Sri Lanka
State of the Economy Report 2015

Chapter 9
Health Sector Reforms

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9. Health Sector Reforms

9.1 Introduction

With universal health care and a robust public health network across the country, Sri Lanka has made noteworthy achievements in health outcomes compared to other developing countries. Sri Lanka is characteristic of increased life expectancy, reduced maternal and child mortality and decreasing levels of communicable diseases, etc. While this success is laudable, the country needs to strengthen its existing health system (both public and private) in order to face changes brought on by demographic and epidemiological transitions. Due to the decline in overall population growth, the percentage of individuals over 60 years in the country is expected to grow at an unprecedented rate to reach 24.8 per cent by 2031.[1] Moreover, there is a shift in the disease burden towards non-communicable diseases (NCDs) such as heart disease, cancer, asthma and diabetes, mirroring that of high GDP countries. In fact, the leading cause of death in Sri Lanka is cardiovascular heart disease. Similarly, due to the increase in per capita income over the years, there is also greater demand for better treatment procedures.

These changes bring a variety of challenges. With regard to health care financing, the system will need to take into consideration the higher cost of providing health services for NCDs that require long-term interventions. As the population ages, demand for health care will increase and change shape. Also, greater globalization will make Sri Lanka more vulnerable to health epidemics. The health sector needs to strengthen its health care organization, provision and regulation not only to deliver services effectively and efficiently, but also to provide quality care and guarantee patient satisfaction.

In this context, this chapter discusses possible health care reforms to be undertaken in order to cater to population demands successfully. The chapter proceeds as follows: Section 9.2 outlines health care financing. Public sector reforms and private sector reforms are discussed in Sections 9.3 and 9.4, respectively. Section 9.5 discusses drug policy and Section 9.6 concludes.

9.2 Health Care Financing

Currently, health care in Sri Lanka is financed through a combination of tax-financed government expenditure and private payments for care. Public sector funds are channelled through a combination of contributions from the Ministry of Health (MOH), provincial and local governments, other ministries and government entities, the President's Fund and the Employee's Trust Fund.[2] The majority of private sector financing sources consists of out-of-pocket expenditure, insurance, NGOs and private employers' arrangements for health expenditure.

Total health expenditure as a share of GDP stood at 3.4 per cent in 2009, having peaked at around 4 per cent during 2002-06.[3] It is evident that the private sector has increasingly become prominent in health care expenditure. Between 2005 and 2012, the

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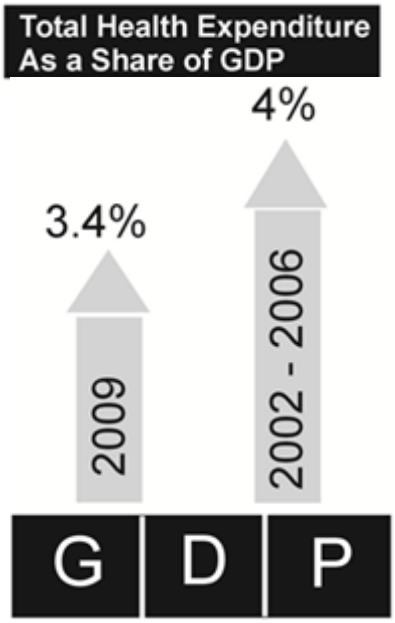
1 De Silva, I., (2012), "The Age Structure Transition and the Demographic Dividend: An Opportunity for Rapid Economic Take-off in Sri Lanka", Sri *Lanka Journal of Advanced Social Studies,* 2(1).

2 IPS (2012), "Sri Lanka National Health Accounts 2005-2009", Institute of Policy Studies of Sri Lanka, Colombo.

3 *Ibid*.

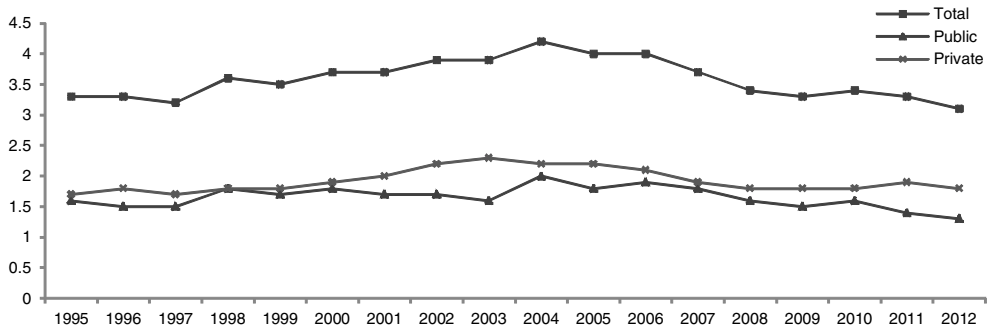


proportion of private health care expenditure increased from 54 per cent to 60 per cent; the government contribution to total health expenditure in 2012 was 40 per cent.[4]

9.2.1 The Health Transition and Financial Challenges

The changing demographic and epidemiological transitions as well as higher demand for better treatment procedures bring with it the need to improve Sri Lanka's health financing system. Health care expenditure is likely to increase in the future because: a) the increase in NCDs and the proportion of the elderly requires long-term care and monitoring; b) the country needs to fill gaps in service delivery of geriatric care and long-term care; and c) it is imperative to respond to the increase in demand for more expensive treatments. Even though Sri Lanka's disease pattern is moving towards mirroring that of high GDP countries, its health care expenditure does not follow suit. In recent years, the rate of growth in GDP has been above the rate of increase in public and private health expenditure.[5] As a result, when expressed as a percentage of GDP, the country's total health expenditure shows a declining trend (Figure 9.1). In 2006, total health expenditure was 4 per cent of GDP, but reduced to 3.1 per cent in 2012. Furthermore, compared to other countries with similar health indicators, Sri Lanka's public health financing per capita is low (Figure 9.2).

Figure 9.1
Health Expenditure as a Percentage of GDP



Source: World Bank, "World Development Indicators", World Bank, Washington, D.C.

[4] World Bank, "World Development Indicators" http://data.worldbank.org/indicator.
[5] IPS (2012).

It is estimated that when life expectancy at birth is less than 68 years, total health expenditure in Sri Lanka needs to be 4.87 per cent of GDP; when life expectancy is greater than 68 years (as it is currently), it needs to be 5.84 per cent of GDP.[6] The current expenditure figure (3.1 per cent) is lower than both estimations. This indicates that Sri Lanka would need to bear a larger burden financially if it is to provide health care services that would adequately cater to the changing demographic and disease patterns.

