

Health Care Reforms in Developing Asia: Propositions and Realities

Xun Wu and M. Ramesh

ABSTRACT

Market-oriented reforms in the health sector continue to dominate health policy agendas in many developing countries despite growing evidence of their negative impacts. This article critically examines eight key arguments that are used to justify market-oriented reforms and that continue to hold widespread appeal among policy makers and analysts. The authors conclude that although the axiom that health care is atypical due to pervasive market failures is widely acknowledged by reformers, the scope and depth of the negative consequences of market competition and private sector involvement are systematically underestimated in policy design and implementation, while the regulatory capacity to overcome them is overestimated. Their analysis suggests that while there is considerable scope for market-oriented reforms, the success of such reforms depends on a tight set of conditions that are often absent in the health care sector, especially but not exclusively in developing countries.

INTRODUCTION

The notion that health care is a vital state responsibility has increasingly been challenged (Preker and Harding, 2000). Confronted with rising expenditure, inequitable access and perceptions of public sector inefficiencies, many governments have turned to market mechanisms for solutions (Berman and Bossert, 2000; Musgrove, 1996; Preker and Harding, 2000). Their new-found confidence in the market's capacity to address social problems is reinforced by the success of similar reforms in sectors as diverse as telecommunications, civil aviation and energy. However, the realities have fallen far short of expectations and, indeed, the reforms have often aggravated the problems they were intended to address (Bertranou, 1999; Fleury, 2000; Hearst and Blas, 2001).

While evidence of the true impact of market-based reforms is steadily accumulating, several key arguments used to justify such reforms continue to hold widespread appeal among policy makers and analysts. The

The authors would like to thank the anonymous referees of this journal for their helpful comments on an earlier draft of this paper.

debate is often framed as a trade-off between efficiency and equity — giving up a bit of equity for a lot of efficiency, so to speak — when in reality the reforms may be eroding both (Bloom and Gu, 1997; Homedes and Ugalde, 2005). When the adverse effects of the reforms are acknowledged, they are frequently attributed to political limitations that encumber governments rather than accepting that the policies themselves may be flawed (Batley, 2004; Russell et al., 1999). Some go so far as to suggest that the ill-effects are the result of political interference that can only be addressed by further reducing government intervention (Gu and Zhang, 2006).

A number of propositions, sometimes specified explicitly but usually assumed tacitly, underpin market-oriented reforms of the health care sector that are currently being pursued around the world.

1. Market competition promotes cost-effective health care
2. Private health care providers are more efficient
3. Private sector participation in health care improves services for the poor
4. Managerial autonomy enhances the performance of public hospitals
5. Contracting out is more cost-effective than direct public provision
6. Individual responsibility for health financing lowers overall health expenditures
7. Market failures in the health sector can be effectively addressed through regulations
8. Universal health is financially unaffordable for developing countries.

While these are all plausible — even attractive — propositions, their validity is open to question. The objective of this article is to appraise the propositions in terms of their true potential for guiding the reform process in developing countries. Our purpose is not to argue against market-based approaches to health sector reforms *per se*; rather, we aim to uncover specific flaws and inconsistencies embedded in these propositions in order to identify the conditions under which they might be valid as well as the circumstances in which their application should be avoided. We recognize that markets can be a very efficient and effective instrument for addressing social problems and their use is perfectly sensible in many circumstances; but their success depends on a tight set of conditions that are often absent in the health care sector, especially but not exclusively in developing countries.

A comparative study of health care reforms in Asia provides particularly fruitful opportunities for examining the propositions above because many countries in the region have implemented market-based reforms in recent years, such as greater private sector involvement in health provision, autonomization and corporatization of public hospitals, higher user charges in public health facilities, and expanded regulation of the sector (van Doorslaer et al., 2005; Griffin, 1992; Newbrander, 1997; Peabody

et al., 1999; Wagstaff, 2007). The extensive adoption of such measures across Asia affords opportunities for identifying their potentials and limitations that would be lacking in a single country context. A comparative understanding of reform experiences in Asia will shed light on how the various reform initiatives have fared in practice, thus contributing to a better understanding of the key assumptions underlying the reforms, which are often accepted uncritically.

This analysis is not intended as a comprehensive empirical testing of the propositions, however, as that would require more extensive and nuanced data than are currently available. Instead we focus on the various assumptions — often implicit — underlying each proposition, and draw evidence from existing literature on Asia to show that while there are some merits to most of the claims, there are often even more compelling limitations, theoretical as well as practical. Our analysis suggests that health policy reforms in many Asian countries are guided by assumptions whose implications and limitations are not fully understood, leading to adoption of measures that are ineffective at best and counter-productive at worst. Policy makers would therefore do well to follow the usual *caveat emptor* when working with fashionable reform ideas.

PROPOSITION 1: MARKET COMPETITION PROMOTES COST-EFFECTIVE HEALTH CARE

The acknowledged efficiency of the market is perhaps the strongest rationale for reforming health systems traditionally dominated by the government. Nothing catches reformers' imagination better than the image of the 'invisible hand' effortlessly and seamlessly allocating resources to their optimal potential. Lack of market competition is often cited as the reason for poor public sector performance (Preker and Harding, 2000), which, *ipso facto*, leads to the policy recommendation to 'encourage suppliers (both public and private) to compete both to deliver clinical services and to provide inputs, such as drugs, to publicly and privately financed health services' (World Bank, 1993: 6). Another version of the thinking suggests that provision of private goods should be left to market competition while merit goods and public goods may be provided by the government, because the former benefits primarily the individuals concerned while the latter has significant externalities (Hsiao, 1995a).

Regardless of the general merit of the argument — and it does seem to work as described in most consumer products and many network sectors — its relevance to the health sector deserves closer examination (Mesa-Lago, 2008). Unlike other markets, consumers in health care markets typically lack the knowledge necessary to assess the quality and even the necessity of the products they purchase, allowing providers to abuse their market position without fear of losing out to their competitors (Hsiao, 2000). For

example, it is estimated that about 20 per cent of drug prescriptions in urban China — a highly competitive market — are unreasonable or unnecessary (Zhong, 2001).

