8 Creating, reclaiming, defending
Non-commercialised alternatives in the health sector in Asia

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The health sector encompasses a very large canvas, including not just health care services but also allied services that contribute to health, such as water supply and sanitation, as well as determinants of health such as food security, secure employment, gender equity, education, housing, and a clean environment. However, for the purposes of this chapter, we limit ourselves to health care services in order to focus the analysis on the ownership and management systems that operate them and the extent to which these systems can be considered "alternatives to privatisation".

A scrutiny of health care provision and health systems in Asia needs to be located in the prevailing economic framework of the region. Like other parts of the world, the neoliberal framework of public policy formulation has permeated Asia over the past three decades. A typical feature that has characterised neoliberal policies is a clear position against the pursuance of policies designed to promote welfare. This has translated into progressive abolition of welfare rights related to economic security, health services, and education. Similar to other regions of the world, policies pursued by most states in the region have imposed wide-ranging cuts on welfare programmes, such as anti-poverty initiatives, food and agricultural subsidies, and free or subsidised public sector services (Haque 2008). In the health sector, it is ironic that this shift in public policy was set in motion even before the ink was dry on the resolution on Primary Health Care (PHC) that was adopted in Alma-Ata in 1978.[1]

There is no single "Asian reality", however, given that Asia is home to 60% of humanity and includes countries with very diverse histories, political systems, and social conditions. But it is remarkable nonetheless that in the last three decades virtually the entire continent has adopted a neoliberal framework while "reforming" the health care sector. Such reforms are evident, for example, in the two largest countries of the world – China and India. China's Gini coefficient (a standard measure of income inequality) was a low 29 in 1981 but reached 41 in 1995, similar to the US. The rural-urban divide increased, regional disparities widened, and access to opportunities became less equal during the 1990s. Only the incomes of the richest quintile of the Chinese population grew faster than the national average – again remarkably similar to the US. The government share of health expenditures fell by over half between 1980 and 1998, almost tripling the portion paid by families (People's Health Movement et al., 2006). In India, while elements of neoliberal policies were introduced in the 1980s, formal structural adjustment measures for the economy were introduced relatively late, in 1991. The immediate fallout was a savage cut in budgetary support to the health sector. The cuts were severe in the first two years of the reform process, followed by some (but not complete) restoration in the following years. Indonesia, Thailand, and the Philippines were forced to undergo neoliberal reforms to access International Monetary Fund (IMF) loans in the midst of the Asian economic crisis in the 1990s. Cambodia, Laos, and Vietnam turned to the IMF/World Bank for funding and advice in the 1980s, while attempting to build their war-ravaged economies (McGregor 2008). In Vietnam, in the process of economic restructuring in the 1980s, more than a million workers and over 20 000 public employees (of whom the majority were health workers and teachers) were laid off. The agreement signed with the IMF prohibited the state from providing budget support either to the state-owned economy or to an incipient private sector.

OVERVIEW OF COUNTRY SITUATIONS

We have discussed above the broad macroeconomic framework that informs the situation as regards health care services provisioning. We now turn to look at more specific trends in different countries in the region. The analysis is limited to a select list of countries – Bangladesh, China, India, Iran, Laos, Malaysia, Nepal, Sri Lanka, and Thailand. The above comprise a fairly good representation of the Asian region – i.e. West Asia (Iran), South Asia (India, Sri Lanka, Bangladesh, Nepal), Southeast Asia (Thailand and Malaysia), Indo-China (Laos), and China. These countries represent broad trends in the specific subregions in Asia and can be seen to provide a macropicture of important trends in the region.

Table 8.1 provides an overview of some important indicators of health service provision, as well as broader determinants of health. Of the four countries from the South Asian region, Sri Lanka stands out as a positive exception. The other three countries (India, Bangladesh, and Nepal) show similar patterns in terms of prevalence of high child mortality and malnutrition rates and poor public expenditure on health. Sri Lanka's performance is discussed later in our analysis of the public health system of the country. The other interesting insight is that some of India's indicators are actually worse than those of Nepal and Bangladesh, which needs to be seen in the context of the hype about India (along with China) being the latest "poster boy" of neoliberal reforms!

Table 8.1 Overview of country situation in health – Asia

	ppp per capita income (US $)*	*Under five mortality rate (per 1 ,000 live births)*	*Life expectancy at birth*		*Health expenditure as % GDP (2004)*		*Human development index (HDI)*	*Prevalence of child malnutrition (2000–2007)*	*Access to safe delivery (% of total births)*
			M	*F*	*Public*	*Private*			
Bangladesh	1 340	69	63	65	0.9	2.2	140	39.2	20
China	5 370	24	70	74	1.8	2.9	81	6.8	98
India	2 740	76	63	66	0.9	4.1	128	43.5	47
Iran	10 800	34	69	72	3.2	3.4	94	–	90
Laos	1 940	75	63	65	0.8	3.1	130	36.4	19
Malaysia	13 570	12	72	76	2.2	1.6	63	–	98
Nepal	1 040	59	63	64	1.5	4.1	142	38.8	19
Sri Lanka	4 210	13	72	78	2.0	2.3	99	22.8	96
Thailand	7 880	8	66	75	2.3	1.2	78	7.0	97

* ppp = purchasing power parity
Source: World Bank (2009), UNDP (2008).

If we disregard the data on public health expenditure, China would be seen to be performing remarkably well. The data, however, hide regional, rural-urban, and income-based inequities that have been widely commented upon, including by Chinese government officials. The income ratio of urban residents over rural residents increased from 2.2 in 1990 to 2.9 in 2003. The National Health Survey in China indicates that nearly 30% of patients in that country did not use inpatient care when they were advised by doctors to be hospitalised. The predominant reason for not accessing inpatient care was affordability (70%) – 54.1% in urban areas and 75.4% in rural areas. The survey also revealed that in rural counties, the proportion of health expenditures in total non-food expenditures was 28.9% for the lowest-income families, while it was 17.6% for highest-income families (CHSI 2004).

Southeast Asia, represented by Malaysia and Thailand, presents a contrast. Identified as part of the "East Asian Tigers" even before the present phase of neoliberal reforms, their indicators approach those of developed nations. There are divergences in the two countries, however, which we will examine later.

Laos is somewhat typical of the three countries – Vietnam, Cambodia, and Laos – in the "Indo-China" region. They embarked on "reforms" in the mid-1980s after a period of promoting a socialised pattern of development. In this region, and particularly in Vietnam (the largest country in the region), public health was considered a state responsibility implemented by a centralised, hierarchical five-tier health care system. Health services were provided free of charge throughout the country's provinces, districts, and over 10 000 communes – extending occasionally down to the brigade level. Services were financed entirely from state finances generated at the commune, provincial, and central levels. Health care coverage was extensive and mostly equitable, and the density of hospital beds and doctors in Vietnam was among the highest in Asia (Sida 1994). The collapse of the commune-based social welfare system led to the collapse of the fiscal base of social programmes. Services were withdrawn, privatised, or supported by user charges. The data on Laos indicate the fairly clear trajectory and consequences related to the dismantling of public systems. The data, for example, show that relative private sector participation is next only to what is seen in India and that public expenditure (as a percentage of GDP) is the lowest of all the countries we examined (Laos, along with India, ranks in the bottom five globally in this respect).

Finally, Iran presents a specific context. Expenditure data show high public as well as private participation. Iran's ability to maintain its public system in the face of the constraints of US-led sanctions is laudable. But it should also be noted that Iran's economic performance continues to be better than most countries in Asia, so Iran does have the internal resources to develop its public systems, supported largely by oil and gas exports, which contribute 60% of government revenue. The relatively high child mortality figures in Iran in spite of better economic performance and a functioning public health system, however, stand out as a cause for concern and deeper investigation.

