

Realigning public and private health care in southeast Asia

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Abstract This paper compares health policy trends in Indonesia, Malaysia, the Philippines and Thailand with the purpose of drawing usable lessons in reform. The study finds that governments in the region are rapidly privatizing the *provision* of healthcare at the same time as they are expanding the government's role in *financing*. The paper argues that expansion of public financing at the same time as private provision is misconceived as the combination would aggravate instances and severity of market failures peculiar to the sector. The dysfunctional trend is particularly evident in Indonesia and the Philippines. In Thailand, in contrast, the expansion of public financing has occurred in the context of a health system dominated by public providers, which has had the effect of restraining healthcare costs. Malaysia occupies a mid position between Indonesia and the Philippines on the one hand and Thailand on the other. All four cases underline the value of state capacity in designing optimal policies and implementing them effectively.

Keywords Health policy; health care reforms; southeast Asia: health; government and market: health care; Indonesia; Malaysia; Philippines; Thailand

Southeast Asians have experienced substantial improvements in their health in recent decades, often under the aegis of massive state involvement in the provision and financing of healthcare (Ramesh and Asher 2000). However, the region now faces new challenges that make further improvements more difficult. The demand for quality and quantity of healthcare is increasing dramatically due to rapid economic growth, urbanization and ageing, which are placing a heavy burden on a public sector that is already stretched thin.

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Further improvements will require more resources than was the case in the past due to decreasing returns to health spending (Griffin 1992). The increase in income inequality and its adverse implications for healthcare access is a burgeoning problem which governments are finding difficult to address due to concerns about costs and uncertainties about the effectiveness of the means traditionally employed to reduce inequality (Peabody *et al.* 1999).

Southeast Asian governments, similar to their counterparts elsewhere, are addressing the emerging challenges by privatizing healthcare, hoping that the ensuing competition will increase efficiency while greater private payments will lighten the government's fiscal burden (Ramesh 2008a). In many countries, outpatient care is already dominated by the private sector and policy-makers are trying to extend it to hospital care. On the financing side, however, governments are expanding their role which, this paper will argue, will aggravate rather than ameliorate problems because of the nature of healthcare markets. If healthcare policies are to be effective, governments need to play an active role in both provision and financing. And to do that effectively, the paper will argue that they need a high level of state capacity which, ironically, is being eroded instead of strengthened due to the misdirected pursuit of privatization.

In this paper we examine the implications of the changing mix of public and private arrangements in the provision and financing of health care in Indonesia, Malaysia, the Philippines and Thailand. The existing literature on the public-private mix in healthcare in the region is based almost exclusively on single-country studies (for example, see Bennett and Tangcharoensathien 1994; Pannarunothai 1996; Aljunid and Zwi 1997; Mongkolsmai 1997; Pongpanich 1997; Roesma 2001; Gertler and Solon 2002). While these in-depth single country studies provide an empirically rich context to understand the specific aspects of healthcare in a particular country, they provide little insight into the patterns and directions of health policies. In contrast, cross-country comparative analysis of the public-private mix and the corresponding performance would enable us to relate differences in provision and financing arrangements to the performance of health systems.

For a systematic comparison of the four countries, we employ a conceptual framework capturing the inter-linkages between provision and financing in healthcare systems, as shown in Figure 1. The horizontal axis tracks the relative shares of public versus private financing in a given health system. In systems where the government is the principal source of healthcare funds, health is treated like any other item of public expenditure that is financed out of its general revenues. It essentially pools society's resources through the tax system (including mandatory social insurance premium) and provides care to those in need. Private financing, on the other hand, involves payment by consumer to the provider, either directly or indirectly through private insurer, employer or charity. In such a scheme, healthcare is treated

