HEALTH SECTOR REFORM AND ETHICS

Public-Private Mix: a Public Health Fix?
Strategies for Health Sector Reform in South and Southeast Asia

International Workshop
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Naresuan University, Phitsanulok, Thailand

WORKSHOP REPORT

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Table of Contents

List of abbreviations

AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife (India)
ARI	Acute Respiratory Infection
AU	University of Aarhus (Denmark)
AYUSH	Ayurveda, Unani, Siddha and Homeopathy
BPL	Below Poverty Line
CBO	Community-based Organisations
CME	Continued Medical Education
Danida	Danish International Development Assistance
DHS	District Health Services/System
DKK	Danish Kroner
DRG	Diagnostic Related Group
FFU	Danida's Research Council
GMU	Gadjah Mada University (Indonesia)
GOI	Government of India
HSRE	Health System Reform and Ethics (Research project)
ICDS	Integrated Child Development Scheme (India)
IEC	Informaiton, Education and Communication
LV	Link Volunteers
MandE	Monitoring and Evaluation
MCI	Medical Council of India
MoHFW	Ministry of Health and Family Welfare (India)
MOU	Memorandum of Understanding
NGO	Nongovernmental Organisation
NRHM	National Rural Health Mission (India)
NU	Naresuan University (Thailand)
NUHM	National Urban Health Mission

OPD	Outpatient Department
ORS	Oral Rehydration Solution
PHC	Primary Health Care/Centre
PNC	Prenatal Care
PP	Private Practitioner
PPM	Public-Private Mix (or Public-Private-People Mix)
PRI	Panchayati Raj Institution (local government, India)
QMP	Qualified Medical Practitioner
RCH II	Second phase of the Reproductive and Child Health Program (India)
RMP	Registered Medical Practitioner (in India, may not be formally medically qualified)
RUF	(Former) Research Council of Danida
SEARO	South-East Asia Regional Office (of WHO)
SLI	Standard of Living Index
U5MR	Under-five Mortality Rate
UC	Universal Coverage Scheme (Thailand)
UHC	Urban Health Centre (India)
UN-HABITAT	United Nations Human Settlements Programme
USD	United States Dollar
WHO	World Health Organization

Introduction

This document reports the proceedings of a research-to-policy workshop that was organized as part of a multi-country cross-disciplinary research project on the private health care sector in urban poor neighbourhoods in India, Indonesia and Thailand, entitled "Health System Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand". The project consisted of a combination of medical anthropological research among private (for-profit) practitioners and among people living in poor urban neighbourhoods; a health economics study among poor urban households and a desk study that assessed existing regulations and ethical guidelines in the three countries. The project period was April 2004 to December 2007.

A number of other studies in the past have shown that the role of the private sector can be problematic, perhaps even more so in India than in the other participating countries. At the same time, there has been a push of public-private partnerships. The workshop intended to discuss the rationale, the benefits and limitations and risks of this strategy. Even if there are examples of successful partnerships that serve sound public health purposes, such partnerships may not address the structural problems that establish effective access barriers for the poor. Based on research that provided a critical assessment of the role of the private sector the workshop should develop relevant strategies to address public health problems related to the role of the private-for-profit health sector. The overall purpose of the project was to identify viable strategies for strengthening ethical practice in the private healthcare sector in poor neighbourhoods through feasible and locally acceptable control mechanisms and other possible means. It was believed that this is only possible through a combined understanding of patients', private practitioners' and drug vendors' perspectives. Health ethics, in this connection, may be broadly understood as a consensus-based normative regulatory framework that primarily works to protect patients against iatrogenic adverse events when utilizing the health system. The existing scientific literature shows that a framework of this type is not in place, or is not working to the desired effect, in a number of countries in South- and Southeast Asia.

The project consisted of four sub-studies that complemented each other in order to give a detailed and multi-faceted understanding of the local health systems under study:

1) Existing regulatory mechanisms, including ethical codes and legislation with direct implications for general private practitioners: desk study
2) Health systems ethics among private practitioners: ethnographic sub-study
3) Family-level treatment and health-related decision-making: interview sub-study
4) Household survey: health economics sub-study

The project was funded by the Danida Council for Development Research (RUF, after 2006 renamed to FFU) with a budget of four million DKK covering a period of three years (2004-07).

Further information about the project is available at www.hum.au.dk/hsre.

The workshop

During 20-22 June 2007, a 3-day workshop was held at Naresuan University, Phitsanulok, Thailand, to disseminate findings of this and related research in the region and develop policy implications. On Day One, research findings and recommendations was discussed; On Day Two, the focus was on comparative perspectives across the participating countries; and on Day Three, country-specific policy recommendations were developed on the basis of the previous days' work. The workshop progamme is attached as Annex 1.

The objectives of the workshop were:

- To identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care for the poor in urban India, Indonesia and Thailand
- To identify lessons learnt and best practices from health policy interventions for the urban poor in the three countries

Inaugural session

Professor Supasit Pannarunothai, Dean, School of Medicine, Naresuan University, opened the session. He stressed that this hospital provided services for the poor and worked with networking mechanisms throughout the community. The objectives of the workshop primarily addressed the need to improve quality of care for the urban poor. Participants came from six countries and constituted a fruitful mixture of policy-makers, researchers and practitioners.

President of Naresuan University, Mondhon Sanguansermsri, welcomed the participants. He stressed the role of Naresuan University as a progressive university that emphasised health ethics as a key issue and that valued international collaboration. He then wished participants a good meeting.

Jens Seeberg. Assoc. Professor, University of Aarhus, then delivered his introductory remarks. He noted that it was a rare opportunity for a research project to be able to organise this kind of research-to-policy meeting and he thanked Danida for funding the project and the meeting. He then took the audience back to an earlier WHO-project on ethics in South-East Asia that had led to the current project. A regional research group was gathered to focus on the private sector. He noted that the private sector encompassed more than private doctors, i.e. insurance companies, private medical colleges, production and distribution of drugs, and others. All these components, he said, are complex and require careful consideration. Moreover, there are many different types of health providers. He stressed the need to conceptualise competing health systems and raised the question whether we need to abandon the concept of system in this context and replace it with a notion of health networks. He pointed out that little research had been conducted on the private sector when the World Bank strategy to down-size government funding of health care had been launched in the late 1980s. Twenty years down the line we still had limited knowledge of private sectors. He asked, where is the trade-off in government funding to ensure quality of the private sector through stewardship versus investment in government sector delivery? He then introduced the workshop by saying that the first day was dedicated to presentations and discussions. Group work sessions would develop comparative

perspectives on the second day and the final day would formulate country-specific recommendations. He stressed the shared interest in public health among all participants and said that mutual and progressive learning would be a key outcome of this workshop. Dr. Seeberg ended his address by expressing his gratitude to the local organisers.

Special Guest of Honour, Dr Samlee Plianbangchang, Regional Director, WHO (SEARO), then delivered the inaugural address. He appreciated that the subject of public-private mix was being revisited. He said there is no fixed formula for public-private mix. It depends on the country context. The government alone may not be responsible for providing health care for the poor; government partnerships with the private sector were necessary to ensure accessibility for the poor, but steps were necessary to ensure access to affordable and quality services.

Dr Samlee said it was timely to revisit primary health care with a focus on the urban setting. If properly designed and implemented, private health care may help to close the gap that currently exists because of the lack of financial resources. He said that private health care must be initiated and promoted by the government to meet the needs of all. Primary health care is the protection of any population's health. In most cases, governments should have a scheme for the poor ensuring that they are insured. Private sector should also participate in the promotion of health in the community. He stressed that the health services are dealing with human beings and those involved must be awarded and fully equipped with the moral and ethical issues surrounding their responsibilities. Ethics is a challenge and there is a need to put ethics into practice. Medical practitioners should be role models for the young people and the next generation should ensure that the needs of the urban poor are met. Primary health care can reduce the illnesses of the poor and make all people healthier. Private sector can make a contribution in addressing primary health care. All people have the right to be free from all illnesses and primary health care should be practised not only at the primary, but also at the secondary and tertiary level. Dr Samlee ended his address by noting that the findings of this workshop would contribute to our understanding of the current challenges as well as best ways of addressing those.

TECHNICAL SESSIONS

DAY 1 (20 June 2007)

Health Sector Reform and Public Private Mix?

Chair: Supasit Pannarunothai

Rapporteurs: Jenifer Lobo and Yati Soenarto

Dr. Chandrakant S. Pandav, after invoking the blessings of Ganesh for the workshop, said that India reviews and plans its health policy at intervals of 5 years. In the 8th 5 year plan (1992), the first health sector reform became evident when the concept of free medical care was revoked while commitment for free or subsidized care for the needy (BPL) population was ensured. User charges were also introduced. The 9th plan looked at the convergence between public, voluntary and private participation in provision of health care, community participation, and accountability of the health sector. In the 10th plan, reform focused on primary, secondary and tertiary health care, and emphasis was on equity, financing of health care and social health insurance for the BPL population. The National Rural Health Mission was introduced and towards the end of the plan period the addition of the National Urban Health Mission was introduced, recognizing the presence of urban poor and the presence of private practitioners of all varieties in these areas.

Health service reform has as yet no accepted definition, Dr. Pandav said. This adds to the problem of initiating change. Two definitions which appeared usable were given: “Sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector” (Peter Berman,1995) and “Defining priorities, refining policies and reforming the institutions through which those policies are implemented” (Cassels,1997).

