health & development in south east asia

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Paul Cohen & John Purcal

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Contributors

Melanie Beresford
lectures in Economics at Macquarie University. She is the author of *National Unification and Economic Development in Vietnam*, and *Vietnam: Politics, Economics and Society* and currently holds a large Australian Research Council grant to research Economic Growth and Institutional Change in Contemporary Vietnam.

Glen Chandler
worked as Community Management Specialist on the AIDAB-funded Environment Sanitation and Water Supply Project in Lombok and Sumbawa during 1992 and 1993 and during 1994 was engaged in a number of consultancies focusing on livestock in Indonesia. She is currently working in the same capacity on the Vietnam Urban Water Supply and Sanitation Project, AusAID (formerly AIDAB) funded.

Chee Heng Leng
is a lecturer at the Department of Nutrition and Community Health of the University Pertanian, Malaysia. She has worked on governmental health policies in Malaysia, health of urban slum dwellers, and is currently doing research on reproductive health and rights of Malaysian women. Her publications include *Amidst Affluence: A Case-Study of an Urban Squatter Settlement with a Focus on Access to Health Care Services* (in press), and *Health and Health Care in Malaysia: Present Trends and Implications for the Future* (1990). She is also editor of the volume, *Behind the Chip: Proceedings of the Conference on Safety and Health in Electronics, Petaling Jaya, Malaysia* (1992).

Lorraine Corner
is currently on leave from Graduate Studies in Demography at the National Centre for Development Studies and holds the position of Regional Programme Adviser for UNIFEM (United Nations Development Fund for Women) in the Asia–Pacific programme based in Bangkok. Dr Corner is well known in Australia and the Pacific for her consultancies and her many publications on the subjects of gender analysis, human resource development and South East Asian economics.

Paul T. Cohen
is a Senior Lecturer in Anthropology and Comparative Sociology in the School of Behavioural Sciences at Macquarie University. He has carried out extensive field-work in Northern Thailand and teaches in the fields of Southeast Asia, medical anthropology and medical sociology and the political economy of Third World health. He is co-editor of *Spirit Cults and the Position of Women in Northern Thailand* (1984) and *The Political Economy of Primary Health Care in Southeast Asia* (1989), and has written numerous published papers on Thailand on issues such as agrarian change, Buddhism and development, and primary health care.

Jennifer Gray
completed field research for her PhD on young women's employment, education and social mobility in Northern Thailand. In the last four years, she has been engaged in HIV/AIDS research focusing on sex workers, injecting drug users among Northern Thai lowlanders and hilltribes. She is currently project director of an AusAID-funded hilltribe HIV/AIDS and Primary Health Care Project located at the National Centre in HIV Social Research, Macquarie University.

Terence H. Hull
is a Fellow with the Demography Program of the Australian National University, on leave to work with the Health Research Centre at the University of Indonesia. His demographic research has spanned topics ranging from the value of children to peasant families, through the evolution of the family planning programs in Asia, to studies of the social and biological determinants of infant, child and maternal mortality. Throughout the 1980s, he worked in collaboration with the UNFPA, the Ford Foundation and AIDAB to design, implement, monitor and evaluate projects in population related areas, in Indonesia, Vietnam, China and the Philippines. Recently, he has been working on the history of sexually transmitted diseases and prostitution in Indonesia.

Valerie J. Hull
as trained in Anthropology and Demography and during the late 1970s and early 1980s, as a Research Fellow with the ANU, was based in both Indonesia and Australia, undertaking research in maternal and child health and family planning. She joined the Australian International Development Assistance Bureau (AIDAB) in 1986 where she was responsible for women, health and population policy and technical advice. She has carried out a number of health studies in Vietnam, Bangladesh and the Philippines. She works with the Population Council in Jakarta, and collaborates on a wide variety of projects to improve the quality of reproductive health care.

John T. Purcal
was, until 1993, a Senior Lecturer in Economics in the School of Economic and Financial Studies at Macquarie University and subsequently has lectured at Lingnan College, Hong Kong, and the University of Western Sydney. His research interests have focused on Southeast Asia and on rural economic development, health and education. His publications include *Price Economy: Employment and Income in Malaysia* (1972), and articles on social integration and development, labour utilisation, and technological development. He is also co-editor of *The Political Economy of Primary Health Care in Southeast Asia* (1989).

