 1977, all universal welfare programmes became targeted and food subsidies largely withdrawn. During the same year, there was a shift in government policy on health when it allowed medical officers and other technical officers within the state health sector to practice privately, outside their official working hours. This was the first instance that unofficial PPP was established. 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.

In Sri Lanka there have been various PPPs in practice informally for the last few decades. Some examples for PPP involvements in the health sector in Sri Lanka are summarised below.

(a) Government doctors doing channelled practice in private hospitals during their off-duty hours;
(b) Government doctors doing their own General Practice in privately owned dispensaries who work as a catalyst to referral system with government or private hospitals;
(c) Involvement of Traditional Health Care Providers- Ayurveda, Homeopathy;
(d) Supply of equipment and drugs by the private sector;
(e) Clinical Investigations and admissions to the state sector hospital through private channel consultations and vice-versa;
(f) Medical consultation services, Laboratory and other diagnostic services in public sector are obtained from private laboratories;
(g) TB/Influenza prevention/ vaccination programs in private sector funded by the government;
(h) President's Fund – assistance in major surgical procedures treatment in private sector;
(i) Govt. servants' insurance – provision (Agrahara) to get treatment by the private sector;
(j) National Blood Bank Operation – Provide blood to the private sector;
(k) Representatives from major private hospitals serving as members of Private Health Regulatory Commission;
(l) Outsourcing of Facility Services – Cleaning, Clinical waste management, Laundering, Cafeteria etc.

In most government hospitals, doctors recommend that patients obtain prescribed medical tests from private laboratories for accuracy and to expedite the treatment process. Patients who seek laboratory tests from private laboratories are satisfied with the costs they paid as they have confidence of the laboratory results amidst government spending a sum of Rs.139.9 million in 2008 by providing essential laboratory equipment to upgrade lab service in major hospitals.[9] Most private hospitals in Colombo have their own medical laboratories and sample collection centres opened up all over the island. Some hospitals have samples bar-coded throughout the entire process from collection to issuing results for the convenience of the customers.

In a country like Sri Lanka, when the situation is emerging that health needs of the patients should get priority whether it is delivered by the public or private sources, it is not the patients with

[9] Ministry of Health, *Annual Health Bulletin* 2008, 105.

common illnesses that need the benefits of PPP arrangement. Instead, it is more useful when it intervenes with patients in government hospitals who are faced with acute illnesses. Especially when Sri Lanka is confronting with a demographic shift toward an ageing population, coping illnesses related to old age process will become crucial to the state health sector.

It was reported that the highest categories of complaint/diagnosis reasons among elderly for current hospital admissions are;

(i) Acute Coronory Syndrome (18 per cent),
(ii) Fever (14 per cent),
(iii) Complication of Renal Failure (13 per cent[10]).

The same study reveals that the number of people with chronic disease needing long-term drug therapy constitute

(a) Ischemic heart Disease (24 per cent),
(b) Diabetes Mellitus (17 per cent),
(c) Hypertension (24 per cent).

According to leading causes of hospital deaths in 2008, death by Ischemic Heart Disease was highest among all deaths in hospitals which accounts for 4,466 deaths, which is 12.5 per cent proportionate to total hospital mortality and 22.1 rate per 100,000 population. Further, Pulmonary Heart Disease and Disease of the Pulmonary Circulation have recorded 3,580 deaths which is 10 per cent proportionate to hospital mortality and 17.7 rate per 100,000 population[11].

Added to the above finding is that government health authorities recently announced that 5,000 patients in government hospitals are waiting for heart operations as at 2013. It is to be noted that patients who undergo heart surgery in government hospitals are not free of charge. They have to purchase surgical items from outside sources at a cost. According to the Private Hospital Association, at any given time, there are approximately 50 patients admitted to the Heart Centres in private hospitals as in-patients and 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.

The above shows the capacity of intervention by two different providers which have two different objectives, while mostly served by the same medical personnel. The increased performance of CABG by private providers indicate their improved capacity intervention mostly patronized by the richest and middle class in urban and suburban areas.

In this context, the private hospitals are in an advantageous position because Private hospital providers have embarked on introducing new bio-medical technologies at a cost with newly built hospital infrastructure to increase their market share in a competitive health care delivery atmosphere among themselves.