Dr Pandav outlined Health Services Reform as dealing with issues of Equity; Effectiveness; Efficiency; Quality; Sustainability; Defining priorities; Refining policies; and Reforming institutions for policy implementation. The need for moving to action as soon as possible was stressed.

Professor Laksono Trisnantoro explained that Indonesia has no history of planned health system reforms. Certain facts were presented: public health expenditure was 25% of the total health expenditure; 75% was private finance; 75% of the income of government doctors was from private practice which was not allowed; there was no control with medical practitioners; there was inequitable distribution of health care; and there was collusion with pharmaceutical companies.
On this background, health sector reforms were triggered by three Acts: Decentralization Acts, 1999 and 2004, Medical Practice Act 2004 and Social Security Act, 2004. Prof Laksono said that the acts did not affect the health scenario as it was difficult to implement the acts to control the private and public practitioners. There was a disparity in the economic status of the specialist and the general practitioners. The inequitable distribution of health care continued. He said that the Social Security Act was a reactive intervention to protect the poor due to the nationwide economic crisis in 1997. Prof Laksono presented a scenario analysis, where the worst case scenario involved failure to implement the Social Security Act and simultaneous rejection of the Medical Practice Act. To reduce the risk of ending up with the worst scenario, he recommended the following: 1) a cultural approach should be implemented to change medical doctors' way of life; 2) regulation to control the private health care sector should be developed alongside with cultural change; 3) a mixed approach of welfare state and market-driven policy should be put on the agenda of health system reform.

Dr. Pongpisut Jongudomsuk initially introduced Thailand as a lower middle-income country. The health indicators of the country were better than average for this group except in terms of human resources for health. The proportion of the poor used to be very high - 42 percent of the total population in 1988 - but declined with the gradual economic growth in the country. The majority of the poor lived in the northeastern region while only a small proportion, 0.5 per cent, was in Bangkok. The Government had previously introduced specific schemes for the poor. These were a) Low Income Scheme for those below the poverty line, b) Fee Exemption Scheme for public health facilities and c)

Health Care Scheme as part of the PHC strategy. As a result of these schemes there were problems of unacceptable quality of care for the poor, discrimination and social stigma.
The Universal Coverage Scheme was launched in 2002 to ensure access to care as a basic right for the entire population. Since it was a comprehensive package, exclusions were minimal. The main contractor was primary care providers. Private providers could participate voluntarily, but problems between the public and private care providers did occur. Dr Pongpisut concluded that the Universal Coverage Scheme is a pro-poor scheme although its nature is universal coverage. Lower utilization of the rich may lead to relatively poor quality of service. Tax-based financing is recommended for countries with a large informal sector to achieve universal coverage. Primary care and district health system (DHS) favor the poor and a financing mechanism should be designed to strengthen their functions. Increased access to care of the population may threaten a health care system with limited human resources, and a drain of experienced medical doctors from the government to the private sector was already happening in Thailand.

Dr Firdosi Mehta showed that the present situation in the global control of tuberculosis (TB) had improved substantially. Prevalence of infection and death due to TB had decreased through the implementation of DOTS. The problem in Southeast Asia is coming under control through strategic planning for each country and appropriate action. Public-Private Mix (public-private, private-private, public-public) enable partnerships to be developed for delivery of care for TB control. Evaluation of PPM initiatives have shown that good treatment outcomes do occur. The benefits of PPM were enhanced quality of TB management and care, decreased financial burden, cost effectiveness etc. The functions of the public and private providers needed to be delineated in order to make this strategy work. The role of PPM in the control of TB could provide lessons for future policy in other areas of health. A detailed example of PPM helping TB control through DOTS was given, where the private and public providers and the TB program collaborated to ensure that DOTS was implemented.

Professor Reidar Lie stressed the role of basic ethical values and human rights to guide health policies. The right to health means that health care has to be accessible to all. Yet there was a realization that economically weak countries would not be able to ensure equal rights to health for all citizens. This gave rise to the fairly popular notion, promoted by the World Bank and WHO, that there was a right

not to comprehensive health coverage, but only to a basic or essential package. But it was essential that improvements in economic status of the countries should be reflected in changes in health policy. While the human rights framework could not be used to prioritize one specific treatment type over another, Professor Lie noted that a human rights framework for health sector reform was needed to give direction to policy development, since differential access to health care was intrinsically unjust and governments should be made accountable for overcoming such inequalities. He stated that one cannot accept a system that as a principle accepts that one group of people receive access to a higher level of services than other groups.

Quality of care and dynamics of the health system (Parallel Session A)

Chair: Dr. Pongpisut

Rapporterurs: Rama Baru and Jens Seeberg

Jens Seeberg's presentation was based on the findings of the study of private health care delivery in Bhubaneswar, Orissa. Dr Seeberg pointed to the rapid growth of the private sector during the 1980's and the role of the World Bank that initially promoted this growth more in order to downsize governments rather than based on evidence regarding the private sector. The downsizing of governments has created benign conditions for the growth of the private sector. While referring to the private sector, he said that a distinction needs to be drawn between the 'for-profit and non-profit' sectors. In the former there are both informal and formal providers. The formal sector not only consists of providers but also includes production, sale and distribution of drugs and technology. In this scenario, the state has an important role in dealing with licensing. This study focused on these aspects in Bhubaneswar, which he divided into centre and periphery. He listed all available facilities at the primary, secondary and tertiary levels. The structure and behaviour of the pharmaceutical industry and its interface with providers and the medical representatives as mediators between the producers, service providers and consumers was discussed. The study showed that fierce competition between pharmaceutical companies led to use of aggressive marketing strategies that was implemented by

medical representatives. The key role of the chemists, how they do not have trained pharmacists and how they act as informal agents for the pharmaceutical industry was delineated. Here, the pharmaceutical companies have deeply entrenched themselves by exploiting the weaknesses of the private sector. While the state has a key role in certification, regulation etc., it was found to be very porous and ineffective, particularly in dealing with the pharmaceutical sector. Dr. Seeberg's suggestions for reform included promotion of transparency in government licensing and control activities, establish control mechanisms for drug promotion in collaboration with the pharmaceutical industry, to establish free primary health care services in urban and peri-urban areas, and to ensure that migrant populations have access to such services.

Rama Baru took as point of departure for her presentation the widespread use of private practitioners for outpatient services and linked that to issues of location and distribution mediated by the socioeconomic characteristics of the population served. The growth of the private sector at secondary and tertiary health care levels is largely an urban phenomenon, and there is a clear class gradient in terms of utilization of public and private hospitals. Pointing to the existence of so-called Registered Medical Practitioners (RMPs), many of whom may have little formal education and training in biomedicine, Dr. Baru said that little had been done to integrate them and upgrade their qualifications. On the contrary, the Indian Medical Association had classified them as quacks and campaigned against them. She pointed to a study showing that most had completed high school and that most had an apprentice relation with qualified medical practitioners, to whom they also refer patients. They tend to use the same equipment as QMP, and they provide the same symptomatic 'cocktail' treatment that many QMPs give in order to ensure patient satisfaction. Dr. Baru went on to discuss the heterogeneity of the private sector at secondary and tertiary levels. In terms of reform of the sector she insisted on a systemic perspective that should look at both the formal and the informal sectors that are organically linked. Regulation is important but cannot be implemented by the government alone. There is a need for self-regulation as well. The NRHM provides a window for policy initiatives. She stressed the need to expand this mission beyond poor districts to cover the entire country and to address issues at secondary and tertiary care levels as well, including plugging the private practice of government doctors.

Roy Tjiong presented a brief overview of health service delivery, health programmes and current health status in Indonesia. The MMR and IMR were high and there is a double burden of communicable and noncommunicable diseases. The available data shows that there is inequality in health status across regions and different income quartiles. As compared to other countries in the region, Indonesia fares poorly with respect to IMR, MMR and malnutrition levels. Data on utilization patterns show that the poor do utilize the public facilities. Only around 55% use allopathic services while a large proportion still depend on traditional healers and other informal practitioners. Indonesia has low investments in health; therefore, 88% of health expenditure is out of pocket.

Chorrul Anwar from Indonesia made a presentation on the policy initiatives undertaken to regulate the private sector in Jogjakarta. He enumerated the difficulties in the policy process in order to ensure the provision of good quality care. He identified the pluralism of the health sector as involving a problem of ensuring quality of care. Rules and regulations are not strictly enforced and are often violated. Some doctors practice without license or with other doctor's license. They may dispense medicines and act as drug distributor. Some nurses practice without license and dispense drugs. Some traditional healers provide medical treatment. Some of these irregularities are in accordance with patient demands, since people prefer providers who dispense rather than prescribe drugs. There is a need to strengthen regulation through licensing, certification and accreditation, including all types of systems. In addition there is a considerable amount of cross-practice that makes regulation difficult. He described in great detail the steps, process and stakeholders in the regulation of private providers. Apart from these, he also provided insight into the institutional mechanisms and bodies that have been created to set standards for the regulatory process and to ensure monitoring and surveillance. An interesting feature of this model is that it has space for the 'voice' of consumers through the creation of a grievance/complaint redressal centre in the Mayor's office where complaints can be lodged against private providers/hospitals. He presented some data on the status of regulation and also pointed to the limitations due to the long process and lack of adequate human resources to carry out all the necessary activities. A multi-stakeholders approach involving different levels of government, professional bodies and users of health services has been used in this process of regulation in Jogjakarta city.

