Introduction

Health systems consist of organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence both determinants of health, and direct health-improving activities. A health action is any effort in personal health care, public health services, or intersectoral initiatives which has the primary purpose of improving health.

A health system is a functional network of health-care providers, including public sector and privately-run services, which range from traditional healers to the most technologically advanced hospitals. It also includes payers (households, insurer, and donors), managers and regulators*. Ideally, all parts of the system act together in an organized way to meet the individual and community health needs of a given population. Nearly everyone, healthy or ill, comes in contact with a health system at some time. Health systems have a responsibility not just to improve people’s health but also to protect them against the financial cost of illness and treat them with dignity.

Countries in the Asia Pacific Region range from very poor to very rich, from free-market to centrally planned economies, from the least to the most highly industrialized. Some have populations in hundreds of millions while others measure only in the thousands; some have predominantly young populations while others are aging rapidly. With this great diversity, it is not surprising to find different levels of development in national health systems in the countries and areas of the Region. Available resources vary widely, as do the “outputs” of health systems, and the health and life expectancy of populations.

* Health systems are different from “health sectors”, which technically are the parts of a national economy that provide health-related goods and services to which economic value can be attributed. In ordinary use the two terms are almost interchangeable, especially when discussing health sector/system reforms. If a health system is defined narrowly (e.g. as the public health-care system), the health sector would include more providers and services. Conversely, a health system could have important non-economically valued functions.
Still, every health system has the same basic functions of stewardship, financing, resources creation (e.g. human resources, medical products and technologies, and information), and delivery of services. It is rare that there is no room for improvement.

The health systems of different countries depend significantly on many factors, including:

1. the level of economic development per capita of gross domestic product (GDP);
2. income distribution profile;
3. total health-care expenditure per capita, public health expenditure per capita and the relative mix of public and private expenditure;
4. availability and spatial distribution of medical and paramedical service providers, and the degree of public and private provision;
5. the geophysical features of the country and their relationship to logistical issues; and
6. the priority given to this sector under the country’s social policy, particularly the degree of risk pooling and social solidarity.

### 10.1 Health systems development in the Asia Pacific Region

Health systems are shaped by local norms and social policies, demographics, education, and the financial and human resources available. In many industrialized countries in the Region, most health-care is provided by urban hospitals and private clinics staffed by qualified practitioners and supported by the latest technology. Countries that are still mainly agrarian rely more on small rural health facilities, supported by secondary hospitals in local urban areas, and a few tertiary hospitals in bigger cities. Many countries have aspects of both situations. Private providers play a major role in most countries in the Region. Pharmacies, small private clinics and traditional healers are favoured by many poor patients for reasons of cost and convenience, and many hospitals are privately owned and operated for profit. This dependence on private providers exists even though quality is not always assured because of inadequate regulatory capacity. Protection from impoverishing health expenditures is not in place due to inadequate risk pooling, and the poor and vulnerable may be excluded from health care because of inadequate social solidarity mechanisms.

Ministries of health establish overall health policies, regulate the health sector, and interact with other government sectors such as finance and public safety. Responsibility for essential public health functions may be shared between central and local governments. Governments are significant financers and providers of care, although involvement varies considerably between countries in the Region. External donors play important roles in less developed countries of the Region through financial support, technical support and advice on policy development.

Some health systems were organized by unevenly consolidating distributed dispensaries, vaccinators and sanitary inspectors into small health facilities and posts covering specific villages and surrounding areas. Existing missionary hospitals were sometimes complemented by newer government district hospitals supplied with trained medical and nursing staff and some diagnostic facilities. The diversity of health systems in the Region makes sweeping generalizations impossible, and each country must analyse and plan its own system based on core principles.
The initial pace of health improvement in the latter half of the 20th century was both visible and impressive, but momentum was lost in the 1970s. Awareness of the need to reduce morbidity and mortality among large, frequently neglected rural populations led to articulation of the primary health-care (PHC) strategy. The Health For All 2000 Alma-Ata Declaration of 1978 aimed to reorient health systems towards PHC, and more effectively deploy limited resources for health with the involvement of local communities. The effectiveness of PHC was improved by such technologies as oral rehydration therapy, vaccine cold chains and integrated treatment protocols based on essential drugs. Cadres of multipurpose health workers working closely with communities were part of this approach, with some countries emulating the “barefoot doctors” of China by training village health workers, supported by local health centres.

External assistance to developing countries for health increased in the 1970s as donors such as the World Bank and the Asian Development Bank (ADB) found that large infrastructure projects alone did not contribute as much to overall development without concurrent progress in the social sectors. The need to simultaneously limit rapid population growth and reduce child mortality focused assistance on maternal and child health and family planning programmes. While the motives and methods of some of these programmes were sometimes criticized, they provided a great deal of support for PHC development in many countries in the Region as they became integrated into national health services.

Sound evidence based on local conditions should guide the development of health systems. However, by the 1980s international financial institutions and aid donors appeared to control the agenda and emphasis was placed on structural adjustment. Highly indebted countries needing continued access to the support of international financial institutions were pressured to introduce fiscal reforms that often included reducing public and health expenditures. A frequent reform was to limit public employment and redeploy existing health staff to serve in rural areas, although the actual success of such redeployment was doubtful. Unfortunately, just as PHC was to be implemented in the post-Alma-Ata Declaration environment, funds available for the health sector decreased. Health sector reforms, meant to increase the efficiency and effectiveness of health systems, were designed to counter the effects of spending cuts and thus caused PHC to be seen as health care “on the cheap” for poor people rather than an overarching philosophy for a holistic, sustainable health sector based on a set of core principles. Donor pressures for health sector reform were sometimes overwhelming. Only countries less dependent on foreign aid, such as China, Brunei Darussalam, Malaysia, Thailand and Singapore, had the relative luxury of developing their own health sectors as they saw fit.

A reform frequently encouraged by donors was the introduction of user fees, or “cost sharing”, for government health services, a measure intended to reduce inequity and increase the amount of funds available. Although many people are willing and able to pay, particularly for drugs, user fees lead to exclusion of the poor and introduce their own set of distortions. Many countries have demonstrated that patients will pay for a large amount of the medicine they consume, but this has also revealed that financing health-care systems by the sale of drugs can lead to problems of inappropriate and irrational drug use. For hospital care, research shows that the poor are deterred if high out-of-pocket payments are required at the time of service. The difficulty of creating exemptions for the poor was underestimated, and this led to wider acceptance of the need for prepayment systems and risk-pooling. Prepayment systems include social insurance, tax-based systems, private insurance, voluntary risk-pooling and the use of donor funds, or some combination of these based on the local situation.
Chapter 10

An expanded role for the private sector became a health sector reform theme of the 1990s which was related to the difficulty of financing and providing all needed health services in the public sector. This reflected the influence of supply-side economics among donors; for example, the belief that free markets and competition improve the welfare of all. Public resources could be reallocated for greater overall impact, and government health services would provide cost-effective “packages” of essential services. Critics noted that this approach sanctioned a two-tier system in which the wealthy used high-quality private provider, while the public sector served as a safety net for the poor. Since health-care markets are far from perfectly efficient, the growth of the private sector required better regulatory systems than usually existed. Even if provision is highly privatized, the government cannot abscond from its position of stewardship of the health sector, especially regarding services for the poor and underserved. Governments have had difficulties in ensuring that subsidies aimed at the poor actually help those most in need. Middle- and high-income earners frequently benefit more from public money for health than those at the lower end of the economic spectrum.