Yulfitra Raharjo
is a graduate in both Demography (MA) and Anthropology (PhD) from The Australian National University. She is currently the head of the Centre for Population and Manpower Studies in the Indonesian Institute of Sciences, Jakarta. Her particular interest is health and women's issues and she has a an international reputation in this field. She has worked with several UN agencies both in Indonesia and internationally. She was recently admitted to the prestigious National Research Council (Dewan Riset Nasional) in Indonesia and in 1995 was awarded the special honour, the Service Star, First Class, by the President for her contribution to social science research in Indonesia.

Kathy Robinson
is Associate Professor in the Department of Sociology and Anthropology at the University of Newcastle. Her published work is principally concerned with development in Indonesia, including health and gender consequences of New Order development policies. Her major publications include *Step-children of Progress: The Political Economy of Development in an Indonesian Mining Town* (1986), four co-edited volumes on politics and society in South Sulawesi, as well as numerous articles on issues such as family planning, maternal and child health and state policies concerning women.

Santhat Sermsri
is a former Dean of the Faculty of Social Sciences and Humanities, Mahidol University, Thailand. He is currently Secretary-General of the International Forum for Social Sciences in Health and Associate Professor of the Department of Social Sciences at Mahidol University. He has a number of publications on health care services, urban crowding, and population and environment in Thailand. He has also served as a member of many committees at national and international levels.

Jane Wilson
has done epidemiological research in India and Madagascar and has acted as consultant health adviser to water projects in Lombok in 1990 and Pakistan in 1991. She has worked in curative mother and child health in Sri Lanka and UK and is currently a medical adviser to British VSO and US Peace Corps volunteers in Nepal. She has recently published a book entitled *Healthy Travel: Bugs, Bites and Bowels (1995).*

Contents

the political economy of health & development in South East Asia

John Purcal and Paul T. Cohen

South East Asia is now regarded as one of the most dynamic regions of the world in terms of economic growth and development. This impression of the region should apply strictly to the six nations comprising the Association of Southeast Asian Nations (ASEAN) where average rates of economic growth were over 7 per cent in the 1970s. In the 1980s there was a general slowing down in the region, but still the average rate of economic growth was over 5 per cent. Even in the dynamic ASEAN, some nations like the Philippines lagged far behind the average rate of growth of 7.8 per cent achieved by Thailand in the years since 1970. In the Philippines economic growth slowed to an average of 1 per cent in the 1980s but is currently over 4 per cent. Compared to the economic performance of the ASEAN, economic growth was slow in the non-ASEAN countries. These economies—Myanmar, Laos, Cambodia and Vietnam—are grouped together as true transitional economies of South East Asia moving from centralised control to more open market economies. While Vietnam has shown greater promise in its transition with deregulation, less controls and attractive foreign investment laws in recent years, Cambodia and Myanmar are making their way slowly because of civil conflicts. Vietnam's transition and openness under *doi moi* has attracted huge investments from a number of countries including Australia, and the economy is currently growing at 8 per cent per annum.

Structural changes in the economies

During the last 30 years the structure of all economies in South East Asia has changed from agriculture based to more industry and services based economies. In non-ASEAN transitional economies, structural changes have been slow, except for Vietnam. Even there, industrial development has been much slower than in ASEAN countries. Today around 25 per cent of Vietnam's total output comes from the industrial sector, and agriculture accounts for about 38 per cent of the total output in (ADB 1993:263). In the other three non-ASEAN economies, Myanmar, Laos and Cambodia, agriculture accounts for between 48 and 60 per cent of the total output. In these economies, industrial development is taking place very slowly, and output from industries accounts

for between 14 and 17 per cent of the total output, with Cambodia and Myanmar being the least industrialised.

