
The Private Sector and Health Services Delivery in the EAP Region:
Background Report to UNICEF on the Role and Experiences of the Private Sector in
Provision of Child Health Services

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Table of Contents

I	Introduction	3
II	Non-State Actors and the Convention on the Rights of the Child	7
III	EAPR Overview	9
	Supply	9
	Demand	9
	Financing	11
	Consolidation and Interpretation	12
	Legislation and Regulation	15
	Programmatic Initiatives	15
IV	Country Case Studies	19
	Cambodia	20
	Philippines	26
	Vietnam	30
	Mongolia	33
	Indonesia	39
	Fiji	43
V	Issues and trends in policy and regulation	48
VI	Framework	50
VII	Conclusion	57
	Appendix A: List of Persons Contacted	58
	Endnotes	60

I Introduction

This report is designed to serve as a foundation for future activities to improve the healthcare available to children in the East Asia and Pacific Region (EAPR). The focus of this report is the role of the private sector (non-State actors), both for profit and nonprofit, in the provision of healthcare services in the Region. It places particular emphasis on services and commodities relevant to the health of poor children, and on the options available to governments to address different aspects of private provision. To illustrate, the report provides an overview of the role of the private sector in health systems in the region; an introduction to the kinds of programs, policies, and activities that are currently having an effect on privately provided healthcare including their relative importance; and recommends a typology of private sector options available to countries in the region.

In preparing this report we have focused on the tools that are available to government to improve the quality, affordability, and accessibility of privately provided healthcare to the poor. To illustrate, the report includes examples of how governments can and do partner with private sector actors to the benefit of poor children. In each example, the authors have looked at the levers governments use to work with existing private sector actors where such collaboration seems appropriate. Throughout the report we focus primarily on three countries, Vietnam, Cambodia, and the Philippines, as ‘case studies’ of collaboration between the public and private sectors. Experiences from these countries are augmented with examples of private sector activities in Indonesia, Fiji, and Mongolia.

A number of academic papers and reports developed for national governments, The World Health Organization (WHO), the World Bank, the Asian Development Bank (ADB), or other international agencies, have already described the role of the private sector and countries’ experience of public-private collaboration. This literature provides evaluations of specific programs and policies that affect the availability, cost, and quality of privately delivered healthcare ⁽¹⁾. Innovations in health service provision have been studied elsewhere as well (e.g. Janovsky and Peters’ WHO working paper on improving health services and strengthening health systems⁽²⁾). This report builds upon both country-specific assessments and cross-country documentation of innovation, most of which are focused on public-private initiatives. The focus is on the EAP region, with a practical emphasis on the options available to government in responding to specific features of the large and growing private sector in the region.

Finally, within this context the authors present a framework for national governments to decide amongst a wide range of options. This important process begins with an assessment of a country’s own capacity to collaborate and manage or regulate, and within that context, to select those options that are most appropriate at a specific point in time.

Methodology

The information used in this report was collected using a number of methods. National and regional data on the use and financing of private healthcare was collected from international surveys, most importantly Demographic Health Surveys, World Health Surveys, and National Health Accounts data compiled by WHO. Country- and program- specific data comes from these sources as well as from academic studies, published and ‘gray’ literature, internal reports made available to us by numerous organizations, and available evaluations of programs involving the private sector. This information was augmented by a number of face-to-face and telephone interviews, and through the authors’ first-hand knowledge of countries and programs.

Context

Group	Private Sector Scale and Role	Countries
1	Private sector provides more than half of all health services. Important for primary care services. Provides some to majority of secondary and tertiary (hospital) care. For-profit private sector much larger than NGOs.	Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, Vietnam
2	Private sector is small, providing less than half of health services. NGOs and FBOs provide a significant proportion of private sector health care .	Fiji, Kiribati, Marshall Islands, Micronesia, Papua New Guinea, Solomon Islands, Timor-Leste, Tonga, Vanuatu
3	Private sector exists in specialty areas (e.g.: dental care) and within structural arrangements in which government is an active partner.	China, Mongolia

The EAP region consists of 21 countries in Southeast Asia, East Asia and the Pacific Islands. The principal health challenges, particularly child health challenges, vary significantly among countries within the region. Yet many of the countries share the double-edged sword of high levels of both communicable and non-communicable diseases. The importance of the private sector to healthcare provision ranges from high to very low among three categories that correspond broadly to the geographic segmentation of the region: Southeast Asian Countries (excluding Papua New Guinea), Pacific Island Countries (plus Papua New Guinea), and the Countries of Northern East Asia.

Group One countries have significant for-profit private sector participation in provision of health services, especially at the primary care level, and often at secondary and tertiary levels. The

importance of non-profit healthcare organizations varies between countries, but is in most cases modest relative to the role of the for-profit private sector. Group Two countries have low levels of private sector participation. However the private sector activity that does exist is primarily non-profit. It is often linked to faith-based organizations (FBOs). Corporate provision of health care tends to occur in the context of corporate social responsibility, or is provided by other non-profit actors. Group Three countries have considerable private sector participation in health provision. However, what private services are provided tend to be at the tertiary level, and within specific sub-specialties (e.g.: adult dental care). Private providers in Group Three countries are typically managed more actively by the state than their counterparts in other EAPR countries.

A second important factor or dimension associated with each of the three groups is the extent to which healthcare is funded by private expenditure – people paying directly for healthcare services, as opposed to healthcare funded by Government. Where the private sector is known to play an important role in provision (in Group One countries above, for example) the level of out-of-pocket payments is a helpful indicator of the social impact of private provision for the following reason: Where healthcare services are obtained from the private sector, it is usually the case that patients have paid directly for their healthcare, through “out-of-pocket” payment [with the exception of Mongolia]. This is because out-of-pocket payments are the primary means of payment available: in nearly all countries in the region private or corporate health insurance coverage is minimal. Therefore private expenditure on health consists almost entirely of out-of-pocket expenditure. Out-of-pocket payments for healthcare are typically made directly by the patient (or their relatives) to a provider at the point of care. A high level of out-of-pocket payments is therefore a significant predictor of household impoverishment resulting from illness.³

Policymakers must therefore appraise possible private sector initiatives on two dimensions: 1. the potential for improved provision/access, especially for the poor; and 2. their impact on private expenditure levels – especially expenditure that causes distortions that may further disadvantage poor families.

Consideration of private sector engagement in the abstract is useful, but has limited practical value. In practice the private sector encompasses a wide range of actors from faith-based organizations to pharmaceutical manufacturers, to informal drugs sellers in village markets. Current mechanisms used to engage the private sector in healthcare, and to meet Governments’ health goals, span an equally broad range, from legislation and regulation, to better enforcement of laws at local and national levels, changed incentives, purchasing, and formal collaboration (such as contracting). The attractiveness, feasibility and outcomes of these options will always depend on the political and institutional environment prevailing in each country at a given point in time.

This report isolates and analyses discrete options for governmental engagement with the private sector. It is designed to assist national level authorities to set priorities and design and implement

concrete actions involving the private sector, where action is merited. The framework for action is based upon the models of interaction already underway within the region, albeit sometimes on a modest scale. The steps taken by each country will require significant preparation, and will be specific to each nation. In common, however, are the twin foundations for future government action vis-à-vis the private sector:

1. First, an understanding of the scale and nature of the sector and its importance for health service delivery, and
2. Second, an assessment of the risks – technical, financial, political, and for the community – involved in engagement with the private sector. Among these risks is the risk to access and equity for the poor, and especially poor children, the main focus of this report.

Given the challenges to child health in the region, and the importance of the private sector to the provision of healthcare, a decision on whether or not to engage deliberately with the private sector should be considered by national governments on a regular basis. The decision should be based on the best data available, and continuously monitored and assessed. Actions should be taken on the basis of need, capacity, feasibility, benefits and risk.

II Non-State Actors and the Convention on the Rights of the Child

UNICEF is quite rightly concerned with inequalities in access, cost, and quality of medical care and health outcomes between the rich and poor. Use of private sector providers is nearly always linked to out of pocket payments, and the quality of care is likely to be lower in poorer areas where lower-level providers work. Thus equity concerns are justified now, and in considering what health care the private sector may offer in future. This report does not explore this issue in depth because the available data does not allow us to say anything conclusive. A recent UNICEF-commissioned situational analysis on health equity in Vietnam, and others like it, has had to rely on regrettably sparse data on the private sector. Consequently, that report, and others like it, observes: "...little is known about the total size of the private sector,"⁴ and proceeds to review service-provision equity issues based almost exclusively on public sector data.

The private sector provides a very significant proportion of health services to the poor in most EAP countries. It remains unclear to what extent this is "good" (because the private sector is filling an important gap) or "bad" (because of cost, quality issues and equity). As noted in the UNICEF Vietnam report cited above, in most instances, even where detailed country-specific analysis of health equity has been done, the lack of information on the private sector precludes meaningful appraisals. A recent meta-analysis of healthcare interventions involving the private sector indicates that regardless of the equity issues arising from current private healthcare provision in low- and middle-income countries, a number of interventions appear able to improve overall equity of healthcare access generally, and specifically access to healthcare provided in the private sector⁵. The absence of more accurate, reliable, and comprehensive situational and outcomes analysis data on the private sector in EAP, remains a major impediment to assuring equity of care. Lack of information leads to a continuing inability to analyze and appraise the current and potential role of the private sector. As a result there is an important need to focus resources on better capturing the role and potential impact of the private sector in healthcare in EAP, and to build sound policy and programs upon this foundation.

Two UNICEF policy frameworks are relevant to the current situation of non-State actors in health throughout the region, and were used as background to this report. First, the Convention on the Rights of the Child is a central UNICEF policy framework⁽⁶⁾. In parallel, UNICEF has also adopted a formal position in relation to engagement with the private sector. The chief concerns about non-State actors' involvement in health and other social services raised in these framework documents are: degree of affordability, universality, and regulation⁽⁷⁾. These three issues arise repeatedly as policy themes in the case studies of private sector involvement in EAPR.

Of special relevance is UNICEF's observation on the role of Regulation:

*Since in most countries there is a for-profit sector already in place, its proper role, behaviour, and complementarity with public provision of services need to be addressed. Its quality, minimum standards, and staff qualifications need to be legislated in order to further the protection of child rights. It should be highlighted that a one-size-fits-all approach will usually not apply and there might be various alternative ways to engage the private sector, or some of its elements, depending on different circumstances in different countries. **This raises governance questions about how to make the assessment of those circumstances, and who will make it, as well as about the various ways to engage and regulate the private sector.** ⁽⁸⁾*

A recent and more in-depth UNICEF paper on Government engagement with Non-State providers contains both a philosophical discussion and extremely practical guidelines for assessing the extent to which initiatives sponsored by Non-State providers contribute to three simple but ambitious goals of child well-being in EAPR. The thrust of this paper can be translated into action by asking, of any proposed non-State initiative: ‘Does this initiative help to “Respect”, “Protect” and “Fulfill” the health needs of poor children?’⁽⁹⁾ If yes, how will it work? How much difference will it make?

Discussions with UNICEF have underscored the challenge of ensuring that private sector engagement results in genuine improvements in health outcomes for children. For instance, while it may be argued that in many instances merely improving access to health care through the private sector is beneficial in itself, the services provided may not necessarily attain a level of quality sufficient to generate significant and lasting health outcomes. Access and quality are both essential, though it is typically much easier to increase access than to monitor and ensure quality.

Most analyses and evaluations of public-private partnerships focus on assessing risk to the major stakeholders – those who may benefit from, or be disadvantaged by, the initiative. From UNICEF’s perspective, it is important to appraise risk to communities, not just the financial, technical and political risks that may be borne by Governments and non-State actors who are to provide healthcare.

III EAPR Overview

The importance of the private sector for health can be measured in three dimensions: supply, demand, and financing. Of particular significance for UNICEF and for EAPR governments is the importance of the private sector to the poorer segments of society, those most at risk. Not only do the poor have inequitable access to quality healthcare, there is also evidence that they are further disadvantaged by the lack of financing alternatives. As explained previously, out-of-pocket payments by the poor are regressive charges, with poorer patients paying both higher rates for goods and services and a higher percentage of their household income for medical goods and services.

Supply

The principal measures of private sector healthcare supply include: the number of private hospitals, clinics, nursing homes, and outpatient clinics; the number of private hospital beds; the number of private pharmacies, drug shops, and drug sellers; and the number of medical personnel at each level of specialization: doctors, physician's assistants or clinical officers, nurses, pharmacists, and lab technicians. From the total numbers the more useful ratio of private to public in each of these areas is, in theory, calculated.

In the EAP region supply measures are largely unavailable, apart from data on formal private pharmacies, tertiary hospitals, and other higher-tier formal facilities. At the level of individual providers, the data are imprecise because of the "dual-practice" by medical practitioners throughout the region. That is, it is commonplace for practitioners simultaneously to hold jobs in the government and private sectors. It is estimated that as many as 70% of all government-employed physicians in Indonesia also work in private practice ⁽¹⁰⁾.

Equity and health service supply for the poor is especially difficult to measure in countries where a high proportion of care is provided by unlicensed or informal practitioners. These providers, variously called traditional healers, 'northern medicine' practitioners, rural medical practitioners, quacks or informal medicine sellers, are common in many countries in the region. By and large, they are also uncounted.

Demand

Demand data is usually the accurate and readily available nationally representative information, and is found in Demographic and Health Surveys, National Health Surveys, other national household survey data. Demand data utility may be limited because most surveys do not differentiate amongst the goods or services purchased from the private sector. While over the counter pharmaceutical purchases are extremely important in many countries, and may represent 60% or more of total expenditure on health, these expenses may or may not be subsequent to interaction with a clinical practitioner who in turn may or may not be in the private sector.

Variability in the reporting of consultations, clinical care, and pharmaceutical sales are a factor limiting the reliability and comprehensiveness of most surveys.

Despite these caveats, demand data is usually the best information available to measure the significance of the private sector in the provision of healthcare. In the absence of other measures demand data can be used as a proxy for the private healthcare sector, with the important caveat that purchase of pharmaceuticals often are a substitute for healthcare services from trained professionals, used in place of ‘primary health care’ where such services are either not available or not affordable – or where families cannot afford both care and drugs and opt for pharmaceuticals. This often cannot be differentiated through existing data and therefore needs to be inferred or explored in complementary sources.

