The influence of equity on health reform: an analysis of the reform process in Thailand and the Philippines

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Masters of Science in International Health
27 August 2007 – 5 September 2008

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A thesis submitted in partial fulfillment of the requirement for the degree of Masters of Public Health

By

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KIT (Royal Tropical Institute of t)/Vrije Universiteit Amsterdam,
Amsterdam, The Netherlands.

August 2008.

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KIT (Royal Tropical Institute), development Policy & Practice
Amsterdam, The Netherlands.

In Co- operation with:

Vrije Universiteit Amsterdam/Free University of Amsterdam (VU)
Amsterdam, The Netherlands.

Acknowledgements

Gratitude to the Erasmus Mundus Programme for the opportunity

Gratitude to my thesis adviser and our programme coordinator for the support and encouragement

Gratitude to Margarita for being a patient and persevering partner

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Abstract

In both Thailand and the Philippines, health equity is one of the articulated goals of health reforms. The widening disparities in health outcomes that disadvantage the poor caught the attention of policy makers, spurring them to take action. This paper takes particular interest in the reform initiatives of the two countries. It is interested in understanding the drivers of health reforms and how influential equity is in framing the reform policy process. Looking at Thailand and the Philippines' rationale for health reform as well as their contents and accompanying policy development processes, there are clear indications that equity influenced health reforms in both countries. Equity's influence was expressed in two ways. It is very overt in the Philippines, expressed as a clearly stated objective for a well-recognised problem, and implicit in the Thailand as a value that pervades health system development and policy process. While equity is organic in Thai health reform, equity influences health reform in the Philippines in so far as it is a political commitment of the government and safeguarded by a sustained civil society advocacy. Also, equity framework for both countries hinges on poverty and disadvantage is defined in terms of individual economic incapacity. Consequently, equity mechanisms that are intended to favour disadvantaged groups are built around poverty issues and do not nuance other special concerns. It is suggested that additional studies supplement this research with a review of additional policies to draw a complete picture of the influence of equity in the health system.

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Introduction

Since the Alma Ata declaration of 1978, no other policy document has had a more profound effect on health systems than the 1993 world development report of the World Bank (WB). The effect has been fundamental in that it changed the health system blueprint and redefined the role of governments in health provisioning. With WB's engagement in the policy discussion, health became an economic issue – an investment assessed in economic terms in the context of free markets. Cost-effectiveness and efficiency became assessment parameters and health sector reforms were subsequently initiated along these lines. Meanwhile, the WHO responded by recommending that governments reorganise their ministries and concentrate on providing the rationale for the national health agenda, allowing participation of other players and subsequently directing the activities of the health system (WHO 2000). WHO's recommendation is a move away from the traditional role of governments as the main provider of services.

Although governments withdrew from providing most services and streamlined operations, equity is still regarded as one of the key metrics against which health system performance is evaluated. Egalitarian ideals continue to assert themselves as universal principles and shape public expectations. Since health systems are traditionally expected to be equally distributive, realisation of equity is desired alongside health system efficiency. The WHO continues to assign this accountability to governments, which have consequently been made to balance between instituting reforms that maximise benefits with minimal cost and attaining equitable health care.

It has been nearly fifteen years since countries in the developing world were introduced to health sector reform and states are still groping with attaining health equity. In fact, evidence from research illustrates significant health disparities even when reforms have been instituted (Blas and Hearst 2002; Commission on Social Determinants of Health 2005; Flores 2006; Mackintosh 2006; McIntyre et. al 2007). Policy discourses have therefore tended to look at health sector reform and the health system as determinants of health disparities. While they can be means to achieve equity, they can also unfairly exclude and marginalise population groups and privilege others. This paper takes particular interest in the reform initiatives of Thailand and the Philippines. Both countries commenced reforms about the same time on the basis of inefficiencies and inequities. The paper looks at how both governments have used their respective reform policies to address the problem of health inequity. It particularly investigates how equity dominated the reform process given local contexts and the influence of international discourses. Interestingly, the two countries created different policy tracks with distinctly different outcomes.

A. Statement of the problem

Health reform in Thailand is interesting in that it happened consequent to the establishment of the new constitution. Health system reform was part of the overall plan to restructure the relationship of the state and civil society and to consequently "democratise" the development process (Phoolcharoen W. 2001). The Philippines' health sector reform, in contrast, did not correspond to any momentous historical event and may be considered business-as-usual. Problems related to public health spending compounded by weak management systems, confronted the health sector and drove reforms. It became significant when the decline in infant and mortality rate slowed in the last decade leaving the Philippines lagging behind other countries in the region in health performance. In large measure, reform is a result of an introspective evaluation of the health sector. (Department of Health 1999).

In both Thailand and the Philippines, health equity is one of the articulated goals of health reforms. The widening disparities in health outcomes that disadvantage the poor caught the attention of policy makers, spurring them to take action. The causes of disparities go beyond the health sector. In both countries, aggressive attempts to transition their economies to an export-oriented manufacturing and service industry exacerbated gaps in the socio-economic conditions among population groups causing uneven distribution of income, widening differences between rural and urban development, neglect of the agriculture sector and eventually an erosion of social services that further aggravated the conditions of the poor. It is important to note that health disparities follow this pattern of widening differences. In this regard, health reforms can be seen as strategy to mitigate health disparities in a changed economic environment. Thailand and the Philippines, in particular, formulate their own versions of health reforms that adapt to economic realities while maintaining egalitarian ideals. Health reform has therefore been a process of policy development. Noting Cassels (1995), it is a political process of striking a balance between the technical and do-able on the one hand, and public expectation and political interest on the other.

This process of policy development is what this thesis intends to investigate in health sector reform. It is interested in understanding the drivers of health reforms in Thailand and the Philippines and how influential equity objectives are in framing their respective policies. The overall objective of this thesis therefore is to determine the degree of influence the value for equity has in developing the health sector reform policies in Thailand and the Philippines. The thesis correspondingly has the following specific objectives:

1. To investigate the rationale of health sector reforms in Thailand and the Philippines and the equity issues that underlie it;
2. To analyse the process of reform, the political and social contexts within which it was put forward and the actors who drove it;
3. To describe the content of policies adopted by the two countries to ensure equity of the reformed system in improving health, responding to people's expectations and providing financial protection against cost of ill-health;
4. To examine the use of equity parameters to monitor performance of their respective health systems; and,
5. To derive lessons from the two countries' experiences in dealing with equity in health system reform.

This paper maintains that health sector reform is a mechanism devised to improve health system performance adapted to current realities. Whereas there are several aspects of health system performance, equity could be overshadowed by other

reform objectives such as efficiency. This paper is specifically interested in looking at how deliberate reforms are in guaranteeing performance in equity. In establishing this, the countries' rationales for reform are analysed as well as the political and social contexts that underpin them. It looks at their understanding of the health system, appreciation of determinants of health inequality and knowledge of people's expectations. Moreover, it investigates whether equity drives political interests and forms public expectation. Contents of the two reform policies are likewise assessed as to how many times and how thoroughly equity is discussed. Finally, it is determined whether this is monitored together with other health system performance indicators. Suffice it to say, the degree that equity influences reforms is determined by how much it is made explicit in guiding health system functions i.e. in improving health status, responding to people's expectation and providing financial protection.

B. Clarifying the concepts

Discourse on health equity has always been discussed in relation to health equality – succinctly they are posited as different but related concepts. Equality most often refers to empirical evidences of differences in health determinants and outcomes among individuals or subgroups. This is pretty straightforward and established on the basis of statistics. Given inherent differences in living conditions, structures of societies as well as biological make up, inequalities are assumed to be omnipresent. Inequity is assumed when unfair treatment explains inequality. Precursory discussions on equity relate to ethical considerations in addressing health disparities among population groups. Notable is the Whitehead (1991) definition of inequity, which has become standard – differences that are unfair and unjust. Although it gives us a starting point, this definition is elusive as the concepts of justice and fairness are elusive. It is problematic because it is subject to value judgement, which makes it inherently normative.

Current discourse on health equity attempts to show how injustice and unfairness are demonstrated. Discussions by the International Society for Equity in Health (ISEqH) are particularly worth mentioning. They ascribe equity to the absence of remediable differences in health conditions across population groups (ISEqH 2005). Here the clear qualifier for inequity is the persistence of inequality even when conditions enable corrective interventions, which is also the definition the WHO maintains (WHO 2008). This definition is used here to surmise that health systems, as they are organised, could themselves be used to advance equity. We follow the definition of Braveman and Gruskin (2003) to explain this argument. To use their words: "equity in health implies resources are distributed and processes are designed in ways most likely to move toward equalising the health outcomes of more disadvantaged social groups with the outcomes of their advantaged counterparts" and that "this refers to the distribution and design not only of health care resources and programmes, but of all resources, policies and programmes that play an important part in shaping health."

It is essential at this point to clarify what makes up health systems. WHO (2000) defines a health system to "include all activities whose primary purpose is to promote, restore and maintain health." This catch-all phrase encompasses not just formal health services but also traditional healing, home care and other activities that directly aim health improvement (e.g. health-related education). However, the delineation of a health system is muddled when discussed in the context of health sector reform. For one, it is unclear whether the health sector embodies the health system or is only a component of it. International organisations even have particular preferences in referring to what should be the object of reform: the health sector to the World Bank, which is health system to the WHO. The Cambridge dictionary

defines a sector as “a part of society that can be separated from other parts because of its own special character.” The examples given are non-profit sector, farm sector, public/private sector, which are all characterized by their economic activities. It is understandable that the World Bank would tend to categorise health sector as such. On the other hand, system connotes interrelated structures that operate together, an image that WHO has of health systems. While the WB sees a closed well-delineated system, WHO maintains that health systems are open and dynamic. Naturally, proposed policy reforms differ in scope between the two organisations.

C. Methodology

To attain the research objectives, this paper conducted a review of policy documents on health reform in Thailand and the Philippines. The main documents reviewed were those available in English and posted on websites of government agencies namely the Ministry of Public Health, the National Health Commission and Health Systems Research Institute in Thailand and the Department of Health in the Philippines.

Thailand conveniently provides English translations of its health agencies websites. The National Health Commission website has most of the documents on reforms. These are the policy documents that are investigated in this paper. Wasi’s “Triangle that moves the mountain” (2000) gives a theoretical framework for health system reform. Phoolcharoen’s “Thailand’s health system reform” (2001) details the context and the process of reform as well as Chuengsatiansup’s “Deliberative action: civil society health systems reform in Thailand” (2005). The most significant document is the National Health Act of 2007, which enumerates the principles of reform. Other documents reviewed were the Health Policy document and Thailand Health Profiles for 2001-2004 and 2005-2007, which contain chapters on health reforms. Assessment of health sector reform in the Philippines is based on two official documents of the Department of Health. The department released a strategy paper in 1999 when it launched the health sector reform agenda. The strategies, however, have since been updated and incorporated in the National Objectives for Health, which is the other document that this paper reviewed. This paper also extensively referred to the Department of Health official website. The website provides reference links to the department’s legal mandates, executive orders and memoranda. A number of them were consulted because they were cited in the health sector reform documents.

Only the policy documents that explicitly relate to health reform were reviewed. While in the Philippines health reform covers the entire health system, Thai policy documents do not account for most activities of the health system making reform seemed like a separate initiative. In such a case, programme strategies were assembled from several policy documents to create the policy reform framework. This is accordingly noted in the discussion. It is clarified at this point that policies are discussed here as they appear in writing and might not reflect actual coherence when practiced. With the same caveat, this paper recognises that not all policies are effectively actualised.

Discussion of policy contexts and actors is supplemented with journal articles and books that are electronically available in the Internet. They were screened and selected for their relevance following an Internet search using Google Scholar. The key words used are shown in Table 1.1.

Table 1.1 Key words used in Internet search

Topic	Key words
Policy context	Health sector reform+Thailand/Philippines Health equity/equality/disparities+Thailand/Philippines Development plan+Thailand/Philippines Social development plan+ Thailand/Philippines Governance+ Thailand/Philippines Culture of politics+ Thailand/Philippines Public health culture/history+ Thailand/Philippines History of Medicine+ Thailand/Philippines Social equity+Thailand/Philippines
Policy actors	Politics+Thailand/Philippines Civil society representation+ Thailand/Philippines Social contract+ Thailand/Philippines

Data is presented and analysed following the matrix below. Table 1.2 shows the formats in presenting findings and analytical models that were used to ascertain equity's influence in the specified areas of investigation.

Table 1.2 Framework for data analysis

Research objective	Formats used in presenting findings	Analytical models used in the discussion
To investigate the rationale of health sector reforms in Thailand and the Philippines and the equity issues that underlie it	Use of equity to justify reforms	McIntryre and Gilson (2002) to identify whether equity is prioritised
To examine the use of equity parameters to monitor performance of their respective health systems	Use of equity parameters in assessing health system performance	
To describe the content of policies adopted by the two countries to ensure equity of the reformed system in improving health, responding to people's expectations and providing financial protection against cost of ill-health	Specificity of content to equity; explicit equity statements; equity dimensions	Daniels benchmarks of fairness (2005) in WHO's functional framework of health systems (2000)
To analyse the process of reform, the political and social contexts within which it was put forward and the actors who drove it	Society's value for equity; ccurrence of equity in the policy-making process; policy actors' interest in equity	Enabling factors that favoured equity

This paper looks at six elements of the reform policy process: rationale, content, context, actors, policy-making process and performance parameters[1]. The influence of equity in each element was established by organising data in specific formats. The paper examines whether equity was cited in the rationale of reform and accordingly

[1] Walt and Gilson (1994) identified four elements of policy analysis: content, context, actors and policy-making process. Rationale and performance parameters are added to further ascertain the influence of equity.

measured as a performance parameter. Reform strategies and policy statutes are examined based on their specificity or explicitness to equity. Also, equity dimensions of programmes are investigated. Finally, it is shown how equity's influence is reinforced by society's values, policy actor's interest and its occurrence in the policy-making process. Some of these data is presented in tables for better clarity. Findings are subsequently synthesised using the analytical models shown in Table 1.2, which are discussed separately in Chapter 5. The corresponding discussions are in three sections that deal with equity in the health development construct, as a component of the health system and as enabled by specific factors.

