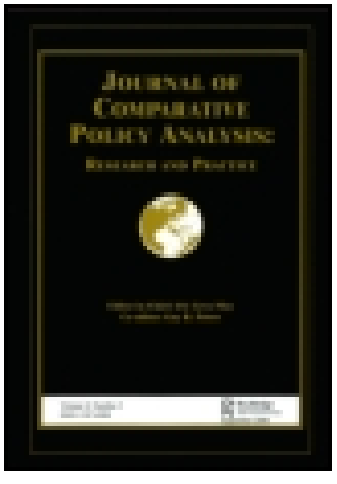

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Second Best Governance? Governments and Governance in the Imperfect World of Health Care Delivery in China, India and Thailand in Comparative Perspective

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Second Best Governance? Governments and Governance in the Imperfect World of Health Care Delivery in China, India and Thailand in Comparative Perspective

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ABSTRACT *The objective of the paper is to assess the usefulness of conceptions of different modes of governance for understanding policy outcomes by studying the experience with hierarchical and non-hierarchical governance modes in the health care sector in China, India, and Thailand. The paper shows their experience with non-hierarchical modes to have been largely disappointing and that all three, but especially Thailand, are in the process of reverting to a more hierarchical mode of service delivery. The conclusion from this study is that non-hierarchical governance is not a substitute for or an improvement upon hierarchical governance in health care due to the many market and government failures that afflict the sector and affect the ability of different governance modes to function effectively. The hierarchical mode of government is also imperfect but less so than the alternatives in delivering health care.*

Keywords: Markets; States; Networks; Health

Introduction

"Anything but the government" has been a popular sentiment in public policy circles for at least two decades. Initially, the sentiment favoured transitions from governments to market-based governance regimes but the tilt has shifted towards transition from governments to network governance in recent years (for discussion of the key relevant concepts, see Lowndes and Skelcher 1998). Much discussion on the subject suggests that such shifts from hierarchical to non-hierarchical governance are both unavoidable and desirable for addressing contemporary complex multi-actor problems which more traditional government-based arrangements find difficult to "steer" (Weber et al. 2011; Lange et al. 2013).

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Many proponents, for example, claim "network governance" or "collaborative governance" combines the best of both government- and market-based arrangements by bringing together key public and private actors in a policy sector in a constructive and inexpensive way (Rhodes 1997). This claim is no more than an article of faith, however, as there is little evidence supporting it and a lot of evidence contradicting this thesis (see Kjær 2004; Van Kersbergen and Van Waarden 2004; Adger and Jordan 2009; Howlett et al. 2009; Hysing 2009). It is entirely possible that network governance combines and indeed compounds the ill-effects of both governments and markets rather than improving upon them and this is a subject area requiring further empirical examination.

Regardless of the inconclusive intellectual debate on the subject, however, governments around the world have shown enthusiasm for non-hierarchical approaches – markets, voluntary organizations, and increasingly networks – to addressing public problems. This has occurred for a number of reasons, mainly related to efforts at cost containment, and is particularly true for some sectors, such as the health care sector in Asia, where the state has retreated from hierarchical governance arrangements over the past decade. The experience of these countries provides an excellent set of case studies from which to assess the merits of the "government to governance" thesis.

The objective of this paper is to assess the effectiveness of the three modes of governance in meeting the goal of delivering affordable services on the basis of the experiences of China, India, and Thailand in providing health care in recent years. What the experiences of these three governments suggest is that non-hierarchical governance is more difficult to implement than often anticipated. Indeed, as shown below, they suggest it may be impossible to substitute non-hierarchical arrangements for hierarchical ones in the health care sector without a considerable loss of both efficiency and equity. This paper proposes a model and a framework for understanding governance failures which helps explain why this is the case.

All three of the case study countries began the modern period with a dominant role for the government in health care provision and all three have tried non-hierarchical governance in recent decades. As is discussed below, however, their experience with non-hierarchical arrangements has been largely disappointing in terms of measures such as quality of service delivery, cost effectiveness, or efficiency. As a result, a substantial reversal of the non-hierarchical governance strategy occurred in Thailand and a nascent reversal is underway in China in order to reduce rising expenditures and improve outcomes. India, in contrast, continues to expand the range of non-hierarchical arrangements despite a similar rise in expenditures and with a similar lack of significant improvement in outcomes. Taken together, the three cases provide excellent case studies illustrating the range of options and dynamics between hierarchical and non-hierarchical modes of health care governance and suggest that "governance failures" is a key concept helping to explain meta-governance dynamics and the transitions between modes of governance.

Governance Modes and Governance Failures

Practical experience and ideological predilections have shaped the substance of the debate on governance, ranging from preference for democracy, popular participation, and consensus to concerns about budget deficits and public sector inefficiencies in hierarchy-based systems. These conditions have fostered a strong preference for non-hierarchical governance, with countries in the Anglo-American tradition usually preferring markets

while others with more corporatist traditions often display a penchant for networks. Lost in the pursuit of these preferred alternatives, however, is understanding of whether or not a preferred solution can actually address the particular sector's problems. Instead of analysing and understanding the specifics of the sector in question, the protagonists often simply extrapolate from idealized conceptions of how non-hierarchical modes of governance *might* work in practice and then apply them across sectors regardless of the contexts in which they are being applied and their relevance to the primary source of the problem in the sector in question. While policy-makers may find the proclaimed superiority of the market and/or network alternatives convenient because it allows them to shed responsibility for difficult problems, thus reducing the scope for criticism of their performance, this short-term gain is offset later when the consequences of governance failures and poor institutional design become apparent (Weaver 1986; Hood 2010).