The late 1990s witnessed global efforts to alleviate poverty by shifting the direction of development and better coordinating donor assistance. The report of the Commission on Macroeconomics and Health established by WHO compiled much of the evidence that has focused policy-makers and donors on the health, social and environmental burdens of the poor. At the same time, following the Millennium Declaration, countries agreed to pursue the Millennium Development Goals (three of which focus on health) and to develop poverty reduction strategies, which are now generally giving more attention to the health sector. The recent work of the Commission on Social Determinants of Health has encouraged countries and regional health partners to address the social factors leading to ill-health and focus on health inequalities.

10.2 Health systems infrastructure

Most countries in the Asia Pacific Region rely on a mix of general and specialized hospitals and smaller facilities such as primary health centres that are part of the public sector. The majority of hospital beds are in general hospitals. China and India have by far the most district-level referral hospitals and

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**Box 10.1: The Bamako Initiative**

Originating in Africa in 1987, the Bamako Initiative (BI) was a model for some Asian countries, including the Lao People’s Democratic Republic, which established community-level revolving drug funds to mobilize resources for PHC. In addition, BI-type revolving drug funds have been implemented in Myanmar, Viet Nam, in some districts in Cambodia, within the Community Drug Programme in Nepal and at the community, or barangay, level in parts of the Philippines. Early critics of BI predicted that health systems could become dependent on revenues from the sale of drugs, leading to irrational drug use. This is believed to be true in the case of the Lao People’s Democratic Republic.

primary health centres in the Region. Indonesia, Thailand and Viet Nam also rely heavily on lower-
level health facilities. However, uncoordinated decentralization can result in overlapping functions and inefficiency.

The number of hospital beds per thousand population is often used as a proxy indicator of availability of health services, but this can be misleading when used to gauge actual access to services, particularly for the poor and disadvantaged in health systems with user fees. Not surprisingly, the most developed countries in the Region have more beds per capita than poorer and less developed countries. Wealthier countries also tend to have more private sector health facilities and a wider variety of facilities to meet specialized needs, such as for older persons and disabled.

While India has only 0.90 beds per 1000 population, China’s ratio of 2.2 beds per 1000 population is the second highest among developing countries in the Region. Small island nations tend to have higher than average ratios due to their dispersed populations. Due to variations in how countries define hospital beds and what services are provided in hospitals, caution must be exercised in comparing hospital bed ratios between different countries. Utilization rates of beds, and the services provided in those beds, may offer a more accurate comparison.

It does appear that some countries have relatively poor access to hospital inpatient care while being more adequately resourced at the PHC level. Bhutan, Cambodia, the Lao People’s Democratic Republic, Malaysia, Papua New Guinea, and Thailand rely heavily on primary health care facilities to compensate for relatively few hospital beds, as do several island nations. Again, there is a wide variation in the functionality of primary health-care facilities across the Region, making intercountry comparisons difficult.

Conceptually, the service centres of a health system need to be decentralized to make them accessible and provide equity in service delivery to the citizenry. The structure adopted for each country, inter alia, depends on: the historical legacy of the health system; the geophysical features of the country; other logistical features such as transport linkages; and distribution of trained health workers.

In a country consisting of several islands, the health system has unique features. These islands must be serviced largely by the public health system, because very few private health service providers are able to create a viable private practice from a small number of widely dispersed patients. Some examples of high public funding support to the health systems of islands in the Region are Cook Islands, the Marshall Islands, the Federated States of Micronesia, Nauru, Palau, Solomon Islands and Tuvalu. The striking exception to this is Singapore, an island state functioning as a global commercial and financial hub. The wealth of individuals and state is sufficient to ensure that a well-resourced medical facility is likely to be available a few streets away and reliance on public service facilities is relatively less. For less well-endowed island nations, the public health facilities catering to an accessible cluster of islands is forced to engage service providers who are capable of independently providing at least primary health-care services. With increasing application of information technology, the telemedicine mode of providing medical services will likely play an increasing role. For medical conditions requiring a specialist and inpatient secondary and tertiary care services, the reliance is on airlifting patients to well-equipped central service centres despite the prohibitive cost involved.
For larger countries, including multi-island nations such as the Philippines, the health system requires a multi-tiered organizational structure. The centralization of health service facilities, except in countries that are very small, results in limited access for the dispersed citizenry. A review of the position in the countries of the Asia Pacific Region reveals that many countries such as China, India and Indonesia have a three-tiered organizational structure for delivery of primary health care.

It is a paradoxical feature of this Region that in some countries, although health services for most people are relatively weak, a few health facilities are state-of-the-art, and the skills of clinical specialists are of the highest quality available anywhere, e.g. India and Thailand. These countries have become promising locations for what is now called “medical tourism”. Patients from developed countries, where health systems are over-crowded or prohibitively expensive, can obtain world class medical services in these developing countries at economical rates. This provides a promising window of opportunity for commercializing health services, but this is not without negative features. It may create what is called the “twin-track” health system, state-of-the-art facilities for foreign patients and substandard ones for local citizens. It is not yet clear whether medical tourism is beneficial or harmful to the medical services of ordinary citizens. Countries that encourage medical tourism must be willing to use regulatory mechanisms to ensure that this does not lead to escalation of general health costs, or harm services to nationals. Potentially abusive practices, such as organ transplantation, require particularly close monitoring.

10.3 Governance, health policy and legislation

Governance

Governments have a clear role to play in the health sector, even in the most privatized systems, which includes issues of equity, efficiency, quality and cost control. There is a growing global awareness that when a national health system aims for universal health coverage, the responsibility for service delivery may have to be shared between the public and private sectors. Any public sector organization trying to discharge this burden by independently delivering health-care services is at risk of becoming too large and unwieldy. However, the public sector could be required to deliver services on a reasonably large scale to provide a counterpoise to the private sector, and to ensure services for the poor and underserved.

In many cases, remote and logistically difficult areas would continue to depend on public services as private for-profit services are not likely to operate in these areas. The promotive and preventive components of health care, often referred to as public goods, can only be provided by the public sector unless clear incentives are given to the private sector to do so. The share of the public sector’s service delivery is particularly critical in smaller, less affluent island countries and areas of the Region. The Pacific island countries and areas in the Region have a scattered target population of about 9 million, making a large role for the public sector almost inevitable.