The critical question is how Sri Lanka can fund an increase in financing. One alternative is to consider increasing taxes on harmful products such as alcohol and tobacco. For example, the country imposes a Rs. 7,000 per kg excise duty on cigars, cheroots, cigarillos and cigarettes containing tobacco. Excise duties that range from Rs. 4,612-18,500 depending on the length of the cigarette are also imposed.[7] When the percentage of tax in retail price is considered, the various lengths of cigarettes have no consistent rate of tax. If the government imposed a standard rate of 60 per cent of excise duty on retail price for all cigarette categories, it would have gained an additional Rs. 8 billion in revenue in 2013.[8] New forms of taxes, such as taxes on fast food, could also be considered.

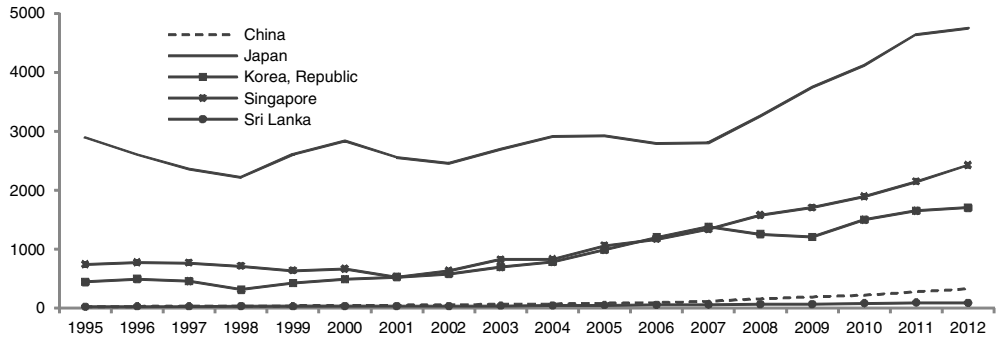
A second strategy is to implement a social health insurance system. The viability of this option, however, is questionable because a large proportion of employment in the country is within the informal sector, making it difficult to collect premiums. Administrative challenges of social health insurance should also be given considerable attention as Sri Lanka does not have prior experience on the matter. With an ageing population and an increase in NCDs, Sri Lankans will require different types of insurance; especially to cover hospital expenses and long-term care which is more expensive. The country should also have a more proactive stance on donations as a third financing strategy. Currently, donations operate on an ad hoc basis, leaving room for untapped potential to be explored.

9.3 Public Sector Health Reforms

9.3.1 Health Care Delivery

Sri Lanka is one of the few countries in the world providing free universal health care as a national

Figure 9.2
Health Care Expenditure Per Capita, Select Countries (US$)



Source: World Bank, "World Development Indicators", World Bank, Washington, D.C.

[6] Ministry of Healthcare and Nutrition (2007), "Health Master Plan – Healthy and Shining Island in the 21st Century", Ministry of Healthcare and Nutrition, Colombo.

[7] Sri Lanka Customs (2013), "Budget Updates – Excise Duty", http://www.customs.gov.lk/tariff/ExciseBudget2013.pdf [accessed May 21, 2015].

[8] ADIC (2014), "Raise Taxes on Tobacco", http://www.adicsrilanka.org/wp-content/uploads/2014/05/No-tobacco-2014-Report-12.pdf, Alcohol and Drug Information Centre, Sri Lanka.

priority for decades, with the state bearing the main responsibility for providing health care services to the people. A majority of the population has easy access to a reasonable level of health care facilities provided by both the state and private sector through the extension of services to every corner of the country. Sri Lanka's health system consists of a well-established network of health institutions providing primary, secondary and tertiary health care services. Whilst the health system consists of public and private health care services, the government plays the major role as the key health care provider serving nearly 60 per cent of the country's population.[9]

The present structure of the government health care system is a result of the Health Services Act of 1953 and the Provincial Council Act of 1988. The government sector covers the entire range of preventive, curative and rehabilitative health care provision. From 1950s until the 1980s a central health department or a ministry was responsible for managing the government health service. In 1987, the responsibility of managing the government health service was devolved to Provincial Councils by the 13th Amendment to the Constitution. Management of national health facilities, medical education, formulation of health policy and bulk purchase of drugs and medical supplies are done by the central ministry.[10] The state health services function under an appointed government minister with nine Provincial Directors of Health Services (PDHS) responsible for management and effective implementation of health services in the respective provinces. The PDHS is responsible for the management of hospitals (Provincial, Base and District Hospitals, Peripheral units, Rural Hospitals and Maternity Homes) and out-patient facilities such as Central Dispensaries and visiting stations.

The public sector runs an extensive network of facilities throughout the country. These are organized into a multi-tiered referral system of facilities ranging from maternity homes and dispensaries upward to teaching hospitals and other national hospitals. By the end of 2012, there were 616 government hospitals with 76,087 patient beds. Further, the public health service had 15,910 Medical Officers (MOs) and 36,486 nurses in 2012. The number of MOs and nurses per 100,000 population was 78.6 and 180.3 respectively, in 2012.[11]

In 2007, the Ministry of Healthcare and Nutrition launched a 10-year Health Master Plan (HMP) with the mission of achieving the highest attainable health status by responding to people's needs and working in partnership to ensure access to comprehensive high quality, equitable, cost-effective and sustainable health services.[12]

Rationalizing and strengthening health network of facilities and services; reducing priority diseases/ conditions through strategic interventions; enhancing quality of service delivery; improving health status of vulnerable populations; increasing public confidence and patient/client satisfaction in the health services; accessing new technologies; strengthening public-private partnerships in order to enhance efficient health service delivery; and ensuring adequate drugs, material and equipment for service delivery, are the eight immediate objectives proposed to be achieved. Moreover, the HMP aims to develop the primary health care system to provide appropriate care and services to deal with new challenges, such as NCDs and care of the elderly. In addition, an appropriate referral strategy (including admission and discharge policies) is proposed to be introduced to ensure that patients receive treatment at the most appropriate level, including home-based care, when and where appropriate.

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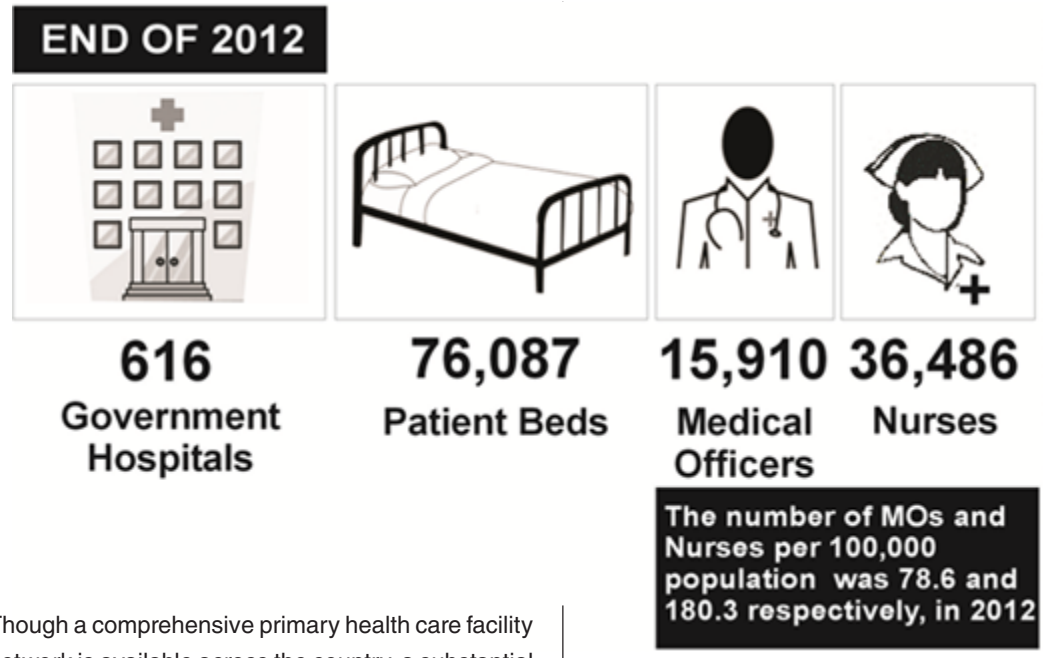
9 Ministry of Health (2008), "Annual Health Bulletin 2008", Ministry of Health, Colombo.