While "governance failures" is a new term in the literature, the role of policy failures of different kinds in affecting choices of governance modes and their design is well known. It is broadly accepted, for example, that there is no substitute for government in sectors with large market failures, effectively ruling out the use of market-based modes of non-hierarchical governance (Wolf Jr 1987; Le Grand 1991; Weimer and Vining 2011). Correspondingly, others have argued that hierarchical modes of governance are problematic in the case of widespread "government failures" (Weiner and Alexander 1998; Provan and Kenis 2008). What is much less known in the governance literature, however, is the existence of "network failures" (Weiner and Alexander 1998; Provan and Kenis 2008; Tunzelmann 2010; Uribe 2012). These include problems such as a lack of societal leadership, poor associational structures, and weak state steering capacities which make adoption of network governance modes problematic. As Keast et al. (2006) summarize: "Networks often lack the accountability mechanisms available to the state, they are difficult to steer or control, they are difficult to get agreements on outcomes and actions to be taken, and they can be difficult to understand and determine who is in charge". Simply put, establishing and operating networks in situations of network failures may cost more than they are worth.

The three main types of governance failures are summarized in Table 1. While all three modes suffer from severe limitations, they do not all afford the same level or type of risk. In situations where both market and network failures are likely and substantial, hierarchical governance may remain a preferred option even in the face of various government failures since at least the needed services will be delivered, although perhaps inefficiently

Table 1. Types of governance failures

Mode of governance	Type of failure	Examples	Sources
Hierarchical	Government failure	Information gaps; lack of incentives; Political interference	Wolf Jr (1987), Le Grand (1991), Weimer and Vining (2011)
Market	Market failure	Externalities; Information asymmetries; Credible commitments	Pigou (1948), Wolf Jr (1987), Weimer and Vining (2011)
Network	Network failures	Difficult to establish in places without experience with it. Poor steering capacities. Weak associational structures.	Weiner and Alexander (1998), Provan and Kenis (2008), Tunzelmann (2010)

Table 2. Governance tools, problem types and modes of governance

		Need for incentive	
		High	**Low**
Need For coercion	High	Type 1 problem: Transaction costs Appropriate governance mode: hierarchy Impediments: information gaps; political interference	Type 2 problem: Authority Appropriate governance mode: market – regulated Impediments: information gaps; capture; implementation capacity
	Low	Type 3 problem: Persuasion Appropriate governance mode: market – subsidized Impediments: wasteful; inclusion and exclusion errors	Type 4 problem: Reconciling divergent interests Appropriate governance mode: networks Impediments: hard to establish; weak steering; collusion

distributed in a technical sense and in all likelihood not as responsive to users' preferences.

Given that all governance modes are vulnerable to failures of different kinds, when governments adopt one or the other mode they need to understand: (1) the nature of the problem they are trying to address and the tools they have at their disposal to address it, (2) the innate features of the different governances mode so that they can match these to the problem they seek to address, and (3) the capabilities of governments and societies to successfully implement the first best option. Table 2 sets out these basic relationships involved in these decisions.

Assuming only two basic types of tools, coercion and incentives, it can be seen that different modes of governance – government, market, and network – correspond to specific problem types. Type 1 policy problems are those whereby the problems and solution are understood but the transaction costs of leaving the solution to private agency (for-profit or non-profit) are high, requiring application of a high level of force and incentives to make private actors accept policy direction. In such cases, it is efficient for the government to maintain a monopoly over it and provide it directly, as is the case with policing or fighting epidemics for example. Type 4 problems are those when it is difficult to comprehend and reconcile deeply conflicting interests of key stakeholders. In such instances, as is the case with drug prices or urban renewal for example, it would be more effective to leave the solution to be worked out in negotiation among networks comprising key stakeholders under varying levels of government oversight. Type 2 and 3 problems are those where voluntary interaction among producers and users is the best solution but the process is handicapped by impediments which can be overcome only through use of state coercion (Type 2) or financial incentive (Type 3). Hospital care, which like other services is technically best provided by private providers that are better equipped to address consumers' diverse demands but also entail the danger of over-servicing and over-charging, is an example of Type 2 and 3 failures.

The conceptualization in Table 2 is different from the traditional understanding, which sees problems more prone to market failures as calling for hierarchical solutions and those more vulnerable to government failure as necessitating market solutions. Networks, on the

other hand, are seen as preferred solutions to problems involving both market and government failures (Ferlie et al. 2011). This line of analysis, however, ignores the many kinds of possible failures which network governance entails (See Davies 2002; Huxham and Vangen 2004; Mann et al. 2004; Stern and Green 2005). While it is possible to combine the best of all three arrangements, reconciling their divergent imperatives is not easy (Meuleman 2008).

The nascent and still small literature on health care governance (Helderman et al. 2012; Brinkerhoff and Bossert 2013; Ramesh et al. 2013) points to the difficulties in governing a sector in which multiple governance failures co-exist and undermines the assumption that networks or markets are more effective than planned efforts carried out by a single organization in a hierarchical manner in delivering services. Yet reformers and commentators continue to make a case for market governance, regulated or subsidized, on the grounds of the existence of pervasive government failures, or for network governance on the grounds that it is best suited for addressing both market and government failures that afflict the sector. Those seeking an alternative to hierarchical governance tend to overlook the significant failures inherent in regulated and subsidized markets as well as networks.