The conclusion comments on the extent of influence equity has on both countries reform processes as can be drawn from the findings and analysis of data. The recommendations answer the final objective by identifying key areas in reform that have relevance to other countries as they institute equity. They are emergent issues from the literature review and recurring themes in the discussion.

D. Significance of the study

This paper gives particular attention to equity with the intention of adding to the ongoing discourse on health system as a determinant of health disparities. Health outcomes are perceived here as being influenced by several factors, the health system being one of them. Proponents of reform claim that reforms make health systems more equitable. What is interesting is that, despite the best efforts of governments and international organisations, developing countries' health system reforms are still not able to achieve a satisfactory degree of health equity. Several studies give evidence of this – one well worth mentioning is the research done by McIntyre et. al (2007), which established that a significant number of low-income and middle-income countries are failing disadvantaged groups. There are a number of reasons that can explain this performance of the health system. The one that this paper investigates is health policy. It investigates this track because policy development has been one of the key instruments used in pushing for reforms of the health system. This is to say that policies are considered valuable tools in achieving equity.

This paper posits that analysis of the policy process offers a supplementary explanation to the performance of health system in equity. It follows from the argument of Walt and Gilson (1994), which insisted on the value of looking at policy processes in order to understand the eventual reform policy outcome. They argue that reform undergoes a process of negotiation and is more as a result of a political compromise than a rational debate. It is in this vein that they cite the importance of understanding the context of reform as well as the policy actors and the processes that transpired. This is meaningful considering that multiple forces shape governments and the way they institute policies as underlined by Reich (2002). It illustrates that even when policy instruments are available from international discourses, the process by which they are incorporated by governments may change their makeup. In effect, the equity objective of reform also undergoes the same process of rationalisation and negotiation when they are adopted. This paper follows the influence of equity as they are adopted as objective of health reform and eventually either internalised or just dealt with. It effectively proposes an additional methodology in assessing equity of health systems, which is established by investigating the extent that equity influenced policies and contingent processes that guide the system.

The paper accordingly situates the discussion in the context of two countries' health reforms. The choice of the Philippines is circumstantial since this is familiar to the

author having lived and worked there. Thailand was chosen because it has relatively the same socio-demographic as well as economic profile. Both countries also began a series of health reforms at about the same time. Although one might expect the findings to be similar, the country choices in fact give good contrast to the study as they differ in health outcomes despite the similarities of their profiles, with Thailand besting the Philippines in most indices. Again, it is noted that there are a number of factors that impact on the two countries' health system performance. They are discussed here is in so far as they relate to equity and they are discussed in the reform policy. Otherwise, they are beyond the limits of this research and are recommended for a separate study recognising their equal importance. Although experiences of the two countries in dealing with equity in reforms are context-specific, there are some elements in their policy processes that are potentially relevant to other countries. These are drawn as part of the recommendations of this paper.

Chapter 2 – background

A. Country profiles: Thailand and the Philippines

Thailand and the Philippines are both situated in Southeast Asia, but other than the climate, they are different in many ways. Countries in Southeast Asia come from a variety of ethnic origins, and have diverse colonial backgrounds, histories and culture. Comparing Thailand and the Philippines offers a variety of contrasts. Thailand lies in a peninsula and is in an area that connects to mainland Asia and juts down to the South China Sea. The people are believed to have descended from the Austroasiatic stock. The Philippines, on the other hand, is part of Insular Southeast Asia, and together with Indonesia, forms a string of islands to the south and east of the Asian mainland. Their inhabitants are supposed to have come from the Austropolynesian stock (Columbia Encyclopaedia 2004). While Thailand experienced Hindu and Buddhist influence from the north, the Philippines had Islam introduced in the south. However, the rest of the Philippine islands had their own local religions as well as a localized social structure and economy that was variable between and within them (Encyclopaedia Britannica 2008) until the introduction of Catholicism.

The Philippines is the only country in Southeast Asia that did not have the opportunity to develop a centralised government nor a dominant culture prior to being colonised by the West. This is in stark contrast to Thailand, which had an established kingdom (Sukhothai) as early as the mid-13th century. In fact Thailand, is the only country in the region that boasts of never having been subjected to Western colonial domination (Encyclopaedia Britannica 2008b). The two countries therefore treaded two very different paths in terms of history and cultural formation. Perhaps the only period in history that the two nations shared is when they became pioneers of the Association of Southeast Asian Nations in 1967.[2] Since then, diplomatic relations have been constant and economic cooperation has practised between them. Interestingly, both countries have the same economic framework and similar social objectives, especially since the advent of globalisation. Not surprisingly, they are both members of the World Trade Organisation.

Below are the countries' relevant statistics lifted from the WHO database. It is evident here that Thailand fares better than the Philippines in most health indicators as well as with other measures. Thailand demonstrates this even when compared to other countries in the region. It has the lowest maternal mortality rate, birth rate, total fertility rate and percentage of under-weight children.

Table 2.1 Relevant statistics: Thailand and the Philippines
(2006; 2006b; SEARO 2008)

	Thailand		Philippines		SEARO best performance
	Year	Available Data	Year	Available Data	
Total population	2005	64.233.000	2005	85.236.913	
% under 15	2006	22	2005	35	
Population distribution % rural	2005	68	2005	38	
Life expectancy at birth	2004	70	2005	69,6	
Under-5 mortality rate per 1000	2004	21	2003	40	16 (2005)
Maternal mortality ratio per 100.000	2003	14	1998	172	14 (2003)

[2] together with Indonesia, Malaysia and Singapore

	Thailand		Philippines		SEARO best performance
live births					
% GDP spent on health	2004	3,2	2003	3,2	9.6 (2003)
Government expenditure on health as % of total government expenditure	2004	12,5	2003	7,4	
Human Development Index rank, out of 177 countries	2003	73	2003	84	
Gross national income per capita US$	2005	2.750	2004	1.170	2.750 (2005)
% population below national poverty line	2002	10	1999-2002	36.8	8 (2004)
Adult (+15) literacy rate	2003	92,6	2000-2004	92,6	
% population with access to improved drinking water source	2005	92	2004	80	
% population with sustainable access to improved sanitation	2002	99	2002	73	

Thailand is also doing comparatively well economically, with the highest gross national income per capita in its region. Both Thailand and the Philippines are based on a free enterprise economy, although Thailand began industrialisation earlier. By the 1960s, the Thai government shifted economic emphasis from agriculture to the manufacturing of textiles, consumer goods and eventually electronic components for export. Industrialisation was not hampered even during the economic crisis in 1997 (Encyclopaedia Britannica 2008b). The country was able to bounce back impressively with an average growth rate of 5.6% from 2000 to 2006 (The World Bank Group 2008). The Philippines, in contrast, is still largely agricultural. However substantial, agriculture is still not the key player in expanding gross domestic product, which has increased by 7.3% in 2007. Sustained oversees remittances drive private consumption and stimulate economic growth (The World Bank Group 2008b). Incidentally, the government-sponsored labour export economy has made the Philippines the leading labour-exporting nation in the world (Choy 2007). The service sector also demonstrates strong growth, which together with the banking sector, added to the average growth of 5.4% from 2003 to 2006. Unlike Thailand, manufacturing growth has been slowing for the past four years.

B. Politics and governance

When Thailand made a monumental move to “democratise” their system of government, the Philippines was strengthening local governments to effectively manage their own affairs in a democratic process. In 1997, Thailand put in place a “people’s constitution,” referred as such because it was drafted by a popularly-elected constitutional assembly. Six years before that, the Philippines had enacted the Local Government Code, which gave local governments autonomy in authority, administration and resource use. Both reforms were intended to broaden civil society representation in government affairs. Thailand for the first time directly elected the two houses of congress (the members of the Senate were previously appointed), apparently a landmark in Thai politics, which had seen decades of autocratic regimes and many different versions of its constitution. The Local Government Code in the Philippines required “all national agencies and offices to conduct periodic consultations with appropriate local government units, non-governmental and people’s organisations and other concerned sectors of the community before any

project or program is implemented in their respective jurisdictions" (Section 2). In this instance, it can be said that the Philippines has made better progress in establishing truly democratic structures in government.

The Philippines adopted a democratic form of government early in its political history. In 1889, when it won independence from Spain, it established a unicameral National Assembly whose members were popularly elected. From then on, the legislative assembly has been one of the cornerstones of the Philippine government system. The Philippines is known as the first republic in Asia. Assertion of people's sovereignty through representation in government survived two other colonial occupations and a dictatorship. In contrast, Thailand did not end absolute monarchy until a bloodless coup in 1932. However, it has alternated between military governments and elite ruled democracies since then. Civilian authority finally gained a stronghold in the 1990s, culminating in the enactment of the current Constitution that reinforced civilian democratic institutions. This ironically was abrogated during a military coup in 2006 but was restored a year later. Thailand considers itself as a constitutional monarchy and the Philippines a presidential government. Thailand assigns the role of head of state to its king and the role of chief executive to the prime minister ≈. In the Philippines, both of these functions are assumed by the president.

C. Organisation of the health system

The organisation of Thailand's Ministry of Public Health

The Ministry of Public Health is a monolithic structure divided into several clusters (shown in Appendix 2.1). While the office of the minister is responsible for political matters that concern the ministry, the Office of the Permanent Secretary translates policy directives into operational plans that pertain to resource allocation, programme supervision, monitoring and evaluation, information management, and finally, public and international relations. The nature of its functions makes it the coordinating agency of health services at the provincial level i.e. it supports services provided by other units of the ministry at the provinces[3]. Thus, the Office of the Permanent Secretary has representatives at the Provincial Public Health Offices. The Provincial Public Health Offices, however, are in the line of command of the Ministry of the Interior, and connect with the Ministry of Public Health only for technical supervision.

Public health agencies that operate in the provinces are the Provincial Public Health Offices, Regional and General Hospitals, District Health Offices and health centres. Provincial Public Health Offices report to their respective governors, who are under the supervision of the Ministry of the Interior. However, the Provincial Chief Medical Officers, who head the Public Health Offices, represent the Ministry of Public Health with provincial administration. The Ministry of Public Health, provides technical supervision and logistical support. There are usually two regional/general hospitals that overseen by each Provincial Public Health Office. Moreover, the province is divided in to districts and sub-districts, which each have health offices technically and administratively supervised by the Provincial Public Health Office. State health agencies extend all the way to the tambon (commune) and muban (villages) in the

[3] Other clusters of the Ministry are on Medical Services Development (includes the departments of medical services, development of Thai traditional and alternative medicine, and, mental health), Public Health Development (includes the departments of disease control and health), and Public Health Services Support (includes the departments of health service support, medical sciences and the food and drug administration). These clusters and their departments provide technical support to state health agencies.

form of health centres staffed by health professionals. The provincial health administrative structure is shown in Appendix 2.2.

The organisation of Philippines' Department of Health

A Cabinet member, the Secretary of Health heads the Department of Health. With the devolution of health services following the Local Government Code, the department's role was redefined to be the "lead agency in articulating national objectives for health to guide the development of local health systems, programmes and services" (EO No. 102). The department is expected to provide technical expertise in disease control and prevention and health and medical research, capacitate local government units and other stakeholders and correspondingly oversee implementation of health programs, projects, research, training and services. Naturally, it also has the responsibility of implementing programmes that have national relevance such as control of communicable diseases, promotion of healthy lifestyles, emergency preparedness and response, compliance to standards and health care financing (EO No. 10[4]2). The department is divided in to several offices that include the Office of the Secretary and offices under five major clusters. It also has regional health centres (Appendix 2.3).

Facilities at the provincial level include the provincial health office and provincial and district hospitals, which are administratively under the governor. Correspondingly, they are expense items in the provincial budget. The municipalities are mandated to provide and finance primary health care services. It is not surprising to see a municipality maintain a secondary hospital, especially affluent ones. The mayor supervises these facilities at the municipal level. Villages usually have village health units, which are staffed by volunteers. The municipal health office supervises these volunteers, who are mobilised during immunisation campaigns, disease surveillance and health promotion. The Local Government Code instructs both the provincial and municipal governments to create respective local health boards. The chief executives are expected to chair and convene the board to discuss health issues and recommend policies to the local legislative councils. The board by law is composed of the chief executive, health officer, local planning and development officer, chair of the legislative committee on health and people's organisation representative, but is able to expand membership composition as needed.

[4] The clusters include Sectoral Management Support (composed of the Bureaus of Health Human Resource Development and Health Policy Development and Planning), Internal Management Support, Health Regulation, External Affairs and Local Health Development.

Chapter 3 – findings: the two faces of health reform

A. The rationale for reform

Aligning health with social reforms as part of the Thai "Peoples' Constitution'

The technical report of Phoolcharoen (2000) dedicates a full section connecting political reform with health system reform. The setup of the new Constitution required review of all public policies including the provision of health service. Health system reform was seen as part of an essential realignment of government structures to reflect the tenets of the new Constitution. By and large, the 1997 Constitution provided for greater involvement of civil society – a mechanism that is used to assert greater accountability and transparency in government as well as representation and participation in governance. Specific to health, the constitution declared health to be a human right. This is the first time that the Thai state asserts a right to health., According to Phoolcharoen, this indicates that there is an understanding that there should be equal entitlement to health in favour of the most vulnerable. In support of this premise, the current health profile report released by the Thai Ministry of Health for 2005-2007 contextualises health policies and strategies with a discussion of the right to health. It is important to note that while most health reform documents begin by citing disparities that need remedy, this report begins by reaffirming the constitutional right to equity.

Wasi (2000) concurs with Phoolcharoen's analysis that, prior to the 1997 Constitution a social crisis severely affected health that demanded reforms. He added that the health sector has particular problems that needed immediate resolution. At the time of his paper, he noted that health funds were threatened as health expenditures had risen due to the climbing incidence of costly but preventable chronic diseases. Furthermore, although health personnel were overworked, clientele were still unsatisfied. In short, Wasi interpreted the crisis as due to cost-ineffectiveness in the health system. Although he provided a menu of specific strategies to correct the system, he emphasized that the initial step be a policy response in order to set the reform process in motion. Wasi recommended that a new national act be drawn from research, public consultation and political dialogue; a prescription that was followed in the creation of the new health act of 2007.