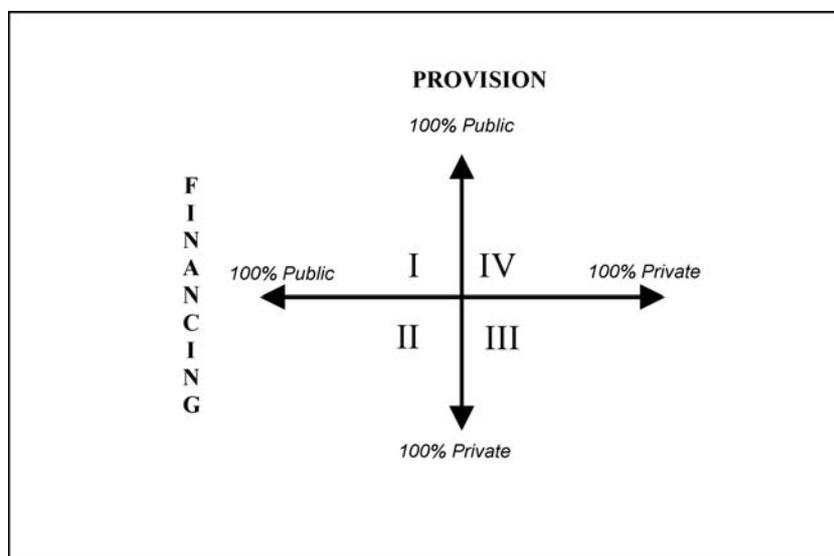


Figure 1 Public-private mix in healthcare.

as any other traded commodity whereby consumers buy, either directly or indirectly through insurer, from the provider of their choice at an agreeable price.

The vertical axis represents the relative position of the public and private sectors in delivering healthcare services. Public provision refers to health services provided by government agencies or other entities owned by the governments, such as public hospitals and clinics. Private provision, on the other hand, refers to health service provided by private entities which may or may not be motivated by profit (Bennett 1991). Indeed in the healthcare market non-profit private providers play a more important role than is the case in most other sectors.

The mix between public and private in any particular health system can be defined by its position in the space spanned by the dual dimensions of financing and provision. Governments play a predominant role in both financing and provision in systems depicted in quadrant I, while the private sector plays the dominant financing and provision role in systems in quadrant III. Systems with primarily public financing and private delivery can be projected into quadrant II, and quadrant IV represents those with private financing and public delivery.

Comparison of healthcare policies in Indonesia, Malaysia, the Philippines and Thailand employing the proposed framework shows that the state continues to play a critical role in the provision and financing of healthcare in the region, despite the rapid growth of the private sector in recent years.

More significantly, the state's role in the financing of healthcare has grown quickly in the region in recent years, which bodes ill for the future, especially in countries with large private provision. However, there are critical divergences among these countries in the mix of public and private mechanisms in the provision and financing of healthcare. At one extreme is Thailand, which has overwhelming state involvement in both provision and financing of healthcare and at the other is the Philippines with private dominance of both spheres. This paper will argue that it is not a coincidence that the former has performed substantially better than the latter in the healthcare arena.

Healthcare systems in southeast Asia

Indonesia

The Indonesian healthcare system is in the middle of major transformation and, as such, is characterized by contradictory trends in which centralization co-exists with decentralization and strong state controls parallel market-driven healthcare (WHO 2004a). Overall, the private sector is the dominant supplier of inpatient care, accounting for 67 per cent of all hospitals (*Jakarta Post* 2006). Private hospitals' share of the total grew particularly rapidly during the 1980s and 1990s – from 32 per cent in 1988 to 55 per cent in 1997 – until the outbreak of the Asian economic crisis reversed the trend somewhat.

Public health clinics (*puskesmas*) and family planning posts are free at the point of delivery, whereas public hospitals charge various fees, differentiated by class of accommodation chosen. User charges at health centres and at third-class rooms in public hospitals are about 50–80 per cent of unit costs, depending on the type of hospital (Setiana 2005).

National expenditures on health in Indonesia increased at a brisk pace during the early and mid-1990s, slowed down in the late 1990s and has recently begun to creep up again. The government's share of total healthcare financing in Indonesia was relatively small and shrank further during the economic crisis of the late 1970s, but has recovered in recent years, rising to 36 per cent in 2003 and is likely to continue to rise due to recent launch of new programmes. Healthcare financing in Indonesia is thus dominated by the private sector, with about two-thirds of total health expenditure coming out of pocket.