The pertinent question in a sector like health care is whether markets or networks are more effective in meeting the health care needs of the population at a reasonable costs or if the deep market and network failures characteristic of the sector overwhelm its potential and lead to outcomes worse than under hierarchical governance. The answer cannot be found a priori but must follow from analysis of the nature of the problem being addressed and matching governance arrangements to it. Given the deep and often zero-sum nature of the conflicts among the stakeholders in health care – providers, insurers, drug companies, users, and different levels of government – network mode is not viable unless a country has a long history with it, as is arguably the case in the Netherlands. As a result, policy makers seeking to reform hierarchical governance inadvertently turn to markets for solutions. But designing effective regulations and enforcing them diligently is difficult, leading governments with weak capacity to take the subsidy route, which is a politically easier option in the short run. However, subsidies in health care are expensive, with high potential for money being siphoned off to private interests without a corresponding improvement in care.

The case studies of health care reforms in China, India, and Thailand in this paper show that the existence of multiple failures in the sector means that the hierarchical mode of governance is the optimal, if second best, solution. Recent experience in these countries confirm that hierarchical modes of governance, if implemented with due regard to avoiding government failures, are more effective than non-hierarchical modes in securing health policy goals, the extensive academic literature promoting alternative modes notwithstanding.

Health Care Reforms: From Hierarchy to Market and Back

The three Asian countries – China, India, and Thailand – have gone through divergent patterns of health care reforms that offer instructive lessons in the implications of different modes of governance. Broadly speaking, China and Thailand started with a highly public system which they privatized in the 1980s and 1990s but they are now undergoing a reversal towards increased hierarchy. This has occurred as increased reliance on non-government provision or financing in the first reform phase was followed by higher total expenditures with no corresponding improvement in health outcomes. The positive recent

experience with the reassertion of the hierarchical mode of governance in health care casts serious doubts on the supposed superiority of non-hierarchical arrangements in this sector.

Pre-1980s: Governments in Command

The architecture of the health care systems in China and Thailand was remarkably similar until the 1980s, in that inpatient care was provided overwhelmingly by the public sector but financed significantly from private sources. All hospital beds in China and over 90 per cent in Thailand were in the public sector. However, India was somewhat different in that while it too started with a dominant role of the public sector in providing inpatient care – 92 per cent of all hospitals in the country were public at the time of independence in 1947 – its share contracted rapidly and within a few decades formed less than half of the total.

The financing system for health care in the three countries was, however, far less public than the provision system. In China, social insurance rather than government budgets was the source of the vast bulk of health care financing. Different social insurance schemes covered the entire population and were financed from members' premiums, though the amount was modest. Public financing played an even smaller role in Thailand, forming only one-third of total health expenditures in the late 1970s, with the remainder paid out of pocket (OOP) (Pannarunothai 1996: 197). The large share of OOP financing in Thailand was due to the fact that public facilities recovered nearly 40 per cent of their costs directly from users. Health care financing in India was even more private, as the central and state governments together formed only 17 per cent of total health spending in the 1950s and 12 per cent in the 1960s (Bhat and Jain 2004).

The heavily public health care system in China and Thailand worked remarkably well in that total expenditures were low and their population enjoyed one of the highest health statuses in the developing world. In 1990, the infant mortality rate (IMR) was 39 and 29 per 1000 in China and Thailand respectively. Yet more remarkably, this was achieved at relatively small cost, as total health expenditures were less than 3.0 per cent of GDP in China and 3.4 per cent in Thailand during the late 1970s (Pannarunothai 1996: 198). The private health care system in India, in contrast, involved large expenditures (4.5 per cent of GDP) and produced poor outcomes, with IMR of 81 per 1000 in 1990.

1980s and 1990s: From Government to Market

The 1980s and, especially, 1990s were a period of rapid transformation of health care governance in China and Thailand, but not India, where private provision and financing continued to expand. Following the success of economic liberalization in the early 1980s, the Chinese government turned to applying the same formula to health care. While public hospitals formally remained in the public sector, public funding for them was drastically reduced at the same time that existing insurance schemes collapsed, reducing coverage from 70 per cent of the population in 1981 to 20 per cent in 1993 (Development Research Center of State Council, 2005).

With dwindling income from insurance payments and government subsidies, public hospitals were forced to earn income directly from users, often by prescribing unnecessary and expensive drugs and diagnostics (Liu and Hsiao 1995; Xu et al. 2010). Indeed, the government encouraged revenue maximization from users by allowing hospitals to generate surpluses and distribute them among staff as bonuses. With their personal income

tied directly to their hospitals' surplus revenues, managers and physicians focussed effort on generating greater income from users. Unsurprisingly, OOP's share of total health expenditures increased from 20 to 60 per cent by the early 1990s.

Similar to China, the Thai government too began to make efforts to reduce its role in the health care sector in the late 1980s. As the health minister at the time declared, "rather than relying on governments to act as fathers who know best, people should look for opportunities where the private sector could be brought in as an alternative or complement to the public dominated schemes" (*Bangkok Post*, 19 October 1994). By the mid-1990s, the public sector's share of all hospital beds shrank to 75 per cent and of all physicians to 82 per cent. Correspondingly, the public sector's share of total health spending declined to around 25 per cent, with the rest paid largely from out of pocket.

