HEALTH SECTOR REFORM AND ETHICS

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

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BOOK OF ABSTRACTS

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<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siddharth Agarwal: Public Private Partnerships for Improving Health of the Urban Poor: Lessons and Best Practices from India</td>
<td>3</td>
</tr>
<tr>
<td>Choirul Anwar: Health Service Policy for Private Sector in the City of Jogjakarta</td>
<td>4</td>
</tr>
<tr>
<td>Rama Baru: Structure and Quality of Private Health Services in India</td>
<td>5</td>
</tr>
<tr>
<td>Nupur Barua: The Discreet Charm of the Private Practitioner: Access, Utilization and Quality of Healthcare in a Slum in Delhi</td>
<td>5</td>
</tr>
<tr>
<td>Reidar Lie: Private health care, health and human rights</td>
<td>6</td>
</tr>
<tr>
<td>Jenifer Lobo: Medical Malpractice in India: Is Regulation the Only Solution?</td>
<td>6</td>
</tr>
<tr>
<td>Firdosi R Mehta: Successes, scope and limitations of Public-private partnerships in Asia. Experiences from TB control and beyond</td>
<td>7</td>
</tr>
<tr>
<td>Widyawati Muhasan: Community Empowerment by Mobile Rehabilitation after Earthquake in Bantul District, Yogyakarta, Indonesia</td>
<td>8</td>
</tr>
<tr>
<td>Widyawati Muhasim: Private Nursing Practice in Indonesia, is it essential? A Case Study</td>
<td>10</td>
</tr>
<tr>
<td>Mark Nichter: Lessons from studies of health care seeking in pluralistic health care arenas of South and South East Asia 1976- 2006</td>
<td>11</td>
</tr>
<tr>
<td>Supasit Pannarunothai: Systems of ensuring ethics and quality in the Thai private health care</td>
<td>14</td>
</tr>
<tr>
<td>Aumnoay Pirunsarn: Private Health Provider behaviour and Clinical Communication Patterns: Cases from Phitsanulok, Thailand</td>
<td>15</td>
</tr>
<tr>
<td>Anil J Purty: Public-Private Partnership for Health Care, Our Experience and the Road ahead</td>
<td>16</td>
</tr>
<tr>
<td>Agus Purwadianto: The New Regulation on Healthcare Services in Indonesia</td>
<td>16</td>
</tr>
<tr>
<td>Soenarto Sastrowijoto and Nur Azid Mahardinata: Regulating Health Professions. The Dilemma in Medical and Health Practice for the Poor in Indonesia</td>
<td>17</td>
</tr>
<tr>
<td>Jens Seeberg: Market dynamics and private health delivery. The case of Bhubaneswar, India</td>
<td>18</td>
</tr>
</tbody>
</table>
Angkanaporn Sorngai, Jens Seeberg and Supasit Pannarunothai: Health Problems and Needs among Low Income Elderly in Muang Pitsanuloke, Thailand .......................................................... 19
Vorasith Sornsrivichai: Experience from Thailand's Deep South Violence ........................................... 20
Bondan Suryanto: Financing Health Sector: Public and Private Mix in Jogjakarta .................................. 22
Roy Tjong: A Dynamic of (Private) Health Sector and Quality of Care .................................................. 23
Laksono Trisnantoro: Health Sector Reform in Indonesia: A scenario planning analysis for controlling private sector ................................................................................................................... 24
C.A.K. Yesudian: Health Seeking Behaviour of Urban Poor in India ......................................................... 26
Siddharth Agarwal

Public Private Partnerships for Improving Health of the Urban Poor: Lessons and Best Practices from India

The rapidly growing urban population especially of the urban poor is a cause of concern for policy makers and program planners. The health of people living in urban slums is poor and is comparable to that in rural areas. An important contributing factor is the poor availability and access of health services to the urban poor. There is a one primary health facility per 1.5 lakh urban population with considerable low utilization and access in urban slums. Partnership with the private sector is emerging to be an effective strategy in rapidly improving access of services to the vulnerable and neglected sections of the population including the urban poor. This paper presents the experiences and lessons learnt from different PPP initiatives to improve health services to the urban poor in India.

NGOs add value in a variety of activities in improving health services. NGOs have been mobilizing slum communities to provide a link between the community and service providers and to generate awareness and demand for health services, e.g. UHRC and its partner NGOs in Agra, Strihikarini in Mumbai, Suraksha in Bangalore. In areas where government is not able to provide health services, partnership with NGOs is proving viable. NGOs such as ARPANA trust in Delhi, SSA in Bangalore, have been managing previously unutilized first tier services in partnership with the government / municipal body. In another instance, the Government identified the underserved pockets and contracted NGOs (e.g. UHRC in Agra) to provide health services from rented premises. In Guwahati, the Assam Government has contracted a charitable hospital (Marwari Maternity Hospital) to provide second tier, referral and outreach services to the population of eight low income municipal wards. Apart from the non-profit sector, the corporate sector through the corporate social responsibility initiatives have contributed to improving health of the urban poor. The example of mobile health clinics by Ranbaxy is an example in this regard.

The above experiences have demonstrated that partnership with the private sector is an effective way to improve access of health services to the urban poor. The important lessons learnt from these experiences are that it is essential to define and streamline the operational aspects of partnership such as parameters of selection of NGOs, performance monitoring, fund release etc. Advocacy is also essential to overcome resistance to change among government stakeholders.
Background: Government Act regulating medical practice was implemented as recently as 2004 in Indonesia through the release of the Government Act No. 29 2004. Prior to this, the government used the Government Act No 23 Year 1992 on health and Government Regulation No. 32 Year 1996 on health worker to regulate health providers in the private sector. The Jogjakarta Health Office has been developing a plan for local regulation of medical practice to control the private health sectors in Jogjakarta City. The aim of this regulation is to ensure good quality health service and health security for the citizens of Jogjakarta. However, the process has a long way to go because it has not yet been signed by the Mayor, neither has it been signed by the people’s representative or the legislative body.

This paper presents the health policy for the private sector in the city of Jogjakarta. In the absence of city ordinance, in the private health sector is regulated by the City Health Office in Jogjakarta.