Table 8.2 Selected indicators of health services

	% Births attended by trained personnel		*% Infants fully immunised (measles + DPT)*		*Oral rehydration therapy use in diarrhoea (%)*	*Anti-retroviral drug coverage (%)*
	1990–1999	*2000–2008*	*1990*	*2007*	*2000–2007*	*2007*
Bangladesh	14	18	65	88	70.1	7
China	89	98	97	93	NA	19
India	42	47	56	62	26	NA
Iran	NA	97	85	97	NA	5
Laos	7	20	18	40	50.5	95
Malaysia	81	100	70	90	NA	35
Nepal	9	19	43	81	29.3	7
Sri Lanka	NA	99	80	98	NA	NA
Thailand	85	97	80	96	68.3	71.5

Source: WHO (2009, 72–79).

The comparative data on indicators of health services (Table 8.2) reinforce what was discussed earlier. The poor performance of countries in South Asia (with the remarkable exception of Sri Lanka) and of Laos (except for anti-retroviral coverage for HIV/AIDS) is striking. Of significance is the laudable performance by Bangladesh regarding usage of oral rehydration therapy (ORT) for treatment of diarrhoea. ORT is often held up as one of the most important public health measures to have been introduced in modern times and is believed to be responsible for saving millions of lives each year. The fact that its use is still far from universal in most settings is an indicator of how health systems often obstinately resist introduction of low-cost technologies in spite of overwhelming evidence of efficacy (Werner and Sanders 1997). Bangladesh is an example of large-scale adoption of such technology. While most countries have shown a significant rise in immunisation coverage, the coverage in India has stagnated, and in the case of China, coverage has actually come down. This is an indicator of the faltering public systems in the two largest countries of the world.

We turn now to examine some indicators of broader determinants of health. Of note in Table 8.3 is the very high prevalence of malnutrition in South Asia. Also striking is the fact that India is worse off in this area than even its much poorer South Asian neighbours. It has been postulated that this phenomenon, termed as the “South Asian enigma”, has its roots in the much larger levels of gender inequity present in the region (Ramalingaswami et al., 1996). We point this out to underline that while in our analysis we limit ourselves largely to health services, other determinants often have a very significant impact on the health status of communities.

Differences also exist across the countries under analysis as regards availability and deployment of health personnel. Table 8.4 provides comparative data. Of particular significance is a fairly clear picture (irrespective of the absolute numbers) of the higher ratio of nurses/midwives to doctors in most countries with better-performing public health systems (such as Thailand, Sri Lanka, and Malaysia in contrast with India, China and Bangladesh). The finding should not come as a surprise, as private systems rely inordinately on personnel with more specialised training (e.g. physicians rather than health workers), specialists rather than general physicians, and so on. Private systems thus rely on health personnel with a narrower and more specialised focus of expertise, each designed to treat very specific patient groups. There is no evidence, however, that this leads to any significant advance in outcomes. In some settings the converse is true. India’s reliance on highly trained personnel, for example, translates into large areas in poorer regions being denied medical facilities as personnel with higher levels of training (doctors) are reluctant to serve there. This may be contrasted with the situation in Thailand, with a much better performing public system, where the density of doctors is lower than in India, but the density of health workers is much higher.

Table 8.3 Determinants of health – drinking water and nutrition

	% of population with access to drinking water		*% of children under five that are underweight*	
	1990	*2006*	*1990–1999*	*2000–2007*
Bangladesh	78	80	52	39.8
China	67	88	NA	6.8
India	71	89	44.4	43.5
Iran	92	95	NA	NA
Laos	NA	60	NA	36.4
Malaysia	98	99	NA	NA
Nepal	72	89	38.2	38.8
Sri Lanka	67	82	NA	22.8
Thailand	95	98	NA	7

Source: WHO (2009, 83–94).

Table 8.4 Availability and deployment of health personnel

Country	*Physician per 10 000 population 2000–2007*	*Nurse/midwife per 10 000 population 2000–2007*	*Ratio of physicians to nurses/midwives*
Bangladesh	3	3	1:1.0
China	14	10	1:0.7
India	6	13	1:2.2
Iran	9	16	1:1.8
Laos	4	10	1:2.5
Malaysia	7	18	1:2.6
Nepal	2	5	1:2.5
Sri Lanka	6	17	1:2.8
Thailand	4	28	1:7.0

Source: WHO (2009, 95–106).

Table 8.5 Financing of health

	Total health expenditure as % GDP		*Public expenditure on health as % GDP*		*Private expenditure as % total expenditure*		*Out-of-pocket expenditure as % of private expenditure*	
	2000	*2006*	*2000*	*2006*	*2000*	*2006*	*2000*	*2006*
Bangladesh	3.3	3.2	0.9	1.0	73.5	68.2	88.1	88.3
China	4.6	4.6	1.8	1.9	61.7	59.3	95.6	83.1
India	4.3	3.6	0.9	0.9	78.2	75.0	92.1	91.4
Iran	5.9	6.8	2.2	3.4	63.0	49.3	95.9	94.8
Laos	3.2	4.0	1.0	0.7	67.5	81.4	91.8	76.1
Malaysia	3.2	4.3	1.7	1.9	47.6	55.4	75.4	73.2
Nepal	5.1	5.1	1.3	1.6	75.1	69.5	91.2	85.2
Sri Lanka	3.6	4.2	1.7	2.0	52.1	52.5	83.3	86.7
Thailand	3.4	3.5	1.9	2.3	43.9	35.5	76.9	76.6

Source: WHO (2009, 107–118).

Table 8.6 Out-of-pocket (OOP) payments in public services in the year 2000

Country	*OOP as % of total expenditure on health*	*Percentage of total OOP on public sector care*
Bangladesh	64.85	0.50
India	80.00	25.61
Malaysia	40.20	7.17
Sri Lanka	45.59	0.86
Thailand	32.74	34.93

Source: van Doorslaer et al. (2005, 33).

Table 8.7 Per capita public expenditure on health

	Per capita government expenditure on health (in "purchasing power parity" US dollars)	
Country	*2000*	*2006*
Bangladesh	7	12
China	42	88
India	14	22
Iran	143	344
Laos	13	15
Malaysia	151	242
Nepal	10	16
Sri Lanka	47	81
Thailand	97	170

Source: WHO (2009, 107–118).

How health care services are financed is a major determinant of access and equity. Table 8.5 provides data on the large variations in health care financing. It is generally accepted by public health advocates, as well as within the World Health Organization (WHO), that public health expenditure should be at least 5% of a country's GDP.[2] By that count all the countries studied lag behind significantly, with only Iran approaching anywhere near the benchmark (at 3.4%). India and Laos stand out as the worst performers with 0.9% and 0.7% of GDP public spending on health. Importantly, in all cases private expenditure is significant and in all countries (except Thailand) outstrips public expenditure. This clearly suggests that in most countries of the region the dominant mode of provision of health services is through the private sector.

It is also important to understand that when public facilities are available they are not necessarily free. Users of public facilities often need to pay, in the form of user fees for facilities. Public facilities also entail out-of-pocket expenses when users are required to purchase medicines prescribed – a prominent cause of expense in the public sector in many countries. Table 8.6 provides data from some countries regarding out-of-pocket expenses in the public sector. While data are not readily available for all countries under analysis, similar trends are discernible. In China, for example, earlier studies estimate that income from user fees is 36% of total expenditure on the public system (Dezhi 1992).

It is significant that in all the countries examined per capita public health expenditure (as purchasing power parity in US dollars) has increased between 2000 and 2006 (see Table 8.7). This is a positive trend, though in some cases the increase is marginal. What is cause for concern is the fact that of the three countries where private expenditure has expanded faster than public expenditure, two are countries that historically have had better-performing public systems (Malaysia and Sri Lanka). Another data set that merits comment is the extent of out-of-pocket expenses in the case of private expenditure, which indicates the limited penetration of private health insurance, even in situations in which the private sector is the major provider of health services.

SEEKING ALTERNATIVES

Having provided a survey of the current state of public/private PHC provision, we turn now to a discussion of instances of service delivery that do not involve the participation of the private, for-profit sector. Essential information regarding these various initiatives are consolidated below and analysed based on a range of predefined "criteria for success". This "mapping exercise" is seen as a step towards identifying health care practices in the Asian context that can be leveraged upon to suggest alternative strategies for health systems that are in the public domain, are sustainable, and advance health equity.

