

Changing healthcare systems in Asia

by

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CHANGING HEALTHCARE SYSTEMS IN ASIA	1
1. AIM/ OBJECTIVES	3
1.1. AIM.....	3
1.2. OBJECTIVES	3
2. MAIN THEMES	3
2.1. CORPORATISATION	3
2.2. HEALTH INSURANCE	4
2.3. PUBLIC- PRIVATE PARTNERSHIPS	4
2.4. CHANGING ROLE OF GOVERNMENT IN HEALTH CARE PROVISION.....	5
2.5. HEALTH TOURISM	5
<i>Key points</i>	5
3. HEALTH AND TRADE.....	6
3.1. GATS	6
3.2. TRIPS.....	7
<i>Key points</i>	7
4. MAIN ORGANISATIONAL PLAYERS.....	7
4.1. WORLD BANK.....	7
4.2. INTERNATIONAL FINANCE CORPORATION.....	9
4.3. ASIAN DEVELOPMENT BANK	9
4.4. ASSOCIATION OF SOUTH-EAST ASIAN NATIONS (ASEAN)	10
4.5. WORLD HEALTH ORGANIZATION (WHO).....	10
5. REGIONAL DEVELOPMENTS	11
5.1. CHINA	11
5.2. INDIA	12
5.3. THAILAND.....	13
6. MULTINATIONAL HEALTHCARE COMPANIES.....	14
6.1. ALLIANZ	14
6.2. APOLLO HOSPITAL GROUP.....	14
6.3. BUPA	14
6.4. CIGNA	15
6.5. FRESENIUS	15
6.6. PARKWAY HOLDINGS	16
7. TRADE UNION ACTION	16
7.1. CAMPAIGN FOR IMPROVED HEALTH SERVICES	17
7.2. CAMPAIGNS AGAINST PRIVATISATION AND CORPORATISATION.....	17
7.3. RIGHTS OF WORKERS AND TERMS AND CONDITIONS	17
8. CONCLUSIONS	18

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1. Aim/ objectives

1.1. Aim

- To provide a regional profile of changes in healthcare systems in Asia

1.2. Objectives

- To identify the main themes emerging in the commercialisation of health services in Asia
- To outline the main organisational players
- To outline key regional developments
- To outline multinational healthcare company developments in Asia
- To outline trade union action

The paper will be structured in six sections:

- Main themes of commercialisation
- Key players
- Regional developments
- Companies
- Trade union action
- Conclusion

2. Main themes

Commercialisation of healthcare is a process that has been taking place in many countries over the past decade. It affects the way in which healthcare is delivered and the pay and working conditions of health workers. There are many dimensions of commercialisation, which may be adopted at different times. Some examples are: the corporatisation of public sector healthcare institutions, the establishment of public-private partnerships, the changing role of the public sector as a provider of healthcare, the expansion of health insurance, and the development of medical tourism. These will be outlined in the following pages.

2.1. Corporatisation

The development of health care institutions within the public sector that operate under business principles, often part of wider organisational restructuring, has been called “corporatisation”. This is taking place in countries throughout the world.¹ When introduced over a decade ago, the process was considered a first step towards the privatisation of health care services. It was assumed that once an institution operated like a business, it could be taken over by the private sector. However with the formal takeover by the private sector, corporatisation is having a major impact on how the public healthcare sector operates, in many cases making the boundaries between public and private sector unclear.

In Singapore, the government introduced a process of corporatisation to its public sector hospitals but this has not led to hospitals moving into the private sector. Some have become successful in competing with the private sector. One of the major private sector healthcare companies based in Singapore, Parkway Holdings, has found that the corporatised public health sector has often an unexpectedly competitive edge, with government hospitals having newer facilities, cheaper prices and also car parks²

Trade unions interviews in Malaysia showed that corporatisation of public hospitals, in the context of competition with the private sector, has had immediate effects on the workforce through efforts to control labour costs by contracting out services, sacking staff and increasing workloads. An illustration of how the public and private sectors interface can be seen in the requirement for staff to work in both the public sector part of the hospital and the private patients' wing, resulting in health workers in the public sector wards covering for colleagues in the private sector wing or health workers working double shifts. Types of contracts have been changed to make staff more "flexible", and staff reductions are affecting particularly those aged over 45. Within hospitals operating under business principles, divisions emerge between high income and low income departments. Performance related pay also breaks down national pay agreements into individually negotiated contracts. The result is deepening divisions between different groups of health workers and different hospital departments in what is already a highly stratified sector.³

2.2. Health insurance

One of the aims of health sector reform is to increase the role of private health insurance in the financing of health care. This is supported by the World Bank promotion of a model of basic public services for low income groups and private health insurance for middle income groups (see Section 2.1).

Health insurance is targeted at middle income groups often portrayed as a "modern" way to pay for health care. The introduction of co-payments for drugs and certain types of treatment in the public sector can also lead people to taking out private health insurance to cover these costs. In other cases, the quality of public health services deteriorates so much that people begin to use private sector providers, eventually funded by health insurance.

In Asia, global insurance companies are beginning to enter national markets. Multinational healthcare companies are aware that an adequate system of health insurance is needed if people are to pay for healthcare and enable private healthcare companies to expand their markets.

Governments are also reviewing systems of financing healthcare. Malaysia has a tax based healthcare system with a parallel private health insurance sector, which has expanded in the last decade due to the option given by the Employees' Provident Fund, which gave its members the option of using their savings for a risk rated health insurance scheme.⁴ There are currently plans to introduce a new national health financing scheme. As part of a strategy to improve the healthcare available to the majority of the population in Malaysia, the coordination between the public and private sectors is to be enhanced so that more people can gain access to the private sector.⁵

2.3. Public- private partnerships

The private sector is being drawn into operating within the public health sector through a series of mechanisms. One of the most influential, in terms of redefining public and private sector relationships, are public-private partnerships (PPPs). This covers a wide range of possible relationships, from contracting the private sector to supply goods (e.g. drugs) or services (e.g. cleaning), through to arrangements where a private company may manage a public hospital or finance a new hospital in return for a long-term concession to provide services.

There are three major problems that can arise with public-private partnerships and private finance initiatives.

1. The quality of the services delivered
2. Pay, terms and conditions for workers
3. Length of payback terms for the public sector, which may result in long-term indebtedness of public sector. It also neutralises any "incentive" for the private sector to be efficient.