Aumnoay Pirunsarn presented some insights from the ongoing study on characteristics and behaviour of private providers in Phitsanulok. He showed the fairly strong presence of the private sector at all levels of care. He pointed to how patterns of health seeking behaviour are mediated by symptoms; period of illness, time spent waiting for practitioner and loss of income. His study showed that the drug store or chemist is the most important player in treatment at the primary level. The attributes of a good drug store were enumerated to include the knowledge of chemists; his ability to give advice and also to follow up patients. The cases of general practitioners showed that they were experienced and had fairly high patient loads.

There was a lively discussion following the presentations. Regulation and the varying patterns across countries were discussed. This is an area for comparative studies across countries in terms of processes, networks used and outcomes – both in terms of successes and failures. Apart from the state there was discussion regarding what NGOs can do to control and regulate pharmaceuticals. There was a recognition that both pharmaceutical and medical providers in the market push their interests aggressively and where these interests are well entrenched, it is harder to put in regulatory mechanisms. There was considerable discussion around the quality of private and public sectors and many of the speakers pointed out that evidence does not support the popular perception that the former provides better quality than the latter. It was felt that in countries (like Thailand) that have higher investments in health, the state is in a stronger position to regulate and define a clearer role for the private sector as compared to countries where the state is either weak or practically non-existent in the financing and delivery of health services.

Health Seeking Behaviour (Parallel Session B)

Chair: C.A.K. Yesudian
Rapporteur: Nupur Barua

Five studies from three countries, India, Indonesia and Thailand, and one drawing from six research projects in the south and southeast Asian region were presented in this session.

The main issues that emerged during C.A.K. Yesudian's presentation on health seeking behaviour among the poor in urban India was the fact that the urban poor is a heterogeneous entity, and that there are significant variations on the basis of income levels and the kind of occupation they are engaged in. As a departure from evidence provided in previous studies, he pointed out that health seeking behaviour is no longer driven by cultural perceptions of illness. He demonstrated, through two studies in Mumbai and Bhopal in India, that pragmatic issues regarding access to, and location of, facilities, as well as the perceived quality of services influenced the ways in which health care facilities are used.

Nupur Barua's presentation examined the reasons for the overwhelming preference of the urban poor for the individual untrained private practitioner in a slum in Delhi. Expenditure on use of government facilities was found to be more expensive than these practitioners. The modalities of treatment inside these clinics and competence constructions of different practitioners by the care seekers were discussed in a context where the patient struggles to survive and the practitioner thrives by providing health services in situations in which they are most needed.

Siwi Padmawati discussed the use of multiple health resources among the poor in urban areas in Yogyakarta, Indonesia and the decrease in the use of public facilities. The increased use of self treatment was emphasized and possible reasons for this development were discussed. The concept of 'cocok' or 'suitable' treatment, amongst the people suggests that the need to formulate and implement public health reform needs to take local perceptions of quality of care into account.

Mubasysyir Hasanbasri's presentation explored the reasons why health card holders in Indonesia use the private sector for treatment and questioned whether the treatment offered by the private practitioners ensured health protection for the public. He suggested ways in which the public sector could be made more accessible and private providers more effective to ensure better health care to the poor.

Angkhanaporn Sornngai presented the health problems among the re-settled elderly 'boat-people' in Phitsanulok, Thailand and explored the economic problems that they faced because of this relocation.

In a discussion of the treatment seeking behaviour of this group, she suggested that a pro-elderly health policy be framed with a holistic focus and with the collaboration of a multi-disciplinary health team.

Finally, Mark Nichter drew upon six of his studies across South and Southeast Asia to present the increasing numbers and use of private practitioners and chemists in several rural areas and towns across the region. The use of primary health centres for the chronically ill, utilization of private services for TB treatment, self medication, and antibiotic use for sexually transmitted diseases were discussed. He drew attention to the need to carefully scrutinize the definition of self–treatment in the context of specific circumstances in which they are used, whether it signifies home remedies alone or whether it is a continuum of earlier prescriptions from a health practitioner or self-prescription of over-the-counter drugs. He emphasized that although providing good quality care is important, changing the perceptions of the people - consumer education - is important and that both the demand and supply of health services are equally crucial in the context of health service reform.

The discussion following the presentations focused on ways in which research could be used to impact policy and how networks of researchers are important in order to raise visibility and translate research into action.

Financing and health expenditures

Chair: Supasit Pannarunothai
Rapporteur: Rama Baru

Dr Agus Suryanto presented the Indonesian health care system and focused on the substantial variation in Indonesia both in terms of demographics and in health system coverage in terms of manpower and infrastructure for both government and private facilities. He pointed to the common dual (government and private) practice among doctors and other health staff in Indonesia. He showed that the current system does not eliminate inequity, measured in terms of health indicators such as under 5 mortality rate and infant mortality rate, which are four times higher for the poorest quintile compared to the richest. He pointed out that 46% of the population in Yogyakarta had no health insurance and that out-

of-pocket spending remained high. He said that the challenges for the health system were underfunding, limited health insurance coverage, social and geographic inequalities and fragmentation, and that there was weak stewardship of the entire system. He then outlined different scenarios with different roles of the state and different mechanisms for financing the health system (insurance-based versus social security). He recommended that the government strengthen its capacity to provide stewardship, preventive care, social health insurance, and free or cheap services to poor and vulnerable population groups. He ended by providing a set of more specific recommendations and stressed the need for new financing mechanisms and provided the case of a quasi-government company that gives health insurance to the poor in Yogyakarta province. Finally, he introduced the Health Care Quality Council that is a recent body in charge of accreditation of medical institutions, among other quality-related tasks.

Prof Supasit Pannarunothai completed the session by presenting comparative findings of the household survey conducted under the project 'Health System Reform and Ethics: Private Practitioners in Poor Neighbourhoods in India, Indonesia and Thailand.' The study was to compare health care seeking behaviour and health care spending within poor households in the three countries. Households were interviewed four times over a period of 12 months. The median income per capita of households in Thailand was substantially higher and household size substantially smaller than in the other three countries. Distinguishing between the poor and the very poor in each site, he noted that these two groups were not very different in terms of income in the Bhubaneswar site, whereas there was more substantial income variation in the other sites. The Poor in Delhi spent 4 times more money on alcohol than the very poor. While there was a big difference in the proportion of the population that reported illness across the four sites, there was not much difference between the two income groups within each site, except for Thailand, where there were fluctuations that could be explained with the small number of participants following depletion due to migration out of the area in the second to fourth rounds of data collection. Health seeking patterns were also very different across the four sites. Interestingly, the Delhi and Bhubaneswar sites showed markedly different patterns, where the former relying much more on private clinics and the latter much more on government services. This was reflected in patterns of spending per visit, which was markedly higher in Delhi that showed a pattern similar to the sites in Indonesia and Thailand – in spite of universal coverage having been implemented in Thailand at the

time of data collection. The study was summarized through a number of observations: The very poor had bigger household size, and income difference was highest in Thailand. The poor and the very poor had similar morbidity patterns, but they fluctuated over the four waves of interviews. They used both private and public services, but the very poor spent less per visit than the poor. They faced similar incidence of payment difficulties, even in Thailand where the universal coverage policy is in place. This difficulty decreased over the period of study. Professor Supasit concluded that private health facilities are important for poor and very poor in urban neighbourhoods and that they should be monitored for quality. The study raised a question as to whether care to the very poor is rationed. This should be further explored. Access to care under the universal coverage policy may be revised to provide better access to the poor in Thailand.

Regulation – scope and limitations?

Chair: Laksono Trisnantoro
Rapporteur: Kira Fortune Jensen and Jens Seeberg

Dr Ashok Kumar stated that Government of India (GOI) is keen to promote various Indian systems of medicine including ayurveda, unani, siddha and homeopathy. GOI has a separate department called AYUSH for this purpose. He said that only 59% of providers are allopathic practitioners. He detailed the system of registration of medical practitioners based on the Indian medical council act of 1956. Medical Council of India (MCI) acts as a statutory body. MCI takes care of medical institutions, defines criteria and rules for medical colleges and recognizes medical schools. MCI also determines the conduct of medical practitioners. If any medical practitioner is found to have carried out malpractice by MCI, he/she is liable to one year imprisonment. MCI has state branches throughout India. Delhi Medical Council was created by an act of the parliament in 1997 and formally established in 2001. The Delhi state council preparers the code of ethics for practitioners in the state of Delhi, receives public complaints against medical practitioners, administers punishment and provides protection to medical practitioners against harassment; it is responsible for ensuring that no un-qualified person practices modern medicine. The concept of ‘quack’, said Dr. Kumar, refers to a person who does not have

knowledge of a particular system of medicine but yet practices that system of medicine. The directorate of health services and the state medical council is responsible for monitoring practice of modern medicine by un-qualified practitioner. However there are many issues and problems in administration of this system. For example, agencies act only on complaints and do not carry out regular surveillance of their own. 163 complaints had been received by Delhi Medical Council but only 22 had been prosecuted. According to an estimate by Indian Medical Association, about 30,000 non-qualified practitioners are offering medical services in Delhi. Factors contributing to quackery include large demand and inadequate health infrastructure; lack of coordination; poor monitoring and vigilance mechanisms; poor enforcement of the law, long and tedious procedures; lack of awareness among people; and self medication. Quackery can be decreased through improving health infrastructure; improving public health outreach systems; on the basis of the Right to Information Act; based on the National Rural Health Mission that aims to provide health care to all areas of the country; and by strengthening health human resources with Public-Private partnership and capacity building.