While the level of public financing is small, the number of public health financing programmes is large, though together they cover only 21 per cent (2004) of the population (Setiana 2005). Public sector workers are covered by ASKES (*Asuransi Kesehatan Pegawai Negeri*), which is a mandatory scheme for civil servants, military personnel, pensioners and their dependants, requiring a contribution of 2 per cent of basic wages from all eligible employees, topped off by a government contribution of 0.5 per cent. ASKES covers 7 per cent of the population. Private sector workers are covered by JAM-SOSTEK (*Jaminan Sosial Tenga Kerja*), which applies to all firms with ten

or more employees, but in reality covers only about 5 per cent of the private workforce due to non-compliance and a preponderance of small firms, which are excluded from the programme. JAMSOSTEK requires contributions of 3–6 per cent of gross wages paid entirely by the employer. There are also about 2 million people insured under the military health services system, covering all members of the armed forces and their dependants. Moreover, there is *Jaminan Pemeliharaan Kesehatan Masyarakat (JPKM)*, which is a voluntary scheme whereby approved health maintenance organizations (*bapels*) provide comprehensive inpatient and outpatient benefits at approved facilities that are paid on a capitation basis. Currently, there are 22 licensed *bapels* enrolling less than a half million people. Perceptions of poor quality and limited choice of services explains its lack of success in attracting more subscribers (WHO 2004b).

To cover the poorer segments of the uncovered population, a new financing scheme called the National Social Security System (*Sistem Jaminan Sosial Nasional*) was launched in 2005. It covers 60 million people, or 3 per cent of the population, and is run on managed care principles. It receives an annual government contribution of Rp5000 (US\$0.55 million) per person which amounts to a budgetary allocation of Rp1323 trillion (US\$144.33 million (Seinana 2005)). It is still a new programme and, if implemented as intended, will expand with maturation in both coverage as well as benefits which is likely to significantly raise public expenditure on healthcare.

Malaysia

Malaysia used to have the largest state presence in the healthcare sector in the region, but has lost the position to Thailand in recent years. The Malaysian public sector contains about 78 per cent of all hospital beds and 54 per cent of all physicians (Kanapathy 2003: 17). However, private hospitals have been proliferating rapidly since the 1980s and are projected to contain half of all hospital beds by 2020 (Malaysia 1996: 540). Outpatient services, in contrast to inpatient services, are dominated by the private sector, except for rural areas where government clinics are often the only health facilities available.

The Malaysian government has been talking about reducing its role in providing hospital care since the early 1980s but has not taken any substantial measure to put it in practice due to fears of political backlash (Ramesh and Asher 2000). In August 1999 the government finally shelved its privatization plan, but indirect privatization allegedly continues in the form of insufficient funds for the public sector, which allows the private sector to expand. The government recently launched pilot projects in two public hospitals involving the opening of a private wing charging full costs. Loss of public hospital medical staff to the private sector is a major problem in Malaysia and the government hopes to address the problem by boosting their income by allowing

them to retain the income they derive from work in private wings at higher fees.

In the realm of financing, Malaysia has a varied system built largely on government grants and out-of-pocket payments, although there also exist user charges in public hospitals, medical insurance (SOCSCO) and compulsory savings schemes (Account III within the Employees Provident Fund (EPF) scheme). All health services provided in rural areas are paid for from the government's general revenues and are free of charge at the point of delivery. Public hospitals, which tend to be located in urban centres, levy varying levels of nominal user charges according to the class of ward chosen. However, the total revenues collected from user charges form only 4 per cent of the government's health expenditure, which represents a huge subsidy. SOCSCO provides limited medical insurance, largely for occupational illnesses and accidents, whereas Account III contains 10 per cent of a member's total EPF funds and can be used only for treatment of serious illness. The Employment Injury Scheme under SOCSCO provides work-related sickness, employment injury and invalidity benefits to all employees earning less than M\$2,000 per month. It is funded from contributions of approximately 1.25 per cent of wages paid entirely by employers. However, payments through SOCSCO and Account III even together form only a small share of total healthcare expenditures because of the limited insurance the former provides and the small savings the latter requires.