For the physically large and highly populated countries of the Region, the private sector’s role in service delivery becomes significant. However, the health sector is known to be prone to the so-called market failure where a free market cannot be expected to regulate itself. The health sector is a market situation where the user has very little knowledge of the technical requirement for services, what a reasonable price for the service is, and the quality of services eventually rendered; while the provider has limited knowledge about the health status of the individual. The state, in its role of governance, faces a paramount responsibility. To ensure that the health system functions in the best interest of the beneficiaries, with a large portion of service delivery undertaken by the private sector, the state needs
to establish and operate an appropriate framework of statutory controls. Generally speaking, most developing countries have relatively weak statutory provisions to regulate health services, and in many cases where statutory provisions exist the enforcement is weak.

A major challenge for health systems is containing costs and obtaining maximum health outcomes for the funds available. For most developing countries, spiralling drug costs are a threat to sustainability. For a struggling developing country trying to achieve universal health coverage, it is imperative that primary health care be based on a list of essential drugs from the generic domain which deal with the commonest conditions that contribute to the burden of disease in that particular country.

There are multiple other issues in cost control and efficiency, including medical technology, health workforce, referral patterns, and the mix of community and institutional services. Increasing efficiency requires an overview of the entire system. A few countries, mainly more highly developed economies such as Australia, New Zealand, the Republic of Korea and Singapore, have stronger statutory frameworks from which some lessons can be learnt.

**Health policy**

Having clear, rational and comprehensive health policies brings health care closer to the centre of national development efforts, which are increasingly focused on reducing poverty. Changes in how governments interpret their roles have implications for policy development and for globally-driven health programmes. The policy environment frequently includes nongovernmental organizations (NGOs) and the private for-profit sector as stakeholders in health and health care. Governments must be accountable to the people who are the intended beneficiaries of health services, and to those providing funding. Countries with limited resources for health must manage them carefully to ensure effective outcomes.

Policy-makers need a broad understanding of what outcomes are expected from a health system. *The world health report 2000* has articulated these as:

1. improved health outcomes in both absolute terms and in relation to different socioeconomic groups;
2. responsiveness to the desires and needs of the population;
3. financial protection from catastrophic expenditure; and
4. efficiency, so that the maximum health gain from available resources is obtained.7

Conceptually, narrowing health gaps is an important policy goal that facilitates target-setting and implies raising the health of the poor and vulnerable at a rate outstripping that of the wider population. This focuses attention on the fact that overall gains in health can occur at the cost of persistent and even widening inequalities between socioeconomic groups and areas and provides clear criteria for monitoring and evaluation. An effective pro-equity policy is one which achieves both an absolute and a relative improvement in the health of the poor and vulnerable, or an improvement in their social conditions or in the prevalence of risk factors.

In the Asia Pacific Region health policy development is actively supported by research at academic institutions, government think tanks and, increasingly, by NGOs and consumer groups. Health impact assessments can help gauge the health consequences of public policies.8 Countries such as Thailand have recently started to implement health impact assessments.
Health competes for public financing with other social and economic sectors, and in many countries the defence budget is also a major competitor. Once the health budget is fixed, policy decisions are needed to establish the balance among subsectors, especially how resources are allocated between hospital care and primary care, urban and rural health services, basic care for many and high-technology care that benefits a few—in effect which communities benefit most or least from public funds. Unless public policy is explicit on a pro-poor focus, public subsidies may actually benefit the better off more than the poor.

**Legislation**

Once health policy has been established and widely agreed on, it has a more lasting impact if enacted as national laws and acts, with secondary regulations and by-laws that grant authority for actions and rights. Although it is important to consider using a range of approaches to ensure appropriate types of behaviour that protect and promote the health of individuals and populations, well-designed legislation can play an effective and important role. Health legislation that supports policies promoting good health can range from legislation establishing and regulating the provision of health services to laws related to the environment, food, vehicles, buildings and occupational health. Healthy public policy (public policy that promotes health) certainly extends beyond the health sector, which must be involved in a multisectoral fashion. Actions may vary, depending on the socioeconomic and political framework of each country or population subgroup.

However, except for countries with well-established parliamentary systems, the capacity of many Asia Pacific Region health ministries to generate legislative proposals is not enough, particularly in the case of the smaller Pacific island nations. The enactment process is generally lengthy and often there is reliance on ministerial decrees that may not necessarily harmonize with those of other ministries, creating severe challenges for intersectoral health issues and actual implementation. Lack of access to and knowledge of existing laws inhibits their development and enforcement in many places.

In developing or amending legislation each government has a responsibility to ensure that, where compliance with the law is needed, an appropriate range of options and mechanisms for enforcement are included in the relevant legislation, and that sufficient resources are allocated to achieve that enforcement. In addition to basic public health laws, core regulatory functions need to be strengthened in many countries to improve the quality and safety of the services that people receive. Governments have a key role in planning and regulating activities of the private sector and the health workforce, and must be prepared to stand up to professional groups when their interests are in conflict with those of the public. Effective and

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**Box 10.2: Government’s role in the health sector**

The most critical considerations in good governance in the health sector and a government’s commitment to the health of its citizens are:

- Is the government placing appropriate priority on health, relative to its means?
- Is the government focusing its resources on public goods and essential public health functions?
- Is the government employing cost-effective health interventions, so that limited health resources go furthest toward improved health outcomes?
- Is the government protecting the poor and other vulnerable populations from catastrophic losses?

fair enforcement of public health law is a critical component of every government’s responsibility to improve and protect the public health of all citizens. Laws and decrees are frequently not enforced due to inadequate regulatory capacity. If legislation is not enforced, its value is greatly decreased. There are many examples of laws being ignored because no action is taken in cases of noncompliance.9

10.4 Equitable access and decentralization

Equitable access

Many countries in the Region face formidable problems in developing equity in health and access to health services. With large variations between and within countries in how these issues are handled, each country must examine its own system and decide individually how best to proceed. However, recurring themes in the Region and country-specific examples provide guidance.

Poor, vulnerable and socially excluded groups, in general, have a higher burden of disease while at the same time, they frequently have lower access and lower utilization of health-care services, both curative and preventive. This is sometimes referred to as the inverse care law, where the availability of good medical care tends to vary inversely with the need for medical care in the population served.10 There are multiple barriers to health equity and equitable health-care access. These include financial, geographical and sociocultural barriers, such as gender, class and ethnicity, as well as the lack of system responsiveness to the needs of the poor, vulnerable and socially excluded. Examples from Indonesia, India and Thailand confirm that those in the lowest quintile of income utilize services less than those in higher income quintiles, and that those in rural areas also receive less care, both publicly provided and privately provided. China attained a fairly high degree of health equity and access in the 1970s and was frequently presented as a model for achieving good health outcomes at low cost,11 but with health system modernization in the post-reform period, health equity has been adversely affected.12

When health systems are highly dependent on user fees from households (out-of-pocket payments), financial barriers arise at the time of service, particularly in countries where risk pooling and pre-payment schemes are not organized. The direct costs of health care deter health-seeking behaviour, as do indirect costs such as transportation and food, and lost income while waiting for care or for family members seeking care. In India, for example, 83% of health-care expenditure is paid for by households at the time of service. The Asia Pacific Region has the highest percentage of out-of-pocket support for health systems among any WHO region in the world.13