Professor Soenarto Sastrowijoto stated that Indonesia has a ‘free market’ system of medical care. He presented a desk study that intended to identify possible regulatory mechanisms for medical practice; to examine existing rules and regulations; and to analyse ethical considerations with special reference to the poor. He outlined the system of regulatory mechanisms in Indonesia and presented ethical cases reported to the Medical Ethics Honorary Committee, including on advertising, mismanagement, and sexual harassment etc. Cases from newspapers were categorised, including wrong or failed medical interventions, illegal abortion and misdiagnosis. Only three cases had reached court. Professor Soenarto discussed the details of these three cases and related them to the existing regulations as well as to contextual factors such as shortage of health providers and the current financing mechanisms. He pointed out that while the government health care system serves the poor, the government doctors engage in private practice in the evenings and cater to the rich. He said that health sector reforms in education, services, financing is required, that new acts and regulation are needed and that a model should be developed urgently to address the issue of privilege regulation in transition for provincial and district levels.

Professor Supasit Pannarunothai then presented the parallel study in Thailand. He pointed to the issue of information asymmetry between health providers and service users and showed a dramatic increase in complaints made to the Medical Council of Thailand following the economic crisis in 1997 and the introduction of the universal coverage scheme in 2000. He reviewed the decisions made by the Council across various types of complaints and suggested that bias could influence decision-making for some of these. He proceeded to analyse claims made to the Medical Licensing Department and found that a substantial number of cases were sent to court. However, in Phitsanulok, only very few court cases were identified. These were presented. Prof. Supasit also illustrated media coverage through a number of cases. He pointed to recent developments, such as community-based organisations, the setting up of an accreditation system that increases emphasis on patient safety issues, and the introduction of a no-fault compensation system. He also pointed out, that this no-fault compensation system so far has been seriously underutilised and that it may be necessary to educate the judges involved in case evaluation to achieve a desired change in assessing claims.

Dr Jenifer Lobo pointed to the existence in India of rampant malpractice at all levels of the health system. She highlighted the lack of implementation and enforcement and asked whether this is due to corruption or factors in the system that tend to enable malpractice. She raised the issue of government doctors indulging in private practice as a main issue in that context and said that the uncovered health needs of the large population also allowed private practitioners to practice without control and quality measures being in place or being enforced. In the context of private hospitals she mentioned pressure from patients and relatives, the mechanisms being put into place to protect health providers against the consumer protection act, and the influence of private insurance companies who want to dictate treatment on the basis of economical rather than medical grounds. She asked whether we can find other solutions to these problems than regulation, which had not been particularly successful in the past.

DAY 2 (21 June 2007)

The proceedings of Day 1 of the workshop were summarized by Jens Seeberg. He pointed to four cross-cutting themes, i.e. Health care seeking and patient rights; Rights, regulation and legislation; Private health care delivery and quality of care; and Health financing. He pointed out some of the

important issues under each heading and said that the group work planned for the day would allow for further discussions of these four themes.

Professional organisations and other NGOs

Chair: Jenifer Lobo
Rapporteurs: Siddarth Agarwal and Jens Seeberg

Dr Siddharth Agarwal in his presentation pointed out that in 2007, for the first time in the history of mankind, the urban population would become larger than the rural. He mentioned the rapid growth of urban slums and said that health care provision to this population was one of the growing challenges for governments and civil society. He proceeded to show that in terms of basic health indicators, there is vast disparity between urban average and urban poor populations, and that the urban poor are often worse off than rural populations in spite of geographic proximity to health care services. He said that public-private mix was required to address the needs or the urban poor and went on to offer a number of different types of partnerships, involving NGOs (private non-profit), mobile clinics and, to a lesser degree and perhaps with more difficulties involved, individual private (for profit) practitioners. Finally he highlighted the need to map the needy urban populations, since, very often, official registration only covers a fraction of the actual slum dwellings. He pointed to the fact that temporary and migrant populations often are denied access to health care services and that partnerships need to be forged to address their needs.

Ms. Widyawati Muhasan then introduced the private health sector seen from a nursing perspective. She described the nursing situation in terms of the number of providers in the province of Yogyakarta and pointed to issues of education, professional organization and legislation. Based on a qualitative study, she found that nurses play a role in private health care and sometimes run their own private clinics where they provide medical treatment, and she pointed to the related licensing problems. However, patients felt they had easier access to these clinics than those run by medical doctors, and that they received quicker and more affordable treatment. She pointed to issues of delegation of medical practice by medical doctors to nurses and said there was a lack of supervision, monitoring and evaluation.

Mr. Marius Widjajarta discussed various pro-poor programmes that had been implemented in Indonesia since the financial crisis in 1997. He went through the implementation process in detail and pointed to various problems in terms of unclear distribution of responsibilities, insufficient transparency and weak monitoring. He also mentioned that insurance cards were sold at the market and that often, they were used by other people than the poor whom they were supposed to benefit. He provided a number of examples of specific problems, such as costs not having been refunded, illegal administration of the system, etc. He concluded by hoping that the current system would improve under tight community-based monitoring.

After a short break, Dr. Somsak Lolekha talked about the "Role of Thai Medical Council in Regulating Ethics of Private Practitioners". He outlined the history, objectives and organization of the Council and its links with educational institutions. He then presented the various activities of the council and presented data concerning ethical claims made during 1973-2005. There had been a steep increase in the number of claims around 1999. He mentioned the various types of sanctions that the council could use when dealing with the claims. These included Dismissing the accusation; Warning; Reprimand; Suspension of the license for a period 1-24 months; and Revocation of the license. He outlined various strategies the doctor could use to prevent litigation, include good communication skills and maintaining a good relationship with the patient. He concluded by introducing a tort reform, that would imply the following elements: No criminal charge against doctors who have good intention to treat patients; Cap damages; Encourage early offers for settlement; Use medical courts; Compensate claims through a no-false administrative system; Implement pre-designated compensable events; and Shift liability from individuals to organizations.

Jon Ungpakorn, in his presentation, focused on the role of civil society to push the medical establishment and the government for reform. He emphasized the role of civil society and community-based organizations and used the flourishing of activism around HIV/AIDS as a case in point. He mentioned how civil society had played a constructive role in the formulation of the universal coverage policy. He stressed that this could not only be based on a concept of health for the poor but had to be

based on a principle of health for all which would also include the poor. Mr Jon stressed the need to include members of communities in medical institutions, from hospital boards to the medical council. Using the case of AIDS, he said that access to antiretroviral treatment had been included under this policy as a result of community-based pressure. He said that while many different groups had joined hands to form a strong community around AIDS, this had paved the way for other groups and networks to follow and pursue issues related to other diseases. He drew attention to the a range of issues where civil society had a crucial role to play in Thailand, such as community health education and care services; policy advocacy concerning access to prevention, care and treatment; support for malpractice and negative outcome compensation; access to essential drugs; and community health funds. He also called attention to the global drainage on the health system, where middle class patients from western countries go to countries such as India and Thailand for treatment, because it is cheaper than being treated in their own country. Such global movements drain the Thai government system for resources.

Anil Jacob Purty set out to define partnership and mentioned issues of capacity of the private partner, advocacy, accreditation and regulation by the Government as being important for the success of such partnerships. Using experiences from the Pondicherry Institute of Medical Sciences, he highlighted activities such as teaching and training, primary health care, community-based research, health education and school health programmes, liaison with Government departments for National Health Programmes (such as immunization programmes and tuberculosis control), and co-ordination with national and international NGOs for public health practice. Dr. Purty then provided morbidity data to illustrate the success of the approach adopted. He concluded his presentation by mentioning some of the challenges for public-private partnerships, such as cost containment, effective use of private resources, logical diversion of public resources, synergy to reduce duplication and resource mobilization.

Group Work 1: Comparative Perspectives

Jens Seeberg introduced a format for the afternoon’s group work. Four groups were established and asked to work with one theme each. All three countries (India, Indonesia and Thailand) would be represented in each group. The groups would address three questions under their respective themes,

both for each country individually and in a comparative perspective. The outcome of the group work was to provide input for the planned country-specific group work that would take place on Day 3. The group work formats with the result from each group have been inserted as Annex 3 of this report.

DAY 3 (22 June 2007)

The meeting had invited Mark Nichter to share his observations. Prof. Nichter called attention to the dual chronic state of ill-health and poverty that sets the agenda for coping and survival strategies for the urban poor. He pointed to questions such as 'why would both sides bother to work together in a public-private partnership?' What could be motivating factors – or convertible forms of capital – besides money? He called attention to the notion of health citizenship as part of the wider concept of biosociality, i.e. mobilizing people in networks around diseases such as HIV/AIDS and diabetes. He mentioned the need to gradually and incrementally enhance the credibility of the health care system. He then shifted focus and said that there was a need to take the aging of populations and the increase of chronic disease much more into account in policy discussions. He called for policy makers to speak up and raise issues for research and tell researchers in which form they can use research. He suggested using stakeholder analysis as a way of translating results into policy. He then mentioned a number of research issues that he felt needed more attention, including research on the role of the pharmaceutical industry; applied research on use of modern technologies to give practitioners swift access to appropriate information and CME; and analysis of the impact of rhetoric and language in general on the way we understand these problems. He posed the challenge to the meeting to move beyond cases and address the issue of 'so what' – where to go after the meeting?