In ASEAN economies, rapid growth and development brought about substantial structural changes. Most have transformed from agricultural economies of the 1960s to industrial economies of the 1980s and 1990s where industrial output now accounts for between 35 and 44 per cent of total output (ADB 1993:263). In the Philippines the pace of structural change has been slower than in other countries. There the agricultural contribution to total output was more than 20 per cent of the total output. In Indonesia, agricultural output was reduced by almost half between 1970 and 1990 from 35 to 17.9 per cent. In Thailand the pace of change was faster, with agricultural output being reduced to 13 per cent of the total output in 1990. In Malaysia too there were dramatic changes, with agricultural output falling from 23 per cent in 1980 to 16 per cent in 1990. These changes have induced movement of people from rural to urban areas throughout South East Asia. The pace of urbanisation has increased in recent years, and the impact of this will be discussed in a separate chapter in this book.

The nations of South East Asia have a total population of around 460 million and an average per capita income of less than US$1000. Today these nations exhibit patterns of economic growth ranging from close to 10 per cent in Singapore to virtual stagnation in Cambodia. With such differential growth rates and incomes, South East Asia represents a microcosm of the world, with countries like Singapore and Brunei enjoying a standard of living of the developed world, while others like Cambodia and Laos are among the low-income countries of the world. With economic growth, disease patterns of the regions are changing from vector borne (and water and airborne) infectious diseases to diseases like cancer, cerebrovascular and heart diseases. Where economic growth is slower, infectious diseases are more prevalent, as in most transitional economies.

Health development

The differential economic growth rates among the ten nations of the region are clearly reflected in the health status of their population, with a few enjoying the health status of the developed world, while others' health status vary from that of the middle income countries to that of low income countries of the world. Health status of the population is one of the most important indicators of economic development. It shows the success or failure of the nation in meeting the basic needs of the population, ranging from food and shelter to sanitation and education. Health is also a form of human capital which plays a crucial role in economic development. Better health increases the supply and productivity of the labour force. It also improves the enrolment and performance of children in school. Further, better health reduces infant and child mortality and thus has a significant influence on reducing fertility rates. This in turn slows population growth rates and improves economic development prospects.

Infant mortality

Infant mortality is a good indicator of socio-economic development in this microcosm of the world. Infant mortality decreases as per capita income increases in South East Asia. The only nation that does not conform to this pattern is Vietnam (see Table 1). Vietnam, though a low income country, has an infant mortality rate of middle income countries. In Vietnam, there was a substantial reduction in mortality among infants below the age of one year between 1960 and 1992, despite its slow economic growth. Vietnam was able to achieve this striking result, despite its low per capita income, by resorting to primary health care as the vehicle of delivering care with emphasis on access and equity. Brunei also performed better than others in South East Asia by matching an 87 per cent reduction (for the years 1960 to 1992) achieved by Japan, the country with the lowest infant mortality in the world. Brunei succeeded by providing medical and health services at no cost to the consumer, thanks to the strong financial position of Brunei from oil revenues (Tiun Ling Ta 1992:115–24). Generally in the countries of South East Asia improvements in standard of living and education and improved provision of health services, especially by the public sector, were the main factors that brought about a reduction in infant mortality since the 1960s. Thailand, with the fastest economic growth in South East Asia over the years since 1960, was able to

Table 1
Infant mortality rates

	Per capita GNP ($US)[a]	Infant mortaliy rate 1960	1992	Change (per cent)
ASEAN countries				
Singapore	15,730	31	6	-80.6
Brunei	11,990	63	8	-87.3
Malaysia	2,790	73	14	-80.8
Thailand	1,840	101	27	-73.3
Philippines	770	73	46	-37.0
Indonesia	670	127	71	-44.1
Non-ASEAN countries				
Myanmar	220	158	83	-19.9
Vietnam	240	147	37	-74.8
Laos	250	155	98	-36.8
Cambodia	200	146	117	-19.9
Australia	17,260	20	7	-65.0
New Zealand	12,300	22	8	-63.6
Japan	28,190	31	4	-87.1
USA	23,240	26	9	-65.4

[a] Most recent estimate 1987–92.

Source: UNICEF 1994; World Bank 1994.

reduce infant mortality by 73 per cent between 1960 and 1992, largely through improved income and educational development, whereas Malaysia and Singapore managed to achieve an 81 per cent reduction during the same period by combining better distribution of health resources among the population with improved standard of living and education.

