The growth of non-state hospitals in Indonesia and Vietnam: market reforms and mixed commercialised health systems

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First draft – April 2012

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This Working Paper represents the views of its author/s and does not represent any official position of the University of Melbourne, AusAID or the Australian Government.

ACKNOWLEDGEMENTS

This paper is the product of previous work on non-state hospitals in Indonesia and Vietnam to which many people contributed, including: Ahmer Akhtar (Nossal Institute for Global Health); Laksono Trisnantoro, Shita Dewi and Andreaasta Meliala (Centre for Health Service Management, University of Gadjah Mada, Indonesia); Khuong Anh Tuan and Tran Thi Mai Oanh (Health Policy and Strategy Institute, Ministry of Health, Vietnam); Kabir Sheik and Lakshmi Prasad (Public Health Foundation of India). All three papers were revised and edited by Peter Annear (Nossal Institute for Global Health).
SUMMARY

This paper is based on studies of the recent growth and the roles and functions of non-state hospitals in Vietnam and Indonesia undertaken by the Health Strategy and Policy Institute, Vietnam, the Centre for Health Service Management, Universitas Gadjah Mada, Indonesia (Hort, Trisnantoro et al 2011; Hort, Tuan et al 2011) and the Nossal Institute for Global Health, Melbourne. It attempts to compare the findings in the two countries, to describe key aspects of their health systems and to examine these developments in the light of literature on similar countries in the region and internationally. The aim is to understand better the significance of the growth of non-state hospitals in the two countries and the implications for policy makers. An initial review of the literature identified a range of approaches to examining the role of the private sector and public sector engagement of private providers, including health sector market reforms and commercialised mixed health systems. These concepts were used in reviewing the findings from the studies in Indonesia and Vietnam.

The country studies demonstrated similarities in the growth of for-profit (FP) hospital providers and in the growing commercialisation, high levels of private health financing and mixed public-private nature of their health systems. Many of these characteristics were consistent with the published literature on commercialised mixed health systems. While there were differences in some aspects of the historical and socio-political contexts behind these developments in the two countries, other factors, such as the influence of medical specialists, community demand and capacity to pay and economic growth, were common between the countries.

The countries faced similar issues regarding the effects of these new developments in their health systems on the achievement of objectives. While there was evidence of gains from the public-private mix in the availability of services and technical efficiency, there were concerns about the impact on allocative efficiency, quality of services and equity. In particular, the growth of FP providers in urban and wealthier areas may be contributing to unequal access to services for rural and poorer communities, despite government investments in social health insurance.

Assessing health service delivery from the perspective of commercialised mixed health systems (rather than purely public or private service delivery) shifts the key policy question from 'how to engage the private sector' to 'how to manage a mixed commercialised system of public and private actors' to achieve national health goals. This will require new approaches and new capacity in the use of a number of different policy and regulatory levers, combined and aligned with appropriate financing and payment incentives and with a stronger partnership between government, civil society and professional organisations.
INTRODUCTION

This paper is the third in a series that reports the findings and identifies the policy implications of studies of the role of non-state sector hospitals in Indonesia and Vietnam. The first two papers focused on each country (Hort, Trisnantoro et al 2011; Hort, Tuan et al 2011); this paper reflects on the major themes emerging from the country studies, how these relate to the literature on non-state providers (NSP) and the implications for policy makers and development partners of countries in the region.

The country studies were undertaken by the Centre for Health Services and Management at the Universitas Gadjah Mada in Indonesia and by the Health Strategy and Policy Institute, Ministry of Health, in Vietnam. The studies were a response to the recent growth of non-state providers, particularly FP providers, in the hospital sector. There is now a large body of evidence on NSP involvement in health systems of low and middle income countries (LMICs), particularly in Asia. The significance of non-state providers (NSP) is demonstrated by the high proportion of total health expenditure contributed by private expenditure (typically 50 to 70 per cent), most of which is in the form of out-of-pocket (OOP) payments at the point of service. In addition to user fees and co-payments for state-funded services, much of this OOP expenditure is for services from non-state providers (WHO 2009; WHO 2010).

Studies have demonstrated that the non-state sector contributes a large proportion of ambulatory or primary health care services despite the existence of extensive networks of state-funded services and facilities in LMICs. This is also the situation in Indonesia and Vietnam. In Indonesia, 30 per cent of all outpatient care is provided privately, while in the more urbanised areas of Java and Bali the private sector provides more than 50 per cent of outpatient services (Rokx, Schieber et al 2009). In Vietnam, the private sector provides an estimated 35 per cent of outpatient care in urban communities and 23 per cent in rural communities (Trieu, Lieu et al 2008).

Less is known about the contribution of non-state hospitals (hospitals tend still to be dominated by state providers) even though the sector consumes a large proportion of health system resources (Hanson, Archard and McPake 2001). The role of non-state providers of hospital services is likely to increase, along with the evident rise in non-communicable diseases as a proportion of the total disease burden, the increasing demand for high technology services from consumers with the capacity to pay and the increased finance available from social health insurance schemes (WHO 2008).