10 Hsiao, W., (2000), "A Preliminary Assessment of Sri Lanka's Health Sector and Steps Forward", Institute of Policy Studies of Sri Lanka, Colombo.

11 *Ibid.*

12 Ministry of Healthcare and Nutrition (2007).



Though a comprehensive primary health care facility network is available across the country, a substantial number of patients bypass these and seek treatment at secondary and tertiary health care institutions, even though they have to travel considerable distances at great expense and inconvenience. Bypassing of primary health care institutions is mostly done because of the erroneous belief that the outpatient treatment in the secondary and tertiary institutions is superior to those in the periphery.[13] Some deficiencies in facilities and services in the primary health care institutions is another reason. Noticeable disparities in facilities in terms of infrastructure, equipment, human resource, etc., make the level of care vary, attracting patients towards the tertiary facilities at the expense of under-utilization of primary health care services.[14] Overcrowding of secondary and tertiary health care institutions, a problem which the public health system currently faces, is exacerbated when primary health care institutions are bypassed, creating an unnecessary burden on higher level facilities.

Provision of quality public health service has become a priority need, especially in the context of an increasing tendency to invest in quality assurance mechanisms by the private sector.[15] The poor state of infrastructure and equipment, unreliable supply and quality of drugs, shortcomings in waste management and infection control, poor performance of personnel because of low motivation or insufficient technical skills, and severe underfinancing of essential operating costs of health services are seen as the main contributory factors for the poor quality of the health care.[16]

Further, continuous upgrading of the health care delivery system is needed in order to face emerging health challenges (such as NCDs, accidents and injuries, long-term care, suicides, homicides and other violence) as well as emergency situations (such as outbreaks of diseases/viruses like Dengue,

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[13] Fernando, J., (2011), "The Urgent Need for a Well-planned Referral System for Health Care Delivery in Sri Lanka", *Sri Lanka Journal of Medical Administration*, Vol. 13.

[14] IPS (2007), "Access to Health Care" in *Sri Lanka: State of the Economy 2007*, Institute of Policy Studies of Sri Lanka, Colombo.

[15] Rishad, M.H.M. and S.S. Kodithuwakku (2008), "An Assessment of Health Service Quality: A Case Study of a Teaching Hospital in Central Province of Sri Lanka", *Tropical Agricultural Research*, Vol. 2, pp. 251-259.

[16] *Ibid*.

Ebola and Avian influenza A(H7N9) and disasters like floods, tsunami, etc.).

The macro-organizational structure of the health care system affects the efficiency and quality of health services. Restructuring of the macro-organizational framework to improve efficiency and equity by splitting outpatient and inpatient services, reclassification of existing health care institutions, and reallocation of resources in order to enhance equal facilities at outpatient services throughout the country are some of the recommendations to enhance the health care service delivery.[17] Strengthening the primary health care delivery institutions and mechanisms is one of the priority areas that should be addressed immediately, when assuring a delivery of quality health care service. A well-planned referral system for health care delivery is needed in reducing the unnecessary cost burden on the secondary and tertiary health care institutions. Further, revitalizing primary health care should be done to address the issue of bypassing primary health care institutions.

9.3.2 Physical and Human Resource Allocation

An adequate health workforce which is committed and motivated, and which has the required public health and clinical competencies is seen as a must for the effective functioning of the health system. The number of different types and categories of health workers and their proper utilization is equally essential for better functioning of the health system, as is the provision of an enabling working environment and proper supporting logistics. Recognizing the importance of maintaining the efficiency of resources, the National Health Policy of 1996 adopts "allocating resources between provinces/districts based on their health needs and national priorities" and "supporting and strengthening human resource development in keeping with contemporary needs" as key strategies to raise the health status of the population. The 2007 HMP also identifies improving health financing, resource allocation and utilization as one of its main strategic objectives.

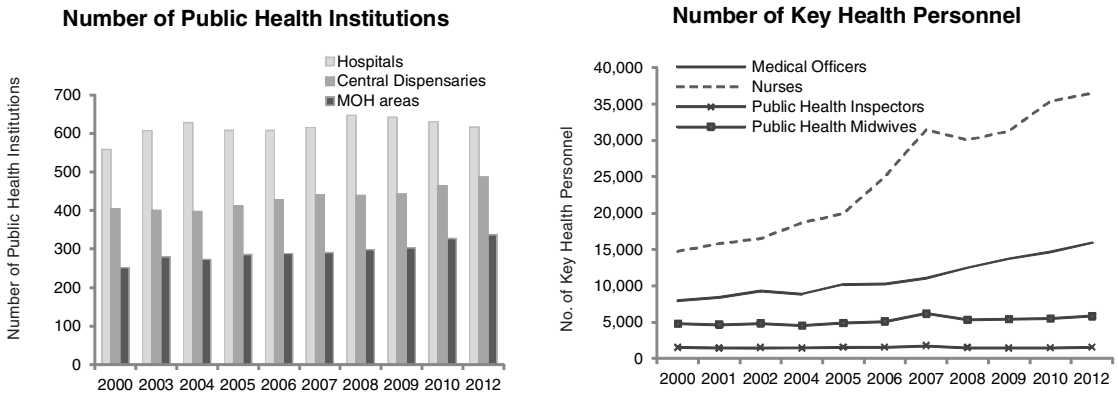
Over the years, an absolute increase could be observed in physical and human resources in the public health care sector (Figure 9.3). A growth can be observed in the number of public health institutions, number and types of facilities available, and number of health personnel employed in the health sector. The HMP estimates that the necessary number of hospital beds for Sri Lanka by 2015 is about 60,000. The country's health system was able to reach that by 2005. The latest available figures show that the country's total bed capacity has reached to 76,087 by 2012.[18] At present, however, the size and the quality of the health manpower are

A well-planned referral system for health care delivery is needed in reducing the unnecessary cost burden on the secondary and tertiary health care institutions.

