HEALTH AND EDUCATION

IN GREATER MEKONG SUBREGION:
POLICIES, INSTITUTIONS AND PRACTICES

A GMS-DAN PUBLICATION

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Chapter 1
Health and Education in the Greater Mekong Subregion: Policies, Institutions and Practices

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1. Introduction

The Greater Mekong Sub-region (GMS) countries have taken major strides in improving the health and educational status of their people in the past two decades. Even the people of Cambodia and Laos, the poorest countries in the GMS after Myanmar, lead healthier lives than in the mid-1990s. Both these countries are also now close to achieving universal primary education, although progress in secondary and higher education has been more sporadic across the GMS. Despite these impressive achievements, the GMS countries, especially Cambodia, Laos, Myanmar and Vietnam (CLMV), face significant challenges in further improving access to effective, quality health and education services at affordable prices (CDRI 2014). There is a need for making access to affordable health care and education more equitable and inclusive, across regions and across rich and the poor (Madhur and Menon 2014).

In the area of health, further reducing maternal deaths by increasing the number of births attended by skilled attendants is the most challenging for Laos, followed by Cambodia, Myanmar and Vietnam; the scope for further reductions in under-five mortality rates is the largest for Myanmar, Cambodia and Laos and more modest for the other GMS countries; curbing the spread of tuberculosis is the most pressing for Cambodia and Myanmar, but that task must not be underestimated even for Laos, Vietnam and Thailand; Thailand and Cambodia, the two countries with very high HIV prevalence rates in the mid-1990s, face the challenge of making further reductions, while Myanmar, Vietnam and Laos face the challenge of preventing the incidence of the disease from escalating; the scope for improving nutrition and reducing undernourishment appears to be the largest for Laos and Cambodia (perhaps Myanmar too) and somewhat less crucial for the other countries.

Although GMS countries either have or are close to achieving universal primary education, there is significant scope for improving the quality of primary education especially in Cambodia, Laos and Myanmar, even in Vietnam. In secondary education, while Cambodia and Laos have the twin tasks of raising both enrolment and education quality, other GMS countries have to focus more on improving the quality of education even as they maintain the hard-earned gains in secondary enrolment rates. As for higher education, almost all GMS countries have huge challenges in improving both the quantity and quality of education especially in STEM subjects (science, technology, engineering, and mathematics) but these challenges are more daunting for the CLMV countries and China, and somewhat more manageable for Thailand.

All these underscore the need for well-coordinated policy actions. For both policy formulation and implementation, institutional reforms in both health and education sectors of the GMS countries are crucial. It is against this background that the subsequent stages of the GMS-DAN project aim to analyse the role of GMS countries' policies and institutions for strengthening their health and education sectors. This chapter provides a synthesis of the key policy messages and conclusions from the individual country studies of the second stage of this GMS-DAN research project. The country studies draw on strategy and policy documents and other published data and information to decipher

the goals, objectives and contents of their country's health and education policies. To translate these policies in to better health and education outcomes, countries have put in place institutional frameworks for policy administration and management.

Institutional frameworks typically involve many actors: government ministries and departments, private sector agencies, civil society organisations (CSOs), bilateral and multilateral donors often referred to as development partners, and similar other institutions such as research institutions and think tanks. These actors play key roles in policy dialogue and formulation, and can have a direct impact on the success of the policies and programmes that emanate from them. Policy implementation takes place within varying settings: the economic, political, social and cultural conditions prevalent in a country may affect the implementation of some policy issues. Ultimately, health and education outcomes are determined by not just policies but also by country-specific institutional frameworks and socio-political-cultural factors (Ostrom, Gardner and Walker 1994; Gibson et al. 2005; Anderson 2006; Basu 2011; Acemoglu and Robinson 2012).

The institutional perspective on policy-making and implementation implies that even good policies could result in bad health and education outcomes either because the institutional frameworks are not well-suited for converting good polices into good outcomes, or because the institutional frameworks, however robust they are on paper, are unable to implement the good policies into good outcomes. There could thus be many gaps between good policies and good health and education outcomes. The main objective of this study is to better understand the nature of these gaps among the GMS countries and draw comparative country lessons.