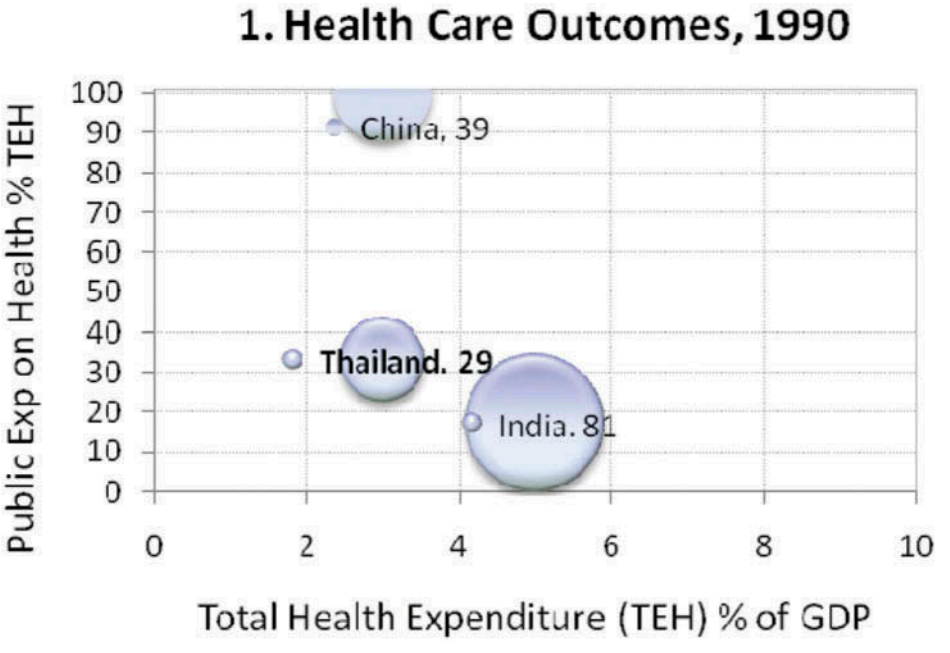
To reduce the rising unaffordability which occurred as a result of the privatization of health care, the Thai government expanded health insurance for the working population and public assistance for the poor. The Free Medical Care for the Low Income programme (originally launched in 1976) was expanded by tripling spending between 1991 and 1996 (Nitayarumphong and Pannarunothai 1997: 152). However, the programme did not cover most of the poor and in fact even those covered faced difficulty accessing health care as payments did not fully cover costs, making providers reluctant to treat such users. Private sector workers were assisted by the launch of Social Health Insurance (SHI) in 1992 which compulsorily covered all workers in firms employing 10 or more workers (gradually reduced to one). SHI was of only little consequence in reality, however, as more than three-fifths of the Thai labour force was in informal employment and hence excluded from coverage. In 1992, the government also established public assistance schemes for the elderly and for children in primary and lower secondary schools. Despite these expansions, however, the various insurance and public assistance health financing schemes covered less than 30 per cent of the population in 2000.

The reduction in public expenditures and, correspondingly, higher private financing in China and Thailand during the 1980s and 1990s was followed quickly by increases in both OOP and Total Expenditure on Health (TEH) (see Figure 1). In China, TEH rose from around 3 to 4.5 per cent of GDP at a time when the economy itself grew at a dizzying pace, while OOP's share of TEH increased from 20 to 60 per cent. Similarly, TEH in Thailand during the 1980s nearly doubled to 6.3 per cent of GDP in 1992 and was projected to rise to 8 per cent of GDP by 2000 if the trend continued (Nitayarumphong and Pannarunothai 1997: 153).

By the late 1990s, these adverse effects of privatized health care were too pronounced to be ignored. The Chinese government's internal opinion polls showed that health care costs were the population's number one concern (Chinese Academy of Social Sciences 2007). This is not surprising given that by 1997 private expenditures on health had increased rapidly to 56 per cent of total health expenditures, of which 95 per cent came from out of pocket. The rising hardships were a major deterrence to accessing health care: in 2006, more than 35 per cent of urban households and 43 per cent of rural households said they had difficulty in affording health care (Hu et al. 2008).

The Thai government's experience with reducing its role in the health care sector was similar to China's, though by the early 1990s it had already begun to expand financing programmes. This reversal accelerated with the onset of the 1997 economic crisis which heightened the population's vulnerability to health care costs. As a result of these measures, the government's share of TEH increased from 47 per cent in 1995 to 55 per

Figure 1. Health care outcomes, 1990



Note: size of bubble indicates infant mortality rate

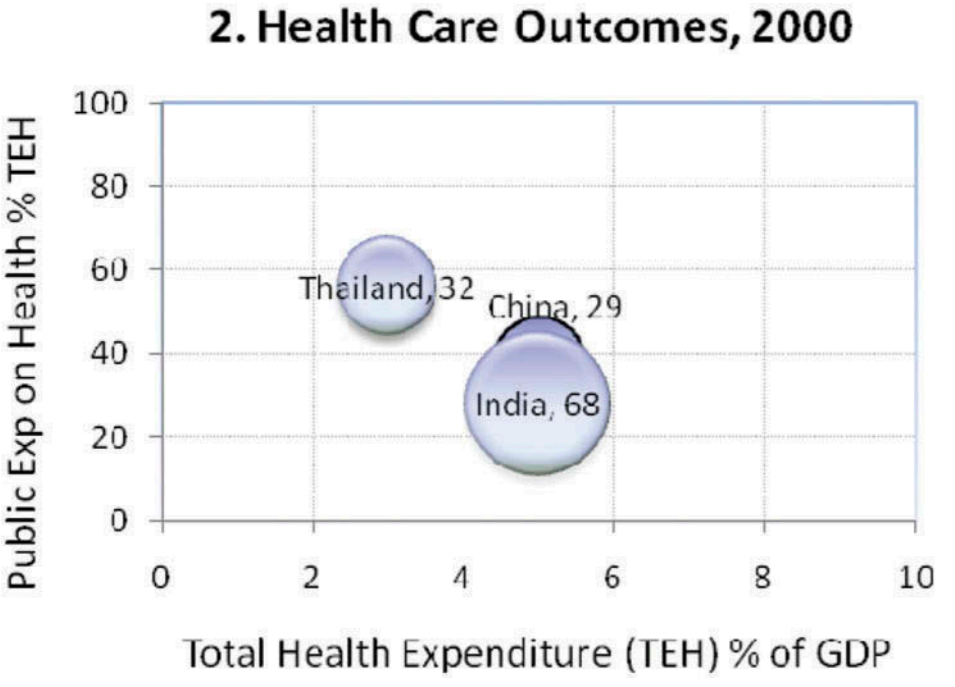
cent in 1998, of which private spending's share declined proportionately. The late 1990s were tough times for Thailand and the enhanced government financing provided much-needed support for the vulnerable population.