[17] Mahipala, P.G. (2011), "Public Health Interventions Then and Now: How They Will Shape the Future Health System in Sri Lanka", *Sri Lanka Journal of Medical Administration*, Vol.13.

[18] Ministry of Health (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

Figure 9.3
Physical and Human Resources in Public Health Care (2000-2012)



Source: MOH (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

inadequate in many areas, especially in rural and estate areas.[19]

Although the numbers related to human and physical resources have increased, the country is still lagging behind global averages for most of the indicators related to health workforce and infrastructure indicating a dearth of resources in the health sector. According to the indicators listed in Table 9.1, Sri Lanka has a long way to go before reaching global averages, apart from the indicator on 'hospital beds per 10,000 population'. Sri Lanka records 36 hospital beds per 10,000 population where the global average for the same indicator is 27.

Despite the fact that resources have increased over the years, regional disparities in the distribution of physical and human resources remain.[20] The available evidence suggests that both health personnel and facilities are insufficient to screen patients and refer to special care facilities as needed. There is a high concentration of medical facilities,

Table 9.1
Health Work Force and Infrastructure

	Sri Lanka	South East Asia	Global
Physicians per 10,000 population (2006-2013)	6.8	5.9	14.1
Nursing and midwifery personnel per 10,000 population (2006-2013)	16.4	15.3	29.2
Dentistry personnel per 10,000 population (2006-2013)	0.8	1.0	2.7
Pharmaceutical personnel per 10,000 population (2006-2013)	0.4	3.8	4.3
Psychiatrists per 10,000 population	<0.05	<0.05	0.3
Hospital beds per 10,000 population (2000-2012)	36	10	27
Radiotherapy units per 1,000,000 population (2013)	0.1	0.3	1.8

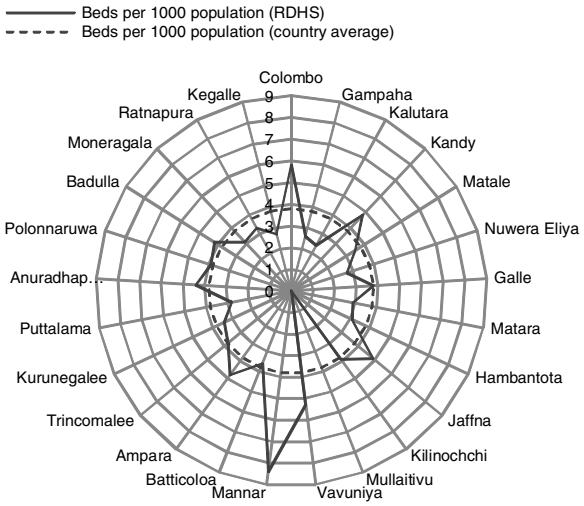
Source: WHO (2014), "World Health Statistics", World Health Organization, Geneva.

[19] *Ibid.*

[20] IPS (2011), "Education and Health Services for Sustainable Growth" in *Sri Lanka: State of the Economy 2011*, Institute of Policy Studies of Sri Lanka, Colombo; UNDP (2012), *Sri Lanka Human Development Report 2012: Bridging Regional Disparities for Human Development*, United Nations Development Programme, Colombo.

[21] *Ibid.*

Figure 9.4
Distribution of Beds per 1,000 Population by RDHS Division (2012)



Source: MOH (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

Although the numbers related to human and physical resources have increased, the country is still lagging behind global averages for most of the indicators related to health work force and infrastructure indicating a dearth of resources in the health sector.

even basic facilities like patient beds, MOs and nurses in metropolitan areas, especially in Colombo (Figures 9.4 and 9.5).

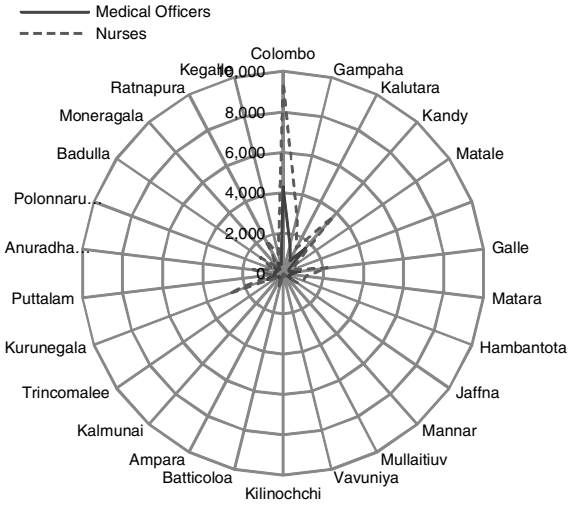
Absenteeism of doctors and other health personnel is another human resource issue, as is encouraging doctors to serve in remote areas. The latter requires the provision of essential facilities (e.g., accommodation and transportation facilities) and incentives such as being afforded priority when selecting for fellowships and training.

9.3.3 Public Health Sector Management and Monitoring

As a result of the implementation of the Provincial Councils Act in 1989, the public sector health system in Sri Lanka has a decentralized structure for providing health care. The MOH operates at the national level while separate provincial ministries of health operate across provinces of the country. The key responsibilities of the MOH include setting policies and guidelines, promoting medical education, managing specialized medical institutions, and purchase of medical requisites. The Provincial Directors of Health Services (PDHSs) are mainly responsible for the implementation and management of health care services.

Despite decentralization, the health system is centrally dominated by the MOH. For example, the Provincial Councils to a large extent are dependent on the central government for block transfers to finance health expenditure. There is a lack of an objective and transparent measure of population needs for the allocation of provincial funds and there is no clear link between the level of financing and performance and outcomes. Furthermore, the public servants employed at Provincial Councils depend on the central government for career promotions, etc., which increase their allegiance to the centre rather than the local area. This has resulted in a

Figure 9.5
Distribution of Key Health Personnel by RDHS Division (2012)



Source: MOH (2012), "Annual Health Bulletin 2012", Ministry of Health, Colombo.

lack of accountability of health officials towards their local citizens.[22]

Since most of the authority lies with the central government, it causes duplication and inefficient use of public resources. In order to rectify this situation, the government needs to: a) clearly define the role and responsibility of the national government, and b) clarify what is expected of its decentralized units. The central government should be explicitly responsible for public sector regulation and managing tertiary care hospitals. With regard to managing non-tertiary hospitals and primary care, what is important is to link financing with performance and targets, and tie responsibilities to decision making authority.