The literature cited above notes that, health system reform has been tied to the promulgation of the 1997 Constitution. The Ministry of health embarked on health reforms to be in alignment with other government agencies as they adapted to the new paradigms of public provisioning. Chuengsatiansup (2005) noted that the Constitution has become a symbol of political transformation to a participatory form of democratic governance. Developed from a collective learning process, it became a model for the reform of government institutions. Chuengsatiansup understood the primary goal of reform as to motivate broad-range public involvement in restructuring and enacting the national health system.

Civil society representation and involvement occur during the discussion of health reform. Equity is mentioned in reference to the basic right to health, which is invoked by the new Constitution. As discussed earlier, the Constitution grants equal rights to health care, which consequently instructs the Ministry deliberately target the vulnerable population. To Phoolchoroen (2000), this creates a different set of demands on the health system – demands that are assumed to reach and eventually shape the national health system. However, the documents are unclear whether the system of civil society representation intends to include the perspectives of the vulnerable groups. It is even less clear about the relationship between civil

representation and equity. Although health disparities were mentioned, the extend of the problem was not discussed.

Improving health sector performance in the Philippines

The Department of Health's strategy paper on health sector reform (1999) utlizes a third of the document to describe the state of health in the Philippines and the conditions that created what the department sees as meagre outcomes. In his foreword, Romualdez (who was the secretary of health) acknowledged gains in health for the past 50 years but expressed concern due to a plateau in performance. The document used a decade of infant mortality statistics to highlight the sliding performance of the Philippines compared to its Southeast Asian neighbours. The maternal mortality rate for the same period was equally disconcerting. Nevertheless, the document noted that Filipino health on average had improved. Despite this, the report took issue with a large variation of health outcomes across populations. Unsurprisingly, statistics reflected disadvantaged health conditions for populations living in rural areas.

The Department of Health detailed the unevenness of health services. A section of the paper dealt with differences in utilisation attributed to physical and financial barriers. The Department of Health identified disproportionate geographical location patterns of health providers in relation to consumers. Comparison of the incidence of respiratory infection and frequency of clinic visits between rural and urban areas demonstrated this imbalance. Moreover, it was observed that the average hospital bill was more than three times the average monthly income. Utilisation rates were observed to fall by as much as 30% given a 10% increase in hospital costs. It demonstrated how spending on hospital services ate away a national budget that could have been more effectively spent for public health services, which the poor were more likely to access. It lamented the condition of public health facilities that were inadequately funded and supervised by local governments. Moreover, the national health insurance program had failed to provide financial protection to indigent families in poor provinces, leaving them burdened with medical costs due to illness. These and a host of other factors were cited by the report, as call for health sector reform. All of these issues hinge on coverage of the poor in public health and primary health care services and inequitable access to personal health care. At base, health sector reform was justified in order to provide effective coverage of public health programmes, better access to quality services, particularly by the poor and disadvantaged and to reduce financial burdens on individual families.

Equity continues to underlie reform initiative even after almost a decade of implementation. In 2005, the Department of Health re-launched the health sector reform agenda. Dubbed "Fourmula One[5]," the department aims to improve the health system with indicators of equity, quality, efficiency and effectiveness. The "Fourmula One" primer (2008) declared that interventions should be conducted in a manner that Filipinos, especially the poor, could feel and appreciate. The specific objectives of the reform target, among other things, affordability of health goods and services, and, access to and availability of essential and basic health packages. The National Objectives for Health for 2005-2007 notes that although health status improved slightly, the health situation is much the same, with variation persisting across populations. The primer however illustrates a different scenario than the first round of reforms. Limited government funds restrict departmental operations and the decentralised system allows mobilisation of funds from an array of sources to fill in national financing requirements. Where the department of health was once the lone

[5] Fourmula One works with four objectives centring around four indicators, thus the name.

player in mitigating health variations, health now requires the engagement of local governments, private sector, and development agencies. This requires new capacities in developing novel and creative means of implementing programmes.

B. Equity as contained in the health reform policy

It is expected that both the policy documents of Thailand and the Philippines would cover a broad range of interventions to achieve intended reform of their respective health systems. Policies identified below are singled out because they have direct bearing on equity. As defined earlier, equity is used here to mean the design of health care resources, policies and programmes in a way that equalises health outcomes of disadvantaged social groups with their advantaged counterparts (Braveman and Gruskin 2003). Policy mechanisms identified below are specifically directed towards disadvantaged groups or explicitly intended to benefit them. All other interventions might improve health outcomes but does not necessarily imply minimization of variations in health. The listing below shows how much equity has occurred in the content of reform policies in the two countries.

The Thai national health system reform

According to the Thailand Health Profile of 2005-2007, published by the Ministry of Health, the Thai National Health Act of 2007 is in itself the tool for health system reform. It contains new structures and functions that evolved after a long process of research, dialogue and conceptualisation (Phoolcharoen 2001). It is important to note that seven years passed between the Prime Minister's issuance of National Health System Reform Regulation and the law's actual enactment. In the exhaustive literatures authored by Wasi (2000), Phoolcharoen (2001) and Chuengsatiansup (2005), including the National Health Profiles in 2001-2004 and 2005-2007 and articles in the websites of the Health Research Institute and National Health Commission, one can see the evolution of the strategies that shaped the National Health Act. In the timeline of reform these documents form an undeniable part of the reform strategies, although they are in theory preliminary. Reform strategies in this period pertain to the process of developing the health act. Table 3.1 presents key reform strategies, their corresponding activities and their implications of equity, as drawn from the enumerated documents.

Table 3.1 Specificity of reform activities to equity – Pre-National Health Act Thailand

Key reform element	Reform activities	Specificity to equity[6]
Creation of knowledge base	Developing of evidence-based health system reform interventions	0: primarily done by technocrats
Civil society mobilisation	Stakeholder analysis Joint assessment of health system status and visioning of way forward	+: Community organisations are involved in mutual learning process and conceptualisation of the National Health Act
Political agenda and commitment	Drafting of the National Health Act Agenda setting and advocacy	++: Assurance of rights, equality and security in health of the people in legislations +++: National Health Security Bill of 2001, which mandates

[6] *Symbols signify specificity of reform activities to equity, with +++ indicating that they are highly specific and 0 not at all.*

Key reform element	Reform activities	Specificity to equity[6]
		universal coverage under the National Health Insurance

Reform strategies during this period centre on three key elements – the so-called "triangle that moves a mountain," which is an allegory for how to overcome health problems despite their apparent immensity. Reform began with technical work, which built on knowledge generated in academic circles through research and interdisciplinary dialogues. The end product was used to educate stakeholders on health system reform as a concept and used as a working framework for the conceptualisation of the Thai health system and its objectives. The documents maintain that participation of civil society groups was key in defining the scope of the health system and envisioning its desired state. It is cited here as an equity mechanism because it gives equal voice to civil society in health policy development, although civil society in Thai parlance falls short of including disadvantaged groups. The health profile document identifies members to be interest groups and professional organisations as well as those that protect public benefits. The third element in this process was agenda setting and political advocacy. The obvious result was the National Health Act, which was finally enacted in 2007. Advocacy was also successful in putting in to law the National Health Security Bill in 2002 that provided universal health insurance coverage under the National Health Care Plan. Likewise "representative democracy", which is the cornerstone of the 1997 constitution, was adopted as procedural protocol in future health policy development.

There is a significant difference in the content of reforms between those that were reported for the period 2001-2004 and the period 2005-2007. While the three years following the Prime Minister's directive included hospital reforms and decentralisation, they were not followed through in the succeeding two years. The period covering 2005-2007 reported solely the activities that preceded the promulgation of the National Health Act. Hospital reforms did not take off because of lack of support from health professionals and the public as well as weak political backing and scepticism about hospitals' capacity for financial autonomy and government's ability to manage system reforms. It was initially intended that hospitals carry out public functions by setting up their own rules and regulations with regards to financial resource management and personnel. Decentralisation intends to shift the current function of central authority from logistical administration and policy control to oversight of compliance to policy guidelines and quality standards. It meant empowering local governments to address their own health issues while at the same time making them accountable for equity and efficiency of services (Phoolcharoen 2001). Mechanisms such as the local councils and local health committees and health assemblies had been put in place to carryout decentralised functions. In any case, discussion on decentralisation was raised in the higher domain of public policy since it is a cross-cutting issue.

With regard to the National Health Act, it does not have an explicit resolution that refers to attainment of equity in health or equalising health outcomes across populations. However, the act gives legal basis to health as a basic right, which effectively mandates that health is afforded to all and, at the same time, health security is universal. It makes special mention of the health of children, disabled and elderly people and those socially deprived as needing relevant and appropriate promotion and protection. Moreover, it declares the right to information about public health services and programmes, to express opinions on such matters and to request and participate in assessment of health impacts leading to formation of public policies. Accordingly, it specifies the conduct of health assemblies, which are forums open to all sectors of society to discuss health issues. Another resolution

directs the establishment of the National Health Commission, its secretariat office and board. Again, membership and participation of civil society groups are assured in these forums (Appendix 3.1 enumerates the powers and duties of the commission). Although the law gives a good illustration of how policies are generated from bottom to up, it is unclear as to how policies would be translated to services and brought down. The law does not clarify the relationship between the National Health Commission and the Ministry of Public Health as well as its connection to the local health commissions and offices down the line. Seemingly it creates multiple layers of bureaucracy that elongates the course of delivering services.

The National Health Commission is directed to prepare the statute for the national health system. The statute effectively sets framework in making policies and strategies and implementing activities for the health system. Actual drafting of the statute will commence with the National Health Assembly in December, although its guiding principles have already been drawn up. Of particular interest is the attention given to establishing the state of wellbeing and suffering in relation to its future impact in health. Also worth mentioning are the key points that the subcommittees are tasked to work on: promotion, support, use and development of local wisdom; self-reliance using Thai traditional and indigenous medicine as well other alternative modalities; quality in terms of humanised service and not profitability; and, attainment of health for all with fairness and equality. Equity statements in the National Health Act and in the working paper for the national health system statute are summarised below.

Table 3.2 Specificity of the National Health Act and National Health System Statute to Equity – Thailand

Policy document	Particular themes	Equity statements
National Health Act	Health as a basic right	Ensures the right to live in a healthy environment and environmental conditions
	Special beneficiaries	Promotion and protection of the health of children, disabled and elderly people and those socially deprived
	Access to information	Equal access to information about public health programmes
	Composition of the National Health Commission	Representation of civil society groups as well as public health and other professionals
National Health System Statute (working paper)	Participation in health policy development	Health assemblies are open to all
	Working principle	Development of local wisdom on health Priority to humanised service over profit Attainment of health for all with fairness and quality

Interestingly, although many articles site the universal health care coverage policy as the Thai poster programme of reform (Towse, et al. 2004; SEARO 2008), it is not included in the major policy papers released by the Thai government that were reviewed. Nevertheless, the Bureau of Policy and Strategy of the Ministry of Public Health lists it as a component of health reform in its published report, “Health Policy in Thailand 2007.” The universal health care coverage policy is often discussed in the context of equity since it specifically targets underprivileged groups. It runs side by side with two other insurance systems namely the Civil Servants’ Medical Benefit Scheme and the Social Security Health Insurance Scheme, which are for

government and private sector employees, respectively. Universal health care deliberately enrols individuals who are not covered under the two insurance systems. Key features of the programme that has implications to equity are summarised below (lifted from Bureau of Policy and Strategy 2007).

Table 3.3 Equity dimension of the Universal Health Care Coverage Programme

Key elements	Key features	Equity dimension
Covered population	People not covered by SSS or CSMBS	It effectively covers children, elderly, the unemployed and those in the informal economy
Benefit package	The same as SSS and CSMBS but without cash benefit	The benefit package equals those of CSMBS and SSS to avoid discrimination in service facilities
Source of funds	General tax	Premium contributions are essentially free
Mechanism in paying accredited providers	Capitation for outpatient and reimbursement for inpatient based on DRGs (taken from provincial budget)	Primary health care facilities in rural areas are given capitation; provincial health budget is augmented by reimbursement
Co-payment	30 baht (0,70 euro) per episode	Lessens payments since user fees have been set-up before the insurance

Indigents are aggressively enrolled in the programme with government subsidy. It is expected that since they receive the same package of benefits as those employed, they will be afforded the same quality of service. Providers are paid using capitation for outpatient services and reimbursements for inpatient, although they need first to be registered. Registration is open to both private and public, which ensures a broad distribution of accredited facilities. A co-payment is imposed per episode to limit indiscriminate utilisation. Incidentally, public facilities in Thailand have already been charging user fees making co-payment less of an issue. There is concern about the financial sustainability of the programme, particularly if the insurance relies solely on taxation and capitation is not adjusted to cost and usage. Towse et al. (2004) poses the scenario of deteriorating services available to indigent beneficiaries if this is not remedied.

The Philippine health sector reform agenda

The health sector reform document lists 22 major reform activities in five key reform areas. Only two directly imply that services are intended for disadvantaged groups, specifically the poor. Five are inherently distributive since they are directed towards health systems of rural communities where most of the country's poor are found. Interventions that benefit local health systems were justified early on in terms of providing greater access to services. Nevertheless, they neither mention targeting of disadvantaged groups nor specify adoption of mechanisms to make services accessible. Five of the reform activities entail revenue enhancement through service fees and could create financial barriers to service especially if they do not correspond to enrolment in the national health insurance programme. Incidentally, the programme is regarded as the core strategy in providing both health security to the poor and additional income to health facilities. Table 3.3 lists the major reform activities and their specificity in referring to equity i.e. delivery of services to disadvantaged groups.