2.4. Changing role of government in health care provision

The introduction of contracting systems and public- private partnerships in the public health system has led to changes in the role of government in the health care system. Moving from being a provider of health services, the public/ government sector has often relinquished direct control over providing health care services and taken on a coordinating and in some cases regulatory role. This is sometimes described as moving from a “provider” to “enabler” role. This process varies from country to country and has been encouraged directly by many health sector reform programmes through technical support from multilateral agencies.

The combination over the last 20 years of underfunding in the public health care sector and the changing role of the government has led to changes in people’s perception of the public sector and the private sector. The introduction of user fees for government health care services has also meant that government services are often no longer free. The perception in some countries is that the public sector is underfunded leading to lack of staff, overcrowding, long waiting times, and lack of drug supplies. This can lead to both patients and staff moving to the private sector.

In terms of the future of public services, there are questions about what type of policies may help to strengthen the role of the government in the health care sector. This includes the development of a strong government regulatory role, which would control the presence of the private sector within the public health sector. However extensive work needs to be done to develop effective systems of regulation.

2.5. Health tourism

Medical tourism can be defined as the provision of ‘cost effective’ private medical care in collaboration with the tourism industry for patients needing surgical and other forms of specialized treatment.⁶ This process is being facilitated by both the corporate sector involved in medical care as well as the tourism industry. Health ministries are also involved. Many governments are promoting health tourism as a way of drawing in foreign exchange. In Asia, India, Malaysia, Singapore and the Philippines are actively promoting medical tourism.

For example, India’s National Health policy (2002) aims to “capitalise on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as ‘deemed exports’ and will be made eligible for all fiscal incentives extended to export earnings”.⁷ The Apollo Group in India has already started to develop medical tourism in India and draws patients from Africa, Asia and the Middle East. Another corporate group in India, the Escorts group, is also expanding the number of patients it treats from overseas.⁸

The advantage that Asian countries present in medical tourism is that their prices are cheaper than private healthcare in either North America or Europe. Medical tourism promotes the view that healthcare is a series of products that can be bought and sold. It takes the pressure off governments to provide accessible, comprehensive health services for their populations. Private healthcare providers, for example in India, are lobbying governments for subsidies to enable further development of medical tourism.

Key points

- Corporatisation affects the terms and conditions of health workers, their working conditions and health and safety
- Health insurance is seen as essential for middle classes to access private healthcare
- The role of government is changing from provider to regulator
- Health tourism is a result of the increased commercialisation of healthcare and both public and private sectors view it as a way of earning foreign exchange

3. Health and Trade

3.1. GATS

The General Agreement on Trade and Services (GATS) is an international agreement aimed to further liberalise trade in services. It will impact on trade and health services. There are four modes or types of trade:

1. Mode 1 Cross border supply - neither supplier nor consumer crosses a border but the service is delivered by mail or telecommunications
2. Mode 2 Consumption abroad – consumers travel across a border to obtain health services
3. Mode 3 Commercial presence or foreign direct investment – companies establish operations or make investments within a country
4. Mode 4 Presence of natural persons (temporary cross-border movement of labour) – health professionals travel across borders to deliver health services on a temporary basis.⁹

Trade in health care services refers to both the import and export of health services. The import of health services in this context may be seen as a way of improving health services through bringing foreign expertise or technology. A country may lower barriers so that qualified health professionals can enter the country. It may send patients abroad for treatment.¹⁰ The export of health services may involve facilitating health service suppliers who want to establish operations in other countries, using existing health care facilities for “health tourism” or making it easier for an over supply of health workers to migrate temporarily.¹¹

One of the most significant principles of the GATS agreement that has long-term implications for the health sector is the “exemptions for services provided in the exercise of government authority and government procured services”. Services provided by government authority (local, regional or national level) or by non-governmental bodies exercising government authority are technically exempt from GATS obligations. However the definition of government authority is “supplied neither on a commercial basis nor in competition with one or more service suppliers”. For health care systems that have an internal market, it is increasingly difficult to argue that government funded health services fit this definition of government authority.

Regulatory reform is seen as an important factor in determining how national governments will control multinational companies. This will be crucial in any attempts to safeguard parts of the health sector e.g. pro-poor policies, cross subsidisation policies, and use of profits. Although within the GATS there is a recognition of the “right of Members to regulate and to introduce new regulation in the supply of services within their territories in order to meet national policy objectives”, the WTO Council for Trade in Services is also required to develop “any necessary disciplines” to ensure that regulations e.g. qualifications, ... do not form “unnecessary barriers”. Lipson (2002) points out that service suppliers may challenge domestic health regulations, designed to promote equity, because they might restrict trade.

The health sector is not a homogenous sector but is made up of several sub-sectors, e.g. insurance, medical supplies, pharmaceuticals, and laboratories. GATS may affect these sub-sectors before it affects the overall supply of health care. Under GATS legislation, health insurance is classified as “insurance” or “banking and other financial services”. Under insurance, most commitments relating to health insurance fall under “non-life insurance” even though there is a category of “life, accident and health insurance”. Health insurance is seen as part of the financial services sector rather than the health services sector because it is one of many services offered by one company, is affected by regulations relating to other insurance services and requires access to capital markets and reinsurance.^{12 13} There is a need for stronger regulation. Eighteen countries have liberalised their insurance services sector. Companies are expected to use this as a way into health care systems.¹⁴ This is significant for many Asian countries where insurance companies have already started to enter domestic markets.

In Asia only a few countries have made market access commitments on a major number of sectors. India has opened six sectors including hospital service and is the only country in the Region that has made a commitment in the health sector. It is under Mode 3 commercial presence.

3.2. TRIPS

In 1994, over 100 countries signed the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement which began to control the way in the property rights (or ownership) of information in a global economy was defined and enforced.¹⁵ TRIPS sets minimum standards in copyright, trade marks, and industrial designs. It has extensive implication for the development and distribution of pharmaceuticals and medical equipment and devices.