Method: Desk study using relevant sources (strategic planning, regulation and ordinance, flowchart for supervision and action taken, etc.)

Results: In 2005-2006, there were about 113 pharmacies, 91 health service institutions, 600 medical and paramedical providers, and 88 registered alternative medicines in Jogjakarta. Regulating the practitioners is a problem for the City Health Office. The regulatory Acts specify no strict and deterring punishment procedures and sometimes are in conflict with the other. It also takes a long time to release the city ordinance. In addition, as far as practice of health providers are concerned, many doctors and nurses are practising without license; they are even dispensing drugs, and in special cases some are also acting as “drug distributors” to other private practitioners. However, the drug dispensing is needed by the poor since they are considered practical and economical. There is a tendency of the general public to visit the local kiosk and traditional healers instead of consulting the public health centre. The City has mechanisms for supervising the practice of private practitioners in the areas where the poor reside. However, this is a big dilemma because those practitioners seem to be really needed by the poor. It is our recommendation to give privilege to the private practitioners practising in the poor areas, for instance, to dispense certain controlled drugs as well as to allow provision of basic services by nurses practising in these areas. However, it should be accompanied by very close supervision of practices.
Rama Baru

**Structure and Quality of Private Health Services in India**

This paper provides an overview of the structure and quality of private health services in India. The evidence from different studies will be used to examine the heterogeneity and regional variations in the distribution of these services. In addition the variation in the social background, levels of training and treatment practices will also be examined across levels of provisioning in order to assess its implications for quality and effectiveness of treatment. Since this seminar is focusing on South and South East Asia, there will be a brief reference to the variations in the structure of private provisioning across some of these countries.

Nupur Barua

**The Discreet Charm of the Private Practitioner: Access, Utilization and Quality of Healthcare in a Slum in Delhi**

A startling majority of the poorest of the poor in Delhi use the private sector for health care. The private sector in the city is dominated by hospitals, nursing homes and clinics but the most popular for those living in jhuggi-jhopdis (slum clusters) are the burgeoning number of individual practitioners who operate ‘clinics’ within the immediate vicinity of these neighbourhoods. A majority of these practitioners are unregistered and not trained in any system of medicine.

Fieldwork conducted over eighteen months in a slum cluster in Delhi has provided ample evidence of misdiagnoses, over-prescription of drugs and incorrect treatment practices but in the absence of any legal accountability, few complaints are registered. During this time, the media has also reported various cases of fatal accidents caused by unsuitable treatment practices. The Delhi government has conducted raids in an attempt to shut their 'clinics'. But the fact remains that most of these 40,000 'quacks' in the city continue to practice, albeit in many cases in clinics that bear no signboards or placards.

Given the existing state of the largely unregulated private sector in these areas, it is obvious that attempts at promoting a public-private mix for delivering health care to the poor would be hazardous. So what then is the way forward? This paper presents an ethnographically grounded understanding of why, despite the presence of free government institutions, the poor still prefer these untrained practitioners. It proceeds to do this by looking at the dynamics underlying the
interactions in these clinics, on the presumption that this will lead to possible strategies in which a
responsible private sector and responsive public sector can ensure better health policies for the
urban poor.

Reidar Lie

*Private health care, health and human rights*

This paper argues that the human rights framework does provide us with an appropriate
understanding of what values should guide a nation's health policy, and a potentially powerful
means of moving the health agenda forward. It also, however, argues that appeals to human rights
may not necessarily be effective at mobilizing resources for specific health problems one might
want to do something about. Specifically, it is not possible to argue that a particular allocation of
scarce health care resources should be changed to a different allocation, benefiting other groups.
Lack of access to health care services by some people only shows that something has to be done,
but not what should be done. The somewhat weak claim identified above together with the
obligation to realize progressively a right to health can be used to mobilize resources for health

Jenifer Lobo

*Medical Malpractice in India: Is Regulation the Only Solution?*

Malpractice has entered the health system at all levels – among the public health providers, private
health providers and in the pharmaceutical companies. Examples of malpractice in the three sectors
are discussed. Public health providers, doctors working in the PHC and CHC, do a private practice
which is not allowed. The multipurpose health worker does the same. The private health provider in
India is of two types – the Registered Medical Practitioner who has legally recognized
qualifications in the allopathic system or the Indian System of Medicine (ISM); the second is the
‘less than fully qualified (LTFQ) providers’. Malpractice among the RMPs runs through the gamut
of the regulations laid down by the MCI Act. The ‘less than fully qualified’ provider functions and
flourishes against all legal regulations. Lastly, some pharmaceutical companies provide substandard
medicines.

India has comprehensive regulation acts for medical practitioners, but medical malpractice
continues to exist. The reasons for this situation are discussed. The first obvious reason is lack of
implementation and enforcement of the stipulated regulations due to inadequate infrastructure and human resources.

Is it corruption or something within the system which leads the registered medical practitioner to indulge in malpractice? The government based doctor doing private practice is doing it for money, but why? Their remuneration vis-à-vis their peers in other fields, facilities available in the PHC, CHC and government hospital, facilities for rearing a family and concern over their own future could be factors having a bearing on their behaviour.

Requirements and the felt needs of the population have lead to the proliferation of the private health provider, both registered and LTFQ. Patient pressure, peer pressure, fear of losing clientele and lack of knowledge fosters malpractice in the RMPs. The LTFQ providers are in any case totally illegal. Private hospitals also come under the same pressure from patients paying out of their own pocket for immediate results. The Consumer Protection Act, the double edged sword, pressures hospitals and doctors to resort to methods which are not always ethical in order to protect themselves.

Insurance is being presented as a reasonable solution for provision of health care to those who can afford it. But the doctor and hospital is dictated to by the insurance company – a well recognized occurrence in the USA, and the doctor is again, at times pressured by the patient to falsify records. Suggestions for solutions are not being presented as studies on new interventions with the impact on costs and behaviour of the health providers need to be discussed in detail with all the stakeholder

Firdosi R Mehta

**Successes, scope and limitations of Public-private partnerships in Asia.**

**Experiences from TB control and beyond.**

Substantial progress has been made in global tuberculosis control in recent years, through the large scale implementation of DOTS. However it has been acknowledged that much more needs to be done and efforts need to be sustained. The Global TB targets of 70% case detection and 85% treatment success, and halving the prevalence and mortality of disease by 2015 as part of the MDG’s, are likely to be met only if current efforts are intensified. One of the important interventions required to reach these goals is a systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population. Thus engaging all health care providers in TB control is an essential component of WHO’s expanded Stop TB strategy.
While access to treatment for TB has increased dramatically, not everyone has the same standard of care opportunities. On a daily basis, thousands of TB patients are exposed to low quality TB care. This causes not only unnecessary suffering and death, often with high costs for the patients, but also damages the reputation of health facilities and staff.