The earlier Indonesia and Vietnam country studies focused on examining the following issues:

- What role in providing services and treating patients are non-state hospitals undertaking in each country?
- What are the main factors determining the current role and future potential of non-state hospitals?
- How does the non-state sector contribute to or impact on the health system objectives of efficiency, quality, equity and availability?
- In relation to these objectives, what are the gaps in the current policy and regulatory framework, and what are the options for addressing them?

This paper identifies and compare the findings in the two countries, describes key aspects of their health systems and examines these developments in the light of literature on similar countries in the region and internationally. The aim is to understand more fully the significance of the growth of non-state hospitals in the two countries and the implications for policy makers.

METHODS

The two country studies combined the analysis of routine quantitative data on non-state hospitals and qualitative studies about the function of and services provided by selected non-state hospitals (Hort, Trisnantoro et al 2011; Hort, Tuan et al 2011). The quantitative data were collected from Ministry of Health reports and databases, while the qualitative studies examined hospital performance data and interview data from hospital managers and hospital staff. In Indonesia, the qualitative study focused on not-for-profit (NFP)
hospitals and medical specialists, while in Vietnam it focused on state and non-state hospital managers and staff.

Methods for cross-country comparison of health systems and health system performance are still developing, and there is not yet a common framework or approach. A key issue is how to deal with differences in context between countries. McPake and Mills (2000) suggest that findings from country studies can be divided into three categories: generalisable, specific (to contexts) and categorisable (applying to contexts with certain similarities). Studies by the World Bank (Gottret, Schieber and Waters 2008) and the European Observatory on Health Systems (Kutzin, Cashin and Jakab 2010) that compare health financing strategies across countries recommend explicit consideration of context and the use of a clear conceptual framework. We have applied these recommendations in this paper. We carried out a purposive search of the literature to identify appropriate and relevant theories and conceptual frameworks, looking at a variety of disciplines including economics, political economy, sociology and politics, and used web-based search engines as well as searches of documents on relevant websites.

The paper is arranged in the following sections:

- theoretical and conceptual frameworks identified in the literature;
- findings, including description and comparison of health system contexts; comparison of findings from studies of the growth and role of non-state hospitals; policy and regulatory frameworks; and impacts on health system objectives;
- discussion, including examination of the findings in relation to conceptual frameworks and identification of the implications for policy;
- conclusion and summary.

Review of the Theoretical Literature

Much of the recent international literature is based on distinguishing the roles of public and private providers and focuses on how to engage the private (non-state) sector in achieving national health goals. Among commentators, some have actively embraced the growth of the non-state sector and propose ways to engage it better (England 2009); some have recognised that the non-state sector is part of the health system and needs to be appropriately managed (Lagomarsino, Nachuk and Kundra 2009); and others have been sceptical of the role of the non-state sector and emphasise the need to invest primarily in state services (Mills, Brugha et al 2002).

Defining and Distinguishing ‘State’ and ‘Non-State’

Hanson, Gilson et al (2008) argue it is not the ownership of health facilities but the nature of the incentives and the quality of management and oversight that determine how providers behave. They question whether the profit incentive of the private sector could be problematic in achieving public-good goals. In the same article, Smith, Feachem and colleagues argue that, in Asia-Pacific countries, the non-state sector already contributes significantly to health care delivery. The question, they claim, is not ‘can the private sector help?’ but rather ‘how can private-public partnerships be made more effective and equitable?’

A series of papers funded by the Rockefeller Foundation in 2009 argued that many countries already had large private markets for health care, and these markets were unlikely to go away in the short term. Consequently, the summary paper of the series concentrated on the barriers to stewardship of the private sector and on the options for reform (Lagomarsino, Nachuk and Kundra 2009). This discussion continued through the work of the High Level Taskforce on Innovative International Funding for Health Systems (Fryatt, Mills and Nordstrom 2010).

This is a complex area, and there is a need for further evidence. One of the complexities is in defining and distinguishing ‘state’ from ‘non-state’ providers. While definitions tend to focus on ownership, the boundaries between state and non-state are blurred by non-state investment in state facilities, by financial autonomy of state facilities and by state-employed medical staff who also work in non-state facilities (dual practice) (Bloom, Champion et al 2009). In many cases, policies intended to reform public sector administration have attempted
to introduce a private sector culture and approach. This is further complicated by reference to ‘public’ and ‘private’ sectors: in some cases ‘public’ refers to government services and in others to population health services; and in some cases private facilities may deliver services that are generally open to the public and partly financed by the state. We have chosen to use the terms ‘state’ and ‘non-state’ to avoid this confusion.

**Market-Based Reforms**

Jakab, Preker et al (2002) describe the rationale and recommended approach for market-based health-sector organisational reforms. They argue that performance issues related to public (i.e. state) provision of health services include:

- technical inefficiency: resource waste, poor morale, high staff numbers, equipment not used;
- allocative inefficiency: high budget allocation to hospitals serving urban elites and neglect of more efficient interventions;
- inequity: hospital services not accessible to the poor;
- poor responsiveness to clients, especially the poor.