Table 1: EAPR Country Total Health Expenditure (THE) Sources

* OOP = Out Of Pocket expenditure by private households

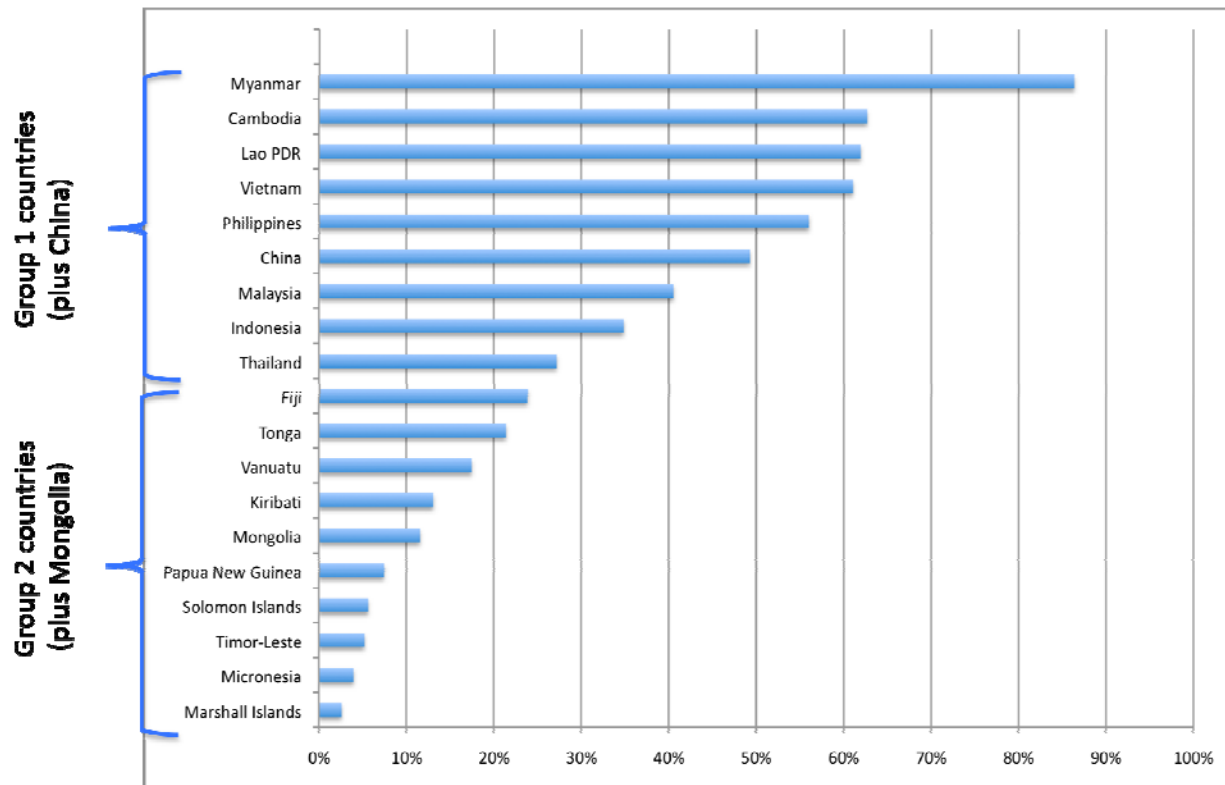
	THE as % of GDP	Government Expenditure as % of THE	External Resources as % of THE	Private Expenditure as % of THE	OOP as a % of Private Expenditure
Cambodia	5.9	26	22.2	74	84.7
China	4.6	40	0.1	59.3	83.1
Fiji	3.7	69.8	2.1	30.2	79.1
Indonesia	2.5	50.5	2.2	49.5	70.4
Kiribati	13.1	86.9	0.4	13.1	100
Korea DPR					
Lao PDR	4	18.6	12.9	81.4	76.1
Malaysia	4.3	44.6	0	55.4	73.2
Marshall Islands	14.4	97.4	66.1	2.6	100
Micronesia	13.3	96	57.1	4	100
Mongolia	5.7	73.7	1.5	26.3	44
Myanmar	2.2	13.1	11.2	86.9	99.4
Papua New Guinea	3.2	82	11.2	18	41.5
Philippines	3.8	32.9	2.9	67.1	83.5
Solomon Islands	5.1	91.5	18.8	8.5	66.7
Thailand	3.5	64.5	0.3	35.5	76.6
Timor-Leste	17.7	86	44.9	14	37.2
Tonga	4.9	74.6	34.4	25.4	84.2
Vanuatu	4.1	65	8.8	35	50
Vietnam	6.6	32.3	2.2	67.7	90.2

Source: WHO, 2006 National Health Accounts Data: <http://www.who.int/nha/country/en/index.html>

The importance of private household spending on health, measured as a percentage of Total

Health Expenditure (THE) is shown for EAPR countries in Table 1, above.

Medicines make up between 9% (Solomon Islands) and 41% (in Vietnam) of all spending on health. In Group One countries, where the private sector is known to be large, it is likely that this spending is primarily out-of-pocket payments by individuals, and therefore a regressive charge on the poor.



Source: WHO, 2006 National Health Accounts Data: <http://www.who.int/nha/country/en/index.html>

Figure 1: Out of Pocket Payments as a % of Total Health Expenditure (NHA data)

Financing

Healthcare financing is captured by the individual countries in National Health Accounts (NHA) data. Much of this data has been consolidated by WHO (see Table 1, above). Although the quality of data is often variable, repeated measurements using similar criteria allows trend analysis of both source of healthcare financing and where financing is directed. Other sources also exist for some of this information. Prime sources include household expenditure data from Demographic and Health Surveys (DHS) and National Health Surveys. In addition, country specific data collection is often supported by the World Bank and national statistics and accounting offices.

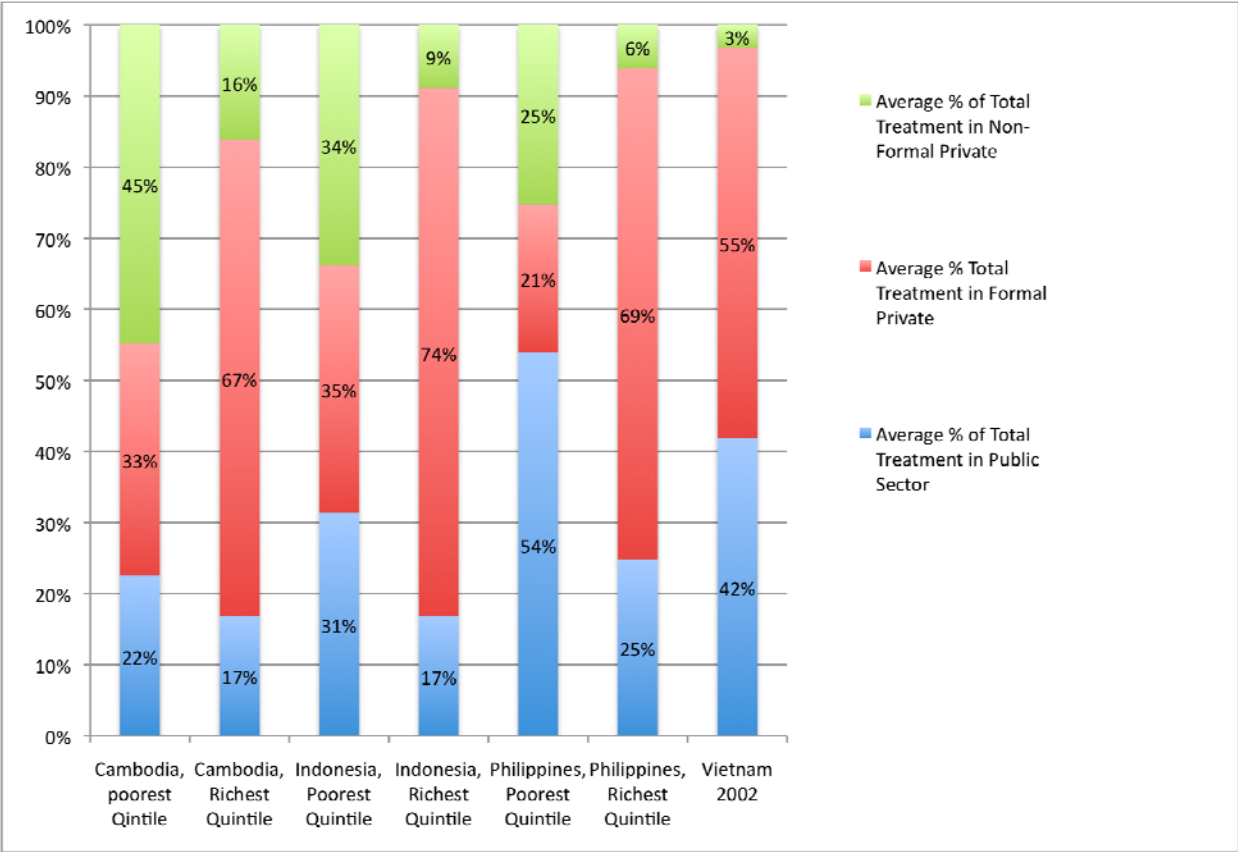
Consolidation and Interpretation

Developing a true picture of the importance of the private sector to health and healthcare in any country requires a multi-faced understanding of what goods and services are provided, to whom, and at what cost. While the ideal remains a comprehensive and nuanced analysis of supply, demand, and financing data, quite a lot can be learned from currently available information.

DHS data gathered in the past six years exist for four countries in EAPR (Cambodia, Indonesia, Philippines, Vietnam). Because children fall ill more often than adults, the DHS question on source of treatment asks, of families with children and for which the children have fallen ill in the two weeks prior to the survey, where the children were taken for treatment. This information is therefore ideal for the purposes of UNICEF, since it focuses on the child population.

DHS data is disaggregated by income quintile. However for the question on source of care some quintiles were not surveyed, so only the aggregate data can be used. For the other three countries, the data from richest and poorest quintiles is shown below (Figure 2).

The aggregate data for Vietnam, shown to the right in Figure 2, provides similar numbers and it is probable that the income breakdown, if it could be calculated, would also show similar use of private sector among both rich and poor.



Source: DHS Data (Cambodia 2005; Indonesia 2007; Philippines 2003; Vietnam 2002)

Figure 2: Source of healthcare by income quintile. (DHS data)

DHS data can be used to disaggregate, quantify and interpret the impact of ‘public’, ‘private-formal’ and ‘private-informal’ treatment on households in different quintiles. As Figure 3 shows for Cambodia, private treatment represents above 80% of care for both rich and poor children. However for poor families ‘private’ largely means treatment (medication and advice) obtained from shops. This pattern is repeated in all other countries for which this data is available, including for the Philippines and Indonesia. A reasonable interpretation is that while the poor and the wealthy are both likely to seek care from the private sector as opposed to patronizing government facilities, the each receives a vastly different type of care. By and large the wealthy seek formal care, from hospitals, doctors, or pharmacies. In contrast, the poor are likely to go directly a shop, a traditional healer, or a private doctor. If they do seek care from the formal private sector they will most likely turn to a private pharmacy or a shop. A quite plausible interpretation is that patients, especially poor patients, are self-treating with advice from shopkeepers or pharmacists.

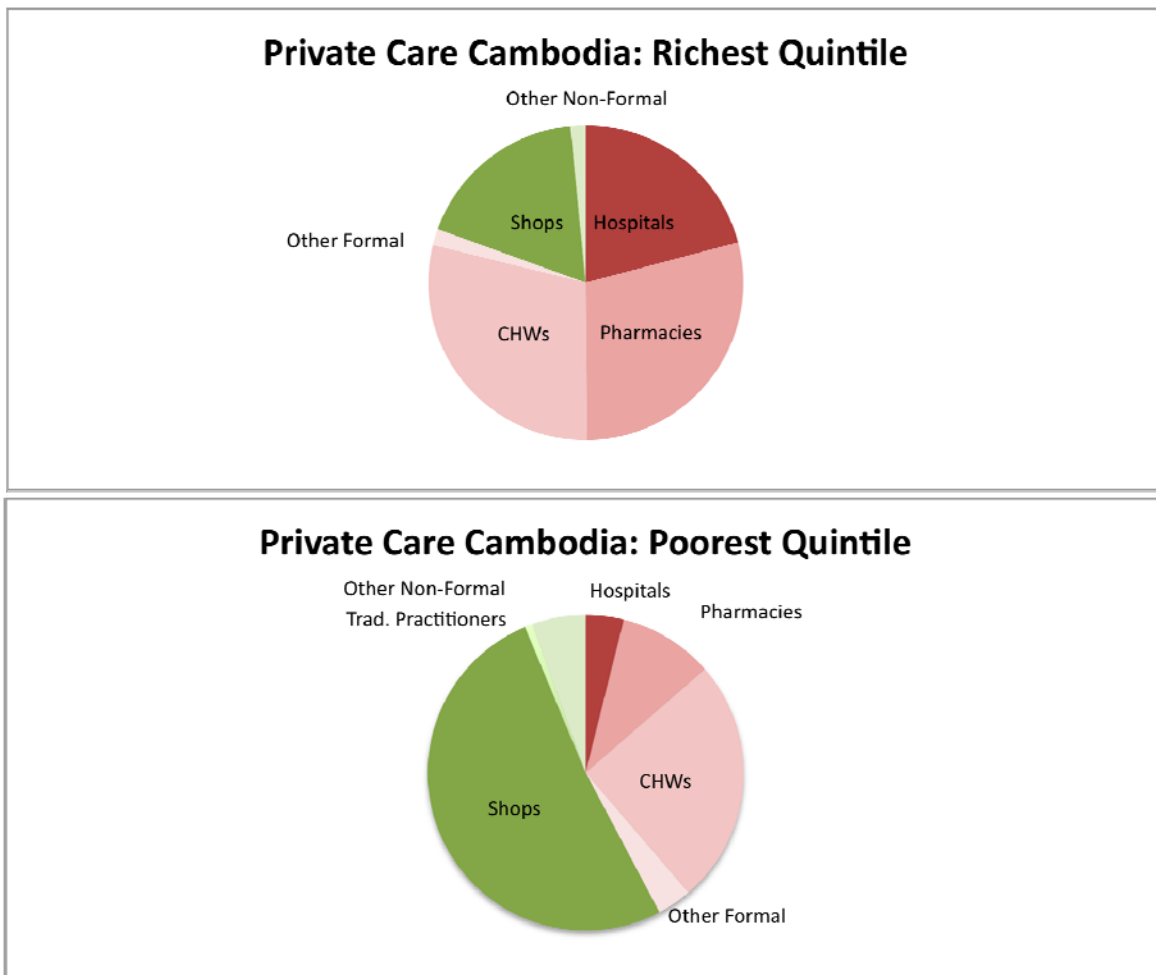


Figure 3: Source of Private Treatment in Cambodia, by Income Quintile

(DHS 2005 data)

This is not inherently a problem: in OECD countries most colds and sore-throats are treated through self-medication with lozenges or drugs purchased from shops or pharmacies. The challenge for EAPR governments is that if the burden of childhood diseases is significant, then self-treatment with medicines from shops or pharmacies may leave the poor beyond the reach of government programs that seek to address these diseases through traditional national health delivery systems. In addition, where shop attendants are not trained to provide accurate and relevant advice, the poor in EAPR countries may receive medication but not appropriate advice, and, in some instances, inappropriate or even harmful medication and/or advice.

World Health Survey data also provides some information on the scale of private sector utilization. Where this information overlaps with DHS data (Philippines and Vietnam among EAPR countries) the two roughly correlate, but WHS data indicates higher use of public facilities. (Table 2) This is likely an effect of the emphasis on in-patient care in WHS questions, and the recall bias that would support this (WHS asks where adult respondents have gone for care in the past 12 months, whereas DHS questions concern treatments of children in the past 2 weeks).