The focus of the paper is thus on the institutional frameworks and their effectiveness in policy-making and implementation in health and education and not so much on assessing whether these polices themselves are appropriate. In assessing institutional effectiveness, the paper does not purport to be comprehensive but selective in that it looks at only a few key issues: national, especially public, resource commitments; intra-governmental coordination, both vertical and horizontal; the roles of non-state actors, including private sector, civil society organisations and civil society more generally.

Section 2provides the backdrop to the institutional analysis by briefly summarising the health and education strategies and policies among the GMS countries. Section 3 details the similarities and differences in the formal institutional frameworks. Section 4 examines the functioning (or lack of it) of the institutional frameworks for health and the main constraints these face in practice. Section 5 offers a similar institutional assessment, but focusing on education. Section 6summarises the main conclusions.

2. Goals and policies in health and education

2.1 Health

Nested within national development strategies, and articulated in the Rectangular Strategy and the National Socioeconomic Development Plan (NSDP), Cambodia's national health policies are based on five key pillars: (i) improving health service delivery, (ii) improving health financing, (iii) increasing human resources for the health sector, (iv)

enhancing the health information system, and (v) improving health system governance through decentralisation. Based on this broad policy framework, the Ministry of Health identifies three areas for special focus: maternal and reproductive health, communicable diseases, and non-communicable diseases.

In Laos, the National Growth and Development and Poverty Eradication Strategy (NGPES) clearly identifies the health sector as one of the four top priority sectors (along with agriculture, education and infrastructure). Within this overall development framework, the health sector policy identifies four major policy goals: (i) creating a robust health infrastructure (covering basic materials and technological hardware), (ii) developing sustainable health financing modalities, (iii) expanding and strengthening the overall health system, and (iv) achieving health sector Millennium Development Goals (MDGs). Various programme and projects are then implemented to achieve these health sector goals.

Within the overall framework of Vietnam's development strategy for 2011-2020, the main objectives of health policy are to increase the supply of healthcare services to meet the increased needs of a growing economy, achieve social equity in access to healthcare, and improve the quality of healthcare services. These strategic objectives are backed by government legislation and health sector policy implementation guidelines of the Ministry of Health. The latter identifies five major elements of health policy: (i) strengthening grassroots health networks to reduce overcrowding in healthcare centres, (ii) reforming the public financing system for health, (iii) formulating and implementing universal health insurance, (iv) reducing the spread of communicable and parasitic diseases, and (v) ensuring that the poor receive adequate healthcare services and medical treatment.

Thailand, being at a higher stage of development than CLMV countries, focuses its health policy on developing further the country's hospital system (already becoming a regional centre for medical services within ASEAN) and strengthening the health insurance system with the objective of achieving universal coverage.

China is somewhat unique among the GMS countries in that rapid growth, accelerating urbanisation, gradual demographic transition that has led to longer life spans and concomitant epidemiological changes are leading to major changes in its health profile. While typical public health problems of a poor country related to maternal and child health and communicable diseases are subsiding, lifestyle-related non-communicable diseases such as diabetes, cardiovascular disease and cancer are becoming the major causes of ill health and mortality (Yang et al. 2013). That said, reflecting the continental size of the country (both in geography and population), disease patterns and health profiles show significant variations across the country: the more prosperous coastal regions experience more lifestyle-related disease patterns whereas the poorer regions such as Yunnan still suffers from the conventional public health problems. As a result, even as the country attends to the unfinished agenda for public-health problems, it is increasingly required to focus on tackling these lifestyle-related diseases. The 2009

healthcare reforms and future priorities are set against this emerging health profile of the country's population.

2.2 Education

Like in the area of health, Cambodia's education policies are nested within the government's overall development strategy. The 2014-18 NSDP emphasises the need for: (i) ensuring equitable access for all to education services, (ii) improving the quality and relevance of learning, and (iii) enhancing effective leadership and management of education staff (Cambodia chapter, this volume). Within this overall framework, the Education Strategic Plan (ESP) of the Ministry of Education singles out three key areas for special focus: (i) equitable access for all to education services, (ii) quality and relevance of learning, and (iii) effective leadership and management of education staff at all levels (MOEYS 2014, 13). Twelve years of education from grade 1 to grade 12 are free of cost in public schools to all children. A nine-year basic education programme, that is, six years of primary education and three years of lower secondary education up to grade 9, is treated as compulsory for all children.