PPM encompasses diverse strategies such as Public-Private, Public-Public or Private-Private Mix, that enable developing partnerships for delivery of TB care. This benefits all – the sick patient, the community, the TB program and ultimately health of the citizens of a nation.

PPM contributes to 6 public health dimensions: 1) Enhanced quality of TB management and care 2) Increased case detection and reduced diagnostic delays 3) Improved and equitable access 4) Reduced cost and financial protection 5) Improved surveillance 6) Improved management capacity.

The swift and often uncontrolled rise of the private medical sector has left TB control and patients vulnerable to non-standardised care. Uncontrolled private sector growth is a part of the health system problem, and a proactive approach to improve private sector care is part of the solution.

Evaluations of about 20 PPM initiatives in eight countries have shown results that are mixed. However, the vast majority have shown both good treatment outcomes and important contributions to case detections concurrent with increased case detection in public sector facilities. These efforts are of course not without problems and failures and there is no “one size that fits all” PPM approach. The health care providers and their roles and interactions with the NTP’s depend on what works best in the local context.

Is Public Private Mix a public health Fix? Unlikely, if taken alone, as most of the initiatives show that though demanding and slow in yielding results in some settings, it is essential and worthwhile to engage all relevant health care providers early enough if the Global targets are to be met and the spirit of the MDG’s pursued.

Widyawati Muhasan

**Community Empowerment by Mobile Rehabilitation after Earthquake in Bantul District, Yogyakarta, Indonesia**

Background: An earthquake measuring 6.2 on the Richter scale shattered Yogyakarta Special Province at 6.00 am on May 27, 2006. It was followed by similar and smaller earthquakes which destroyed several areas in the 5 districts in Yogyakarta, namely: Bantul, Kulon Progo, Gunung Kidul, Sleman, Yogyakarta City. It also affected several areas in Klaten, a small city in Central Java.
Province close to Yogyakarta Special Province. Bantul is the district that was most affected. Bantul consists of 17 sub-districts, 74 villages, and 933 sub-villages. Among 799,210 population in Bantul, 4280 people died, 8973 people severely injured, and 3250 people were injured. Among 26 Primary Health Centres, 5 of them were badly damaged, the rest of them needed reconstruction. It was reported that thousands of people have been suffering from fracture, many of them from head and spinal injuries followed by neuralgic, defecation and urination defects and other body organ defects. Mental defects such as post trauma stress disorder/post trauma stress reactions (PSTD) have been largely found in children, adults as well as elderly people.

Mobile Rehabilitation is an integrated health care team approach. This team consists of nurses, physicians, physiotherapists, and psychologists to deliver health service and to supervise the cadres providing basic rehabilitation services to the victims of the earthquake.

Objective: to produce competent cadres who are able to deliver basic rehabilitation services for their own community, including basic physiotherapy, and nursing care, and to conduct mobile rehabilitation provided by an integrated health care team (consists of nurses, physician, physiotherapists, and psychologists)

Method: This was a descriptive analytical research study funded by JICA-CEP. This research was conducted in two sub-districts: Pleret and Jetis; Bantul during July to November 2006. The integrated rehabilitation team and cadre training was imparted to the community. A simple pre-post questionnaire and observation schedule were used to measure the knowledge and skills of the cadres after training and after mobile rehabilitation.

Result: The Mobile Rehabilitation was implemented in August to November 2006 by 387 cadres. They were established Posyandu cadres who were recruited for a Mobile Rehabilitation Team from among 444 existed cadres. They were trained to deliver basic rehabilitation services for two weeks. The training was conducted by the trainers from School of Nursing and Sardjito Hospital who divided the participants into 8 groups (50 cadres each). It consisted of 1) classical training, 2) field training, and 3) feed-back and strengthening. There was an increase in the knowledge and skill of the cadre on basic rehabilitation services, from 53% to 71% correct answer before and after training, respectively. Total patients who have been treated by the mobile rehabilitation team were 2,393. From the total patients treated, 80% were fractures and 20% others. More than 54% was aged 15 – 59 years old; and 68.3% of them were female. Although they have been trained to deliver the basic rehabilitation skills, they still had lack of confidence when treating the victims.
Conclusion: Mobile Rehabilitation and training of basic rehabilitation skills of the cadres can be used as an approach to enable community empowerment in the earthquake area of Bantul.

Key words: Community Empowerment, Mobile Rehabilitation Team, Cadres

Widyawati Muhasim

Private Nursing Practice in Indonesia, is it essential? A Case Study

Background: The Ministry of Health of the Republic of Indonesia has declared a decision for independent private professional practice for nurses in Indonesia, in 2001. It was a significant decision for all of nurses in Indonesia. Many of them who have already running their own practice felt happy but some of them did not share this sense of optimism. The Ministry of Health has been limiting the criteria of those who could have their nursing practice. This Health Ministry decision determined the competence level of the nurses who were involved in independent private nursing practice in Indonesia. The Indonesian Nurses Association (2005) said that about 10% of Indonesian nurses have bachelor degree, about 70% have Nursing Diploma, and 20% of them are senior high school level.

Patient safety depends on the competence levels of the health care provider Data from Indonesian Nurses Association (2005) showed that the majority of nurses who were active in setting up private practice were nurses who have the same level as senior high school although they have more than 5 years in clinical practice. They set up their practices because of the demand of the community in the periphery areas. To regulate the practices, the role of the Indonesian Nurses Association should be examined.