Unlike China and Thailand, India stayed on the privatization path: the comparatively large TEH in India funded largely from OOP increased during the 1980s and 1990s as government spending did not keep up with growing demand. Indeed, the Indian government's health spending of less than 1 per cent of GDP was one of the lowest in the world: in 2007, it ranked 184th among 191 countries in terms of public health expenditure as a percentage of GDP. If private expenditures produced good health care outcomes, then the Indian experience undermined the claim, as evident in Figure 2.

Recent Reforms: Retreat from Market

Faced with repercussions from earlier reforms, in the late 1990s China and Thailand launched another wave of reforms. In China, the government launched the Urban Employees Basic Medical Insurance (UEBMI) programme in 1998 for all urban workers – public and private, formal and informal, current and retired. A decade after its launch, UEBMI covered only 67 per cent of the target population due to various exclusions and lax enforcement (World Bank 2010: 7–11). Insurance protection was further expanded with the launch of New Rural Cooperative Medical Insurance Scheme (NRCMIS) for the rural population in 2003 and Urban Residents Basic Medical Insurance (URBMI) for urban migrant workers as well as the non-employed (children, students, elderly, disabled) in 2007. Participation in both schemes is voluntary, but over

Figure 2. Health care outcomes, 2000



Note: size of bubble indicates infant mortality rate.

97 per cent of the rural population has joined NRCMS and over 60 per cent of the target population has joined URBMI. The premiums and benefits vary greatly across localities for both schemes, depending on local fiscal capacity and local leaders' policy preferences. As a result of the expanded and new programmes, insurance coverage increased from 15 per cent of the population in 2003 to 95 per cent in 2012.

Recognizing the hardships caused by private financing of health care, in 2005 the Chinese government acknowledged that the earlier reforms had been a failure (Development Research Center of State Council, 2005), and launched yet another wave of reforms.The current Five-Year Plan (2012–2017) sets out three goals for health care reform in the near future. First, the government has committed to increasing the reimbursement rate from 50 to 75 per cent by 2015 by increasing its contributions to NRCMS and URBMI. It is also trying to standardize premiums and benefits across schemes and regions and adopting a fixed payment system, (for example, capitation and diagnostic related groups) to reduce the perverse effects of fee for service payments that lead inexorably to supply-induced demand. Second, the plan seeks to reign in drug prices by tightening regulations while at the same time removing those that are known to be harmful or ineffective. Third, it aims to improve the performance of public hospitals by separating regulatory and management functions and allowing greater autonomy to managers and physicians. To enhance competition among providers, the plan seeks to increase private hospitals' share to 20 per cent of hospital beds.

India entered the twenty-first century with an inadequate health care system dominated by the private sector, which accounted for 64 per cent of all hospital beds, 80 per cent of physicians, 80 per cent of outpatient care, and 57 per cent of inpatient care (World Bank

2001). Worryingly, only half of all beds in public hospitals were actually functional due to human resource constraints (http://uhc-india.org/reports/hleg_report_chapter_5.pdf). It was estimated that the country required an additional 750,000 beds, 520,000 doctors, and overall investment of Rs. 1.5 trillion (approximately US$27.6 billion) to provide minimum basic services to the entire population (National Commission on Macroeconomics and Health 2005). The government responded to the challenge by expanding "public–private partnerships" (PPP) as a means of meeting the shortage rather than expanding its direct role in provision. The Tenth Five-Year Plan (2002–2007) proposed an enhanced role for the private sector in the delivery of health services. The proposed PPP mechanism was strongly supported by the World Bank and the National Commission on Macroeconomics in Health on the grounds that it would enhance efficiency as well as bridge the resource and skills shortage in the public sector (Raman and Björkman 2006).