Table 3.3 Specificity of reform activities to equity – Philippines

Key reform area	Major reform activities	Specificity to Equity[7]
Health financing (through the National Health Insurance Programme)	■ Increase benefits	0: programme attractiveness is the stated reason to increase benefits; this has no direct impact to disadvantage groups unless they are enrolled
	■ Expand coverage	+++: programme is explicit about providing subsidies to indigent families
	■ Secure financing	0
	■ Expand accreditation of providers	0: accreditation of health facilities is beneficial to disadvantage groups if the system grants them access
	■ Develop administrative infrastructure	0
Local health system	■ Inventory and assessment of local health system	+++: assessment intends to describe the uniqueness of health needs and local systems of rural communities and islands
	■ Development of local health system	+: although it was discussed how upgrade might benefit the poor, it was not specific to improving their access to services; reasons cited were lack of trained manpower, clinical equipment and physical structures
	■ Advocacy/marketing of local health system menu	+: equity is not part of the advocacy for local health system development; marketing nevertheless engages the community
	■ Adoption and institutionalisation of local health system	0: institutionalisation recognises local health system as an essential component of the overall health delivery network but does not commit local governments to servicing disadvantaged groups
	■ Inter-LGU linkages	0: inter-LGU cooperation allows coordination and integration of local health services as well as sharing of resources; it was not established how this could benefit disadvantaged groups
	■ Sustainability	+: mechanisms that sustain local health systems for long term ensure continuous availability of services
Public health programme reforms	■ Increase of investments in public health programmes	+: public health programme reforms respond to the double burden of disease and are designed to be universal; they do not segregate disease burden according to population groups
	■ Upgrading of the physical and management infrastructure at all levels of health care delivery system	+: investments for public health flow to diseases of high incidence and cost, which does not necessarily mean the poor especially with the rise of chronic diseases
	■ Development and	0: technologies are not localised much less

[7] *Symbols signify specificity of reform activities to equity, with +++ indicating that they are highly specific and 0 not at all.*

Key reform area	Major reform activities	Specificity to Equity[7]
	strengthening of technical expertise in public health practice	intend to incorporate socio-cultural and economic dimension of marginalisation
Hospital reforms	■ Revenue enhancement in regional and medical centres towards financial viability and fiscal autonomy ■ Preparation of conversion of hospitals to government owned corporations ■ Expansion of the government hospitals networking, patient referral system to include private hospitals to form the Philippine Hospital System ■ Expansion of the Lung Centre of the Philippines to include Neuroscience Centre, Hematology diagnostic facilities, bone marrow transplant unit and blood centre ■ Rationalised upgrading of DOH hospitals for corporatisation ■ Upgrading of core district/provincial hospitals	--: reforms intend fiscal autonomy of national and regional hospitals through revenue enhancement mechanisms such as expansion of pay wards, private rooms and OPD clinics and improved efficiency in income generating areas (laboratory, x-ray, delivery room, operating room, etc.); collection of hospital service fees is highly recommended but tied to the national health insurance program; with no insurance, this mechanism is prohibitive to the poor
Health regulatory reform	■ Strengthen the mandates of health regulatory agencies ■ Enhance the capacities for regulation and enforcement	0: regulations do not account nor provide incentive to services directed at disadvantage groups

The National Health Insurance Programme is used as the main instrument to effect health financing reforms. It is seen as a more cost effective financing mechanism than fully subsiding public health facilities. In this framework, subsidies are diverted to paying membership premiums in the health insurance programme. Since it could effectively distribute costs to a bigger pool, it ends up costing less per capita. In place of welfare benefits for poor families, the government pays for their enrolment in the National Health Insurance Programme. Health financing reforms is therefore deliberate about enrolling indigents and reaching universal coverage. It creates a system whereby the local governments share part of the membership premiums of their indigents with the other part being shouldered by the national government. Health reform is clear about the legislations it needs to set up to earmark funds for indigents' membership. Other financing reform activities likewise have implications to providing services to disadvantaged groups. However, this was not made explicit in the document. Expansion of insurance benefits, for instance, is rationalised on the basis of improving marketability of the insurance to individual payers and not equalising the service package in favour of the poor. Reform includes expansion of accredited facilities to bring services closer to members but does not specify inclusion of facilities operating in poor and remote areas. Equity is peripheral in the

discussion of the programme's financial security and administrative competence. Ultimately, the poor are expected to benefit from health financing reforms when they are enrolled under the national insurance.

Local health system development is undertaken in the context of devolution of services and the need to improve the capacities of local governments to manage their local health facilities. Reforms intend that local health facilities credibly provide primary health care services to decongest regional and national hospitals. Other than this, it is envisioned that local governments take an active role in developing and implementing public health programmes. Local health system development is tied to public health reforms. The Department of Health undertakes research and technical support to local personnel on public health technologies and even upgrading of facilities if needed. The need to invest in local health systems and public health to reach underserved populations has been exhaustively argued in rationalising reforms early in the reform document. Ironically, this association was not reflected when the paper actually discusses particular reform activities.

By strengthening management capabilities, local governments are expected to design health systems that are responsive to their unique needs. Local health planning purposely incorporates community perspectives and health demands. Nevertheless, reforms do not commit local governments to provide services to its disadvantage groups. Neither do reforms suggest equitable distribution of services. Inventory and assessment of health systems establish gaps in personnel, clinical equipment and clinical structures. It is not clear whether reforms establish communities' health seeking patterns or determine matches between health supply and demand particularly in remote areas. In fact, most of the interventions on local health systems and public health are supply-side corrective measures that assume the inadequacy of services rather than account for probable inconsistency with demand especially among underserved populations.

Hospital reforms pertain mainly to institutional sustainability and focus on hospitals' financing and administration. Hospitals are being restructured to operate as autonomous and self-liquidating organisations. This involves setup of payment systems to recover operation costs and relies fundamentally on the National Health Insurance Programme. Essentially, if the national programme fails to enrol indigent members, hospital reforms would significantly marginalise them. Given that reforms cut hospitals' welfare subsidies, there are no clear safety nets that the poor can alternatively rely on to access hospital services. Incidentally, health regulation reforms do not segregate and track utilisation of disadvantaged groups. Neither do they give incentives to health facilities and local governments that have good performance in equalising service provision and local health outcomes.

Fourmula One, which is a reformulation of the health sector reform agenda, updates reform activities according to gains of the past five years and emerging issues in the course of implementation. It is immediately noticeable how the agenda is aligned with WHO's goals for health systems: better health outcomes, responsive health system and equitable healthcare financing. Health financing still occurs as an important component of health reform but it is noteworthy that equity is used as a qualifier. Also significant is the restatement of the other objectives. Reforms objectify affordability of health goods and services and access and availability of essential and basic health packages. The fourth component is the improvement of the health system. The reformulated reform strategies builds upon achievements in 30 provinces, which successfully improved the coverage of their health services. Experiences of these provinces however demonstrate inflexibility of health budgets given large overheads and staff payouts. The Department of Health is likewise

restricted by rising costs, compounded by the declining real value of its share of the national budget. It is easy to see how inequity in provision of services is regarded as a financing issue. This paradigm shift corresponds to adjustments in the reform activities. Table 3A.3 shows adjustments made following reformulation of the health reform agenda.

Table 34 Adjustments in selected reform activities that relate to equity – Philippines

Reform area	1999 health reform	Fourmula One
Health financing	■ Enrolment of indigents in the national health insurance programme through shared subsidies from national and local governments using earmarked funds	■ Other than the National Health Insurance program, financing is secured through user fees and charges for regulatory services as well as use of real property assets. Financial efficiency is induced through performance-based allocation. Access to the poor is mentioned as priority, but reforms do not specify clear safety net.
Local health system	■ Localisation of health systems ■ Upgrade of critical capacities i.e. improvement of physical plant, provision of equipment and development of technical and managerial capability of health personnel ■ Sustaining local systems through equitable sharing of national revenue, provision of block grants and other assistance	■ Local health system development falls into the general heading of good governance in health, which also involves improvement national capacities to manage the health sector. One of the reform strategies to improve local systems is to ensure adequate distribution and retention of health personnel in underserved areas.
Public health programmes	■ Increase investments in public health with contingent improvement of management capacity for proper utilisation of funds	■ Public health reforms are subsumed under intervention in service delivery, which aims at improving accessibility and availability of basic and essential health care especially to the poor. Quality is assured through upgraded facilities and personnel capability, compliance to standards and specialised diagnostic procedures.
Health regulation		■ The objective of health regulation was restated as assuring quality and affordable health services especially those used by the poor. Quality seals will be used to enable consumers to make informed decisions. Quality essential medicines are assured through promotion of generic products, distribution networks, pooled procurement and identification of alternative sources.

As it seems, Fourmula one installs more safety nets for the poor than its predecessor. It is also more aggressive in sourcing out alternative financing for the

Department of Health. It detaches itself from the National Health Insurance Programme, which by now has its own separate mandate, and deals with the financing issue not only in relation to health security and medical reimbursement but more so the general framework of financing national and local health systems. The department continues to advocate for broader coverage of the health insurance programme but is looking more at instituting user fees and service charges for licensing as well as its property assets. It also banks on external sources through development agencies and private sector partnership arrangements. Reform underscores that revenue generation should be coupled with performance-based allocation to ensure that funds are utilised efficiently. Nevertheless, it is wary of the potential implications to the poor and makes provisions for direct subsidies to basic and essential health goods and services at the national and local levels.

In the other three components of Fourmula One, access and affordability of services likewise appear to direct reform activities. Both good governance and health regulation interventions are at the national policy level but employ mechanisms that directly benefit the poor. Governance measures pick up from previous reform accomplishments and want to further enhance management capacities of local health personnel. Recognising the absence of health professionals in remote areas, the department aims to distribute and retain critical personnel in underserved areas. Regulation on the other hand assures that essential medicines are affordable through promotion of generic products, alternative distribution networks, e.g. community pharmacies, and identification of other alternative means of acquiring quality but inexpensive medicines. Standards are imposed so that populations are afforded the same quality of service. Issuance of quality seals gives the consumer, including the poor by virtue of their insurance membership, freedom to choose service providers. Finally health service delivery reforms assure that upgraded facilities and technical capability complement improved access and availability. Still, none of the reform activities mention formalising commitments of local governments to ensuring provision of services to disadvantage groups. Neither do they suggest the creation of a system to keep track of utilisation by the poor or incentivate local governments that do so.

Chapter 4 – findings: equity in the reform process

This chapter illustrates the context, actors and processes that accompany health reforms in Thailand and the Philippines. They are discussed here apart from the content of policy because they further illuminate the influence of equity in pushing for reforms. This chapter establishes whether equity is part of the socio-political discourse and the interests of actors who drove reforms, and examines how often equity has occurred as an issue in the process of formulating the policies. This framework of policy analysis picks up from the argument of Walt and Gilson (1994), which contends that investigation of policy should not only look at content but should be supplemented by an understanding of the different mechanisms that underlie it. They argue that policy reform is a political process made up of these interrelated elements that characterise its origins, development and implementation.

Walt (1994) identifies actors as the agenda setters, which include the government that controls legislation as well as organised interests like the WHO and WB at the international level, and, civil society groups, the business community and the bureaucratic institutions at the national level. The media can also draw attention to particular issues. Meanwhile, factors such as changes in political regime, dominance of a particular ideology and even historical experience and culture affect the context within which policies are formulated. The process of policy-making is determined by looking at how issues get on the policy agenda (Walt and Gilson 1994). The authors maintain that these elements influence each other when they play out. Thus, the discussions below describe them separately but account for their interactions in forming the reform policies.

The last part of the chapter investigates the use of equity indicators in assessing performance of the health system. This further validates the influence of equity in reform as previously shown in the technical features of policy content and verified here in its occurrence in political processes. Determination of whether equity measures are organic to the countries' health development plans provides another standpoint in looking at the influence of equity. It therefore triangulates the results of investigation that establish equity's influence on the content and process of reform.

A. Equity in the context of reform

In the 2000 world health report, the WHO pointed out that health systems underwent three generations of reforms. The first was the establishment of national health care systems. This resonated with post-war reconstruction values and bolstered adherence to egalitarian ideals in providing health. The second-generation reform advocated for primary health care as an approach to achieve affordable "health for all." Substantial efforts were made to set up community-based health programmes managed by local people to deliver basic cost-effective services. The WHO report recounts that these reform initiatives worked fairly well until new trends changed the landscape wherein health systems operate. Demands for increased coverage, medical technology advancement and huge overheads significantly burdened health care systems. Many authors suggest that the emergence of neo-liberalism caused traditional practices in public provisioning to be questioned. Neo-liberalist policies push for a minimal state, specifically, the withdrawal of direct government interference in health care to encourage other players and enable competition to correct inefficiencies and incite quality improvements. The third generation reform followed from this rationale and is fittingly described by the WHO as "money following the patient." This framework supported payment by consumers (through out-of-pocket or publicly or privately financed insurance) and prioritised efficiency interventions to take advantage of restructured financing mechanisms. Its supporters

regard it as a more effective way to address inequity since it was supposed to free government resources and allow their redistribution according to need.

Both Thailand and the Philippines follow similar trajectories in the development of their respective health systems. The Thai Ministry of Public Health provides a comprehensive account of the development of the national health system, which it traced back from the medical practice at the royal court to its Ministry's creation in 1942 (in Wibulpolprasert 2004 and Chuengsatiansup 2005). Wibulpolprasert (2004) credits the monarchy with the systematisation of medical practice and later provision of health to the public. Several articles likewise attribute the introduction and consequent adoption of western medicine and concepts of public health to the monarchy (Chuengsatiansup 2005; Bhikku 2007). In the Philippines, a national health board was created as early as 1899. It was established soon after the United States ceded the islands and established it as colony. With the country's transition to a commonwealth government, the board spun off into a bureau and later a full-fledged department with a secretary under the Office of the President (DOH 2006). Ong (2004) noted that the system was patterned after the American model, while there was considerable pressure to "Filipinise" (indigenise) medical practice. In the literature reviewed, the two countries were found to be very receptive to primary health care strategy. In fact the Alma Ata declaration utilized some models from community-based health programs in the Philippines (Commission on Social Determinants of Health 2005). In Thailand, the Bureau of Health Policy (2007) claimed that village health communicators were already being tapped during the 60s for health promotion and education. In effect, the primary health care approach only formalised what was already being practised and confirmed the role of the community in health development (Bureau of Health Policy Thailand 2007; Gonzales 1996). In the above events, the two countries' governments are seen to take on the overall responsibility for healthcare and consequently expand their authoritity to accommodate mechanisms that generally benefit the health of their population.