Competition for patients among care providers may also bias resource allocation towards over-investment in specialized clinical services and technology. Hospitals may invest heavily in high technology equipment just to convey a sense of quality to potential clients, the additional costs of which are recovered from unsuspecting consumers in the form of higher charges (Kumaranayake, 1998). It is believed that South Korea, where nearly all providers are private, has three times the number of CAT scanners per population compared to Canada (Zwi and Mills, 1995).

A convenient explanation for why market competition fails to produce desirable outcomes is the continued presence of unwanted government interventions. For example, based on their assessment of apparent failures of Chinese health care reform, Gu and Zhang (2006) suggest that the role of the state should be further reduced if market-oriented reforms are to succeed. This is incredible given that Chinese providers are already subject to intense competition in urban areas with virtually no policy restrictions on their behaviour; more competition is only likely to aggravate the ills that afflict the post-reform health care system in China. In fact, the existence of pervasive market failures in the health sector suggests that competition works only if the state can effectively address the failures that occur. As Singapore, an early adopter of market-oriented reforms, found out in the early 1990s, enhanced competition without appropriate controls promotes escalation of expenditures in the health care sector (Ramesh, 2008b).

A retreat by the state can be disastrous in situations where demand for health care exceeds supply and, as a result, competition is low, as is often the case in developing countries. When governments reduce their involvement in the hope that resource allocation can be optimized through market mechanism, it opens opportunities for providers to exploit their market power based on supply shortage. In rural China, access to health care deteriorated significantly as the state withdrew from providing health care, resulting in a high percentage of patients forgoing treatment (Hsiao, 1995a).

Competition may be outright undesirable in areas where collaboration across different organizations is important (Fleury, 2000). In public health, for example, information sharing among various public and private stakeholders is essential, but competition creates dis-incentives for co-operative behaviour. Liu and Mills (2002) report that when public health agencies were forced to compete with each other, their willingness to share information and work collaboratively declined noticeably. One would therefore expect a decline rather than an increase in efficiency in aspects of medical care predicated on co-operation among providers.

PROPOSITION 2: PRIVATE HEALTH CARE PROVIDERS ARE MORE EFFICIENT

A fundamental claim in support of an expanded role for the private sector is that it is inherently more efficient than the government in producing and delivering goods and services, including health care. As the World Bank put it in the 1993 *World Development Report*: 'greater reliance on the private sector to deliver clinical services . . . can help raise efficiency' (World Bank, 1993: 12). The logic here is persuasive: in the absence of claims to net income, there is inadequate incentive for efficient behaviour in the public sector, unlike the private sector where the lure of profits drives managers to offer strong incentives to efficiently use, preserve and maximize the value of the resources at their disposal (Shaw, 1999). Some economists suggest that governments should cease delivery of health products and services altogether (Preker and Harding, 2000).

A potential flaw in this argument lies in confusing *productive* (or technical or operational) *efficiency* with *allocative efficiency* (Carr-Hill, 1994). Productive efficiency is defined as the highest outcome given a certain amount of inputs at the firm level, while allocative efficiency refers to optimal allocation of resources across all activities from the societal perspective. In a perfectly competitive market, a productively efficient allocation is also allocatively efficient and the two terms may be used interchangeably.

However, the likelihood of finding a perfectly competitive market in the health sector is slim. Private hospitals might be able to deliver a given service with lowest operating costs to reach productive efficiency at the firm level, but this does not establish the desirability of the services from the societal perspectives. If the service is based on supplier-driven demand for clinically unnecessary services, allocative efficiency is undermined. A clear example of the divergence between productive efficiency and allocative efficiency is the high concentration of health care resources in urban areas. In Thailand, for example, private hospitals are overwhelmingly concentrated in urban areas where the ability to pay is higher, while rural areas in dire need are ignored (Nittayaramphong and Tangcharoensathien, 1994). Another example is that private providers prescribe far more Caesarian deliveries than their public counterparts, even after adjusting for clinical outcomes. Korea, for instance, has a Caesarian section rate of 43 per cent of all births, compared to 20 per cent in UK; the difference is explained by the profit motives of the private providers that dominate in the former country (Kwon, 2003a). The divergence between productive efficiency and allocative efficiency is also seen in the imbalance between resources devoted to curative and hospital-based care compared with those dedicated to preventive care.

Furthermore, there is no conclusive evidence to suggest that productive efficiency of private providers is higher than that of their public counterparts. In Thailand, for example, bed occupancy is 99 per cent for public sector hospitals and only 56 per cent in the private sector (Nittayaramphong

and Tangcharoensathien, 1994). The same is true in Hong Kong (Ramesh, 2004). Efficiency differences between private and public providers depend on payment mechanisms, economies of scale and internal incentive structures, and ownership may play a smaller role than suggested by conventional wisdom (Eggleston et al., 2007). More importantly, even if private ownership does promote gains in productive efficiency, these may be appropriated as windfall profits with few savings for consumers due to the information asymmetry and monopoly often encountered in the health sector (Hsiao, 2000).

PROPOSITION 3: PRIVATE SECTOR PARTICIPATION ALLOWS GOVERNMENTS TO CONCENTRATE ON THE POOR

With the emergence of poverty reduction as a top policy priority in the developing world, market-oriented health care reforms are increasingly presented as conducive to achieving this goal. It is argued that if the private sector is tasked to provide care to all who can afford to pay, then more of the limited government resources will be available for the poor, thus improving equity and contributing to poverty reduction (World Bank, 1993). This argument has played a critical role in strengthening political support for private sector participation in the health sector.

