Case studies on Governance of mixed health systems: Indonesia and Vietnam

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Introduction

- Collaboration between PMPK at UGM, HSPI in Vietnam, and Nossal Institute at University of Melbourne through Health Policy & Health Finance Knowledge Hubs (AusAID)
- Country studies to examine role of non state sector in hospital service provision in Indonesia and Vietnam
- Growth, factors responsible, policy & regulatory frameworks, gaps, and contribution to health goals including equity
Mixed health systems in Indonesia & Vietnam

Commonalities

• Decentralized
• Public network: health centres, referral hospitals
• High OOP: Vietnam > Indonesia
• High use private providers for PHC
• State dominates in hospitals – but autonomy ⇨ operate as ‘for profit’
## Comparison of Indonesia & Vietnam health systems

<table>
<thead>
<tr>
<th></th>
<th>Indonesia</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP / capita ($PPP)(2008)</td>
<td>3600</td>
<td>2700</td>
</tr>
<tr>
<td>% Poor</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Life expectancy yrs (2008)</td>
<td>67</td>
<td>73</td>
</tr>
<tr>
<td>U5MR / 1000 (2008)</td>
<td>41</td>
<td>14</td>
</tr>
<tr>
<td>Total health % of GDP</td>
<td>2.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Per-capita $ USD</td>
<td>55</td>
<td>80</td>
</tr>
<tr>
<td>Public Expenditure % of total</td>
<td>51.8</td>
<td>38.7</td>
</tr>
<tr>
<td>Public % Govt expenditure</td>
<td>6.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Out of pocket % of private</td>
<td>73.2</td>
<td>90.2</td>
</tr>
<tr>
<td>Population covered by SHI</td>
<td>38%</td>
<td>42%</td>
</tr>
</tbody>
</table>
## Hospital Sector

<table>
<thead>
<tr>
<th></th>
<th>Indonesia</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Population (million)</strong></td>
<td>227</td>
<td>87.1</td>
</tr>
<tr>
<td><strong>Total hospitals (2008)</strong></td>
<td>1320</td>
<td>1163</td>
</tr>
<tr>
<td><strong>Beds / 10,000 population</strong></td>
<td>6.3</td>
<td>16.9</td>
</tr>
<tr>
<td><strong>No. hospitals / % non state</strong></td>
<td>653 (50%)</td>
<td>82 (7%)</td>
</tr>
<tr>
<td><strong>Not for Profit %</strong></td>
<td>85%</td>
<td>None</td>
</tr>
<tr>
<td><strong>For Profit</strong></td>
<td>85 (14%)</td>
<td>82 (100%)</td>
</tr>
<tr>
<td><strong>No. Beds / % non state</strong></td>
<td>53288 (37%)</td>
<td>6289 (4.4%)</td>
</tr>
</tbody>
</table>
Differences

Indonesia:
• Pluralistic – civil society power
• Relatively weak central govt - fragmented
• Parliament > executive

Vietnam
• Monolithic – party maintains power; weak civil society
• Central govt remains strong
• Executive > parliament
Case studies:
(1) Hospitals - Indonesia

- 50% hospitals NS; 85% NFP
- No specific policy until recent law: defines ‘public’ = state + NFP; ‘private’ = FP
- NFP adopting FP activities to maintain income
- Poor governance NFP – role of ‘hospital board’ in ‘governance’ not appreciated
- Hospital run by executive medical director
Case studies:
(1) Hospitals - Indonesia

NFP Associations: Christian (weak), Muslim (strong)

• Successful lobbying for new law
• Joint working party to develop regulations
• Not progressing: MoH reluctant to lead; MoF oppose
• Difficulty in dealing with conflict
Case studies:
(2) Hospitals – Vietnam

• NS hospitals < 10%
• All FP (no NFP entity)
• Targets in health strategy: 10% beds
• Incentives: land, taxes
• No direction on location / services
• Urban growth + profitable services
• ? Provincial level capacity to control / direct new growth
Case studies: (3) Workforce – Indonesia

• Low numbers specialist doctors – but key role in providing hospital services
• Concentration in cities and islands of Java-Bali
• Very few in rural – remote islands
• Low, scattered populations
• Income primarily private 85-90%
• Dual practice but primarily private time; neglect state hospital duties
Case studies:
(3) Workforce – Indonesia

• Govt policies:
  • Incentives for rural / remote work
  • Limit private practice to 3 locations
  • Scholarships for rural doctors to study

• Poor implementation
  • Rich local govts add incentives ⇒ competition to attract specialists among districts
  • 3 practice location limit largely ignored
  • Scholarship holders ‘buy out’ on gaining qualification
Case studies:
(3) Workforce – Indonesia

• Role professional associations
• Nominated in law: to provide CPD; colleges determine standards for specialist training
• Not professionally run – low income
• Resist measures to reduce influence – control new entrants at local level
• Focus on members’ interest rather than public interest
• Little involvement in consultation with MoH
Case studies:
(3) Workforce – Indonesia

• Role professional associations
• Result of study visit
• Invited to MoH workforce seminar
• New policy focus: specific policy for rural and remote areas
• POGI withdraws opposition to GP Plus
• POGI prepared to link specialist training to areas of need identified by MoH
Case studies:
(4) Workforce – Vietnam