Methodology

The research was carried out by first identifying possible initiatives that needed to be documented, predominantly through literature reviews. The process was augmented by sending out requests to contacts in different parts of the region to provide information about interesting initiatives that fit the criteria of "alternatives to privatisation" (see Chapter 2, this volume, for a fuller account of research methodology). Additional information was also obtained from available documentation of the Health Systems Knowledge Network of the Commission on Social Determinants of Health (Gilson et al., 2007).

Based on the above, examples of "alternatives to privatisation" were short-listed for more detailed analysis. These initiatives were researched further using information received from respondents in different countries, published reports and papers, and material available on the Internet.

Typologies of "alternatives"

The word "alternatives" is intentionally placed in quotation marks. Some of the cases identified and discussed do not fit an ideal notion of alternative (as contradistinctive to the present trend towards privatisation and commercialisation of health care and delivery mechanisms). However, as the short narratives provided below attempt to make clear, many of these initiatives are important because they do bring out the tension between the neoliberal ethos on one hand and the designed intent of addressing issues of inequity related to health and access to health care. Nevertheless, although none of the cases discussed have an overt agenda to promote privatisation, the prevalence of an ideological mindset that is unable to visualise a system of health care delivery that is entirely publicly owned and financed is evident in many of the cases identified.

Below, we discuss some of the important features of the identified alternatives within different typologies. There is a degree of overlap, and we have, for example, grouped together NGO and government programmes which address a specific aspect of access to health services.

The initiatives we have mapped can be classified as follows:

- large national initiatives by governments that aim to provide comprehensive access to health services;
- primary care initiatives by not-for-profit non-governmental organisations, which have a large span of coverage;
- primary care initiatives, which have a limited span of coverage but are useful models to take note of;
- initiatives that address a specific aspect of access to health services, such as access to medicines, HIV treatment, etc.

LARGE NATIONAL INITIATIVES BY GOVERNMENTS

China: New Rural Cooperative Medical Scheme (NCMS)

NCMS was introduced in China in July 2003. It is a consequence of the Chinese government's stated effort to restructure health services, with a larger focus on improvement of equity in health and health care (Meng 2007). The scheme is the result of a large consultative process and aims to remedy the visible decline in access to health care services in China since the economic reforms initiated in the 1970s. The decollectivisation of agriculture resulted in a decrease in support for the collective welfare system, of which health care was part. In 1984, surveys showed that only 40%–45% of the rural population was covered by an organised cooperative medical system, as compared with 80%–90% in 1979. Specifically, the NCMS aims to reverse this situation and target the problems related to catastrophic out-of-pocket expenditures incurred by people to take care of medical expenses.

The scheme started operating in 2003, and by 2008 over 800 million people in China's rural areas were covered by it. The premium under the NCMS is paid by three sources. In 2003, Chinese national and local authorities each contributed 10 yuan per person, while individuals contributed at least 10 yuan. By the end of 2009, the total annual premium was targeted to be raised to 100 yuan, of which 80 yuan will come from the central and local governments and individual payments will be 20 yuan (Wang 2009).

Review of the programme shows that the scheme has led to some increase in access to inpatient care for vulnerable populations, but out-of-pocket expenses continue to be a major issue. Reimbursement of expenses for inpatient care is still low (but expanding), at approximately 30% of total costs (Parry and Weiyuan 2008). The scheme envisages that by 2020, it will help achieve its goal of “safe, effective, convenient, and low-cost” medical care for the entire population. Higher-end treatment will continue to be available, although funded only through private insurance schemes. A more detailed implementation plan for the three years until 2011 is being developed and is expected to receive 850 billion yuan (U$124 billion) for the reform in three years. This is the largest and most sustained initiative in post-liberalisation in China to reverse the trend of privatisation and inequity in health care and access. The programme is designed to provide comprehensive coverage by 2020, and its importance is immense as it seeks to reverse a three-decade trend of rolling back public support for health services. Over the last five years, there has been significant expansion, and there seems to be a political will to sustain the momentum (Wang 2009).

Iran: PHC through “health houses”

The Iranian “health houses”, conceived and introduced during the 1980–1988 war with Iraq, lie at the core of the PHC system in Iran. The system relies on the following components: (i) establishing health houses in remote and sparsely populated villages; (ii) staffing health houses with health workers, known as *behvarzan* (meaning “good skills” in Farsi), recruited from local communities; (iii) developing a simple but well-integrated health information system; and (iv) a referral system linking with rural and urban health centres and hospitals (Sadrizadeh 2004).

The health house is the most basic unit of the Iranian PHC network. Located in individual villages, it is designed to cover a target population of about 1 500. The distance between the village in which the health house is located and the satellite villages served by it is typically no more than a one-hour walk. The health houses refer patients to rural health centres, which cover about 6 000 to 10 000 people, and have up to two physicians and several health technicians. These centres are responsible for elective and emergency case management, supporting the health houses, and supervising both the health technicians and the *behvarzan,* or community health workers (Abbas 2007).

One male and one or more female health workers run each rural health house. The health workers are chosen among local people familiar with the households in the village. Training occurs at the district level; students receive free training and financial support throughout the two-year training period. In return, they are formally obliged to remain and serve at the village health house for a minimum of four years after completing their study. Almost 30 000 community health workers are working in these health houses; more than 16 000 of them are women. The minimum age for male and female health workers is 20 and 16, respectively.

The system is funded entirely by the national government. Challenges now faced include sustaining financial support in the face of sanctions that are imposed on Iran, the need to strengthen the referral system, the need to better address non-communicable diseases and the need to strengthen secondary and tertiary levels of care (Tavassoli 2008).

The system is perhaps the most comprehensive of all the alternatives discussed here – both in terms of service coverage and the range of services offered. The primary care elements are better organised than secondary and tertiary care, but overall its sustenance and expansion appears to be an integral part of public policy. As a result, it may be argued that there is merit in not being part of the global economic architecture (even when forced, as in the case of Iran!).

Malaysia: PHC system

PHC is seen as the thrust and foundation of the public health system in Malaysia. It is a two-tier system comprised of health clinics, which cater to a population of 15 000–20 000, and community clinics that cater to 2 000–4 000 people. It is a nationwide programme funded by the country's national budget. Health clinics provide eight identified essential services, as well as dental and mental health care. Community clinics provide maternal and child health services and outpatient care for minor ailments. The system is comprised of about 900 health clinics and 2 000 community clinics across the country. The health clinics are linked to public hospitals by a referral system (Awin 2002).

The system caters to the bulk of the population (about 65%) but is served by just 45% of all registered doctors, and even fewer specialists (25%–30%). Patients pay only nominal fees for access to outpatient and hospitalisation services. Medical and surgical emergencies are also adequately provided for, with a government-managed fleet of ambulances, including airlift capacities for more remote sites.

Doctors, nurses, pharmacists, dentists, and other allied health care workers are employed and deployed by the Ministry of Health to various health care centres: from rural clinics to district hospitals to tertiary specialist hospitals throughout the country. The distribution of these resources is based on the size, need, and population of the various districts and states. However, in rural and more mountainous or remote regions, the deployment of facilities as well as manpower is uneven, and there remains great disparity and inequitable distribution of health care personnel, especially doctors.

There appears to be a covert – if unannounced – shift in thinking that eventual corporatisation of the public sector facilities and services should be allowed to unfold in Malaysia, where market forces dictate the price, extent, and quality of the services offered. However, public dissent has ensured that over the past 20 years, or so, there have been only sporadic and partially successful attempts to privatise or corporatise various components of the public health sector – e.g. the government's drug procurement and distribution centre, and the divestment of its support services (cleaning, linen, laundry, clinical waste management, biomedical engineering maintenance). Nevertheless, commercialisation trends remain a concern, with a shortage of trained personnel and some specialty services being purchased by the public system from the for-profit private sector (Chee Khoon 2010).