Current reforms in the two countries are laid out in the same economic neo-liberalist platform. Neo-liberalism has caught on conspicuously in the two countries, especially with Thailand's early push towards industrialisation. True to form, both countries' development plans pursue economic growth in free market frameworks. Although Thailand has attempted to temper this stance with a human-centred approach to development for the past three consecutive planning cycles[8]. This contrasts greatly with the Philippines where the economic approach has been to develop enterprises to accelerate growth and generate jobs (Medium Term Philippine Development Plan 2004-2010). The Philippines aspires to be globally competitive by bringing down the prices of basic commodities and services (including healthcare) and disseminating knowledge in order to lower labour costs and encourage investments. Thailand's markedly different approach is to invest in people and bring them to the core of development programmes. Thai strategies could be classified as more social than economic: education reforms, health protection and rural development among others (8th National Economic and Social Plan; again in the 9th and 10th plans centring on social development and knowledge base respectively). While the Philippines has anti-poverty strategies to distribute economic gains to disadvantaged groups, Thailand has mainstreamed social programmes as an overall development strategy. The Philippines looks at healthy population as an outcome that follows development, while Thailand sees it as both an intended end of and means to development.

[8] To quote the Eighth National Economic and Social Development Plan, "human beings shall be the originator and recipient of both benefits and effects of development." It accordingly focuses on empowering people, distributing wealth and supporting underprivileged groups to meet their full potential (The Eight National Economic and Social Development Plan 1998).

The duality of the two countries' approaches to development mirror their differing approaches to reform. In the previous chapter it was shown that the reforms in Thailand tend to focus on process, while in the Philippines, they are more oriented towards structures and inputs. It is suggested here that the difference also lies in the conceptual constructs of health and health systems. In its policy papers, Thailand insists on a broad perspective on health and the consideration of the multiple factors that affect health systems. Bhikku (2007) explains that health in the Thai context has always been viewed as holistic. The Thai National Health Act confirms this as it defines health as "the state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic and in balance." Health system is regarded as the "overall relations in connection to health" – a definition which characterises it as multi-dimensional. The Philippine Department of Health (2006) similarly mentions the different factors affecting health and health systems. But although it recognises that socioeconomic differences significantly influence health status, it deals only with the unfair distribution of health that disfavours the poor and not the conditions that predispose them to illness. The Department therefore delineates and limits the health system to the factors that affect the delivery of services and leaves out (perhaps as a matter of priority) non-health factors such as income, education, food security, etc. It is clearly-defined but has the shortcoming of not being able to relate with other government programmes. The Thai health system is inclusive, and as a matter of principle, engages all sectors to cover all factors that affect health.

There is a clear indication that the Thai concepts of health, health system and development follow from a cultural worldview. Bhikku (2007) connects attainment of health as well as altruism to the Buddhist humanistic ideal of enlightenment. Writing for the Ministry of Health, Phoolcharoen (2001) highlighted the inclusion of spiritual health in the WHO definition implying that there should be a "sound commitment to a healthy life" through belief and faith. He explains that this has a basis in various religious preachings and has been validated by pragmatic experiences of scholars. He further argued that, at a broader societal level, spiritual health denotes public commitment to equity, which translates to strategies and actions that result in real and sustained reduction in unfair health and health care disparities. The cultural construction of health and health equity deserves deeper discussion and is not the scope of this paper. Nevertheless, it is mentioned here to point out that the cultural worldview defines how health and equity are conceived and that this could explain the differing principles of reforms between the two countries. Incidentally, Hedman and Sidel (2000) claim that commodity culture and market forces are significantly shaping value systems in the Philippines.

This final point provides the political scenarios in the two countries at the time when reforms were advocated. It was earlier pointed out that, at the time of reform, Thailand had just enacted its new constitution. The so-called "Peoples Constitution" bolstered the legitimacy of an elected civilian government and intended to hamper a return to a military regime. Handley (1997) writes that subsequent capitalist growth changed the political setting by allowing the rise of the middle class which decreased the influence of political elites. This culminated in middle class demands for political change after the 1997 financial crisis exposed corruption in government (Chuengsatiansup 2005). Other than instituting oversight agencies for corruption, institutionalisation of civil society participation characterised this political change. Chuengsatiansup (2005) notes that participation is justified on the basis of broadening political legitimacy and the incorporation of different sectoral viewpoints into the holistic development discourse. The new constitution also saw the entry of businessmen into politics. The most notable is Mr. Thaksin Shinawatra, who was

prime minister when the National Health Act was being drafted and the Universal Health Care Programme was launched. Thaksin supported social welfare and maintained pro-poor programmes during his administration, in defiance of the IMF whose liberalization policies he opposed (Hewison 2004). He was, however, accused of benefiting business cronies and overthrown and exiled by a military junta. The Philippines during this time had elected a popular president, Mr. Joseph Estrada, who had made a campaign promise of people-centred programmes. Health sector reform aligned in this direction but was not raised as a flagship programme of the administration. With no coherent development policy, he was forced to give up his seat through a series of public protests incited by charges of corruption – he was the first president to be impeached and later convicted. His vice president, Mrs. Gloria Macapagal-Arroyo, assumed power and later won the following election, but not without controversy. Her legitimacy has been in constant challenge, initially because she did not have the backing of the masses, which her predecessor did, and later due to an exposé of financial irregularities and charges of election fraud. The Arroyo presidency is still under fire, with nearly constant accusations of corruption, senate investigations, military mutinies and mass demonstrations. The government however is able to hold on to power by generating mass support with her pro-poor programme banner. A flagship health initiative is the aggressive enrolment of indigents for sponsorship under the National Health Insurance Programme.[9] As can be seen in both Thailand and the Philippines, health sector reform, albeit piecemeal, is used as an instrument to secure political legitimacy and gain public support.

Table 4.1 Global trends and local developments in Thailand and the Philippines that relate to health reform and equity

	Global context[a]	Thailand	Philippines
Intellectual discourse	Interest in the social determinants of health – health system seen to bear on equality of health outcomes	Health is seen as an interplay of bio-psycho-social (including spiritual) factors – health system should be holistic[b]	Expected outcomes of the health system are better health, responsiveness and equitable health care financing[c]
Economic paradigm	Neo-liberalism favouring establishment of internal markets, separation of providers and purchasers, and competition	Economic growth tempered by humanistic values[d]	Poverty reduction through job creation and enterprise development[e]
Cultural context	Health reforms initially based on classical universalism; current reform adds criterion of cost-effectiveness in achieving equity	Reciprocity and caring for the ill are core values in Buddhist tradition; care for the other leads to enlightenment[f]	Identity influenced by market and commodity culture characterised by modern individualism[g]
Political scenario	Entry of WB in health systems development discourse with assistance extended for reforms	Adoption of a new constitution with broadened civil representation and reformulated public policy	Bickering between the office of the president and senate; department of health maintains business as usual
Politics of health	Advocacy for health	Health system	Pro-poor strategies,

[9] President Arroyo was accused of using public funds when she distributed free insurance memberships at the height of her campaign bid for presidency. Many would argue that this gave her unfair mileage over her opponents (Adranedy and Calica 2005).

	Global context[a]	Thailand	Philippines
	investments coupled with good governance and accountability	development made sure of broadest range of public participation to ensure legitimacy; pro-poor strategies to win public support	particularly, sponsorship of indigent families in the health insurance as means to broaden public support
Historical development	Challenge to structural adjustment programmes of WB; global trend to health reform and commitment to millennium development goals	Economic crisis exposed corrupt politics causing the sizable middle class to demand political change	First impeachment of a president; successor tries to win popularity through pro-poor programmes in light of charges of election fraud and corruption
Social structure		Succession of authoritarian regimes although civil society participation led to local initiatives and empowerment of organisations outside the state	Civil society groups have mobilised popular movements resulting in governmental change and kept constant watch on abuses of power

[a] *WB 1993; WHO 2000 and Commission on Social Determinants of Health 2005*
[b] *Chuengsatiansup 2005*
[c] *Department of Health 2005*
[d] *National Economic and Social Development Plans of Thailand (8th, 9th and 10th)*
[e] *Medium-Term Philippine Development Plan 2004-2010*
[f] *Bhikku 2007*
[g] *Hedman and Sidel 2000*

Table 4.1 summarises the above discussion into a matrix. It presents contextual information in a way that reveals how issues of health reform and equity fit with local and global contexts. Following the entries horizontally, it exposes the degree to which global frameworks have influenced local systems. It is obvious that in terms of intellectual discourse and economic paradigms, Thailand and the Philippines adapt international trends. As far as the other aspects of the discussion are concerned, issues tend to be localised and very particular to national situations. It is striking that the two countries show historical struggles to fight corruption in the midst of economic growth. Alongside this struggle are the attempts of their governments to assert legitimacy through either consensus or adoption of mass-based programmes. Equity is conveniently invoked in this light, i.e. in the context of equal participation or equal distribution. Therefore, while internationally it was discussed in economic terms as part of health sector reform, equity is a political discussion locally. Following the entries vertically shows how equity weaves into the different socio-political aspects of the two countries. It can be seen here that both Thailand and the Philippines have a strong civil society sector to check government and ground policy development. Thailand, however, has the added advantage of having a strong belief system that justifies egalitarian values and holistic health. If the belief system does not act as a countervailing force against government abuses and lapses, it ensures at least that the government operates within this moral compass. In the Philippines, this compass has to be actively rallied by a dynamic civil society.

B. Policy-making in the reform process and its reference to equity

Chuengsatiansup (2005) gives a detailed chronology of the policy-making activities from the period 2000 to 2004 in Thailand. The Thailand Health Profile 2005-2007

was used to fill in the remaining period until the enactment of the National Health Act in 2007. It is immediately noticeable that upon issuance of the Prime Minister's directive that created the National Health System Reform Committee in July 2000, activities rolled out following the reform framework, "the triangle that moves the mountain." A civic society forum with 1,500 participants was conducted to discuss about the problems of the health system and establish consensus on the model, which would be the intended outcome of reform. Immediately after, research and technical groundwork were done to build on the developed working model. The result of the research was published and disseminated to stakeholders. This was followed up with 500 workshops to generate inputs from organisations, civic communities and public agencies about the basic values they feel should be incorporated in the agenda. By September 2000, during the National Health Assembly, there were already concrete principles and concepts drawn up that were presented to the Deputy Prime Minister. The main content of the national health bill was distributed by the end of 2001. The committee made great strides in propagating and validating the contents of the bill to the districts and provinces until another National Health Assembly was held in August 2002, where it was finalised. The Committee approved the final draft of the bill and transmitted it to the Cabinet two months later. What followed after that is a long-drawn policy advocacy for the passage of the Act. Signature campaigns were launched initially to convince the Cabinet to transmit the proposal to Parliament and later to invoke the constitutional provision that compels Parliament to act on the proposal without Cabinet endorsement. This eventually got the attention of the Cabinet, which made its own deliberations and public forums before it forwarded its version almost a year later to the Parliament. In between those times key reform principles were reviewed and added to. The bill was further circulated for comments of different national agencies until it was finally deliberated on first reading at the House. With no better luck, the bill was stalled with the dissolution of the Parliament and left pending with the coup d'etat. It underwent the same process under the established National Legislative Assembly of the military regime. In less time, however, it was put into law in January 2007, seven years after the reform was initiated.

Health sector reform in the Philippines did not undergo the same ordeal as Thailand's mainly because reform did not require the passage of legislation. Except for the National Health Insurance Act, the reform was limited to the organisation of the Department of Health and was mainly administrative. In place of legislation, the policy instruments used were the health sector reform document, change management plan and administrative orders. There were, however, no accounts of how these policies were developed (literature reviewed were the main reform document and annual and technical reports). The reform document shows the formation of a technical working group and mobilisation of technical writers and contributors, who are mainly unit heads and also former secretaries and notable academicians. There is no indication that the policies were validated with other audiences outside the department. The reengineering document of the department mentions the conduct of organisation studies prior to reform. It also noted the conduct of forums, which were mainly information dissemination and confined to the department staff.

Thailand's attention in engaging civil society groups in policy development is noteworthy. The number of forums and public consultations attests to its commitment in incorporating multiple viewpoints and seriousness in changing public policy. However, civil society participation does not necessarily mean equal participation of the disadvantaged groups in health policy development. In this mechanism of democratic participation, groups need to be formal organisations to be able to put forward their issues on the table. Unless they are organised themselves or, at the

least, credibly represented by another group like NGOs, disadvantaged groups would not be able to access this mechanism. The policy documents of Thailand gives the impression that civil society discourse has so far been among technocrats, academicians and interest groups who are part of the established middle-class. Despite of this, health policy development in Thailand was more inclusive than the Philippines, where the reform process had been mainly technocratic.

C. The policy actors and their interests in equity

The previous section highlighted that even when reforms went with international trend, they had to carry specific socio-political relevance in order to locally take root. The two countries adopted health reform because it resonated local concerns and, in a way, responded to issues that various actors recognise as vital and the governments find worth pursuing. The actors are therefore important because they situate the health policy discourse in local settings. However, actors would only champion issues that they find worthwhile and aligned with their interest. Among them, governments have the greatest stake in health reform because they are accountable for the health system's performance. As pointed out earlier, the interest of the Thai government in equity is to ensure legitimacy of its institutionalised policies. The Philippine government meanwhile implements pro-poor interventions to raise popular support to reinforce its legitimacy. Table 4.2 lists the actors who were involved in the reform process and their corresponding interests in equity.

Table 4.2 Policy actors in Thailand and the Philippines and their stakes in equity in health reform

	Thailand		Philippines	
	Stake in health reform	Interest in equity	Stake in health reform	Interest in equity
Government	Health reform needed to correspond with changed public policy paradigm	Equal participation of all sectors broadens legitimacy of policy	Minimised public spending through cost-effectiveness measures and budget cuts	Pro-poor strategies as means to secure public support
Civil society	Robustness of policy with inclusion of multiple perspectives	Equal representation in policy-making	Minimal stake in health reform – runs parallel service programmes	Enabling the poor and the excluded with empowerment strategies
Bureaucracy[10]	National health act and corresponding statutes clarify role of the ministry in changed political setup	Expressed organisational mission	Department's role redefined following decentralisation and multi-stakeholder engagement	Expressed organisational mission

NGOs have a very strong tradition in the Philippines and have been supplementing services in areas where government lacks motivation. Historically mobilised to overthrow a dictator, NGOs have become important agents in empowering the poor and excluded. They operate in every settings working with disadvantaged people to overcome poverty and powerlessness. The NGOs are such a force in number, estimated to be about 60.000 to 95.000 before the end of the century, that they earned the Philippines the label "NGO paradise" (Racelis 2000). Nevertheless, unlike

[10] Pertains to the Ministry of Public Health in Thailand and Department of Health in the Philippines

Thailand, they do not have formal channels to engage in health policy development at the national level, although at the local level they participate as members of the health board. They remain outside of the policy-making domain and do parallel programmes and advocacies i.e. they do not need government to achieve their goals. This does not diminish their effectiveness in pushing for equity in the health discourse with their innovations and best practices. Thailand's civil sector is seen as an important stakeholder in the health systems development and has become very influential in policy-making processes. But their advocacies have been about pluralism of policies and civil society representation and less about poverty alleviation or even representation of marginalised groups. Freedman (2006) further claims that civil society representation coincides with middle-class' interest in curbing the power of government and entrenching its role in the political process.