With minor differences, Laos' broad objective and policies for education are very similar to that of Cambodia. The Education for All National Plan of Action (EFA NPA) seeks to achieve equitable access, improved quality and relevance and strengthened education management (Laos chapter, this volume). Within this broad policy framework, the EFA NPA focuses on four aspects: (i) early childhood care and development, (ii) primary education, (iii) lower secondary education, and (iv) non-formal education and skills training. Five years of primary education is free and compulsory in public schools for all children in Laos. (The EFA NPA also emphasises the need for the private sector to play a greater role in education provision at all levels, and aims to increase the share of public expenditure on education in the budget from the current level of 12 percent to about 18 percent in the next few years).

Vietnam's development plans accord high priority to education. The country's education law underscores the need for an education policy that aims at enhancing people's knowledge, improving human resources and nurturing human talent (Vietnam chapter, this volume). Within this overall legal framework, raising enrolments (quantity) and improving education quality at all levels are emphasised. Pre-schooling plus nine years of education beginning from primary school up to lower secondary education are free in public schools and compulsory for all children in the relevant age-group.

Education in Thailand is more advanced than in CLMV countries. The country has long achieved universal primary education and enjoys robust secondary and tertiary education enrolment rates. The key objective of Thailand is to consolidate past gains and strengthen education quality at all levels but especially in higher education, aptly summarised in the country's slogans: "All for Quality Education and Quality Education for All" and "Graduates with Quality and Social Responsibility" (Thailand country chapter, this volume). By the end of the 1980s, Thailand had already introduced comprehensive higher education plans. The Ministry of University Affairs was created and a 15-year higher education plan covering 1990-2004 formulated. Learning from these past experiments,

the country recently developed a Long Range Plan on Higher Education for 2008-2022. Cast within the context of the AEC, the Plan aims to improve quality, accessibility and affordability of higher education, including technical and vocational education and training (TVET) (Thailand chapter, this volume).

China has made impressive progress in primary and secondary education. The country has achieved universal primary education and its secondary gross enrolment rate of 81 percent is the highest among the GMS countries (Madhur and Menon 2014). Progress has been less impressive in tertiary education. China's tertiary enrolment rate of 26 percent is much lower than Thailand's 48 percent and is only marginally higher than Vietnam's 24 percent. The main objective of China's education policy is to increase the tertiary enrolment rate and improve the education quality at almost all levels. Increasing the access to higher education, especially by potential students from outside the major cities, especially from the country's western regions, is a key objective of education policy, as is improving the quality of education. In this context, Yunnan, one of the less developed provinces of China, faces education policy issues quite similar to that of, say, Vietnam.

3. Institutional framework for health and education

A wide range of actors can have an influence on health outcomes, but not all of these actors may be included in planning and implementing health sector policies. Existing institutional arrangements for health are country-specific; they are a reflection of each country's culture, norms, governance structure and level of development at a given point in time. For instance, in former planned economies, institutional arrangements for health may continue to be government-centric, with the public sector playing the roles of policy-maker, service provider, and financier. In more developed, market-oriented economies, a more diverse set of actors may be involved in fulfilling these roles. Given the complexity of these interactions from an institutional perspective, we restrict our analysis to arrangements for policy-making and policy implementation, focusing on health care provision and financing.

3.1 Arrangements for policy-making and health administration

The institutional arrangements for policy-making and health administration in Cambodia, Laos and Vietnam are all highly centralised and vertically controlled by the Ministry of Health (MOH), which has overall responsibility within the government for health matters. In these countries, the tasks of the MOH include not only policy-making and administration, but also resource mobilisation and allocation, monitoring and evaluation of national health targets and outcomes, and overall coordination of the health system with the rest of the government (both vertically with the subnational layers of governmentat the provincial, district, and commune levels and horizontally with other ministries and departments). All three countries have a decentralised structure with the MOH at the centre, and local governments at provincial, district and commune levels administering health policies, programmes, and projects at subnational level.