Thailand: Universal health care coverage scheme

Thailand's National Health Insurance Bill was enacted in 2002, creating the Universal Health Care Coverage scheme (UC; formerly known as the "30-baht scheme", in reference to the Thai currency). The UC scheme shifted away from a means-tested health care coverage insurance programme for low-income patients, to a comprehensive health care plan that provides universal coverage. Originally, participants in the UC scheme were charged a co-payment of 30 baht (approximately US$1 in 2002), but this co-payment was later abolished. The UC scheme focuses on providing PHC services to Thais who were left out of the health care system prior to 2002. Thais joining the UC scheme receive a "gold card", which allows them to access services in their health district and to be referred to a specialist if necessary. The scheme is administered by the Thai National Health Security Office and is primarily funded by the government, based on a budget calculated on a per capita rate. At present the scheme covers an estimated 46.95 million Thais (out of a total population of 62 million; Tangcharoensathien et al., 2007).

One of the key elements of the programme is that reimbursement of expenses to public hospitals by the government is based on enrolled populations in the hospitals' service areas. The system is geographically structured, and hospitals have fixed revenues based on the local population and financial viability depends on an ability to control costs (Wibulpolprasert and Thaiprayoon 2008).

The Thai public health system is of more recent vintage as compared to Malaysia but has seen an opposite trajectory. Before introduction of the scheme, public health insurance covered only 9% of the population. There has been progressive strengthening of the system in recent years, in spite of overall economic liberalisation programmes pursued by the government. Among all the alternatives that we analyse here, the Thai UC scheme appears to have had the fastest trajectory in transforming a largely private health care system into a robust publicly funded system.

Sri Lanka: Public health system

The public health system in Sri Lanka, unlike other countries in the South Asian region, dates back to its pre-independence (1948) period, with free health care subsequently being introduced in 1953. In spite of political changes, the public system has survived and expanded, with the public health system comprising a network of medical institutions (larger, intermediate, and smaller peripheral institutions) and health units. As of 2008 there were 258 health unit areas with populations ranging from 40 000 to 60 000 (Rannan-Eliya and Sikurajapathy 2008).

The health unit area is a clearly defined region congruent with the administrative divisions of the country. Health units are managed by Medical Officers and are supported by a team of public health personnel comprising one or two Public Health Nursing Sisters, four to six Public Health Inspectors, one or two Supervising Public Health Midwives, and 20–25 Public Health Midwives. Each health unit area is subdivided into Public Health Midwife areas, which constitute the smallest working units in the public system. Each Public Health Midwife has a well-defined area consisting of a population ranging from 2 000–4 000 (Perera 2007).

Of the total ambulatory care market, 50% is serviced by the private sector, although 95% of inpatient care is still provided by the public sector. Although all Sri Lankans have this entitlement, those who can afford to can choose to use private sector services. The private health sector only began to develop in earnest during the 1960s. It focuses particularly on ambulatory care in the form of general practitioners. Although there are some full-time private general practitioners, most private provision takes the form of dual practice by doctors who are employed in the public health sector and have a limited private practice outside of official working hours (Rannan-Eliya and Sikurajapathy 2008).

Problems with this system include lower utilisation of peripheral facilities and overcrowding in secondary and tertiary facilities. New challenges to the system are emerging in the form of policies related to the overall neoliberal thrust of the economy, although the health system is still relatively secure. Challenges are also being faced with the entry of the corporate private sector (often imported from India).

The Sri Lankan system is often discussed as one of the "success stories" of a public system. There is considerable merit in these arguments given that the country has consistently performed in a situation in which its other South Asian neighbours have floundered. There are several historical reasons why this has been so. The development path followed by Sri Lanka has been described as "support-led security", in which public provision and funding of health and other social services has promoted social progress. Even before independence in 1948, there was a rapid expansion of public investment in education and health facilities in the 1930s and 1940s. Free education was introduced in 1947 and free health care in 1953. Along with strong support for publicly funded social services, the commitment to social justice, with particular emphasis on addressing the needs of the worst off, was a key feature of state policy. Despite having low income levels and only gradual economic growth, as well as relatively low levels of spending on health (with public health care expenditure only being equivalent to 2% of GDP), Sri Lanka has achieved remarkably good health status and a high literacy rate. These achievements are testimony to the effectiveness of sustained public spending on social services and the consistent commitment to equity and social justice, which is also borne out by the relatively equitable distribution of income (with a Gini index of only 33; McIntyre 2006).

Similar to the Malaysian situation, Sri Lanka's system faces the threat of reforms that seek to align it with the neoliberal ethos of commercialisation. The attempted reforms have been less sustained than in Malaysia but do pose a threat. The unfolding of the dynamics would be useful to study in detail, especially given that public investment in social infrastructure in Sri Lanka has enjoyed such a large consensus across the political spectrum for decades.

India: National Rural Health Mission

The National Rural Health Mission (NRHM) was launched in April 2005, as a response to a large body of criticism regarding the performance of the public health system in India. The NRHM is designed to strengthen the existing public health system, which is a three-tiered system offering primary care linked to a network of secondary and tertiary public health facilities. The primary care system is an extensive network comprising subcentres (covering population areas of between 3 000–5 000), Primary Health Centres (covering 20 000–30 000 people), and Community Health Centres (covering a population of 100 000). Across the country, as of 2007, there were a total of 145 272 subcentres, 22 370 Primary Health Centres, and 4 045 Community Health Centres. While impressive on paper, in large parts of the country the network barely functions as a consequence of poor resourcing and maintenance. Shortage of personnel and material resources plague the system (Rao 2009).

Some of the important strategies that form part of the NRHM include:

- Access to health care at household level through trained Accredited Social Health Activists (ASHA). The programme targets the training and deployment of one activist in each village (i.e. about 550 000 trained activists across the country). ASHA trainees should have a minimum of middle school level education and are provided a three-month long training module. They are required to be chosen from the community and remunerated based on services performed, e.g. facilitating family planning, safe deliveries, etc..

- Architectural correction of the health system to enable it to effectively handle increased allocations and policies to strengthen public health management and service delivery.
- Effective integration of health concerns through decentralised management at district level.
- Health Plan for each village through village health committees.
- Strengthening of the different tiers of the public system.
- Promotion of public-private partnerships for achieving public health goals.
- Regulation of private sector to ensure quality service.
- Reorientation of medical education to support rural health issues.
- Risk pooling and social health insurance. (Government of India 2009)

In 2008–2009 the allocation by the central government for the programme was Rs107.9 billion (approximately US$2.4 billion). This is augmented by funding from state governments (Government of India 2010).

The achievements have been modest. There has been a perceptible advance towards some strengthening of the public system, but the impact is still fragmented and inadequate to prevent a high dependence of patients on the private for-profit sector. The flagship programme of the mission is the training and deployment of ASHAs. While a massive drive towards this has been initiated, the impact is still limited. This is due, in part, to the fact that the ASHA is not conceived as a full-fledged and fully remunerated health worker but rather as a health "assistant" who is remunerated for services delivered. However, some states are moving towards providing a fixed honorarium for ASHAs. Although strengthening of the primary care facilities is taking place, the pace is still too slow to address current needs. Public-private partnerships are being pursued at the secondary and tertiary level of care, and remain an issue of concern as they lend to private infrastructure creation and strengthening. There are also trends towards privatisation in the form of outsourcing of auxiliary services such as ambulance and laundry services. The promise of the programme was to increase public spending to 2%–3% of GDP, but this has stagnated at around 1%. A major part of the shortfall is a result of state governments being unable to mobilise resources to support the programme, a consequence of fiscal measures in the last two decades which have starved state governments of finances due to a sharp fall in the tax-to-GDP ratio (People's Rural Health Watch 2008).

In ways similar to China, the "alternative" being discussed here is the first cogent response of the government in India to growing health inequities in the neoliberal era. India, of course, differs from China in that it has always had a flourishing private sector in health and a relatively weak public sector. The imbalance has worsened since the early 1990s. Given this background the NRHM merits a close look as it unfolds. Parts of it continue to be informed by the neoliberal ethos)e.g. its stated intent to promote public-private partnerships in the secondary and tertiary sectors, some attempts to promote user fees, and so on). However, the initiative is important because it is an attempt to go against the overall trend of neoliberal reforms in other sectors.