Objective: This paper describes the needs of private professional nursing practice based on community perspectives, as well as the role of Indonesian Nurses Association in regulating the professions

Method: This is a presentation of a case study. In-depth interviews were carried out on 10 informants. Simple open-ended questions and observations were used to find out the perspective of the community about private nursing practice. Secondary data and documentary study were also used to obtain information from the Indonesian Nurses Association. The results were analyzed using descriptive qualitative analysis.

Result: The respondents who have been treated by these nurses said that it was very essential for them to consult private professional nurses, although sometimes they also went to the hospital or to the physician as they had more confidence in their diagnoses and treatment practices. Financial
limitation was a constraining factor for the informants to seek treatment from the physician or hospital. The perspective of other informants who have not been seeking treatment from the nurses stated that private professional nurses can be helpful for them. However, they can also be harmful if they or patients needed a specific medical treatment. They felt that the nursing community was not using modern instruments for specific medical treatment. All the nurses said that it is essential to do the nursing practice, with or without the Decree of the Ministry of Health. The Indonesian Nurses Association found that private nursing practice were (1) determining the medical diagnoses (92.6%); (2) writing a prescription (93.1%); (3) conducting medical treatment (97.1%); (4) conducting prenatal care examination (70.1%); and (5) conducting intra natal procedures. According to the Decree of the Ministry of Health on Private Nursing Practice, the private nursing practice requires (1) minimum education background of Nursing Diploma, (2) nursing practice is based on nursing competencies, and (3) medical intervention is based on the delegation/supervision or an order of medical doctor. The Indonesian Nurses Association is supposed to play important roles in (1) protecting the public from unsafe nursing practice, (2) become the law protection of the nurses in public, (3) maintaining and improving the quality of nursing practice, and (4) protecting the safety and job risks of nurses. However, those roles have not been played yet.

Conclusion: The need of Private Nursing Practice is dependent on the community perspective and its utilization. The socialization of the Decree of the Ministry of Health on the independent professional nursing practice to the community is very important as a guide for them in choosing the appropriate health care services.

Key words: Private Nursing Practice, Health Ministry Decision, Community Perspectives

Mark Nichter

Lessons from studies of health care seeking in pluralistic health care arenas of South and South East Asia 1976-2006

In this presentation I highlight lessons learned from a series of studies I have been involved in conducting over the last thirty years. I begin with a longitudinal household study conducted in 1980 of the health care seeking behaviour of 280 poor rural families living in two neighbouring districts of Karnataka State India. One district is more developed than the other and has a more cosmopolitan health services available to residents. Data on household consultations of and expenditures on public and private doctors and specific types indigenous practitioners and healing
rituals are presented. Patterns of inter and intra community difference are noted. On a more general level the poor are found to consult a wide variety of practitioners and spend between 13-16% and 14-20% of their household income on health purposes ($22-$30), the lions share going to private cosmopolitan practitioners in both districts. The study points out that the poor have been paying a significant amount of their income for poor services Health insurance as a possible means of improving health care is briefly visited and critically examined. A second study carried out in the mid 1990s looks at health care seeking in Kerala state India for chronic disease-hypertension and diabetes. Most of the afflicted consult private cosmopolitan practitioners and suffer from the financial burden of doing so – a burden which is the chief cause of “non compliance”. A case is made for developing PHC programs for the elderly and chronically ill. Next a few lessons from studies of TB in India (1980-2003) are presented to point out the importance of coordination between the private and public sectors- drug resistant TB being one of the prices of not doing so. Next, lessons are drawn from studies of sexually transmitted disease in India, the Philippines and Thailand in the 1990s These studies call attention to use of medicines purchased from chemist shops as a form of diagnosis by treatment, and prophylactic antibiotic use as a means of reducing the risk of risky sexually behaviour. This form of behaviour contributes to drug resistance of essential drugs like the TB drug rifampicin. Next, a 1990’s study of women’s health care seeking for reproductive complaints in Thailand is presented to illustrates patterns of self care as harm reduction, ways the pharmaceutical industry fosters iatrogenic medicine use, and reasons why women who use government services have every right to be dissatisfied with these services. Finally, I critically examine the meaning(s) of “self care” and self medication in light of several different studies. Greater specificity in use of these terms is called for and better studies of what such behaviour tells us about the entire health care system, perceptions of medications and the factors that influence these perceptions, people’s response to living in “risk society” and environments of risk, and their attempts to manage best they can with the resources they have at hand.

Financing Health Sector: Public and Private Mix in Jogjakarta

12
Retna Siwi Padmawati, Laksono Trisnantoro, Soenarto Sastrowijoto, Amalia Muhaimin, and Nurazid Mahardinata

Searching for Suitable Cure: Understanding Medical Pluralism in the Urban Poor Neighbourhood in Jogjakarta, Indonesia

Since the 1980s, the Indonesian government has been implementing a essential health package for the people by building a public health centre for each sub district all over the country. Despite the easy access for all people, it has been seen as inefficient especially in the urban neighbourhoods because of the minimal care they have provided in these areas. Many sophisticated health care resources were made available they did not entirely reach the poor. Traditional medicines - Chinese and indigenous medicine, faith healers, and other alternatives medicines were also widely spread. Along with the people’s concept of “ichtiar” or sparing no effort to regain health, people switch from one medical system to another. This study focuses on the perceptions of people in the poor neighbourhood in Jogjakarta on the locally available healthcare system and on what people do to treat their illness. Several factors which determined the decision-making process during illness will also be seen. A qualitative in-depth interview study with 28 households and a longitudinal survey of 220 households in the poor neighbourhood were applied. They were originally from various places in Central Java, who occupied government land along the riverbank and railways. This paper is about seeking suitable medical care or the process of seeking actual and various treatments during illnesses. Here, the study tried to understand the process of “ichtiar” that is not only governing a practical point of view on seeking of suitable care but also a moral duty for the people. It is argued that such treatment seeking was heavily influenced by social economic factors, social network, personal experiences, the encounters among actors, attachment to the original land, and the various choices of medical systems. This paper suggested that a greater degree of social and cultural sensitivity is applied for the formulation and implementation of public health reform.
Supasit Pannarunothai

**Systems of ensuring ethics and quality in the Thai private health care**

Background: In an asymmetrical environment such as health care system, ethical health care providers are very important in ensuring that health services are delivered efficiently and equitably. Good communication makes knowledge and understanding symmetrical between consumers and providers. Uninformed and unsatisfied services usually lead to consumer complaints and later medical litigations.