The Malaysian government has proposed the establishment of a health insurance scheme called the National Health Financing Scheme (NHFS) scheme. It is expected to be jointly funded by employers and employees, with the government making contributions for the poor, the disabled, civil servants and retirees. An Australian consultancy has been appointed and is in the final stages of preparing its report (as of early 2008). Indications are that the scheme will have universal coverage but will provide only basic insurance. When established, it would represent a massive expansion of the role of the government in the financing of healthcare.

The Philippines

The Philippines has the most privatized system of providing healthcare in the region. Only two-fifths of all hospitals, about half of all hospital beds and two-fifths of physicians in the republic are in the public sector (Department of Health, Philippines 2005). A majority of providers are thus in the private sector.

National expenditure on healthcare rose in the early 1990s, but then declined rapidly and is yet to fully recover. Of the total in 2002, private out-of-pocket expenses formed 47 per cent and private insurance and HMOs 13 per cent; the remainder comes from the government budget or social insurance. While nearly half of the health expenditure in the Philippines is out-of-pocket, social insurance schemes have existed for more than 25 years.

Under the National Health Insurance Act of 1995, the government is committed to covering the entire population within 15 years. A newly formed Philippine Health Insurance Corporation (PhilHealth) took over the health insurance functions of social security schemes for public and private sector employees in 1999 and administers a unified health insurance programme providing inpatient and outpatient care. The health insurance premium is set at 2.5 per cent of monthly salary shared equally by employers and employees. In reality, the scheme has little relevance for majority of the population, who remain outside its coverage for various reasons, most notably because of the existence of a large informal sector.

The main programme for the poor is the Indigent Program or Medicare *para sa Masa* (MpM) which was established in 1997 to cover the poorest 25 per cent of the population within five years. However, by 2002, it had succeeded in covering only 15 per cent of the target group. The national government provides 75 per cent of the funding while local governments provide the remainder, which is a major problem due to the latter's precarious fiscal situation.

Thailand

Thailand has the largest public hospital care system in the region, with the public sector containing 77 per cent of all hospital beds, though this is a sharp decline from about 98 per cent in the mid-1960s. The share of all doctors working in the public sector is 79 per cent, though this is again a sharp decline from 93 per cent in 1970 (Ramesh and Asher 2000).

After rising rapidly during the 1980s and early 1990s, total healthcare expenditures as percentage of GDP in Thailand declined somewhat and in recent years have stayed below 3.5 per cent. The stable share of GDP spent on healthcare is remarkable because of the expansion of public financing schemes throughout the 1990s and, particularly, during the 2001–3 period. The expansion of the government's role in financing is reflected in the composition of total healthcare expenditures: the public sector's share increased from 33 per cent in 1978 (Pannarunothai 1996: 197) to 47 per cent in 1996 and 65 per cent in 2005. Public hospitals in Thailand used to recover a considerable portion of their costs from user charges but this is no longer the case following recent reforms.

Unlike other Southeast Asian countries, Thailand stands out in its efforts to systematically develop a universal healthcare financing system. There are three main health insurance funds: Social Health Insurance (SHI) under the Social Security Scheme, the Civil Servants Medical Benefits (CSMBS) and the Universal Healthcare Coverage scheme (UC) and together they cover almost the entire population. SHI is a compulsory social insurance scheme for those working in establishments employing one worker or more. It is funded from contributions from employers and their employees and it reimburses providers on a capitation basis. CSMB, on the other hand, is a tax-funded

program for active and retired military personnel, policemen, civil servants and employees of state enterprises and up to three of their dependants. It pays providers on a fee-for-service (GSS) basis which is believed to be a significant reason for rapid increase in expenditures compared to the other two schemes in Thailand.