Geographical barriers include the concentration of health facilities and health workers in urban areas, or in areas close to adequate transportation. Even where roads and transport are adequate, health workers and health facilities tend to congregate in urban, higher-income settings where there are more opportunities for career advancement or raising health worker income levels. The remoteness of some areas remains a barrier, even in well-funded systems, and the cost of supplying such populations with adequate care can be expensive. Rural and urban differences in health care are well documented in many countries in the Region.14,15,16

Another barrier is social exclusion, which can be based on ethnicity, gender, sexual orientation or other social factors. Minority groups frequently have language and cultural differences from the majority population, including health workers. Such differences serve as disincentives or barriers which keep them from seeking and receiving adequate care, or in receiving care in harmony with their traditional beliefs. Gender is a determinant of access to care in many settings, with women and girls receiving less, or more delayed, care in many settings. In addition, the gender differences in population in several countries in the Region may be partially attributable to differential rates of health care, in addition to the well-known issue of sex selective abortion.
Even where health facilities are available, there is often a lack of responsiveness of the health system in areas where a high proportion of the client population come from the poor and underserved. Issues include inconvenient working hours, rude or abusive health workers, more frequent stock-outs of core medicines, and missing or malfunctioning equipment. Voices of complaint from the poor and underprivileged are less likely to be heard or to receive a response from the authorities.

Inequities in both access and utilization of health services and in health outcomes exist in most countries of the Region. The assumption that economic development and modernization of the health sector will automatically lead to improved access and equity is false; therefore, issues of equity and access require explicit planning.

Decentralization

Decentralization in many countries in the Region, and varying political, economic, geographical and demographic situations, has led to large differences in how national responsibilities for health are allocated. These range from highly centralized and controlled systems in countries such as the Philippines, Thailand and Viet Nam, where there is dependence on local governments to organize services, to highly decentralized systems that depend to a large extent on privatized providers of care, such as in India and Singapore. Whichever system be utilized, the central government must retain its stewardship role for health services even if implementing responsibility is decentralized. Many countries are still working out the respective roles of various levels of government, particularly where decentralization is relatively recent. Experience has shown that it may take years, or even decades, for systems to adjust to decentralization. The equalization of health resources between rich and poor regions within countries has been a particularly difficult issue in many decentralized countries, with richer regions frequently having fewer health needs but more health resources. If a country opts for decentralization, equalization formulas for resources must be found; and the central health sector should strive to implement that policy and learn how to be a support service to the decentralized implementers of health services.

Box 10.3: Decentralization

Decentralization has usually taken three forms. The first involves the devolution of authority and responsibility from central to local government agencies. For example, provincial or district governments are responsible for health and other social sectors in Bhutan, India, Indonesia, Myanmar, Nepal, Papua New Guinea, the Philippines, Sri Lanka, and Thailand.

The second process involves deconcentration of functions from higher to lower levels for managing financial resources, deploying human resources and managing health facilities.

The third process entails delegation of responsibility and functions from central government units to autonomous or specialized government agencies, such as institutes for health research and training, national nutrition centres and institutes of policy studies.

Decentralization has also meant the transfer of functions from government (public responsibility) to NGOs and private for-profit enterprises.

10.5 Primary health care and the health system

Keeping PHC and universal access on the health system development agenda is one approach for increasing both equity and efficiency. In countries with effective health-care networks that have largely resolved problems of access, PHC is today mainly seen as a level of care. In low-resource countries where there are still significant access challenges, the PHC concept is a system-wide strategy for development with emphasis on the right to health care, social justice and reducing inequality. There are several common obstacles to scaling up PHC in the Asia Pacific Region and some examples include, but are not restricted to the following:17

- levels of public funding are too low to provide basic public health services (Cambodia and Nepal);
- allocation of public funding is skewed to tertiary hospitals and better-off areas (China, Nepal and Viet Nam);
- shortage of qualified health workers (Cambodia and Nepal);
- health workers are unwilling to work in rural and poorer communities (most countries);
- overemphasis on the role of doctors within the health system, leading to an over-qualified skill mix (Bangladesh, Mongolia and Nepal);
- physical inaccessibility to services (Indonesia, Mongolia, Nepal and the Pacific island countries);
- aid is a significant funding source for health, but is not well coordinated and may also be short-term or unpredictable (Bangladesh, Cambodia and Nepal);
- social and gender issues (Regionwide); and
- quality of health professional education (most countries).

Community involvement and self-reliance is a basic underlying principle of the primary health care approach as enshrined in the Alma-Ata Declaration.18 Community involvement is proposed as a strategy to counter the failure of past rural health systems development strategies which did not actively develop skills and encourage initiative, resulting in services that could not be sustained by local knowledge and resources.19 Engagement and commitment by local communities can contribute in many ways to health improvement. By identifying, mobilizing and committing their own resources (and advocating more effectively for outside resources), communities build an enhanced sense of collective purpose and solidarity and improve their capacity for self-help. Small, action-oriented, local initiatives can be both effective and efficient. The healthy settings initiatives in the Asia Pacific Region, such as Healthy Cities and Healthy Islands, draw on this approach.

There is a long history of community involvement in health20 in the Region. However, most people live in rural areas where roads, irrigation, electricity, schools and employment are often higher priorities than health services. To raise the priority of health, community involvement in health can be integrated into overall community development programmes, consistent with the intersectoral principles of the PHC approach.21 There are known preconditions for successful community involvement: strong political commitment, capabilities of the communities for self-directed development, availability of a basic health structure and coverage, and strong bureaucratic support.
10.6 Public and private health services

In the last two decades of the 20th century neoliberal economic philosophy has held that health systems should be reformed through privatization. However, evidence from the Asia Pacific Region and other parts of the globe shows that in developed countries and developing countries having good quality health systems, the aggregate share of public health expenditure is a key, though not the sole, determinant of the quality of the health system.

Developed countries typically allocate a larger percentage of their GDP to health expenditure. This, to an extent, is to be expected, as they have a larger amount of available resources and can afford to spend more on sophisticated health services. However, what is striking is that even developed countries, with a free market model of development, continue to provide high levels of public funding to their health systems. Even in the United States of America, with one of the most market-oriented systems in the world, 40% of health expenditure comes from the government. While the developed countries are examining alternative options for service delivery to achieve greater efficiency, and alternative models of financing, they do not appear to be reducing the overall contribution of public resources to the health system.

Developing countries in the Region, particularly in South-East Asia, incur a health expenditure which is relatively low as a share of the total economy or a share of public expenditure. Although WHO has never made an official recommendation on desired expenditure levels for health, WHO documents since 1981 have used a 5% of GDP figure as an indicator for health-care expenditure that should be monitored. This indicator, according to Savedoff, has evolved into being referred to as a recommendation by other authors, although there is no recommendation based in any formal WHO document. That said, out of the 48 countries and areas in the Region, as many as 20 have a total health expenditure below even this modest level of 5%, and of the 11 countries in the WHO South-East Asia Region, only India, Maldives, Nepal and Timor-Leste reach this level. Also, since the aggregate GDP of developing countries is smaller, the monetary resources available in these countries for a given share of GDP is much lower. The lower per capita availability of monetary resources in the developing countries will have its inevitable impact on the quality of the health system. WHO’s Commission on Macroeconomics and Health has estimated the cost of a minimal package of health services to be US$ 34. With the low current base of health sector allocations in many countries, the effort of funding the minimum package poses a huge challenge, making compromises inevitable.