Objective: to study existing regulatory mechanisms within the Thai health care system that ensured ethical conducts among health care providers focusing on private practitioners including informal private practitioners.

Method: Desk and documentary review research covered printed documents, annual reports and web pages related to private practitioner, medical professional council, court of justice and government health insurance scheme from 2000 to 2005.

Result: Health care reforms in Thailand have emphasized equity, efficiency, quality and social accountability objectives through financing strategy as main entry point. Awareness among consumer of health care has seen significant increase of cases related to ethical conduct and professional standards filed to the Medical council.

Conclusion: Private health providers face higher scrutiny on their ethical conducts than their public counterparts. Independent professional organizations can ensure ethical conducts only within the framework of formal health professionals. Health ministry and court system are complementary mechanisms to control quality of care and ethical conduct of providers in a wider context. Quality improvement system is a positive approach for patient safety objective. People voices and no-fault compensation system should be used for better positive approach.

Keywords: law, ethics, private practitioner, health system reform

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1. *Health Systems Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand. Sub-study 1 – Regulatory mechanisms, ethical codes and legislation with direct implication for general private practitioners: Desk study.*
Private Health Provider behaviour and Clinical Communication Patterns: Cases from Phitsanulok, Thailand

Recently changes in the world economic crisis have created both problems and opportunities for many countries. In case of Thailand, during 2001 - 2006, the Thai governments had launched a famous health insurance policy that named the “30 Baht (US$0.70) health policy”. This policy, which has provided all people, especially the poor, with access to high standard health services in both public and private sector, can ensure equitable access to health care and help to achieve a nation’s dual objectives of equity and efficiency for its people’s health. The success of this policy depends on many factors and players: consumers, providers, and third parties/payers/purchasers. At present, a person opting out of the 30 Baht scheme is being questioned by consumers and academicians. Thus, in this presentation I highlight the finding from the result of research project I have been involved especially private health provider behaviour and clinical communication patterns.

Finding showed that the urban poor had bad experiences with public services. They complained that they always suffered from long waiting but short consultation time with medical doctor. They needed to know what their illness was and how severe it was. They wanted that the doctor or practitioner should spend more time discussing with them. Thus, people opting out of the 30 Baht scheme, in which case they sought private health services such as drugstore, biomedical practitioners, or practitioners of alternative medicine.

Moreover, the interview about experiences of using health care service show that the quality of care and conditions of services of private health care provider better than public health care provider. In finding about the benefit of health care provider it exclude case of chronic illness and accident, they used the 30 Baht health policy and the public health service.

It is important to note that quality of care or service and conditions of services are important effect on how do the poor make the decisions for self-care and healthcare service. Moreover, the evident of the study can be the one part to successful the health care policy in level of policy-making and to improve the health care providers for all. In this view, not only understanding in biomedical sciences but ,for health care providers, an understanding individual factors such as physical activity,
attitudes, beliefs etc. and empathy for low-income patients and the effects of poverty can open up avenue for care seeking and providing as well as health education.

Anil J Purty

**Public-Private Partnership for Health Care, Our Experience and the Road ahead**

Objectives: To assess the Public-Private Partnership experience at PIMS in providing community based health care in and around Pondicherry.

Design: A descriptive study of the concept and development of PPP strategy at PIMS.

Study Area: Three urban and three rural areas in Pondicherry and surrounding Tamil Nadu

Study Unit: Each community health centre of PIMS

Data Analysis: Monthly report of health care activity and expenditure from each health centre.

Results: Pondicherry Institute of Medical Sciences is a private teaching medical institute having six health centres- three in the rural and three in the urban areas. This is a unique experience as the health care services at two State Government Primary Health Centres (PHC Kalapet and PHC Katterikuppam) and one Central Government Health Centre (Pondicherry University) are being jointly run with staff, infrastructure and logistic support from PIMS. There are three health centres wholly owned and run by PIMS, one of which has been constructed by an international NGO. There has been good collaboration to implement the National Health Programmes.

The Government based public health care system even after 50 years of independence is faced with several challenges, which affect the delivery of effective health care services to the community. In this experience the health care services and community response has markedly improved after this partnership. This paper presents the concept, inception, indicators as per MDGs and the cost analysis and future plans for this Public Private Partnership.

Agus Purwadianto

**The New Regulation on Healthcare Services in Indonesia**

Professionalism is a recent issue among Indonesian health personnel, but not elaborated enough in health regulations. Doctors and dentists have incorporated this concept through the Medical Practice Act 2004 and National Social Security Act 2004 as well. But “malpractice fever” among them has not eased yet. The cumulative miscommunication gaps among doctors/hospitals – patients still
common in Indonesia, even in rural areas. The Indonesian people become more litigious. As a result, most Indonesian doctors/dentists become defensive practitioners, giving the more turbulence “out of pocket” health care system that existed.

For doctors and dentists, the Medical Council with its subordinate, the Medical Disciplinary Board as well as the Ministry of Health and The National Health Insurance Corporation and Indonesian Medical Association with its “subordinate” Medical Ethics Board and Indonesian Dentists Association with their Dentist Ethical Board will play a significant role to make “law as a medical practitioners engineering” to regulate and prescribe the good competency, quality and professional services and conduct of Indonesian doctors/dentists as well.

Other health personnel i.e. midwife, nurse and pharmacist tend to promote their Practice Act respectively, by admitting their drafts bills to the parliaments, whom now has the initiative rights to make the law. But due to huge protests from doctors towards the excess of Medical Acts which “criminalized” them, there are slow down process to progress the bills.

Our policy to reform these regulations based also on decentralization and responsiveness to the medical scientific and technological progress as well as the ethical and self-disciplinary ones. We call it the “ethicolegal” or legal ethics system. This presentation describes the legal implication of health personnel’s regulation in Indonesia.

Keywords: professionalism, medical acts, legal ethics, disciplinary proceeding.