PRIMARY CARE INITIATIVES WITH LARGE SPAN OF COVERAGE

Bangladesh: Integrated rural health care (Gonoshasthaya Kendra)

At the time of the Liberation War of Bangladesh in 1971, a group of Bengali expatriate doctors working in London organised the Bangladesh Medical Association. Two of the doctors, Dr Zafrullah Chowdhury and Dr M.A. Mobin, visited the frontlines of the war and began treating wounded soldiers who were fighting a guerrilla war against the Pakistan army. With the help of the Bangladesh government in exile in Calcutta, they established a 480-bed makeshift hospital on the eastern border of Bangladesh. After the independence of Bangladesh in December 1971, some of the volunteers of Bangladesh Field Hospital formed an NGO called *Gonoshasthaya Kendra* (GK, "People's Health Centre") to provide health care to rural communities as part of the national effort to rebuild the war-torn country (Upham 2004).

GK has come a long way since this time, both in terms of programme coverage and achievements. During the last three and a half decades, it has increased its basic health care coverage, including reproductive and child health care, from serving about 50 000 people in 50 villages in 1972 to now over 1.2 million people in 592 villages geographically spread across the country in 31 unions of 17 *upazilas* in 15 districts. Presently, GK runs two 150-bed hospitals – one in Savar and another in the Dhanmondi area of Dhaka city. GK has two other rural hospitals with 30 beds each, and all other centres run by GK have five hospital beds where patients with severe diarrhoea, respiratory infections, simple fractures, abortion complications, and difficult delivery are admitted (Gonoshasthaya Kendra, 2009).

GK provides an integrated package of health services, through its village/community-based health workers and secondary- and tertiary-level care through strong referral linkages to both GK and government hospitals. GK also offers a locally organised *Gonoshasthaya Bima,* a community-based cooperative health insurance scheme, and runs a continuing training programme for Traditional Birth Attendants (TBAs) to upgrade their skills to become trained TBAs. GK health workers link with the TBAs to ensure an effective referral system. GK is known for its advocacy role on many issues and its innovations to promote gender equity (Huda and Chowdhury 2008).

GK is explicit in stating that it is not in competition with the government of Bangladesh, arguing that its role is to supplement the public health system. GK's primary focus is to work with the state so that its innovative schemes, if found result-yielding, can be adopted by the public sector. Many activities are self-supporting (e.g. the hospitals, pharmaceutical unit, medical college), but a large annual subsidy (20%–30% of the overall budget, largely sourced from donor agencies such as the French Support Committee to GK-Savar, Medicos, Germany, etc.) is still necessary to continue the programme.[3] Major challenges being faced include problems in retaining trained personnel who are lured away by the growing private sector (as well as better-funded NGOs), the need to constantly seek donor funding, and the paucity of a robust second-line leadership. The hospital in Dhaka also faces difficulty in competing with the private hospitals that have emerged in the city.

The GK alternative is an important initiative that has attracted attention in the South Asian region, partly because of its early association with the country's liberation struggle. The organisation also played host to the first People's Health Assembly in 2000, out of which developed the global People's Health Movement.[4] The important aspect of the "alternative" is the purposive links that have been forged with the programme and political campaigns on access to health and medicines. Also of importance is the strong focus on gender issues and gender empowerment.

Bangladesh: Essential health care by BRAC

Also in Bangladesh, the Bangladesh Rural Advancement Committee (BRAC) started its activities in 1972 in the district of Sylhet, as a relief and rehabilitation project to help returning war refugees after the Liberation War of 1971. Currently BRAC is present in all 64 districts of the country, with over 7 million microfinance group members, 37 500 non-formal primary schools, and more than 70 000 health volunteers. BRAC employs over 120 000 people, the majority of whom are women. BRAC has also diversified its activities outside Bangladesh and operates different programmes such as those in microfinance and education in nine countries across Asia and Africa. The organisation is 80% self-funded through a number of commercial enterprises that include a dairy and food project and a chain of retail handicraft stores called *Aarong* (BRAC[5]).

In 1979, BRAC began working on health issues through the nationwide Oral Therapy Extension Programme, a campaign to combat diarrhoea, the leading cause of the high child mortality rate in Bangladesh. Over a 10-year period, 1 200 BRAC workers went door-to-door to teach 12 million mothers the preparation of homemade oral rehydration solution (ORS). Since 2002, all of BRAC's health interventions have been incorporated under the BRAC Health Programme. The maternal, neonatal, and child health programmes currently target 8 million urban slum dwellers and 11 million rural people. The tuberculosis control programme has already reached 86 million people in 42 districts. Some 70 000 community health volunteers and 18 000 health workers have been trained and mobilised by BRAC to deliver door-to-door health care services to the rural poor. It has established 37 static health centres and a Limb and Brace Fitting Centre that provides low-cost devices and services for the physically disabled. Until 2006, the programme provided health support to the members of BRAC's village organisations. In 2007, there was a shift in operations towards a more community-centred approach, meaning that everyone in the community was offered BRAC's essential health care services.

Perhaps no discussion of NGO initiatives is complete without a discussion of some aspects of BRAC's work in Bangladesh, if for no other reason than BRAC operates the world's largest NGO programme and is the second largest employer in Bangladesh after the state! The health programme has been scaled up to the extent that it is an alternate structure to the government's public health system. To be fair, the two often collaborate and work together, though governance systems remain fairly distinct. The growth of such large NGO-led programmes is also related to large donors putting their faith in NGOs rather than country governments, as the former are often perceived as more honest, more responsive to community needs, and more efficient (Green and Matthias 1995). What is also interesting is to contrast the trajectories of the GK health programme and that of BRAC's. While the former is also large, BRAC has scaled up much faster and is by far the larger programme. This has occurred in a situation in which BRAC has focused more on expanding its operational activities and has not been as upfront about linkages to ideological movements and its own positions regarding inequity and access. It may be argued that this has made it easier for integration and collaboration with public systems. Another important aspect of BRAC's work is its practice of cross-subsidising its developmental work through incomes from its commercial activities, raising questions about just how non-commercial their health initiatives really are.

PRIMARY CARE INITIATIVES WITH LIMITED SPAN OF COVERAGE

Laos: Comprehensive PHC project in Sayaboury Province

In partnership with the Ministry of Public Health and with funding support from AusAID, a comprehensive PHC project began in 1992 in Sayaboury Province in Laos with Save the Children Australia (SCA) and the Sayaboury Department of Health. Project activities have gradually extended to cover the entire province, with 10 districts and 547 villages, and a population of 307 086 comprised of many ethnic minority groups. The programme has been carried out in four phases, each phase spanning three years and building on its predecessor's successes (Perks et al., 2006).

The first phase focused on strengthening the management and training skills of the provincial management team, which conducted in-service training for district teams and dispensary staff. During the second phase, the programme expanded into four additional districts and was geared towards integrating PHC activities at all levels. The third phase expanded into four newly created districts in the north that were quite remote. The International Fund for Agricultural Development constructed dispensaries, augmenting the construction programme instituted by SCA and expanding access to first-line health services. The fourth phase aimed to strengthen the skills of health workers, with an emphasis on those in the northern districts. The Integrated Management of Childhood Illness strategy was adopted in all districts.

The Sayaboury programme has shown significant successes, at the very affordable rate of only US$1 per person each year, or US$4 million over a 12-year period. The district's maternal mortality ratio fell from 218 per 100 000 live births in 1998 to 110 in 2003. The median age at which infants received complementary foods increased from 2.8 months in 1999 to 3.7 months in 2001, while the rate of exclusive breastfeeding for the first four months rose from 28% in 1999 to 66.2% in 2004. Vaccination coverage remained inadequate, however, with only 50% of children under one year of age receiving three or more doses of the vaccine for diphtheria, pertussis, and tetanus in 2007. The project is seen as a model for the country and efforts are under way to upscale the programme in other provinces (SCA[6]).

As we saw earlier in the chapter, Laos has very poor health indicators and a high incidence of private expenditure on health. In such a situation the present initiative to extend primary health coverage in one province is important to examine, especially given that the initiative is now being scaled up in other provinces of the country.