The Doha Declaration on the TRIPS Agreement and Public Health, adopted at the Fourth Ministerial Conference of the WTO, held at Doha, Qatar in November 2001, was the first time that an international trade declaration related to public health was adopted. The declaration, while defining the relations of TRIPS with public health, stressed that TRIPS should be addressed as part of the wider national and international initiatives taken to address global health problems. The Doha Declaration provided the mandate to the WTO Council for TRIPS to find a solution to the problem of countries, especially those with little or no manufacturing capacity in the pharmaceutical sector, in making effective use of compulsory licensing. It decided that the least developed countries would not be obliged to implement patent protection of pharmaceutical products until 2016.¹⁶

In August 2003, the WTO decided to lift TRIPS restrictions on compulsory licensing for the export of generic medicines to countries, which are unable to manufacture them. However, the United States has recently been developing a series of bi-lateral trade agreements, for example with Singapore, Thailand, that threaten the impact of the August 2003 agreement. This will restrict the access of developing countries to affordable medicines.¹⁷ Some of the restrictions cover: extending the period of time for patent protection beyond the 20 year period agreed in TRIPS; new provisions giving patent holders powers to block parallel import of drugs; new provisions blocking companies from using clinical trial data from brand name companies which would delay or prevent generic competition; new provisions blocking national drug registration authorities from registering generic versions of drugs after the patent has expired.¹⁸

Key points

- Increasing emphasis on the buying and selling of health services
- GATS commitments to health services by individual countries still limited
- India is the main country in Asia that has GATS commitments to Mode 3
- TRIPS agreement will have a significant impact on developments of pharmaceuticals, medical devices and medical equipment
- Increasing bi-lateral agreements between the US and individual countries will undermine the achievement of Doha

4. Main organisational players

Healthcare policies at national and local level are strongly influenced by policies and strategies of multilateral and regional agencies. The World Bank and the International Finance Corporation, the Asian Development Bank, and ASEAN all influence the provision of healthcare in different Asian countries through specific healthcare policies as well as through trade and private sector development strategies.

4.1. World Bank

The annual World Development Report can be seen as a strong indication of World Bank policy. One of the most influential World Development Reports (WDR) in relation to healthcare was 'Investing in Health'

(1993) which presented strategies for providing cost-effective basic packages of public health and healthcare services.¹⁹ It argued that in order to deliver basic healthcare packages, the rest of the healthcare system would have to become self-financing. Extensive reforms and reallocation of public spending were needed to achieve this.

Governments were recommended to adopt user fees and self-financed insurance as well as investing in local level health centres and community care rather than more specialised care. Privatisation of drug distribution, decentralisation of healthcare management and more involvement of the private sector were also highlighted. Government regulation of insurance and the private sector were presented as an integral part of these reforms.²⁰ This report has influenced many government healthcare policies, which have often led to a deterioration in the quality of services and level of accessibility rather than improvements in care.²¹

Although essential elements of public sector reform involve the promotion and development of the private sector to deliver public services, the process of outsourcing and contracting out of services has been slow in many developing countries. The introduction of specific private sector development strategies in the late 1990s by multilateral financial institutions may be interpreted as an indicator of the lack of response of the existing private sector to the process of economic and public sector reform. The new more targeted approach of formulating specific private sector development strategies aims to develop a private sector that can both contribute to economic growth and deliver a wide range of public services.

The revised Private Sector Development (PSD) strategy, launched by the World Bank in 2002, anticipates a wider role for the private sector in providing health and education services. It is anticipated that the International Finance Corporation (IFC), part of the World Bank Group, will increase its lending to private companies working in health.²² The World Bank Group's Implementation Progress Report – PSD Strategy highlights its work so far in building up a private sector to deliver health and social services. There are signs that there has been extensive debate within the World Bank about how to promote private provision in health and education. The World Bank Private Sector Advisory Services Department (PSAS) has commissioned research, training and operational activities and has identified that staff need technical assistance to develop initiatives that increase access by poor people to health and education services. Issues that World Bank staff need technical assistance include how to promote competition between public and private providers, the development of accreditation and regulation frameworks, the design of incentive and subsidy schemes, and the design and awarding of contracts, especially output based aid contracting systems.

Output-based aid (OBA) refers to the focus on agreed outputs that private sector providers negotiate with the government or public sector. Often used in relation to infrastructure projects, the responsibility for delivery is with the private sector provider. The World Bank Private Sector Development (PSD) strategy argues that this arrangement provides “*competitive disciplines that ensure that the profit margins would be bid down to normal levels and that the subsidy would eventually be reflected in lower prices to customers or lower cost to taxpayers.*” In reality these can be seen to be a form of concession arrangements. However, if the income stream from these projects is secured in order to minimise risk for the investor, the supposed advantage of output based aid is an illusion. The investor has no particular advantage to deliver the output more efficiently and effectively, because the income is the result of negotiations, not of market forces.²³

The World Development Report 2004 ‘Services for the Poor’ deals with the provision of services to poor people. It addresses health and nutrition programmes and begins by stating that

“Health and nutrition services are characterised by a variety of market failures; externalities associated with disease, asymmetrical information between professional providers and patients and the failure of insurance market. These market failures – as well as a concern for equity - justify some form of government intervention in health”

It argues that services fail because of a lack of accountability. It recommends that three measures will improve accountability: stronger client power over service delivery; strengthening people's voice to influence public spending; strengthening the compact between policy makers and providers, to protect clients and ensure an equitable distribution of services. The report identifies problems of access, affordability, poor quality and insensitivity to client needs in relation to the supply of services. It also adds that

“ensuring regular and predictable availability of qualified health staff and affordability of care compounds the problem of insufficient use of clinics or hospital services”.

This is one of a number of comments in the report that implies a critical attitude to public service staff, in this case health workers, and this permeates the text. There is no attempt to analyse why health staff are not always available and what conditions shape their behaviour. Instead, apparently simplifying changes in accountability relationships are presented as solutions to the problems of public services.

The report recommends that ‘client’ power can be strengthened by a wide range of measures some of which are supported by evidence of successful practice. Some examples include:

- Making the income of service providers depend more on the demand from poor clients
- Encouraging people to pay providers directly for services
- Influencing pricing, for example cross subsidising preventive and mother and child services with adult health care together with generic drugs
- Demand side subsidies, which mention some of the problems of targeting
- Co-producing health services, which is a term used to cover self-care, client involvement in health services and community led initiatives.

Information, monitoring, enforcement and regulation are seen as essential elements to control private provision. Whilst making more information available can help service users to make more informed choices about health care services, the focus of all these measures is on the consumption of health care. The rights to health and health care are not mentioned.

4.2. International Finance Corporation

The International Finance Corporation (IFC) is part of the World Bank Group. It describes itself as *‘the largest multilateral source of loan and equity financing for private sector projects in the developing world’*.²⁴ (www.ifc.org).