Both the Thai Ministry of Public Health and the Philippine Department of Health cite the importance of redefining their roles in a changed political milieu. Thailand's public policy reforms necessitate the bureaucracy to incorporate society's health perspectives and create a health system that builds around their expectations. The Philippines deals with diminished roles under decentralisation, reduced budget and multi-sectoral partnerships. While drastic political change accompanies Thailand's health system transformation, the Philippine bureaucracy pursues health reform following an introspection of its performance. Internal motivations therefore differ in the two institutions. Thailand has a fundamental reason in redefining the ministry's role, since there is a general call to ensure relevance of its bureaucratic institutions. The Philippines' Department of Health has to argue the need for reform and defend its formulated strategies especially within the bureaucracy that would not easily admit to ineffectiveness and accept radical measures such as reorganisation and streamlining. Nevertheless, the Philippines readily associates bureaucratic reforms with reducing health disparities unlike Thailand, where the association is less obvious.

Aside from the above actors who were the main authors of the reform policy, other institutions have been influential in constructing the reform frameworks of the two countries. Foremost to this is the WB. Its 1993 World Development Report provided the most compelling diagnosis and prescription for health reform (Green 2000), despite controversies surrounding its motivation.[11] The influence of WB can be seen in the content of reforms of the Philippines whose strategies mirror those suggested in the report. It likewise used WB's parameters in diagnosing health system problems, justifying reforms and accordingly coming up with strategies. Not surprisingly, the Philippines has continuously received assistance from the WB since the reform initiative started (WB 2008). Having graduated as an ODA recipient, Thailand enjoys autonomy in developing its reform policies (Green 2000). However, it had to conform to WB and Asian Development Bank's policy prescriptions when it necessitated loans to mitigate the impact of the financial crisis in 1997 (WB 2008b; ADB 2008). Despite the participatory nature of the policy development process, public consultations and political deliberations did not wipe out completely their imprint in the health reform policy.

Thailand and the Philippines are both beneficiaries of technical assistance provided by international organizations. Thailand has been working with the European Commission to develop its health system reform strategies. It also partners with the

[11] Many researchers take a cynical stand towards the WB, hinting that concern for debt servicing (Walt and Gilson 1994; Ziwi and Mills 1995; Standing 2002; Messkoub 1992; Farmer and Bertrand 2001), and private sector capitalist interests (Hart 2004; Messkoub 1992; Waitzkin et al. 2005) actually underpin its advocacy.

International Labour Organisation to improve its social security systems (Green 2000), which include the Universal Health Care Programme. In the Philippines, USAID through Management Sciences for Health funded the initial implementation of the health sector reform. The WB follows this through with support to public health programmes and the indigent programme of the National Health Insurance (WB 2008). ADB is providing technical assistance in streamlining policies and developing monitoring systems while the German Technical Cooperation (GTZ) is assisting in the improvement of organisational capacities of the Department of Health and the social health insurance system (ADB 2005; GTZ 2008). These international organisations follow already established health reform policies but are still influential in revising implementation approaches and operational plans as well as outcome parameters. All of the above international organisations mention alleviation of poverty and improved access of the poor to services as the objectives of their assistance.

D. Equity as a measure of health system performance

True to its aim of equitable health system, the Philippine Department of Health adopts a monitoring and evaluation tool that measures performance on equity. Administrative order 2008-0016 gives a very detailed guideline for offices and bureaus to track the progress of health sector reform implementation (Fourmula One) using equity and effectiveness as performance parameters. The administrative order reasons that the poor and underserved are the government's important clients as it upholds the value of social justice, equity and fairness. It asserts that the uniform monitoring and evaluation system allows accurate measurement of outcomes most valuable to the Filipino poor. Health reform is evaluated at three levels – at the higher and intermediate outcome levels and at the output level. Health status, financial protection and client satisfaction are key indicators at the higher outcome level. Access, quality, efficiency and financial burden are examined at the intermediate level. Outputs pertain to goods and service deliverables of the health reform strategies. It is remarkable that these outcomes and outputs translate to conventional result indicators when detailed in the tool i.e. there are no exceptional performance measures for equity. The administrative order explains that once performance measures are laid out across population groups, health disparities would become evident. Nevertheless, the tool does not segregate data into population groups that would allow data consolidation in this way. Furthermore, it makes use of the same field data gathering instruments despite the fundamental change in the required data sets.

Thailand interestingly follows two different health development plans. The Ministry of Public Health shares the first plan with nine other government agencies. It claims that this ensures consistency, integration and coordination of administration systems in promoting good health and preventing risky health behaviours, improving universal health coverage and reforming the health system. The plan enumerates general targets and does not particularise the poor as intended beneficiaries. The other plan is specific to the ministry and targets the same outcomes as the first with the addition of protection of traditional medicine, prevention of drug abuse, promotion of health care enterprises and development of responsive public health policies. The plan likewise does not specify disadvantage groups as deliberate targets but singles out people in the southern border provinces, presumably with poor health outcomes, as needing more attention (Wibulpolprasert 2007). It was not made clear how these plans relate to each other or how accountabilities of the responsible agencies are drawn. Health outcomes among women and children in different social groupings are especially looked at in assessing performance against Millennium Development Goals (Bureau of Policy and Strategy 2007). The National Economic and Social Development Board has oversight of this however and this is done separate of the

health reform initiative. In the end, there is no indication that Thailand monitors progress in reducing health disparities with the poor and disadvantaged groups.

Chapter 5 – discussion: equity's influence on health sector reform

Equity in the health development construct

In their work on South Africa, McIntyre and Gilson (2002) identified several factors that resulted in prioritizing health equity in the country's social policy agenda. Some of them are cited here because they bring to light Thailand and the Philippines' expressed rationale in pursuing health sector reform and how they tie in with the overall goal of health equity. First, the authors cited the comprehensiveness of the South African social policy package and the explicit recognition of the gains of non-health sector policies in health. They highlight the importance of coordinated action of all social policies including health in order to equalise health outcomes. Incidentally, related studies by Braveman and Tarimo (2002), Wagstaff (2002) and Walters and Suhrcke (2005) likewise point to socio-economic interventions other than health measures to remedy disparities. Second, the country made considerable effort in resolving the conflict between macro-economic and social sector policies. When the economic policies limited social programmes, informed strategic actions were conceptualised to work around the constraints. Finally, the South African experience showed the need to translate policies into strategic action and, subsequently, adoption of new roles by the government. This also included encouraging other stakeholders to take pro-equity actions and fostering society's concern for health equality.

Health reforms in Thailand and the Philippines can be seen as responses to emergent roles of government in a changed health setting. These roles tie in with the governments' overall vision of development and plans of how they intend to bring their respective countries to this ideal. It was made clear in the previous chapter that the development perspectives of the two countries are mainly economic. Naturally, if health is seen as part of the development picture, then obstacles to a healthy population become economic issues. It is not surprising, then that problems are seen on the basis of cost-effectiveness, although this is less so in Thailand. Health reforms are in a way measures to recalibrate the health system so as not to burden the government on its way to development. However, a key difference between Thailand and the Philippines is that Thailand sees health as a means to development. The distinction between human development and economic development (which pertains to the country) is implicit in Thailand's policy documents. This signifies the importance of holistic health – a composite of physical, mental, spiritual and social dimensions, for which it desires perfection and balance. Health is seen as an ideal state of human development. Its relation to economic development is simple logic: a healthy population translates to a robust workforce that will drive the country to economic prosperity. The Philippine development perspective is on the other hand down-right economic and capital-oriented. Health is an outcome that follows after economic prosperity.

The two countries therefore respond differently to situations posed by their poorly performing health systems. The Philippines' reaction is to contain costs with focused high priority programmes and clearly-defined strategies. Thailand reacts by broadening the scope of the health system with the intent to further actualise holistic development. It is clear that Thailand is able to adequately reconcile its economic paradigm with its social policies. It makes a firm standpoint that health is a requisite to development. The Philippines, on the other hand, has always had to resolve the conflict between public needs and the economic policy of fiscal austerity. The pursuit of equity is likewise argued on two different standpoints. In a system where cost-containment is a strategy of reform, there is a concern that the poor and disadvantaged might lose out in availing of streamlined services and suffer unfair

marginalisation. The system is therefore made deliberately distributive i.e. purposely to target disadvantage groups. In the Philippines, the concepts of social justice and fairness are invoked to make reforms the safety net of the poor. The Thai system treats holistic development as a right of every individual. Consequently, equity is taken to mean giving everyone equal opportunity to achieve holistic health. While in the Philippines the government must be constantly reminded of their commitment for social justice in the midst of its economic pursuits, the Thai concept of equity in health and development is fundamental. Table 5.1 shows the logical alignment of reform to the development paradigms of the two countries.

Table 5.1 Logical alignment of reform to development paradigms

	Thailand	Philippines
Development paradigm	Human-centred approach to development: investment in human capital	Economic growth-oriented
Functions of health system	Holistic view of health; health system incorporates all aspects including non-health factors such as education, agriculture and the like	Follows WHO-proposed function of health improvement, responsiveness and equitable financing but mostly dealing with health delivery and access
Rationale for reform	Need for participatory governance in health in alignment with political and public sector reforms	Poor performance of the health system: poor coverage of public health and primary health care services and inequitable access to personal health care
Stated objectives	Mobilising broad-range public involvement in restructuring and enacting the national health system	Improving the quality, efficiency, effectiveness and equity of the health system in a manner that is especially felt and appreciated by the poor
Performance parameters	No specific measurement for equity	Equity as assessment parameter established through distribution of health care across population groups

What is unique about Thailand is that it has had the opportunity to define its health system anew and institutionalise mechanisms following this framework. The whole point of reform was to develop a national health system that would embody the concepts of health and development. It helped that the enactment of the new constitution allowed civil society groups to engage in the discourse and further enrich the concepts. Despite the protracted process, health system was broadened to include social determinants of health and accordingly coordination of the Ministry of Public Health with other agencies, which improves its equity impact. Equity in the Philippine reform meant improving access of the poor to services. The issue is mostly the provision of service and does not go beyond the health domain. The change in the role of the Department of Health was necessitated more because of the streamlining of services than the realignment of programmes towards equity objectives. The Philippines, however, has a much more coherent strategy compared to Thailand. The downside of Thailand's pluralist view of health system is that roles are confused and activities lack harmonisation. It, understandably, does not have a specific measurement to assess performance of health system in equity. The Philippines commits to social fairness by taking accountability of health system's equity performance. In the end, both countries show priority on equity on its health

reform. Thailand broadens its health equity impact by incorporating measures that target social determinants of health. The Philippines have a clear rationale and reform objectives that strongly relate to equity. It can be said, however, that the influence of equity in Thailand's reform rationale is much more profound because it fits logically in its overall framework of development.

Equity in reforming health system functions

In its World Health Report in 2000, the WHO states that there are three main functions of the health system. The report asserts that improvement of health of the population is foremost to these functions. It explains that better health is the defining goal to which health systems have sole accountability from among other social systems. Also, health systems have to respond to people's expectations on treatment both physically and psychologically, which meant respect of individual's right to be treated with dignity. Health system's third function pertains to providing protection against financial risks that follow ill-health. The WHO's health system framework is useful here in outlining the content of reforms to help ascertain whether Thailand and the Philippines deal with equity issues in these core functions. However, it needs to be pointed out that whereas the WHO looks at countries' health outcomes to establish health system performance in equity, this paper investigates policy inputs as embodied in the two countries' health reform agendas. Thus, despite the usefulness of the health system framework, the World Health Report's assessment indicators have little use in interpreting information generated in the previous chapters.

Daniels' comprehensive work on the benchmarks of fairness (Daniels et. al 2005; Daniels et. al 2000) offers an alternative set of assessment parameters against which findings of this paper could be interpreted. Although their indicators still intend to measure health outcomes, they could well be used to assess policy inputs as with the study done by Pannarunothai and Srithamrongsawat (2000). Daniels et. al (2000) developed benchmarks that ascertain fairness in terms of equity as well as efficiency and accountability (Appendix 5.1). The equity benchmarks are used here and grouped according to their logical relationship with WHO's identified health system functions. The combination of WHO's framework and Daniels' benchmarks provides a list of equity indicators in each of the health system function. Table 5.2 shows that once indicators are laid out, they could serve as checklist with which to base whether reform strategies deal with equity issues in each function. In the table, the country's performance in the equity indicators are established based on the findings in chapter three i.e. the analysis of the specificity of reform content to equity.