Soenarto Sastrowijoto and Nur Azid Mahardinata

Regulating Health Professions. The Dilemma in Medical and Health Practice for the Poor in Indonesia

Background: Based on the mobility and mortality rate and human development index, compared to ASEAN Countries, the health status development in Indonesian is lower. This condition may be related to the long history of health care system, in which health care is not financed as public goods, and left to market forces or related to the fast development of autonomy system. Medical education and health, health care and the financing system are not integrated. As a result, the growth of private medical and health service is fast and the regulatory mechanism has difficulties to catch. The objective of this paper is to describe and analysis the existing regulatory mechanism, ethical codes and legislation with direct implication for medical and health practice, especially for the poor.
Methods: Desk-study of acts and regulations, text books, articles of journals and websites, newspapers and court cases.

Results: Hierarchy of Law and Regulation in Indonesia consisted of five levels, the Constitution of the Republic of Indonesia, Act or Government Regulations replacing Act, Central Government Regulation, Presidential Regulation, and Provincial and District Regulation. There are seven groups of health providers; medicine, nursing, pharmacy, public health, medical technician, nutritionist, and traditional healer. Government had stipulated limited number of Act for regulating medical professions and health. The most recent Act is the Medical Practice Act No. 29 in 2004. However, this act has not cover the regulation for nurse and alternative/traditional practices. Their practice is similar with medical doctor which is against the law. It is not easy to enforce this law for regulating private nurse practice and traditional medicine for the poor. It is also because of the limited number of medical and health professionals, related to Acts No. 20 in 2003 and Act No. 29 in 2004, both are regulating professional education and training. Some Poor Indonesian prefers to pay the private practice (doctor, nurse, and alternative medicine) rather than using the subsidized government medical facilities and health. To avoid the legal and ethical dilemma, privilege regulation in transition of the permanent regulation should be developed (both for provincial and district levels) for the nurse and alternative medicine in the poor area. The national policy or regulation in producing the appropriate health professionals to response the need and demand of the community, particularly the poor, should also be developed

Recommendation: Act for regulating the practice and training of health care for the Poor (doctor and nurse, and alternative medicine) should be developed. While waiting for the new Acts, District regulation based on Act No, 29, in 2004 and Act No 20 in 2003, should be stipulated.

**Jens Seeberg**

**Market dynamics and private health delivery. The case of Bhubaneswar, India**

The World Bank and a number of multilateral and bilateral organisations have promoted growth of the private health care sector in developing and transition countries since the late 1980s. This strategy has been based on a combination of faith in market mechanisms – particularly competition – and inability of the government sector to cover health needs and growing demands in the entire population. The State of Orissa, India, has been comparatively late and cautious to adopt a pro-
private strategy. Yet, in urban centres of the state, primary and secondary health care is largely left to private-for-profit clinics. This is due to the vacuum left by the government system rather than a deliberate health sector policy. This paper examines the role of competition and assesses positive and negative implications of market competition for health care delivery.

Competition is indeed a very important aspect of the private health care sector, both in production, distribution and delivery. At the production level, India has a rapidly growing pharmaceutical industry (9% growth in 2005). The industry adopts very aggressive marketing strategies, exploiting the insufficient control and quality at various levels of the private health care sector. This analysis shows how these strategies negatively influence health care delivery to the urban poor in Indian cities, using Bhubaneswar as a case. The study also points to current governance issues related to control of sale of drugs and services in the private sector.

The current private sector setup benefits local entrepreneurs and large-scale businessmen at the cost of public health. The paper points to policy level needs to promote good governance and strengthen the capacity to control quality of drugs and movement of money among all involved actors.

Angkhanaporn Sornngai, Jens Seeberg and Supasit Pannarunothai

Health Problems and Needs among Low Income Elderly in Muang Pitsanuloke, Thailand

The elderly is a high risk category for chronic illness. To maintain quality of life among the elderly within a rapidly transitional society is a great responsibility for health care providers. The main purpose of this descriptive qualitative study was to explore health problems and needs among low-income elderly residents of Pitsanuloke. Twelve elderly respondents who used to live in floating houses and were moved out by the Municipal Council to stay in the suburb area were chosen. Data collection was conducted during November 2005 to May 2006, through participant observation and in-depth interviews. Data analysis was performed by inductive method and content analysis.

The main results indicated that almost all of the elderly still live with their children as is a traditional Thai custom. Since they moved to a new environment, they had to adjust to many difficulties such as new living arrangements, and new occupation for family income. As a result, the elderly faced with three main problems, specifically physical and mental illnesses, economic problems, and faced difficulty in the new living arrangements. Concerning their illnesses, the main physical health problems included urinary tract infection, musculoskeletal and back pain, insomnia,
hypertension, heart disease, cataract, and hemorrhoid. Some of the elderly got more than one illness during the study period. The prominent mental health problem among the study elderly was stress as a result of both economic pressure and new living arrangements. It was also found that gender, and socioeconomic status influenced the kind of illness conditions they faced, that is, the female elderly were found to be more ill than their male counterparts, and low income elderly tended to have a higher incidence of health problems than the others. Health seeking behaviour among the elderly began at the stage of symptom definition, with the ability perceive and interpret an abnormal symptom. The interpretation of a condition as well as the decision to manage that condition in a particular manner was influenced by lay or community-level consultations. The elderly preferred to begin illness management in the popular sector. If such management was ineffective, they would interchangeably select management recommended by the folk or professional sector.

Regarding economic pressure, some of the elderly had to work for income generation since the money they got from their children was insufficient. However, many of the elderly pointed out that both economic and living arrangements produced more stress. Stress management was done by consulting with neighbours, doing household chores or exercise, and praying. Further, they expressed the need for a system where they could do exercises together, to develop their own community, and to have physical examinations from time to time.