They suggest that market organisational reforms can improve efficiency and responsiveness but are unlikely to reduce inequities in access or financial protection. Such reforms need to address two aspects: internal organisation of hospitals and external operating environments (Boxes 1 and 2).

**Box 1: Health Sector Market-Based Reforms: Internal Hospital Reforms**

- **Autonomy**: Allow hospital management the right to make decisions on aspects of hospital function, including inputs (labour as well as capital and investment), outputs and process (user fees).
- **Market exposure**: Ensure the hospital is subject to competition from other suppliers, in both the product market (production of outputs and delivery of services) and factor markets (obtaining inputs such as physicians and capital).
- **Residual claimant status**: An organisation’s residual claimant status reflects the degree of enforced financial responsibility, both the ability to keep savings and responsibility for financial losses (debt). Limit or remove any residual claimants external to the hospital.
- **Accountability**: Hold the hospital responsible and answerable for performance to patients, payers, owners or regulators.
- **Social functions**: Explicitly define the services the hospital is required to provide for which the revenues earned do not cover costs, but there are social benefits to the community or public.

Source: Jakab, Preker et al 2002

**Box 2: Health Sector Market Reform: External to the Hospital Operating Environment**

- **Government oversight**: The government provides adequate oversight in the health sector in (1) formulating health policy by defining vision and direction for the sector; (2) regulating the actors in the health system; and (3) collecting and using information.
- **Organised purchasing**: Purchasing services through collective or organised purchaser(s) determines the financial incentives embedded in the payment mechanisms and the extent of competitive pressures on hospitals.
- **Market pressures**: The hospital’s relationship with its consumers (market-driven purchasing) determines the extent of competitive pressures the hospital is subject to from unorganised individual consumers, exercised through choice and user fees.
- **Ownership and governance**: Governance is commonly defined as the relationship between the owner and management of an organisation; good governance is said to exist when managers closely pursue the owners’ objectives rather than their own.
Commercialised Mixed Health Systems

A number of commentators have drawn attention to the mixed public-private nature of many health systems in LMICs, and some have referred to the increasing commercialisation of these systems (Mackintosh 2007; Bloom, Champion et al 2009, Nishtar 2010). Mackintosh and Koivusalo (2005) define commercialised mixed health systems as:

the provision of health care services through market relationships to those able to pay; investment in and production of those services and of inputs to them, for cash income or profit, including private contracting and supply of publicly financed health care; and health care finance derived from individual payments and private insurance.

Key aspects include:

- marketisation: the shift from provision and input supply without fee to fee-for-service provision and cash payment for inputs;
- commoditisation: the specification of items of service provision in a form capable of being sold on a market;
- privatisation: the shift of an asset from government ownership into private hands; and
- liberalisation: removal of constraints on private provision of health care services and purchase and sale of inputs; (Mackintosh 2007).

Nishtar (2010) identifies similar characteristics in what he terms the ‘mixed health systems syndrome’:

- insufficient state funding for health;
- an environment that allows the private sector to deliver social services without an appropriate regulatory framework;
- lack of transparency in governance.

He suggests that this syndrome compromises the quality of public services and equity of access.

Bloom, Standing and Lloyd (2008) have drawn attention to some of the underlying social characteristics of markets in LMICs countries that persist in commercialised mixed systems. They note that these markets are typically unorganised, informal and unregulated, with porous boundaries between public and private sectors, and weak government regulatory capacity. They identify the importance of trust in relationships between seller and purchaser in all markets, noting that trust based on social norms ‘impose[s] a self enforced order on a market, compelling agents to behave fairly and constrain individual interest ... in exchange transactions’.

However, they also note that LMICs, where such markets have developed only recently, lack a history of the gradual development of institutional arrangements and accepted roles that govern behaviour in more developed Western markets. They suggest that in these situations there is a need to foster trust-based institutional arrangements that provide a reasonable guarantee of competence and effectiveness for market transactions.

FINDINGS

Health System Characteristics

Both Indonesia and Vietnam have mixed health systems, with large networks of state-owned facilities as well as significant provision and use of private providers and private facilities. In primary care, the use of private providers for ambulatory care through the formal sector (Western or traditional medicine), the informal sector (traditional healers) or direct purchase of medicine from retailers may equal or exceed the use of state providers.

Both countries have invested over the last few decades in a state network of primary health care facilities (village and subdistrict community health centres), as well as district hospitals, now reaching most areas of each country. However, at only 1.2 per cent of GDP in Indonesia, and 2.8 per cent in Vietnam, government
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expenditure on health is low in comparison to similar countries. Private, mainly OOP, expenditure is a major source of expenditure on health care, accounting for 40 per cent of total health expenditure in Indonesia and 55 per cent in Vietnam.