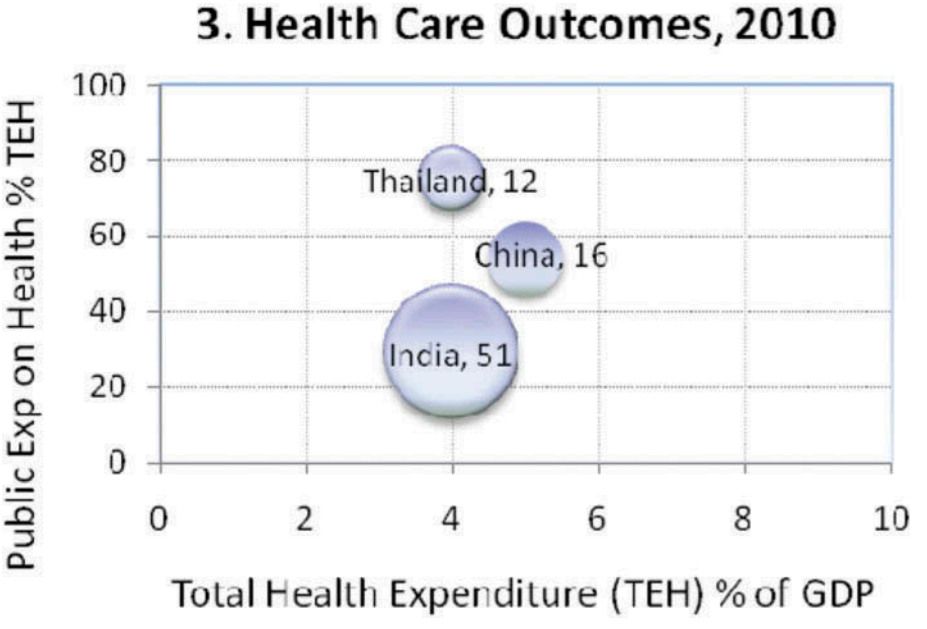
In 2005, the government launched the National Rural Health Mission (NRHM) providing primary care to rural populations in the 18 least developed states (out of 28). It is a decentralized programme co-financed and administered by state governments. Since many states lack both administrative and fiscal capacity to implement the programme, however, less than half the funds allocated by the national government were actually spent (Rao and Choudhury 2012).

The Indian government took the first serious steps towards establishing national health insurance with the launch of Rashtriya Swasthya Bima Yojana (RSBY) in 2007. The scheme provides free inpatient and daycare in designated private and public facilities to recognized poor households to a maximum of Rs. 30,000 (US$553) per annum. State governments identify eligible families but the scheme is implemented through private insurance companies. The premium for the scheme is shared 75:25 between central and state governments. The annual insurance premium in 2011 was Rs. 750, which was less than one-third of the capitation amount in Thailand.

As a result of the new government's measures, over 300 million people, or more than a quarter of the population, gained access to some form of health insurance by 2010, up from 55 million in 2003–2004. More than 180 million of the newly covered were people below the poverty line (Planning Commission 2011). More than 630 million persons, or about half of the country's population, are expected to be insured by 2015, when insurance financing is expected to reach 8.4 per cent of TEH, up from 6.4 per cent in 2009–2010 (www.worldbank.org/en/news/feature/2012/10/11/government-sponsored-health-insurance-in-india-are-you-covered). However, the depth of coverage remains low, as RSBY only covers hospitalization and not out-patient care, which accounts for 74 per cent of all OOP. Most of the OOP expenditures continue to be spent on drugs, much of them purchased over the counter without prescription.

The most comprehensive change among the three occurred in Thailand with the launch of Universal Health Coverage (UHC) in 2001. The scheme offers free health care to those not covered by any health scheme, at the time around 70 per cent of the population. It is an insurance scheme financed from general tax revenue that pays providers on a capitation basis (set at THB2401 in 2010 per person per year). The National Health Security Office (NHSO) functions as the purchaser of medical services on the behalf of the Universal Health Coverage and SHI schemes. As the largest purchaser of medical services in the country, NHSO is in a position to impose prices and service conditions on providers. The launch of UHC dramatically increased the government's role in financing health care and further reinforced its already dominant role in provision.

Figure 3. Health care outcomes, 2010



Note: size of bubble indicates infant mortality rate.

The steep increase in the government's role in provision and financing of health care in Thailand did not, however, lead to an increase in TEH as alleged by proponents of private health care. In fact, Thailand's TEH declined from 3.7 per cent of GDP in 2003, when UHC was established, to 3.5 per cent in 2006. Notably, TEH decline occurred despite a large increase in usage: ambulatory utilization rate increased by 4.3 per cent annually and hospital admission rate by 2.2 per cent annually between 2002 and 2005. Hospital admissions on average across the country increased from 6.3 per cent of population in 2003 to 6.9 per cent in 2004. Infant mortality decreased by 6.5 per 1000 births following the launch of UHC (Gruber et al. 2012).

As a result of the recent series of reforms, total expenditures on health have stabilized while out of pocket payments have declined. At the same time, health outcomes, as indicated in the infant mortality rate, has continued to decline, as shown in Figure 3.

Discussion

The description of the sequence of health care reforms in China, India, and Thailand cast valuable light on the implications of governance failures for the adoption of specific modes of governance. The hierarchical mode of health care governance – characterized by public provision and financing – in China and Thailand until the 1970s produced reasonably good health care status at modest cost. As a part of broader shift to privatization during the 1980s, China and Thailand turned to non-hierarchical governance in the form of increased private provision and financing. The rhetoric of partnership with private firms and societal groups that accompanied the reforms barely disguised the emphasis on private provision and private financing they involved. The governments responded to

the ensuing decline in access to health care (and the corresponding increase in providers' income) by increasing public subsidy for health insurance. India, which already had a highly private health care system, rationalized the arrangement as a "public–private partnership" and promoted it with renewed vigour, accompanied by a modest increase in subsidy. By the 1990s, all three countries were thus promoting private provision and financing of health care, supplemented by insurance, behind the rhetoric of greater partnership with the private sector and civil society.

The effects of these moves towards private provision and financing of health care were felt quickly and widely. Instead of increasing efficiency and reducing costs, as had been expected by the reforms, the privatization measures increased costs and reduced access. However, the measures did broaden choice and improve the quality of services for those who could afford it. In the face of mounting evidence of the adverse effects of the reforms, towards the late 1990s governments in the region began to reassert their role in the health care sector and to reinstitute aspects of hierarchical governance. China and, especially, Thailand expanded insurance coverage and increased government financing of health care while tightening controls over providers. India too began to take small steps towards increasing its role in financing of health care in the mid-2000s, although it left the private providers' dominant role largely untouched.