Under the UC scheme, people not covered by SHI or CSMB can access the same healthcare without paying anything (the payment of 30 baht or 70 US cents per visit or per hospitalization was abolished in late 2006). It covers nearly two-thirds of the Thai population and provides comprehensive service coverage, including treatment for catastrophic illnesses and prescribed medication. It is almost entirely funded from the government's general tax revenues. Similar to SHI, and unlike CSMB, UC pays providers on a capitation basis. The annual capitation amount per subscriber is Bt2089 (approximately US\$65). UC members are required to register with one provider network, and have a choice if there are competing networks within their geographic area. The primary care provider is intended to act as the gate-keeper of access to higher-level services available at general and specialist hospitals because patients without a referral pay the entire cost out of pocket.

Thailand is a notable case because total healthcare expenditures did not increase despite expansion of tax-funded programmes to the entire population. Nor was there a decline in the admissions rate, which remained largely constant at around 6.4 per cent (NSO 2006). The salutary outcome is likely the result of efficiency gains within hospitals which had to learn to live within their capitation income despite the increase in their patient load.

Health policies in Southeast Asia in comparative perspective

The changes in the public-private mix in healthcare provision and financing during the last decade in the four Southeast Asian countries are summarized in Table 1. It shows that in all four countries the public sector's share in healthcare provision is declining and that of the private sector is expanding. There are many factors underlying these trends, but government policies have undoubtedly played a key role. In Indonesia, for example, the government adopted a policy in 1990 to limit the construction of new public hospitals to reduce its responsibility for financing secondary and tertiary care (Gani 1996). Similarly, the Seventh Plan (1996–2000) in Malaysia clearly stated that the government 'will gradually reduce its role in the provision of health services privatization in healthcare provision'. In Thailand, the share of total beds in private hospitals expanded rapidly in the 1980s and early 1990s due to the availability of corporate tax holidays, waivers for import taxes and financial support for new private hospitals (Berman 1997). The Philippines has had a large private healthcare system for a long time and the trend has deepened since the 1980s due to the country's wide-ranging privatization and deregulation programme.

Table 1 Public-private mix in healthcare provision and financing

	Provision. % of all hospital beds in the public sector		Financing. Public health expenditure as% of total health expenditure	
	1990s	2000s	1996	2005
Indonesia	69 (1990)	53 (2006)	28.5	34.7
Malaysia	86 (1989)	78 (2001)	48.0	54.4
Philippines	57 (1990)	51 (2003)	41.0	38.3
Thailand	88 (1988)	79 (2002)	47.2	63.9

Source: Griffin 1992; WHO (www.who.int/nha/country/en/index.html)

Nevertheless, the government continues to play an active role as provider of hospital care in every country in the region despite efforts to expand private provision. Even in the Philippines, where the private sector is the largest, the government still owns and operates slightly over half of all hospital beds. There are, however, critical differences among the four countries: in Thailand and Malaysia the governments continue to dominate the healthcare provision, as shown in the percentage of hospital beds owned by the public sector, whereas in Indonesia and the Philippines the private sector is almost at par with the public sector (Table 1).

The pattern in healthcare financing, as distinct from provision, is yet more different. While the overall level of healthcare expenditures in the four countries is small, they have grown rapidly since 1990 (Table 2). More remarkably, the role of the government in financing has actually expanded in recent years, with the exception of the Philippines where it has shrunk noticeably. Public health expenditures' share of total health spending increased modestly in Indonesia, sharply in Malaysia and spectacularly in Thailand.

Table 2 provides more details on the healthcare financing arrangements in the region. Over 50 per cent of the national health spending in Malaysia and Thailand is funded from the government's general revenues or, to a lesser extent, mandatory health insurance. The government's share is considerably smaller in Indonesia and the Philippines. Not only is the share of total expenditures accounted for by private expenditures large, albeit declining, around three-quarters of it is from out-of-pocket (OOP). Correspondingly, private insurance plays a small role in all four countries. The large share of OOP is likely to have a seriously deleterious effect in Indonesia and the Philippines because of their less developed government-financed schemes, unlike Malaysia and Thailand where the population can expect to receive healthcare even if they lack personal resources to pay for it. In Malaysia and Thailand, much of OOP is on outpatient care where the payments involved are relatively small and people prefer private clinics to public clinics which often involve considerable queuing.