While the intentions are undoubtedly noble, they are hard to realize in practice. Private providers are often small and offer services of inconsistent quality, especially in rural areas; greater reliance on them will thus expose the poor to inferior quality service. More significantly, the proposition ignores the importance of non-financial constraints to health care provision. In many developing countries, the major obstacle to providing adequate health services to the population is not financial but a shortage of qualified medical personnel. Not only is there emigration of trained medical professionals from developing to developed countries; it is often hard to persuade those who do remain to work in rural areas. The higher salaries available in private practice are also a great lure for professionals working in public health care facilities. In Malaysia, for example, the number of private beds increased from 3,666 to 7,511 between 1985 and 1995; at the same time, many qualified medical professionals left the public sector for higher pay and more flexible working conditions in the private sector (Barraclough, 1999). It cannot simply be assumed that the retreat of the state from looking after the non-poor will automatically lead to better care for the poor.

In order to prevent 'brain drain', public sector providers have to either pay their staff more or allow them to operate private practices while employed in the public sector, both of which adversely affect access for the poor. Without budgetary support from the government, public sector providers often have to raise user charges in order to fund the salary increases necessary to retain their staff, thus reducing access for the poor. Dual medical practices have been accepted or even encouraged in many Asian countries, including

Thailand (Chunharas et al., 1992): although this probably slows down the loss of professionals from the public sector, there are substantial negative effects such as absenteeism from the public sector facilities and redirection of public resources to private practice.

Last, the validity of the proposition depends on the assumption that government expenditure on public hospitals would be maintained after the truncation of public health care services. In reality, an expanded private sector is likely to be used to justify reduction in government expenditures. More importantly, the entire government involvement in health care may be threatened as the rich and middle classes withdraw support for the public system because they no longer benefit from it (Newbrander, 1997). The public hospital system in Hong Kong enjoys widespread political support precisely because it is used by almost the entire population, rich and poor alike (Hsiao and Yip, 1999).

While service quality in the public sector is a legitimate concern, private sector involvement does not necessarily offer a solution and may in fact make matters worse. The public sector would find it hard to maintain, much less improve, service quality as expanded opportunities in the private sector lure professionals away with the promise of higher salaries. As a result, the choice for the poor would be to either purchase services from private hospitals on a fee-for-service basis or to forgo the treatment altogether because of low service quality in the public sector.

PROPOSITION 4: MANAGERIAL AUTONOMY ENHANCES PUBLIC HOSPITALS' PERFORMANCE

Centralized and direct governmental management of public hospitals is often considered a major source of inefficiency in the health sector and, accordingly, substantial relaxation and even withdrawal of controls is proposed as a solution (World Bank, 1993). By granting hospital managers greater autonomy in operational, financial and strategic matters through organizational reforms such as corporatization or privatization, it is expected that managers will rise to the challenge of running their establishments like their private sector counterparts. In other words, it is proposed that autonomy would make public hospitals more efficient, in addition to improving service quality and strengthening accountability (Preker and Harding, 2003).

Experiences with hospital autonomy offer little evidence to support these expectations, however. Empirical studies in India and Indonesia found no change in efficiency measured by bed occupancy and average length of the stay after autonomization, and very little change in accountability to the community (Govindaraj and Chawla, 1996). While greater management autonomy does lead to improvements in service quality, these are often limited to areas such as inventory management, maintenance and guest relations. At the same time, access for the poor deteriorates both at the facility and national levels as reform hospitals raise user charges to fulfil their

financial obligations to the state. In Indonesia, Swadana hospitals¹ reduced resources devoted to the poor following reforms that gave them greater autonomy (Bossert et al., 1996). Similarly in China, where hospitals enjoy very high level of autonomy, access to health care is low and deteriorating (Gao et al., 2001).

A potential problem with hospital autonomy is that it weakens the mechanisms for enforcing accountability over public hospitals. The gradual erosion of traditional accountability mechanisms based on hierarchy and civil service rules weakens the capacity of governments to monitor performance and require improvements. Often the only mechanism the government is left with is the *ex post* financial audit, because it is notoriously difficult to monitor other more substantial aspects of health care facilities' performance, such as level, quality and accessibility of services. Even budgetary controls are less effective in improving efficiency than might appear, as it is easier for managers to improve their financial performance by means other than improving efficiency. For example, they can concentrate on serving the healthier and wealthier population in order to reduce costs, or exploit their market power to extract more revenue by increasing prices for services (Govindaraj et al., 1996). In fact, public hospitals which demonstrate improved levels of efficiency might even be penalized as they can be targeted for budget cuts.

Managerial autonomy may also undermine the role of public hospitals as the service provider of the last resort for the poor (Shaw, 1999). The common reform measure which allows public hospitals to set their own user charges and retain the additional revenue thus collected has led to the proliferation of charges which have had a particularly deleterious effect on the poor. One hears harrowing tales of public hospitals turning away patients who cannot afford to pay their charges. In Indonesia, the government allows some public hospitals to impose user charges on a certain number of beds in the hope that the additional revenue will be used to improve services for all patients. But evidence shows that most of the additional revenue thus generated is used for increasing staff salaries or expanding discretionary funds available to hospital managers, while the access of the poor to services deteriorates (Suwandono et al., 2001). In China, where generating revenues through user charges is a vital management function at public hospitals, 60 per cent of the poorest income quintile in urban areas reportedly do not seek medical help despite being ill, and 41 per cent do not seek hospital treatment despite being advised to do so (Ministry of Health, 2004).

Another fundamental weakness of this proposition is the lack of management expertise for assuming the new responsibilities that accompany autonomy. Just because governments are willing to grant hospitals more autonomy does not mean the hospitals are ready to assume the responsibility. The Public Organization Act 1999 in Thailand, for instance, confers

1. Swadana hospitals are publicly owned hospitals which are allowed to retain fee revenues rather than remitting them to the government.

management autonomy on public hospitals, but most district hospitals are yet to accept it due to lack of management expertise at the local level (Wibulpolprasert and Pongpaiboon, 2001). This is hardly surprising given that management skills are a new area for public hospitals and there are simply not enough trained health care managers available to fill the expanded number of positions. Furthermore, the generous salaries often paid to such managers may well erode whatever cost savings might otherwise be achieved through autonomy.