The bars in Figure 4 show the rise and subsequent decline of private expenditures in all three countries. Correspondingly, and curiously though not unsurprisingly, the rise in

Figure 4. Expenditures on health, total and private

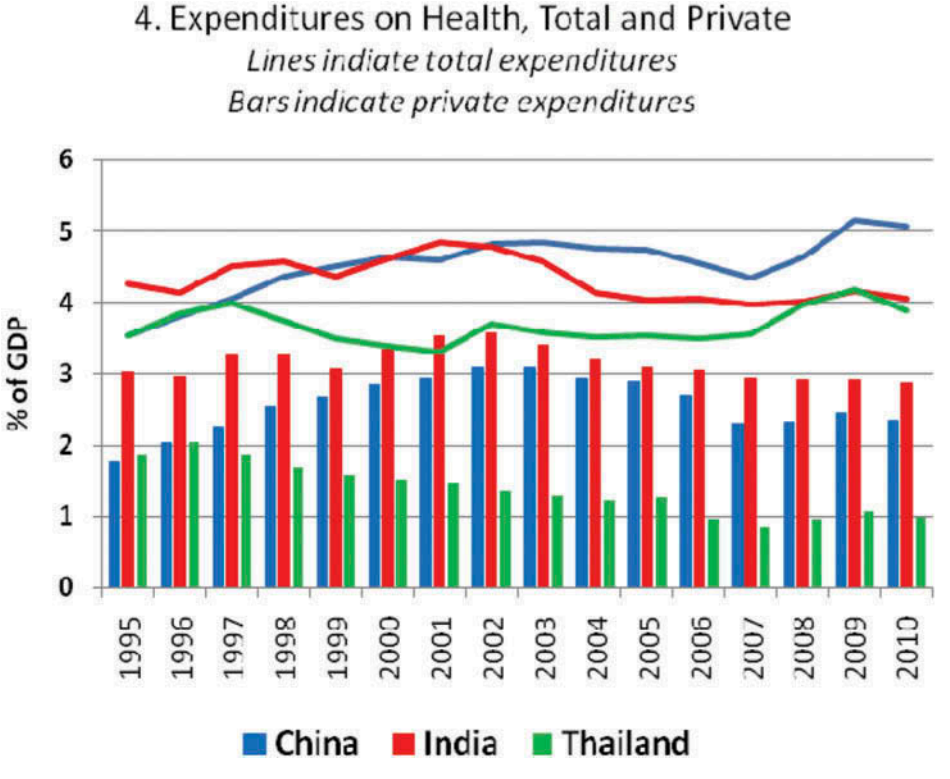
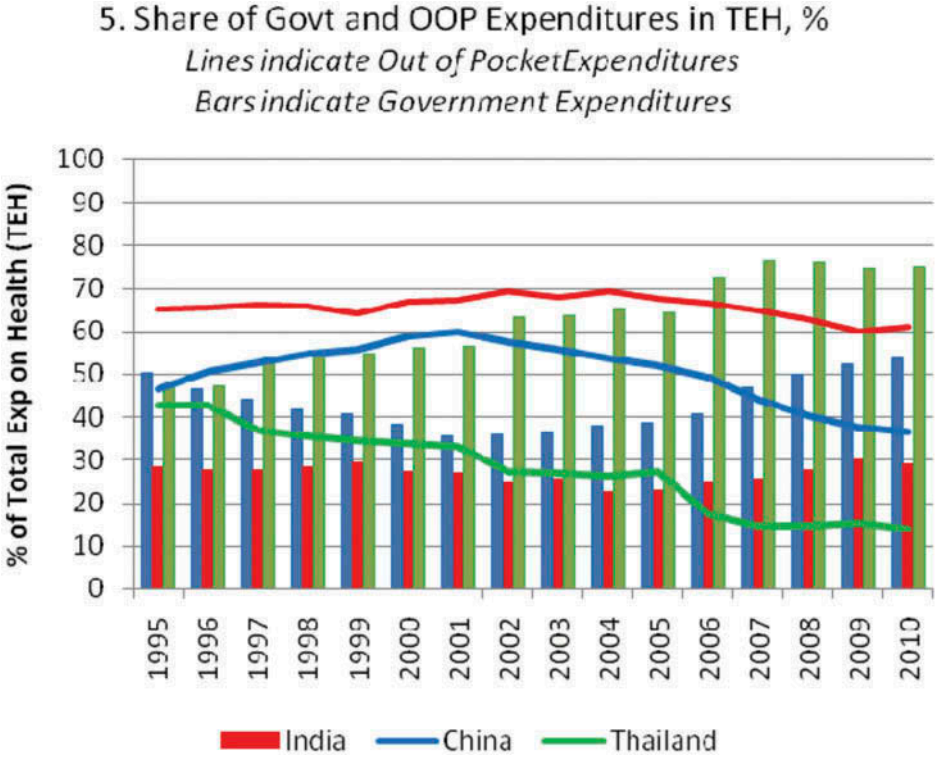


Figure 5. Share of government and OOP expenditures in TEH (%)



private expenditures was mirrored in total expenditures, contrary to the commonly heard argument that private expenditures improve efficiency and thus decrease total expenditures.

The increase and then decrease of private expenditures was closely associated with OOP spending, which is a crucial indicator of accessibility to health care. The increase in government expenditures in recent years has been accompanied by sharp decline in OOP expenditures, as evident in Figure 5. Thus, OOP's share of GDP in China declined steadily from a peak of 60 per cent in 2001 to 37 per cent in 2010 and the downward trend continues. Similarly, OOP's share in Thailand declined from 34 per cent in 2000 to 14 per cent in 2010. In India too OOP's share has declined, though it still forms a majority. Thus, the increases in public expenditures reduced OOP and slowed down the increase in TEH while improving access, undermining the scepticism of the proponents of private health care towards hierarchical tools.