In 2002, the IFC in Investing in private health care sees its main role as contributing “to the financial protection against ill health and to strengthening of the middle class” (IFC, 2002). The IFC states that *“because of the structure and financing mechanisms of health care systems, (it) cannot directly target the poor but rather gives loans to institutions that work with the lower-middle and middle class groups”* (IFC, 2002).

In Asia, IFC investments are concentrated in high technology and hospital healthcare projects (Table 1 p.18). Two types of Asian companies are partners in these investments: a) specific Asian healthcare companies e.g. Apollo Group of India; 2) conglomerates e.g. Lopez Group, a large diversified conglomerate in the Philippines. A recent loan to the Max Healthcare company in India is for the development of a range of healthcare facilities at primary, secondary and tertiary levels which is unusual in its focus on primary care facilities.

4.3. Asian Development Bank

The Asian Development Bank is a regional investment bank. Its health policy locates health within a social protection framework and focuses on improving the health of the poor, women, children and indigenous peoples. The Asian Development Bank also aims to support governments to *“increase public investment in primary healthcare, facilitating private sector involvement in health and public goods”*.²⁵

The Asian Development Bank wants to test *“innovative approaches to the management and financing of the health sector”* and strengthen the managerial capacity of governments, part of its support for health sector reform. It has provided loans for relatively few specific health projects and these are set within the framework of the Asian Development Bank’s social protection programme.²⁶ The amounts invested in either healthcare or social services are relatively small with most loans being less than \$20 million. Only Indonesia,

in 1998 during the Asian economic crisis, received two larger loans of \$300 million for development programmes for the health and nutrition sector and the social protection sector.

Health sector reform is the focus of one or two loans but other loans have gone to rural health, nutrition and HIV/AIDS prevention projects. However within these broader health projects there are often some elements of health sector reform. The loan for the development of rural health in Vietnam includes “*interventions to improve affordability of services by introducing innovative health financing mechanisms*” which involves a pilot model for voluntary rural health insurance. A loan for capital market development in Pakistan and the development of financial intermediaries in Kyrgyzstan show how the ADB supports the development of the private sector within the broader context of social protection.²⁷

4.4. Association of South-East Asian Nations (ASEAN)

The Association of South East Asian Nations (ASEAN) is a regional economic grouping of countries in Asia. It is active in several areas of healthcare. The ASEAN Working Group on Technical Cooperation in Pharmaceuticals (AWGTCP) exchanges information in such areas as drug safety; improving access to medicines, the Doha Declaration on the TRIPS and public health.²⁸

4.5. World Health Organization (WHO)

The World Health Organization, although the global UN agency with responsibility for public health, is often not considered as strong an influence on national healthcare systems as multilateral funding agencies such as the World Bank and International Monetary Fund. One of the areas in which WHO has had to define its role is in relation to multilateral trading agreements. It is developing work on the effect on health of GATS and other trade agreements. In relation to TRIPS, WHO set up a Commission on Intellectual Property Rights, Innovation, and Public Health in February 2004. The terms of reference of the Commission are:

- to summarize the existing evidence on the prevalence of diseases of public health importance with an emphasis on those that particularly affect poor people and their social and economic impact;
- to review the volume and distribution of existing research, development and innovative efforts directed at these diseases;
- to consider the importance and effectiveness of intellectual property regimes and other incentive and funding mechanisms in stimulating research and the creation of new medicines and other products against these diseases;
- to analyse proposals for improving the current incentive and funding regimes, including intellectual property rights, designed to stimulate the creation of new medicines and other products, and facilitate access to them, and
- to produce concrete proposals for action by national and international stakeholders.²⁹

Although WHO has developed a wide range of policies and initiatives that aim to address many of the health issues that face individual countries, its resources are often limited and its is often dependent on donor funding. There have also been criticisms of its relationships with private sector interests at an international level. A recent research report has analysed the safeguards that have been put in place within WHO to control and monitor public interests in its work with the private sector.³⁰ The report found that that although new safeguards had been introduced, they were not strong enough to mediate the strong conflicts of interest involved in working with the private sector.

The report points out that the term public-private partnerships often had three meanings: 1) a policy framework; 2) different categories of public-private partnerships or interactions, 3) a specific public-private partnership.³¹ The umbrella use of the term makes it difficult to analyse some of the processes involved. The report found that the term ‘conflict of interest’ within WHO has become taboo. Work that had been commissioned to help WHO staff deal with conflicts of interest had often not been used. The report made a series of recommendations including: that WHO abandon the partnership terminology; clarify which types of public-private partnerships allows for technical and conflict of interest assessment; hold a public review of the benefits of different global public-private health initiatives; and formulate a public disclosure policy.³²

Unless the issue of public- private partnerships and the public interest is addressed effectively, the credibility of WHO will be undermined.

Key points

- World Bank – dominance of the 1993 World Development Report on national health policies
- Some recognition of need for public services although the importance of health workers is not recognised.
- IFC investments – hospital and healthcare infrastructure to promote the private sector
- Asian Development Bank – addresses healthcare within social protection policy
- WHO - increasing work on health and trade agreements
- Inadequately dealing with public interests with public-private sector partnerships

5. Regional developments

China, India and Thailand are profiled to show some of the changes that are taking place in national health systems in Asia.

5.1. China

China has been undertaking a health reform during the past two decades. The main areas of health system reform are: development of community health services (CHS); the reform of the health insurance system; changes in regional health planning and restructuring of services; reforms to drug management.³³

In China, the health insurance system consists of two parts, the social health insurance system and commercial health insurance. There are four parts to the social health insurance system: the Urban Employee Basic Health Insurance Scheme (UEBHIS), the Rural Cooperative Medical Scheme (RCMS), the Medical Aid and the Supplementary Health Insurance Scheme. The introduction of UEBHIS, a social insurance scheme for urban workers, aims to address issues raised by the restructuring of enterprises and the increase in retired workers. The reforms are also intended to address the escalation of costs of medical care. The Urban Employee Basic Health Insurance Scheme (UEBHIS), pools risks for some urban workers, including both public and private sector employees at city level but will not cover all the urban population. Those excluded include some of the poorest urban groups, for example, older people not entitled to pensions, working age adult not in the labour force, children and students, unemployed people not entitled to unemployment benefits, rural migrants who are not registered and employed. Provinces are responsible for developing their own schemes and implementing them at municipal level.³⁴

The UEBHIS program is financed by premium contributions from employers (6% of the employee's annual wage) and employees (2% of their annual wage). Currently the same rate of premium is paid whatever the income level. The government and companies where workers used to work, pay part of the premium for retired workers. The funding is split into two elements – an individual savings account and a social pool account. There is a ceiling on expenditure at four times annual salary. Insurance covers treatment at community services as well as higher hospitals and the use of primary care facilities is encouraged by giving higher reimbursement rates. To help control the costs of the social insurance scheme, Essential Drugs Lists and Essential Services Lists have also been developed to specify which drugs and services are covered or not covered by the scheme.