The uninspiring outcome of hospital autonomy policies has renewed the debate on the future of public hospitals. It has been suggested that the failure of hospital autonomy is an inevitable result of the dual roles expected of autonomous public hospitals: they are expected to mimic private firms, but they are also required to function as public instruments for enhancing social welfare goals (Preker and Harding, 2003). Our analysis, however, suggests that the main problem lies in the inability of governments to ensure that managers pursue these twin objectives, which leaves them free to concentrate exclusively on generating financial flows, with their potential for personal pecuniary benefits.

PROPOSITION 5: CONTRACTING OUT IS MORE COST-EFFECTIVE THAN DIRECT PUBLIC PROVISION

Contracting out offers an attractive alternative to introducing market mechanisms into the public sector in situations where more radical reform measures, such as privatization or even corporatization, may not be politically feasible. Proponents argue that contracting out publicly funded health services to private agencies or to autonomous public providers can increase cost-effectiveness by simulating market competition and by linking payment to performance (Liu, 2004). It allows governments to substitute their role as direct providers for that of active purchasers. While contracting out has, to date, been mostly adopted in non-clinical services such as laundry, catering, cleaning and security, there are pressures to expand it to clinical services, including primary care (Loevinsohn and Harding, 2005; Mills and Broomberg, 1998).

Actual experience with contracting out hardly justifies such high hopes (Loevinsohn and Harding, 2005). Indeed, the available evidence suggests that the potential of contracting out for simulating competition among providers — supposedly its main strength — is highly overstated (Mills and Broomberg, 1998). Most contractual arrangements are reached through direct negotiations between governments and private contractors, and the number of bidders is often too few for genuine competition. Due to high asset specificity in the health sector, there are often few qualified providers, especially in countries where the non-government sector is weak or undeveloped (Mills, 1998). As a result, efficiency gains are more likely to be captured by contractors in a position to exploit their market power.

Another supposed benefit of contracting out — linking payment to performance — may also fail to materialize in practice due to the difficulty of measuring and monitoring performance. While it might be possible to specify price and quantity of services in the contract, it is notoriously difficult to specify quality due to uncertain linkages between inputs and outcomes in health services (Liu, 2004). Unsurprisingly, quality specifications are almost non-existent in contracts for clinical services (Mills and Broomberg, 1998). Bhatia and Mills (1997) find that while contracting out of dietary services by public hospitals in Bombay led to cost-saving for the hospitals, as the cost per meal was lower, the quality of the meals served was also lower.

More rigorous estimates based on cost-benefit analysis may further weaken the evidential support for contracting out. Most empirical studies ignore transaction costs in comparing contracting out with direct public provision, resulting in potential biases for the former. The size of transaction costs, including preparation, tendering and negotiation of contracts as well as monitoring of contract enforcement, can be substantial in the health sector (Perrot et al., 1997). A literature review by Mills (1995) found that transaction costs can be as much as 20 per cent of the contract value in the United States, and in the UK the costs could be up to 30 per cent higher than the cost of monitoring direct supply of the same services. It is doubtful whether many of the successful contracts reported in the literature would pass the cost-benefit analysis test if transaction costs were factored in.

Lastly, contracting out requires a set of new skills — such as designing and negotiating contracts and monitoring enforcement — which may be absent or inadequate in the public sector in many countries (Mills and Broomberg, 1998). Tendering and contracting entail plentiful opportunities for corrupt practices; contracting out may therefore be undermined by a set of factors commonly found in developing countries, such as corruption and weak law enforcement capacity (Liu, 2004).

PROPOSITION 6: INCREASING INDIVIDUAL RESPONSIBILITY IN HEALTH FINANCING LOWERS OVERALL HEALTH EXPENDITURES

Many health policy analysts see rising health care costs as the result of moral hazard problems inherent in third-party payment arrangements which lead individuals to demand more health services than socially optimal. Accordingly, they recommend full recovery of costs from individual users, anticipating that they would be more restrained in their demands if they had to pay directly. Recognizing that some treatments involve huge expenditures, proponents recommend public funding only for ‘catastrophic’ episodes, leaving individuals to pay for treatments involving small and predictable costs (World Bank, 1993). These measures are expected to reduce total as well as government expenditures on health without imposing an undue financial burden on households.

Although the logic of the argument is compelling, there is little evidence that increased individual responsibility in health financing reduces overall health expenditure. The percentage of out-of-pocket payment in overall health expenditure in China has increased three-fold since the early 1980s, but the rise of total health expenditure has accelerated. Even in Singapore, which is a pioneer in user-pays health care financing arrangements, large out-of-pocket payments have been ineffective in constraining health care costs (Yip and Hsiao, 1997). Similarly, high co-payment requirements in Korea have failed to stem increasing demand and the corresponding rise in expenditures, due to the providers' capacity to shape demand (Ramesh, 2004).

Several atypical characteristics of health care markets call for a more nuanced understanding of the relationship between individual responsibility and overall health expenditure. First, due to pervasive information asymmetry and monopolistic power in the sector, health care providers are in a good position to encourage demand for their services. Therefore, any reduction of demand achieved through increased individual responsibility may evoke demand-inducing responses from providers to offset the potential loss of revenues, resulting in no net gains for the society as a whole. Second, individual patients are in a weak position to negotiate with health care providers in exercising their purchasing power. Unlike institutional purchasers such as governments and insurance firms, which have the capacity to scrutinize and monitor hospitals' behaviour, individual patients are price takers and must accept what is prescribed by the providers. Thus while it sounds reasonable to argue that people who are able to pay ought to pay for services, increased out-of-pocket payment may actually increase overall health expenditure since individual patients can do little to influence providers' behaviour. Third, individuals typically lack adequate knowledge to make good judgements regarding the type and timing of treatment needed. In developing countries, self-treatment and forgoing treatment are common among the poor when the portion of user charges is high (Eggleston et al., 2007). Inadequate treatment has, as is well acknowledged, severe negative economic and social impacts on the society as a whole.