Even though centralization of government funds is prevalent, this in itself is not problematic. What should be changed are the terms on which funds are allocated to Provincial Councils. Grants should be given based on the needs of each individual provincial government. It should also be directly linked to specific targets and individual performance. Furthermore, with regard to hospitals, what has proven to work internationally is to allow the administrators of each facility the flexibility and responsibility to maintain quality and efficiency and manage human resources.[23] In order to manage human resources effectively, the roles, responsibilities, individual performance targets, and lines of authority and accountability need to be clearly defined. Performance evaluation needs to be carried out so that incentives and rewards are attributed accordingly. Each province should be reviewed for their achievements and drawbacks; annual reports should be produced on the progress and challenges faced by each council in order to ensure transparency and accountability.[24] Furthermore, to measure effectiveness and efficiency of the health care model, Sri Lanka should also adopt a well-designed management information system (MIS). An MIS in health care is a specially designed information system that aids in managing and planning health care programmes.[25] It will help health care managers shift towards an evidence based decision making process. Since different levels of administration within the system have different roles and responsibilities, different data needs should be identified and collected. Afterwards, such data should be linked to local community, demographic and epidemiological information to respond to different local needs effectively.

[22] World Bank (2006). "Service Delivery and Decentralization in Sri Lanka: Assessment and Options", World Bank. Colombo.

[23] *Ibid.*

[24] Ministry of Healthcare and Nutrition (2007).

[25] WHO (2004), "Developing Health Management Information Systems: A Practical Guide for Developing Countries", World Health Organization, Geneva.

9.4 Private Sector Health Care Reforms

9.4.1 Provision of Health Services

During the past two decades the private sector has grown rapidly, with expansions in hospitals, laboratories and clinics. Over 100 private hospitals, with investments of over Rs. 50 billion, entered the health care sector between 1990-2013.[26] The demand for private sector health care has increased rapidly due to reasons ranging from improvements and investments in health technology in the private sector, and poor public sector performance. The private out-of-pocket expenditure of households in 2009 was about 45 per cent of total heath expenditure and 83 per cent of total private health expenditure.[27]

Sri Lanka's private health care sector is predominantly engaged in providing curative care services such as laboratory tests, medication, surgeries, and nursing care. In 2009, 51 per cent of total health expenditure was spent on curative care.[28] Moreover, private facilities are disproportionately concentrated in the Western Province in urban or semi-urban areas due to its higher income level and population density. For example, approximately 50 per cent of private hospitals are in Colombo, while the rest are scattered across a few districts such as Galle, Kurunegala and Kandy; in a review of four District Secretariat (DS) areas it was found that three-fourths of such facilities were located in close proximity to government hospitals.[29]

It is always the poorest (in rural areas) that suffer most from the limitations (limited curative care, drugs shortages, limited availability of specialty treatment) of the public sector. Even though the private sector is able to compensate for these limitations, it is evident that the supply of private facilities does not necessarily expand in order to address these limitations. To overcome the drawbacks in each sector independently, public-private partnerships (PPPs) can be considered as a solution.

9.4.2 A Role for Public-Private Partnerships

Public-private partnerships in the health care sector in Sri Lanka are minimal. Almost all of the private health facilities are owned and operated by private persons or organizations; a small fraction (about 3.5 per cent) of medium scale private hospitals are partly foreign owned/operated.[30] Furthermore, the government provides only minimal support for private participation in public health programmes. For example, during 2007-2010, only 25 per cent and 10 per cent of reviewed private facilities received financial and technical assistance, respectively, for programmes on childhood vaccination; similarly, only 25 per cent and 8 per cent, respectively, received financial and technical support for antenatal care.[31]

Given that Sri Lanka has an ageing population, it is bound to face an increase in demand for acute care. Since acute illnesses are predominantly treated in public facilities, it will add further pressure to an already overburdened public sector. For example, it was reported that over 5,000 patients are on the waiting list for heart surgery.[32] Similarly, it is expected that the demand for certain services such as diagnostic testing in the private sector will increase due to a reduction in public financing in

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[26] Dayaratne, G.D. (2013), "Private Hospital Health Care Delivery in Sri Lanka: Some Issues on Equity, Fairness, and Regulation", Institute of Policy Studies of Sri Lanka, Colombo.

[27] *Ibid.*

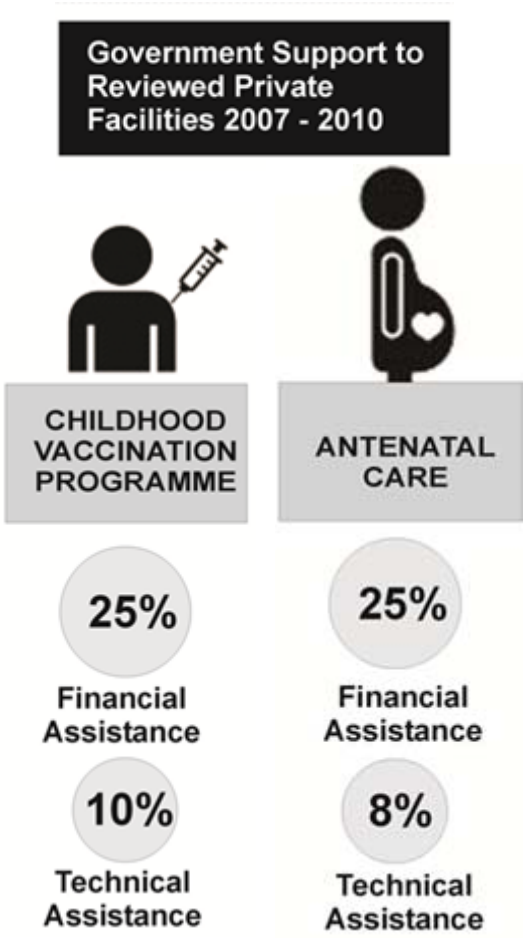
[28] Govindaraj, R., *et al.*, (2014), "Health Care in Sri Lanka. What Can the Private Health Sector Offer?", Health, Nutrition, and Population (HNP) Discussion Paper, World Bank Human Development Network (HDN).

[29] *Ibid.*

[30] *Ibid.*

[31] *Ibid.*

[32] The Island (2013), "*Over 5,000 on Waiting List for Heart Surgery*", *The Island* http://www.island.lk/index.php?page_cat=article-details&page=article-details&code_title=74821 *[accessed 27 April, 2015].*



such areas. However, the private sector has limited capacity to provide diagnostic services.

In light of this evidence, it is counter-intuitive for the two sectors to operate independently. Public-private collaborations will help alleviate capacity constraints; improve equity and efficiency due to synergies between public and private sectors through pooling of resources such as funds and technology; improve access and reach of health care services for the population; and strengthen regulation of quality within the health sector.

One option is for the government to contract with private providers to deliver health services in remote areas.[33] If, through public funding, the private sector can expand coverage it will result in improved efficiency and effectiveness. Initially, the country can start pilot operations in a limited geographical area to benefit from economies of scale and concentrate in an area with poor health indicators. Bangladesh, Cambodia and India are examples of countries that have used such contracts. A second option is to implement demand-led financing strategies such as vouchers; the government provides a demand side subsidy to ensure that private health services are more affordable to vulnerable groups. It also acts as an inducement to the private sector to provide services in areas they might not have considered before. Nicaragua is a country that has successfully implemented such a strategy. It is important to note that implementing such options requires an increase in public sector financing. Strategies on improving financing were discussed in an earlier section (Section 9.2.1).