The results of this study suggest that health care providers should tailor health care services for the elderly as a collaboration involving a multidisciplinary team. These services should be done with holistic approach by integrating physical, mental, and social perspectives to address the real problems and needs among the elderly, in other words, to ensure what could be termed as a “culturally competent health care system”

Vorasith Sornsrivichai

**Experience from Thailand's Deep South Violence**

The three southernmost provinces of Thailand, Yala, Pattani and Narathiwat (referred to as "Deep South"), are home to 1.5 million Muslims, a minority population in the nation. ‘Deep South violence’ erupted in January 2004 when an army depot was raided followed by widespread terrorist attacks targeting symbols of authority and civilians alike. Between 2004 and 2007, there have been 5.4 violent events and 4.6 injured people (1.8 dead) per day. In 2004, ranking 4th of DALYs burden in this area.
Our unit started to get involved in 2004 when coordinating a group of volunteer epidemiologists, rural doctors and NGOs to develop a package of security preparedness in the health care setting (http://medipe.psu.ac.th/securityandsafety/). We subsequently cooperated with the Military College of Medicine developing an Incidence Action Plan and Emergency Incident Command System. Secondary data from various sources, e.g. news clippings from the mass media, police crime investigation, and military incidence reports were analyzed as situation analysis since 2004. Violence-related Injury Surveillance-VIS in 47 hospitals was implemented in January 2007 (http://medipe.psu.ac.th/vis/). It was used to monitor the magnitude and trend of events, to identify risk factors, to improve Emergency Medical Service (EMS) and referral system and to allocate resources, e.g. EMS and security-related hardware and officers.

The Deep South Coordination Centre-DSCC (http://medipe.psu.ac.th/~dscc/) was established in 2006 under the National Reconciliation Committee funding to coordinate academic activities to support the victims and their dependants. Its integrated Deep South database was linked to the Mental Health Crisis Centre (MCC) in every hospital to help its community psychologists and psychiatric nurses in identifying those people in need.

Apart from the violence-related injury, which is just the tip of the iceberg, we are also working in the area of participatory community development to decrease structural violence. Prince of Songkla University's Graduate Volunteer Project, aiming for bridging the gap between academia and the community, was launched in 2004. A Self-help group for widows of the victims from the Deep South violence was established in 2006.

We have also participated in multidisciplinary peace and reconciliation activities, focusing on facilitating right understanding among locals in the Deep South and Thai society, e.g. Multicultural Project among local primary students and teachers, Cultural Competency Project among 5 health science profession students in 6 universities, Policing in Multicultural Society Training, dialogue and negotiation training for local community leaders and health officers. The Intellectual Deep South Watch (http://www.deepsouthwatch.org) was set up in 2006 in cooperation with the Thai Journalists Association to serve in the area of situation analysis, investigative journalism and balanced information of the Deep South situation.
Financing Health Sector: Public and Private Mix in Jogjakarta

Although the Yogyakarta Special Province has among the best health status in Indonesia, yet there is inequity and inefficiency of health care provision. The poor, who constitute about 19% of the population, pay more for health expenditure than the better-off, and the remaining population has not been adequately covered by health insurance. The Government budget from central, provincial and district levels are considered insufficient to fund the needs of health care of the population. Coverage of health insurance is low, as a result of which a majority of the people lack financial protection, and rely on private practice health services. They pay for these services out-of-pocket while at the same time they are not assured of good quality services. The objective of this paper is to describe and analyze the financing system in Yogyakarta Special Province, and its impact on delivery of care, and identify some effort to strengthen the role of public and private sector in order to pursue more equity and quality of health care.

Methods: Desk analysis of national and provincial health surveys and documents (National health surveys, Provincial health Account, articles, text books)

Results: The high number of self treatment and use of private practice including traditional healer under “out of pocket paying system” lead to inequity, because the poor have less access to adequate health care. Dual practice or working in government institutions and at the same time engaging in private practice reflects the low motivation of health workforce, undermining quality and professionalism. This also leads to non-compliance with good practice protocols and high absenteeism. Lack of regulation and monitoring of health providers and alternative medicine practitioners also reflect stewardship weaknesses of the public and private health system. To cope to these problems, the Yogyakarta Special Province has been trying to strengthen its role by establishing local health insurance and health care quality institutions.

Recommendation: Government should increase its role in financing, stewardship of health care, given its responsibility to deliver preventive, promotion, as well as curative cares. In addition, the private sector should be optimizing its role by collaborating with public sector in providing a private-public mix of services.
A Dynamic of (Private) Health Sector and Quality of Care

Indonesia, the fourth-most-populous country in the world, made substantial progress in economic development before the financial crisis that started in late 1997. To guarantee an even distribution of health services, the Indonesian government expanded its network of public health facilities under the principle of Health for All, or universal access to basic care. Initially focusing on hospitals, the government began in the mid-1980s to expand its network of primary care facilities which number more than 7,000 health centres and 21,000 sub-centres today, plus more than 250,000 integrated community health posts (posyandus). The government allocated health facility construction based on population targets, with one health centre per 30,000 people and one auxiliary centre per 10,000. Java-Bali and Outer Java-Bali are used by the central government as designations for allocating public resources on which regional governments rely, including qualified medical staff. If one were to take deployment of physicians to health centres, for example, one to four physicians are targeted per health centre based on facility type and region. At the highest level of staffing, four physicians are deployed to large health centres serving densely populated regions in urban Java-Bali. At the lowest level, health centres in rural Outer Java-Bali receive one per facility. This allocation system sets higher physician-staffing standards for the more populated regions and deploys more nurses and midwives for Outer Java-Bali. Facility construction favors Outer Java-Bali, where facility-per-population targets have exceeded the norms. Public health centre staffing, however, reflects the allocation rules with higher numbers of physicians in Java-Bali and higher numbers of nurses in Outer Java-Bali.

However, health expenditure in the public sector is still very low, not even constituting 4% of the national budget. As a result, private sector expenditure ranged from two to three folds of the public expenditure. Only around 25% of private sector expenditure on health is borne by health insurers, the remainder is paid through out-of-pocket. Meanwhile around 55% of public sector health expenditure is allocated for preventive medicine, whereas 90% of private sector expenditure is spent on curative efforts, i.e. consultation fees and medicine. Out-of pocket payments are the main source of financing for discretionary care. Except for the very rich, out-of pocket financing cannot cover expensive care or deal with catastrophic illness. The problem of inequalities in the health sector goes hand in hand with other injustices that permeate every aspect of the citizen. The medical industry has created expectations and artificial needs. It has managed to establish a consumer
market for sophisticated services and complex technology. The market comprises not only the medical profession but also the public at large. A mistaken belief that sophistication and high cost is a guarantee of quality has been created. As a result, consumerism has become the trend in the big cities, patients demand new and sophisticated treatment, and people opt for irrational medication more out of fashion rather than out of felt need.