The government in each country has invested in improving financial protection against health costs, through social health insurance for the formally employed population and subsidised schemes covering the majority of the poor. Socio-economic and health indicators are summarised in Table 1.

Health Outcomes
Health outcomes have improved in both countries. Life expectancy has increased, and both are mostly on track to achieve the health MDGs. Vietnam is likely to achieve both MDG 4 and 5; while Indonesia is making good progress on reducing child mortality, it is not making as much progress on reducing maternal mortality and may not achieve MDG 5. However, both countries face challenges in three areas:

• persistent inequalities in access to health services and health outcomes between rural and urban areas, and between rich and poor; in Vietnam, recent evidence suggests these inequalities are widening (Lieberman and Wagstaff 2009);
• a rising burden of illness and mortality from non-communicable diseases; the need to refocus health systems to address chronic diseases; and the need for public policies to prevent them (Trieu, Tien et al 2009);
• expanding financial protection and moving towards universal coverage; different schemes provide some protection for the poor, and social health insurance covers formal sector workers in public service or private enterprises; the challenge is to provide coverage for the large informal sector and to reduce OOP expenditure at the point of service. In Vietnam, total health expenditure has grown rapidly, reaching 7.2 per cent of GDP in 2008 (Trieu, Tien et al 2009).

The Hospital Sector
Interesting differences between the two countries are evident in the hospital sector. Vietnam has a much higher bed-to-population ratio (one of the highest in South-East Asia), much higher average bed occupancy rates (often exceeding 100 per cent) and higher case-flow rates than Indonesia. The referral system functions poorly, causing an overload of central and provincial hospitals while district and community level facilities are bypassed. State hospitals are dominant, and hospital funding uses 79 per cent of government health expenditure (Rokx, Schieber et al 2009), while non-state hospitals comprise only 7 per cent of all hospitals nationally.

Table 1. Socio-Economic and Health Indicators, Indonesia and Vietnam (2008-09)

<table>
<thead>
<tr>
<th></th>
<th>Indonesia</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP/capita (US$PPP)(2008)</td>
<td>3600</td>
<td>2700</td>
</tr>
<tr>
<td>Poor as per cent of total population</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Life expectancy in years (2008)</td>
<td>67</td>
<td>73</td>
</tr>
<tr>
<td>USMR/1000 live births (2008)</td>
<td>41</td>
<td>14</td>
</tr>
<tr>
<td>Total health expenditure as per cent of GDP</td>
<td>2.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Health expenditure/capita US$ER/PPP</td>
<td>55/99</td>
<td>80/213</td>
</tr>
<tr>
<td>Government health expenditure as % total health expenditure</td>
<td>51.8</td>
<td>38.7</td>
</tr>
<tr>
<td>Government health expenditure as % total government expenditure</td>
<td>6.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Government contribution to SHI as % govt health expenditure</td>
<td>13.7</td>
<td>31.4</td>
</tr>
<tr>
<td>Out-of-pocket as per cent of private health expenditure</td>
<td>73.2</td>
<td>90.2</td>
</tr>
<tr>
<td>Per cent of population covered by government-funded SHI schemes</td>
<td>38</td>
<td>42</td>
</tr>
</tbody>
</table>

Notes: ER = exchange rate; PPP = purchasing power parity; SHI = social health insurance.
Indonesia has a much higher proportion of non-state hospitals, around 50 per cent of hospital numbers in 2008, with the big majority (82 per cent) managed by NFP organisations. Indonesia also has much lower hospital bed-to-population ratios and lower hospital utilisation, resulting in a much lower proportion of government health expenditure being used in hospitals (38 per cent). Hospital indicators are summarised in Tables 2 and 3.

Role of the Non-State Sector

The studies in Indonesia and Vietnam demonstrated significant growth in the non-state hospital sector in both countries over the last five to ten years. This was particularly evident in the growth of FP hospitals. While still a relatively small proportion of the total number of hospitals (4-7 per cent), the numbers nearly doubled in the last five years in both countries. In Indonesia, the numbers increased from 49 to 85 and in Vietnam from 45 to 82.

However, a major difference is in the contribution of NFP providers of hospital services, which are 85 per cent of the non-state hospitals in Indonesia but are virtually non-existent in Vietnam. This is largely the result of decisions made early in the political development of the two countries: colonial era charitable hospitals in Vietnam were nationalised but in Indonesia were allowed to continue to operate.

Thus, consideration of the role of the non-state sector needs to differentiate between FP and NFP providers. For-profit providers in both countries tend to focus on the urban and wealthier segments of the population and to provide higher technology services with improved amenities, targeting specific market segments. Each of the non-state hospitals in the Vietnamese study specialised in particular areas, determined by demand and the availability of the required medical workforce. Thus a large hospital in Ho Chi Minh City specialised in haemodialysis and assisted reproductive technology, while a smaller hospital in a provincial centre specialised in endoscopy, which was not available at the local state hospital. Similarly, in Indonesia many of the non-state hospitals were founded by specialist doctors and provided services in the area of their medical specialty.