Demand data from both sources show that private care is extremely important in EAPR, for both rich and poor populations, and that for poorer populations the source of care is likely to be the less formal private sector sources of health care. Furthermore, levels of provision for the poor are lower across both formal and formal provider types.

	Cambodia	Indonesia	Philippines	Vietnam
WHS Q6564				
% Public			70.8%	58.4%
% Private			29.2%	41.6%
DHS				
Average % of Total Treatment in Public Sector	22.1%	28.8%	47.6%	41.8%
Average % of Total Treatment Private Sector	77.9%	71.2%	52.4%	58.2%

Table 2: Comparison of DHS and WHS measures of source of care
*(DHS Data: Cambodia 2005, Indonesia 2007, Philippines 2003, Vietnam 2002;
 NHA Data from WHO 2006)*

Financing data from National Health Accounts (NHA) analysis underscores the importance of private provision. Table1 shows NHA summary data compiled by WHO on the source of financing for healthcare in EAPR countries. While the correlation between private out-of-pocket expenditure and private provision is confounded by other factors (notably private expenditure in public facilities) the relationship is clearly causal: The high rates of private expenditure in Group One countries (Southeast Asia excluding Papua New Guinea) is likely to be related to the importance of the private sector as a source of treatment.

Likewise, in Group Three countries (Pacific Island Countries plus Papua New Guinea), quite low levels of private financing for healthcare are most probably indicative of the lesser importance of

private provision within these countries.

Country specific data, where it exists, supports these findings. In Indonesia, for example, private expenditure for health more than tripled throughout the 1990s (Marzolf, 2002), rising to 70% of total health expenditure by 1998 (ibid), in line with NHA results. In Vietnam, the large role of the private sector has been well documented (Ha et al. 2002) and the implications, particularly concerning self-medication, are well documented and well understood by academics and government (Nguyen et al. 2009). Similar data exists from other countries in the region.

Legislation and Regulation

Government policies aimed at addressing the high level of private provision of health care in countries in the region have been many, and varied. They typically aim to ensure effectiveness of private sector healthcare services by assuring quality, affordability, and accessibility of medical treatment, especially for poor children. By and large the effectiveness of these policies is unsubstantiated by evidence. Legislation and regulation varies from outdated and not relevant to the forms and scale of private sector healthcare provision by the private sector, to updated, but not affordable or feasible to enforce, with some notable exceptions.

Programmatic Initiatives

As illustrated by the program case studies in Section III of this report, a large number, and wide range, of initiatives are currently being undertaken by EAPR governments and non-profit organizations to collaborate with the private sector as a means to improve health and healthcare. Evidence presented in Patouillard 2007, Bennett et al. 2005; Smith et al, 2002, IHSD 2002 and others can be summarized as follows: The variety of interventions available to improve the effectiveness or quality of private providers, or to increase the coverage and availability of goods or services of high priority to public health, is broadly agreed to include the programs focused on provision or ‘supply-side’ interventions, or ‘demand-side’ interventions. In practice many programs incorporate aspects of both demand and supply actions, and increasingly programs are linking to financing and risk-pooling initiatives as well. Commonly identified interventions are listed in the box below.

Common Interventions Used in Work with the Private Sector for Health

- Social marketing
- Social franchising
- Vouchers
- Insurance
- Accreditation
- Certification
- Contracting
- Output Based Aid
- Purchasing
- Provider Training
- Patient Education
- Manufacturer-based supplements
- Manufacturer-based product subsidies
- NGO and FBO direct provision of care

Nearly all of the program types above exist, in one form or another, in the EAP region.

Social marketing programs use commercial marketing techniques to make subsidized products available more widely. The programs are most commonly used to distribute and promote products such as contraceptives, oral rehydration salts, and insecticide-treated bed nets. Social marketing programs are common throughout the region, often supported by governments, and often undertaken by local and international NGOs in most countries in the region.

Social franchising programs resemble social marketing, in that they, too, apply models of for-profit service franchising to social ends. Social franchising programs focused on clinical family planning services, malaria treatment with ACTs, tuberculosis diagnosis and treatment, safe delivery, and identification and management of STDs, exist in Cambodia, Indonesia, Philippines, and Vietnam. In Vietnam one particularly innovative social franchising initiative (see the *Tinh Chi Em* case in Section 3) is a collaboration between government and a private NGO. More traditionally, social franchising programs organize private doctors, nurses, or midwives into networks, branding, training, and supporting them in a range of ways to provide services they would otherwise not have offered.

Voucher payments are a way of subsidizing a specific service, or a targeted population, by providing a ‘cash-equivalent’ voucher that can be exchanged for the good or service. Vouchers are currently being used to subsidize payment for care in programs in, at least, Myanmar, the Philippines, and Vietnam.

Insurance or risk-pooling is practiced in many countries in the region. Recent innovations in expanding insurance to parts of the private sector include the Philippines, PhilHealth program, which provides reimbursement to private midwives for safe deliveries, and to private lung specialists for treatment of TB. Many other exciting social health insurance programs exist (note Vietnam’s new Health Insurance for the Poor program) however the target is usually government providers or clinics and expansion to private providers is generally limited.

Accreditation of hospitals takes two forms: 1. as full facility accreditation of quality, assured by an objective outside entity, and comparing the facility to a range of equivalent facilities; and 2. as a single-topic certification of quality. The first type of accreditation has some similarities to ISO 2002 certification of quality processes, and is common in all wealthy countries; in the US the accrediting agency is called the Joint Commission (JCAHO). An accreditation body exists in Malaysia, the Malaysian Society for Quality in Health, but not in any other EAPR countries to date. The second type of accreditation is exemplified by UNICEF’s Baby Friendly Hospital program.

Certification of providers, clinics, hospitals, and most other actors in medical care provision (e.g. labs, blood banks, etc) is the norm across EAPR. Certification is usually a one-time process following opening of a facility, or graduation from medical training for individuals, in which

governments confirm, and ‘certify’, that the facility or individual meets the standards necessary to practice medicine. Re-certification, made conditional on individuals securing Continuing Medical Education (CME) credits, is being considered in some countries of the region but is not widely practiced.

Contracting for health services by governments can take different forms, including ‘contracting out’ to suppliers or providers of clinical services outside of government and ‘contracting in’ for external agencies to manage services within government facilities. Both were carried out between 1999 and 2003 in Cambodia in large geographic areas with the support of the World Bank and the Asian Development Bank. See Case Study in the Cambodia section below.

Output Based Aid(also often known as Output Based Assistance, Performance Based Financing, or Pay for Performance) is being applied in EAPR primarily through voucher programs (see above) although performance based incentives have been used with varying degrees of formal structure in many countries. Current incentives, or bonus packages, are used with government staff in a number of countries.

Purchasing of externally provided services such as transport, laundry, cleaning, or a host of other goods and services, differs from contracting in that it is limited in duration and entails lower risk and limited commitment by either party.

Provider training, to increase the counseling capacity, interest, or skills of private practitioners, has been undertaken in large programs in Indonesia, and in a host of smaller interventions in Cambodia, Vietnam, and Laos. It has also been incorporated into other multi-faceted programs in Myanmar and the Philippines. Evidence from a number of countries suggests that provider training alone is rarely sufficient to change practices. However, with repeated training interaction and some modicum of external incentives (through demand creation for example) new practices can be successfully adopted by providers.

Patient Education programs have been successful in limited ways, in a number of countries. Most programs have linked education to new supplies of treatment goods or services (through social marketing for example), or to large-scale media campaigns (e.g.: accident prevention programs).

Manufacturer-based supplements have, as the case study from Fiji shows, been highly successful in a number of programs around the region. Iodized salt has also been widely adopted and highly effective in reducing incidence of goiter.

Manufacturer-based product subsidies have been little used until now. However it is expected that Cambodia will be one of the first countries to be supported by the Affordable Medicines Facility-malaria (AMFm) with manufacture-based product subsidies for any treatments anywhere in the country.

NGO and FBO direct provision of care exists in limited degrees in Indonesia, Papua New Guinea, and some island states, but remains relatively minor compared to the scale of the markets in the region.

IV Country Case Studies

The aim of this section is to explore the opportunities and experiences of a representative number of countries. An equally important objective is to examine major types of private sector initiatives with the potential to improve the health of poor children. Not all of the case studies describe programs that have as their sole or even principal aim the needs of young children. This is deliberate: one of the challenges nations face in the increasing involvement of the private sector is whether or not to attempt to align these initiatives with Government goals and targets in child health, and, if so, how to achieve this. Both child-focused and general initiatives should be considered according to their outcomes on the well-being of poor children, without limitation. Thus a further aim of this section is to extract the benefits of experience obtained in various countries – “Lessons Learned” – while recognizing that and specific initiative may not be applicable to different contexts.

Six countries are examined in more detail in this section. For each country a succinct overview is followed by one or two case studies illustrating the engagement of non-state actors (the private sector) in support of the health of poor children. Each overview covers the nation’s health context, including Burden of Disease; the current health care system; the current role of the private sector; health care funding and expenditure; and policies and regulation concerning the private sector, including policy trends.

Three countries are examined in greater depth (Cambodia, Vietnam, and the Philippines), and three more for programmatic examples of public-private collaboration (Fiji, Indonesia, and Mongolia). The aim is to illustrate the importance of private provision of health services used by the poor, the context in which this occurs in EAPR countries, and the innovations used today to address these issues depth. The six countries profiled and the 12 case studies provide an overview of what can be done to effect private healthcare provision, how, with what consequences – and what actions are incumbent on Government to assure that productive partnerships with the private sector develop and benefit the poor.

Cambodia

In the last fifteen years Cambodia has made significant progress toward the Millennium Development Goals for health. These achievements stem from innovations in healthcare delivery, financing, and organization led by the government in collaboration with local and international NGOs, supported by a number of bilateral and multilateral donors.

Within the EAP region, Cambodia has the highest rates of infant mortality, maternal mortality, and HIV/AIDS deaths, and the lowest immunization rates and life expectancy⁽¹¹⁾. It is one of the few countries within the EAP region where the burden of communicable diseases remains more significant than the burden of non-communicable diseases. Of the 58% of the total disease burden attributed to communicable sources, major contributors include respiratory infections (12.7% of total disease burden), peri-natal conditions (12.5%), diarrheal diseases (8.0%), HIV/AIDS (5.4%), and tuberculosis (4.6%). Non-communicable disease accounts for 34.4% of the total burden of disease. Among NCD conditions, highest are neuropsychiatric conditions (9.0%), cardiovascular diseases (7.2%), and sense-organ diseases (2.9%). Injuries represent 7.5% of the total burden of disease⁽¹²⁾. Although population health measures are poor in the country, many markers (particularly immunization rates) have steadily improved in the last decade^(13,14,15).

Health financing is sourced primarily from out-of-pocket funds and foreign assistance. Over four-fifths of all money spent in the Cambodian health system originates from out-of-pocket household expenditures^(16,17). Government expenditure on healthcare is only .5% of GDP, putting the government's spending within the lowest quintile of all countries worldwide⁽¹⁸⁾. Foreign NGO assistance is nearly double government spending⁽¹⁹⁾. In spite of this, Cambodia as a whole spends 12-13% of its GDP on healthcare -- the highest rate in Asian developing countries⁽²⁰⁾, all due to private expenditure and informal user fees. Because healthcare payments are primarily out-of-pocket, normal health expenditures can easily tip individuals into poverty. Utilization of health services in Cambodia is, unsurprisingly, low^(21,22).

Cambodia Case Study 1 – Private Sector Distribution of Malarial Diagnostics and Medications

Background

An estimated two million people of Cambodia live within two kilometers of forests where general prevalence rates for malaria are 15-40%. Within this population, children under five are at particular risk, as are forest-workers, primarily young male adults.

The Cambodian government was the first to distribute subsidized artemisinin combination therapy (ACT) and malaria rapid diagnostic tests (RDT) through the private sector, starting with a pilot program in 2000 that was transferred to Population Services International (PSI)/Cambodia in 2003. PSI/Cambodia receives ongoing financial support for programming from the Global Fund for AIDS, TB and Malaria (GFATM). PSI distributes, promotes and socially markets Malarine (artesunate and mefloquine, sold in co-blister packs) and has successfully increased sales from approximately 30,000 units in 2003 to 270,000 units in 2009. In the same ‘family’ brand, PSI also socially markets Malacheck (a rapid diagnostic test kit) and Malanets (family and hammock nets). To encourage responsible and rational drug prescribing, PSI carries out comprehensive trainings of both medical and non-medical providers in 17 of the 24 endemic provinces. Training cover topics ranging from the national guidelines, malaria transmission, high-risk groups, uncomplicated and severe symptoms, correct drug regimens and the dangers of counterfeit malaria drugs and sub-optimal doses. In a supportive umbrella covering its nationwide social marketing programs, PSI designs and launches communications campaigns to raise awareness and change the behavior of the population and providers alike.

Despite these efforts to assure quality of care in ACT provision, an alarming resistance to artesunate (an active derivative of artemisinin) was recently documented in western Cambodia. The poorly regulated private sector, where approximately 70% of fever-sufferers seek treatment, is believed to have contributed to this resistance development by dispensing artemisinin monotherapies and sub-therapeutic doses of artemisinin.

The government reconsiders its use of the private sector in its battle against malaria

While the government considers making public health facilities the main access point for malaria treatment, international support programs are offering new opportunities to test market-based incentives that will compel the private sector to provide optimal malaria care. The Affordable Medicines Facility – malaria (AMFm), working through the GFATM has invited Cambodia (and 10 other countries) to participate in its plan to flood their markets with highly subsidized ACT formulations that are so inexpensive that private sector providers can sell them as profitably as artemisinin monotherapies and other ineffective treatments. In its proposal to the AMFm, the Cambodian government has requested supplies of dihydroartemisinin-piperazine (DHA-PIP)

the new official first line ACT in the region where resistance to artesunate and mefloquine ACT has been confirmed. The new ACT will be co-formulated in a single tablet. The AMFm program requires participating countries to partner with the private sector for ACT distribution.

An Artemisinin Resistance Containment Project, funded by the Bill and Melinda Gates Foundation, is just getting underway in two districts in western Cambodia. A goal of this public-private mix pilot is to help the government and its policy makers identify what incentives are most effective at inducing private providers to carry out best practices. These include testing all presenting patients or customers before selling them ACT or referring them to public health centers. The pilot will also experiment with incentives for collecting and reporting malaria surveillance data to the government by private providers and vendors.