Amidst this situation, it is heartening to know that health authorities have stepped into import bio-medical equipment for intervention.[12]

According to the health authorities, the government has allocated in 2014 over Rs. 2,000 million to procure bio-medical equipment (BME) required by government hospitals. These sources further say that the government might have to form a partnership with the private sector when acquiring BME. But the issue is, that procurement of BME by the hospital authorities will be subject to usual procedural delay which contributes to add more patients into the category of 5,000 patients already waiting for heart operations in government hospitals. On the other hand, the government offers subsidies to private hospitals for import of high tech bio-medical equipment and as a result, there is an abundance of medical equipment and technology in metropolitan areas mainly in Colombo city. It is therefore imperative to initiate some feasible contractual arrangement with private hospitals to attend to the backlog of waiting heart patients until the government imports of BME materialized.

The most important fact when initiating PPP arrangement is to emphasise that there is need to do away with the notion that PPP will lead to privatization of public health care delivery. Government health officials are of the view that the general public are in fear of PPP thinking that the government is moving towards privatization of public services.

In the world today with the globalization process, countries

[10] Indian Journal of Gerontology 2010, 24.*139 Characteristics of Older Patients admitted to a Tertiary Care General Medical Unit in Sri Lanka.*

[11] Ministry of Health, *Annual Health Bulletin 2008*, Table 19. 132.

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

have moved toward the market economy in which the health sector is not excluded. Instead, it is the responsibility of the authorities to reap the benefit from PPP arrangement to reduce cost, sharing resources, quality assurance, and increase efficiency of health care delivery with equity and fairness. In this context, institutional changes may be needed in both public and private sectors to increase accountability, improve efficiency and to better meet the social mandate such as providing a humanely service to the population.

The Government officials are said to be more positive towards the government policies on PPP initiatives in the country. They all accept that the government should move in the direction of PPP to address the rising health care needs of the population with budgetary provision to fund adequately to develop the health care industry. As per the government officials, the biggest challenge ahead is to convince the Trade Unions and the general public of the country to implement PPP models.

In the absence of government capacity for broad leadership of health markets, governments and private entities can foster models that harness private markets and address their failures by reducing provider fragmentation, creating incentives for quality, providing subsidies for targeted populations and high impact interventions, and using technologies that expand access and improve quality. In this context, the Ministry of Health (MOH) should make it a point to know what private innovations are occurring in the country and consider how these programs can complement existing government services. Ideally, they should view high impact models that harness and improve the performance of health care delivery as a part of the health system, considering direct contracts with successful programs. And implementers of innovative models that harness and manage the private sector should be aware of national health goals and determine how their programs will contribute. They should work to form relationships with government and integrate with existing public services.

There needs a strong legislative framework and a number of guidelines and tools that have to be developed by the MOH and the Treasury for managing partnerships. The review of literature confirmed the need for the state to have effective regulations in order to oversee quality and standards and to provide stewardship and oversight. The existing Private Health Regulations need to be re-visited and modified to accommodate PP arrangements. The public sector requires sufficient capacity not only to manage relationships with the private sector but also to enable innovation and experimentation. Evaluation is an integral part of all interactions not only to learn from successes but also to identify any perverse incentives that may lead to unintended consequences.

The following case study shows that the private for-profit sector is already engaged in a number of high tech projects that are closely aligned to current health system needs. Factors that increase the likelihood of interactions being successful include:

(1) Increasing the government's capacity to manage public – private relationships;
(2) Harnessing the contracting expertise in private providers; and
(3) Encouraging innovation and learning among other factors.