Table 2 Sources of healthcare financing, per cent

	Indonesia		Malaysia		Philippines		Thailand	
	1996	2005	1996	2005	1996	2005	1996	2005
Total health expenditure (THE) as% of GDP	2.2	2.7	3.1	3.5	3.5	3.4	3.8	3.5
Government health expenditure (GHE) as% of THE	28.5	34.7	48.0	54.4	41.0	38.3	47.2	63.9
Social security funds as% of GGHE	9.6	21.3	0.8	0.8	12.2	24.1	7.2	12.4
Private health expenditure on (PHE) as% of THE	71.5	65.3	52.0	45.6	59.0	61.7	52.8	36.1
Private households' out-of-pocket payment as% of PHE	75.4	74.3	78.9	74.2	81.8	77.3	80.4	76.6
Prepaid and risk-pooling plans as% of PHE	4.3	6.0	9.0	13.2	6.6	12.8	9.5	15.6
External resources on health as% of THE	1.4	1.2	0.61	0.02	2.5	2.6	0.02	0.24

Source: National Health Account Tables 2007, World Health Organization, accessed at www.who.int/nha/country/en/index.html.

The differences in healthcare financing arrangements in the region may soon decline, however, as all four countries are moving towards comprehensive social health insurance. In Indonesia a social insurance scheme (SJSN) was launched in 2005 which provides comprehensive, if frugal, coverage to the less well-off segments of the population. MPM established in the Philippines in 1999 serves a similar purpose. The boldest reform is, however, Thailand's Universal Coverage scheme which provides basic healthcare to the entire population for negligible fees. Malaysia has had a comprehensive tax-financed hospital financing system and so is now looking at establishing a universal health insurance scheme co-funded by employers and employees, supplemented by government funding for premiums for the poor, disabled and the aged. All four countries are thus projected to continue to expand public financing of healthcare based on social insurance arrangements.

At the beginning of the 1990s, all four countries had healthcare systems characterized by public provision (as indicated by percentage of all hospital beds in the public sector) and private financing (as indicated by private expenditures as percentage of total health expenditures). Policy changes since the 1990s have, however, been expanding public financing while at the same time public provision is being reduced.

The recent changes in public-private mix in healthcare provision and financing will have profound impacts on healthcare costs and expenditures.

While the four countries (except Indonesia) currently spend similar proportions of their economic resources on healthcare, the differences in relative changes in health expenditure as a percentage of GDP during the last decade are revealing. In Indonesia and the Philippines, where the private and public sectors are broadly of equal size, the increase in total health expenditure has been greater than in Malaysia and Thailand where the public sector remains dominant. Indeed the country with the largest government involvement in healthcare, Thailand, health expenditure's share of GDP did not noticeably increase in the 2000s despite massive expansion of government-funded programs.

These counterintuitive findings – that total health expenditures grew faster in countries with relatively larger private payments – are not as odd as they appear if viewed in the context of the intricate relationship between provision and financing in the healthcare sector. In particular, the proliferation of national health insurance in countries where the private sector is the dominant supplier of healthcare is strongly correlated with explosion in expenditures. Based on their studies of public and private hospitals in Manila, Solon *et al.* (1995) report that for insured patients, private hospitals on average mark up prices by 20 per cent and physicians mark up prices by 50 per cent, while no such effect is discernible in the public sector. In Malaysia and Thailand too it is arguable that the public sector's dominance of healthcare provision is a key reason for maintaining healthcare costs at a modest level. That private provision of healthcare leads to cost inflation rather than restraint is further corroborated by Chan (2003), who found that privatization of hospital support services in Malaysia in 1996 tripled costs with no commensurate expansion of services or improvements in quality. The prospective payment system, whereby providers are paid through a global budget in Malaysia and on a capitation basis in Thailand, also helps keep expenditures down as providers do not have incentives to provide more services than necessary. This is unlike the fee-for-service payment system, dominant in Indonesia and the Philippines, which encourages providers to over-supply services and over-service.