Potential New Roles for PSI/Cambodia

If THE GFATM accepts the Cambodian government's strategy proposal for participating in the AMFm rollout, PSI's role will change significantly. PSI will no longer import ACTs and brand them as Malarine. With the arrival of AMFm drugs, the Malarine brand may cease to exist despite high brand recognition (97% of private providers are aware of Malarine). PSI will also no longer move ACTs down the supply chain with sales and distribution teams. Instead PSI will work with the chosen manufacturer(s) at the top of the supply chain to ensure easy-to-use instructions are applied, with wholesalers (creating "push") to ensure they stock the new ACT, and at the bottom of the supply chain to create "pull" by the outlets. PSI will design and launch supporting communications campaigns to increase consumer and provider awareness of the new drug using every appropriate channel from TV, radio, billboards, inter-personal channels and special events. PSI will also continue running its training programs to inform and change the behaviors of private providers to ensure they are in line with the country's new national treatment guidelines.

Following political democratization in the early 1990s, Cambodia's health system has undergone rapid change characterized by decentralization, privatization, and increased private financing of healthcare⁽²³⁾. In 1994, Cambodia began to decentralize its health services, shifting the jurisdiction of budgeting and implementation of health programs from the central Ministry of Health to district and provincial health departments, and allowing the Ministry of Health to focus on broad policies and selective vertical health interventions⁽²⁴⁾. At present, the decentralized system has variable staffing levels, unclear roles and functions in decentralized parts, a lack of financial transparency, and a recognized need for more effective management⁽²⁵⁾. Differences between the rural and urban health sectors are pronounced within Cambodia: medical human resources are skewed towards large cities and towns, with fewer and lower-quality staff in rural areas⁽²⁶⁾. Utilization is low because user-fees often exceed the financial capability of families⁽²⁷⁾. The private sector provides the main source of care in rural areas.⁽²⁸⁾ In the past, the government has successfully engaged in contracting-out and contracting-in with private sector

health providers in rural provinces to increase utilization by poor patients ⁽²⁹⁾. However these experiments have since ended. The government has acknowledged that contracting arrangements, piloted in a few provinces, are a model for assuring infrastructure and human resource availability, as well as for lowering operating costs to the public health system ⁽³⁰⁾. What this will mean in practice is currently uncertain.

Private provision of care in Cambodia has grown from 66% to 76% between the most recent two DHS surveys ^(31, 32). Shops, community health workers, and pharmacies provide most care ⁽³³⁾, particularly for the poor ⁽³⁴⁾.

Cambodia Case Study 2: Distribution of Diarrhea Treatment Kits through a Private-Public Channel

Background

Less than 20% of Cambodia's rural population has access to a safe water supply. Consequently, diarrhea prevalence for children under five years is 19.5% and diarrhea is linked to 24% of under-five mortality. In 2006, supported by USAID, UNICEF and WHO, Population Services International (PSI)/Cambodia introduced a novel diarrhea treatment kit (DTK) tailored to meet WHO and UNICEF 2004 guidelines. Trademarked Orasel KIT, it includes both low-osmolarity oral rehydration salts (two sachets) and a 10-day supply of zinc tablets. To reach rural areas that could most benefit from the kits, PSI/Cambodia partnered with two local NGOs, Reproductive and Child Health Alliance (RACHA) and the American Red Cross/Cambodian Red Cross. PSI sells the DTKs to the NGOs at a subsidized cost and provides social marketing materials and promotional services, but does not fund these partners.

Sustainable Distribution Channel Uses Private-Public Strategy

Since its establishment in 1996, RACHA has developed expertise in child survival programs (including food fortification, breastfeeding promotion and vitamin A distribution), health promotion, and capacity building for local public health providers. PSI/Cambodia had previously collaborated with RACHA to distribute condoms and contraceptives directly to vendors within RACHA's Village Shopkeeper Network. For the Orasel DTK, RACHA took a different approach and included public health sector personnel within the distribution channels. RACHA works through provincial health departments and operational districts to enable public health personnel to sell kits both directly to clients at local health centers, as well as to local shopkeepers within RACHA's Village Shopkeeper Network. RACHA trains local village health center staff who, in turn, deliver kits to village shops, educate shopkeepers and monitor sales numbers throughout the distribution channel.

With a 33% pass-through profit margin on each unit, the public health workers have a strong incentive to maximize distribution of the kits. The strategy is designed to develop a sense of ownership among the public health workers and thus to create a sustainable distribution channel when RACHA's involvement is phased out. Using this channel, over 26,000 diarrhea treatment kits were sold through 12,013 shops in the provinces of Pursat and Siem Reap during the pilot phase between May 2006 and May 2007. The program was renewed in September 2009.

To date, cooperation among the provincial health departments, operational districts, RACHA and the private shopkeepers has been smooth. One notable conflict of interest has arisen in areas where public health promotion activities to improve awareness of hygiene and sanitation have resulted in lower diarrhea incidence, causing shopkeepers to complain about their decrease sales of DTK.

Legislative and regulatory environment

Cambodia lacks an effective system of regulation for most private providers⁽³⁵⁾. Enforcement of quality standards for pharmaceuticals is limited by the human resource, logistical, and purchasing power limitations of the Ministry of Health. Drug selling shops do not comply with the Food and Drug Department regulations and provide drugs of variable quality⁽³⁶⁾. Only 13 drug inspectors regulate the quality of medicine dispersed in thousands of pharmacies and shops and there are few standards or treatment guidelines^(37, 38). The government regulates health services primarily through contract management and performance monitoring of NGOs⁽³⁹⁾. Under the Ministry of Health's sector-wide management (SWiM), non-governmental health provider interventions must complement governmental disease and intervention priorities^(40, 41). Several umbrella organizations represent domestic and international NGOs in Cambodia as a means to help assure this complementary structure. Since 2004, MEDiCAM has been designated the primary NGO to represent all 112 health sector NGOs in Cambodia and to serve as the link between them and the government^(42, 43). International groups such as the UNFPA have independent representation in meetings and committees⁽⁴⁴⁾ that coordinate the health sector within the country⁽⁴⁵⁾.

Cambodia has yet to establish any significant form of public or private health insurance. In recent years however, several Health Equity Funds have been established to improve access for poor individuals. These funds, wherein a third party NGO pays user fees at a public sector site of service for pre-selected indigent members, have been set up at 26 hospital or health districts, but are reported to have financial sustainability^(46, 47, 48). Nonetheless, the Ministry of Health plans to expand Health Equity Funds countrywide to replace the current exemption scheme for the poor offered by the government in public facilities⁽⁴⁹⁾.

Cambodia Case Study 3 – Contracting primary care service provision to NGOs.

Background

After achieving peaceful self rule and establishing a market economy, by the mid-1990s, Cambodia's public health care system still lagged other developing countries in the provision of basic services such as childhood vaccinations and prenatal care.⁵⁰

The Contracting Experiment

From 1999-2003, supported by the Asian Development Bank, the Cambodian Ministry of Health conducted an experiment to compare the effective and equitable delivery of a standard package of primary care services by private providers versus public providers in nine health districts. International NGOs successfully bid for contracts to provide health services at fixed per capita price. In three districts, NGOs “contracted-in”, using existing government procurement systems and staff. They were empowered to implement user fees to subsidize performance-based monetary incentives for the staff. Incremental management fees were provided by the Asian Development Bank, and all other funds were provided by the Ministry of Health. In two other districts, NGOs “contracted-out” with full liberty to retain or replace staff, raise salaries and expectations for staff attendance, procure supplies and manage health centers. Their funding was provided by the Asian Development Bank.

At the end of four years, it was found that outcomes for seven of eight selected health service indicators (including childhood immunization, administration of vitamin A, and delivery of antenatal care) were superior for contracted districts, compared to the four control government-managed districts. While out-of-pocket private expenditures were significantly reduced in contracted districts by US\$4.50 per capita, the average total per capita spending in these same districts increased by US\$2.50⁽⁵¹⁾.

The future of contracting in Cambodia

The shift of private out-of-pocket spending to public spending benefited the poor in the contacted districts of Cambodia, yet this experiment was conducted with rich subsidies and considerable managerial experience from international NGOs. The Government of Cambodia has not made public statements as to why the program was not continued or expanded. The Ministry of Health currently proposes to test a new version of internal contracting-in within 23 health districts⁽⁵²⁾. In the new model, the district health office assumes the role of the contractor with responsibility for planning, financial and human resource management. The Ministry of Health will implement performance-based funding, monitoring specific outcomes as in the previous pilot program.

Philippines

In the last two decades the Philippines health system has increasingly decentralized, focusing on local health provision and expanded coverage. Most importantly, public healthcare provision has been devolved to local government units in an effort to increase revenue mobilization, reduce access inequity, facilitate local accountability, and encourage efficiency gains through provider choice and competition.⁽⁵³⁾

Private expenditure on health is greater than public expenditure (Figure 5) and the overall level of government expenditure, (6.1% of total government spending) is among the lowest in EAPR⁽⁵⁴⁾. The majority (83%) of private expenditure is out-of-pocket payments⁽⁵⁵⁾. Much of this is spent on pharmaceuticals, and medicines make up 46.6% of total health expenditure – among the highest in the region. Generics represent only 15 to 20% of the market, and distribution is limited to a small number of large private chains⁽⁵⁶⁾.

Philippines Case Study 1: Private Sector Drug Distribution and Retailing

The costs to patients of medicines in the Philippines have been reported to be 3.4 to 184 times higher than international reference prices⁵⁷. For households, drugs and medicines make up 46.4 percent of their total medical care expenditure. To increase access to affordable medicines, the Government of the Philippines has partnered with the private sector to create alternative distribution channels, while applying price regulations.

Harnessing the private sector while controlling the cost of drugs for patients

In 2004, the Ministry of Health initiated its BotikangBayan project which established a franchise of privately owned drug stores, BotikangBayans. The program is operated by the Philippine International Trading Company (PITC), a chartered, government-owned organization. Franchisees receive seed money and training. The PITC designates which drugs are sold at the BotikangBayans and controls the prices at which they are sold. The PITC procures the drugs centrally, using parallel drug importation from India and China as well as from the very small number of local generic manufacturers. There are currently 1,971 BotikangBayans across the Philippines. A second program operated by the PITC relies less on private sector entities, targeting the rural poor through a network of BotikangBarangay (“Village Pharmacies”). These outlets now number 12,814 and are owned primarily by local government units (LGUs) but they are open to ownership by community organizations (including NGOs). They sell a small number of essential prescription medicines and some OTCs as authorized by the PITC.

An alternative distribution channel was established in 2000 as a public private partnership between the Department of Health and the NGO, National Pharmaceutical Foundation (NPH). This partnership operates with support from the German Development Bank (KfW) and the German Development Agency (GTZ). The NPH operates on two tiers, as a wholesale distributor in 27 provinces to BotikangBarangays, LGUs and hospitals, and as the operator of the 575

HEALTH Plus social franchise outlets (targeting the urban poor). They offer quality controlled generic medicines at prices that are fixed and published throughout the country. The NHP situates many of their franchises in poorer areas where commercial pharmacies do not operate.

Challenges remain

NPH still struggles to achieve full cost recovery. While a revolving fund (initially established by KfW) provides capital for drug purchasing, NPH must overcome distrust toward generic medicines by brand-loyal prescribing physicians and their patients. The NGO invests in expensive social marketing programs to raise awareness about value of high quality, low cost generic drugs. It must also invest in training programs for franchisees who lack business skills and knowledge, but who are geographically accessible to underserved, low income communities. NPH loses revenue opportunities to commercial pharmacies because the government regulates it more stringently than it does those pharmacies. For example, HEALTH Plus franchises may sell only prescriptions drugs listed in the national essential medicines formulary. Thus HEALTH Plus may not stock one the most requested drugs in the country because is not included in the formulary. Even minor changes to the formulation or preparation of drugs require that they be dropped from HEALTH Plus shelves if the national formulary is not updated. Sales are also lost to less tightly monitored commercial pharmacies that are known to sell prescription drugs to patients without valid prescriptions

The impact of Government price regulation

More recently, the Government has reduced drug prices through regulation. The Universally Accessible Cheaper and Quality Medicines Act of 2008 (Republic Act No. 9502) authorized the Department of Health to set maximum drug retail prices (MDRPs) for drugs it deems to be essential to address leading causes of morbidity and mortality. In June 2009, the DOH released MDRPs for 22 medicines, including antibiotics, anti-diabetic medication and chemotherapy drugs. Manufacturers voluntarily cut prices for all but five of the drug formulations by an average of 50% before the new prices were enforced by an executive order from President Arroyo on July 27, 2009. Monitoring the MRP violations for the remaining five drugs will now be coordinated by the Bureau of Food and Drugs. Although price reductions of these drugs are welcome, there is concern that this is only a partial and politically-driven solution to the bigger problem of the poor having inadequate access to quality medicines. To address the problem more fully, the government will need to reform current quality assurance procedures for low-cost generic drugs; enforce rational drug dispensing by private vendors; and extend low income beneficiaries' coverage of outpatient drugs by PhilHealth.

The national decentralization process has increased inequity in service provision and reduced quality of care in the public sector ^(58, 59). Health access is marked by social and geographic inequalities, and is biased against the poor in less affluent regions ⁽⁶⁰⁾. Although government primary health facilities are reported to be, on average, 15 minutes from 94% of households, patients often bypass them for higher-acuity facilities ⁽⁶¹⁾. Although the Philippines maintains

the highest ratios of nurses and midwives to population in all EAPR countries, only 60% of all births are attended by skilled birth attendants ^(62, 63).

Philippines Case Study 2 – PhilHealth Accreditation of Private Practice Midwives

The Sponsored (Indigent) Program of the Philippine National Health Insurance Corporation (PhilHealth) targets the lowest-earning 25% of the population. The program is pro-family in that membership is household-based and covers all children younger than 21 years of age. While the plan is focused on in-patient care, Sponsored members are eligible for an outpatient diagnostic and consultation package. Because Local Government Units (LGUs) share the premium cost with the national government, PhilHealth pays a capitation payment of 300 pesos per enrolled member to LGUs. The LGUs, in turn, release the funds to Rural Health Units or public health centers proportional to the enrolled members they serve. Capitation funds are used for the purchase of medical and laboratory supplies and equipment, and for administration and salaries. At their discretion, facilities may purchase drugs for Sponsored patients, but PhilHealth does not explicitly cover medicines required by families for outpatient care.

For most primary outpatient care, PhilHealth does not cover services provided by private sector health care professionals and facilities. Exceptions to this rule are for maternal and newborn care and tuberculosis treatment. PhilHealth covers services provided by accredited midwives in accredited private maternity facilities and covers accredited TB-DOTS centers for tuberculosis treatment.

Welcoming the opportunity to expand access of maternal and child care, PhilHealth has collaborated with the Private Sector Mobilization for Family Health (PRISM), a five-year projected initiative initiated in 2004 by USAID. One of the PRISM initiatives is to assist privately practicing midwives to achieve PhilHealth accreditation. Currently, PRISM is facilitating the accreditation of private practice midwife-owned birthing facilities.