To protect the poor, the central government has recently launched a special insurance scheme for the poor (askeskin). This was done in the wake of rising fuel prices caused by reduction in the government subsidy for fuel following the advice of the IMF and World Bank. As a matter of fact, immediately after the 1997 multi-dimensional crisis, the government, backed by the multi-donors, launched a social safety net program, including social safety net program for health.

Traditional health indicators as represented in the HFA by the year 2000, i.e. life expectancy at birth, infant mortality and under-five mortality rates are not sensitive enough. Indonesia crossed the target in 2003. However, the Human Development Index launched by UNDP and the Millennium Development Goals (MDGs) are more sensitive. The last review of the achievement of MDGs in Indonesia showed that most probably Indonesia could not meet the target of MDGs by 2015. This is a wake-up call for Indonesia to improve the health care services; although the government has already created a social safety net, it is not enough. Indonesia needs bolder initiatives, a breakthrough to overcome the health problems, double burden, which in long term could become more as a liability rather than an asset for the nation.

Laksono Trisnantoro

**Health Sector Reform in Indonesia: A scenario planning analysis for controlling private sector**

Background: Health sector reform policy in Indonesia was triggered by three new Acts on: (1) Decentralization in 1999 and 2004; (2) Medical Practice in 2004; and (3) Social Security in 2004. Decentralization policy transferred the authority and financing system for health sector from central to local government. The Medical Practice Act aims to strengthen the legal basis for medical service and improving quality of care. Social Security Acts aims to develop a universal coverage of health insurance for Indonesian and change the way medical doctors practise. This study examines whether the health sector reform will be successfully implemented or not.
Methods: A historical analysis of the health system and scenario planning were used. Legal and policy documents were analyzed from the Dutch colonial period to the present. A scenario planning method is used for projecting the future of health sector reform.

Results: Since the Dutch colonial time, Indonesia is not a welfare state. At present, Indonesia’s health system can be classified as a market driven one in which around 25% of health finance is funded by government. The current policy aims to increase the government source for health. However, most health expenditure is made out-of pocket. Concerning policy for protecting the poor, the social security scheme was a reactive intervention due to a nation-wide economic crisis in 1997. This pro-poor policy was introduced in a market ideology health sector. For centuries, the private sector has grown with limited regulation. Regulation of the private sector was implemented in 2004. Some symptoms of anarchism in the health sector exist, which is difficult to be removed by the new Acts. Using scenario planning, there is a possibility that medical culture and market-ideology in health sector cannot be changed with the new Acts. The worst scenario describes that anarchism in health sector may increase.

Recommendation: To reduce the risk of approaching the worst scenario: (1) a cultural approach should be implemented in changing medical doctors way of life; (2) regulation for controlling private sector should be developed alongside with cultural change; (3) a mixed approach of welfare state and market-driven policy should be put in the agenda of health system reform.

Jati Untari and Mubasysyir Hasanbasri


Background: The Government in Indonesia has established a public health program and provided health cards to the poor to ensure that the poor have no barriers in accessing health care. Ensuring proper health services protects the public from the spread of infectious diseases and the social burden of illness. This study evaluate whether the poor use their health card for attending government health services. The program would be considered to have failed if health card holders use private rather than public health services.

Method: This descriptive study uses the 2004 National Socioeconomic Survey. It covers 6,588 respondents with health cards in 30 provinces of Indonesia. Respondents with illness complaints during the past month of the survey were asked to report the type of health facilities they attended.
Results: More than half of card holders do not seek medical help when they have illness complaints. Twenty eight percent used public health services. About one third of those seeking medical help or about 15 percent of health card holders used private services. The proportion of card holders in Java and Bali seeking private practices were almost the same in urban and rural areas. While in outside Java-Bali, private providers were more likely to be used by an urban card holder. Distance and the inconvenient timing of public health care facilities were important factors that drove card holders to seek private practitioners.

Conclusion: The use of private providers among card holders reflects the gap between the card and its implementation. If the government wants to help the poor in rural and remote areas, it should seek collaboration strategies to work with practicing health workers.

Key words: health card, private practice, poor families

C.A.K. Yesudian

Health Seeking Behaviour of Urban Poor in India

Urbanization in India is mainly due to push factor of rural poverty rather than urban pull factor. As a result, cities across the country experience heavy in-migration from rural areas. These migrants are normally poorly educated and have no job skills to perform in the urban formal sector. Therefore, they mostly end-up doing odd jobs in the informal sector of cities. This has led to large slum population in large cities. They live in poor living condition leading to all sorts of health problems. On an average, a quarter of the population in large cities live in slums but in cities like Mumbai, a majority of the population live in slums.

To cope with their health problems, the urban poor living in slums resort to health seeking behaviour that differs from one city to another and differs among different groups of poor within the city. First of all, urban poor is not one homogeneous group in a city. They differ in their income, place of migration and their geographical location within the city. All these factors have bearing on the health seeking behaviour of the urban poor. The health seeking behaviour also depends on the kind of options that the urban poor have in a city. In an economically vibrant city like Mumbai, the poor have the option to seek both public and private health services. There are qualified and unqualified private practitioners practicing in slums to deliver healthcare for the poor. Their charges suit the pocket of the poor in that area. On the other hand, in a city like Bhopal, where the city is not economically vibrant, the poor mainly depends on the government provided services. Thus the health system in the city influences the health seeking behaviour.
The health seeking behaviour of the urban poor is also dependent on the disease pattern of the urban poor. For minor ailments, the poor may seek care from the local private healer or the pharmacists. For hospitalization, which involves high expenditure, the poor may seek care from government facilities. The study conducted in Bhopal shows that the poor had incurred indirect cost of substantial amount for seeking healthcare in government facilities.

For the last two decades, the public health sector in cities in India has deteriorated, whereas private health sector has mushroomed in all parts of the cities. Since the public sector is unable to cope with the health needs of the urban poor, the poor are seeking care from those private providers, who do not provide quality care but the cost of their healthcare is cheaper. In an environment of unregulated healthcare practice in India, this trend has serious health implications for the urban poor.