Total contributions are divided into two parts: individual medical account and social risk pooling. 3.8% of the employee's wage goes into the individual medical account, which enrollees can only pay for outpatient health care expenses in public hospitals or purchasing drugs in drug stores targeted by government. The individual account is held by the enrollers themselves and the amount of the money in the individual account depends on the level of employee's wage.

If the enrollee uses up the money saved in the individual medical account in one year, they have to pay for the treatment out of their own pocket. If not, then the remaining money will automatically be transferred to the next financial year. 4.2% of the wage goes into the social risk pooling, which is used to cover inpatient

medical expenses. The social risk pooling limits its payment for each enrollee to four times the average annual wage of the workers in that city. Expenses exceeding the ceiling can be covered by supplementary insurance schemes, or be paid by the patient out-of-pocket, or be paid through purchasing commercial health insurance. By the end of 2002, the UEBHIS has covered about 94 million urban populations, approximately accounting to 19% of total urban population.³⁵

The Chinese government is also encouraging other kinds of health insurance models, including supplementary health insurance, socio-medical aid and commercial health insurance. In China, there are about 11.2 million populations covered by commercial health insurance in 2002, about 8.6% of the total population.³⁶

Since China entered the World Trade Organisation, it has started to open up its insurance market to foreign investment. It is expected that foreign insurance companies will provide supplementary insurance for urban employees, the catastrophic in-patient health insurance for non-urban residents and group health insurance for students.³⁷ As the Chinese government cuts government welfare benefits, large numbers of workers will have to provide for their own health insurance and pension costs. Health insurance companies view the Chinese insurance market as having great potential for expansion. The problem has been getting the conditions for entry right.

5.2. India

There have been extensive changes in the Indian healthcare system in the past twenty years, which have resulted in a greater involvement of the corporate sector in healthcare provision. In the 1990s several state level governments restructured their secondary level hospitals with support from World Bank loans. The funds have been used to renovate buildings, purchase equipment and drugs. Part of the restructuring introduced user fees to provide a source of revenue for the secondary level hospitals.³⁸

The corporate sector experienced growth during the 1980s but this was unevenly distributed among states. In 1973, 22.3% of total hospital beds were in the private sector but by the early 1990s, this had increased to 37%.³⁹ About 65% of private sector beds are now in urban areas. The largest part of the private sector consists of individual private practitioners both trained and untrained, who are based in both urban and rural areas. Nursing homes and hospitals are generally in the urban areas and owned by one owner or a partnership.

There has also been an increase in imports of medical technology. By 1998 several multinational companies had set up units to manufacture medical equipment, for example, ultrasounds and scanners. Multinational companies either operated alone or set up joint ventures with Indian companies. There was no public sector provision of equipment. Few limits were placed on the import of equipment and the only government requirement was that private hospitals importing equipment should provide some services free of cost to low income patients.⁴⁰

The Apollo Group set up the first corporate hospital in 1987 in Chennai. Large business groups, for example, the Tata Group, involved in hospital provision before then had set up trusts which could benefit from charitable status rather than establish corporate entities. The Apollo group first involved non-resident Indian doctors into medical care investments. Governments provided subsidised land and duty free import of medical equipment. The expansion of the Apollo Group will be discussed in Section 6.2.

The costs of healthcare in the corporate owned hospitals have increased and the costs of specific surgical procedures are often twice that of a smaller hospital or nursing home. The increased costs are partly due to the costs of imported equipment. The rising costs of corporate care have led middle and upper income groups to demand access to health insurance schemes that will cover the cost of healthcare.⁴¹

The development of the insurance sector has also been an important step in the continued privatisation of healthcare. In 1999, an insurance bill was approved which has encouraged some foreign companies to enter into joint ventures with domestic companies. However, there has still been a requirement for companies to

invest a certain amount of capital, which has acted as a barrier to entry into the Indian market for many foreign insurance companies. There is still no effective system of regulation for either hospitals or health insurance companies.

5.3. Thailand

Thailand has an increasing older population with a decreasing young population. There is an increasing incidence of non-communicable chronic diseases. However, levels of immunisation and life expectancy rates are not as high as other Asian countries.⁴² This suggests that investment in health care facilities is being made in secondary care at the expense of primary health care for the majority of the population. The increase in the number of Magnetic Resonance Imaging and CT scanners from 1990-1998 reflects this trend towards capital expenditure in both the public and private sectors.⁴³

75% of financing for public health facilities comes from public sources (including insurance) and 25% from private sources. For private health facilities, 75% funding is from private sources and 25% from the public sector. Private health facilities are located in urban areas. Public health facilities dominate the rural areas.

By 1998, the health insurance market in Thailand had started to expand.⁴⁴ However there was no national policy on health insurance and insurance-related law was out of date. Public and private health insurance schemes often overlap. For instance, members of the Civil Servant Medical Benefit Scheme can opt for treatment in private facilities if they are prepared to co-pay.

There have been debates in the last decade about the need for a new system of universal coverage. It was proposed that the Voluntary Health Care programme and the Free Medical Care Programme/ Low Income Card Scheme were merged to form a system of universal coverage for poorer people. In 2001, a new government medical plan was introduced to 44 provinces. It was aimed at poor income groups and provided treatment at a set price (30 baht) per consultation. This initiative led to an increased public concern about health and health insurance is expanding. The government has a set budget that will cover 40 million population at 1,202 baht per person per year. The total population of Thailand is 62 million.⁴⁵

In May 2002, the Commerce Ministry outlined plans to allow insurance operators to extend health and personal accident insurance to more patients from the government's medical plan. The government called a meeting with insurance companies and hospitals to discuss the possibility of bringing more customers into the health insurance system by reducing premium charges but maintaining the quality of medical treatment.⁴⁶ A working committee was set up to calculate standard medical charges by applying a DRG (disease-related group) formula and so calculate a central payment price. The committee included representatives from five private hospitals: Bumrungrad, Bangkok Nursing Home, Bangkok Christian, Vichaiyudh and Lertsin, along with the life and non-life insurance associations, Bupa Blue Cross and Thai Health Insurance Co.⁴⁷

A law on national health insurance was passed in 2002, which set up a National Health Insurance Fund together with policies and guidance for health insurance scheme implementation. A National Health Insurance Office was established as an autonomous agency, governed by a Board chaired by the Minister of Public Health. This is a significant development in making healthcare accessible for a large part of the population.