India: "Public-private partnership"[7] for PHC (Karuna Trust)

Karuna Trust, a leading NGO in India working to provide PHC services, was tasked with the responsibility of managing the Gumballi PHC Centre, in the state of Karnataka, in 1996. This was part of an experiment by the government of Karnataka to outsource the running of some Primary Health Centres to non-government entities. A Primary Health Centre, within the public health infrastructure of India, is the second tier of the three-tier system designed to provide primary care. Each centre covers a population of about 30 000 people and provides outpatient care and basic inpatient services, and coordinates preventive and promotive services such as antenatal and postnatal care, immunisation, etc.. While Primary Health Centres are the hub of the primary care system, a large majority of them function sub-optimally. In a majority of cases, inpatient services are not available, and in a significant number the centre is reduced to a dispensary that functions for just two to three hours a day. This is the context in which the Karnataka government chose to outsource the running of the Primary Health Centre to an NGO (Karuna Trust[8]).

Karuna Trust integrated the activities of all national health programmes, including reproductive and child health, into the activities of the centre. It ensured that, under its management, it would provide round-the-clock emergency and casualty services, outpatient facilities six days a week, a 10-bed inpatient department, and 24-hour labour and essential obstetric facilities. Additionally, the Karuna Trust has introduced innovations such as integration of mental health services, eye care, and specialist services at primary care level. The Primary Health Centre provides services to 47 surrounding villages, with a population of around 39 000 people. There have been significant improvements as regards a number of indicators in the area covered by the Gumballi Primary Health Centre, in comparison to indicators in the state of Karnataka (e.g. infant mortality rate is 23.6 in the project area in contrast to 48.01 for the state).

The success of the Gumballi Primary Health Centre and its impact as a "model" have strengthened the idea of public-private partnerships as a viable model among policy makers. Its success has led the Karnataka government to issue a formal policy on public-private partnerships in 2000. Today the model has been upscaled and Karuna Trust runs 26 such centres in all the districts of the state of Karnataka and nine more in the north-eastern state of Arunachal Pradesh, covering a population of approximately 1.2 million people. The initiative has been a subject of considerable debate within the country. The Trust sees itself as building "models", and does not see the initiative as an alternative to the state taking the responsibility in managing and maintaining the public health care system. Its experience in managing the Primary Health Centres indicates that success is variable and depends crucially on strong support from the local public health department.

India's public health system, especially at the primary level of care, has been perennially plagued with problems, including issues regarding inability to attract human resources, inefficiency, poor infrastructure, and corruption. A way out is sought in outsourcing primary care facilities, especially in resource-poor areas, to private entities. The Karuna Trust alternative examines one of the largest such ventures involving a not-for-profit trust that has been promoting primary care through its own programmes. While the outsourcing of public facilities is an issue that is a cause for a larger debate, the apparent initial success of the initiative merits further investigation (Ghanshyam 2008).

India: Comprehensive Rural Health Project (CRHP) in Jamkhed, Maharashtra

The Comprehensive Rural Health Project, Jamkhed (CRHP), was founded in 1970. The extremely poor and drought-prone area of Jamkhed, India, was plagued by high rates of malnutrition, infectious diseases, maternal deaths, and occupational injuries. Social injustices such as the low status of women and caste-based prejudices contributed significantly to this chronic state of ill health. Initially covering eight villages with a combined population of 10 000, the project rapidly expanded in its early years, reaching out to a larger number of village communities. By 1980 CRHP expanded to cover a total of 70 villages with a combined population of 100 000. By 1985, a total of 250 000 people in 250 villages in Karjat and Jamkhed *talukas* were working with CRHP. Eventually over 300 villages with a combined population of 500 000 were participating with CRHP through the selection, training, and support of Village Health Workers (VHWs) and through the formation of community-based organisations (CBOs) such as farmers' clubs, women's clubs (*Mahila Vikas Mandals*), and self-help groups (SHGs; Jamkhed[9]).

The trained VHW acts as the local agent of positive health and social change. She is selected by her community and receives training in health, community development and organisation, communication skills, and personal development from CRHP. Her primary role is to freely share the knowledge she obtains with everyone in the community, to organise community groups, and to facilitate action, especially among women, the poor, and the marginalised. At the outset, many of these VHWs were often illiterate women from the "untouchable" (Dalit) caste. The VHWs, working entirely as volunteers, became empowered by learning skills with which to earn a living through microenterprise.

The impact of the programme is visible. The number of leprosy cases in the project area declined from 157 in 1988 to just six in 2006. Similarly, new tuberculosis cases have declined from 592 in 1988 to six in 2006. The infant mortality rate, which was 176 in 1971, has come down to 24 (against a national average of 62 per 1 000 live births). Child malnutrition rates are less than 5% against a national average of 47%, and 99% of women receive antenatal care and a similar proportion have access to safe delivery.

Unlike many other NGO-led programmes in the region, the Jamkhed project has resolutely resisted the temptation to scale up. In fact, the present reach of the project is lower than in the 1990s; it currently works in 120 villages and the mobile team actively visits 45 of them. However, scaling up can be seen in a different way – small programmes all over the world, from Nepal to Brazil, use Jamkhed's principles. The Indian government also sends its own officials for orientation and training to Jamkhed. The project is financed (the annual budget is about US$500 000) through fees (which are very reasonable and sought only from those who can pay) from a small hospital that is run in Jamkhed and individual donations from people across the world.

The Jamkhed project has been held up, globally, as a true example of a community-based and community-owned primary care programme, and one that has been in existence for over four decades. Also interesting to learn from are the community mobilisation and health worker training methodologies used in the programme (Rosenberg 2008).

INITIATIVES ADDRESSING A SPECIFIC ASPECT OF ACCESS TO HEALTH SERVICES

India: Home-Based Neonatal Care (HBNC) in Gadchiroli, Maharashtra

This programme was initiated by the Society for Education Action and Research in Community Health (SEARCH), a non-profit NGO set up by a husband and wife team of doctors in 1986. They identified the main causes for infant mortality in the region and devised a strategy of home-based neonatal care to address them. Gadchiroli District, in Maharashtra, had an infant mortality rate of 121 per 1 000 births when the programme started. This has been brought down to less than 30 per 1 000 (SEARCH et al., 2009).

The programme hinges on trained community health workers (CHWs), or *arogyadu,* who are at the centre of the efforts to reduce neonatal and infant morbidity and mortality. SEARCH recruited village women with a minimum of four years schooling and trained them to provide care for women during pregnancy and for their babies after birth. The CHWs visit pregnant women to provide information on care for themselves during pregnancy, and recognition of danger signs, which may indicate that there are complications. CHWs' work is complementary to that of the traditional birth attendants; their focus is on newborns, and the roles are kept distinct. After the birth, they visit the mother and baby at home eight times during the first month (or 12 times if the baby is at high risk).

Among the types of preventive care they can offer are examining the baby, checking weight, temperature, and respiratory rate, and administering vitamin K. The CHWs also advise mothers on caring for the newborn, including breastfeeding, prevention of hypothermia, and recognising danger signs. They can diagnose asphyxia, sepsis, low birthweight, and breastfeeding problems using simple, standardised criteria. Simple treatment is carried out on sick newborns at home by following standard practices learned during training. Many innovations have been introduced to provide support to the programme. One such innovation is the design and local fabrication of "breath counters" that are used by CHWs in place of stethoscopes.

The programme operates in 42 villages, and around 80 village health workers and 120 traditional midwives have learned to diagnose and treat major killers such as neonatal sepsis and infant pneumonia. An evaluation of the work of CHWs showed that there was a 62% reduction in the neonatal mortality rate, 71% reduction in the perinatal mortality rate, and 49% reduction in incidence of neonatal illnesses. In addition, the fatality rate in cases of sepsis/pneumonia fell from 16.6% to 2.8%, and the fatality rate among premature newborns and/or newborns with low birthweight went down by 60% (Bang et al., 2001). The incidence of post-partum maternal illness was reduced by 51%. The positive findings from the Gadchiroli project have resulted in trials to upscale the programme, including some by the government's health department in its National Rural Health Mission.