All the ASEAN countries, except Indonesia and the Philippines, were able to achieve a faster reduction in infant mortality during the years 1960 to 1992 than the average 65 per cent reduction achieved by Australia, New Zealand and the USA during the period. Singapore and Brunei rank high on the ladder of success in reduction of infant mortality in the world, with Singapore improving its rank between 1960 and 1992, whereas Australia's rank slipped from 4 to 9 in the table published by the United Nations Children's Fund (UNICEF).

Life expectancy

The health indicator of life expectancy also emphasises the strong interrelationship between health and economic development. Life expectancy varied from 74 years in Brunei and Singapore to 51 years in Laos and Cambodia (see Table 2). Vietnam's life expectancy was again an outlier in this general pattern. With an annual per capita income of less than $300, Vietnam has a life expectancy of 64 years—very close to life expectancy of the Philippines, which had a per capita income of $770 in 1992.

The middle income countries of ASEAN with significant growth rates—Thailand, Indonesia and Malaysia—were able to add over 17 to 21 years since 1960. Those nations that had a low starting life expectancy in 1960 gained more with comparable growth rates. Laos and Cambodia, despite starting from a low base of 40 to 42 years in 1960, with their poor economic performance were only able to add between 9 and 11 years by 1992. Both Singapore and Brunei made substantial improvements and have life expectancies just 5 years less than the highest life expectancy of 79 years achieved by Japan in 1992.

Life expectancy of females was consistently 6 per cent higher than that of males in most countries of South East Asia in 1992. The two exceptions were the most rapidly growing countries of Singapore and Thailand. In these two countries the life expectancy of females in 1992 was 8 per cent higher than that of males, as in Australia and other economically advanced countries.

Child mortality

This indicator is defined as the probability of dying before reaching the age of five years per 1000 live births, and it has a number of advantages over other indicators by focusing on one of the end results of economic and human development. This indicator is the final result of various inputs ranging from nutritional intake, availability of maternal and child health care, sanitation and potable water to health knowledge of the mother and income and food

Table 2
Life expectancy at birth

	GNP per capita, annual growth rate (per cent)		Life expectancy		Life expectancy of females as a percentage of males
	1965–80	1980–91	1960	1992	
ASEAN countries					
Singapore	8.3	5.3	64	74	108
Brunei	n.a.	n.a.	n.a.	74	n.a.
Malaysia	4.7	2.9	54	71	106
Thailand	4.4	5.9	52	69	108
Philippines	3.2	-1.2	53	65	106
Indonesia	5.2	3.9	41	62	106
Non-ASEAN countries					
Myanmar	1.6	b.a.	44	57	106
Vietnam	n.a.	n.a.	44	64	106
Laos	n.a.	1.2	40	51	106
Cambodia	n.a.	n.a.	42	51	106
Australia	2.2	1.6	71	77	109
New Zealand	1.7	0.7	71	76	108
Japan	5.1	3.6	68	79	108
USA	1.8	1.7	70	76	109

Source: UNICEF, 1994.

availability within the family. Moreover, the indicator does not suffer from the averaging process which others like the per capita GNP are susceptible to. For example, child mortality is hardly affected by the presence of a small proportion of high income families in the economy, whereas other indicators like per capita income are heavily affected by the presence of such a group. For these reasons, UNICEF uses child mortality as a principal indicator of economic and human development (UNICEF 1994:79–81).

These child mortality indicators for South East Asian countries show a close relationship with economic growth in most countries. The rate of child mortality varied from 40 in Singapore in 1960 to over 200 in Indonesia and in the four transitional economies of South East Asia in 1960 (see Table 3). Since then there has been very rapid reduction of child mortality rates in the fast growing economies of Singapore, Brunei, Malaysia and Thailand, with Singapore achieving the same rate as Australia in 1975. In all other countries there were reductions, albeit rather slow ones with the only exception being Cambodia where the child mortality rate increased from 217 in 1960 to 239 in 1975, followed by a substantial increase to 330 in 1980 mirroring the atrocities committed by the Khmer Rouge in the late 1970s. Since 1960 all ASEAN countries, except the Philippines and Indonesia, performed very well in