9.4.3 Incorporating Elements of Patient Centred Care

The private sector is heavily reliant on the public sector for the supply of doctors. Government doctors are permitted to work in private facilities provided that they have completed their official hours. Only 700 medical doctors were employed full time in the private sector in 2011.[34] There is a potential conflict of interest that arises from this form of dual practice. Since many people seek out private care based on the belief that it is of superior quality, it can potentially influence the quality of care provided by the private practitioner; they might give preferential treatment to a private client compared to one seeking care in the public sector.[35] The potential negative effect of working double the hours (official duty hours in the

[33] Harding, A., (2009), "Partnerships with the Private Sector in Health: What the International Community Can Do to Strengthen Health Systems in Developing Countries", Center for Global Development, London.

[34] Govindaraj, R., *et al*., (2014).

[35] Dayaratne, G.D. (2013).

Public-private collaborations will help alleviate capacity constraints; improve equity and efficiency due to synergies between public and private sectors through pooling of resources such as funds and technology; improve access and reach of health care services for the population; and strengthen regulation of quality within the health sector.

public sector and off-duty hours in the private sector) on a doctor's performance also cannot be ignored. Additionally, since most private practitioners consult at more than one hospital per day, they invariably appear late to consultations because: a) private hospitals are scattered across Colombo, and b) they are held up in previous consultation rounds. This has led to an increase in patient waiting times at private hospitals. Many patients end up waiting more than what they consider to be an acceptable waiting time at private hospitals; in fact, some wait over 20 minutes for a scheduled appointment when they believe that an acceptable waiting time is only 5-10 minutes.[36]

One way around such limitations is to have a permanent cadre of medical specialists in private hospitals. Also, one method to ensure that quality is not compromised is to be more responsive to patient expectations (patient centred care). Currently, Sri Lanka's private sector is doctor-centric.[37] Patient centred care requires acknowledging and incorporating patient needs, values and choices in the service delivery system. Regular evaluation of patient satisfaction by conducting surveys is a step in this direction. It will also signal to the consumer that their considerations are taken into account and that the private sector is committed to ensuring value for money for the services they provide.

9.4.4 Regulation

In 2006, the Private Medical Institutions (Registration) Act (PMIRA) came into effect with the aim of regulating private medical institutions in Sri Lanka. Under the PMIRA, all private medical institutions are required to obtain a Certificate of Registration. Furthermore, the PMIRA established the Private Health Services Regulatory Council (PHSRC), an independent statutory body that is primarily responsible for licensing, regulating and monitoring private medical institutions.In addition, the PHSRC gathers information and data on quality assurance and service standards which are subsequently used to grade the performance of private medical institutions. Private medical

[36] Samarakoon. S., (2015), "Patient Waiting Times in Private Hospitals: A Growing Concern in Sri Lanka" http://www.ips.lk/talkingeconomics/2015/01/07/patient-waiting-times-in-private-hospitals-a-growing-concern-in-sri-lanka-2/, Institute of Policy Studies of Sri Lanka, Colombo.

[37] RAM Ratings (2013), "Private Pills for Public Pains: The Private Health Care Sector of Sri Lanka", Ram Ratings (Lanka) Ltd., Colombo.

providers, the central government, Provincial Councils and other professional body representatives form the PHSRC. As a result of the Act, private sector regulation is outside the domain of the MOH.

Existing evidence, however, point out that the regulatory system is functioning sub-optimally. Though the basic purpose of the PHSRC is registering and licensing private medical providers, it has failed to register and/or license a large number of institutions.[38] The body has been ineffective in implementing a system to monitor the registration status of medical providers. Though the PHSRC has a database on registry of licences, it has not been able to gauge the number of currently registered providers or the number of renewed applications each year. There is also a lack of follow-up action such as warnings, suspensions or cancellation of licences against providers who fail to renew or obtain licences. In the absence of strict legal enforcement, there is no incentive for medical providers to comply with rules and regulations. For example, a study that mapped four DS areas in the country, found that 68 per cent of reviewed private health facilities were not registered with a relevant authority.[39]

A regulatory body should ideally be independent, unbiased and transparent. However, the PHSRC allows direct involvement of private medical providers in the regulation process when such providers are essentially those that are to be regulated by the PHSRC. As a result, this could potentially increase the risk of regulatory capture. Moreover, the PHSRC suffers from understaffing and underfinancing. For example, in 2012 only two full-time employees were employed to carry out the basic functions. This is in stark contrast with Malaysia where the licensing unit for private medical providers employs 62 staff members - a number deemed insufficient by Malaysian experts.[40] Given that the demand for private sector health care is increasing, it is imperative for Sri Lanka to strengthen private sector regulation to maintain quality standards.

One option is to benchmark Sri Lanka's regulatory system against other comparable countries in the region. This would require returning the regulatory functions of PHSRC to MOH, mirroring the scenarios in countries which have similar institutional backgrounds (Singapore, Malaysia, Hong Kong) or level of economic development (Thailand). As depicted in Table 9.2, compared to these countries, it is only in Sri Lanka that the regulatory body is not independent of private medical providers, regulation lies outside of the MOH, and private hospitals do not have a strict requirement to report patient data annually. Such features point to the relatively weak performance of the regulatory body in comparison; for example, the effectiveness of licensing in Sri Lanka is only 48 per cent for 2011 while it is full or near full in other comparable countries.

If the country is to retain the PHSRC, a second option would be to reinforce its regulatory effectiveness. This can be implemented by: a) limiting or eliminating private sector provider representation within the PHSRC, and including representatives from the Independent Medical Practitioners Association, Attorney General's Department appointed by the Minister to the Council and Sri Lanka Medical Association; b) training and strengthening the regulatory capacity of officers in charge. It is imperative to train and appoint more persons in charge of the PHSRC to carry out the necessary regulatory mechanisms. In terms of regulatory capacity, according to the PMIRA, only the Provincial Directors of Health Services (PDHSs) or their deputies are permitted to carry out inspections and investigations of private medical providers. These appointees, however, have limited authority compared to the Deputy Director Generals

[38] IHP (2012). "Private Health Sector Review", IHP Technical Reports Series Number 2, Institute for Health Policy, Colombo.

[39] Govindaraj, R., *et al*., (2014).

[40] Rosnah, N.R., *et al*., (2011), "Impact of the Private Health Care Facilities and Services Act 1998 (Act 586) and Regulations 2006 on the Medical Practice in Corporate Private Hospitals in Malaysia", *International Journal of Sustainable Development*, 2 (9):89-106.