Key points

China – introduced a new system of social insurance and trying to promote a growing private insurance market

India – the expansion of the corporate sector has influence the public sector.

Thailand – also introduced a new social insurance scheme to widen access to healthcare

6. Multinational healthcare companies

A group of multinational companies involved in health insurance and healthcare provision are outlined below.

6.1. Allianz

Allianz is a global insurance, banking and investment company. In 2002 the company made substantial losses globally and has been restructured since then. It views health insurance as an area of expansion.

In Asia, it has subsidiaries in Australia, Brunei, China, Indonesia, Japan, Laos, Malaysia, Pakistan, Singapore, South Korea, Taiwan and Thailand. Its Australian subsidiary is its largest in Asia. In March 2003, Allianz launched its business in China, which is currently limited to Guang Zhou.⁴⁸ The company is aiming to expand its business throughout China in the medium term. In India, Allianz is involved in a joint venture.⁴⁹ Korea and Taiwan provide the largest revenues for the company in Asia. It has withdrawn from the Singapore insurance market because of depressed long term prospects.⁵⁰

6.2. Apollo hospital group

The Apollo hospital group was set up in 1987 as one of the first corporate hospitals in India. It has since expanded throughout Asia. It owns a network of 34 hospitals in several Asian countries.⁵¹ Most important, is the range of activities that the company has diversified into. It has been a leader in the development of medical tourism in India. In 2004, it established its first health insurance company, which is an example of a company expanding into both health insurance and healthcare provision.⁵² The company plans to buy three more hospitals overseas where it will employ Indian health staff.⁵³

In December 2004 it announced that it was negotiating a contract for medical business process outsourcing with a New York teaching hospital. This will include billing and coding operations and claims processing.⁵⁴ It is also involved with telemedicine, education and training, home healthcare and hospital project management.

6.3. BUPA

BUPA is an example of a non-profit company set up in 1947 in the United Kingdom (UK) at the time that the National Health Service was established, to provide health insurance and healthcare services for privately insured patients. BUPA has expanded into South East Asia in the last 15 years and recognises that its expansion depends on a growing middleclass demand for healthcare. BUPA has taken advantage of the opportunities for private sector provision of primary care as well as expanding its health insurance activities.

BUPA entered Thailand in 1996 when it joined with Blue Cross. Blue Cross was a Thai company founded over thirty years ago that became Blue Cross in 1985. BUPA Blue Cross is a provident association, which reinvests profits into the business. BUPA Blue Cross has between 65% and 80% of the Thai health insurance market. The company has contracts with 119 hospitals and about 100 clinics. It provides insurance coverage for at least 1,500 firms and 8,000 individual members. It has offices in Bangkok, Pattaya, Phuket, Chiang Mai and Nakhon Ratchasima.⁵⁵ Although BUPA Blue Cross has a large percentage of the health insurance market in Thailand, it is in competition with life insurance companies that also sell health insurance policies as part of their life packages.

BUPA has been expanding into both health insurance and healthcare provision in Asia over the last few years. In 2001, BUPA bought Vista Healthcare in Asia which has contributed to BUPA's expansion in the Asia market. In 2002, BUPA together with Macquarie Bank bought AXA Asia Pacific Holdings, a health insurance in Australia. It is now the third largest private health insurer in Australia. BUPA owns half the business.

6.4. Cigna

Cigna is a US insurance multinational company, which is active in South Korea, Hong Kong and Taiwan as well as the United Kingdom and Spain. It provides individual and group life insurance, accident and health insurance. The Cigna group also provides benefits for expatriate employees of multinational company in many countries.

Cigna's health insurance products mainly provide indemnity insurance, with some products subject to managed care schemes. These health insurance products usually provide an alternative or supplement to government provision. Health insurance includes life and medical insurance products that are provided through group benefit programmes as well as medical insurance products that are marketed directly to individuals.

In 2002, a year after China joined the World Trade Organisation, Cigna was the first company to receive formal approval from the China Insurance Regulatory Commission to enter the Chinese life insurance market, and the following year, it formed a joint venture to sell insurance products in Shenzhen, China. In 2003, Cigna sold its Japanese pension operations.⁵⁶

6.5. Fresenius

The main activity of the German company, Fresenius, is the manufacture of equipment and products for renal care. It is a key player in the global medical devices industry.. The global medical devices industry is highly competitive, and manufacturing of kidney dialysis equipment has currently little scope for innovation. Fresenius views health care delivery as an area of potential expansion. In 1997 it began to run renal dialysis clinics, and health care activities are now its largest division. It aims to *'become a large international health care company'* arguing that globally *'due to the expected privatisation of health systems we will have good opportunities to build up a company that can command a leading position in the hospital field'*⁵⁷.

The company provides kidney dialysis equipment, products and services through three divisions. Fresenius Medical Care runs 1,300 dialysis clinics worldwide. Fresenius Kabi, provides products for nutrition and infusion therapy, blood treatments and some outpatient care. Fresenius ProServe, provides management services such as project development, consulting, and staff training to hospitals and other health facilities. Vamed is part of the Proserve healthcare management division of Fresenius. It has been involved in planning, building and equipping hospitals in both the public and private sectors in several Asian countries, for example, China, Indonesia, Malaysia, Vietnam during the last decade.⁵⁸

The majority of renal care patients are found in Latin America and Asia but renal care companies only treat 5% of patients in these regions. This is almost certainly due to a lower rate of diagnosis and more limited access to health services. Type 2 diabetes is the leading cause of end-stage renal disease. The incidence of type 2 diabetes is expected to increase in the coming decade, especially in China and the Indian sub-continent. It is closely linked to increased rates of urbanisation and changing patterns of nutrition characterised by higher consumption of refined foods including sugars and carbohydrates. The demand for renal care will increase.

Fresenius has already targeted Asia as an area of expansion. In 2003, the Asia region (excluding Japan) had the strongest rate of growth (5.8%) with China and India contributing most to growth. 5% of the company's 66,264 employees work in Asia and the region's revenues increased by 7%.