Government perspectives

Chair: Prof. Soenarto
Rapporteur: Jens Seeberg

Dr. Deoki Nandan started his presentation by stating the dominant role of the private health care sector in India and compared it with the government sector in terms of quality, access and costs for the

payment, mentioning that existence of corruption in the government sector often required patients to pay bribes to doctors to receive appropriate treatment. He said that Indian Medical Association systematically had resisted regulations and that Medical Council of India had taken very little action against doctors violating the code of ethics. He noted the change in the private health sector from individual clinics and small nursing homes to private hospitals and hospital chains. He noted that the quality of private clinics and nursing homes varied dramatically. Key issues with unsatisfactory quality included disposal of medical waste, lack of labour rooms, dirty beds, poor lighting, unsatisfactory recording procedures, and not displaying license prominently. He said that the sector is poorly regulated and that quality assurance mechanisms are not in place, but that regulation has been passed recently in some areas, including for drugs, medical practice and health facilities. He said that it was necessary to impose greater social accountability on private providers, to make a certain proportion of private services available to the poor, to reconsider geographical distribution of health services, and to explore the potential of franchising. He then introduced elements of the National Rural Health Mission (NRHM) in terms of community involvement, financing, monitoring of standards of care, improved capacity for management, and innovation in human resource management. Recognizing the dominant role of the private sector, he said that there was a need to reform regulation and make processes transparent and people involved accountable. Dr. Nandan outlined the existing scenario for public-private-people-partnerships under the NRHM that included guidelines for PPP in national health programmes, social franchising, contractual appointments, contracting services such as diet and catering, laundry, security and IEC programmes. He said that Government of India has constituted a Technical Advisory Group, consisting of government officials, development partners and other stakeholders to conceptualize strategies under this heading. An Urban Health Task Force has been established as an offshoot of the NRHM, which recommended collaboration with NGOs, situational analysis and mapping of slums, improved management of urban health centres, use of outreach clinics in urban slums, and emphasis on community-based organizations.

At the workshop, it was announced that the Government of India was about to launch its Urban Health Mission. Dr. Siddharth Agarwal provided information on this topic, as follows:

India has been urbanizing rapidly in recent decades. The urban population of India grew by 68 million during the decade 1991-2001 which translates to a decadal growth rate of 31.2 per cent. This is nearly double the rural population growth rate. Along with urban growth there is a rapid urbanization of poverty. 100 million persons or one-third of the urban population of India resides in slum or slum like conditions. The urban poor are the fastest growing sections of the population and the UN-HABITAT estimates that the urban poor will reach 200 million by 2020.

The urban slum communities suffer from poor health outcomes, which do not get reflected in the commonly available data sources that show rural-urban comparisons. Disaggregating health indicators within urban areas by Standard of Living Index (SLI) reveals some startling findings. Among urban poor households child mortality rate (U5MR) (101.3) is nearly thrice, severe under nutrition is twice (23%) and complete immunization is almost half (43%) than corresponding figures among urban high income groups. Likewise the reach and utilization of essential preventive health services is overwhelmingly low with 4% using birth spacing method and only 3 out of every 10 children affected with diarrhoea receiving ORS.

The Government of India has recognized the growing urban poverty and their poor health. Urban health received special mention in National Population Policy 2000, National Health Policy 2002, 10th Five Year Plan, and the second phase of the Reproductive and Child Health Program (RCH II) and the very recent National Rural Health Mission (NRHM) (2005-2012).

In June 2005, the Government of India constituted a Task Force to advise the NRHM on strategies for urban health care. After a series of deliberations between August and October 2006, the Task Force has recommended that there should be a National Urban Health Mission on the model of NRHM. In terms of urban health care strategies, the Task Force recommends a) an Urban Health Centre (UHCs) catering to every 50,000 population (which is anticipated to include about 25,000 urban poor); b) a Second Tier Health Facility for 250,000 population covering 5 UHCs and forming a ‘Health Zone’; c) regular outreach services in the slums by ANMs to ensure the provision of preventive, promotive and curative services; d) community level activities primarily by slum based Link Volunteers (LVs) and Women’s groups with coordination support from NGOs; e) an enhanced role of urban local bodies, private sector,

NGOs; and f) improved coordination of the health department with other relevant departments including Ministry of Urban Housing and Poverty Alleviation, ICDS in improving the health of urban slum communities. The package of services recommended for First Tier Level and through outreach services includes ANC, PNC, child health services, family planning services, treatment of communicable diseases, counselling, and laboratory services. At the second tier maternity services, neonatal, paediatric services, reproductive health and other general hospital services have been recommended. The Government accepting the recommendations of this Task Force, in June 2007 announced the decision to soon launch the National Urban Health Mission.

Dr Agus Purwadianto, on behalf of the Government of Indonesia, in his presentation gave an introduction to the Indonesian health care system in terms of organization and structure. He said that current priorities for the system included maternal and child health; poor people health services; empowering health personnel; communicable diseases and malnutrition, health crises due to disasters; and health services for remote areas and islands. Using key health indicators, he highlighted some of the achievements in the past. Dr Agus then shifted attention to the legal framework and discussed the complaints to the Medical Ethics Honorary Board in terms of type of complainant, medical specialty involved and type of complaint. He continued by looking at cases reported to the police and related these to the issuance of the Medical Practice Act. He raised the issue of professionalism and said that there was a public perception that medicine failed to regulate itself in a way that can guarantee competence, and that it put its own interest above that of patients and the public. Also, he said that in the past, the medical fraternity protected incompetent and unethical colleagues in the name of collegiality. He introduced a series of steps that were taken since 2003 to address this issue, including reform of the bodies that were responsible for addressing these problems on a daily basis. Dr Agus highlighted the concept of professionalism as a key to address such problems and said that professionalism had to be based on a principle of primacy of patient welfare; a principle of patient autonomy; and a principle of social justice. He related this discussion to the ethico-legal framework in Indonesia and to the role of bureaucracy as a formative force in the system, which could work both in positive and negative directions. He said that transparent administration and management were keys to improving the system and used the dispensing and sale of drugs as a case in point. He concluded that in Indonesian health regulation, the concept of professionalism was being considered. Health reform

policy to support the poor and least advantaged people could be a panacea for their dissatisfaction of "out of pocket" health care system while going to a managed care system using the social security act and health insurance regulation, beginning with the Minimum Service Standard.

Group Work 2: Country-specific Perspectives

Chair: Yati Soenarto

The purpose of the final group work was to develop key recommendations for policy makers for each country on the basis of a) the research input that had been fed into the workshop, and b) the group work about comparative perspectives that had been completed on the previous day. Three groups were formed, one for each country, and the assignment, that was presented by Jens Seeberg, was to address all four themes that had been discussed by individual groups on the previous day. The results are provided in the formats below.

INDIA

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights.

1. Access barriers in terms of a) physical, social access and quality of public health facilities; and b) affordability of the public sector.
2. Inadequate health infrastructure and manpower vis-à-vis established norms
3. The poor often use private sector providers with questionable qualifications; or are forced to visit expensive private providers
4. High proportion of out-of-pocket expenditures for health and lack of health insurance for the poor

Primary recommendation for policy

- Policies should focus on demand, strengthen supplies and quality of services and establish linkages between available public and private health providers.
    - Motivation, sensitization, capacity building (about social skills) and recognition of better performers should be pursued
    - Regular outreach services for vulnerable slum clusters should be ensured
    - Linkages with available health providers through slum based *'link volunteers'* should be developed; community-based health groups should be engaged to enhance utilization of health posts
    - Education of urban poor communities should be strengthened. This should include knowledge about a) healthy behaviour; b) appropriate services; c) rights to health care

Secondary recommendations

1. Capacity of informal sector should be built and practitioners linked to the public health system and/or organized
2. Partnerships with socially responsible private providers should be developed

THEME 2: Rights, Regulation and Legislation

Prioritize the three main problems/needs related to rights, regulation and legislation in terms of impact.

1. Poor understanding among urban poor of their rights vis-à-vis the public sector and provisions available to them; weak negotiating power
2. Migration, domicile challenges and social exclusion that impair the ability to access rights/health services/entitlements
3. Weak regulation for the informal private health sector
4. No separate legislation/regulation for private sector

Primary recommendation for policy

- There is a need to design and implement an urban health care service delivery system, keeping in mind city-specific situations

Secondary recommendations

1. To map all ***listed*** as well as ***unlisted*** urban poor clusters including pavement dwellers, brick, lime-kiln workers, construction workers on city map for urban health planning, implementation and ensuring right to health services
2. To enhance negotiating capacity of urban poor communities to improve ability to avail entitlements
3. To develop regulation of private informal sector to ensure that they play a meaningful role
4. To develop regulations for need-responsive public-private mix and modify them based on initial experience

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care.

1. Lack of standards of quality and fee structure in a context of demand, utilisation and growth of less qualified practitioners
2. Lack of continued upgrading of knowledge and skills of all private providers
3. Inadequate linkages between private and public health sectors

Primary recommendation for policy

- Legislation to ensure optimal standards of private providers in the informal as well as the formal sector should be framed and energetically implemented.

Secondary recommendations

1. To establish a system of periodic CME for both formally qualified practitioners and informal private practitioners, involving available agencies and professional bodies
2. To promote and ensure quality of care

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing

1. High out-of-pocket expenditure owing to high cost of health care
2. Low investment and poor distribution of financing for human resources and infrastructure
3. Imbalance of financing on preventive and Primary care/OPD vs curative/hospital care
4. Lack of health insurance systems for the poor

Primary recommendation for policy

- Increase rational (i.e. balanced with respect to preventive, primary and hospital care) investment in public health services with a focus on the urban poor

Secondary recommendations

1. Establish health insurance for the poor, based on learning from small-scale community health financing initiatives in different states

INDONESIA

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights.