The Thai case illustrates why public provision helps restrain costs. The establishment of universal health insurance in Thailand did not lead to cost escalation as expected, and indeed predicted by conventional economic thinking, because of the government's dominance of healthcare provision. The fact the government owned and operated an overwhelming majority of hospitals in Thailand allowed it to maintain tight reins on providers, which stymied the free-for-all behaviour that often accompanies third-party payment systems. The political will of the Thaksin government to provide universal healthcare without allocating additional financial resources, as reflected in the low capitation fees, further helped restrain expenditures. The Thai experience is in sharp contrast to South Korea's, where the combination of private provision and public financing led to explosion in healthcare expenditures following the launch of universal health insurance (Ramesh 2004).

Table 3 Per capita health expenditure, life expectancy and child mortality rate, 2004.

	Total health expenditures, per capita (at international \$ rate)	Life expectancy at birth	Child (under 5 years old) mortality rate (per 1,000 live births)
Indonesia	113	67	38
Malaysia	374	72	12
Philippines	174	68	34
Thailand	260	70	21

Source: WHO 2006.

Healthcare systems' performance needs to be evaluated with reference to expenditures rather than in absolute terms, as shown in Table 3. The table shows that the performance of health systems (measured by life expectancy and child mortality rates) roughly parallels healthcare expenditures in Southeast Asia. Further scrutiny of the data reveals more interesting findings.

The table shows that child mortality rates in Indonesia and the Philippines are high compared to Malaysia and Thailand, reflecting inadequate access to healthcare in the former. This in turn is likely a function of the dominance of private providers and private payments in Indonesia and the Philippines because their share of GDP spent on healthcare is similar to that in Malaysia and Thailand. The Philippines' case is particularly notable because its child mortality rate in 1960 was similar to the level in Malaysia but is now almost three times higher. It is possible that further expansion of public financing in Indonesia and the Philippines in the context of growing role of private provision will lead to accelerated growth in expenditures without corresponding improvement in health status.

The trends are clear: countries where the government dominates both provision and financing of healthcare have performed better than where this is not the case. This does not imply that public provision and financing is a sufficient condition for successful healthcare policy. To play its role effectively, the state needs capacity: analytical, administrative and, above all, political (Painter and Pierre 2005).

Without a bureaucracy with the capacity to analyse policy problems, governments will be unavoidably swayed by factors other than evidence (Evans 1995; Clark 2000; Polidano 2001). Without adequate analytical capacity, such bureaucracies are likely to resort to reform fads and formula responses, which over the last few decades have consistently favoured privatization and deregulation. International organizations groomed in mainstream economic thinking with which they often interact further entrench this line of thinking. When confronted with evidence of declining access due to privatization, and when it becomes politically unsustainable to ignore it, governments respond by expanding public financing for healthcare. However, due to the inextricable links between financing and provision, the drawback of weakening role in

provision cannot be overcome by strengthening financing. Indeed enhanced financing would worsen the situation because profit-driven providers now find a mechanism for expanding their services paid for by the government. If genuine reforms are to come about, health ministers need to understand that that inadequacies on the provision side cannot be compensated by strengthening the role of the state in financing.

Low administrative capacity may suggest the need for the state to shed more functions to the market, but markets can only work if there is adequate regulatory capacity to govern the behaviours of market participants. It is not surprising that demand for marketization reforms is the strongest in countries with lowest administrative capacity – Indonesia and the Philippines – when in reality these are the countries that need to be most cautious towards it. The privatization of healthcare provision that is going on will only further undermine the capacity and make future reforms even more difficult for these countries.