China is currently one of the most important markets for Fresenius Kabi in the Asia-Pacific region. Two joint-venture companies, Sino-Swede Pharmaceutical Corporation (SSPC) and Beijing Fresenius Kabi Pharmaceutical (BFP), employ about 1,000 people in China. SSPC was founded in 1982 and was the first Chinese-Swedish joint venture. Fresenius has owned 51% of the shares since 1998. SSPC manufactures infusion solutions for parental nutrition here. Fresenius owns 65% of the shares. SSPC exports products to Asian countries and to Europe. Fresenius has two other subsidiaries in India and Korea.

6.6. Parkway Holdings

Parkway Holdings is a multinational company based in Singapore, that operates hospitals, healthcare centres and laboratories in Singapore, Malaysia, Indonesia and India. It has attempted to expand into several Asian countries. Tony Tan, formerly the managing director of Parkway Holdings until 1999 when he sold a 19.6% stake to Schroeder Capital Partners Asia, has recently returned as deputy chairman. He outlined some future directions for the company. It is expected to expand its primary healthcare network in China and Vietnam “where income is growing and health care service is low” in order to get referrals for its hospitals. There will also be more joint ventures e.g. with PWD Corp to provide management contracts for hospitals and basic health care services. Tony Tan said “we plan to tie up with the Singapore government and see them as partners rather than the competition”.⁵⁹

An example of a subsidiary that failed to thrive was the London Heart Hospital. In August 2001, Parkway Holdings sold its only European subsidiary in the UK, the London Heart Hospital to the NHS. The London private health care market is more competitive than in the rest of the UK, partly due to the competitive role that Private Patient Units (PPUs) of NHS hospitals play.⁶⁰

The corporatisation of public hospitals in Singapore and Malaysia has led to increasingly intense competition between public hospitals and private sector providers for private patients. Parkway sees government services as potential competition in its target for high income private patients, though it is also taking advantage of the Singapore government’s policy of outsourcing some clinical services.

Parkway has also started to run its own managed care programme (combining insurance with provision of care) in a joint venture with Allianz, a large European insurance company, three years ago. Parkway now has 40,000 members in Singapore and is hoping to expand this programme to Malaysia and Indonesia in the future. It is currently finding out how many members are needed to break even, and is targeting ‘high end’ patients. Parkway views the expansion of private health insurance and private health services as complementary market processes.⁶¹

The company is also investing in new hospitals in India and Brunei Darassulam. In India, Parkway Holdings through its unit Gleneagles Development had made a shareholders agreement with Apollo Hospitals Enterprise Ltd from which Apollo had acquired Duncan Industries 50% stake in Duncan Gleneagles hospital in Calcutta, India. Gleneagles Development now has a 51% stake in Duncan Gleneagles and Apollo has 49%. Gleneagles will provide a 10 million Singapore \$ loan to Duncan Gleneagles. When this is repaid, Gleneagles Development will transfer 1% of its stake to Apollo and the two companies will own the new hospital jointly.⁶² The new hospital is seen as the “central health hub for Bangladesh, Myanmar and Bhutan”.⁶³ This has taken over a decade to achieve. Gleneagles Development had initially gone into partnership with the Duncans group. Duncans left the project two years ago over financial differences and Apollo has taken their place.

Key points

- Company expansion in both health insurance or health service provision is not always successful
- China and India health insurance markets are seen as potential growth areas
- Renal care has the potential to expand with growing rate of type 2 diabetes
- Some healthcare companies are diversifying in to a wide range of activities

7. Trade union action

Health sector trade unions have responded to the increased commercialisation of healthcare with a variety of actions and strategies. In some countries, health trade unions have taken action in alliance with other trade unions and civil society groups and have developed longer term coalitions to fight for improved health

services. Whatever the success of specific actions, there is a continual struggle for improved health services and improved pay and conditions for health workers.

7.1. Campaign for improved health services

In 2004, the Bangladesh Diploma Nurses Association has been active in a campaign to improve health services, nursing standards and preventive health services, particularly in rural communities. The association developed an 11 point platform of demands which includes demands for increases in public health funding, for new nursing posts that would help to improve nurse to patient ratios, to establish new nursing colleges and improvements in pay and terms and conditions of employment. As a result of this activity four members of the union have been transferred to work out of Dacca in a remote rural health centres which is seen as intimidation against the union.⁶⁴

7.2. Campaigns against privatisation and corporatisation

The Malaysia Citizen's Health Initiative (CHI), which was launched in March 1998 and describes itself as an "informal grouping of organizations and individuals seeking to promote greater community involvement in healthcare reforms, and more generally in matters of health policy". As an alliance of trade unions and civil society groups, it won a campaign to stop the privatisation of public sector hospitals in Malaysia in May 1999.

The Malaysian TUC played an important role in the campaign to stop hospital privatisation by collecting 10,000 signatures which were delivered to the Health Minister at the beginning of the campaign. CHI marshalled intense public pressure on the government to stop the corporatisation of state-run general hospitals. The signature campaign began in late May when doctors at a state-run general hospital in Ipoh city, circulated a letter to the health minister expressing concern over the privatisation of general hospitals. Soon after, more than 80 doctors at the city's hospital had endorsed the letter. Another 80 doctors attending the Malaysian Medical Association's annual general meeting in Penang in May added their signatures to the petition. The Malaysian Medical Association (MMA), representing 80% of Malaysia's doctors called for a moratorium on corporatisation, supported by its members. The Malayan Nurses' Union, representing government service nurses, and the Estates Hospital Assistants Association of Malaysia supported its demands. They declared "scepticism and apprehension about the benefits of corporatisation".⁶⁵

In South Korea in 2002, KCTU conducted a sit-in at Jongmyo Park in Seoul and more than 5,000 union members paraded after the sit-in. The KCTU called for the withdrawal of privatisation plans for state-run enterprises and protested the introduction of a five-day working week.⁶⁶

7.3. Rights of workers and terms and conditions

In June 2000, 500 ancillary workers from the laundry, catering and gardening areas at Princess Alexander Hospital, Queensland went on strike because of the increased use of casual and contract labour as well as under-staffing, high workloads and low pay.⁶⁷

On 13 June 2001, South Korean health workers joined airline workers and manufacturing workers in strikes with demands for pay increases and an end to government-led economic restructuring that has led to thousands of job losses.⁶⁸

On 23 May 2002, the Korean Health and Medical Workers' Union (KHMWU) launched strikes in 16 hospitals. Two hospitals staged full-scale walkouts, while workers at 13 hospitals took part in partial strikes. Union members called for more staff, demanding that the distinction between full-time and part-time workers be abolished.⁶⁹

8. Conclusions

- This is a period of rapid change in national healthcare systems.
- National governments are reviewing how healthcare is financed which is leading to the development of new social insurance schemes and the encouragement of private health insurance
- Corporatisation of healthcare institutions has a significant influence on health workers and blurs the lines between public and private sectors.
- Increasing commercialisation of healthcare leads to healthcare being seen as a service that can be bought and sold not as an essential right for the population.
- Trade agreements also strengthen the view of healthcare as a commodity.
- Health insurance and healthcare provision are both seen by multinational companies as having potential for growth but the process of market expansion is not easy
- Trade unions continue to struggle to maintain pay and conditions and improve working conditions.