On the other hand, as noted, NFP hospitals in Indonesia made up the majority of the non-state providers and tended to provide more charitable services, with a significant proportion (38 per cent) located in rural areas outside the main islands of Java and Bali. However, it was clear that NFP hospitals in Indonesia were facing significant pressures to commercialise and were having difficulty maintaining their social welfare mission. These changes resulted from the loss of subsidies previously provided by government and parent charitable organisations.

<table>
<thead>
<tr>
<th>Table 2. Hospital and Population Indicators, Indonesia and Vietnam (2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indonesia</strong></td>
</tr>
<tr>
<td>Total population (million)</td>
</tr>
<tr>
<td>Total number of hospitals (2008)</td>
</tr>
<tr>
<td>No. of non-state hospitals and per cent of total hospitals</td>
</tr>
<tr>
<td>Total no. of hospital beds (2008)</td>
</tr>
<tr>
<td>Beds/10,000 population nationally</td>
</tr>
<tr>
<td>No. of non-state hospital beds and per cent of total hospital beds</td>
</tr>
</tbody>
</table>

Source: Data compiled from Ministry of Health reports in Vietnam and Indonesia.

<table>
<thead>
<tr>
<th>Table 3. Hospital Performance, Indonesia and Vietnam (2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indonesia</strong></td>
</tr>
<tr>
<td>Bed occupancy rate</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
</tr>
<tr>
<td>Average no. of cases/bed/year</td>
</tr>
<tr>
<td>Hospital funding as per cent of government health expenditure</td>
</tr>
<tr>
<td>No. of doctors/100,000 population</td>
</tr>
</tbody>
</table>

Source: Rokx, Schieber et al (2009), Trieu, Tien et al 2009
organisations and the current lack of tax concessions. As a result, there had been little growth in NFP hospitals over the last decade and some conversion to FP management.

**Policy and Regulatory Frameworks**

The regulation of the non-state sector differs historically between Indonesia and Vietnam. At the time of independence, Indonesia recognised the colonial health providers, allowed them to function and permitted dual practice to continue. Indonesia has not, however, developed a clear policy or regulatory framework for the non-state sector and uses the common legal entity of foundations (yayasan) to cover NFP providers. Vietnam nationalised colonial non-state hospitals at independence, prohibited private sector providers for a subsequent period and introduced a policy for the engagement of the private sector in the late 1990s; although nominally NFP, most non-state hospitals have been established as FP entities. The government provides specific targets in national plans for non-state hospital bed provision but gives little guidance on the expected role or contribution of non-state providers. In both countries the regulatory frameworks focus on licensing procedures, based on workforce and facility inputs, with little ongoing monitoring or measurement of the quality or standards of care.

Despite recent developments in the licensing of hospitals and the medical profession, the studies identified a number of gaps and weaknesses in the policy and regulatory frameworks, summarised in Table 4. For many regulations, enforcement and compliance are weak. Each country passed laws for the health sector in 2009 and 2010 that introduced new requirements for the licensing of health professionals, licensing of facilities, accreditation of quality of services and rights of consumers. The provisions in these laws are being translated into regulations, but full implementation will take some time.

<table>
<thead>
<tr>
<th>Policy or regulatory aspect</th>
<th>Indonesia</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy direction</strong></td>
<td>Little mention of non-state sector in policy directives.</td>
<td>Targets for hospital beds but little direction on role or services.</td>
</tr>
<tr>
<td><strong>Market entry</strong></td>
<td>No structure or process for regulator dialogue with non-state sector.</td>
<td>No structure or process for regular dialogue with non-state sector.</td>
</tr>
<tr>
<td><strong>Quality standards</strong></td>
<td>Licensing requirements focus on inputs. No controls over location or services / technology provided.</td>
<td>Licensing requirements focus on inputs. No controls over location or services / technology provided.</td>
</tr>
<tr>
<td><strong>Lack tools / instruments to measure quality.</strong></td>
<td>No regulation.</td>
<td>No regulation.</td>
</tr>
<tr>
<td><strong>Prices / Payment</strong></td>
<td>No regulation.</td>
<td>Government standard charges, but non-state not required to comply.</td>
</tr>
<tr>
<td><strong>Consumer voice</strong></td>
<td>No regulation of information to be provided to consumers.</td>
<td>No regulation of information to be provided to consumers.</td>
</tr>
<tr>
<td></td>
<td>No specific mechanism for consumer complaint.</td>
<td>Local complaint mechanisms only.</td>
</tr>
</tbody>
</table>
Contribution to Health System Objectives

In general, health systems should achieve objectives related to access, efficiency, quality and equity in the distribution of health services (WHO 2007).