It is especially problematic when user charges are extended to preventive health services, such as immunizations, to increase individual responsibility in health financing. In China, for instance, imposition of user charges has led to a sharp decline in the use of public health services. The negative impacts of such short-sighted measures threaten to reverse decades of advances in public health.

PROPOSITION 7: MARKET FAILURES IN THE HEALTH SECTOR CAN BE EFFECTIVELY ADDRESSED THROUGH REGULATIONS

While regulation is often associated with network industries such as civil aviation, it is also one of the essential pillars in health care reform in terms of

addressing the adverse side-effects of market operations. As the 1993 *World Development Report* puts it:

Strong government regulation is also crucial, including regulation of privately delivered health insurance to encourage universal access to coverage and to discourage [perverse] practices that lead to overuse of services and escalation of costs. . . . Regulations are required to ensure that quality standards are met, that financial fraud and other abuses do not take place, that those entitled to care are not denied services, and the confidentiality of medical information is respected. (World Bank, 1993: 7, 131)

In recent years, there has been an increasing tendency to view regulation as a substitute for direct government provision of health care. In the words of the Seventh Malaysia Plan (1996–2000): '[the government] will gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions' (Government of Malaysia, 1996: 544). The government thus sheds its role as a provider and assumes the mantle of regulating private producers. Whether as a means of supplementing the market or substituting for it, however, effective regulations are difficult to design and enforce in the health care sector.

Although regulation is indeed indispensable for effective health care delivery and financing, its effectiveness in correcting market failures should not be overstated. For example, price regulations are often chosen to deal with the monopolistic power of providers, but such measures may be counter-productive if providers increase the volume of services by inducing demand, altering medical practice patterns and shifting to higher price drugs (Hsiao, 1995b). In China, price regulation — a policy ostensibly designed to keep medical services affordable to the poor — has been widely regarded as a leading cause of cost escalation and rising inequity in access (Gao et al., 2001; Liu and Mills, 2002) because it encourages providers to substitute controlled services and pharmaceuticals with those that are unregulated. The effectiveness of regulation in correcting market failures is undermined by the same set of factors that precipitated market failures in the first place.

The politics surrounding health care regulation is another impediment. Health care reform efforts often generate some of the most intense politicking found anywhere and this severely constrains governments' capacity to design and enforce appropriate regulations. The sector consists of a large number of interests that are sometimes complementary, often conflicting and almost always overlapping, which makes it nearly impossible for governments to devise regulatory arrangements that would satisfy all parties. The situation is aggravated by the expansion of private provision and financing which leads to an increase in the number of firms and their representative organizations whose interests need to be accommodated. In Pakistan, a proposal to require pharmaceutical companies to produce essential drugs to meet acute shortage was scuppered due to industry opposition (Mirza, 1996). The violent strike action by Korean doctors in 2001 against a government decision to ban them from selling pharmaceuticals is another example of the lengths to which

self-serving groups will go to protect their interests (Kim et al., 2004; Kwon, 2003b). It is hardly surprising that regulatory interventions which effectively and directly target market failures are rare in the health sector (Mills and Broomberg, 1998).

Even when appropriate regulations are adopted, they may not be enforced due to weak implementation capacity, which is common in developing countries. Enforcement of health regulations requires an immense amount of technical and administrative skill which is often beyond the capacity of regulatory agencies, and as a result, many of these regulations end up being regulations on paper only (Soderlund and Tangcharoensathien, 2000). For example, more than 50 per cent of hospital service charges in China are estimated to be higher than the regulated prices (Liu et al., 2000).

Contrary to the advice that the state should shift its role from provider to regulator of health care services, regulations are more effective when the state maintains a large presence in the provision and financing of health care. In Singapore, the state is able to effectively regulate the health sector because of its pervasive role as owner of nearly three-quarters of all hospital beds in the country (Ramesh, 2008b). Without having a direct stake in an overwhelming number of hospitals, it is unlikely that the Singapore government would have been able to overcome information asymmetry problems and effectively regulate the sector.

Fifteen years after the landmark 1993 *World Development Report* which inspired widespread market-based reforms in developing countries, regulations have failed in their intended aim of mitigating adverse side-effects. Those blaming weak regulatory capacity on the part of the state, however, should keep the American experience in mind: effective regulations can be in short supply despite plentiful financial resources and technical expertise. Without majority ownership or dominant financing roles in the health sector, the American government is unable to adopt socially optimal regulations against the wishes of the major industry players. The developing countries currently in the process of privatizing health care should pause and reflect if the reforms they are pursuing could eventually lead to a whittling away of their capacity to regulate the industry.

PROPOSITION 8: UNIVERSAL HEALTH IS UNAFFORDABLE FOR DEVELOPING COUNTRIES

In recent years, attention has been directed at the development of universal health insurance as a solution to unequal access. Yet it is also suggested that the process of expanding coverage must be gradual due to fiscal limitations. The case against universal health coverage is often built on two assertions: 1) that it will unleash unmeetable demands for health care; and 2) that public expenditure required to implement universal coverage may exceed governments' fiscal capacity.

South Korea's experience in establishing universal health insurance indicates that such worries are indeed justified. Universal health insurance in Korea evolved over the course of two decades, with coverage expanding from less than 10 per cent of the population when it was launched in 1977 to nearly the entire population by the late 1980s. However, this achievement was accompanied by explosive growth in total health care expenditures, which grew from 2.8 per cent of GNP in 1975 to 4.2 per cent in 1985, to 7.1 per cent in 1991. Public expenditures grew correspondingly (Kwon, 2003a).

While universal health insurance in Korea was indeed accompanied by steep increases in health expenditure, the apparent causal relationship between the two is spurious. It is the lethal combination of fee-for-service (FFS) payment and the profit orientation of providers coupled with universal insurance, rather than insurance *per se*, that accounts for the explosive expenditure growth. With universal health insurance, private providers had an additional opportunity to expand the volume and intensity of services and treatments with the greatest profit margin, due to the fee-for-service arrangement under which they are paid (Hillman et al., 1989).