Table 1: International Finance Corporation (IFC) investments in Asia)

Name	Loan/ total budget	Project description	Sponsors/ investors
Franco-Vietnam Hospital, Vietnam 2001	\$8.0m Total budget \$40.0m	A new tertiary hospital in Ho Chi Minh City.	Asian Development Bank, Bank for Investment and Development of Vietnam, Proparco (private of Agence Francaise de Developpement)
Philippines Asian Eye Institute (AEI)	Total budget \$4.2m	To establish the first centre providing a complete range of services for diagnosis and management of eye diseases.	Main sponsor : Lopez Group (the largest diversified conglomerate in the Philippines) through First Philippines – a holding company of the Lopez Group – other subsidiaries/ affiliates of the Lopez Group
Wanjie Cancer Hospital, China	\$15m Total budget \$59.0	Expansion of cancer centre includes the installation of a Proton Treatment System (PTS) to be housed in a new 600 bed facility.	Zibo Wan Jie Tumor a wholly owned subsidiary of Wanjie Ind Co.Ltd - a flagship company of the Jie Group a non-state, limited liability company
Asian Hospital, Philippines	‘A’ loan \$10m from own account ‘B’ loan \$10m from accounts of participating banks ‘C’ loan \$5 m convertible loan Total budget \$91m	To construct and operate a 247-bed private tertiary hospital.	Vista Healthcare Pte.Asia Ltd Dr. Jorge Garcia and Ms. Evelyn Singson
Apollo Sri Lanka Hospital	Considering a \$5m loan, and \$1m equity/ quasi equity loan Total budget \$32m	To establish a 350-bed private hospital in Colombo	Apollo Hospital Group of India. Indian Hospital Corporation Ltd will help to design and manage the project
Duncan Gleneagles Hospital, India	\$7m IFC loan and equity investment \$1m Total budget \$29.4	To establish a 270-bed private hospital in Calcutta.	A joint venture between Duncans Goenka India and Gleneagles Development Pte.Ltd . Gleneagles Management Services Pte.Ltd will manage the hospital
Siliom-Glneagles Hospital, Indonesia	‘A’ loan \$8.3m quasi-equity loan \$3.6 Total budget \$48m	To provide high-quality hospital care to residents of Greater Jakarta seeking private health care.	Glneagles Hospital Company is the technical partner with 30% ownership 70% owned by Lippo Land , Indonesian developer company publicly traded
MedCen Samoa Ltd	‘A’ loan \$8.3m and quasi equity \$3.6m Total budget \$48m	A start up business which will include 22 private bed hospital	IFC’s Pacific Islands Investment facility
Max Healthcare 2003	Total budget \$84million	To establish and operate a comprehensive network of healthcare facilities in New Delhi and its neighbouring townships, India, including 16 Dr. Max primary care clinics, five "Medcentres" (30/40-bed short-term stay secondary care nursing homes with complete range of diagnostic services), and two tertiary level hospitals (a 212-bed multi-specialty hospital and a 150 bed super-specialty hospital).	Max Healthcare Institute Limited (MHIL or Max Healthcare), a wholly owned subsidiary of Max Institute Limited (Max)

Source: www.ifc.org/projects/

Table 2: Asian Development Bank healthcare loans

Country	Programme	Details	Date	Amount	Partners
Mongolia	Health sector development To help the Government in implementing health system reforms and investment that will improve effectiveness, efficiency and sustainability of health services	Policy reforms, investments and technical assistance	1997	\$15.9	-
Vietnam	Rural health To provide primary and preventive health care to the poor and disadvantaged, including ethnic minorities, women and children, in the rural areas of 13 provinces of Viet Nam	To improve access to health services by upgrading health centres in rural areas. To enhance the skills of health care service providers. To strengthen demand for health services through targeted information, education and communication activities, improved community participation and more equitable health financing. To support the Government's scheme to provide free health cards to the poor. To support preventive health care through strengthening of food safety infrastructure and behaviour change communication.	2000	\$68.3m	UNFPA, UNICEF WHO Co-financing partners
Philippines	Early childhood development The Project will develop, provide and promote an integrated set of early childhood development service delivery packages to address the health, nutrition, cognitive and psychosocial development needs of children under six at various stages of growth and development	There are three components: (i) early childhood development service delivery - programme support for provinces and local government unit financing facilities for municipal/ city projects; (ii) support for service delivery; and (iii) research and development.	1998	\$24.5	
Indonesia	Health and nutrition sector development Policy measures to help alleviate the impact of the crisis on the most vulnerable groups while laying the foundation for longer term, sustainable reform in health services delivery.	The policy reforms concentrate on four broad areas: (i) maintaining access and equity (regional and socio-cultural), especially for the poor; (ii) maintaining quality; (iii) enhancing decentralized management; and (iv) improving efficiency	1999	\$300	
Central Asian Republics	Asian countries in transition for improved nutrition for poor mothers and children To reduce the prevalence of iodine deficiency disorders and iron deficiency anaemia in ACT, thereby reducing prevalence of poverty	To test an umbrella regional program for delivering micronutrient-fortified salt and wheat flour to the populations of participating Asian Countries in Transition (ACT), Azerbaijan, Kazakhstan, Kyrgyz Republic, Mongolia, Tajikistan, and Uzbekistan.	2001	\$6.85	

	through raised intelligence, improved learning, and greater productivity.				
Greater Mekong Delta	Community action for preventing HIV/AIDS Support HIV/AIDS prevention in strategically important areas for the transmission of HIV in the region	Strengthen capacities of the national and local HIV authorities and selected NGOs for the development of community based prevention and care programs	2001	\$7.0	

Source: www.adb.org

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