Service utilisation and access

In Vietnam, given the limited size of the non-state sector, its contribution to services provided or patients treated is obviously small. The Vietnamese study estimated that 7.2 per cent of outpatients and 3.4 per cent of inpatients across the country were treated in non-state facilities. In Indonesia, the much larger non-state sector makes a larger contribution to patients treated (though the precise numbers and the proportion of total hospital numbers are not available).

Notwithstanding this variation in the contribution of the non-state sector, the question is whether the services provided address unsatisfied demand or provide for populations in need. In Vietnam, the FP providers addressed a niche market, but were able to provide significant contributions to services in certain areas, particularly those using high technology. For example, non-state providers contributed a much higher proportion of the number of X-rays and CT scans (up to 20-30 per cent in some settings) than would be expected from their proportion of total hospital beds. However, their services were concentrated in urban and wealthier locations and may not have contributed to addressing the needs of rural or poorer populations.

The Indonesia study was unable to locate data on the proportion of services provided, but it is likely that the extensive network of NFP providers makes a significant contribution to services for the poor, particularly in urban areas, but also in regional and rural areas.

Efficiency

Evidence on efficiency was limited, particularly in Indonesia. However, in Vietnam, there was evidence of potential improvement in technical efficiency through the more efficient use of resources, particularly in reducing staffing ratios (which by contrast are fixed in state hospitals by Ministry of Health decree). Non-state hospitals demonstrated more flexibility in responding to different markets and adapting staffing ratios to different service mixes.

In both countries, allocative efficiency may be jeopardised by investment, particularly in high technology hospital services that provide an incentive for over-servicing and therefore raise expenditure on curative care at the expense of primary care and preventive or promotive health activities. One study of the use of ultrasound examinations in pregnancy in Vietnam demonstrated over-use (Gammeltoft and Nguyen 2007). Vietnam experiences high demand for hospital services, which consume a large proportion of state health funding, and this is likely to be a major contribution to rising total health care expenditure. However, demand for hospital services and expenditure on hospital services have not risen as sharply in Indonesia, despite a similar policy, suggesting that other factors, such as community willingness to pay, may influence hospital utilisation and consequently resource allocation.

Quality of care

While the country studies were unable to compare quality of care between state and non-state providers due to the lack of common standards and data, there were some indications that FP providers focused investment in the more marketable aspects of quality than in the less visible but clinically significant aspects, as suggested in the literature (Deber 2002). In both countries, non-state hospitals focused investment in high technology and higher profit services, and in improving amenities rather than on increased workforce to bed ratios.

There was also some evidence of potential negative impacts on the quality of care in public hospitals due to doctors practising in both public and private sectors (dual practice). In Indonesia, doctors in the study area (particularly medical specialists) neglected their duties in the state hospital and spent more time in their non-state practice; neither the hospital management nor the local health office was willing and able to enforce regulations. While dual practice was generally less extensive in Vietnam, in urban areas 50-60 per cent of doctors working in private hospitals were also working in public facilities.
Equity in distribution of services
Achieving equity in access to services and in health status was identified as a key challenge for health systems in both Vietnam and Indonesia. In both countries, despite progress in achieving improved average health outcomes, there were significant inequalities in outcomes and service access between urban and rural/remote communities and between rich and poor. Studies in Vietnam have demonstrated a worsening of inequalities (Lieberman and Wagstaff 2009).

Many factors contribute to these inequalities. Even so, because of their focus on urban and wealthier clientele, it does not appear that non-state providers are making much contribution to addressing inequalities. In fact, they may contribute to worsening inequalities by attracting health providers to urban areas.

On the other hand, some have argued that dual practice, by allowing doctors to supplement their income from private practice, enables them to continue to work in the state system and provide services to the poor, and that forbidding dual practice may lead to doctors leaving the state system and opting to work only in the non-state sector (Eggleston and Bir 2006).

Recommendations for Policy and Regulation Identified by Country Partners
The recommendations related to policy and regulation in each country study was determined by the in-country study partners, based on the policy environment and opportunities to influence policy.

In Indonesia, the country partner focused on two specific policy issues from the broad range of potential policy implications of the studies. These were:

- the role of NFP hospitals and the opportunity to introduce taxation relief for NFP in the new hospital law;
- the behaviour of medical professionals and the potential role of medical professional associations in setting and applying standards of behaviour.

In both these cases, the study partner could engage with civil society organisations (the association of NFP hospitals in the first case, and medical professional associations in the second) to pursue policy changes. This has already had some success in the first case, with the NFP hospital associations lobbying for and obtaining provisions allowing taxation relief in the hospital law of 2009.

In Vietnam, the study partner identified the definition of social responsibilities for non-state providers and the development of regulatory tools for monitoring of quality of care as priorities for further policy development. This is consistent with its role in supporting regulation within the Ministry of Health. The results of the studies have informed development of the next 10-year health sector strategic plan, but the results are not yet available.

These selected priorities and mechanisms of policy influence reflect the different roles of the study partner organisations (an academic group in Indonesia, and a research section of the Ministry of Health in Vietnam) in policymaking and the different policy opportunities in the two countries.