- Difficulty attracting / retaining doctors in district / remote provinces
- ‘Bypass’ of district hospitals / health centres ⇒ overload of central / provincial hospitals
- Decree 1810: compulsory rotation to peripheral hospitals ? Effectiveness
- Regulation of dual practice by hospital director ? Ineffective
- Prof associations exist by ? Role
Implications for governance

• Sense of ‘Ungovernable’ systems
  – Market dominates: limited supply + growing demand and capacity to pay
  – Fragmented and competing – institutions, levels of government, providers
  – No sense of collective purpose – loss of ‘public welfare’ mission
  – Limited respect for the ‘rules’
Implications for stewardship

• Sense of trying to regain power / control
  – Focus on ‘rules’ – licensing
  – Central level tries to ‘re-centralize’
  – Limits autonomy by limiting ‘discretionary’ funds – earmarked funding streams, complex planning process

• Inconsistent policy responses
  – Demand side financing – UC
  – Little control of costs / service standards – institutions don’t have capacity for DRG funding
  – Administer public programs but ‘marginal’
Literature lessons on regulation

• Regulation of dynamic system of inter-related markets and actors (Bloom & Champion)

• Use range of mechanisms including co-regulation (partnerships), self regulation, and market mechanisms (collective purchasing, contracting)

• Cannot rely on ‘command & control’ mechanisms only

• Feasible processes, which build trust & enhance social cohesion

• Include monitoring of compliance and action on non compliance

• Coordinated and integrated to provide consistent incentives and direction, rather than contradictory
Potential regulatory options

- Strengthen state provision as ‘beneficial competitor’ (Mackintosh)
- Build ‘public benefit culture’ (Mackintosh) – encourage NFPs, define social responsibilities
- Collective purchasing with payment linked to expected quality, users
- Strengthen consumer voice: provide information, deal with complaints
- Develop role of third parties / professional groups in ‘co-regulation’
Regulatory challenges

• Providing overall policy framework to coordinate & integrate regulation
• Developing regulatory culture and capacity in decentralised government system
• Developing skills and capacity in collective purchasing arrangements
• Avoiding regulatory capture in co-regulation
• Balance incentives, sanctions, trust & compliance monitoring
Questions

• What are the issues / themes for governance in health systems of LMIC?
  – Context: mixed health systems & commercialised; LMIC government context – resource limits; policy
  – low regulatory capacity; autonomy, fragmentation
  – Policy challenges in a new situation: equity of access; quality (Kabir’s 4)
  – Old model: MoH directive
  – New models: responsive regulation; collaborative governance; institutional governance
Questions

• Where / what can research contribute?
  – Policy actualization in real world; not just documented policy
  – Analysis of ‘new models’
  – Analysis of policy issues / questions: policy objectives (innovation, quality, equity)
    • Dual practice
    • Planning / directing growth of private facilities / providers
    • Addressing workforce distribution
    • Informal payments
    • Institutional governance – hospitals, HEF
Questions

• Type of analysis? How to bring governance lens?
  – Link to mixed health systems?
  – Link to weaknesses in policy making / policy implementation / failure to harness non-state
  – = problems / challenges in governance
  – Clarify governance concepts / definitions
  – Draw out governance implications from country studies on policy issues
  – Identify governance at different levels: national, subnational, institutional
Questions

• Where can we / Nossal contribute?
  – Which have policy relevance?
  – Which are likely to impact on the poor?
Workforce distribution

- Context – mixed health systems + countries selected
- Concepts & definitions: governance, stewardship, regulation
- Describe policy issue / problem statement: equitable distribution to provide access to rural / poor / remote
- Describe governance arrangements - + ideas, ‘software’, values; institutions – state, non state
- Describe lessons from case studies relevant to governance, policy making / implementation
- Discuss / identify options to address policy / governance challenges (accountability, government – non govt roles, levels of autonomy & decisions)
- Discuss / identify implications for broader development agenda / development partners
Concepts

• Define question first!
• Context description – LMIC mixed health systems / typologies (Kabir)
  Leichter 4 contexts: situational, structural, cultural and external. (Abby)
• Concepts – multilevel governance (delegation of powers, continual
  negotiation) ? Governance as sites of negotiation (Paul – conceptual
  /analytic inputs)
• Governmentality – neoliberal: creating self governing domains in civil
  society ; governing ‘freedoms’ (Paul)
• Health governance – frameworks (Kabir) (plus Abby)
• Governance interventions / options – national, subnational, institutions
  (Nossal) (+ Abby)
• Evidence of effectiveness of governance interventions
• Tools
Next steps

• Outline paper on health workforce distribution issues – circulate + additions
• Identify papers that might grow out of this
• Or move to other topics
Next steps

• Definitions – many different definitions and concepts: mixed systems, policy, stewardship, governance, regulation
  – Don’t aim for comprehensive definition but state definition for each piece of work

• Tools – policy analysis approach
  – Responsive regulatory pyramid – explore dynamics
  – Regulatory architecture tool
  – Context (but how to measure- typologies?)
• Research topics – criteria to decide
  – Synthesis level
  – What conditions lead to successful intervention? What were processes or mechanisms thru which successful intervention undertaken?