Table 9.2
Private Health Sector Regulatory Characteristics of Select Countries

Regulatory characteristic	Sri Lanka	Singapore	Malaysia	Hong Kong	Thailand
Responsible authority for regulation	PHSRC (independent body outside MOH)	MOH	MOH	DOH (Health Ministry)	MOPH (Health Ministry)
Responsible authority for regulation and licensing	PHSRC (independent body outside MOH)	MOH	MH	DOH (Health Ministry)	MOPH (Health Ministry)
Independence of regulatory body from private sector	No	Yes	Yes	Yes	Yes
Requires license to operate	Yes	Yes	Yes	Yes	Yes
Effectiveness of licensing	48% (2011)	100%	>98%	100%	>90%
Statistical reporting requirements of private	None	Annual patient statistics; patient morbidity and mortality every 3 months	Annual patient statistics	Annual patient statistics including mortality	Annual patient statistics returns

Source: IHP (2012), "Private Health Sector Review", IHP Technical Reports Series Number 2, Institute for Health Policy, Colombo.

(DDGs) of the central government. Therefore, uniting the PDHSs and their deputies with the DDGs in the form of joint regulatory teams will strengthen regulatory functions.

In addition, a committee should be appointed to handle the problems private providers face at the registration stage. This would also entail that private providers are supported in areas where they may need assistance. It is important to implement this committee at a high level of government to strengthen the regulatory process. Adequate financing should be allocated to the regulatory body to carry out their roles and responsibilities effectively. It would also help in maintaining an accurate and complete health information system within the sector.

9.5 Drug Policy

9.5.1 Evolution of Sri Lanka's Drug Policy

In 1957, led by Senaka Bibile, a National Formulary Committee (NFC) was set up as the apex body with a mandate to manage the whole spectrum of pharmaceutical preparations. Subsequently, the 'Ceylon Hospital Formulary' was prepared which recommended 600 selected drugs with their generic names. Price control of medical drugs under the Control of Prices Act No. 29 of 1950 was another milestone in the process of drug policy evolvement. In 1971, confronted with a trade deficit and import restrictions, the government called for an assessment of the pharmaceutical system and proposals for its future development, without compromising on accessibility and availability of drugs within the country. The resultant 'Bibile Report' was considered the pioneer in drug policy not just nationally but also internationally.[41] With the change in economic policies and liberalization of imports in 1977, the few proposals of the Bibile Report that were implemented started to be diluted. Price controls by the government were removed and drug promotion was allowed. Though the State Pharmaceutical Corporation (SPC) continued, it ceased to be the sole importer of drugs. Consequently, thousands of drugs with a variety of brands flooded the country since the private health sector as well as private

[41] Siribaddana, S., and A. Sumathipala (2005), " Essential Drugs, Senaka Bibile and Sri Lanka: Rejoinder to a Eurocentric Debate Led by WHO on the TRIPS Agreement", Technology Innovation Group, (3)3.

Box 9.1
Health Care Reform for the Elderly

Sri Lanka is known as a country which advanced well in its demographic and epidemiological transition and it was among the first developing countries to achieve below replacement level fertility. A decline in fertility rates, rising life expectancy at birth, and increasing out-migration (particularly among the younger group) are the main contributory factors behind the demographic transition in Sri Lanka.

The National Health Policy of 1996 identified health problems of the elderly as a priority area which need focused attention. The Presidential Task Force which was appointed in 1997 to formulate a health policy and identify the strategies to address health problems and issues of the country specifies "expanding the services to areas of special needs" as a priority issue, where the elderly health care is identified as an area of special needs. Identifying the elderly as a vulnerable group as well as a challenge to the health system, the HMP of 2007 aims to expand health care services and training in the area of geriatric medicine to meet the emerging health care requirements of the elderly.

Sri Lanka has to face a number of challenges with population ageing such as social protection to the elderly, ageing of the labour force, rising demand for geriatric care, and institutional capacities to take care of the elderly. Elderly people demand health care and treatment more than younger people. The pattern and causes of their illnesses also differ (e.g., Alzheimer and dementia), requiring special care and geriatric treatment that can be costly. Further, the elderly are more vulnerable to chronic illnesses such as heart diseases, stroke, lung and liver diseases, cancer, asthma and rheumatism, as well as degenerative diseases like hypertension, diabetes, cancer, etc.

With the increasing number of elderly, the demand for intensive diagnostic tests, long-term hospitalization and better treatment as well as rehabilitation and social and clinical therapy will go up. Further, geriatric health care needs special medical training and skills. In order to meet this demand, the country's health service should be well equipped with required resources - both financial as well as non-financial resources.

However, it is questionable whether the country would be able to cater to the increasing demand for elderly care with current resource allocations. Under the current system, it is difficult to identify the health expenditure for elderly separately as the government provides free medical treatment for all, irrespective of age. However, the comparatively low budgetary allocation for the health sector would be a barrier in meeting the rising demand for geriatric health care, while maintaining standards in maternal and child care. To address this dilemma, strengthening geriatric health care investments by increasing the overall budgetary allocations for the health sector seems inevitable. Better provision of long-term care by both public and private sectors, and re-orientation of preventive and promotive care to cater to the health needs of the elderly are other pressing areas requiring policy attention.

Source: IPS (2014), "Demographic Challenges of an Aging Asia" in Sri Lanka: State of the Economy 2014, Institute of Policy Studies of Sri Lanka, Colombo.

pharmaceutical companies had the liberty to import drugs directly. Also, thousands of private pharmacies opened across the country and sold drugs on a prescription or on over- the-counter basis.

The Cosmetics, Devices and Drugs Act No. 27 of 1980 came into operation in 1986 with a Technical Advisory Committee. However, this was not adequate to act as a central regulator of medicinal drugs management from pre and post stages. In 1989, the Fair Trading Commission Act introduced a maximum retail price, and a price formula to which the SPC as well as private sector importers had to conform. Two National Medicinal Drug Policies were

Box 9.2
Salient Features of the Bibile Report

Introducing a single purchasing agency for the country: The report proposed the public sector to act as a sole importer, and distributor of approved drugs by the formulary for the country. Further, bulk purchasing was also recommended to reduce taxes and alter the mark-ups which reduce the cost of pharmaceuticals.

Establishment of the SPC: In 1971, the SPC was established under the Industrial Corporations Act No. 49 of 1957. The reason was to transfer the monopoly of pharmaceutical trade to the government. This reduced not only the outflow of foreign exchange, but also the financial burden on patients.

Reduction of numbers of medicines imported and expansion of quality testing facilities: Formulations imported to the country in the 1970s reduced from 3,000 to 800. When limiting the varieties of drugs, price variation of drugs can gradually go down. This can then meet the availability and affordability criteria. But to meet the quality of drugs, accredited lab facilities had to be set up within the country, as proposed.

Mandatory use of generic names in import and prescription: Thousands of non-essential drugs in different brand names imported to the country could be reduced with the introduction of mandatory use of generic names in import.