Table 5.2 Indication of equity in the reform policies that guide health system functions

	Thailand	Philippines
Equity in improving health		
Degree to which a population benefits from reductions in exposures to risk	+++: policy covers social determinants aside from health aspects	++: agenda includes strengthening of public health programmes but confined to the health sector
Development of information infrastructure for monitoring health status inequalities	0: no mention of health inequalities monitoring	+++: health system monitoring ascertains equity and effectiveness
Reduction in geographical maldistribution	0: equity in distribution of services is not mentioned as key strategy	+++: includes subsidies to essential health goods and services and improvement of

	Thailand	Philippines
		health personnel capacities at the local level
Responsiveness to the disadvantaged		
Degree of intersectoral participation to improve social determinants and degree of engagement of vulnerable groups in defining efforts	+++: there is strong call for civil participation in reform and civil society representation in policy development; health assemblies at national and local levels were instituted	++: local health boards are opened for community engagement and multisectoral partnerships, although this is weak at national level
Gender sensitive provision of services, involvement of political groups to address gender barriers	+: National Health Act ensures provision of services to women and children	+: does not give special treatment to women and children although monitoring segregates health outcomes in this group
Perception of public sector quality	0: there was no mention of quality standards for public health facilities	+++: imposition of quality standards to public health facilities
Discrimination by race, religion, class, sexual orientation, disease, including stigmatization in receiving public care	0: service provision is universal and does not give special treatment for minorities	+: there was no special programme for minorities although monitoring checks for potential disparities
Equity in health financing		
Informal sector coverage	+++: Universal health care policy targets primarily poor and disadvantaged who are not covered by SSS and CSMBS	+++: National health insurance has an indigent programme that specifically targets the poor
Reduction of obstacles in enrolling people to the formal sector	+: health sector reform is tied to economic programmes but creation of employment and livelihood not mentioned as part of strategy	0: there was no mention of integrating indigents to the formal sector
All effective and needed services deemed affordable	+++: Co-payment of 30 baht per incident; capitation given for outpatient services	+++: Limited out-of-pocket expense by the poor; capitation given for outpatient services
Reduction of tiering and achievement of uniform quality; integration of services to the poor and others	+++: uniform services across the board	+++: uniform services across the board
Financing is according to ability to pay	+++: Free for indigents	+++: Free for indigents

Note: symbols signify explicitness of reform policies to specified indicators, with +++ indicating that they are highly explicit and 0 not at all.

On broad examination, the Philippines is able to successfully translate its equity rationale in to a coherent reform policy that addresses health inequalities. This supports the findings in chapter three where a number of reform strategies (under Fourmula One) were demonstrated to have equity implications. The above table further demonstrates that the Philippine reform adequately covers equity issues in the three functional areas of the health system. It could be established here that the Philippine reform policy is very much content-based, meaning the belief is that a well-written policy would push intended reforms. Yet the content itself is mostly an adaptation of WB prescriptions. Clearly, the technocrats of the Department of Health, who dominated policy development, subscribe to the WB's vision of a health system

and push this in the bureaucracy with the expectation that it would propel the desired change. This is also the approach for other innovative mechanisms that are not part of the WB formula but are regarded as essential in achieving equity, particularly improvement of local health systems capacity. Informed of the successes of community-based health programmes, the Department formalised structures that encouraged self-reliance in local health systems development so that they would be replicated nationwide. It is evident that the overall approach to reform is to formalise mechanisms and processes for the health system to internalise, thus the focus on the detail of the policy content.

Thailand's content of policy reforms does not have the Philippines' sophistication. In fact, it could be considered vague. For one, there is no policy paper that ties the reform strategies together in one coherent whole. Another reason is that, the reform policy papers that are currently available predominantly discuss the reform process and rarely talk about their translation into clear-cut strategies. In a way, Thailand's reform policy content is about the process. And interestingly, since the reform process is about redefining the health system, it prescribes how the content of reform should be formulated i.e. the content of reform is about the process of defining the content of policy. As convoluted as this may sound, the approach makes sense when tied in with the rationale of reform, which gives importance to the multi-faceted nature of health systems. This is seen in the table above, where much of the strategies pertain to engaging civil society in the health policy development consistent with the health system's function of being responsive to population's needs. Moreover, although Thailand has a gap in articulating reform policies and communicating this in a coherent plan, Table 5.2 demonstrates that there are parallel strategies (again not explicitly connected as part of the reform in the policy paper) being undertaken to address equity issues, the most important of which is the Universal Health Care programme. It gives the impression that implementation of health system solutions actually precedes development of a policy framework (indeed the National Health Statutes are yet to be finalised). This shows that policy has a different use in Thailand compared to the Philippines. While the Philippines uses policy to effect the intended change in the health system, Thailand's policy is more after-the-fact, and intends to institutionalise the change that is already happening in the system. And as pointed out several times, this does not bode well in terms of the content of policy, especially when establishing whether stated policies address equity of health system functions as reflected in Table 5.2.

Enabling factors favouring equity

Chapter four places the equity discussion in the two countries' socio-political contexts, the interests of policy actors and the process of policy-making. The intention was to demonstrate how equity occurred as an issue in these elements of the policy process. This section picks up from that discussion the enabling factors that contributed to the incorporation of equity in the reform agenda. The table below is used to illustrate the extent to which policy is embedded in the process by identifying the precipitating factors.

Table 5.3 Enabling factors that contributed to the incorporation of equity in the reform agenda

Policy elements	Enabling factors: Thailand	Enabling factors: Philippines
Context	■ Political transformation created opportunity to redefine health system ■ Public sector reform	■ Equity wins public support and secures legitimacy of incumbent administration

Policy elements	Enabling factors: Thailand	Enabling factors: Philippines
	emphasizes civil society participation ■ Cultural value for equity ■ Equity wins public support and secures legitimacy of incumbent administration	
Actors	■ Strong civil sector which has formal access to reform process ■ Government's commitment to human-centred development ■ Established institutions: National Health Commission, National Health Assembly, etc. ■ Technical support of agencies in targeting poor and disadvantaged	■ Strong civil society which are persistent advocates for the poor and disadvantaged ■ Government's commitment to poverty alleviation ■ Strong involvement of donors with equity aims
Policy-making process	■ Participatory and pluralistic	■ (Highly centralised)

It is immediately evident that there are several factors in Thailand that allowed equity to influence the discussion of reform. It is also evident that the influence of equity has fundamental basis on the Thai society's worldview. The economic aspect of health was already discussed in the previous section, as well as the multi-faceted nature of human development that justifies civil sector participation. Underlying them is the cultural value for equal opportunity to develop holistically. What is significant in Thailand is that these found expression with the change of the constitution as civil society groups avidly rallied to them. And since health equity could be argued in both cultural and economic terms, the government finds legitimacy in pushing for health reforms that objectify equality in human development. Thus, the combination of these factors makes a solid basis for equity to be incorporated in the reform process. Even when the policy-making process itself is not necessarily representative of the disadvantaged population, policies would default to ensuring services to them since they are generally recognised to have the least opportunity in achieving holistic development.

From the table, it can be said that the primary enablers of equity in the policy reform process in the Philippines were the policy actors. In a setting where there is no clearly expressed societal basis for equity, its expression and degree of influence were dependent on whose value systems predominated in the policy discourse. Naturally, the government has had the upper hand. Its overt bias for economic development placed health equity on thin ice since it could always be argued that there was a need to hold social spending in favour of job creation and economic reforms, which could also be invoked on the basis of social justice. The action of other policy actors, particularly the civil society sector, might have balanced the government's hardline economic programmes but in a process that is a compromise of value systems. This provides another explanation why there was particular emphasis on equity on the reform content, as a way to substantiate government's commitment to alleviate health disparity and satisfy public expectation in the light of its aggressive economic undertakings. And even with a strong emphasis on equity in reform, this does not necessarily translate to actual resource allocation. In fact, priority to health in resource allocation is similarly a conciliatory process. It helps that equity musters public support and for this reason draws government interest but, as shown earlier, government regards equity as an issue only when its legitimacy is in

question. In the end, equity's influence goes in and out of the policy agenda depending on government's need for legitimacy and public support as well as civil society's advocacies.[12]

[12] In Hall's model (Hall et al. 1975) of politics-as-usual, an issue is included in the policy agenda when legitimacy, support and feasibility in implementing the policy are high. In the Philippines, where the call for equity does not follow any radical political reform, it loses priority when the three elements are lacking.

Chapter 6 – conclusion

Looking at Thailand and the Philippines' rationale for health reform as well as their contents and accompanying policy development processes, there are clear indications that equity influenced health reforms in both countries. Equity's influence was expressed in two ways. It is very overt in the Philippines – it is a clearly stated objective for a well-recognised problem. The Philippine rationale starts by problematising health disparities and justified reforms on the basis of the health system's inability to remedy the gap. The content of the policy is remarkable in its sophistication in coherence and logic and more importantly, clarity in addressing health disparities. It was also very explicit in assessing the health system using equity as well as effectiveness as indicators of performance. The influence of equity in Thailand, on the other hand, is very tacit. It is implicit in the Thai concept of an individual's right to achieve holistic development. And it is silent in its pervasiveness of the health reform discourse, informing the conceptualisation of the health system and policy development process. This paper has sought to demonstrate that in both countries, equity's influence is rooted in the need for governments to broaden their legitimacies. Beyond a commitment to social justice, the Philippine government used health policy to help gain public trust. The Thai government redefined health policy roles due to a changing political setting that demanded equal representation. Needless to say, equity in the two countries was reinforced by public support.

The degree of equity's influence on both countries' reforms can be established based from several points made in the previous chapters. There are reasons to view equity as organic in Thailand's health reform. The Thai vision of human-centred development and recognition of the need for a multi-faceted approach effectively placed the health system's equity ideal in its overall development agenda. The alignment of equity, health and development is correspondingly communicated in the reform policy. Another reason is the underlying culture that gives philosophical basis to this development paradigm. Culture provided a common worldview that policy actors share and public expectations are based upon. All of this found expression in the new constitution, which created an opportunity to redefine the health system and the public sector according to the local ethos. In the Philippines, health disparity statistics necessitated the need for reform. It was neither precipitated by any historical event nor grounded by any commonly-held cultural worldview. Calls for equity are essentially in reaction to the interests of policy actors' and thus enter the policy agenda from diverse viewpoints. Thus, equity influences health reform in so far as it is a political commitment of the government and safeguarded by a sustained civil society advocacy.

Clear validation of the conclusion above is found in the actual performance of the health systems of Thailand and the Philippines. Data presented in chapter two indicates that Thailand fares better than the Philippines in most of the health indices. This is further confirmed in Appendix 6.1, which shows Thailand having better figures compared to the Philippines in most core health indicators. It also does well when compared to its regional neighbours, besting them in maternal mortality rate and percentage of under-weight children. Unfortunately, data available on the health disparities in the two countries come from different sources limiting further comparisons. While the Philippines has figures on health inequities in the WHO website, Thailand has its own figures published by the Ministry of Health with its own set of measures. Nevertheless, available figures demonstrate that the difference in health system performance matches the observation made about the degree of equity's influence in health reforms i.e. performance is better in Thailand where equity has profound influence. Interestingly, this is despite the fact that the Philippines has a very well-articulated policy on reform, while Thailand's policy from a

documentation standpoint is a bit disjointed. This paper sought to better understand policy outcomes by looking beyond the standard investigations of their rationale and content but also by contextualizing it and examining the actors and policy-making process. It is further suggested that analysis of these policy elements can credibly provide a supplementary explanation for the existence of health disparities.

It can be assumed that the equity framework for both countries hinges on poverty since policy documents rarely mention cultural minorities, women or other recognised disadvantaged groups as intended targets of reform. Reform strategies likewise are silent regarding cultural differences, gender or sexual orientation biases and other accessibility issues other than actual physical access to facilities. There is reason to assert that disadvantage is defined in terms of individual economic incapacity. Where minorities and other marginalised groups effectively fit in this category, they are helped by policies that are pro-poor. When they do not, the literature is silent. In effect, the vast majority of equity mechanisms that are intended to favour disadvantaged groups are built around poverty issues and do not nuance other special concerns. It is recognised, however, that there might be special policies and programmes specifically intended for these groups, which are beyond the scope of this research. Thus, there is a need to supplement this research with a review of additional policies to draw a complete picture of the influence of equity in the health system.

Recommendation

It is difficult to generalize from two dissimilar frameworks with different policy outcomes. It is equally difficult to draw recommendations out of the countries' experiences since reforms were laid out to correspond to their particular local circumstances. This paper refrains from attempting to determine which country's reforms are more effective in pushing for equity as each country's process may be relevant to its particular context. Although it is immediately obvious that Thailand is doing better in terms of health outcomes, it does not mean that the Philippine approach is not effective. An overt expression of equity in a well-defined reform policy could be the best way to stand on firm ground in government reforms. A clear policy agenda that governs practice could just as well influence mindsets to be conscientious of equity. Therefore, instead of making judgements on which country's approach is recommendable, this paper considers it more relevant to identify key areas in the countries' reform policies where equity found expression. This is helpful in policy development as it identifies areas to examine equity in future agendas.

Content. It is the most obvious but not the tell-all sign of equity's influence in health reform. Content has a tendency to be rhetorical and should be verified with other elements of policy. However, it should also be considered that policy documents could be a tool to push the value for equity in the health system bureaucracy and even in individual mindsets, as in the Philippines.

Problem recognition. Reforms are drawn on the basis of equity if health system problems are recognised to be about disparities in health outcomes and inequitable distribution of services. There is a tendency for policy content to be very thorough when equity problems are clearly defined and characterised.

Historical and cultural contexts enable internalisation of equity. A shared value for equity makes clear the accountabilities of government that civil society and the public could legitimately demand.

Health system construct. When health system is defined broadly to include non-health aspects, inter-agency cooperation, multi-sectoral engagement and coordinated development planning become its components. This addresses not only health issues but their social determinants as well, which has positive implications to reducing health disparities. Equity also benefits when health system development is aligned with the country's overall development agenda.

Government interest. Government pursues equity so far as it broadens its legitimacy. If public advocacies are weak, then the government has the upper hand in setting the policy agenda and legitimacy in laying down its value systems. There is a tendency to overlook equity issues and not to prioritize health especially if the value system does not hold the government particularly accountable to health disparities.

Policy development culture. Equal representation in the policy development process signifies the intention for policies to be responsive to people's needs. Generally, reforms are favourable to equity when the policy development process allows voices to be equally heard.

Assessment parameters. The influence of equity is clearly demonstrated when equity is part of the assessment parameters of health system performance.

Finally, it is strongly advocated that policy analysis look beyond the rhetoric of content to provide a more relevant assessment of the effectiveness of policies. In a time when most policy discourse happens external to countries, it is important to look at how these resonate local issues and made to fit specific contexts. In the end, policies are most effective when they respond to issues that matter to those in power and the ones they serve.