Political capacity has also changed in recent years due to democratization, with serious consequences for healthcare reforms. Democratization has transformed the objectives policymakers pursue and how they pursue it. The ill-conceived privatization of healthcare facilities following the success of similar measures in economic policy sectors hit the rocks when its adverse effects became gradually known. The subsequent spread and strengthening of democratic norms and practices meant governments could no longer ignore public demand for affordable healthcare and had to respond by expanding publicly financed schemes. The expansion of publicly financed programmes in response to democratic imperatives compounded the problems, as was mentioned earlier. The contradictory policy responses – privatization of provision and publicization of financing – are therefore understandably strongest in countries with the weakest state capacity: Indonesia and the Philippines.

Conclusion

Health policy reforms in Southeast Asia have been inspired by new public management ideas in vogue rather than the need to address actual public problems. In fact, the health systems in the four countries prior to the reform had fared reasonably well by international standards. The application of these ideas to the provision of healthcare had undesirable outcomes – rather predictably, in hindsight – to which the governments responded by expanding public financing, which in turn further compounded the problems.

While the optimal public-private mix in healthcare depends on a range of contingent circumstances, comparative analysis of four Southeast Asian countries in this paper reveals some enduring patterns. First of all, reforms directed at provision of healthcare cannot be considered in isolation from financing, and vice versa, due to intricate linkages between the

two. For example, the public sector's dominance of healthcare provision in Thailand played a critical role in preventing cost escalation following the introduction of universal health insurance. A proper public-private mix can only be formulated when the provision and financing of healthcare are jointly considered and alignment between the two is consciously sought.

Second, the analysis suggests that countries with larger government presence in healthcare have outperformed countries with smaller government involvement, a finding that is also corroborated by evidence from OECD countries (OECD 1992). Malaysia and Thailand – where the state dominates both the provision and financing of healthcare – have clearly outperformed Indonesia and Philippines in controlling health expenditures and maintaining access to healthcare. In the Philippines, limited state involvement in both provision and financing of healthcare has limited the tools available to the government to shape the sector. Talks of financing reforms have run up not only against limited financial resources but also weak organizational capacity, partly resulting from the existence of a large private sector which resists reform efforts that may curb its profit opportunities. In Indonesia during the early 1990s, the government deliberately reduced public provision in healthcare in order to promote the private sector, but the slack created by government disengagement was not filled by the private sector, resulting in reduced access for population. The recent launch of universal health insurance in Indonesia in the context of a provision system dominated by the private sector does not augur well because of the possibility of explosion in healthcare expenditures.

Third, the marketization and privatization of healthcare provision in Southeast Asia at the same time as public financing is being expanded is worrying, as the two together are a certain recipe for explosion in healthcare expenditures (Evans 1997). The availability of third-party financing to profit-motivated providers makes for few government- or market-based checks on providers' propensity to over-charge and over-service and thus drive up expenditures. In the healthcare sector, unlike most goods and services, competition among a multitude of providers promotes duplication of expensive equipment and services and an emphasis on frills, the combined result of which is higher rather than lower expenditures. This is not to deny that competition among providers improves services at the level of individual patients, but rather to point out that the costs to society as a whole may be high.

Fourth, our analysis indicates that universal health insurance is a more viable option for developing countries than commonly believed. The case of Thailand suggests that even if public expenditure on healthcare increases following the introduction of publicly financed universal health insurance, total health expenditure as per cent of GDP may decline under appropriate circumstances. The key to success is the government's ability to restrain providers' profit-maximizing urges, which in the case of Thailand was achieved through public ownership of hospitals combined

with payment on a capitation rather than a fee-for-service basis (Ramesh 2008b).

Finally, the healthcare reform experiences of Indonesia, Malaysia, the Philippines and Thailand with healthcare show the vital role that the state must continue to play in the healthcare sector. The willy-nilly extension of privatization to healthcare in these countries without fully comprehending the severities of the market failures that afflict the sector raised expenditures and restricted access. The spread of democratization has compounded the problem by pressuring governments to shoulder greater financing responsibilities which in the context of private provision aggravates total expenditures. If the goal of affordable and efficient healthcare for all is to be achieved, states must reassert themselves in provision before expanding public financing.

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