Ideally, basic health-care requirements would be uniform for people everywhere, and not directly linked to the level of economic development within countries. In reality, the amount of spending on health tends to increase in both absolute terms and in percentage of the total economy as national wealth increases, which is sometimes defined as a luxury expenditure. If developing countries wish to provide services equivalent to richer nations, they would have to allocate even higher percentages of their national wealth than richer countries, exactly the opposite of what occurs now. An absolute increase in health-care funding is needed, but it must be combined with increased efficiency.

Public health expenditure as a percentage of GDP is high in most of the developed countries in the Asia Pacific Region as it is in other parts of the developed world. There are only a handful of developed countries where public health expenditure is less than 5%, and in most countries it is well above that. The percentage of public health expenditure for most low- and middle-income developing countries is small. As a reference, the average global figure of public health expenditure for such countries is 2.8% of GDP. By comparison, the public health expenditure in most South-East Asian countries is much lower.

A comparison of the public health expenditure in different countries of the Asia Pacific Region with developed countries indicates that the role of the state in financing national health systems is very weak in many of the countries in the Region. In as many as 15 developing countries in the Region, the public contribution to total health expenditure is less than half of the total.
The reason why public health expenditure is a significant component of a quality health system in any country, including developed market economies, is that the preventive and promotive services required in a balanced health system are public goods which can only be delivered by a public health system. It is the preventive and promotive initiatives that reduce disease burden and minimize the requirement for the more expensive curative services. Curative services, to a very large extent, provide a “back-stop” for the failures of these initiatives.

Global statistics consistently lead to the conclusion that total health expenditure as a percentage of GDP does not by itself determine the quality of the health system. The breakdown between public and private expenditure significantly determines the composition of the services provided under the health system. Public health expenditure almost exclusively provides the preventive and promotive inputs as well as curative services for the poor and vulnerable in countries where there is a strong social safety net. In addition, public health expenditure is concentrated on a wide span delivery of primary health-care services. On the other hand, private health expenditure provides all categories of curative services—primary, secondary and tertiary—but its coverage is generally urban-centric and concentrated in areas where income levels are high and social infrastructure is well-developed. Many contributory features of the health system, including the share of total health expenditure, determine its quality.

Several countries in the Region receive multilateral or bilateral donor funds to support their health systems. There is a wide range of variation in the degree of dependence on donor resources for the health sector across the Region, ranging from levels as low as 0.1% in China and Malaysia to the Lao People’s Democratic Republic and Cambodia, where donors provide the majority of the public budget in health. It is generally perceived that excessive dependence on external funding makes a country’s health system vulnerable. External funding may vary widely over time, depending on geopolitical factors, thereby subjecting the domestic health system to large budgetary fluctuations. It is often asserted that national health priorities become distorted under donor influence, whether it is a grant or loan.

External assistance has supported the health systems of the developing countries of the Region since the 1970s. The fiscal reforms introduced by international financial institutions, usually as a response to fiscal crises, required reduction of public expenditure, with the social sector often being the first to be reduced. The reforms recommended by the multilateral agencies were expected to compensate through efficiency gains for the funding cuts imposed on the health sector budget. This expectation did not materialize in most developing countries. As a result, health expenditure did not rise fast enough to ensure that health systems acquired or maintained a critical mass to make a discernible impact. Countries less dependent on external aid, particularly aid from international financial institutions, such as Brunei Darussalam, China, Malaysia and Singapore, may have been able to follow independent policies regardless of the prevailing policy of these institutions.

An interpretation of evidence from the Region and elsewhere is that the state’s contribution to total national health expenditure should be a significant share to achieve a minimal health system quality. Without such balance in funding, inputs to health systems are at risk of becoming excessively tilted towards biomedical care and health services for the more economically advantaged, at the cost of the preventive and promotive inputs that play a large role in moderating the basic disease burden.

Primary health care, which by definition includes promotive and preventive inputs, in addition to curative initiatives is the most cost-effective of the three categories of services. It is widely accepted that about 90% of medical conditions can be appropriately treated at the primary level. Attention of health system planners was focused on this category of initiatives after the Health For All by 2000 Alma-Ata Declaration of 1978. This realignment of approach in the health system, through efficient deployment of limited resources on essential services and by reliance on community partnerships, contributed significantly to improvement in access to health services.
However, recent trends across the world have revealed an undesirable shift of expenditure toward the tertiary sector, and also to some extent to the secondary sector, at the cost of the primary sector. With rapid scientific advancement, new clinical testing procedures and sophisticated diagnostic equipment has flooded the market. The adoption of such innovations, while relevant in specific medical situations, is unduly driven by commercial forces, as distinct from medical requirements. The requirement of a strong primary sector is particularly important in resource constrained settings or in the small island countries that have geographical problems in providing services, but a strong primary sector is necessary for an effective and efficient health system in all settings. Developing countries in the Region allocate a varying share of resources to the primary sector, but there is a growing tendency to shift resources away from the primary sector. Against this backdrop, the question arises as to what is the appropriate share of resources for the primary sector.

Health care of any category – preventive, promotive or curative – requires an appropriate mix of services according to circumstances. Services may consist of preventive initiatives through the supply of public goods; promotive initiatives to bring about a desirable behavioural change; clinical observation of the sick by trained professionals; clinical laboratory investigations; and invasive and non-invasive investigations using sophisticated diagnostic hardware. Depending on the severity and the complexity of the condition, there should be a rational move from the simpler methods and procedures to the more expensive and technically sophisticated ones. Conceptually, the patient should move through referral from primary services to secondary services, and then, if required, to tertiary services. The health systems of many countries have difficulties in finding the most efficient balance of generalist and specialist providers, primary and referral facilities, and preventive, promotive and curative care.

The increasing reliance on high-cost procedures and tests has created a resource problem in several countries of the Region. This increase is sometimes scientifically justified, but supplier induced demand for economic gain also plays a role. Thailand has a health system that places substantial reliance on modern medical technology. As a result, health costs have risen at a much faster rate than even their fast-growing economy. Per capita health expenditure showed an average growth rate of 8.2% against an average GDP growth rate of 5.8% in the period 1980–2000. Indonesia was hit initially by rising health-care costs and then by the South-East Asian financial crisis. Per capita public health expenditure in 1997–1998 and 1998–1999 respectively fell by 2.9% and 6.6%. The greater emphasis on secondary and tertiary care expenditure at the cost of primary and secondary care expenditure was also experienced by India. In the period 1985–2000, expenditure in the primary and secondary sectors in India rose by 50% as compared to 100% in the tertiary sectors.