Thailand's universal care (UC) scheme offers an appropriate example of how developing countries may expand public health care financing in a fiscally sustainable manner. In 2001, the Thai government launched the UC scheme under which those not covered by other insurance schemes were provided nearly-free health care at participating facilities. Since the new scheme was financed almost entirely from the government's general budget, it was to be expected that public health care spending would increase after the implementation of UC: it rose from one-quarter of total health care expenditure in 1994 (Supasit, 1996: 197) to two-thirds in 2002 (WHO, 2005: 198). The share of out-of-pocket payments declined correspondingly. However, unlike the case of Korea, total health expenditures have remained stable in Thailand (at 3.8 per cent of GDP in 1994 and 3.5 per cent in 2005), despite a sharp rise in utilization by the previously uninsured population (Ramesh, 2008a). Thailand's success in containing cost escalation can be attributed to two factors. First, the UC scheme pays providers prospectively on a capitation basis, thus offering incentives for providers to stay within the budgetary limits established by the per capita amount. Second, under the tiered network of providers, primary care providers act as the gate-keeper of access to expensive facilities because patients without a referral pay the entire cost themselves (*ibid.*).

The practices of universal health coverage in Asia suggest that it can be affordable for developing countries if accompanied by appropriate cost-containment arrangements. Although public expenditure would no doubt increase substantially after adoption of universal health coverage, overall expenditures may not necessarily increase. The fact that, Thailand — with per capita GDP of US\$ 6,600 (PPP adjusted) — is able to reach universal health coverage while the US — one of the wealthiest nations in the

world — has not, suggests that economic development status is not a crucial determinant of universal health care financing.

CONCLUSION

Health care has been at the centre of public policy reforms around the world for some decades now. These reforms are single-minded in their goal of transforming health care systems into more market-oriented forms, apparently oblivious of the highly inconclusive evidence regarding the nature and causes of health policy problems and the solutions to them. After nearly two decades of experience with market-oriented reforms in the health sector, evidence is mounting that they have failed to live up to expectations. In fact, there should have been no expectation of success, given the shaky intellectual foundations on which the reforms are based. In general, they are founded on eight essential propositions, each of which is found wanting in some significant respect.

The analysis presented in this article shows that it is erroneous to believe that market competition would increase the cost-effectiveness of health systems (Proposition 1). The potential for price competition is limited in health care due to information asymmetry innate to the sector. Similarly, competition over quality may lead to less rather than more efficient allocation of resources due to the imperatives to invest in expensive technology and specialties, the extra costs of which are eventually recovered from patients. Confidence in the greater efficiency of private health care providers (Proposition 2) is also misplaced because private ownership alone may contribute little to productive efficiency and even less to allocative efficiency while limiting access for the poor. Similarly, expansion of private provision may worsen rather than improve services for the poor (Proposition 3), because of the loss of middle class political support for health programmes due to their exclusion from it.

Proposition 4 regarding the desirability of managerial autonomy for hospitals is also problematic. The lack of management and technical expertise and the difficulties of devising contracts between the government and hospitals specifying performance indicators is a challenge which is difficult to overcome in the real world. While contracting out may seem to offer a way to improve on public providers' efficiency (Proposition 5), the cost-effectiveness may not be realized for practical reasons. Empirical evidence suggests that competition is hard to generate among contractors and that the higher transaction costs of negotiating and enforcing contracts undermine much of the case for contracting out.

Nor is making households share a greater part of the financial burden of health care a workable solution to the problems that afflict public financing (Proposition 6). Individual households have neither the financial resources nor the technical skills to convert their potential purchasing power into

bargaining power *vis à vis* providers. It is also unlikely that the bulk of the population will ever be in a position to bear the treatment costs of serious illnesses entirely on their own. Regulation cannot effectively address the market failures that characterize the sector or substitute for government provision and financing (Proposition 7): the challenges of market failures facing regulators will be no less than those facing the agencies in charge of delivering the services. The deep and divisive multitude of interests that exist in the sector make it difficult to devise and implement effective regulations.

Another ill-founded but widespread assumption framing health care reform debates is that governments everywhere, but especially in the developing world, simply cannot afford to pay for the health care costs of the entire population (Proposition 8). As the case of Thailand shows, government-financed universal health care is in fact possible, but to succeed, there need to be corresponding measures designed to contain expenditures, such as replacing fee-for-service payment with per capita and global budgets. Policy makers need to think beyond simply reducing public expenditures on health and should focus instead on the total picture from the perspective of the society as a whole. From this broader perspective, they will find that higher public expenditures, if complemented with other appropriate instruments, have the potential to reduce total costs while expanding access.

Instead of acknowledging these flaws, proponents of market-oriented reforms attribute their failings to the political context in which the reforms are implemented. They argue that governments are often unable to carry out reforms in a comprehensive manner due to lack of policy capacity or political commitment (Russell et al., 1999; Shaw, 1999). While it is no doubt true that health care reformers often pay too little attention to the distinct social, economic and political context that obtains in each country, this is not the only shortcoming in the reforms that they propose. As we have pointed out, there are deep flaws in the very thinking on which the reforms are founded. The protagonists seriously underestimate the scope and depth of the negative consequences of market competition and private sector involvement and overestimate the potential for regulation to overcome them. Nor does the argument that the ill-effects of the reforms are an inevitable part of the trade-off between equity and efficiency hold water, because it is possible to experience deterioration along both dimensions.

The axiom that health care is an atypical sector in terms of the extent of information asymmetries and public goods effects needs to be acknowledged, not just in words but also in actual reforms. The same reformers who acknowledge the uniqueness of the sector readily depart from it while designing reform measures, because of their intellectual outlook or material interests. Health care debates in recent times have been dominated by economists who are intellectually uncomfortable with policy solutions involving extensive government intervention. The political power of medical professionals, insurers and private hospitals also militate against solutions that might reduce their income or limit their autonomy.