DISCUSSION
In this section we compare some of the findings from the studies with the conceptual frameworks identified in the literature and identify some of the policy implications from this comparison.

Common Themes and Characteristics of Mixed Commercialised Health Systems
A number of common themes emerged from the comparison of the growth of non-state hospitals and recent developments in health systems in Indonesia and Vietnam. These themes demonstrate some consistency with the characteristics of mixed commercialised health systems identified in Mackintosh and Koivusalo (2005) as well as by Nishtar (2010), Bloom, Standing and Lloyd (2008) and Bloom, Champion et al (2009).
Porous boundaries between state and non-state sectors
The boundaries between state and non-state sectors are not clearly defined. Non-state or private service provision occurs within state facilities, and state service providers operate in non-state facilities. In both countries, state hospitals provide private wards, where, for additional charges, patients can enjoy improved amenities and (possibly) a higher standard of service. In Vietnam, private investment has resulted in the installation of non-state equipment that is operated as a private business within state facilities. The boundaries are further eroded by doctors’ unregulated dual practice in state and non-state facilities, which is nearly universal in Indonesia. While it is less common in Vietnam, the majority of doctors working in non-state hospitals also work in state hospitals.

Private finance a major contributor to health care expenditure
The high proportion of OOP payments in total health expenditure in both countries indicates a high level of commercialisation. In Vietnam, OOP payments are made primarily for a user fee at state and non-state facilities, while about one-third is spent on self-treatment (Trieu, Lieu et al 2008). In both countries, state hospitals collect user fees and co-payments from insured patients, except for the very poor. In Vietnam, user fees have become the primary source of operating revenues for state hospitals, while state and non-state hospitals compete in the market to provide services and to attract and retain staff.

Low levels of government investment and inequalities in distribution of services
Government expenditure on health services is relatively low in both countries, despite recent increases through government contributions to social health insurance. While service delivery in urban and wealthier areas has been maintained, government facilities in rural and poorer areas are facing increasing difficulties in obtaining and retaining staff. The distribution of the health workforce (particularly doctors and specialists) is skewed towards urban and wealthier areas. In Indonesia, there are reports of poor performance in rural facilities, high rates of absenteeism and lack of supplies and equipment. Vietnam too reports higher levels of budget allocation to urban areas than to rural, and difficulties in attracting staff to rural facilities.

Weak regulation, with many transactions taking place outside the formal or regulated system
The studies identified a number of gaps in current policy and regulatory frameworks. These existed in the strategic direction and expected roles and functions of the institutions and facilities contributing to the mixed health system, as well as in the regulations that control the operation of the system. Weak or absent regulatory frameworks included the quality and standards of care, the distribution of facilities and personnel and the provision of information to consumers. Even where regulations were applicable, the studies found that monitoring and enforcement were often weak. For example, many doctors exceeded the number of practice locations allowed by the regulations in Indonesia, while many hospitals, both public and private, did not satisfy the facility standards set by regulations in Vietnam.

Factors Involved in the Development of Mixed Commercialised Health Systems
Whether the commercialisation of the health system in the two countries is the result of conscious policy or of factors extraneous to the health system remains an open question, but the two studies have identified some factors that appear to be involved in this shift.

Political, economic and social context
Changes in the political, economic and social context in both countries have encouraged greater devolution of authority from central government, reforms to reduce government spending and greater openness to private investment.

In Vietnam, in response to deteriorating economic conditions, market reforms were introduced in 1986, which reduced government funding for health services and encouraged user fees and a greater market orientation. This was followed by decentralisation reforms in the 1990s that reduced the control of the central government (Fritzen 2007). Similar reforms were undertaken in Indonesia in 2000 following the financial crisis of 1997.
and the 1998 fall of the Soeharto regime. Here too significant falls in government funding accompanied decentralisation, but the introduction of a social safety net provided some protection for the poor (Kristiansen and Santoso 2006).

At the same time, the different political situations in the two countries have influenced policy and regulatory capacity. The more fragmented political context in Indonesia has hindered the development of a strategic policy framework, while the more centralised context in Vietnam has led to a more directed reform process.

Legal and financial environment
The regulatory and financial environment has encouraged commercialisation. One example is the move to hospital autonomy in the state sector following the application of health market reform concepts (proposed originally, for example, by Jakab, Preker et al 2002). Vietnam provides greater authority and opportunity for non-state investment in the state sector than does Indonesia. In Indonesia, the lack of government support (either through subsidies or taxation concessions) and the reduced financial capacity of NFP hospitals have contributed to relative stagnation in the growth of NFP hospitals and a move to commercialised activities. Government incentives for private investment in Vietnam have contributed to the growth of non-state and FP facilities. The relatively liberal regulatory environment in Indonesia enables doctors in state hospitals to engage freely in private practice; in Vietnam, restrictions on dual practice are tighter, but in both countries weak enforcement has undermined regulations.