The Republic of Korea’s health insurance system is known to be under severe resource strain on account of rising costs. China has also experienced rapidly escalating health costs in the post-reforms period, rising by 12% per year in the 1990s, compared to a significantly lower economic growth rate in the same period. With the introduction of economic reforms the health service cooperatives disintegrated, and health service delivery was provided increasingly by private doctor’s clinics, with greater reliance on high-tech procedures and expensive curative regimens. All of these developments resulted in larger allocations to the secondary and tertiary sectors at the cost of the primary sector. Rising costs are not only threatening the stability of health systems in parts of the Region but also in much of the world.

10.7 Globalization, trade and health

Once deemed the preserve of industrialized nations, chronic diseases such as obesity, diabetes, mental ill-health and alcohol- and tobacco-related illness are now worldwide problems. The dramatic increase in the incidence of HIV/AIDS and tuberculosis in some countries, and the emergence of avian influenza in the Asia Pacific Region, pose major international health threats. Narcotics, unhealthy lifestyles and chemical and biological pollutants cross borders as easily as infectious diseases.
Expanding trade has been a central component of increasing connectedness among countries of the Asia Pacific Region, and has affected health in several ways. Rules set out in international trade agreements have impacted health policies and regulations. This has caused apprehension, since trade rules are not specifically designed for the health sector and trade agreements are often negotiated without inputs from health policy-makers and experts.

The adoption by the Fifty-eighth World Health Assembly of the revised International Health Regulations (2005) provides the legal framework for mandating countries to link and coordinate through a universal system of surveillance networks. While novel environmental threats and outbreak-prone diseases have been increasingly identified during the past three decades, new influences have appeared more recently, driven by real or perceived threats of bio-terrorism and disruption of the global economy.

At the national level, health policy-makers are increasingly interested in the two-way connection between trade and health, particularly for emerging public health issues such as avian influenza. In the Asia Pacific Region, 24 countries and areas are members of the World Trade Organization (WTO) (Table 10.1). Six of them are Least Developed Countries (LDCs) with special rights under WTO rules. An Interregional Workshop on Trade and Health, held in October 2004, assisted countries to identify issues critical to public health relevant to WTO membership, and to develop clear plans of action.

There are three main WTO agreements that affect health and health policies:

1. The General Agreement on Trade in Services (GATS), the first multilateral agreement dealing with trade in services, entered into force in 1995. While many countries have not yet made commitments in health or health-related services, this may change since ongoing and future WTO negotiations are aimed at further liberalization of trade in services. Even if commitments have been made with regard to health services, the GATS Agreement leaves countries considerable flexibility to manage trade in health services in ways that are consistent with national health policy objectives. Ministries of health face challenges of accurately assessing the risks and opportunities of trade in health services, and identifying policy measures that can be used to ensure quality and accessibility.

2. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) requires WTO Members to comply with certain minimum standards for protecting and enforcing intellectual property rights. Awareness of the importance of intellectual property rights (notably patents) with regard to access to medicines has increased among ministries of health in countries of the Region. Health authorities may find it difficult to keep up with the evolving and intricate developments in this area, which fall outside the scope of their normal area of work and responsibility (also see Chapter 11.4 Essential Medicines).

3. The Agreement on Sanitary and Phytosanitary Measures (SPS) was negotiated in response to concerns that countries might use non-tariff barriers to protect domestic agricultural sectors, such as using human, animal or plant health as an excuse to restrict trade. Such measures could negate benefits from reduced tariffs and subsidies obtained in trade negotiations. Poorly developed food safety policies, legislation and plans of action, as well as a lack of inspection, food safety training, and surveillance and monitoring have, at times, hindered the ability of the food production and processing systems to provide a safe supply of food for domestic consumers.

There remain significant challenges for many countries in the Region to create or strengthen regulatory systems required to guide health services trade in the desired direction, and the development of standards necessary to ensure quality and protect consumer and patient safety. The provision of services across borders (related to “e-health”) is particularly relevant for many small Pacific island countries.
Even in the absence of a clear legal and regulatory framework, distance education within countries, such as online training courses offered by universities or training institutions, is increasing, limited only by the availability of appropriate technology. Some countries are emerging as important players in this field such as India where companies are providing medical transcription services to hospitals in the United States of America. India is also increasingly using telemedicine services within the country.

Patients seeking treatment abroad are common in small countries such as Bhutan, Maldives and those in the Pacific, where certain specialized medical services are not available domestically. It is also taking place in Indonesia, where a specialized foreign medical institution may be closer than a comparable domestic hospital. Meanwhile, private hospitals in India, Malaysia, Singapore and Thailand are actively seeking to attract foreign patients. By providing services of good quality at prices significantly lower than those in more developed nations, these countries have seen a steady increase in the number of patients from abroad.

**Box 10.4: General Agreement on Trade in Services modes of supply**

GATS identifies and distinguishes four ways (modes) in which services can be supplied:

- **Mode 1**: Cross-border supply, mainly through telecommunication, e.g. e-commerce. In the medical field this can include telemedicine, telediagnosis and outsourcing of medical transcription services.

- **Mode 2**: Movement of consumers, e.g. tourism, or patients travelling abroad to seek medical treatment.

- **Mode 3**: Commercial presence, through the establishment of a branch or subsidiary, e.g. foreign investors setting up hospitals or clinics.

- **Mode 4**: Supply of services through movement of persons, e.g. employment of foreign nurses and doctors.

The commercial presence in the hospital sector, while still relatively small, is increasing in several countries. Investment is coming from outside Asia, and hospital corporations in India, Singapore and Thailand are also investing in neighbouring countries. Foreign investors are also active in health insurance. An issue of concern related to foreign investment in this sector is whether these private hospitals and insurers will primarily target only patients who can afford to pay high rates.

International trade, population migration, changes in living conditions and in production, marketing, and the availability of consumer goods are revolutionizing the human environment. While such changes have improved the health and economic status of many people in developing countries, risk behaviours have also emerged that adversely affect maternal, child and adolescent health.

The regulatory control of dietary fat to fight obesity is an important issue in countries in the Pacific. Domestic measures to address obesity problems may include measures affecting trade in obesity-causing foods, thereby requiring consideration of the Agreement on Agriculture and the Technical Barriers to Trade (TBT). There is a need to increase understanding of these WTO agreements and how to take advantage of their special and differential provisions. Being better informed would help guide policy decisions and assist in selecting appropriate regulatory approaches.
<table>
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Note: The accession of Vanuatu has been approved by the WTO membership but is awaiting ratification at the national level (as of June 2008).


10.8 Key issues and challenges in health systems

Modern health systems in the Region arose only recently and most are still in a stage of continuous development, although almost all health systems around the world are being challenged to keep pace with accelerating change. Health systems are most successful where curative providers are linked closely with preventive activities, and inputs are focused on the needs of the communities they serve and on achieving established health targets. A certain basic level of funding is necessary, but health system performance also depends on overall health system functioning. The goal of health systems development is to improve the organization, vision, management, governance and efficiency of systems; and to use appropriate information, training, communication, and policy formulation for attaining health outcome targets.