The private sector represents a significant force within the Philippines health system, commanding more than two-thirds of total health expenditure and 52.4% of total treatment ⁽⁶⁴⁾. Private sector treatment is concentrated in the formal sector, with 27.8% of private sector treatment occurring in private hospitals, 19.3% by private doctors, and 17.3% from private pharmacies. The poor utilize the non-formal private sector for more than half of all treatments ⁽⁶⁵⁾. As noted previously, spending in private sector pharmacies makes up nearly a half of all total health expenditure, the highest percentage in the EAP region, as a result of market concentration and government regulatory limitations ^(66, 67). A recent government survey has shown private health facilities rate higher on measures of patient satisfaction and quality, equal on measures of convenience, and inferior on issues of cost aspects as compared to the public sector ⁽⁶⁸⁾. To address these issues, the Ministry of Health has made engaging the private sector in attaining health goals one of the four principal tenets of its most recent health system plan ⁽⁶⁹⁾.

Legislative and regulatory environment

The Government of the Philippines experiences difficulty regulating private providers of health services and multiple regulatory and enforcement agencies have overlapping authority in many areas. The Philippines Department of Health (DoH) licenses health providers to practice within the country. The DoH Bureau of Health Facilities and Services is also in charge of accrediting and licensing health facilities. The National Health Insurance program, PhilHealth, accredits public rural health units and public and private hospitals. However the standards for accreditation are minimal and rarely is accreditation revoked ⁽⁷⁰⁾. In principle the Bureau of Food and Drugs (BFAD) regulates the manufacture, importation, and distribution of pharmaceuticals, and accredits drugstores with quality seals certifying pharmacies and drugs that offer quality at competitive prices ⁽⁷¹⁾. In practice, however, BFAD is severely constrained by limited human resources and accreditation of dispensaries is minimal ⁽⁷²⁾.

The government has transferred regulation of NGOs to the Philippine Council for NGO Certification (PCNC). The PCNC evaluates NGO compliance with criteria for financial management, governance, and accountability. Successful accreditation by PCNC confers NGOs with significant tax benefits. However, in its first four years of operation, PCNC certified only 445 of 70,000 NGOs ^(73, 74). NGOs also self-regulate through membership in umbrella NGO coalitions and adherence to a code of conduct regulating NGO actions ^(75, 76).

In the 1990s, the Philippines implemented a national health insurance plan, PhilHealth, with the aim of attaining universal coverage by 2010. PhilHealth covers both public and private facilities and enjoys coverage of over 70% of the population, but enrolment varies widely across geographic regions and socioeconomic levels ^(77, 78, 79). Although PhilHealth only covers 9% of total health expenditure, it has stimulated an expansion of government health expenditure ⁽⁸⁰⁾. Private health insurance is adopted mainly by more affluent individuals in urban areas, and has grown to cover 11% of total health expenditure in 2006 ⁽⁸¹⁾.

Vietnam

Health outcomes in Vietnam are much better than in other countries with comparable levels of GDP. However, as the country transitions from a low to middle-income country, Vietnam faces a growing burden of non-communicable disease, incomplete and unequal coverage of health services throughout the country, and rising out-of-pocket spending. The private sector is prevalent, has made an important contribution to the health gains achieved by the country, and will be increasingly important as a source of health care in the future.

Vietnam Case Study 1: Social Franchising of Reproductive Health Services

Background

In the four-tier public sector health system of Vietnam, communal health stations (CHSs) are charged with providing primary care. Services provided include reproductive health and family planning services to help reduce maternal and infant mortality, sexually transmitted infections and to inform fertility choices. In recent years, underfunding of the CHSs has led to the widespread perception that their free services are low in quality. Even low-income patients have as a consequence turned to alternatives: private sector providers and pharmacies or to already over-burdened provincial and central public hospitals.⁸²

Applying a social franchising model to improve quality of public reproductive health services

With the financial support of the Atlantic Philanthropies, and technical support of the NGO Marie Stopes International Vietnam, the first social franchising project in Vietnam's health sector began in 2006. The provincial government ministries of health in two provinces, Da Nang and Khanh Hoa, assumed the role of franchisors and invited 10 CHSs in Da Nang and 28 CHSs in Khanh Hoa to become franchisees. Franchisees were provided with funds from private foundations to upgrade their facilities and equipment. Training that covered clinical updates, quality of care and social marketing was also provided. The CHS staff were introduced to the principle of expanding a customer base by satisfying clients and winning their referrals to new potential customers. Branded as *Tinh Chi Em* (Sisterhood), the *Tinh Chi Em Franchise* was launched in July 2007 at 15 sites, supported by media advertising as well as brand ambassadors in each commune to provide face to face promotion of each franchise clinic.

Challenges

Initial evaluation of the program has shown increased awareness of FPRH services at CHS clinics, improvement in quality of services delivered at the clinics and satisfaction among CHS clients.⁸³ Reported challenges include variation among CHSs in their service offerings and in standard of equipment used, and some insufficiencies in human resources.

The instigation of service fees remains a key component of the program that has been implemented only in Da Nang province due to complex government approval requirements. Designed to be affordable to a low income client base, the fees are important not only to help instill the perception of service value among clients, but also to provide a revenue source for a CHS employee incentive plan. Government-provided FPRH services have historically been provided free of charge, and this shift to a fee-for-service model is difficult. Concerns that fees charged at franchise CHSs would cause a loss of business to non-franchises CHSs have been addressed in Da Nang by making service fees for FGRH service standard for all CHS clinics.

This initial success of the *Thi Chi Em Franchise* suggests that government cooperation with private sector NGOs and foundations can help government clinics to shift their goals from achieving quotas to valuing clients, and in so doing to find the motivation and means to improve the quality of public healthcare services.

Non-communicable diseases comprise 58.7% of Vietnam's disease burden. Major contributors include neuropsychiatric conditions (18.5% of total disease burden), cardiovascular (10.7%), sense organ (8.7%), and cancer-related diseases (5.2%). Communicable diseases constitute 30% of the total disease burden and include peri-natal conditions (5.9%), nutritional deficiencies (3.7%), and respiratory conditions, HIV/AIDS, and tuberculosis (3.1%)⁽⁸⁴⁾. Prevalence rates of HIV/AIDS and tuberculosis have increased in recent years⁽⁸⁵⁾. Injuries, primarily road traffic accidents and self-inflicted injuries, contribute 11.3% to Vietnam's disease burden⁽⁸⁶⁾. Vietnam excels in population health given its per capita gross domestic product, with key indicators such as life expectancy, maternal and infant mortality, and prevalence rates of communicable diseases comparable to much wealthier EAPR countries. Age specific mortality rates have declined over the last ten years, contrary to the experience of more affluent neighboring countries⁽⁸⁷⁾.

Total health expenditure in Vietnam, at 6.6% of GDP per capita, ranks above average in the EAP region. However, of this amount, private expenditure on health is double that of public spending. Accordingly, government spending on health, at 1.5% of GDP is below the recommended 3 – 6% reference range for developing countries⁽⁸⁸⁾. The vast majority (90.2%) of private spending derives from out-of-pocket expenditures, which has risen sharply from 59% in 1989 following legalization of private health practice⁽⁸⁹⁾.

In the last decade, the Vietnamese health system has been marked by decentralization and a gradual shift away from inpatient care to primary healthcare. The health system operates in a four-tiered structure. The Ministry of Health assumes responsibility for outlining and executing health policy and programs, in addition to coordinating training and running central hospitals. The Provincial Health Bureaus, due to increased decentralization, assume primary responsibility for planning regional health services and programs. District Health Centers and Commune Health Stations provide primary and secondary care^(90, 91). Vietnam maintains a physician per

population ratio above the EAPR average, but has the second lowest rate of nurses and midwives per capita in the region ⁽⁹²⁾. The health delivery system has shown to be distributed inequitably with a bias towards urban areas and inpatient care. Lower health service quality, access, and utilization, as well as health outcomes, are present in less affluent and rural populations, particularly in the hill-mountain regions and among ethnic minorities ⁽⁹³⁾.

The private sector is a significant source of treatment within Vietnam, and accounts for 58.2% of treatment provided. Treatment in the private sector overwhelmingly occurs in the formal private sector. Pharmacies and doctors comprise the most significant sites of care, accounting for 41% and 35% of private treatment respectively ^(94, 95). Poor and rural populations favor self-treatment and treatment from private providers. The poor access public services less, and at a lower level of care, than the rich, but report paying fees similar to those paid by more affluent individuals ^(96, 97). Compared with public providers, private services have more even geographic distribution and are accessed at the same rate by all socioeconomic groups because of more variable pricing schemes ⁽⁹⁸⁾.

Legislative and regulatory environment

Regulation and accreditation of health services in Vietnam is minimal because of the government's historical liberalization of the sector. In light of this, the quality of health services, as measured by resource availability and clinical knowledge, is reported to be low for both public and private providers ⁽⁹⁹⁾. The Vietnamese Ministry of Health, and Provincial Health Services, have a mandate to actively assure the safety of medicine, regulate public provider fees, and license private providers. However, they do not play an active role in quality assurance or regulation of the private sector. As coverage with health insurance grows, the government is seen to be moving toward creating additional oversight by certifying providers, rejecting reimbursement to sub-par providers, and establishing aggressive quality standards ⁽¹⁰⁰⁾. The contradiction between this new approach and decades of decentralization by government, may challenge the effectiveness of the new regulatory approach ⁽¹⁰¹⁾.

Vietnam's social health insurance system has flourished in recent years, attaining coverage of half of the population. The various forms of public health insurance were designed to alleviate the high out-of-pocket spending which disproportionately affected individuals of lower socioeconomic status, and to address health inequalities stemming from access to and utilization of healthcare, and in disparities in health outcomes ^(102, 103). Coverage is mandatory for formally employed, poor, and children under 6 years of age, and voluntary for students and children ⁽¹⁰⁴⁾. The insurance system fee-for-service and budget payment system has led to increased utilization in hospitals but not resulted in a decrease in out-of-pocket spending ⁽¹⁰⁵⁾. Although concerns over financial sustainability of the system persist, the program's success in targeting poor and minority populations and increasing utilization is a significant achievement.

Vietnam Case Study 2: Social Health Insurance and the Private Sector

Vietnam's national health financing schemes began in 1992 and have evolved continuously since then. By 2007 the nation's national insurance programs covered 50% of the country's population. Under the umbrella of its Compulsory Health Insurance Program, all children under six years of age receive free healthcare, and low-income citizens can be covered through the government-subsidized Healthcare Fund for the Poor (HCFP). Children older than six years of age in higher income families can be enrolled in the country's Voluntary Health Insurance Program. Benefit packages are generous, and include outpatient consultation, diagnosis, and treatment as well as inpatient care. A short-term study found evidence that after its introduction in 2002, HCFP had reduced out of pocket spending and self-care among poor beneficiaries.

The private sector is an important source of outpatient care for the poor, providing 52.6% of their outpatient services. Although a government decree in 2005 allowed coverage of benefits by providers in the private sector, very few private providers have been contracted by Vietnam Social Security (VSS), the agency operating the country's social health insurance. Private healthcare quality is poorly regulated and has been found to be significantly lower than publicly provided services.

In order to respond to the increased use of health services enabled by social insurance programs, the private sector must be engaged with a strategy that ensures their delivery of quality healthcare through training, accreditation and alignment of incentives to prevent over treatment.

Mongolia

Mongolia is a landlocked, formerly communist country nestled between China and Russia, that experienced financial and social turbulence in the decade following emergence from Soviet influence. Social spending was halved in real terms between 1990 and 1996⁽¹⁰⁶⁾. Before 1990 the state was the sole provider of healthcare. By 2001, 20 percent of all health transactions were facilitated by private providers¹⁰⁷. In recent years Mongolia has introduced major reform measures aimed at increasing the funding available for healthcare and improving the efficiency of the system. The healthcare system now has a mix of public and private funding and provision. Mongolia's challenges are compounded by the increase in non-communicable diseases, and by persistent inequities in health status and health care availability between urban and rural populations.

Mongolia is in the throes of an epidemiological transition, with mortality from communicable diseases decreasing over time, and mortality from non-communicable diseases is on the rise. Cardiovascular diseases, cancers (particularly liver cancer) and injuries arising from accidents are the leading causes of mortality⁽¹⁰⁸⁾. The three main causes of mortality in Mongolia are currently cardiovascular diseases, neoplasms and injuries and poisonings.¹⁰⁹ Non-communicable diseases are the leading contributor to the nation's burden of disease accounting for 63.5% of all DALYs⁽¹¹⁰⁾. Leading causes include neuropsychiatric conditions (14.6%), cardiovascular diseases (13.7%), cancers (8.5%) and digestive diseases (7.7%). Communicable diseases contribute to 23.5% of the burden of disease. The leading contributors are perinatal conditions (6.7%), respiratory infections (5.2%), diarrheal diseases (4%) and tuberculosis (1.9%). Injuries are also a significant issue, contributing 13%; road traffic accidents (5.6%) are the leading causative factor⁽¹¹¹⁾.

According to official Mongolian statistics, both infant (30 per 1000 live births) and child mortality (38.7 per 1000), are low relative to comparable countries, and on track for achieving the Millennium Development Goals target. The steady improvement in rates is thought to be attributable to vaccination, notably against measles, diphtheria, pertussis, tetanus, polio, mumps, rubella, and hepatitis B – with Mongolia declared polio-free in 2000. However, official infant and child mortality statistics are not universally accepted, and WHO has suggested the figures may be almost double¹¹². Maternal death rates, for which the latest available figures are dated, appear excessively high, at 124 per 100,000 live births (2002). Mortality rates vary starkly between wealthier and poorer households, and between rural and urban households, though available data are dated¹¹³

The Mongolian healthcare system is in principle dedicated to providing universal effective and affordable primary healthcare. In urban areas, the first point of contact is a family group physician (FGP) who, based out of a small health centre, would usually be responsible for an entire family's health management. In rural areas, District Health Centres (DHC) (also referred to as soum hospitals) provide care using FGP principles. They are essentially state run health centers that provide PHC services and limited in-patient care, they typically have 10-15 beds¹¹⁴

Reproductive health and AIDS prevention activities are mainly carried out by NGOs. However, the provision of health care in Mongolia is dominated by an excessive number of public hospitals; although small, an average of 10-15 beds each, the ratio of hospitals to population is nearly double that in former CIS states¹¹⁵.

Mongolia spends 4.3% of GDP on healthcare¹¹⁶. Private expenditure on health accounts for 22.5% of Total Health Expenditure. Health funding is sourced from the state budget, health insurance, out-of-pocket payments and international grants and loans. Health financing is dominated by public expenditure which accounts for approximately 77% of Total Health Expenditure⁽¹¹⁷⁾. The health budget accounts for 11% of the government's budget expenditure¹¹⁸. Per capita public expenditure on health is \$87 (PPP Int.) per annum, leaving individuals to pay a difference of \$26 (PPP Int.) between public and total expenditure.¹¹⁹ Expenditure on private services accounts for 22.5% of all health expenditure; of that amount 86.5% is out-of-pocket payment for services¹²⁰.