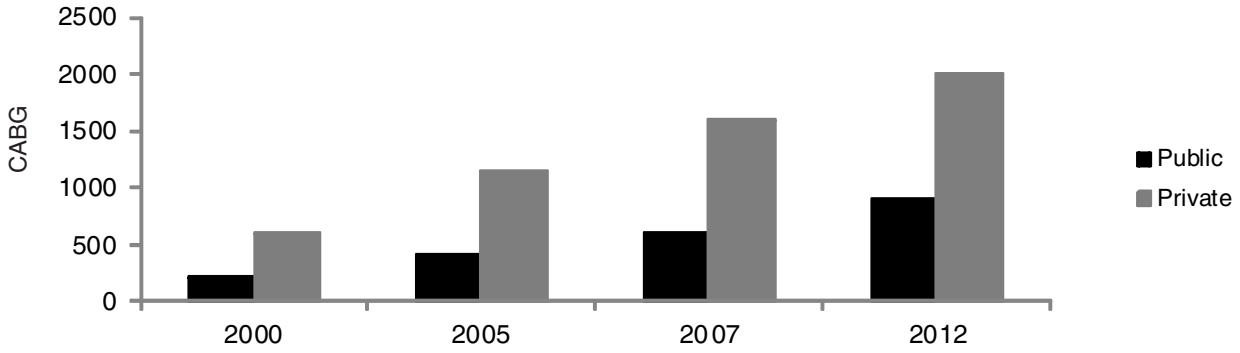
Success of this mechanism depends mainly on the functioning of health care delivery by increasing quality, availability, and affordability of health care for poor people in the country.

10. Case Study 1

Figure 5 below, depicts the incidences of Coronary Artery Bypass Grafts (CABG) performed by the public and private health care sector providers. The Figure shows that Private Hospitals have improved their capacity of CABG intervention by 2½ times from 600 CABG in 2001 to 2000 in 2012, while the 'public sector was lagging behind from 200 CABG in 2001 to 900 CABG in 2012.

The situation depicted above clearly highlights the disparities in the capacities of the state and private sectors, despite being mostly served by the same medical personnel. The increased instances of CABG performed by private health providers indicate their improved capacity for intervention for a service mostly patronized by the upper and middle class segments from urban and suburban areas.

Figure 5
Coronary Artery Bypass Graft (CABG) - Public and Private



Source: IPS Private Health Database (2000-2012).

11. PPP Potential

PPPs are most useful in relation to patients suffering from acute illnesses – who are primarily being treated in government hospitals. This is especially important in light of the fact that Sri Lanka is confronted with a demographic shift towards an ageing population – a factor that is adding further pressure to the overburdened state health sector. Table 2 below summarizes the current situation of the demand for health care in the country.

Table 2
Summary Highlights of Health Care Demand in Sri Lanka

Main Reasons for Hospitalization of the Elderly	%
Acute Coronary Syndrome	18
Fever	14
Complications of Renal Failure	13
Patients needing long-term drug therapy	**%**
Ischemic Heart Disease	24
Diabetes Mellitus	17
Hypertension	24

Source: Adhikari, A., Rajapakse, A., Rajapakse, S., Rodrigo, C., Perera, Y.S. (2010), *Characteristics of Older Patients admitted to a Tertiary Care General Medical Unit in Sri Lanka*, *Indian Journal of Gerontology*, Vol. 24 (139-149).

Ii is evident that the public health sector is finding it harder to cope with the rising demand for its services. This is made evident by the fact that as at present, over 5,000 patients are waiting heart surgery according to a recent announcement made by the government health authorities.

In this context, the private hospitals are at an advantage because administrators have embarked on the large scale introduction of new bio-medical technologies at a high cost, with the sole purpose of increasing their market share in a competitive health care delivery environment.

The expected improvement in Sri Lanka's macroeconomic climate over the next decade will expand the health care gap, as higher incomes will create new demand. The biggest individual investment opportunities will be in building and improving the sector's physical assets. Around 10,000 –15,000 additional hospital beds to the existing bed strength of 80,000 beds (75,000 in public hospitals and 5,000 in private hospitals) will need to be added to the existing base. An additional 10,000 physicians, about 25,000 nurses, and 10,000 community health workers will be required over and above the numbers that will graduate from existing medical colleges and training institutions. Demand for better distribution and retail systems and for pharmaceutical and medical supply facilities will also be strong.

In this context, it is an uphill task for the public revenue funded public health system to meet the above requirement to fulfill the health care needs in the long run.

Under these circumstances it is important to look at the PPP arrangements that are existing world over. These include the following.

Management Contracts - The private sector provides a service or manages a contract to a public sector health service.

Joint Ventures - The government acts as a regulatory and shareholder in the operating company.

Leasing - The private sector is responsible for operating and maintenance of the asset while government is the owner of the asset.

Build Operate Transfers - The private sector is responsible for funding, designing, building and operating the project. The public sector controls and takes the ownership of project at the end of the contract.

Build, Own, Operate - The control and ownership of the project remains in private hands.