Health system weaknesses constitute a key constraint to progress in many technical programme areas. The early years of the 21st century have seen large increases in health-care spending for disease control programmes, particularly in using external donor support in lesser developed countries. This increased spending has not always been followed by proportional gains in health outcomes. Weak health systems have been an obstacle to the effective use of increased funds. Strong and robust health systems are a prerequisite for sustained health gains and consequently, there has been renewed interest for health systems strengthening initiatives at the national and international levels. International partnerships, such as the Global Fund to Fight Aids, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunizations (GAVI), have demonstrated an interest in health systems strengthening.

The problems encountered by policy-makers in relation to health systems development vary from country to country. Notwithstanding differences between them, countries in the Asia Pacific Region share common challenges:

(1) **Poor and inequitable health outcomes**: The ultimate goal of national health systems is the attainment by all people of the highest possible level of health. Although life expectancy has risen and overall infant mortality has declined in the Region, some countries still have unacceptably high maternal mortality and infant mortality levels. Health outcomes in the Region are also unequally distributed. The poor, less educated, marginalized and rural populations have lower life expectancy and higher infant mortality rates than the non-poor. Biases in service provision and service access rooted in ethnic, gender and class discrimination contribute to these poor health outcomes.

(2) **Lack of access to care**: Over recent decades, primary health-care facilities and district hospitals have been established to increase health service coverage. Millions of health personnel and volunteers have been trained and deployed. Unfortunately, large segments of the population have not benefited from these developments. The poor, those who live in rural and remote areas, and other vulnerable groups still have limited access to quality health care. Social, economic, gender, ethnic and geographical barriers prevent them from utilizing health care when needed. It is estimated that 25% to 30% of the Region’s population lacks access to essential preventive and curative health care.\(^{21}\)

(3) **Lack of quality, continuity and integrated services**: Ensuring appropriate quality of care, including patient safety, is a challenge in most countries in the Region. Many countries face problems created by implementing multiple vertical programmes, which can lead to duplication, diversion of resources, and disruption of other programmes due to competition for staff time and limited resources, and by distractions caused by poorly coordinated activities.\(^{22}\) Verticality itself is not a problem, and in some situations it is the best way to achieve positive health outcomes. The difficulty arises when individual programmes and
activities are implemented without regard to the overall capacity of health systems or other competing demands on health systems. Providing adequate continuity of care for newborns and people living with HIV/AIDS, for example, remains a major challenge.

(4) **Poor responsiveness to clients’ needs and demands**: Responsiveness is a measure of performance with regard to non-health aspects of the health system; and focuses on how well the health system meets peoples’ expectations of how they should be treated by health-care providers when interacting in a personal and non-personal way with public health services.\(^\text{33}\) This includes respect for people (i.e. dignity, confidentiality and freedom to participate in choices about one’s own health), and client orientation (prompt attention, amenities of adequate quality, access to social support networks, and the ability to choose a provider). The lack of responsiveness of health systems to peoples’ needs and demands can be inferred from such indicators as underutilization of free services provided by government health facilities. The condition of physical infrastructure and patient autonomy in decision-making are two key concerns in the quality of ambulatory care services.\(^\text{34}\) There is growing evidence that many people feel increasingly alienated from their health systems, even in countries that have good health outcomes. Patients’ rights movements are a response to this. In the Asia Pacific Region, WHO has launched the People-Centred Health-care initiative in 2007, which aims in part to address this problem.\(^\text{35}\)

Country actions to improve the performance of health systems range from small-scale adjustments in specific subsystems to complex reforms of the financing, organization and management of entire health systems. The evidence base for cost-effective interventions is increasing, and a wide range of initiatives and strategies can be called on to improve the functioning of the health system leading to better health through improved access and coverage, higher quality and increased efficiency and effectiveness.

### 10.9 A framework for health systems strengthening

Health systems are complex and denying this complexity and concentrating on only one aspect of the system may yield short-term results, but often creates distortions of the overall system and threatens the sustainability of gains already made. There are many ways to analyse health systems, but one way is to look at the desired goals or outcomes of the system. Another is to examine the building blocks or inputs that go into achieving the desired outcomes.

The WHO Secretariat adopted a framework for action for health systems strengthening in 2007. The framework, entitled *Everybody’s business: strengthening health systems to improve health outcomes*,\(^\text{36}\) builds on earlier work of WHO, particularly *The world health report 2000 – Health systems: improving performance*.\(^\text{37}\) Both reports recognize that there are four overall goals or outcomes that are expected from a health system:

1. Improved health, both in the level of health and equity in health.
2. Responsiveness of the health system to the desires and needs of people.
4. Improved efficiency, namely that full value is received for the resources invested in health.
The WHO framework then goes on to identify six building blocks for a health system. The six building blocks identified in this framework are:

1. Health service delivery—safe, quality personal and non-personal health interventions.
2. Health workforce—sufficient numbers and mix of competent staff, who are fairly distributed, responsive and productive.
3. Health information systems—production, analysis, dissemination and use of reliable and timely information.
4. Medical products and technology—high-quality, safe, efficacious, cost-effective and scientifically sound.
5. Health financing—adequate in amount, ensuring that there is access to needed services, and raised in ways that protect people from financial catastrophe and impoverishment.
6. Leadership and governance—ensuring strategic and policy frameworks combined with oversight, working with partners, regulation and accountability.

Individual health systems can be analysed using a variety of categories. The important principle is that the health system must be looked at in totality. Working on only one aspect of a system, while ignoring the rest, is likely to cause distortions and inefficiencies or even damage health systems, thereby worsening health outcomes.

Different modes and priorities for care are required to cope with changing disease patterns. For example, treatment of chronic noncommunicable diseases (NCDs) can be expensive and involving laboratory procedures and drugs, the costs of which must be covered either by the government, individuals, or third-party insurers. While aging cannot be prevented, many NCDs, such as diabetes and hypertension can now be prevented or mitigated as effectively as most communicable diseases. Failing to address chronic conditions, such as hypertension and diabetes or even HIV, in a holistic manner early in the progression of a disease can actually increase long-term care costs to the health system and households, and increases the amount of human suffering and pain.

Multisectoral approaches are increasingly needed to effectively combat certain communicable disease threats. HIV/AIDS prevention and control requires collaboration of the health, labour, construction, transportation, migration and police sectors, as well as social research institutions and blood banks. The need for international coordination became evident in the Region with the severe acute respiratory syndrome crisis and the current avian influenza threat, which has also brought the agriculture and veterinary sector into the picture. In many countries, health-related sectors, such as agriculture, education, industry and trade and communications, are beginning to work together and take the health consequences of their decisions into account when formulating policies.