The government-owned health insurance scheme is the linchpin of the Mongolian health financing model. It is intended to provide universal coverage. In practice, however, vulnerable groups (herders, rural women) still encounter obstacles to accessing funded services¹²¹

The insurance scheme draws approximately half of its funding from compulsory employment-based contributions, with the remainder financed by the government through payments on behalf of disadvantaged groups. The operating costs of health facilities are directly funded by the government⁽¹²²⁾. Official as well as unofficial copayments are often required to obtain services, and people may pay out of pocket for private services. social health insurance can be used to cover treatment in a private hospital.¹²³

However, care for infants and young children is also legislated and funded by social insurance, and includes maternity leave benefits, infant care benefits and benefits for mothers with five children or more¹²⁴.

The majority of PHC services are available free of charge to patients. However, significant co-payments exist for pharmaceuticals.⁽¹²⁵⁾

Reforms enacted since the emergence of a market economy sought to improve efficiency in service delivery and financing. Privatization of the health sector in Mongolia began with the establishment of several small medical practices and a private pharmaceutical factory in the early 1990s. Retail pharmacies in Ulaanbaatar were privatized in 1997. A range of management contracts has been let to private parties, and private hospitals have grown, financed by the HIF and by out-of-pocket payments. By 2006, in addition there were 76 private hospitals health providers in operation throughout the country.¹²⁶ 2002 data on other private facilities will be updated soon (Personal communication, ADB), but in 2001 there were 540 private clinics, 320 pharmacies, and the 55 private businesses were engaged pharmaceuticals sector. Two-thirds of all private providers operate in the capital Ulaanbaatar. The emergence of a significant private sector in Mongolia has not, it is believed, contributed significantly to either greater efficiency in service provision or improved health outcomes.^(127,128)

Legislative and regulatory environment

Five different Government organizations have governance responsibility for healthcare and health financing in Mongolia. Coordination among them is reported to be inadequate for achieving efficiency and maximizing clinical and health outcomes

The “fragmentation” of responsibility has been identified as a major factor for what a World Bank report called “The unrestricted growth of private health care organizations, especially in Ulaanbaatar....The unregulated growth of the private sector is a recipe for future disaster as Mongolia already has too many hospitals and health professionals¹²⁹

In 2002, Social Sector Restructuring and Privatization Guidelines established the legal regulations governing accreditation for (private) healthcare practitioners. Soum and family doctors must pass accreditation examinations and must hold a current general practitioners license, which must be renewed every 5 years, but the licensing and regulation processes are weak, and there is no follow-up, support, or supervision.

The Health Insurance Law and Health Law legally enshrine the state’s goal of providing equitable and accessible PHC for all Mongolians. In practice, however, hospitals absorb the lion’s share of funding and health indicators such as maternal mortality rates are evidence of gross inequities in health outcomes in rural compared with urban areas¹³⁰

The Economic Growth Support and Poverty Reduction Strategy (EGSPRS) aims in part to implement the National Program on Reproductive Health and Child Health, and thereby reduce maternal and child mortality and achieve the Millennium Development Goals¹³¹.

Since 2005 a series of policy and strategy directives and reforms have been introduced, all aimed at improving efficiency and at achieving national and global health outcome targets. These include the Health Sector (Strategic) Master Plan (HSMP), 2005 governing medium and long-term development of the health sector for 2006–2015; disaggregated analysis of the National Health Accounts; establishment of Mongolian Millennium Development Goals (MDGs), including SWAP; amendments to the Health Act (2005), increasing financing for PHC; the 2006 Amendments to the Health Insurance Law¹³².

Mongolia Case Study 1: Privatization of Family Doctor

Privatizing and consolidating for better access and better performance

The majority of public health, primary care and hospital services in Mongolia continue to be publicly -funded and -operated. The prominent exception is the Family Group Physician program(FGP).In 1999, family physicians (who were previously on a government salary) were privatized. Among other things, this forced them to compete for patients.

After a significant public education/health promotion program, patients were asked to register with a FGP. The government’s modus operandi here was to increase uptake of PHC services and decrease in-patient hospital services. In order to achieve this, patients who registered with an FGP were to be provided with free services (services were free for unregistered patients in case of an emergency)⁽¹³³⁾. The continuation of co-payments for clinical services in DHCs was designed to motivate patients to register with a (more cost-effective) FGP.

All Mongolian citizens were able to register with their preferred family doctor. But there were no disincentives or penalties imposed on family doctors who did not elect to become private practitioners. Doctors were to receive a risk-adjusted capitation fee from the government for every patient registered 134 In keeping with the government’s desire for the development of an equitable and accessible health system, the capitation payments were weighted by age and income status. Thus, the capitation payments are higher for disadvantaged patients (low income, women, over 60s). The highest payment was for ‘poor’ children between the ages of 0-1, for each patient meeting those criteria doctors received a payment 3.79 times the normal rebate¹³⁵. The aim of this system was to create an incentive for physicians to work in disadvantaged areas and actively seek to promote the health of their patients – under the threat of losing their funding to competitors if their patients were unhappy and ‘voted with their feet’.

Family doctors relieved of their salaried Government jobs were assisted to establish private group practices. Their income was to be guaranteed – for a limited period of time. In exchange, thee newly-privatized doctors were expected to provide both out-patient, clinic-based and home services to a defined population.

Initial Results Encouraging but Program Falters

The model was adapted for doctors serving rural and nomadic populations, and, by 2002, 247 Family Group Practices (or FGPs) were covering in principle 56 % of the Population of Mongolia⁽¹³⁶⁾.

An evaluation conducted at the time concluded that young children and the poor, were receiving “appropriate attention” with preventative services (including health education) and treatment for common childhood illnesses. It also concluded that the main objectives of the model, to increase service provision to poorer populations by a payment mechanism that favored treating poor patients, also seem to be being achieved to a satisfactory degree.¹³⁷ More cautious was another assessment at the same time: “...the new program has created a sensible way of reducing the excessive numbers of GPs and of increasing the rewards for innovative and competent doctors.”⁽¹³⁸⁾ Moreover, the program was judged to deliver healthcare more equitably to families with children⁽¹³⁹⁾.

In contrast to other settings, in Mongolia, one of the perceived benefits was to grant the doctors more clinical freedom beyond their “narrowly preventive” scope previously, to include opportunities for curative treatment and “more holistic care” of their patients⁽¹⁴⁰⁾. Doctors were said to value their increased autonomy and higher status. However, relationships between public and private sectors deteriorated over payment delays. Serious internal problems developed within the first years of the program. They included delays in paying doctors and in refurbishing the doctors’ clinics, and (poor) relationships between the local governments that are responsible for administering the contracts with the doctors, have limited the program’s potential to generate improvements in the health of poor children. Moreover, vulnerable groups were effectively precluded from the coverage that would have enabled their free treatment by FGPs. A World Bank report concluded in 2006, “Primary care and family group practices are under-funded, under-regulated, and suffer from poor public perception¹⁴¹. By 2006 legislative change was urgently needed to redress inequities.

Legislation to Protect Vulnerable Groups and Promote PHC

The amended Health Act (January 2006) allowed for universal access to PHC services, regardless of whether a person is insured, by moving funding for FGPs from the HIF to the state budget. The state budget funds a core package of essential services (including vaccination, HIV/AIDS prevention services, adolescent health care, health education, as well as primary care services provided by FGPs¹⁴². However, an assessment of the FGP program in 2006 found that they did not have the clinical capacity to have a substantial impact on hospital admissions, and the level of funding they received was still insufficient for their viability. At the time, it was observed, most patients by-passed the FGPs and sought primary care at hospitals, which themselves were under-resourced for this function. significant corrections are made, this experiment in family medicine is likely to fail.¹⁴³

Indonesia

Indonesia has moved increasingly to decentralize the health system over the last several decades, implementing a health insurance program for the poor, and encouraging expansion of private sector health services.

Like most established middle-income countries, Indonesia is at the end-stage in a burden of disease transition. Although communicable diseases represent 28.9% of the total burden of disease, Indonesia must contend with a burden of non-communicable diseases and injury, accounting for 48.1% and 23% respectively of total burden of disease. Neuropsychiatric conditions, including depression, make up 11.5% of the total burden, and sense organ diseases such as cataracts and hearing loss make up 7.0% of the non-communicable burden disease. Indonesia must also battle communicable diseases including peri-natal conditions (5.7% of total disease burden), tuberculosis (4.8%), respiratory infections (4.0%), and maternal conditions (3.6%). Indonesia ranks sixth among 192 surveyed countries for percentage of disease burden comprised of injuries, with major contributors including road traffic incidents, unintentional injuries, and falls ⁽¹⁴⁴⁾.

Indonesia Case Study 1 – Role of a faith-based NGO in providing healthcare

Background

Muhammadiyah is a moderate Islamic organization in Indonesia with 29 million members and a mission to provide education and healthcare. Its health network is concentrated in Java and includes approximately 69 hospitals, 98 polyclinics, 62 maternity clinics, 25 maternal child health centers, 16 general health centers and numerous small health outposts. The Muhammadiyah's semi-autonomous sister organization, Aisyiyah, oversees the clinics and health centers focused upon women's and child health. New health Muhammadiyah-Aisyiyah centers are founded through community-based, grassroots efforts and operate with high levels of autonomy. Standards of care across the network, and caliber of management, vary in quality, and communication and information collection are inconsistent.

Extensive reach but an apparent shift away from the needs of poor families and children?

Muhammadiyah's extensive reach into the Muslim community has enabled it to partner effectively with USAID to implement family planning programs respectful of the Islamic religious context. It has recently been awarded a grant from the GFATM to treat TB patients referred by drug vendors and pharmacies. Muhammadiyah follows government requirements to make at least 15 percent of beds available to lower income groups. Some of its health facilities contract with the government to care for individuals covered by Jamkesmas/Askeskin, Indonesia's public health insurance plan for the poor. While fees at most Muhammadiyah-Aisyiyah facilities are lower than at many private hospitals, most of its health facilities are

currently positioned to serve middle class patients and clients; many of the facilities are situated in urban and semi-urban lower middle class neighborhoods. The conversion of many Aisyiyah MCH centers to general hospitals indicates a trend towards curative, secondary care and away from prevention and primary care.

Engaging Muhammadiyah-Aisyiyah as a collaborator to improve healthcare services for children and families will require a clearer strategic vision by the Indonesian Ministry of Health and tighter regulation of quality and reporting standard from within and outside of the organization.

Indonesia has shown improvement in population health indicators including child mortality, vaccination, and infectious disease surveillance and treatment, but is not likely to achieve Millennium Development Goals targets on malnutrition, maternal mortality, and sanitation. Large variations in health status exist between urban and rural populations, and among different economic levels⁽¹⁴⁵⁾.

Indonesia has followed a path of rapid decentralization in recent years, increasing the importance of its 700 health centers and 21,000 sub-health centers in resource allocation and specific health intervention matters, leaving broader levels of policy formation, standard settings to the central Ministry of Health^(146, 147). Indonesia maintains one of the lowest ratios in Asia of doctors per person. This is made more challenging by high reported rates of absenteeism and officially condoned “dual practice” in the private sector. Despite this, access to care is equitable throughout the country, with rural areas actually noting a higher number of medical providers per capita⁽¹⁴⁸⁾. The health system has a higher level of nurses and midwives than many neighboring countries. Indonesia has low rates of health facility utilization in both the public and private sector, with the poor opting for self-medication or forgoing treatment in many instances^(149, 150). Levels of healthcare quality are consistent between socioeconomic groups in the same geographic setting, but quality declines outside of urban areas⁽¹⁵¹⁾.

Government expenditure on health has quadrupled in the last decade, raising the level of expenditure to the recommended minimum threshold for low- and middle-income countries. However even now only 2.5% of GDP is spent on the health sector, the second lowest rate in the EAP region. Per capita expenditure on health ranks within the lower quintile of SEA countries at \$82 PPP.^(152, 153) Expenditures on health are split evenly between public and private sources; 70.4% of the private expenditure is from out-of-pocket expenditure.

Indonesia Case Study 2 - Improving Quality of Care by Private Providers in Outpatient Settings

Background

Private, solo-provider facilities run by full-time private or dual (public and part-time private) practice doctors, nurses and midwives provide the majority of outpatient medical treatment in Indonesia, yet they are subject to almost no accreditation or regulatory oversight.¹⁵⁴ While private and public training institutes produce tens of thousands of nurse and midwife graduates each year, no professional associations with regulatory authority certify or re-certify the competency of these graduates.¹⁵⁵ Following rapid decentralization of government health functions, District Health offices have the responsibility of overseeing private individuals and facilities, but they lack the capacity and skills to carry out this function.

Enhancing quality of private sector midwife services

One route to establishing professional standards among private providers is exemplified by the Indonesian Midwives Association (IBI). With funding and technical assistance from USAID, its *BidanDelima* (BD) program has updated clinical midwife training content with evidence-based interventions; created a midwife certification program; and worked towards the financial and managerial sustainability of the organization. BD currently has more than 7,800 members in 203 districts of 15 provinces, representing about 10% of Indonesia's midwives.¹⁵⁶ There is concern that full-time private midwives may have difficulty accessing the BD program because many IBI officials are biased towards the public sector.

The use of contracting standards and targeted financial incentives for midwives by government health financing programs such as Jamkesmas is an additional possibility recommended by a newly released study of the Indonesian private health sector.¹⁵⁷

Private practice nurses: unacknowledged providers

It is estimated that the largest proportion of solo-provider facilities (46%) in Indonesia are staffed by privately practicing nurses despite the fact that is an illegal activity.^{158 159} Providing services for relatively low fees and at convenient times and locations, nurses are popular among the low-income sick. While district health officials know of their existence, government offices collect no information about the extent and kinds of care or treatment they provide, and the offices neither enforce regulation nor lobby for its removal by legislators.

The private sector plays a major role within health services delivery in Indonesia. Recent DHS data indicates that private sector treatment represents a little less than three-quarters of all treatment provided (71.2% private vs. 28.8 public). The formal private sector comprises two-

thirds of the private care with significant sites of care including private clinicians (16.6% of private care), pharmacies (13.6%), and informal shops (16.9%)⁽¹⁶⁰⁾. The private sector is additionally bolstered by the government's sanctioning of public providers practicing in the private sector⁽¹⁶¹⁾. In contrast, private practice by nurses is illegal but it is estimated over 60% of all nurses (and 40% of all health facilities) are private. Over 90% of all healthcare facilities throughout the country are private health facilities; the vast majority of these are the clinics of solo outpatient health providers⁽¹⁶²⁾. The private sector employs nearly 40% of all doctors, and the numbers are expected to grow in the future⁽¹⁶³⁾. On the whole, the poor utilize the private sector in Indonesia less than the rich, but have almost three times the rate of utilization of the informal private sector (including shops and chemical sellers), which suggests increased self-treatment⁽¹⁶⁴⁾. Private nurses were reported to have a lower level of quality in practice than their public peers, though private physicians and midwives were noted to have high quality levels of care⁽¹⁶⁵⁾.