The stabilization of total expenditures on health care and improved access following the reassertion of the government's role is easy to comprehend if the mechanism underlying it is understood. This is best illustrated by Thailand's case, which is characterized by universal insurance financing, public provision, and capitation payment. UHC coverage not only protects those who would not otherwise be insured but also allows the

government to be a powerful active purchaser which can use its dominant position to pressure providers to hold down costs and raise service standards.

In addition, the government's overwhelming ownership of hospitals in Thailand gives the government a powerful instrument to improve access and contain costs. While more competition is certainly conducive for improved services, its absence offers own advantages in the form of reduction in duplication of equipment and services and emphasis on frills that are endemic to hospitals in a competitive market. The under-supply and the consequent implicit rationing of public health care in developing countries lead hospitals to provide only what users need rather than what they desire. Unlike other services where wastefulness is whittled away by competition, in a market-based system the health care sector hospitals are able to recover their costs by over-servicing unsuspecting customers. It is arguable that the bureaucratic, impersonal services provided by public hospitals are an effective rationing mechanism, in that they keep away those who value frills over clinical services.

In India, in contrast to Thailand, the government's small role in providing and financing health care leaves it largely to private providers to shape the market in their own interest with little concern for the financial implications of their actions on users or the society as a whole. The fundamental problem of the Indian health care system lies in the public–private "partnership" in which the government plays little role, leaving users exposed to the demands of private providers. It is possible and indeed likely that the recent increase in public financing would allow expanded pecuniary opportunities for private providers. If PPP is to succeed, the government requires strong regulatory and steering capacity to restrict providers' behaviour and limit their profits.

The need for strict regulation of public–private partnerships if they are to succeed is well recognized in the literature (see ADBI 2000). The government's capacity to design and enforce contracts and establish appropriate organizational and management systems for partnerships are similarly emphasized. There is little evidence that these conditions are in place in India or China. As one assessment of health care partnership in India concluded:

> In most of the projects the private partners are free to decide what additional services to offer, free to generate additional resources except through user-fees, and free to appoint staff and determine their service conditions. In fact, in Karnataka and West Bengal, the private sector has been influential in shaping the government policy towards the private sector. (Raman and Björkman undated: 10)

It is arguable that most governments, especially in the developing world, lack both the technical and political capacity to regulate the health care sector. Unfortunately, a government lacking capacity to regulate private partners is likely also to be limited in its capacity to provide the services directly. However, in situations of publicly provided health care, the main problem will be inadequate and poor quality services rather than excess supply at inflated prices, as occurs under poorly regulated public–private arrangements, with massive repercussions for total expenditures. As mentioned earlier, a network governance arrangement would work the best in such situations, if only one could be established in sectors, such as health care, characterized by deep zero-sum relationships.

Conclusion

China, India, and Thailand have had three decades of experience with hierarchical and non-hierarchical arrangements that offer insights into the characteristic features and effects of the different modes of governance. The conclusion to emerge from studying their experience is that non-hierarchical governance is not a substitute for hierarchical governance in situations where many market and government failures exist. While a network mode would be hypothetically superior, the potential is hard to realize in reality due to pervasive and deep network failures. Establishing and maintaining networks in the health care sector involve significant costs that potential members would rather not pay. And if they do establish networks, as is avowedly the case in India, network members may collude to advance their mutual interests at the expense of those outside the network, such as users. A recurrent problem faced by efforts to utilize network governance is that the routines, trust, and reciprocity which characterize successful network governance (cf. Klijn and Koppenjan 2012) take a long time to emerge. Such relationships cannot simply be established by fiat, as in the case with hierarchy, or emerge spontaneously in response to forces of demand and supply, as in markets. Networks are thus hard to establish where none exist, which is the case in health care sectors in much of the world.

So the default reform often adopted, in practice, by governments seeking to improve upon hierarchical governance is to turn to the market rather than network. In contrast to networks, the adoption of market governance arrangements, in at least their simplest form, is relatively easy because all the government needs to do is reduce its involvement in the provision of goods and services in question with the expectation that the market would fill the void. In all likelihood, however, such a health care market will be both inefficient and inequitable due to the many deep market failures that characterize the sector. To function effectively, health care markets require tough but sensible regulations that are diligently implemented, conditions that are difficult to meet for most governments due to lack of analytical, administrative, and political capacity. Without adequate capacity to regulate the sector, governments turn to subsidizing users and particularly providers. While subsidy for health care improves access and is politically expedient, it is vulnerable to explosion in costs that will undermine the long-term viability of the system.

Hierarchical governance of health care need not be as dysfunctional as stylized descriptions by proponents of market and network governance may suggest and, in fact, may be superior to the alternatives. A health care system characterized by government provision and financing supplemented by capped payment is an effective means of delivering health care at affordable cost, as the case of Thailand shows. There are of course inherent limitations to command and control, the adverse effects of which may be contained through offsetting measures in some instances. Thus, market competition in standardized services (such as cataract surgery or pathological diagnostics) or when consumer preferences are diverse (such as hospital catering) may improve efficiency without compromising access. Similarly, network governance may perform well when dealing with sensitive issues such as HIV AIDS when trust and understanding is paramount. For the bulk of health care, however, hierarchies offer the best opportunity for health care delivery in an imperfect world.

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