Design, Build, Finance, Operate - Includes one private sector and one public sector party to the contract.

Design, Build, Operate - A single contract is awarded to a private business which designs, builds, and operates the public facility, but the public sector retains legal ownership.

Co-operative Arrangements - This type of arrangement makes provision for equity partnership deals and concession type franchise arrangements.[13]

12. The Need for Complementary Solutions

While legitimate concerns about private sector participation in health care exist, the sheer size of the country's health challenge has driven a growing realization — including among government, that engaging and developing the private sector should be an important part of the strategy to improve health care. By serving broad segments of the population, increasing access, expanding the range of services and products available, and improving the quality of services, the private sector can have a positive impact on health and the quality of lives of the people.

In this regard, from interviews with a cross-section of stakeholders, three main imperatives emerged that together create an agenda that can mobilize the responsible development of public private health care partnership in the country.

[13] Widdus, R. (2004). *Public-Private Partnerships for Health and Health Care in the Developing World, Initiative on Public-private Partnerships for Health,* pp. 14-101.

- Develop and enforce quality standards. Initial efforts at enhanced regulation could have large and immediate benefits. Financial and technical support is needed to strengthen the ability of the existing regulatory body (Private Health Regulatory Commission) to develop and enforce transparent and effective quality standards.

- Modify existing policies and regulations to foster the role of the private sector. Opportunities exist to reform the regulations that inadvertently impede the development of the private health sector. The primary areas of focus should be streamlining bureaucratic processes that limit market entry, liberalizing human resource regulations that perversely reduce the number of active health care workers, and reducing tariffs and other import barriers that impede access to or raise the cost of health supplies.

- Foster risk pooling programs. Risk pooling arrangements —such as government-funded national schemes, such as EPF, Agrahara Health Insurance Scheme for State Employees; Improved health coverage for Samurdi Recipients; affordable private insurance schemes for informal sector and households; will have enormous potential to improve the financing of health care in the country, thereby encouraging the development of higher-quality, more organized public and private sector providers.

13. Conclusion

There are many possible traps the country may get into but one important trap which impedes the country's 'stepping-up' initiative is the inability of the government to continue with a high public sector investment program to meet the growing investment needs of the country without going for costly commercial debts.[14]

The need for public-private partnerships in health care is required due to the inadequacies of the public sector in addressing the total health care demands. Although the PPP generates a powerful tool for providing solutions to the difficult problems by leveraging on the strengths of two different partners, PPP also answers the challenges of the changes in the processes (WHO, 1999).

An overall reduction of the disease burden in a country is critical for the effective functioning of a modern health care system. In other words, disease prevention through inter-sectoral action needs to be elevated to a higher level goal of the health sector. In this context, Sri Lankan government has to find remedial actions to reform the health care service across the country in order to provide better health care services to the nation.

The fact that Sri Lanka's major private sector health care players are listed on the Security Exchange reflects the government's favourable disposition towards the commercialization of health care services. In the meantime,the new government formed in January 2015 allocated 3 per cent of the GDP for public health sector to revive the public health care delivery. In the meantime, foreign pharmaceutical and biotechnology companies have approached Sri Lanka, including multinationals like Schering-Plough, GlaxoSmithKline, Merck, Sharp & Dohme, Aventis and Pfizer, realising that Sri Lankan doctors enjoy a good reputation, as attested by the increasing trend of foreign patients who came from the surrounding region since the end of the war in 2009.

The mounting health care challenge facing the country has forced a reassessment of traditional approaches to addressing its needs. Government and the stakeholders have begun to accept that engaging the private sector should be an important part of any overall

[14] Wijewardana, 2014, *Public-Private Partnership To Keep Public Investments Going.* https://www.colombotelegraph.com/index.php/public-private-partnership-to-keep-public-investments-going/.

strategy to improve health care. This is not particularly radical. Other countries have already embraced the private sector as a means of improving health care provision. Harnessing market forces to address the country's health challenges will require increased engagement and stewardship from the public sector. In this context however, new thinking is required regarding how best to leverage the capacity and resources of the private sector through investment, partnerships, and public sector oversight. This report seeks to begin the process of developing those new approaches with the primary objective of highlighting the importance of the private health sector in Sri Lanka, suggesting ways in which key policy makers, donors, and other stakeholders can engage and develop it as a complement to the over-stretched public sector health care systems.