Role of the medical profession
In both countries, the medical profession, particularly specialist doctors, has played a significant role in the establishment and operation of non-state facilities. In Indonesia, individual doctors or groups of specialists have established new facilities, both NFP and FP. Generally, through dual practice, doctors and particularly specialists play a key role in non-state medical facilities and frequently take on the additional role of owner or manager. In Vietnam, doctors and specialists are closely involved in all three areas, and the availability of medical specialists is a major factor in determining the type of services provided. Despite the increasing numbers of specialist doctors, high demand for specialists in both countries has created an internal market, in which hospitals compete to attract and retain the specialist doctors. This is particularly so in rural and poorer areas, where specialist doctors have a strong competitive advantage and are able to command a high price for their services. In Indonesia, the regulatory authorities are reluctant to enforce limitations on private practice in these circumstances for fear of driving specialist doctors to practise elsewhere.

Economic growth and increased community demand and capacity to pay for quality services
In both countries, non-state hospitals, particularly FP providers, are concentrated in urban and more affluent areas, where demand is greater and there is a clientele with the capacity to pay. The gradual expansion of state-funded demand-side financing, through social health insurance, has increased the ability of even poorer segments of the population to demand hospital services. As the World Health Report 2008 commented, there is a growing segment of the population with sufficient income to afford these services, which is influenced by global economic and social cultural values and expectations and which provides the demand for services that non-state providers supply (WHO 2008).

Implications for Policy Makers
Our country studies suggest that policy attention has been focused on the provision of services by the state sector and has tended to neglect a policy framework and direction for the growth of the non-state sector. International policy attention has also tended to view the issue as a question of engaging the non-state sector in contributing to state health system goals. However, the lens of a mixed commercialised health system reveals the need for a different approach to the non-state sector, one with a greater emphasis on stewardship and regulation of a mixed system of state and non-state actors without distinct boundaries.

The proponents of health sector market reforms have also identified some of the management and regulatory challenges that need to be addressed by policy makers (See Boxes 1 and 2 above). Our studies suggest that particular attention is needed in a number of areas.
Establish a clear policy framework
Provide a clear policy framework establishing expectations on outputs and objectives, directions for mixed health system development, definition of roles and contributions from state and non-state providers and mechanisms for dialogue, communication and coordination among state and non-state players in the health sector. Such a policy framework should be developed through a partnership between state and non-state actors. Bloom, Champion et al (2009) point to the shared interest of government and health system actors in achieving an efficiently functioning and growing health system.

Effective regulatory controls
Effective regulations are required to ensure protection of the public interest and efficient operation of markets, including the competence of providers, defined standards for safety and operation of health services, protection of consumer rights, fair competition among providers and prevention of unfair advantage over patients being taken by practitioners. A range of regulatory mechanisms will be required, ranging from self-regulation and co-regulation, involving third party and professional associations, to rules and enforcement and meta-regulation (Healy and Dugdale 2009).

Market and financial incentives
These measures need to be complemented by more strategic use of market and financial incentives to ensure consistent alignment between the regulatory framework and health policy goals. In particular, this requires a shift away from patient fee-for-service payments and towards collective purchasing through the use of pooled funds. Payment mechanisms can then create appropriate incentives through contracts, subsidies, incentives or case-mix payments that are more tightly linked to performance (Jakab, Preker et al 2002). This, however, requires increased capacity in purchasing skills, monitoring and reporting systems (Ensor and Weinzierl 2007).

CONCLUSION
The growth of the non-state sector and the increasing commercialisation within mixed health systems leads to greater challenges in regulation in the LMICs of Asia. The shift to mixed health systems affects the achievement of health system objectives and may lead to increasing availability of resources, responsiveness to consumer expectations and efficiency in the use of resources, but raises greater challenges for quality and equity.

Effective regulation and management of these systems will require a change in approach that:

- acknowledges that the health system functions as a mixed commercialised system, with varying proportions and contributions from state and non-state providers, and the need to engage with all providers and stakeholders, including consumers and community, in stewardship of these systems;
- develops policy and regulatory frameworks that are appropriate to different contexts, such as the more fragmented and pluralistic context of Indonesia or the more centralised system in Vietnam;
- uses a balanced mix of command-control regulation, co-regulation with non-government partners and market and financial incentives to achieve a balance among the objectives of service availability, quality, efficiency and equity in usage and payment.

Proposed changes that will liberalise health markets among ASEAN countries from 2010 will further increase market pressures on health systems and require careful management by policy makers (ASEAN-US Facility 2007). Without appropriate regulation and greater attention to the inequitable distribution of services, demand-side financing reforms such as social health insurance may not improve equity and could result in unproductive cost escalation (Ramesh and Wu 2008). Policy makers are now facing these challenges in the rapid transition to mixed health systems; the careful implementation of regulatory approaches can be decisive in achieving health goals.
References


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KNOWLEDGE HUBS FOR HEALTH
Strengthening health systems through evidence in Asia and the Pacific

A strategic partnerships initiative funded by the Australian Agency for International Development