Table 3
Child mortality rates

	1960	1980	1992	Average annual rate of reduciton (per cent) 1960–80	1980–92
ASEAN countries					
Singapore	40	13	7	5.6	5.2
Brunei	87	n.a.	10		
Malaysia	105	42	19	4.6	6.6
Thailand	146	61	33	4.4	5.1
Philippines	102	70	60	1.9	1.2
Indonesia	216	128	111	2.6	1.2
Non-ASEAN countries					
Myanmar	237	146	113	2.4	2.1
Vietnam	219	105	49	3.7	6.3
Laos	233	190	145	1.0	2.3
Cambodia	217	330	184	-2.1	4.9
Australia	24	13	9	3.0	3.8
New Zealand	26	16	10	2.5	3.7
Japan	40	11	6	6.6	4.5

Source: UNICEF 1994.

reducing child mortality since with their average annual rate of reduction matching closely the average increase in per capita income. In the Philippines and Indonesia, the annual rate of reduction was much slower than the rate of income growth.

In the non-ASEAN countries, Vietnam's performance in child mortality reduction was much faster than others. Despite its low level of income, the performance of Vietnam since 1960 is better than that of the Philippines and Indonesia, with Vietnam having a child mortaliy rate lower than both these middle level income countries in 1992. Four countries in South East Asia—Indonesia, Myanmar, Laos and Cambodia—have child mortality rates over 100, with Cambodia having the highest rate of 184. Of the others, Singapore and Brunei have rates similar to the most developed countries of the world. The remaining countries—Malaysia, Thailand and the Philippines—have mortality rates varying from 19 in Malaysia to 60 in the Philippines. Of the three, Malaysia shows potential of reaching developed country status in child mortality by the year 2000.

Burden of mortality

All the indicators discussed so far—life expectancy, infant and child mortality rates—show a strong correlation between health and economic growth in

Table 4
Years of life lost per 1000 population, 1990

ASEAN countries		Non-ASEAN countries	
Singapore	6	Myanmar	n.a.
Malaysia	15	Vietnam	36
Thailand	22	Laos	93
Philippines	27	Cambodia	n.a.
Indonesia	36	Australia	8
		New Zealand	9
		Japan	5

Source: World Bank 1993: 292–3.

South East Asia. The burden of mortality shows a similar pattern. This indicator is the sum of years lost to premature death per 1000 population, and it tends to decrease as the country's economy grows and per capita income increases. In the region, the burden varied from 9 years in Singapore to 93 years per 1000 population in Laos (see Table 4). This loss of life due to premature death conveys the burden in absolute terms. Again, as we have seen elsewhere, Vietnam's health status according to this indicator is good despite its poverty. The burden of mortality in Vietnam was similar to that in Indonesia, despite Vietnam having a per capita income of one third of Indonesia. Singapore has the least burden of mortality in South East Asia, a burden lower than that of Australia. On this indicator, Singapore is among the top four nations in the world, with only Japan having a lower one than Singapore in 1990. For the region as a whole, the burden of mortality, on the average, decreases by 3.5 years of life lost for every $US1000 increase in per capita income.

Health expenditures in South East Asia

Health spending and the manner in which that spending is distributed among the population also influence health status. There are considerable differences in the distribution of health spending nationally and internationally most particularly between developed and developing countries. Of the total global health spending of US$1700 billion in 1990, around 87 per cent was spent in developed industrial countries where 15 per cent of the world population lived. In the developing world, with 78 per cent of the population, the total health spending came to US$170 billion or 10 per cent of the total global spending on health (World Bank 1993: 52). The share of the developing countries of South East Asia with about 8 per cent of the world population came to just over 1 per cent of global spending.