When completing this research, many in the public took the opportunity to make clear their opposition in principle to the involvement of the private sector particularly for-profit entities in health care. Even those not opposed in principle, often criticized the adverse societal impact the private sector can have on health care. They pointed to examples of a range of unethical business practices. While many private sector providers are honest and well-intentioned, there are too many examples in which the pursuit of excessive profits leads to unethical business practices such as under- or over-servicing, collusion, false billing, price gouging, and unlicensed practice.

There is no question of achievement of the public stewardship toward the community health services which is unique. But that Sri Lanka confronts an unearthed health crisis of overwhelming proportions is widely understood. Increasingly, so-called lifestyle ailments of non-communicable diseases such as cancer, diabetes, heart disease and chronic kidney diseases in the North Central Province are afflicting the Sri Lankan population and compounding the country's health crisis, reflecting the poor state of its health systems in the public sector. And also with the increasing tourism potentials after the conclusion of the war in the year 2009, the spread of HIV-Aids cannot be ruled out in addition to persisting parasitic diseases such as Dengue which are all well documented.

Much of Sri Lanka's gains in the health sector have been the result of focused and intelligent government spending. Public outlay on health amounts to 1.7 per cent of GDP (2013 figures). This is significantly higher than the 1.3 per cent of GDP average for South Asia and also places Sri Lanka as among the better performing of the 11 countries of the World Health Organisation (WHO) South-East Asian Region.

While this is a solid base to build on, it needs to be recognised that the future trajectory of public health issues in Sri Lanka might deviate from the known path. This would be triggered by social and economic evolution, new compulsions and the changes in people's needs. For a start, there is the accelerated rise of the private sector as a health-care provider. While public/government spending on health is a strong 1.7 per cent of GDP (as we saw earlier), it is matched and even bettered by private sector spending (1.8 per cent of GDP). Gradually a pattern is emerging. The public sector appears to dominate in-patient provision (over 90 per cent). The out-patient burden is seeing an expanding role for the private sector, concentrated in urban areas.

This has implications for health financing, especially in a society that has pioneered a "health for all" approach paid for by tax revenues and managed by the state. Long waiting times in public health facilities – not unknown in other parts of the world either – the quicker availability of new technologies developed elsewhere, the propensity of people to seek direct specialist care, even without primary referrals, and increasing household Out-of-Pocket expenses are cases in point.

This process is being pushed ahead by rising incomes, following recent years of economic growth. As a consequence, equity, one of the cornerstones of the public health policies of the Sri Lankan government, is starting to come under pressure. How this is addressed by Sri Lankan health authorities would be enormously educative for other countries.

Like many other emerging and newly-independent nations in the second-half of the 20th century, Sri Lanka needs to work hard to address communicable diseases and vaccine preventable diseases. Today, though, non-communicable diseases (NCDs) are the leading killers. Urbanisation, lifestyle transformations and related factors are causing a surge in cases of cardiovascular diseases, diabetes, various cancers and carcinomas.

Even so, communicable diseases have not ceased to be a threat. While the number of mortalities

may be small, Dengue, Leptospirosis and Tuberculosis remain a problem or have encountered a recrudescence. A greying population points to anticipated gaps in areas such as rehabilitation, medicine and geriatrics.

Sri Lanka has done well in respect of the Millennium Development Goals and reduced its infant and maternal mortality rates sharply. Nevertheless, maternal and child under-nutrition are noticeable. One in six children born in the country is of low birth weight, a predicament that could have long-term physical and cognitive consequences.

This set of emergent challenges will require inter-sectoral collaboration (to neutralise for example, the phenomenon of under-nutrition), meeting human resources lacunae (among others for care-givers and specialists who can work with the significant elderly population), and pursuing an information and communication programme that would stress the cheaper option of NCDs prevention rather than the more expensive one of NCDs treatment.

To be fair, the Sri Lankan government is alive to these realities, and is putting in place mechanisms to meet them. The efficacy and success of these mechanisms would be closely watched. When it set up an exemplary basic health-care system, Sri Lanka constructed a template for other developing countries. Now, as it copes with the health implications of its many parallel transitions, it has a chance to repeat history.