Although this is not an alternative to commercialisation that covers the entire spectrum of health services, the programme nonetheless dovetails with primary care systems. Of interest are moves to scale up the programme through adoption in the country's public system. Innovations used in training and training materials are useful to take note of, especially in the context of fairly high success rates reported in controlling childhood mortality and morbidity.

India: Sonagachi HIV/AIDS International Project (SHIP)

In 1992 the All India Institute of Hygiene and Public Health (AIIHPH) initiated a conventional sexually transmitted infections treatment and prevention programme in Sonagachi, the principal red-light district of Kolkata, home to over 7 000 sex workers. The Sonagachi HIV/AIDS International Project (SHIP) was implemented through an intersectoral partnership of the WHO, AIIHPH, the British Council, and a number of ministries and local NGOs. The project quickly moved beyond traditional treatment and education modalities to focus on the empowerment of the sex workers. Key interventions during the first five years included vaccination and treatment services for the sex workers' children, literacy classes for the women, political activism and advocacy, microcredit schemes, and cultural programmes (Jana and Singh 1995).

The sex workers created their own membership organisation, the *Durbar Mahila Samanwaya Committee* (DMSC), which successfully negotiated for better treatment by madams, landlords, and local authorities. In 1999, the DMSC took over the management of SHIP, and has since expanded it to include 40 red-light districts across West Bengal, including a community of around 65 000 male, female, and transgendered sex workers based in brothels, streets, and hotels. DMSC's work includes struggle against extortion and harassment by local hooligans and police, fighting against eviction of individual sex workers from their homes, running an HIV helpline, and action against forcible HIV/AIDS surveillance. DMSC's efforts have resulted in the creation of a self-regulatory board that, whenever a new girl/woman arrives in Sonagachi, scans legal issues such as her age and whether she is willingly entering this sector of work. The initiative receives support from the Ford Foundation, the United Nations Development Programme (UNDP), Action Aid, and the National Aids Control Organisation (NACO) of the government of India (Smarajit 2004).

Efforts to empower people with knowledge and tools for health are at the centre of this programme. Peer educators provide sexual health and HIV education to sex workers and madams and distribute condoms. To support non-formal education efforts, 29 educational centres in and around Sonagachi have been set up. To foster economic security, sex workers seeking financial credit are encouraged to become members of a community-lending cooperative that provides affordable loans. As part of its empowerment strategy, the Sonagachi Project also promotes the various talents of sex workers through a cultural wing – the *Komal Gandhar*. In addition, an anti-trafficking unit, controlled by self-regulatory boards, works across West Bengal to protect children; two homes are also in operation to provide a safe shelter for children in distress.

Evidence suggests that the project has had a major impact. In 1992, the rate of consistent condom use with clients in the previous two months was a mere 1%. By 2001, that figure had increased to 65%. Prevalence of syphilis dropped during that period from 25% to 8.76%. The programme has attracted substantial attention as an example of a health-sector intervention that is premised on community involvement and organisation. Of particular importance is the fact that the community of sex workers is one of the most marginalised. Within such a context, it is useful to examine the success of the alternative to provide a political voice to the community and to combine it with programmes that address several determinants of good health in the sex-worker community. The expansion of the initiative and its proposed adoption within the public health system are also areas that merit further scrutiny.

Nepal: Community-based management of childhood pneumonia

Pneumonia is a leading cause of mortality of children aged under five in Nepal. Female community health volunteers (FCHV) were selected to manage childhood pneumonia at community level using oral antibiotics. A technical working group composed of government officials, local experts, and donor partners embarked on a process to develop a strategy to pilot the approach and expand it nationally. Community-based management of pneumonia doubled the total number of cases treated compared with districts with facility-based treatment only. Over half of the cases were treated by the FCHVs. The programme was phased in over 14 years and now 69% of Nepal's under-five population has access to pneumonia treatment (Dawson et al., 2008).

The FCHVs were selected by the communities and trained by the Ministry of Health. The WHO, United Nations Children's Fund (UNICEF), and United States Agency for International Development (USAID) supported the development of technical guidelines for programme implementation. UNICEF conducted a focused ethnographic study to understand community-perceived danger signs of pneumonia and care-seeking practices. Training and behaviour-change communications materials were developed by members of the technical working group. To address the low literacy level of some FCHVs, extensive effort was given to developing pictorial training manuals, educational materials, and reporting booklets. This preparation phase took place in 1993–1994.

Training began in June 1995 involving role play and practical skills development. FCHV supervisors were included in training to strengthen their links with the FCHVs for future follow-up and field monitoring. Four districts were selected for the pilot intervention, two "treatment" and two "referral", with a total of 1 497 FCHVs and 525 health facility staff trained. In all four districts, health facility staff were trained in both pneumonia case treatment and programme management to ensure that FCHVs received necessary supportive supervision, feedback, and replenishment of supplies. District health office staff were trained on monitoring and supervision for follow-up and documentation. Mothers' groups and village leader orientations were held in all villages to encourage prompt care seeking and local support. In 1997, the two "referral" districts were converted to "treatment" and the programme gradually expanded. By 2007, 42 of Nepal's 75 districts were included, where 69% of the population of children aged less than five years reside. Quality of care provided by the FCHVs is regularly monitored by district and partner staff and remains high. Standardised checklists are used and immediate feedback given. Community-based pneumonia treatment data are part of the government's routine Health Monitoring Information System. An estimated 6 000 lives are currently saved each year through this intervention in Nepal (Dawson et al., 2008).

Nepal is one of the poorest countries in Asia and has suffered the consequences of political turmoil and devastation through natural disasters in recent decades. What has gone largely unnoticed, however, is some remarkable progress in Nepal in recent years in terms of reduction in mortality and morbidity indicators. Some commentators have ascribed this to the success of focused, donor agency-supported programmes that have been successful in harvesting the "low hanging fruits" of PHC. While such an analysis has some merit, it would be interesting to examine such programmes, such as the one described above. The FCHV initiative is also interesting to follow as it addresses one of the key downstream causes of childhood mortality. Also of interest is the impressive scale-up of the programme as evident from the fact that more than half of Nepal's expected pneumonia cases (56%) in 42 programme districts (of 75 districts) currently receive treatment, and community management of pneumonia provides over half of that treatment (Dawson et al., 2008).

India: Affordable drugs for everyone (Locost)

Low Cost Standard Therapeutics, or Locost, was set up to enable all Indians, even the poor in remote areas, to access quality medicines at affordable prices. Locost was founded in 1983 as a non-profit charitable trust registered in Baroda, Gujarat. Locost's medicine prices are significantly lower than those of other manufacturers. For example, Atenolol, a drug used to treat high blood pressure available at retail stores for Rs20–25 a strip, is sold by Locost at Rs3 per strip. A strip of paracetamol from Locost costs Rs2, while proprietary brands cost Rs9 per strip (1 Rs is approximately US$0.02; Locost[10]).

Locost's small-scale manufacturing unit makes over 60 essential medicines in 80 formulations (liquid, capsule, tablet). Locost buys the active pharmaceutical ingredient from bulk drug manufacturers and then manufactures its own formulations. Locost also pays its workers more than the regular wages; its wage scales are, in fact, the highest among the small-scale industries. Despite all the expenses that go into maintaining a high standard, Locost is able to sell its drugs at one-fourth to one-tenth of the price of drugs being sold in the retail market. With such competitive prices, Locost makes a profit of about 10% on annual sales, which it ploughs back to scale up its production volumes.[11]

Locost has been supplying drugs to over 100 civil society and charitable organisations. The idea of making the Locost drugs available at various retail outlets is, however, a relatively new concept. Besides its manufacturing unit in Baroda, Locost has a retail store in Vadodara, a depot in Karnataka (Bangalore) and the Northeast (Guwahati), and small retail outlets in various parts of Maharashtra.