Alternatives to strictly public provision for increasing the coverage of good quality health services should not be overlooked. However, the increasing role of the private sector in the Region has led to more focus on profitable curative services and the relative neglect of preventive and public health programmes. It has also led to increasing dependence on user fees at the time of service to finance health systems, which risks excluding the poor and impoverishing families due to medical expenses, and aggravating the long-standing problem of concentrating services in urban areas where financial profit is more likely. Regulation and guidance appear to be needed to maintain an adequate level of preventive services. Thailand, for example, has encouraged a multiplicity of providers and mechanisms, which still requires public sector involvement and financing. A mixed economy exists in most lower-income countries, and a combination of mechanisms can use the strengths of different types of
providers to maximize public benefits. In the short term, strategies should focus on influencing health-seeking behaviour to promote initial consultation with public providers, and bringing first-line curative services closer to the people by linking these to regular outreach activities.

**Box 10.5: Using private sector capacity**

Some Asia Pacific Region countries have built successfully on private sector capacity in order to improve health service access and coverage:

Contracting out health service delivery in Bangladesh, Cambodia and India. Social marketing of commodities and social franchising of specific services, e.g. a USAID-supported project in Indonesia has piloted a franchise for village midwives called Bidan Delima or the Red Seed Midwife.

Other social marketing programmes in the Region include the subsidized sale of impregnated bednets in malaria-endemic areas, and the sale of condoms targeted to limit the spread of HIV/AIDS, such as the Sutra project to promote condom use in Indonesia.

The delivery of specific services to groups which governments find hard to reach, e.g. funding NGOs to provide services for injecting drug users in Bangladesh, and providing a continuum of care to HIV/AIDS patients in Cambodia.


While low-income countries are still struggling to raise sufficient resources for essential health care, countries in the middle-income group that can deliver basic health services are turning their attention to issues of universal health coverage, financial protection and health system efficiency. Ambulatory care in the developed (high-income) countries in the Region is provided largely by the private sector, although to a large degree it is still publicly financed in most countries. Differences emerge in the hospital sector: the hospital sectors of Hong Kong (China) and Singapore are both largely public, while hospitals are largely private in large social insurance systems such as those of Japan and the Republic of Korea. In terms of the private-public mix, these systems span a wide range of ownership and financing combinations.

### 10.10 Better coordination of aid funds

Several countries in the Region have a high level of external aid dependence in health, with external sources making up more than 50% of the total government expenditure. Bangladesh, Cambodia, the Democratic People’s Republic of Korea, the Lao People’s Democratic Republic, Nepal, Solomon Islands and Timor-Leste are examples of such a case. With such a large share of government health funding from aid, coordination becomes crucial to avoid duplication of effort, and ensure that national priorities and strategies are implemented rather than the preferences of donors.

External funding, especially through large global health partnerships, can create distortions or imbalances in the overall allocation of resources and may lead to a pattern of allocation which local policy-makers would not have chosen. An alternative approach, which the major donors have adopted in relatively few instances, is to shift their financing from specific sectors and programmes to general budgetary support. The proliferation of different global initiatives also creates the potential for them to weaken rather than strengthen health systems, especially when each initiative competes for scarce
human resources. The Paris Declaration on Aid Harmonization and Alignment was endorsed by the Organisation for Economic Cooperation and Development and calls for improved practice in providing aid so as to mitigate some of the adverse effects of external aid in all sectors.

The Sector-Wide Approach (SWAp) in health is one method of improved aid coordination, harmonization and alignment. Defining a method of working between government and development partners, SWAp is a mechanism for coordinating support to public expenditure programmes and for improving the efficiency and effectiveness with which resources are used in the sector. In the Region, several countries such as Bangladesh, Cambodia, Papua New Guinea and Solomon Islands are at various stages of SWAp in the health sector. It is clear that a SWAp must be adjusted to the conditions of each individual country. Other countries, such as the Lao People’s Democratic Republic and Vietnam, are developing alternative coordination mechanisms.

Box 10.6: Mechanisms to improve aid management

Some Asia Pacific countries have introduced mechanisms to improve the way that aid is managed in health to encourage coherent support to health sector development:

In Papua New Guinea the Health Services Improvement Programme (HSIP) focuses budget support on agreed priorities within the National Health Plan. Its financing mechanisms are essentially a SWAp based on a single, accountable government-managed mechanism to hold and disburse pooled donor funds. It closely resembles the government financial system in its expenditure procedures and accounting and, in theory, is integrated with national and provincial planning and budgeting.

Bangladesh introduced sector-wide management (SWIM) in 1999, based on the Health and Population Sector Plan. All of the health donors supported these both through earmarked support and pooled funding.

Cambodia developed a Health Sector Strategy and encourages partners to follow it, also using sector-wide management in which funds provided by the Asian Development Bank, the World Bank, United Nations Population Fund (UNFPA) and Department for International Development (DFID) are pooled to strengthen the highly fragmented health sector, while at the same time keeping direct donor oversight in the allocation of funds.

Nepal is in the second year of implementing its Health Sector Programme based on a sector-wide approach.

An action plan for harmonization and coordination was agreed among European Union donors for Vietnam. There has been enhanced cooperation among European Union donors in education, private sector development and health. As a first case of harmonization, European Union countries have started to work on integrating the funding of tuberculosis programmes.


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The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over 100 ministers, heads of agencies and other senior officials adhered and committed their countries and organizations to continue to increase efforts in harmonization, alignment and managing aid for results. www.oecd.org/document/18/0,2340,en_2649_3236398_35401534_1_1_1_1,00.html - 27k
First and foremost, a SWAp explicitly mandates the ministry of health with the leadership of health development efforts. The defining characteristics of a SWAp are: all significant funding for the sector supports a single policy, plan and expenditure programme; government provides leadership for the programme; common implementation and management approaches, such as joint missions and joint reporting requirements, are applied across the sector by all partners to a varying extent, depending on the individual arrangements in a particular country; and budget support and pooling of funds can be part of a SWAp.

Summary

Health systems encompass all organizations, institutions and resources devoted to producing health actions in specific environments. The Asia Pacific Region has wide diversity in political and economic systems, and that diversity is reflected in its health systems. Health systems vary from having a high degree of both public financing and public provision to systems that are highly dependent on both private financing and private provision of services.

No matter what mix of public and private financing and provision of health systems is present in a country, the government still has a strong role to play in the leadership and governance of the sector, sometimes called stewardship. The government in particular has a strong responsibility to see that public goods in the health system are delivered and that those people most vulnerable, namely the poor and underserved, are included in service delivery. An issue in many countries is the relatively high percentage of health services that are paid by households through user fees at the time of service. User fees at the time of service are deterring people from accessing needed services, and at the same time putting them at risk for impoverishment if they do use services. Where donor funding is an important part of the health-care system, coordination mechanisms become particularly important. The increasing influences of globalization and trade on health have added complexity to governance issues as governance issues often transcend borders.

Weak health systems are an obstacle to improved health outcomes in many countries and there is a need to strengthen them throughout the Region. Experience has shown that health systems must be analyzed holistically, by looking at the entire health system and not just one part. Working on one part, while neglecting others, can lead to distortions which can have an adverse effect on health outcomes. There are many challenges and no simple solutions, but frameworks for strengthening health systems are being developed and their use should be encouraged.

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