Similar imbalances in health expenditures are also seen in the allocation of expenditure between emerging industrial countries and developing low-income countries of South East Asia. Annual health spending per capita

Table 5
Health expenditure

	Health expenditure as per cent of GDP 1990	Per capita health spending 1990 ($US)	Per cent of central government expenditure (1986–92)	
			Health	Defence
ASEAN countries				
Singapore	1.9 (3.1)	219 (502)	5	24
Brunei	2.0	n.a. (324)	(4)	n.a.
Malaysia	3.0	67	5	12
Thailand	5.0	73	7	17
Philippines	2.0	14	4	11
Indonesia	2.0	12	2	8
Non-ASEAN countries				
Myanmar	n.a.	n.a.	7	22
Vietnam	2.1	2	n.a.	n.a.
Laos	2.5	5	n.a.	n.a.
Australia	7.7	1331	13	9
New Zealand	7.2	925	12	4
Japan	6.5	1538	n.a.	n.a.
USA	12.7	2763	14	22

Note: Figures in brackets are for 1992 in Singapore and for 1987 in Brunei.
Source: World Bank 1993; UNICEF 1994; and others.

varied from less than US$5 in Vietnam and Laos to US$219 in Singapore in 1990. To a great extent these differences reflect variations in per capita incomes, as all these countries spend between 2 and 3 per cent of their GNP on health, with the exception of Thailand. In absolute terms the highest per capita spending in the region of $502 in Singapore in 1992 was only a fraction of that spent on health in the developed industrial countries of the world. All countries in South East Asia spend more on defence than on health. In Singapore, defence expendidure as a proportion of central government expenditure is almost five times that on health. Generally, the South East Asian countries spend less on health, as compared to defence, as a proportion of their central government expenditures than Australia and New Zealand (see Table 5).

As a proportion of GDP, health spending in South East Asia varied from 2 per cent in Indonesia and the Philippines to 5 per cent in Thailand in 1990. On the average, the nations in the region spent about 3 per cent of their GDP on health, which was considerably lower than the average of 8 per cent spent in the industrially advanced countries. The health indicators for most South East Asian economies should be worse off than stated in the Tables we have discussed. But some countries in the region enjoy better health despite their

lower spending. For example, Singapore spent full 10 per cent points of GDP less than USA or close to 5 per cent less than Australia in 1992, yet health status in terms of life expectancy, infant and child mortality is quite comparable. Similarly Vietnam, despite its lower spending of 2.1 per cent of its GDP in 1990, has health outcomes significantly higher than nations at the same level of development.

In both Vietnam and Singapore, the public sector is very prominent in the delivery of health care. Public sector policies in both countries emphasised equity in the distribution of health resources. There health investment in the poor has reduced poverty in both these countries. Malaysia has also reduced the problem of poverty through more egalitarian distribution of health services, especially among the poor living in rural areas. In all these countries, the public sector was able to achieve economies of scale both in the production and distribution of health services, and this was a significant factor in keeping health costs down. In Singapore a number of health measures were effective in containing costs of medical and health services (Purcal 1989:132–34).

While some of the policies and measures were keeping costs down, others operated within the system to send costs up. Generally in the region, there was a trend for health costs to grow faster than incomes. The growing number of doctors and specialists, increased personnel costs, and use of costly technology and drugs are raising the costs of health care. The problem of costs is exacerbated by rising expectations and the demand for better medical and health services and the misallocation and inefficiency inherent within the health systems. In the region wastage is clearly noticed in the inefficient deployment of health workers and in the use of expensive drugs and technology, especially in the rapidly growing economies of Malaysia and Thailand. Misallocation is also a feature of the public sector services with their centralised decision-making and emphasis on curative care in the hospitals rather than cost effective preventive measures and intervention in lower cost facilities.

The preeminence of the public sector in the region has eroded in some countries in recent years. For example, the private sector has become the leading player in Thailand accounting for 3.9 per cent of GDP, as against 1.1 per cent of health spending in the public sector in 1990. In Malaysia and Indonesia, the role of the public sector in providing health care has dwindled, with the private sector health spending exceeding that of the public sector. In Singapore the government is encouraging the private sector to play a greater role in the production and delivery of health services. In Vietnam, with the dynamic effect of *doi moi*, the private sector is emerging with a vengeance.

In the transitional economies of South East Asia there is considerable emphasis on primary health care as the vehicle of delivery of health care, whereas in the ASEAN countries, despite their commitment to the principles and philosophy of primary health care, the emphasis is on the provision of basic medical and health services. The primary health care approach before the onset of *doi moi*, as mentioned earlier, made it possible for people to have access to