REFERENCES

- Barraclough, S. (1999) 'Constraints on the Retreat from a Welfare-orientated Approach to Public Health Care in Malaysia', *Health Policy* 47(1): 53–67.
- Batley, R. (2004) 'The Politics of Service Delivery Reform', *Development and Change* 35(1): 31–56.
- Berman, P. and T.J. Bossert (2000) 'A Decade of Health Sector Reform in Developing Countries: What Have We Learned?'. Data for Decision Making Project. Boston, MA: Harvard School of Public Health.
- Bertranou, F.M. (1999) 'Are Market-oriented Health Insurance Reforms Possible in Latin America? The Cases of Argentina, Chile and Colombia', *Health Policy* 47(1): 19–36.
- Bhatia, M. and A. Mills (1997) 'The Contracting-out of Dietary Services by Public Hospitals in Bombay', in S. Bennett, B. McPake and A. Mills (eds) *Private Health Providers in Developing Countries: Serving the Public Interest*, pp. 250–63. London: Zed Books.
- Bloom, G. and X.Y. Gu (1997) 'Health Sector Reform: Lessons from China', *Social Science & Medicine* 43(3): 351–60.
- Bossert, T.J., S. Kosen, B. Harsono and A. Gani (1996) *Hospital Autonomy in Indonesia*. Boston, MA: Harvard School of Public Health.
- Carr-Hill, R.A. (1994) 'Efficiency and Equity Implications of the Health Care Reforms', *Social Science & Medicine* 39(9): 1189–201.
- Chunharas, S., P. Wongkanaratanakul and A. Supachutikul (1992) 'Appropriate Doctor Payment for the Thai Health Care System'. Bangkok: Thai Medical Council.
- van Doorslaer, E. et al. (2005) 'Paying Out-of-Pocket for Health Care in Asia: Catastrophic and Poverty Impact'. Equitap Working Paper 2. Manila: Equitap.
- Eggleston, K., L. Ling, M. Qingyue, M. Lindelow and A. Wagstaff (2007) 'Health Service Delivery in China: A Literature Review', *Health Economics* 17(2): 149–65.
- Fleury, S. (2000) 'Reshaping Health Care in Latin America: Towards Fairness?', in S. Fleury, S. Belmartino and E. Baris (eds) *Reshaping Health Care in Latin America: A Comparative Analysis of Health Care Reform in Argentina, Brazil and Mexico*, pp. 225–62. Ottawa: International Development Research Centre (IDRC).
- Gao, J., S. Tang, R. Tolhurst and K. Rao (2001) 'Changing Access to Health Services in Urban China: Implications for Equity', *Health Policy and Planning* 16(3): 302–12.
- Government of Malaysia (1996) *Seventh Malaysia Plan, 1996–2000*. Kuala Lumpur: Economic Planning Unit, Prime Minister's Department.
- Govindaraj, R. and M. Chawla (1996) *Recent Experiences with Hospital Autonomy in Developing Countries: What Can We Learn*. Boston, MA: Harvard School of Public Health.
- Griffin, C.C. (1992) *Health Care in Asia: A Comparative Study of Cost and Financing*. Washington, DC: The World Bank.
- Gu, E. and J. Zhang (2006) 'Health Care Regime Change in Urban China: Unmanaged Marketization and Reluctant Privatization', *Pacific Affairs* 79(1): 49–71.
- Hearst, N. and E. Blas (2001) 'Learning from Experience: Research on Health Sector Reform in the Developing World', *Health Policy and Planning* 16 Supplement 2: 1–3.
- Hillman, A.L., M.V. Pauly and J.J. Kerstein (1989) 'How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?', *New England Journal of Medicine* 321(2): 86–92.
- Homedes, N. and A. Ugalde (2005) 'Why Neoliberal Health Reforms Have Failed in Latin America', *Health Policy* 71(1): 83–96.
- Hsiao, W.C. (1995a) 'Abnormal Economics in the Health Sector', *Health Policy* 32(1–3): 125–39.
- Hsiao, W.C. (1995b) 'The Chinese Health Care System: Lessons for Other Nations', *Social Science & Medicine* 41(8): 1047–55.
- Hsiao, W.C. (2000) *What Should Macroeconomists Know about Health Care Policy? A Primer*. Washington, DC: International Monetary Fund, Fiscal Affairs Department.