All three countries engage many actors, ranging from external development partners to CSOs, in health policy-making and administration. In Cambodia, the MOH coordinates closely with external development partners, the private sector, health service providers, health care users and CSOs (Cambodia country chapter, this volume). In Laos, a Sector Wide Coordination (SWC) mechanism helps to coordinate actions at policy, operational, and technical levels. The SWC is made up of high-level representatives from government, health, labour, social welfare and finance ministries, and development partners (WHO Laos Country Health Service Delivery Profile 2012). In Vietnam, domestic research institutes, universities, hospitals and clinics provide policy advice. Professional associations and CSOs such as the Vietnam Women's Union, Youth Union, Vietnam General Confederation of Labour, and the War Veterans Union are also involved in policy-making. In particular, the Women's Union and Youth Union have been active in the country's HIV/AIDS initiatives (Vietnam country chapter, this volume).

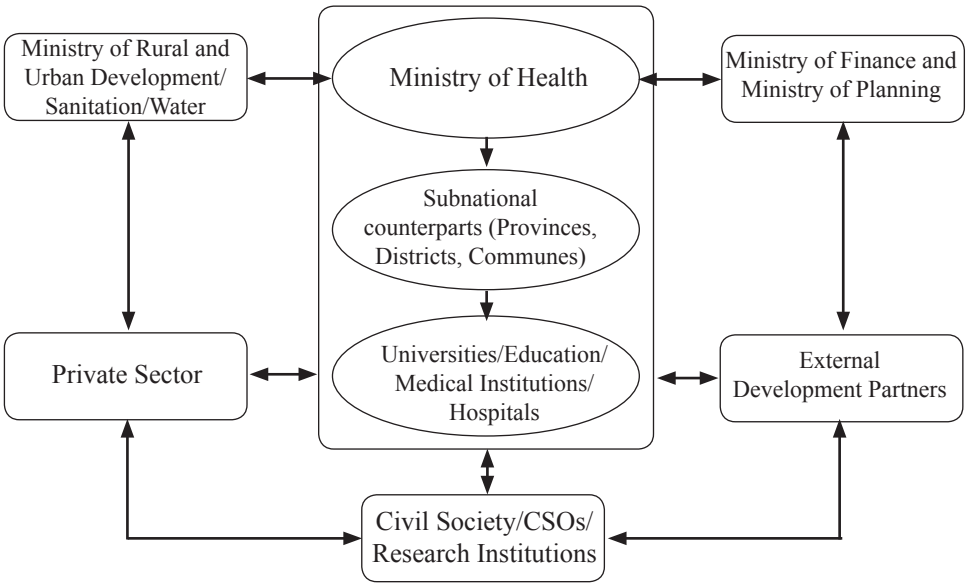
Until 2002, Thailand's institutional framework for health was very similar to those in Cambodia, Laos and Vietnam, but the enactment of the National Health Security Act and the adoption of the Universal Coverage Scheme in 2002 introduced substantial changes. Three new autonomous institutions—the National Health Security Office (NHSO), National Health Security Board (NHSB), and the Standard and Quality Control Board (SQCB)—were created to manage the Universal Coverage Scheme. The NHSB (chaired by the Minister of Health and consisting of another 29 members drawn from other ministries, local governments, NGOs and private hospitals, as well as health professionals and experts from various fields such as law, finance and the social sciences) is responsible for setting the healthcare financing policy, i.e. the allocation of budget to different health service items, making decisions on the benefit packages, deciding on appropriate payment methods, and setting rules and guidelines. It is accountable to the cabinet and parliament. The NHSO is an autonomous body that performs the health care purchasing role under the direction of the NHSB and the SQCB. Under the new institutional framework, the centralised control of the health system by the MOH is vastly reduced and health care purchasers are separated from health care providers (purchaser-provider split).