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Chapter 6 – conclusion

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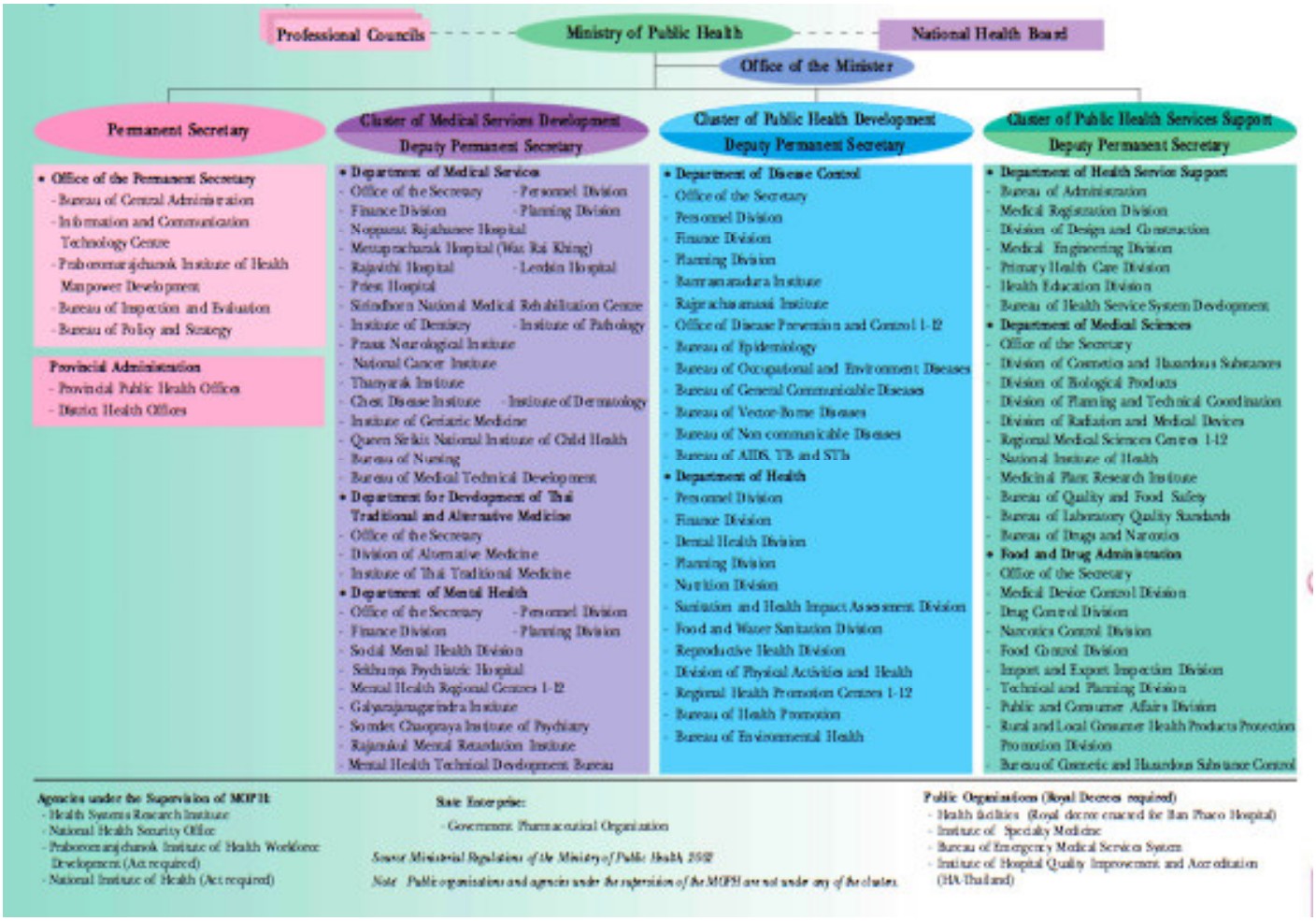
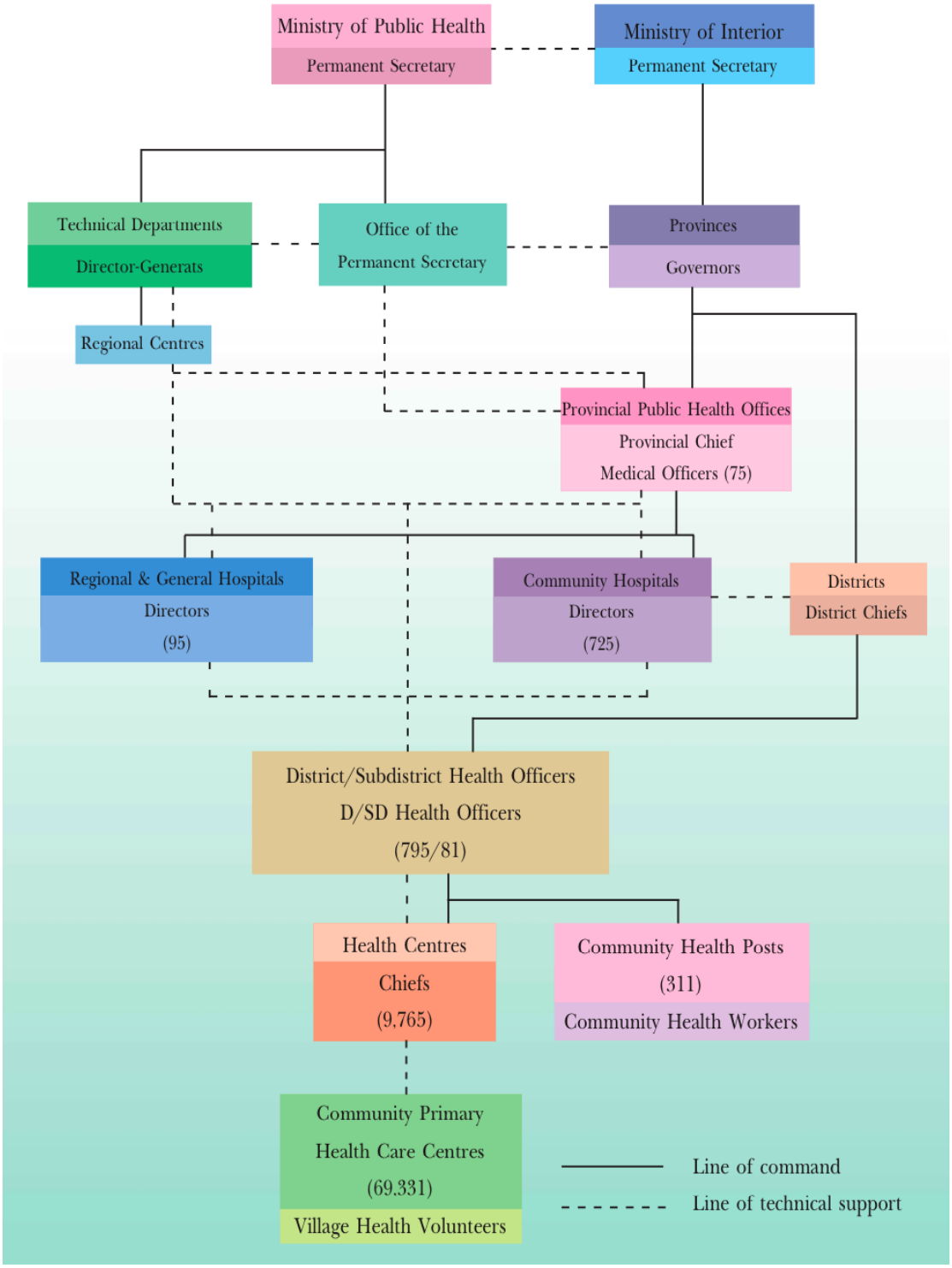
Appendices

Appendix 2.1 Structure of the Ministry of Health , Thailand (Wibulpolprasert 2004)



Appendix 2.2 Structure of the Provincial Health Administration, Thailand (Wibulpolprasert 2004)



Appendix 2.3 Philippine Department of Health Organisational Structure (DOH 2008)

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Appendix 3.1 Powers and duties of the National Health Commission – Thailand (NHC 2006)

1. To create a national health system statute that provides framework for policy, strategy and work and to review it every five years;
2. To sustain participation in the process of developing healthy policies and strategies;
3. To establish parameters in monitoring and evaluation of the national health system and the conduct of health impact assessment;
4. To organise and support health assemblies at local and national levels and on specific issues in a participatory manner towards the development of public health policies;
5. To be advisory to the council of ministers on policies and strategies related to health, track the results thereof and communicate them to the public; and,
6. To establish the executive board of the National Health Commission Office, which acts as secretariat to the commission.

Appendix 5.1 Benchmarks of fairness: equity (Daniels, et al. 2000)

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Appendix 6.1 Core Health Indicators in Thailand and the Philippines
(WHO Statistical Information System 2008)

Core Health Indicators	Philippines	Thailand
Adult mortality rate (probability of dying between 15 to 60 years per 1000 population) both sexes	219 (2006)	210 (2006)
Adult mortality rate (probability of dying between 15 to 60 years per 1000 population) female	157 (2006)	155 (2006)
Adult mortality rate (probability of dying between 15 to 60 years per 1000 population) male	277 (2006)	264 (2006)
Age-standardized mortality rate for non-communicable diseases (per 100 000 population)	642.0 (2002)	559.0 (2002)
Deaths among children under five years of age due to diarrhoeal diseases (%)	12.0 (2000)	16.2 (2000)
Deaths among children under five years of age due to HIV/AIDS (%)	0.0 (2000)	6.2 (2000)
Deaths among children under five years of age due to injuries (%)	2.7 (2000)	4.8 (2000)
Deaths among children under five years of age due to malaria (%)	0.4 (2000)	0.3 (2000)
Deaths among children under five years of age due to measles (%)	1.2 (2000)	0.1 (2000)
Deaths among children under five years of age due to neonatal causes (%)	36.9 (2000)	44.9 (2000)
Deaths among children under five years of age due to other causes (%)	33.5 (2000)	16.0 (2000)
Deaths among children under five years of age due to pneumonia (%)	13.4 (2000)	11.5 (2000)
Deaths due to HIV/AIDS (per 100 000 population per year)	<10 (2005)	33 (2005)
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	45.0 (2006)	16.0 (2006)
Deaths due to tuberculosis among HIV-positive people (per 100 000 population)	0 (2006)	4 (2006)
Healthy life expectancy (HALE) at birth (years) both sexes	59.0 (2003)	60.0 (2003)
Healthy life expectancy (HALE) at birth (years) female	62.0 (2003)	62.0 (2003)
Healthy life expectancy (HALE) at birth (years) male	57.0 (2003)	58.0 (2003)
Infant mortality rate (per 1 000 live births) both sexes	24.0 (2006)	7.0 (2006)
Infant mortality rate (per 1 000 live births) female	20 (2006)	7 (2006)
Infant mortality rate (per 1 000 live births) male	28.0 (2006)	8.0 (2006)
Life expectancy at birth (years)	68.0 (2006)	72.0 (2006)
Life expectancy at birth (years) female	71.0 (2006)	75.0 (2006)
Life expectancy at birth (years) male	64.0 (2006)	69.0 (2006)
Maternal mortality ratio (per 100 000 live births)	230 (2005)	110 (2005)
Neonatal mortality rate (per 1 000 live births)	15 (2004)	9 (2004)
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) both sexes	32 (2006)	8 (2006)
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) female	26 (2006)	7 (2006)
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) male	37 (2006)	8 (2006)
Years of life lost to communicable diseases (%)	45.0 (2002)	43.0 (2002)
Years of life lost to injuries (%)	13.0 (2002)	17.0 (2002)
Years of life lost to non-communicable diseases (%)	42.0 (2002)	40.0 (2002)
Incidence of tuberculosis (per 100 000 population per year)	287.0 (2006)	142.0 (2006)
Prevalence of HIV among adults aged >=15 years (per 100 000 population)	<100 (2005)	1144 (2005)
Prevalence of tuberculosis (per 100 000 population)	432.0 (2006)	197.0 (2006)
Antenatal care coverage - at least four visits (%)	70 (2003)	74 (2003)
Antiretroviral therapy coverage among people with advanced HIV infections (%)	24 (2006)	46 (2006)

Births attended by skilled health personnel (%)	60.0 (2003)	97.0 (2006)
Neonates protected at birth against neonatal tetanus (PAB) (%)	64.0 (2006)	88.0 (2006)
One-year-olds immunized with MCV	92 (2006)	96 (2006)
One-year-olds immunized with three doses of diphtheria tetanus toxoid and pertussis (DTP3) (%)	88 (2006)	98 (2006)
One-year-olds immunized with three doses of Hepatitis B (HepB3) (%)	77 (2006)	96 (2006)
Tuberculosis detection rate under DOTS (%)	77.0 (2006)	73.0 (2006)
Tuberculosis treatment success under DOTS (%)	89 (2006)	75 (2006)
Children under five years of age overweight for age (%)	2.4 (2003)	8.3 (2006)
Children under five years of age stunted for age (%)	33.8 (2003)	15.7 (2006)
Children under five years of age underweight for age (%)	20.7 (2003)	7.0 (2006)
Newborns with low birth weight (%)	20 (2000)	9 (2001)
External resources for health as percentage of total expenditure on health	5.1 (2005)	0.2 (2005)
General government expenditure on health as percentage of total expenditure on health	36.6 (2005)	63.9 (2005)
General government expenditure on health as percentage of total government expenditure	5.5 (2005)	11.3 (2005)
Out-of-pocket expenditure as percentage of private expenditure on health	80.30 (2005)	76.60 (2005)
Per capita government expenditure on health at average exchange rate (US$)	14.0 (2005)	63.0 (2005)
Per capita government expenditure on health(PPP int. $)	73.0 (2005)	207.0 (2005)
Per capita total expenditure on health (PPP int. $)	199.0 (2005)	323.0 (2005)
Per capita total expenditure on health at average exchange rate (US$)	37.0 (2005)	98.0 (2005)
Pharmaceutical personnel density (per 10 000 population)	6.00 (2002)	3.00 (2000)
Physicians density (per 10 000 population)	12.00 (2002)	4.00 (2000)
Private expenditure on health as percentage of total expenditure on health	63.4 (2005)	36.1 (2005)
Private prepaid plans as percentage of private expenditure on health	10.5 (2005)	15.6 (2005)
Ratio of nurses and midwives to physicians	5.3 (2002)	7.6 (2000)
Social security expenditure on health as percentage of general government expenditure on health	31.6 (2005)	12.4 (2005)
Total expenditure on health as percentage of gross domestic product	3.2 (2005)	3.5 (2005)