Legislative and regulatory environment

With the progression of decentralization, local providers are increasingly reliant on local government for financial regulation and direction. Yet only vague and incomplete minimum standards are imposed on local providers. Accreditation of educational providers is minimal, and is very decentralized⁽¹⁶⁶⁾. The Foreign Affairs Department determines registration and licensure for international NGOs; in practice, it is claimed, the regulatory climate is "quite liberal"⁽¹⁶⁷⁾. In response to minimal government oversight, NGOs engage in self-governance though adherence to a self-monitored code of ethics⁽¹⁶⁸⁾. Indonesia lacks an umbrella organization for NGOs to allow interface and coordination with government regarding their role and shared interests⁽¹⁶⁹⁾.

Indonesia has three mandatory insurance programs: one for civil servants, one for private employees, and one for the military, yet only 16% of Indonesians are covered by any form of insurance. Insurance payments only make up 8.5% of private expenditure on health^(170, 171). In 2005, Indonesia's government implemented the Askeskin health insurance program for poor individuals to prevent catastrophic out-of-pocket healthcare spending. The program compensates for a package of services provided by the public sector, but only one-third of private providers accept Askeskin⁽¹⁷²⁾. Coverage currently stands at 16 million poor people. Studies have shown the program increases access and utilization for health services among the poor⁽¹⁷³⁾.

Fiji

Burden of Disease

Diabetes is the major cause of mortality in Fiji. In 2002 the prevalence of Type 2 diabetes in Fiji was 16% of the adult population, the third highest rate per capita in the world. Of the 187 amputations carried out in the most recent year for which data are available, one of every 7 patients died.¹⁷⁴

Obesity, a prime indicator for a range of debilitating chronic conditions, is rife amongst school-age children: approximately 25% of all school-age children are overweight, and more than 10% obese.¹⁷⁵ Whereas infection and parasitic disease (including TB and dengue fever), respiratory illness and HIV/AIDS are major causes of morbidity, non-communicable diseases, including conditions of the circulatory system and neoplasm, account for two-thirds of all deaths.¹⁷⁶

Diseases of underdevelopment are also common: both infant mortality rates and maternal mortality rates have worsened over the decade between the mid-nineties and 2007: infant mortality increase from 16.8 to 18.4 per thousand live births over the period, and maternal mortality rates from 26.8 to 31.1 per 100,000 live births over the same period. The reported peri-natal conditions that account for these statistics are commonly associated with poor health of mother and inadequate maternity services: sepsis, congenital malformations incompatible with life, gross prematurity, peri-natal asphyxia, meconium asphyxia, severe HMD and congenital syphilis.¹⁷⁷ Concomitantly, levels of vaccination coverage (80%) have retreated after a short-lived improvement.¹⁷⁸

Health System Overview

The Ministry of Health of Fiji owns, operates and funds a system of facilities and healthcare personnel that provides basic healthcare to all residents of the island. The health system is structured as a hierarchy based on village health workers, nursing stations, health centers, sub-divisional hospitals and divisional and specialized hospitals. The structure dates back many years, but suffers from problems common in emerging economies: shortages of essential drugs and other supplies; lack of functioning equipment; understaffing in many areas – reportedly 36% of senior medical positions unfilled¹⁷⁹ (but overstaffing in some); frequent staff turnover; and declining Government funding while health needs and expectations rise

While the Government-run Ministry of Health is the dominant provider of healthcare at all levels, both the for-profit and not-for-profit (NGOs) is active and growing.¹⁸⁰ The main segments are:

- ❑ One major private hospital, one small private hospital/clinic with more limited services, and plans for a new private hospital in Lautoka.
- ❑ More than 120 private medical practitioners– including a small number of specialist medical officers – representing approximately 25% of all doctors in practice in Fiji. The number of patient visits to private practitioners is estimated to be of the order of 400,000 to 600,000 consultations per year. Several specialists working within the government service have rights of private practice within the private hospital on an out-of-hours basis. Most doctors are in

general practice, though there are a few private specialists. Private general practitioners play a significant role in antenatal care and childhood vaccinations.

- 49 private pharmacies.
- NGOs, who previously provided “support” services like training, are moving into direct service delivery (ex: Marie Stopes – family planning, social marketing and other clinical reproductive health services).

Fiji Case Study 1: Flour Fortification to Improve Infant, Young Child and Maternal Health

Background

Fiji and other Pacific Island nations suffer from what has been called “the double burden of nutrition” – both under nutrition (especially deficiencies of energy, protein and micronutrients) and over nutrition (fats and carbohydrates)⁽¹⁸¹⁾. Moreover, the past two decades have seen a recognition amongst Government and healthcare experts of the relationship between these nutritional deficiencies and the well-documented and dramatically increasing prevalence of non-communicable diseases among the Pacific Island Nations⁽¹⁸²⁾, including obesity. Further, Governments of the Pacific Island Nations have increasingly acknowledged the link between “Healthy Islands” and overall economic productivity and development.⁽¹⁸³⁾ The overall aim is to become food secure by reducing imports, increasing exports, and improving health simultaneously.⁽¹⁸⁴⁾ Thus the public-private partnership described in this case study is part of a much wider Government economic and political strategy.

By the late 1990’s the growth in anemia among pregnant women was a major concern to the Ministry of Health. The problem was evident not only amongst Indo-Fijians, but among the wider Fijian population. Measures to improve women’s health through iron and folic acid supplementation at their first presentation for prenatal care were too late, and poorly tolerated. Compliance was low and the intervention therefore did little to reverse the trend.

The alternative of fortifying flour with essential nutrients was proposed to Fiji’s Permanent Secretary and UNICEF in 1997. Following an assessment of the disease burden of the problem, dietary patterns and the feasibility of fortification, a test trial of the fortification of flour for bakery bread was conducted in 2000.⁽¹⁸⁵⁾ The trial demonstrated convincingly that fortification would not adversely affect perceptions of taste, but political turmoil halted the expansion of the initiative. By 2004, however, the situation was conducive to an expanded trial.

Going national – commercial and legislative measures in support of health goals

The successful launch of a nation-wide program of flour fortification was enabled by strong collaboration and support between the MOH and UNICEF, and persistent negotiation with the private partner, Flour Mills of Fiji. Flour Mills of Fiji manufactures not only most flour produced in Fiji, but also exports its flour throughout the Pacific. Consequently this public-private partnership had potential

to improve maternal and child nutrition and health status throughout the region. UNICEF stepped in at critical stages with vital equipment and the initial supply of fortificant; the MOH covered the cost of mandatory labeling changes in the initial stages, thereby lowering the financial risk of the private partner.

Legislation and regulation have been essential aspects of this successful public-private partnership. The private partner understandably was concerned that fortification might put their product at a disadvantage to competitor products. To have a significant impact on maternal and child health, the Government needed to ensure that pregnant women would receive adequate quantities of nutrients – i.e., that the bulk of the flour consumed by pregnant women would be fortified. Legislation was an obvious solution.

Together Flour Mills of Fiji, the Ministry of Health, and UNICEF developed and promoted a new law (enacted in 2004) that provided that only fortified flour and salt could be produced or imported into Fiji. An early obstacle was the (erroneous) preconception that the law would violate the World Trade Agreement, causing a 6-month delay. A consultation with Foreign Affairs and Customs quickly dispelled the concern, and the legislation was enacted.

Wider Implications

The initiative has had flow-on effects beyond Fiji, and beyond the specific public-private partnership: Flour Mills of Fiji have become a champion for fortification and voluntarily fortify all the flour they export to Pacific countries including Vanuatu. In steps that may have an impact on non-communicable diseases linked with obesity, Flour Mills of Fiji are currently examining how they might reduce the energy density of their popular sweet biscuits by reducing sugar content, etc. The Government of Fiji has also negotiated with Nestle that the flour used to produce “Maggi” two-minute noodles will be fortified from June 2006. This product is now in the market.

More ambitious goals have been adopted as part of a Pacific-wide strategy to introduce harmonized regulations and, if necessary, laws that will increase the proportion of imported foods which are fortified with vitamins and minerals. This initiative includes developing and agreeing on regionally-adopted standards for the fortification of widely-eaten foods, with iodized salt; flour with iron, folic acid and zinc; and cooking oil with vitamin A.

Healthcare Expenditure

The major source of funding of healthcare in Fiji is apparently the Government. However, healthcare expenditure data do not capture private expenditure, so the evidence for this assertion is weak. According to National Health Accounts, out-of-pocket spending on healthcare comprises 20% of national health expenditure. Of this amount, almost 3.5% (\$4.8 million) is spent on health insurance premiums and 5.4% (\$7.3 million) on pharmaceuticals purchased from private providers. Some of this expenditure relates to co-payments (“cost recovery”) at Government facilities, a source of discontent

amongst patients and their families, and it is reported, along with lack of equipment and needed drugs, and waiting times, a factor motivating people to use the private sector. Fees collected account for no more than 1% of total expenditure.⁽¹⁸⁶⁾ The UN estimates out-of-pocket spending on healthcare in Fiji at 38% of total health expenditure⁽¹⁸⁷⁾. However, since data on payments to private general practitioners is not collected, the total level of private expenditure, notably out-of-pocket expenditure, is undoubtedly much higher.⁽¹⁸⁸⁾

According to experts, the feasibility of health insurance in Fiji, as in all Pacific Islands, is limited for several reasons: in addition to the very small populations, which thwart effective risk-rating, a high proportion of the population works in “informal” employment, and in remote areas.⁽¹⁸⁹⁾

Legislative and regulatory environment

Most of Fiji’s legislation and regulation of health is out of date. More than 140 items of legislation are scheduled to be revised and enacted into law. According to Roberts et al, the Public Health Act, Medical and Dental Practitioners Act have been revised but not yet enacted.

Fiji shares with other Pacific Island nations a fragile ecological environment. This vulnerability has been compounded by the extreme impact that external socio-political influences have had on the islands’ nutrition patterns, health behaviors and epidemiological profile. Recent developments trends in health policy and program implementation are part of a broader strategy that integrates economic development, climate change and health. One official described this in plain language. Referring to Fiji’s public-private partnership with Fiji Flour Mills, she stated: “It is part of an overall strategy to avoid Fiji becoming a dumping ground for unhealthy, cheap, imported foods.”

Fiji Case Study 2: Engaging Non-State Actors in Non-Communicable Disease Management - Childhood Diabetes Management

Background

Prevention and treatment of Non-communicable diseases (NCDs) is a formidable financial and logistical challenge for countries that are still waging battle against persistent and resurgent communicable diseases – in the case of Fiji, TB and syphilis as well as parasitic and respiratory illness, diarrheal disease as well as heart disease, diabetes, and HIV/AIDS. While Type 2 Diabetes is the leading cause of mortality in Fiji, the island nation also has a small but growing number of children with Type1 (Childhood) diabetes. The Fiji Ministry of Health has been able to obtain supplies of insulin, and does so at a favorable price, the syringes, needles, glucometers and testing strips necessary to monitor and thereby manage the condition were only available intermittently, and in limited quantities, from selected hospitals. Families therefore were paying out-of-pocket for needles and syringes, and, more often than not, for glucometers and testing strips.⁽¹⁹⁰⁾

The Public-Private Partnership for Continuous Management of Type 1 Diabetes

The International Diabetes Federation established a multidisciplinary children's diabetes clinic in the Ministry of Health’s Lautoka Hospital in 2001. It was formalized in a Memorandum of Understanding

with the Ministry of Health of Fiji. Under the supervision of a pediatrician, the program initiated a National Childhood Diabetes Register⁽¹⁹¹⁾.

The Federation, an NGO supported largely by private donations, but also by substantial donations from governments including Australia, funds the purchase of syringes and needles and glucometers. The funding for these supplies is channeled not to the Ministry of Health, but through a trust fund managed by the local office of a well-respected international accounting firm. The orders are placed by the program coordinator at the hospital. The accounting firm then processes the orders and invoices, and payments are made from the funds held in trust. The supplies are obtained from the Government's pharmaceutical warehouse, and are bought at a favorable price.⁽¹⁹²⁾ The Ministry of Health is responsible for the purchase of the most expensive recurrent supplies - insulin and glucometer strips. The MOH uses its recurrent funds budget to purchase these items, which are provided free of charge to patients. Provision of care for children with diabetes is through the usual MOH out-patient facilities, and treatment is free of charge.

The program is coordinated by an MOH employee whose job is paediatric health, and who is responsible for reporting program's performance statistics to the regional IDF Coordinator based in Sydney, Australia. Other activities include a "camp" where children and parents in the program receive further education.⁽¹⁹³⁾ The program is modest, but the health and social costs of Type 1 diabetes are high. Designed, promoted and oversees by an international NGO, the program is firmly integrated with the Ministry of Health. Yet it uses a for-profit entity for the disbursement, accounting and auditing of funds – a model that has proven to be transferrable to 19 countries around the world.⁽¹⁹⁴⁾

V Issues and trends in policy and regulation

This report has placed special emphasis on country policies and regulatory frameworks. This section summarizes the policy and regulatory issues and trends that are common throughout the region:

1. First and foremost, **there is a high level of interest on the part of Governments in effective policies and programs to better engage Non-state actors in the interest of national health goals and priorities.** This has led to **very active research, analysis,** discussion and debate, often supported by a number of donors in each country. Policies are under review and being revised (Vietnam, Mongolia), and Governments are seeking guidance and positive examples.
2. **Governments recognize that the private sector – in the form of provision and certainly private funding - is present and, in most countries, growing. There is widespread acceptance that private provision will be a permanent feature: Non-state providers can potentially complement Government’s role in protecting the health of poor children.** The question is “How best to achieve this?” Several examples suggest a range of mechanisms: Fiji’s flour fortification program; the Philippines’ partnership to lower the cost of drugs; and Vietnam’s social franchising of reproductive health are useful examples.
3. **Governments need deliberately to appraise and quantify the extent to which non-State-sponsored programs effectively do complement Government initiatives to improve the health of poor children – not just assume they will.** Moreover, distinct country contexts mean that cross-country generalizations are inevitably inappropriate.
4. **There is in parallel a growing appreciation across the region of the inequity in widespread private funding of healthcare. Out-of-pocket payments,** the most prevalent form of private funding, oppress poor families and **are inimical to the health of poor children. Alternatives that relieve this burden on poor families are urgently required.**
5. **Careful design and structuring of initiatives – and continuous monitoring – is required to for poor children to reap benefits of private sector initiatives. In any arrangement, however, it is likely that both the private sector and Government will have commitments that must be met.** Is Government contributing its share to help programs succeed? Government-supported health financing schemes in Indonesia and the Philippines cover ambulatory primary care for children provided by public providers, but not by private providers. Furthermore, periodic appraisal of ongoing programs is essential to ensure that non-State actors’ involvement is in reality in the interest of children. The Mongolia family doctors program’s issues exemplify the issues that can arise, and the need for monitoring and mid-course correction.
6. **In most countries legislation and regulation needs to be reviewed and probably updated.** Questions being asked include: Are Government policies and regulations current and adequate?

Do they adequately reflect both the current role and the potential contribution of the private sector? Are they adequately translated into practical – affordable - regulatory regimes?