Expansion of local manufacture: As an outcome of the report, the State Pharmaceutical Manufacturing Corporation (SPMC) was set up in 1986, managed by the SPC.

Change drug information system: Under this, advertising medicinal drugs was proposed to be stopped, and preparation of formulary notes made available to all medical practitioners was recommended.

Changes in patent law: This allows purchasing drugs from the process patent holders where drugs are cheaper than that from the product patent holders. However, whilst drugs are currently being imported from cheaper sources to reduce drug costs, it can lead to poor quality in some instances.

Source: Siribaddana, S., and A Sumathipala (2005), "Essential Drugs, Senaka Bibile and Sri Lanka: Rejoinder to a Eurocentric Debate Led by WHO on the TRIPS Agreement", Technology Innovation Group, 3(3); Abeykoon, P. (2012), "A Long history of NMP: Where are We Now? The Sri Lankan Experience" http://www.apcnmp2012.com.au/images/P6-ABEYKOON.pdf.

drafted in 1991 and 1996, but did not proceed to the stage of Cabinet approval.

Whilst medicine shortages in government hospitals were frequently reported, no proper planning and management was taken to remedy the situation. In 2005, Cabinet approval was finally given to a National Medicinal Drug Policy (NMPD). Allopathic medicine was the main concern of this policy, and policies for other systems of medicines are to be developed later. Ten years on since Cabinet approval, the National Medicinal Regulatory Authority Bill (NMRA) was approved in March 2015 to serve as an umbrella to facilitate the implementation of the NMDP.

The NMDP focuses on the following areas: a) ensure availability and affordability of efficacious, safe and good quality medicines relevant to the health care needs of the people in a sustainable and equitable manner; b) promote the rational use of medicines by health care professionals and consumers; and c) promote local manufacture of essential medicines. The policy was framed within the overall health policy of the country based on the 'essential medicines' concept. It focuses on the health sector but includes coordination with relevant areas such as education, finance, agriculture, animal husbandry, pharmaceutical industry and trade, and acts to safeguard the rights of the patients/consumers.

9.5.2 Implementing National Medicinal Drug Policy

Successive governments in Sri Lanka have provided health care over the decades without a proper drug management system. This happened not because of unavailability of a policy, but due to poor commitment to implement the drug policy which was introduced in the 1950s. Use of poor quality drugs by state hospitals is frequently reported. Inadequate capacity to align with international standards by the National Drug Quality Assurance Laboratory (NDQAL) is the foremost cause. On the other hand, more than 15,000 drugs are reportedly flooding in to the country because of the absence of a drug formulary. With limited capacity, it is impossible for the NDQAL to check all such drugs. Accordingly, reducing the variety of imported drugs can make room for the NDQAL to test for quality assurance. Therefore, the country should commit to select essential drugs, and increase the capacity of the NDQAL further.

Another issue is that more than 25,000 pharmacies have been established in the country very rapidly. Many do not hold licences, and dispensing of drugs is not done by trained pharmacists. Therefore, a proper regulatory system should be formed to regulate and monitor pharmacies consistently.

Price control of drugs is another area which requires urgent action. As per the last price formula by the Fair Trading Commission in 1989, the maximum retail price should not be more than 65 per cent of the cost at which the drug is imported. However, usage of this formula has been inactive since 2002, and since then no price formula has been introduced. Therefore, price variation of drugs in the market at present is immense. Hence, a pricing committee to be appointed under the NMDP should consider the CIF value of the drug, the company's profit margin and the commissions to be paid to the agents and pharmacies in determining the price.

9.6 Conclusion

With the onset of the demographic and epidemiological transitions, it is apparent that the organization, delivery and regulation of Sri Lanka's health sector needs to be strengthened. Greater resources need to be brought together from the public and private sectors for prevention and control of NCDs, increase efficiency and effectiveness, and ensure consumer satisfaction. Mechanisms such as increasing excise duties on harmful products such as tobacco, alcohol and even fast food need to be considered in order to increase health care financing. It is imperative to consider donations and social health insurance as alternative financing mechanisms as the country moves towards the future. Moreover, in order to strengthen financing, especially in the public sector, Sri Lanka should continually measure performance against set targets so that financing and planning are used to the best effect.

Within the public sector, it is necessary to continually upgrade the health care delivery system to be able to meet not only emerging health challenges such as NCDs but also emergency situations such as outbreak of viruses, and disaster situations (tsunamis, floods, etc.). Some possible recommendations to improve the delivery system include: a) restructuring of the macro-organization framework so as to enhance efficiency and equity; b) reclassification of existing health care institutions; and c) reallocation of resources in order to improve equal facilities at outpatient services across the country. Sri Lanka also needs a clearly defined referral system to reduce the cost burden on secondary and tertiary institutions. Gaps in the primary health care system need to be revitalized to address the issue of bypassing primary health care institutions. Providing essential facilities such as accommodation and transportation, as well as training to doctors is equally important to encourage doctors to serve in the underserved parts of the country.

It is clear that both the private and public sectors have drawbacks when considered independently. Sri Lanka could benefit immensely if it benchmarks countries in the region (e.g., India, Bangladesh) that have successfully implemented public-private partnerships in the health sector. Possible options include: a) government contract with private providers with the aim of providing private health services in remote areas; and b) implement demand-led financing strategies such as vouchers where the government provides a demand side subsidy so that vulnerable groups are better able to access private health services. The private sector also needs to ensure that patients' perspective is better incorporated in the health care delivery model. Long waiting times, for example, is a trend that is of growing concern in Sri Lanka. Implementing strategies to regularly evaluate patient satisfaction will help understand what gaps in the delivery model need to be addressed. Private sector regulation reform is of utmost importance due to its current lack of effectiveness. The regulatory council, PHSRC, is independent of the MOH. Returning the regulatory functions back to the MOH (as is the case in other countries with similar backgrounds) is an option that needs to be considered. Alternatively, the effectiveness of the PHSRC needs to be reinforced by limiting private sector provider representation, and training and strengthening the regulatory capacity of officers in charge.

With regard to the drug policy, it is necessary for Sri Lanka to commit to select essential drugs so as to avoid the influx of many drugs and to maintain quality assurance. Implementing a proper regulatory system to manage importation of drugs is important in this regard. It is also necessary to regulate the pharmacies to ensure they are licensed and trained to dispense drugs appropriately. Price control of drugs is another vital area to be addressed; a committee should be appointed to determine prices rationally.

Greater inter-sectoral collaboration, therefore, will help the health sector of Sri Lanka face the imminent challenges.

Important influences that affect the health of a population and health inequities across a country are sometimes outside the health sector. Therefore, it requires the health sector to collaborate with other sectors of government (education, finance and planning, pharmaceutical industry, etc.) to address health needs. Greater inter-sectoral collaboration, therefore, will help the health sector of Sri Lanka face the imminent challenges.