1. Self-medication (70%) and harmful medication
2. Patients' demand leading to irrational medical treatment
3. Imbalance in accessibility, affordability, and distribution of health services

Primary recommendation for policy

- Strengthen proper information and education (both for patients/consumers and providers)
    - Socialization concerning and enforcement of regulations on patients' and consumers' right
    - IEC through CBOs

Secondary recommendations

- Conduct research related to financial and cultural barriers to formal health care system

THEME 2: Health care seeking and patient rights in terms of impact

Prioritize the three main problems/needs related to health care seeking and patient rights in terms of impact. 1. Growing market of traditional and lay medication (health resources) 2. Black Market 3. Increasing burden of illness due to untreated and chronic diseases
Primary recommendation for policy • Enforcement of related regulations • Quality improvement of public primary health care, thereby increasing the credibility of the public health system
Secondary recommendations 1. Involving district health office in monitoring and controlling 2. Ethics and legal awareness of various parties (universities, MoH, professional organizations)

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care. 1. Private providers are marginalized or neglected by the public health agencies 2. Over/irrational medication 3. Cost variation
Primary recommendation for policy

- Optimizing the use of private health care in accessing the poor
- Integrating private providers to act as agents for public health
- Purchase of private health service for the poor by the government (outsourcing the service for the poor through private sectors)

Secondary recommendations

- Purchase of private health service for the poor by the government (outsourcing the service for the poor through private sectors)

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing.

- Although there had been an increase of public finance in health, in fact private finance still dominates the health sector
- The main problem: insufficient government budget and low willingness to improve the quality of public health care.

<u>Impact</u>

- Low credibility of primary health care service (out-patient)
- No equitable distribution of in-patient care resources
- In terms of in-patient care, the urban poor are better off than rural and remote poor. For out patient care they have an alternative to public service in the "unregulated" private sector
- For rural poor and remote areas: In-patient is not as good as urban poor (geographical in-equity). Less hospitals and medical doctors.

Primary recommendation for policy

Tapping more resources for health

- Increasing public budget: central, provincial and district governments
- Expanding private finance through insurance scheme, not fee-for-service

Secondary recommendations

- Improving the quality of primary care (requires more research)
- Reducing the gap of geographic inequity: "more suitable medical doctor/specialist education for remote areas" and push medical doctors to work in remote area (operational research)
- Developing medical care network in outer provinces

THAILAND

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights.

Consumer:

- Accessibility problems in terms of physical and social environments, affordability problem related to travel expenses, etc.
- Lack of knowledge of rights for service.
- Unrealistic expectation; false need; low trust on services provided under the universal coverage scheme.

Provider:

- Health care service not suitable in terms of consumer needs (convenient timings, etc.)
- No strict regulation of access to services.

Primary recommendation for policy

Empowerment of both consumer and provider.

Consumer:

- Provide knowledge about the rights to service and regulation.
- Encourage community participation in health care system.

Provider:

- Develop leadership skills among health providers.

Secondary recommendations

Further research is recommended to answer these research questions:

- How to understand the lifestyle of the urban poor and how to improve the quality of care to fit their needs?
- How to raise the trustworthiness on the public system from the patient and provider perspectives?

THEME 2: Health care seeking and patient rights in terms of impact

Prioritize the three main problems/needs related to health care seeking and patient rights in terms of impact.

1. Most of health workers in private sector are not MDs, whereas in public sector there are more MDs.
2. There are limitations in the ability to reduce inequity problems; gender equity.
3. The law to control health premises is available, but it addresses only the private sector.

Primary recommendation for policy

Enhancing health personnel to provide a holistic health service; as well as increasing the standards of hospitals according to Hospital Accreditation or ISO 9000.

Secondary recommendations

- Explore the weaknesses and strengths of the private health systems.
- Research and development on implementation and evaluation of health service quality.

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care.

1. Inaccessibility of the private health sector for the poor.
2. Lack of monitoring and evaluation system on private health sector.
3. Over-treatment and expensive treatment.

Primary recommendation for policy

- Core package of universal coverage scheme should be designed to cover private health care and extended to community health.
- Strengthening the monitoring and evaluation of private health sector using internal and external assessors with coordination of multiple agencies and based on clearly defined quality standards.
- Payment to hospital on DRG basis should be integrated into private hospitals.

Secondary recommendations

- Feasibility study of UC core package for private health care.
- Study on effectiveness of private health care providers.
- Study on cost-effectiveness of private health care delivery and quality of health care.

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing.

1. Inequities in health service delivery between income groups (intra-urban and rural-urban differentials).
2. Risk for catastrophic illness (and out-of-pocket payment) especially in private sector.
3. Lack of resources for preventive care.

Primary recommendation for policy

- Inequity of health service delivery between income groups (intra-urban, rural-urban) should be reduced.
- There should be adequate source of financing for provision of preventive care by both public and private sectors.
- Source of fund for the compensation of adverse events in private sector should be studied.

Secondary recommendations

- The purchasing role to enhance equity and a strategy to increase sources of financing should be explored.
- Methods for controlling quality of health care (i.e. regulations, monitoring systems etc.) in relation to financing methods should be arranged.
- Methods for encouraging preventive care through payment systems should be studied.

CLOSING SESSION

Chair: Prof. Supasit Pannarunothai.

Rapporteur: Nupur Barua

The concluding session brought to the table final comments from participants from all the countries. Jens Seeberg began the session by outlining the main themes that had emerged during the deliberations in the past three days under the following heads: patient rights, self-medication, inequity in access to health services, out-of-pocket expenditure on health and issues around insurance for the poor. The provision of health services was the central issue in all the three countries – India, Indonesia and Thailand.

In the discussions that followed, it was felt that while the workshop offered a very useful forum to discuss the complexities of the problems regarding the urban poor in all the countries, there had not been enough time to discuss the recommendations and lessons learnt from each country in detail. It was suggested therefore that all the recommendations be placed on the project website to enable access by all countries. The possibility of framing advocacy materials for each country was deliberated.

Supasit Pannarunothai from Thailand facilitated a discussion on 'what next?' - at both the network-level and country-level. Soenarto Sastrowijoto from Indonesia announced that they would hold a meeting of representatives from the government, the NGO sector, and the university to discuss and analyze inputs from India and Thailand and to develop a plan of action of reform of various regulations at the district level in Yogyakarta. They would present the same to the government to stimulate action at the regional level. C. S. Pandav from India felt that this workshop had provided an opportunity to bring together people from various levels – from the ministry, the research community, the political arena, and from medical colleges – to discuss and share experiences of the complexities of health provision for the urban poor in all three countries. He informed that an India Group would be formed, along with the National Institute of Family Welfare, to discuss the current research findings and policy implications of the same vis-à-vis the recently announced Urban Health Mission by the Govt. of India.

The group would also draw lessons from the Indonesian and Thai experiences to see ‘what works’. Furthermore, he emphasized the need to go beyond the local level in each centre to frame a regional agenda keeping in mind common areas of interest within the overall focus on urban health and hoped that Danida would be associated with subsequent efforts in the region. Prof. Supasit carried the discussion further by emphasizing the need to develop action plans at provincial, country and regional levels and said that it was important to focus on particular examples as a basis for policy development and on ways to do advocacy for a more equitable and rights-based health system.

C.A.K. Yesudian from India emphasized the timeliness of this meeting when the Govt. of India, for the first time, was focusing on urban health as a priority area and that this exercise should feed into the proposed Urban Health Mission. The learning about the less-qualified practitioners could be of particular importance in this context. At the regional level, he asserted that this group could contribute to larger studies on public-private mix and health financing and suggested that more countries from the region, Sri Lanka, Bangladesh and Malaysia, could be added to form an Asian Health Observatory in the lines of the European Health Observatory. This would not only expand the area of study but could also influence policy.

Dr. Deoki Nandan, as a representative head of the National Institute of Health and Family Welfare emphasized that his organization functions as the think tank for the MoHFW in India and offers opportunities for capacity building, research and advocacy on urban health management and health financing. He emphasized that beneficial collaborations across various levels could be forged with his organization to focus on various issues regarding urban health development in the country. Dr. Ashok Kumar from the Govt. of India conveyed that the Director General of Health Services was very pleased that this inter-country effort was taking place. He said that he would carry the experience back and would be interested to facilitate a possible development of a network, so that the technical competence of this group could be used to invigorate a wider movement in the region to eventually translate the research into action.

A representative from the City Health Office in Yogyakarta said that lessons learnt during the workshop could be implemented at the district level and collaborations with the university and between

NGOs and the government could provide research grounding for improving the quality of life in the city, especially with regard to primary health care provision. Laksono Trisnantoro from Indonesia stressed that an international perspective could be gathered through collaborative ventures of this sort and emphasized the importance of holding meetings of this kind. He sought information on post-project avenues for holding subsequent meetings. He particularly drew attention to the need to focus on regulation and financing for the poor.