7. **What is the right balance between incentives and regulation?** Are current notions about “regulation” practical? Is the monitoring and enforcement they require affordable or even achievable? Or are they “in-principle tenets” that will remain in force mostly on paper, not in practice? Are there affordable and effective alternatives to rule-based regulation and enforcement? The recent example of the Philippines in encouraging high standards in private pharmacies in exchange for commercial advantages is a case in point. Can Government make better use of self-regulating professional organizations such as the Indonesian Midwives Association? In spite of its problems, the Mongolia Family Doctors initiative illustrates that incentives can be inserted in these programs to encourage the private sector to respond to Government policies, such as Mongolia’s aim of expanding coverage of the poor. Cambodia is on the verge of testing whether the profitability of selling highly-subsidized, first-line malaria medication will cause a decline in the sale of ineffective monotherapies by private vendors better than regulation.
8. **Achievement of Millennium Development Goals, and advancement of the Convention on the Rights of the Child, need explicitly to be identified and given priority in private sector initiatives.** There appear to be assumptions on the part of some governments that any activity aimed at children, and carried out in poor areas, will automatically have positive effects on poor children. The authors’ research and experience shows this is not the case. Governments must actively encouraging such initiatives. Governments must set formal criteria that appraise proposed private initiatives against policy priorities, like MDGs, and the rights of children. Two examples from Cambodia, focusing on prevention of malaria and treatment of diarrheal disease respectively, illustrate how Governments can – with activities that are carefully designed - harness the private sector to achievement of MDGs.

VI Framework

Working with the Private Sector: A Risk-Focused Taxonomy of Options for Governmental Relationships with Private Healthcare Providers and Institutions

One of the biggest challenges facing Governments that want to enlist the private sector in the interest of public health goals is where to start and how to choose among the endless opportunities. An inherent and frequent problem is that the fundamental features necessary for successful implementation of a program are ill-defined or lacking. In the authors' experience a major reason that well-intended public-private partnerships fail is that they are poorly matched against Government's goals and capabilities. All too often the options chosen require more robust systems (including accreditation as well as regulation) than are present when the initiatives are launched. A better understanding of conditions present in country, particularly the robustness of major systems, and the requirements of different types of PPPs, can help avert disappointment and failure.

We have identified nine key activities which governments, primarily ministries of health or finance, can initiate or support in order to improve health services used by the poor and through this improve the health status of the poor, particularly children.

We have grouped these activities into three groups according the level of risk that governments and communities take on when selecting each type of activity. In general, higher risk necessitates higher levels of technical capacity within government prior to undertaking an approach.

Risk here is an aggregate of technical risk, political risk, and financial risk. We have added a scale of "community risk" to indicate that communities, too, assume risk when the private sector is engaged.

This framework is intended as a tool for self-assessment. Health professionals working within or in support of the Ministry of Health, alone or in groups, should assess their country upon a series dimensions and then use the ratings to evaluate which activities might be appropriate for their context. All of the self-assessment questions below are scored high/medium/low.

<i>Gvt capacity for regulatory enforcement</i>	High	Medium	Low
<i>Gvt history of engagement with private providers</i>	High	Medium	Low
<i>Gvt history of engagement with professional representative bodies</i>	High	Medium	Low
<i>Gvt commitment to collaboration with the private sector</i>	High	Medium	Low
<i>Gvt capacity and/or donor support for collaboration with the private sector</i>	High	Medium	Low
<i>Likelihood of new financing availability to support private provision</i>	High	Medium	Low
<i>Degree of fragmentation in the private sector</i>	High	Medium	Low
<i>Strength of professional bodies representing specialists</i>	High	Medium	Low
<i>Strength of professional bodies representing high and mid-level medical practitioners</i>	High	Medium	Low
<i>Strength of professional bodies representing lower-level medical practitioners</i>	High	Medium	Low

LOW RISK ACTIVITIES

Limited Incentives for Pharmacists and drug sellers, principally to increase access to health commodities

<i>Gvt Capacity</i>	Limited regulatory or enforcement capacity; limited history of engagement
<i>Private Sector characteristics</i>	Fragmented and includes large number of solo-providers, independent pharmacists, informal practitioners and drug sellers
<i>Sample activities:</i>	Supply of subsidized products, training, information to willing retailers to make available goods that are of public health value and which might not have been accessible previously: condoms, informational materials, ante-natal supplements, clean water tablets, etc.
<i>Likely Health Benefits</i>	<i>Low to Moderate</i> primarily due to increased access to commodities and limited effect on quality of provider counseling

Potential risks to government



Potential risks to community



Potential benefits to community



Self-Regulation by Pharmacists and Clinicians to improve quality of goods and services provided

<i>Gvt Capacity</i>	Limited history of engagement, but political commitment for engagement within some departments of the MOH
<i>Private Sector characteristics</i>	Fragmented and includes large number of solo-providers and independent pharmacists
<i>Primary target:</i>	Pharmacists and registered private clinics
<i>Sample activities:</i>	Revise law to permit multiple facility ownership, especially for pharmacies and solo clinics. Encourage development of provider networks and/or provider franchises.
<i>Likely Health Benefits</i>	<i>Moderate</i> due to standardization of prices necessitated by consolidation, and by making regulation and enforcement easier for government.

Potential risks to government



Potential risks to community

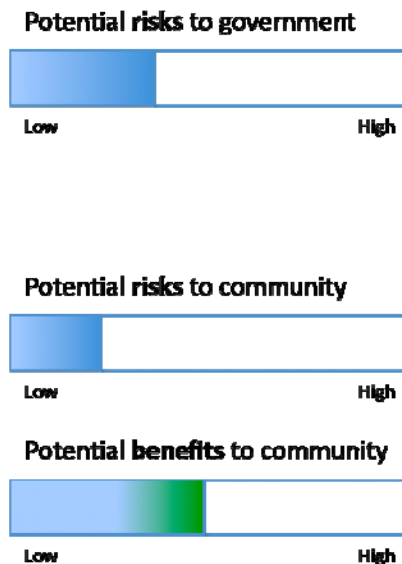


Potential benefits to community



Engagement with professional representative organizations to improve standards and quality; service effectiveness and efficiency (coordination); funding and pricing

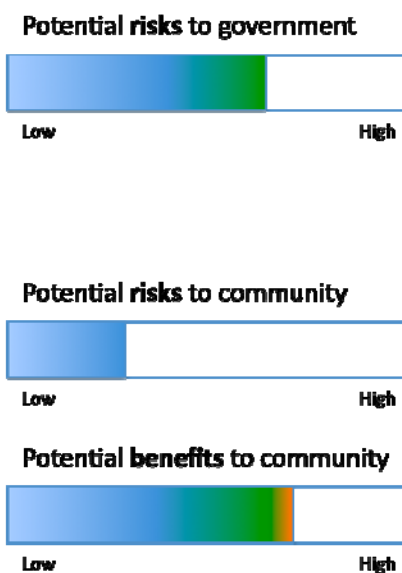
<i>Gvt Capacity</i>	Limited history of engagement
<i>Private Sector characteristics</i>	Established professional organizations exist and are in dialog with government, or the government is actively seeking partners for dialog: eg for quality and price setting within national social health insurance.
<i>Primary target:</i>	Professional organizations primarily lower level professionals who may be less self-organized than specialists.
<i>Sample activities:</i>	Linkages between clinicians and national programs, for example malaria, dengue, safe deliveries, and IDD/ARI. Support through existing professional bodies, through training opportunities, through outreach and encouraged referrals, and possibly through subsidized medicines or lab services (e.g.: PPM-DOTS).
<i>Likely Health Benefits</i>	<i>Moderate within targeted services</i> through improved training of private providers, new delivery points for national health insurance programs, and development of more appropriate policies.



MODERATE RISK ACTIVITIES

Engagement with professional organizations on clinical services to improve service quality and pricing; access to needed medical goods and services

<i>Gvt Capacity</i>	Some history of engagement
<i>Private Sector characteristics</i>	Private sector includes mid-level or higher clinical practitioners. Government capacity to interact with providers exists to some extent.
<i>Primary target:</i>	Professional organizations, primarily middle level professionals who may already be somewhat effective in self-organization.
<i>Sample activities:</i>	Linkages between clinicians and national programs. Safe motherhood/safe deliveries, abortion services, eye surgeries, long-term family planning methods, helminthes and other infectious diseases, HIV/AIDS care, TB with complications.
<i>Likely Health Benefits</i>	<i>Moderate to high within targeted services</i> due to uptake of appropriate treatment regimens and stronger reporting systems.



Engagement with professional organizations to support self-regulation to improve service quality

<i>Gvt Capacity</i>	Established history of engagement and trust
<i>Private Sector characteristics</i>	Some organizational hierarchy exists within the private health sub-sectors. Potential subsidies or other benefits of professional organization membership are possible to encourage providers.
<i>Primary target:</i>	Professional organizations, primarily mid or high level professionals and specialists.
<i>Sample activities:</i>	licensure procedures and the creation of privately managed Continuing Medical Education (CME) programs or the institutional equivalent
<i>Likely Health Benefits</i>	<i>Moderate</i> due to uptake of appropriate treatment regimens and stronger reporting systems.

Potential risks to government



Potential risks to community



Potential benefits to community



HIGH RISK ACTIVITIES

Increased regulatory enforcement to improve quality of services and pharmaceuticals

<i>Gvt Capacity</i>	Existing enforcement systems exist and can be strengthened. New financing and/or new and sustained political commitment exists.
<i>Private Sector characteristics</i>	Private sector includes mid-level or higher clinical practitioners.
<i>Primary target:</i>	Private hospitals/clinic; private pharmacies
<i>Sample activities:</i>	Drug verification at pharmacies. Credential checks among providers at private clinics.
<i>Likely Health Benefits</i>	<i>Moderate to High</i> in assuring quality-related compliance with national guidelines

Potential risks to government



Potential risks to community



Potential benefits to community



Financial incentives for services to improve access and affordability

<i>Gvt Capacity</i>	Existing mechanisms for financial transfer and service-verification exist. Should be combined with accreditation/certification or contracting initiatives.
<i>Private Sector characteristics</i>	Private sector is organized via professional organizations, franchises, shared ownership (chains) or other intermediary actors.
<i>Primary target:</i>	Private hospitals. Private clinics
<i>Sample activities:</i>	Legalize or co-invest in private or public/social insurance programs. Mandated targeted population coverage for private insurers. Expand social insurance to priority disease coverage (eg. Tuberculosis).
<i>Likely Health Benefits</i>	Moderate to High within targeted services through greater affordability and accessibility of essential services.

Potential risks to government



Potential risks to community



Potential benefits to community



Certification and Accreditation to improve quality

<i>Gvt Capacity</i>	Government has established relationships with private representative bodies.
<i>Private Sector characteristics</i>	Private sector is well organized via professional organizations, franchises, shared ownership (chains) or other intermediary actors.
<i>Primary target:</i>	Blood banks and hospitals. Possibly nursing homes
<i>Sample activities:</i>	Increasing third party payments for facilities meeting new certification or accreditation standards. Could be accomplished through insurance, social insurance, HMOs, or government payment for private provision
<i>Likely Health Benefits</i>	Moderate to High through creation of standards and transparency regarding quality metrics, combined with larger role for well educated third-party payers of healthcare services.

Potential risks to government



Potential risks to community



Potential benefits to community



Contracting for services or for private management to increase access; improve quality and affordability; increase efficiency

<i>Gvt Capacity</i>	Government has management capacity and/or donor engagement to support management; government has clear gaps in provision capacity.
<i>Private Sector characteristics</i>	Private sector includes large scale intermediaries (for profit or non-profit) who are potential contractors.
<i>Primary target:</i>	Geographic regions; specific priority clinical services with high measurability
<i>Sample activities:</i>	Capitated service contract for a district or region. Attended delivery services for Ob/Gyns. Provision of DOTS for TB treatment in areas with low government infrastructure.
<i>Likely Health Benefits</i>	Moderate to High through expansion of service availability and affordability.

Potential risks to government



Potential risks to community



Potential benefits to community



VII Conclusion

Non-state actors, “the private sector” – including both for-profit and not-for-profit organizations - play a major role in the funding and provision of health care throughout the EAP region. Discussions with country experts indicate that that the role of the private sector in healthcare funding and provision will increase.

For Governments and organizations like UNICEF, with strong commitments to Millennium Development Goals that incorporate the health of poor children, the private sector presents both an opportunity and an obligation: an opportunity to enlist non-State resources and capacity to improving equity of access, and quality of healthcare, for children. And an obligation on the part of Government to use its governance functions and authority to assure support towards those goals from non-State actors. The active presence of the private sector in health and healthcare also invokes opportunities and obligations in the framework of the Convention on the Rights of the Child: Governments must interact with non-State actors in the health arena so as to advance the rights, survival, development and protection of children.

The aim of this Background Paper has been threefold:

- **to establish** the context and summarize the current role of non-State actors
- **to illustrate**, with in-depth country profiles and case studies, the breadth of private sector involvement and contribution to child health in the EAP region
- **to prompt** consideration and debate on the additional potential for Governments to enhance the contribution of non-State actors.

The authors have intentionally not sought to make recommendations, but instead to provide a framework and “Checklist” to assist individual EAPR countries to:

- **appraise** their current situation and the role of the private sector;
- **analyze** their capacity to guide the private sector, using a range of measures in addition to “regulation;
- **weigh** the feasibility of different forms of private sector initiatives; and
- **determine** what, if any forms of engagement with the private sector are most appropriate.

The authors extend their thanks to UNICEF and to the specific individuals cited in the Appendix, and invite comments to:

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7. Surechimeg Vanchinkhuu, Health and Nutrition Specialist, Sukhbaatar district Ulaanbaatar, Mongolia
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16. *Nguyen Van Kien, Vice President of Vietnam Union of Friendship Organizations (VUFO), Vietnam
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23. Dr. Peter Annear, Nossal Institute for Global Health, University of Melbourne, Australia
24. Dr. Pandu Harimurti, Health Specialist, World Bank, Jakarta, Indonesia
25. Dr. Rosalia Sciortino, Institute for Population and Social Research, Mahidol University, Thailand
26. Professor Peter Heywood, Menzies Center for Health Policy, University of Sydney.
27. Dr. Eduardo Banzon, Senior Health Specialist, Manila, Philippines
28. Dr. Madeleine R. Valera, Senior Vice President for Health Finance Policy and Services Sector, Philippine Health Insurance Corporation, Pasig City, Philippines
29. Ms. Teofila Remotigue, CEO, National Pharmaceutical Foundation, Inc. , Manila, Philippines
30. Dr. Ofelia Ocana-Alcantara, Deputy Chief of Party, PRISM, Manila, Philippines
31. Dr. Ian Anderson, Senior Advisor, Regional and Sustainable Development, Asian Development Bank, Manila, Philippines

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as monitoring and education, builds local capacity to prevent and manage childhood diabetes, and lobbies governments.

¹⁹³ Rigamoto Taito. Report, Kids Diabetes Camp, 2008.

¹⁹⁴ This case study is also based on personal communications with individuals engaged in the program.