- Hsiao, W. and W. Yip (1999) 'Improving Hong Kong's Health Care System: Why and for Whom'. Report to the Hong Kong SAR. Hong Kong: Government Printing Department of Hong Kong SAR.
- Kim, H.J., W. Chung and S.G. Lee (2004) 'Lessons from Korea's Pharmaceutical Policy Reform: The Separation of Medical Institutions and Pharmacies for Outpatient Care', *Health Policy* 68(3): 267–75.
- Kumaranyake, L. (1998) 'Effective Regulation of Private Sector Health Service Providers'. Working Paper prepared for the World Bank Mediterranean Development Forum II, Marrakesh. Washington, DC: The World Bank.
- Kwon, S. (2003a) 'Healthcare Financing Reform and the New Single Payer System in the Republic of Korea: Social Solidarity or Efficiency?', *International Social Security Review* 56(1): 75–94.
- Kwon, S. (2003b) 'Pharmaceutical Reform and Physician Strikes in Korea: Separation of Drug Prescribing and Dispensing', *Social Science & Medicine* 57(3): 529–38.
- Liu, X. (2004) *Contracting for Primary Health Services: Evidence on its Effects and a Framework for Evaluation*. Bethesda, MD: Partners for Health Reformplus, Abt Associates.
- Liu, X. and A. Mills (2002) 'Financing Reforms of Public Health Services in China: Lessons for Other Nations', *Social Science & Medicine* 54(11): 1691–8.
- Liu, X., Y. Liu and N. Chen (2000) 'The Chinese Experience of Hospital Price Regulation', *Health Policy Plan* 15(2): 157–63.
- Loevinsohn, B. and A. Harding (2005) 'Buying Results? Contracting for Health Service Delivery in Developing Countries', *The Lancet* 366(9486): 676–81.
- Mesa-Lago, C. (2008) *Reassembling Social Security: A Survey of Pensions and Health Care Reforms in Latin America*. New York: Oxford University Press, published in association with the Pan-American Health Organization.
- Mills, A. (1995) 'Improving the Efficiency of Public Sector Health Services in Developing Countries: Bureaucratic Versus Market Approaches'. Health Economics and Financing Programme, Health Policy Unit. London: London School of Hygiene and Tropical Medicine.
- Mills, A. (1998) 'To Contract or Not Contract? Issues for Low and Middle Income Countries', *Health Policy and Planning* 13(1): 32–40.
- Mills, A. and J. Broomberg (1998) *Experiences of Contracting Health Services: An Overview of the Literature*. Working Paper, Health Economics and Financing Programme. London: London School of Hygiene and Tropical Medicine.
- Ministry of Health, P.R. China (2004) *An Analysis Report of National Health Services Survey in 2003*. Beijing: Union Medical College Press.
- Mirza, Z. (1996) 'Non-emergence of Pakistan's National Drug Policy', *The Lancet* 348: 119.
- Musgrove, P. (1996) *Public and Private Roles in Health: Theory and Financing Patterns*. Washington, DC: The World Bank.
- Newbrander, W. (1997) *Private Health Sector Growth in Asia: Issues and Implications*. Chichester: John Wiley & Sons.
- Nittayaramphong, S. and V. Tangcharoensathien (1994) 'Thailand: Private Health Care Out of Control', *Health Policy and Planning* 9(1): 31–40.
- Peabody, J.W., M.O. Rahman and P.J. Gertler (1999) *Policy and Health: Implications for Development in Asia*. Cambridge: Cambridge University Press.
- Perrot, J., G. Carrin and F. Sergent (1997) 'The Contractual Approach: New Partnerships for Health in Developing Countries'. Macroeconomics Health and Development, Series No 24, Technical Document. Geneva: World Health Organization.
- Preker, A.S. and A.L. Harding (2000) *The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organizational Theory*. Washington, DC: The World Bank.
- Preker, A.S. and A. Harding (2003) *Innovations in Health Service Delivery: The Corporatization of Public Hospitals*. Washington, DC: The World Bank.

- Ramesh, M. (2004) *Social Policy in East and Southeast Asia: Education, Health, Housing and Income Maintenance*. London and New York: Routledge.
- Ramesh, M. (2008a) 'Against the Tide: Healthcare Reforms in Thailand', in M. Ramesh and S. Fritzen (eds) *Transforming Asian Governance*, pp. 154–67. London and New York: Routledge.
- Ramesh, M. (2008b) 'Autonomy and Control in Public Hospital Reforms in Singapore', *The American Review of Public Administration* 38(1): 62–79.
- Russell, S., S. Bennett and A. Mills (1999) 'Reforming the Health Sector: Towards a Healthy New Public Management', *Journal of International Development* 11(5): 767–75.
- Shaw, R.P. (1999) 'New Trends in Public Sector Management in Health'. World Bank Institute's Flagship on Health Sector Reform and Sustainable Financing. Washington, DC: The World Bank.
- Soderlund, N. and V. Tangcharoensathien (2000) 'Editorial: Health Sector Regulation: Understanding the Range of Responses from Government', *Health Policy and Planning* 15(4): 347–8.
- Supasit, P. (1996) 'Public and Private Mix in Health Care: Case of Thailand', in R. Haas, S. Mahbob and S.Y. Tham (eds) *Health Care Planning and Development: Conference Proceedings*, pp. 194–210. Kuala Lumpur: Friedrich Naumann Foundation and Malaysian Institute of Economic Research.
- Suwandono, A., A. Gani, S. Purwani, E. Blas and R. Brugha (2001) 'Cost Recovery: Beds in Public Hospitals in Indonesia', *Health Policy and Planning* 16 (Supplement 2): 10–18.
- Wagstaff, A. (2007) 'Health Systems in East Asia: What Can Developing Countries Learn from Japan and the Asian Tigers?', *Health Economics* 16(5): 441–56.
- WHO (2005) *The World Health Report 2005*. Geneva: World Health Organization.
- Wibulpolprasert, S. and P. Pongpaiboon (2001) 'Economic Dynamics and Health: Lessons from Thailand', *Development* 44(1): 99–107.
- World Bank (1993) *World Development Report 1993: Investing in Health*. New York: Oxford University Press.
- World Bank (2003) *World Development Report 2004: Making Services Work for Poor People*. New York: Oxford University Press.
- Yip, W.C. and W.C. Hsiao (1997) 'Medical Savings Accounts: Lessons from China', *Health Affairs* 16(6): 244–51.
- Zhong, J. (2001) 'Influencing Factors on Medical Quality and Measures for Management', *Chinese Journal of Hospital Management* 17(9): 536.
- Zwi, A.B. and A. Mills (1995) 'Health Policy in Less Developed Countries: Past Trends and Future Directions', *Journal of International Development* 7(3): 299–328.

Xun Wu teaches at the Lee Kuan Yew School of Public Policy in the National University of Singapore (e-mail: sppwuxun@nus.edu.sg). He has published extensively in reputed international journals on water resource management, health care reforms and energy policy.

M. Ramesh is Professor of Social Policy at the University of Hong Kong. He is the author or co-author of *Studying Public Policy* (OUP Canada, 3rd edn, 2009), *Social Policy in East and Southeast Asia* (Routledge, 2004), *Welfare Capitalism in Southeast Asia* (Macmillan, 2000), and *The Political Economy of Canada* (OUP Canada, 1999). He is the editor of the journal *Policy and Society* and co-editor of the *World Political Science Review*.