Locost also has an education cell that focuses on issues related to education and training for rational use of medicines. It brings out a Gujarati language monthly, *Apnu Swasthya*, and other publications for the general public, the latest being the Gujarati version of the famous classic *Where There Is No Doctor;* as well as *A Lay Person's Guide to Medicine,* a guide on the use and political economy of medicines. Locost is also active in pharmaceutical policy advocacy at regional and national levels. Its partnership, as respondent, in an ongoing case in the Supreme Court has resulted in the elimination of several categories of harmful and irrational drugs.

India's generic pharmaceutical industry has been called the "Pharmacy of the South" because of its ability to supply low-cost medicines to a large number of poor countries across the globe. However, within India, access to medicines is still a big issue, and the major constraint continues to be the prices of medicines. An estimated 50%–80% of people in India do not have access to essential medicines. The "alternative" presented here addresses this issue by making available medicines at low prices to community health programmes. It is an alternative to commercial pharmaceutical production and distribution that has the potential for replication in many resource-poor settings.

EVALUATION OF ALTERNATIVES

It would be inappropriate to suggest overly specific trends or make broad generalisations based on the limited evidence contained in the alternatives to commercialisation presented here. There are, however, some general developments that can be commented upon, divided into two areas: those relating to the public sector and those related to the private not-for-profit sector.

Public sector

There is an interest and some urgency among governments that have followed neoliberal reforms and dismantled public systems (e.g. China, India, Laos) to attempt to remedy the negative impacts of these reforms through some strengthening of public systems. Unfortunately, most public initiatives continue to be informed by, and located in, an understanding that public strengthening must go hand in hand with partnerships with the private sector.

- Neoliberal ideologies permeate the thinking on health systems even in countries in which public systems are acknowledged to have produced laudable results (e.g. Sri Lanka and Malaysia). However, proposed commercialisation reforms face popular opposition and have not proceeded at the pace projected by the neoliberal lobby.
- The presence of a growing private sector impacts on the ability of the public system to thrive and expand by drawing away technical and human resources.
- Generally, "reform" ideology is prominent in the secondary and tertiary health care sectors, for the good reason that the for-profit private sector is not interested in the primary level of care. This is creating a move towards the bifurcation of health systems, where the primary sector is seen as the domain of public systems and the secondary/tertiary sectors are opened up to the private sector.

Not-for-profit sector

- Several alternatives are being developed and implemented by the not-for-profit sector, which have the potential for adoption within public systems. A systematic analysis of these can inform many public initiatives.

- CBOs implementing alternatives find it difficult to scale up when they need to reach out to regions that are outside their immediate geographical area of work.
- There appears to be a trade-off between ability (and intent) to scale up and engagement with issues of solidarity and ideological commitments to a public ethos. This adds an element of dilemma, whereby larger programmes may need to "compromise" more with basic principles of community mobilisation, solidarity, ownership, and empowerment.
- The role of donor agencies in supporting programmes by not-for-profit organisations, in preference to government programmes, needs to be analysed.
- The dividing line between a "contractor" of services for the government and a community mobiliser is often blurred. Some criteria need to be developed to examine programmes that involve partnerships between government and not-for-profit organisations.

WAYS FORWARD

The "public" has virtually disappeared from health care systems in many parts of the world. It is therefore necessary to address wrong perceptions and blatant untruths about the public sector, particularly given the systematic attempts to portray the private sector as more "efficient" and to argue that market-based competition and incentives lead to better care and more choices. Such arguments turn a blind eye to the fact that the public sector has played the major role in almost all situations in which health outcomes have improved significantly. Health systems that have depended on the public sector have been the norm, rather than the exception, even in wealthy countries. The success stories of health system development in the global South (e.g. Sri Lanka, Costa Rica, and Cuba) are success stories of public sector health systems. But the success of the public sector is not limited to health care systems. Publicly funded research in national institutes of science and universities has laid the foundations for many, if not most, developments in the medical sciences.

Public systems are desired because they promote equity. This is perhaps the most important reason why the public sector needs to play a leading role in health care systems – no matter which part of the world we are talking about. People have a right to health care in an equitable manner, not dependent on their ability to pay. Governments, not markets, can ensure that health systems address the needs of the poorest and the most marginalised. It is also true, however, that there needs to be conscious elements within public systems that promote equity. The mere fact that a system is funded through public funds does not mean that it necessarily promotes equity. There are various elements that come into play, including, for example, how such a system targets those who need health services the most. This does not mean that public health services are "poor services for poor people". They should be seen as attempts to provide the best services possible to all, while addressing the special needs of those most vulnerable.

An equitable and efficient health care system requires planning that is based on local conditions. It is impossible for a profit-driven, fragmented system with multiple (often contradictory) objectives to do so. For such a system to work optimally, it needs to regularly connect with peoples' needs and priorities. This is best achieved when popular participation ensures that the public is not just a recipient of public health care but is also involved in its planning and execution. It is only through the operationalisation of an adequately financed public service that the link between the income of health care providers and the delivery of health care can be broken. Unethical behaviour of health care providers is directly linked with the fact that if care is linked to profit, more ill health means more profit!

Public initiatives that need to be reclaimed

The alternatives discussed above indicate some ways of moving forward and suggest that there is a genuine concern in many countries of the region that the marginalisation of the public sector needs to be reversed. Some of this interest may be more practical than ideological, however, suggesting an ongoing tension between the neoliberal ethos of "new public management" and the practical evidence that commercialised health care systems are failing to deliver. Many neoliberal economists now admit this and have even taken recourse in coining the phrase "market failure" to explain away the fundamental flaw in neoliberal economics towards welfare programmes (People's Health Movement 2006). However, especially in the Indian case, there is still hesitation to go "all the way", and methods are being sought to still find a significant role for the private sector.

Within the public systems discussed here, that of Thailand merits special mention. For countries in the region, there is a strong case to study the Thai system and to draw appropriate lessons for emulation.

Public initiatives that need to be defended

We have consciously chosen also to discuss public systems that exhibit tendencies towards undermining the public ethos, e.g. the cases of Malaysia and Sri Lanka. Of importance in these cases is the fact that while public policy in some sectors has shown a faster trajectory towards liberalisation, public scrutiny and resistance have slowed down intended reforms in the health care sector. This indicates a strong case for promoting civil society scrutiny and mobilisation around the issue of public provision of health services.

Innovations and alternatives: Models for adoption

The alternatives in the not-for-profit sector raised a different set of issues to inform future directions. It would be incorrect to dub any of these as alternatives that can transform the entire health care system. However, these programmes carry innovations that public systems can nurture and scale up. Importantly, these alternatives often keep alive the notions of public provisioning, community participation, comprehensive care, etc. – notions that were at the core of the Alma-Ata Declaration in 1978 but which governments worldwide have failed to take forward.

Finally, notwithstanding short-term and intermediate-term tactics, public systems can survive and grow only at the expense of the private sector. This is a central message that we need to take forward. An analysis of many of the alternatives in the health sector in Asia shows that the private sector is a pernicious influence that erodes public systems. The future battle, in situations in which public systems are being resurrected, is to ensure that they are built at the expense of the private sector and not to complement the private sector.

NOTES

1. *Inter alia*, the Alma-Ata Declaration, issued at the conclusion of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, stated: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (Article V).
2. While the recommendation that at least 5% of GDP should be spent on health has never been formally adopted by the WHO, the figure is extensively quoted in WHO documents. For an explanation of its genesis, see Savedoff (2003, 9–11).
3. Based on personal communications between the author and Dr Zafrullah Chowdhury, one of the founders of GK, a face-to-face meeting on 26 August 2009, and several visits by the author to GK before 2007.
4. For more information on the People's Health Movement, see www.phmovement.org.
5. BRAC. www.brac.net.
6. SCA. www.savethechildren.net/australia/where_we_work/lao_pdr/primary_health.html (accessed 3 October 2010).
7. While we describe a partnership between a not-for-profit NGO and government, it is termed as a public-private partnership, as this is the nomenclature used by the Indian government regarding initiatives in which individual PHC centres are given out to NGOs to administer and provide services.
8. Karuna Trust. www.karunatrust.com/.
9. Jamkhed. www.jamkhed.org/.
10. Locost. www.locostindia.com/.
11. Information based on personal communication of the author with founder and director of Locost, S. Srinivasan, July 2009.

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