Thailand has created a number of formal mechanisms to increase public participation in the development of health policies. The National Health Act of 2007 called for the creation of three categories of health assemblies—the Area-Based Health Assembly (AHA), the Issue-Based Health Assembly (IHA) and the National Health Assembly (NHA)—that would provide a forum for all stakeholders to discuss health policy issues. The NHA is made up of representatives from area-based constituencies, civil society, government organisations, health professionals, academia and the private sector. The National Health Commission (NHC) is mandated to convene the NHA at least once a year, and submits recommendations to the National Assembly based on the outcomes and resolutions of the NHA (WHO Thailand Country Cooperation Strategy 2012-16).

China's institutional framework for health is more akin to those of Cambodia, Laos and Vietnam than to that of Thailand. The National Health and Family Commission (NHFC), a government body similar to the health ministries in other countries, is at the helm of

health policy-making and implementation, with health bureaux/health departments at the provincial, district, and commune subnational layers of the government working under the NHFC's jurisdiction and guidance. However, other aspects of the healthcare system, including social health insurance, have been divided and are now managed by different ministries (WHO China Health Service Delivery Profile 2012). Within this framework, a large number of stakeholders, including the private sector, external development partners and others influence both policy-making and implementation (Figure 1.1).

Figure 1.1: Prototype institutional framework for health in GMS countries



National health ministries are at the helm of institutional frameworks, with health departments and health centres at provincial and commune levels supporting the implementation of national heath polices, programmes and projects. The model of health sector governance is one of policy-making at the national level and policy implementation at the subnational levels of government. National health ministries also have the task of the horizontal coordination of health policy and public health funding with the ministries of finance and planning. Since health issues are inextricably linked to rural and urban development, particularly in the provision of sanitation and drinking water, health ministries are supposed to act in coordination with ministries responsible for sanitation, water and waste management.

3.2 Arrangements for health service provision and financing

Health services can be provided by (i) the government, either through a centralised national health service or through autonomous public health care facilities, (ii) private, for-profit healthcare organisations, such as private hospitals, (iii) private, non-profit organisations, such as voluntary or charitable institutions, like the Red Cross, or (iv)

private individuals, such as private practitioners or traditional healers. Meanwhile, health care can be financed through general taxes, earmarked taxes, social insurance, private insurance, loans and grants from donor agencies, private donations and out-of-pocket payments. The healthcare systems covered in this report occupy different spots on the public vs. private spectrum in terms of provision and financing.

In Cambodia and Laos, healthcare services are predominantly provided by a government-owned and operated network of health centres and hospitals, with varying degrees of private sector provision. Public health service delivery in Cambodia is organised through two levels of services: the Minimum Package of Activities, which is provided at health centres, and the Complementary Package of Activities (CPA), which is provided at referral hospitals. There are some private practitioners and international NGOs, but these do not provide the minimum or complementary packages and only deliver a limited range of services (WHO Cambodia Health Service Delivery Profile 2012). The private health sector in Laos is also small, but expanding; private facilities typically provide only basic treatment. Most of these private health facilities are owned by public health staff who offer services after hours and at weekends. The existing facilities are likely to face some competition from the foreign-owned and joint venture clinics and medical centres that have begun to spring up in the cities (Laos country chapter, this volume).

Although health services are predominantly state-owned, services are financed primarily by out-of-pocket expenses, as both countries allow public facilities to charge user fees. In Cambodia, the minimum and complementary packages and medicines are subsidised by the government but only in terms of facilities, equipment, staff salaries and essential medicine; users must shoulder consultation and treatment fees, as well as medicines that are not in stock at public facilities. In Laos, consultations with health care professionals are free, but users must pay for patient registration and ancillary services. User fees for drugs are set at cost plus 25 percent (WHO Cambodia and Laos Health Service Delivery Profiles 2012).

To ensure that the poor and vulnerable are able to access services, both countries have social safety nets such as fee exemption schemes and donor-funded health equity funds which reimburse health providers for services delivered to targeted beneficiaries. In Cambodia, health equity fund beneficiaries are entitled to a comprehensive package that includes transport cost and food allowance (Tangcharaensathien et al. 2011).