Jens Seeberg said that he hoped that this meeting would establish the much-needed platform for follow-up stakeholder meetings, involving researchers, NGOs, and civil society organizations. The main problems that needed attention are issues regarding access, wrong medication (over-use or under-use), equity, financial security, and the functioning of the private sector. In addition, he stressed the need to look more closely at the pharmaceutical industry and the impact that the lack of regulation of the industry has on the urban poor residing in slum areas through the private practitioners. Issues concerning private insurance and the way it influences health service delivery in the private sector to the poor need to be examined. He asked what could be done with the research and pointed to the need to go beyond the case studies. The potential influence of WHO in taking the agenda further beyond the local level was emphasized.

Rama Baru pointed out the need to go beyond the policy makers and to take into consideration the people's health movements which play an important role in policy advocacy. She suggested that a summary of the present study be given to such groups and highlighted the importance of publishing the proceedings in reputed journals like the National Medical Journal of India and The Economic and Political Weekly. Media reporting of such a meeting would influence civil society.

Yati Soenarto shared experiences about the decentralized management in the Indonesian initiative in control of diarrhea and emphasized the need to influence the government to translate research results into policy. The Indonesian team highlighted the importance of budget allocations, transparency of public health administration and surveillance of data in public health programmes for the poor and drew attention to problems that accrue from bad regulations.

Further discussion centered on the importance of development of research of this kind in the region and the possibility of further collaborations of this kind. The need for academic publications and collaborations with academic organizations for such research was highlighted.

Finally, Jens Seeberg summarized the main issues that emerged from each country under four cross-cutting themes:

1. **Health care sector and patient rights:** Harmful medication consumption, the need to focus on the real problems, for instance urbanization and migration into cities, the role of health citizenship and the need to rethink health care delivery to people who are on the move;
2. **Rights, regulation and legislations:** Implementation and enforcement, mechanisms for conflict resolution, enforcement of disciplinary measures that have been put into place as one mechanism, strengthening of positive motivations as another important mechanism, and issues regarding how to make profit and still provide good quality services in the private sector;
3. **Quality of services:** Strengthening of government services in urban areas, the need to include the middle class to ensure that service delivery mechanisms go beyond providing poor public health for the poor, incorporation of less- qualified private practitioners, establishment of dialogue in a scenario where the current move of raids in Delhi have proven not to be very effective, and finding news ways to access continued health education;
4. **Health Financing:** The Universal Coverage Scheme held suggestions for India along the same lines, but there were also important lessons to be learnt from the Thailand experience in pursuit of equitable funding mechanisms.

He closed the session by reiterating that this forum, the ongoing research, and inputs from the participants could be used by the group during the proposed national-level workshops in each country. He suggested that policy briefs be prepared by each country for these meetings to facilitate the process of taking research to action. Furthermore, he said that this forum could also facilitate the formation of networks and collaborative groups in the region.

ANNEX 1: Programme

20 JUNE: RESEARCH

08.00-08.30 Registration

08.30-09.30: Inaugural session
Introduction by Supasit Pannarunothai
Welcome address by Mondhon Sanguansermsri, President, Naresuan University
Opening remarks by Jens Seeberg, University of Aarhus
Inaugural Address by Special Guest of Honour Samlee Plianbangchang, Regional Director, WHO (SEARO)

09.30-10.00: Coffee (registration cont.)

10.00-12.00: Health Sector Reform and Public Private Mix? Keynote presentations and panel discussion *(Chair: Prof. Supasit)*

- Chandrakant S. Pandav (India): *Health Sector Reform in India*
- Laksono Trisnantoro (Indonesia): *Health Sector Reform in Indonesia: A scenario planning analysis in controlling private sector*
- Pongpisut Jongudomsuk (Thailand): *Health Sector Reform: the case of Thailand*
- Firdosi Mehta (Indonesia): *Successes, scope and limitations of public-private partnerships in Asia. Experiences from TB control and beyond*
- Reidar Lie (Norway): *Private health care, health and human rights*

12.00-13.00: Lunch

13.00-15.30: Private health sector – Parallel sessions

A. Quality of care and dynamics of the health system *(Chair: Dr. Pongpisut)*

- Jens Seeberg (Denmark): *Market dynamics and private health care delivery. The case of Bhubaneswar, India*
- Rama Baru (India): *Structure and Quality of Private Health Services in India*
- Roy Tjiong (Indonesia): *A Dynamic of (Private) Health Sector and Quality of Care*
- Choirul Anwar (Indonesia): *Health Service Policy for Private Sector in the City of Jogjakarta*
- Aumnoay Pirunsarn (Thailand): *Private Health Provider Behaviour and Clinical Communication Patterns: Cases from Phitsanulok, Thailand*

B. Health Seeking Behaviour *(Chair: Dr. C.A.K. Yesudian)*

- C.A.K Yesudian (India): *Health seeking behaviour of urban poor in India*
- Nupur Barua (India): *The discreet charm of the private practitioner: Access, utilization and quality of health care in a slum in Delhi*

- Siwi Padmawati (Indonesia): *Searching for Suitable Cure: Understanding Medical Pluralism in Urban Poor Neighborhoods in Jogjakarta, Indonesia*
- Mubasysyir Hasanbasri (Indonesia): *The use of private provider among health card holders in Indonesia*
- Angkhanaporn Sornngai (Thailand): *Health Problems and Needs among Low-Income Elderly in Phitsanulok, Thailand*
- Mark Nichter (USA): *Lessons from studies of health care seeking in pluralistic health care arenas of South and Southeast Asia*

15.30-16.00: Coffee Break

16.00-16.50: Financing and health expenditures *(Chair: Prof. Supasit)*

- Bondan Suryanto (Indonesia): *Financing Health Sector: Public and Private Mix in Jogjakarta*
- Supasit Pannarunothai (Thailand): *Health seeking and spending of people in four urban poor neighbourhoods in India, Indonesia and Thailand*

16.50-17.00 Break

17.00–18.30: Regulation – scope and limitations? (*Chair: Dr. Tawesak)*

- Ashok Kumar (India): *Regulation of Medical Practitioners in India*
- Soenarto Sastrowijoto (Indonesia): *Regulating Health Professions: The Dilemma in Medical and Health Practices for the Poor in Indonesia*
- Supasit Pannarunothai (Thailand): *Systems of Ensuring Ethics and Quality in the Thai Private Healthcare*
- Jenifer Lobo (India): *Medical Malpractice in India: Is Regulation the Only Solution?*

19.30: Workshop Dinner

21 JUNE: COMPARATIVE PERSPECTIVES

09.00-09.30: Summary of Day 1

09.30-10.40: Professional organisations and other NGOs *(Chair: Dr. Lobo)*

- Widyawati Muhasan (Indonesia): *Independent Private Nursing Practice in Indonesia, is it essential? A Case Study*
- Marius Widjajarta (Indonesia): *Poor Community Health Monitoring In Indonesia Since Monetary Crisis*
- Siddarth Agarwal (India): *Public Private Partnerships for Improving Health of the Urban Poor: Lessons and Best Practices from India*

10.40-11.00 Coffee Break

11.00-12.00 Professional organisations and other NGOs (Cont.)

- Somsak Lolekha (Thailand): *Role of Medical Council in Regulating Ethics of Private Practitioners*
- Jon Ungpakorn (Thailand): *Roles of NGOs for Health of the Poor*
- Anil Jacob Purty (India)**:** *Public-Private Partnership for Health Care. Our experience and the road ahead*

12.00-13.00 Lunch

13.00-15.30 Afternoon: Group Work – Cross-country perspectives (South and Southeast Asia)
(Chairs: Gr.1: C.A.K. Yesudian, Gr.2: Deoki Nandan, Gr. 3: Ashok Kumar, Gr.4: Rama Baru)

15.30-16.00: Coffee Break

16.00-17.00 Plenary presentation of group work results (Dr. C. S. Pandav)

22 JUNE: COUNTRY PERSPECTIVES

09.00-10.20

- Government perspectives (Chair: Prof. Soenarto)
  - Deoki Nandan and Siddharth Agarwal (India): *Private Sector in the context of the National Rural Health Mission and Urban Health Task Force Recommendations*
  - Agus Purwadianto(Indonesia): *New Regulation on Health Services in Indonesia*

10.20-10.40 Coffee Break

10.40-12.30 Group Work – Country-specific Policy Perspectives

12.30-13.30 Lunch

13.30-15.00 Plenary presentation of group work results (Chair: Dr Yati Soenarto)

15.00-15.30 Coffee Break

15.30-17.00 Report with recommendations (Chair: Prof. Laksono)
Closing Session

SATELITE MEETING

22 JUNE

20.00-22.30 Disaster management in the light of the Yogyakarta 2006 earthquake and the 2004 tsunami

- Retna Siwi Padmawati (Indonesia): *The 27May06 Earthquake in Yogyakarta Province*
- Widyawati Muhasan (Indnesia): *Community Empowerment by Mobile Rehabilitation*
- Jain Veeraphing (Thailand): *Mudslide and Community Help in the North of Thailand*
- Vorasith Sornsrivichai (Thailand): *Man-made Disaster: Violence in the Deep South of Thailand*

ANNEX 2: List of participants

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ANNEX 3: Group work on comparative perspectives

Below, the outcome of the first group work on cross-country perspectives is reproduced in a minimally edited form. The outcome was used as basis for the second group work on country-specific recommendations that has been integrated in the main report.

Health Care Seeking and Patient Rights

Chair: Prof. C.A.K. Yesudian. Rapporteur: Nupur Barua. Members of the group: Indonesia: Roy Tjiong, Widyawati Muhasin, Siwi Padmawati. India: CS Pandav, C.A.K. Yesudian, Nupur Barua. Thailand: Dr. Angkhanaporn Sprnngai, Panada Taechasubamorn, Vorasith Sornsrivichai. Observer: Mark Nichter (USA).