Public expenditure on health in this country remains less than 2 per cent of the GDP (increased to 3 per cent in the Interim Budget of 2015), though private expenditure has also been increasing. Yet, the day-to-day experience of ordinary citizens with respect to availability, accessibility, affordability and quality of health care is much to be desired. While allocation of more resources coupled with institutional improvements can go a long way in improving health care services, it needs to be recognised that the future trajectory of public health issues in Sri Lanka need to deviate from the known path of welfarism.

Sri Lanka as a middle income country has a rising demand for health care with the lifestyle changes and an ageing population like in Singapore, Thailand and Japan .Government itself cannot find the solution for all the health care needs due to budgetary restrictions and inherent inefficiencies due to an overstretched health workforce and age old infrastructure. Various PPPs implemented in other countries provide useful guidelines to the Sri Lanka health sector to reform the health industry by adapting PPPs to suit the Sri Lankan health sector.

Therefore it has become imperative to engage the private sector, in the form of partnerships with the public sector, in order to expand the scope and improve the health care services in the country. The Government should therefore embrace PPPs in the provision of health care services in Sri Lanka. The use of the resources and expertise of the private sector organizations, through PPP arrangement, can help renovate and modernize health care facilities in the country.

In an attempt for a PPP arrangement there needs to be some basic requirements that have to be met in advance. The most important strategy among others to embrace PPP in the provision of health care is to establish a National Policy Framework for Public Private Partnership. Without such a policy framework, it would be very difficult to have an efficient and effective PPP. And the next most important requirement in introducing PPP is the necessity to change the mindset of the health care workforce. In this context, changing attitude also matters in health care delivering activities toward a patient friendly approach to new technology, to improve the delivery for the health seeking general public.

Bibliography

Bennett, S. (1991), *The Mystique of Markets: Public and Private Health Care in Developing Countries*, PHP Departmental Publication, No. 4. London: London School of Hygiene and Tropical Medicine.

Berman, P. (1995), *Health Sector Reform: Making Health Development Sustainable*, In "Health Sector Reform in Developing Countries: Making Health Development Sustainable", edited by Peter Berman, Boston: Harvard University Press.

Central Bank, *Annual Reports 2010-2013.*

Dayaratne, G. D. (2013), *Private Hospital Health Care Delivery*, IPS Research Studies: Working Paper Series No. 18 June.

IPS, *Census of Private, Co-operative and Estate Hospitals 2013 Series* No. 1 Issue No. 6.

IPS (2001), *National Health Account 1990-1999*

_____ **(2005),** *National Health Account 2000-2002.*

_____ **(2008),** *National Health Account 2003-2004.*

_____ **(2012),** *National Health Account 2005-2009.*

_____ **(2014),** *National Health Account 2010-2011.*

Kelegama, Saman (2013), Review of *Famine, Fevers and Fear: The State and Disease in British Colonial Sri Lanka* by Dr. S. A. Meegama, 2012.

Ministry of Health, *Annual Health Bulletins 2008-2012.*

Ministry of Health Sri Lanka, Japan International Cooperation Agency (2010*), Health Master Plan 2007-2016.*

Research Intelligence Unit of Sri Lanka (2007), *PPP Arrangements and Its Advantages for Sri Lanka.*

The World Bank, *Impact of Universal Coverage In Developing World. A Review of Existing Evidence.* Universal Health Coverage Studies Series (UNICO) UNICO Study Series No.25.

Wijewardana, W. A. (2014), *Public Private Partnership on Public Investment*.

https://www.colombotelegraph.com/index.php/public-private-partnership-to-keep-public-investments-going/

World Health Organization (1997), *Public Private Sector Partnerships for Health: Role of Governments*, SEA/HSD/212, WHO Project: ICP ICO 001/ICP RPS 002, New Delhi: WHO Regional Office.

World Health Organization (2001), "Making a Public-Private Partnership Work: An Insider's View", *Bulletin of the World Health Organization*, 79 (8).

Institute of Policy Studies of Sri Lanka
100/20, Independence Avenue, Colombo 7, Sri Lanka
Tel: +94 11 2143100 Fax: +94 11 2665065
Email: ips@ips.lk
Website: www.ips.lk
Blog 'Talking Economics': www.ips.lk/talkingeconomics
Twitter: @TalkEconomicsSL
Facebook: www.facebook.com/instituteofpolicystudies

ISBN 978-955-8708-91-0