	INDIA	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related to health care seeking and patient rights?	1. Access – location and quality of public facilities. Raising levels of credibility of the formal system - 'nothing in the govt. system 'works' 2. Less-than-qualified practitioners providing questionable (dangerous) treatment to fill the gap – issue of patient safety ▪ Networks (?cartels) between various levels of health care providers (Practitioner -	1. Self- medication very high. Delay – TB, ARI 2. Patients demand for health service leads practitioners to give irrational treatment Quick fix – practitioner pressure 3. Patient rights: (Accessibility and affordability of the health services)	1. Lack of knowledge of patient rights for services 2. Unrealistic expectations and dissatisfaction; low quality of care if free 3. Accessibility and Affordability of the Health service	1. How to raise the credibility of the public system. Study from the patient and provider perspective 2. Documenting legislations related to patient rights and safety and their implementation status

	diagnostic centres - nursing homes) ▪ What do we do? (rid, regulate, train) 3. Lack of awareness of patient rights (quality of care) ▪ Out-of-pocket medical exp and complete lack of health insurance			
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	1. National Rural Health Mission ▪ Private Practitioners ▪ Urban Health Task Force ▪ Recent announcement about an Urban Health Mission 2. Legal Framework ▪ Delhi Med Council Act ▪ Consumer Protection Act ▪ Other State Acts 3. Govt. and Private sector health insurance initiatives (initial stages)	1. Community-based organizations, for instance, Desa Siaga (village alert), PKK (women's group), Integrated Health Posts, and school Education programmes 2. Insurance for the poor 3. Patient awareness - Communication information and education programmes	1 Community – base approach and holistic approach to identify the health problem in each age group and improve the quality of care to raise the reputation of service 2. To educate and mobilize the people to know their right 3 Create self help group and network for illegal migrant, elderly, etc 4. Provide global fund for Illegal migrant, deserved people 5 Collaboration between sectors for proactive care	
Please identify the	Governance issues:	1. CBOs – need	1. Lack professional	

main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures.	1. Lack of political will 2. Corruption in the system 3. Translating legislation into an implementing missionary 4. No accountability Examples of successes: 1. Marwari Mat. Hospital in Guwahati 2. LIP in Kolkata Failures: 1. Absence of recognition of urban poor as group with specific needs and design of programmes FOR the urban poor 2. Focus on averages: disaggregated analysis absent absence of recognition of differences between registered and unregistered slums	strong leadership and some budget 2. Insurance – need proper identification and targeting 3. Needs media channel to reach the people, incl. human resources - Communication, information and education	(no, proper allocation) 2. Discrimination to provide service for the people 3. Has a network between the provider and the community Example of success : 1. case net work between sectors at Samuthprakarn province	

Health Care Seeking and Patient Rights

Chair: Dr.Deoki Nandan. Rapporteur: Yati Soenarto. Members of the group: Sanjay Gupta, Deni Sunjaya, Soenarto Sastrowijoto, Marius Wiojajarta, Corul Anwar, Sakchai, Somsak Lolekha, Sirinard Nipaporn, Bupawan Phuaphanprasert, Reidar Lie

	INDIA1.neglcgent+	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related to health care seeking and patient rights?	1 Low understanding of existing rule regulation in private sector 2 legislation for infrastructure. 3. No separate legislation/ regulation for private sector. Inequality in patient right Lengthy procedure for justice 4. Human right commission, women right commission. 5. Medical council act 6. No: proper guideline, control, evaluation	1. Right: Legislation is available, no implementation Low capacity of the local government. although already decentralization. 2. Difficult to implement the regulation; monitoring, punishment are not recommended/clear. 3. Rights related to private health care is available but not similar across private and public sectors	1.The law is available, but enforced only for private sector all are being controlled → quality is better than the public sector 2. Inequity: limit private in limit/target. Society fix.: not available. Gender equity 2. administrative staff: in private, sector are not MDs, whereas in public sector, they are more MDs	1. There is lack of MONEF (monitoring and evaluation), however, norms are used, Initiative: develop its MOU. 2.Over regulation as bed as under regulation 3.several initiative have been conducted: CPD, research, etc 4. PPP (Private-public partnership) should be developed Compilation of document and dissemination of rules/regulation
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	Abolition of quackery NRHM: • Decentralization • Public-Private Partnership Advocacy by NGO's	Local government and parliament develop act appropriate with local issues Improving local government capacity concerning regulation function.	Research: private should be approved by MOH. Whereas pubic/university can do by themselves. Now improved---less trust. Even color	

		-advocacy fr0m NGO and private	of the private hosp is certain color, given by the MOH	
Please identify the main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures.	Corruption and community awareness - Solution: specific regulation and legislation for private sect and independent body for monitoring	Corruption and community awareness Solution: specific regulation and	Policy is always TOP-DOWN → Now, by the initiative of Med. council, all health professional societies creates initiative proposed to the government	

Private health care delivery and quality of care

Chair: Ashok Kumar. Rapporteur: Jenifer Lobo. Members: Andreasta Meliala, Mubasysyir Hasanbasri, Yuliawati, Anil Purty, Petcharee Reungon, Dounghathai Janchua and Aumnoay Pirunsarn

	INDIA	INDONESIA	THAILAND	LESSONS LEARNT
Three main problems/needs related to private health care delivery and quality of health care	1. Rapid Growth of RMP and Unqualified persons 2. Lack of continued upgradation of knowledge and skills 3. Unequal geographical distribution in rural, urban and remote areas 4. Inadequate linkages with Public health system 5. Lack of standards of quality and fee structure	1. Lack of public health responsibility 2. Rejection of poor patients 3. Uncontrolled/varied fee structure	1. Inaccessibility to poor 2. Lack of monitoring and evaluation 3. Over-treatment and expensive treatment	1. PP need to be involved in the national health challenges 2. Equal Geographical distribution of PP 3. Clearly defined quality of standards and fee structure to be ensured 4. Monitoring and Evaluation system to be defined and ensured
Describe recent planned/current initiative to address these issues	1. Launch of NRHM, and NUHM- infrastructure, delivery of care, quality, outreach with PPP and	1. Licence to practice has been simplified 2. Insurance system extended to PPs so that	1. Social Health Insurance for workers- limited coverage and claim	1.Co-ordination of multiple agencies is a challenge 2. Registration of health

	Public health standards 2. Re-registration of RMP every 5 yrs after CME 3. Orientation of rural medical practitioners 4. Review by GOI of various regulatory councils	poor are served 3. Assignment of specific health care in the community they are serving	2. Licence for doctors and nurses 3. Private clinics and hospitals registered 4. Private hospitals accredited	care workers is possible
3. Identify the main difficulties related to the successful implementation of these initiatives. Examples of a. successes and b. challenges	1. Lack of mobilization of resources to implement NR/UHM in the states 2. Inadequate review by MCI of State councils 3. Inefficient implementation and long drawn out regulatory mechanisms a. Decentralization to district and PRI to ensure PPP b. Implementation due to large population, area, diversified geographic and socio-cultural factors	1. Lack of resource and willingness to participate In public health activities 2. No independent monitoring agency 3. Lack of public agency to follow up complaints 4. Lack of consistency of NGOs to help the poor. 5. Lack of eligibility criteria for poor to be covered by social insurance	1. Lack of Community awareness of benefits of social insurance schemes extended to PPs. 2. Lack of infrastructure to monitor accredited hospitals	1.Monitoring mechanisms are difficult to implement 2. Mobilisation of resources (human and finance) is a challenge.

Health Financing

Chair Rama Baru. Rapporteur: Siddarth Aggarwal. Group members: Laksono Trisnantoro, Yulita Hendrartini, Supasit Pannarunothai, Nilawan Upakdee, Kira Fortune Jensen, Dr Rama Baru, Siddharth

	INDIA	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related health financing and equity?	Primary care/OPD: The poor mostly go to private, including less qualified practitioners and drug stores	Primary care/OPD: the poor mostly go to Govt facilities and few go the private Hospitalization care: Mostly poor receive	Primary care/OPD: mostly poor go to private facilities, including not so qualified and drug stores	

	Hosp: the poor go to public more often and less often to private	care at public hospital There is a VIP/paid Pvt ward being introduced in most hospitals, which provides more financing to the hospitals and this improves care to the poor as well.	Hospitalization: poor mostly go to public sector	
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	Janani Suraksha Yojana (for delivering women) Health insurance for the poor under NRHM State Govt. schemes e.g. Chiranjeevi scheme - Gujrat	Poor family scheme (National Govt) Social Security System Local Municipal Schemes complementary to those un-insured by 'poor family' scheme	Universal coverage program Focus on infrastructure and manpower	
Please identify the main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures.			Universal coverage scheme for all sections of society: free for all people Mostly curative Separate budget for preventive care No co-payment, completely free Focus on strengthening infrastructure and human resources to bridge gaps Have VIP wards at	Similarities: Mixed service provisioning and financing Access and utilization of services are different across countries Challenges: How to bring doctors to the remote areas? Poor distribution of human resources and infrastructure Poor quality of services deters slum dwellers to avail services

			hospitals to improve overall quality at hospital Thailand made a small increase in taxation which was utilized for providing resources for universalization Enforcement of referral system has helped Thailand to encourage utilization of funds Examples of community based health financing initiatives	Lack of resources on preventive care