Risk-pooling insurance schemes are in their nascent stages. Eighteen operational districts in Cambodia have voluntary community-based health insurance targeting the informal sector (WHO Cambodia Health Service Delivery Profile 2012). Laos introduced social health protection in 2002 and currently has: a social insurance scheme for public and private sector employees, a voluntary community-based health insurance scheme, and the Health Equity Fund. However, these schemes are estimated to cover only 18.5 percent of the population (WHO Laos Health Service Delivery Profile 2012; WHO Country Cooperation Strategy, Laos 2012-15).

Health care in China is also mainly provided by the state, and covers 90 percent of emergency and inpatient services. The private sector is becoming more active in providing outpatient care, and its share of this segment has increased in recent years. China's financing sources are diverse and include not just tax-based general revenues, but also social health insurance and private medical insurance. There are four social insurance schemes in China: the Urban Employee Basic Medical Insurance (UEBMI), the Urban Residents Basic Medical Insurance (URBMI) the New Rural Cooperative Medical System (NRCMS), and the recently established Urban–Rural Medical Assistance System, which targets poor and vulnerable groups (WHO China Health Service Delivery Profile 2012; WHO Country Cooperation Strategy, China 2013-15).

Health service delivery in Vietnam features a more public-private mix. Active government support, an expansion in private medical practice since 1986, and the deregulation of the pharmaceuticals industry have given private services a much greater role in service delivery (Vietnam country chapter, this volume). Currently, however, private sector provision consists primarily of outpatient clinics and pharmacies, with a few hospitals (WHO Vietnam Health Service Delivery Profile 2012). Government allowed user fees in hospitals in 1989, and since then Vietnamese hospitals have been given greater autonomy in managing their services, finances and human resources. This seems to have empowered hospitals in urban areas to effectively reorganise services and mobilise investments (Vietnam country paper, this volume).

Different components of national poverty reduction programmes and projects seek to improve access to health, particularly for the poor (Vietnam country paper, this volume). A national social health insurance scheme has been in place since 1992, and compulsory participation is slowly being rolled out to cover the whole population (WHO Vietnam Health Service Delivery Profile 2012). The scheme offers a comprehensive benefit package, but co-payment can be substantial, ranging between 5-20 percent of medical bills (Tangcharaensathien et al. 2011).

Thailand has also been promoting private sector involvement since 1992, when it began providing tax incentives to encourage investment in private hospitals. This increased the number of private hospitals. More recently, the government's decision to develop Thailand into a medical hub has helped revive the private health sector. CSOs are also actively involved, particularly in the control of HIV/AIDS, malaria, tuberculosis, emerging infectious diseases, tobacco and alcohol (WHO Country Cooperation Strategy, Thailand 2012-16).

Thailand arguably has the most sophisticated and successful model for health care financing in the GMS. Its social health protection schemes include the Civil Servant Medical Benefit Scheme (CSMBS), the Worker Compensation Scheme (WCS) and the Social Security Scheme (SSS) for private employees, and a Universal Coverage Scheme coveringthe rest of the population. All of these schemes offer a comprehensive benefit package, but the financing sources, payment schemes and service providers for each are different (Thailand country chapter, this volume).

3.3 Institutional framework for education

Cambodia's institutional structure for administration and management is very similar to that for health. The Ministry of Youth, Education and Sport (MOEYS) is largely responsible for designing strategies and policies, providing guidance, examining budget plans and ensuring quality for general education; subnational layers of government at the provincial, district and commune levels work with MOEYS and the schools and education institutions within their jurisdiction (Cambodia chapter, this volume). There is a variation when it comes to the higher education segment, though. While general higher education in colleges and universities is still under the jurisdiction of MOEYS, TVET is under the overall responsibility of the Ministry of Labour and Vocational Training (MOLVT). In addition, a few more specialised higher education institutions are within the purview of their respective sectoral ministries (Sen and Ros 2013).

With minor variations, the institutional structure for education in Laos is very similar to that of Cambodia. The MOEYS is at the helm of policy-making and implementation. It is also responsible for vertical coordination across the subnational education units and horizontal coordination across the other national-level ministries and departments (Laos chapter, this volume). As in Cambodia, TVET is administered and managed by the Ministry of Labour and Welfare.

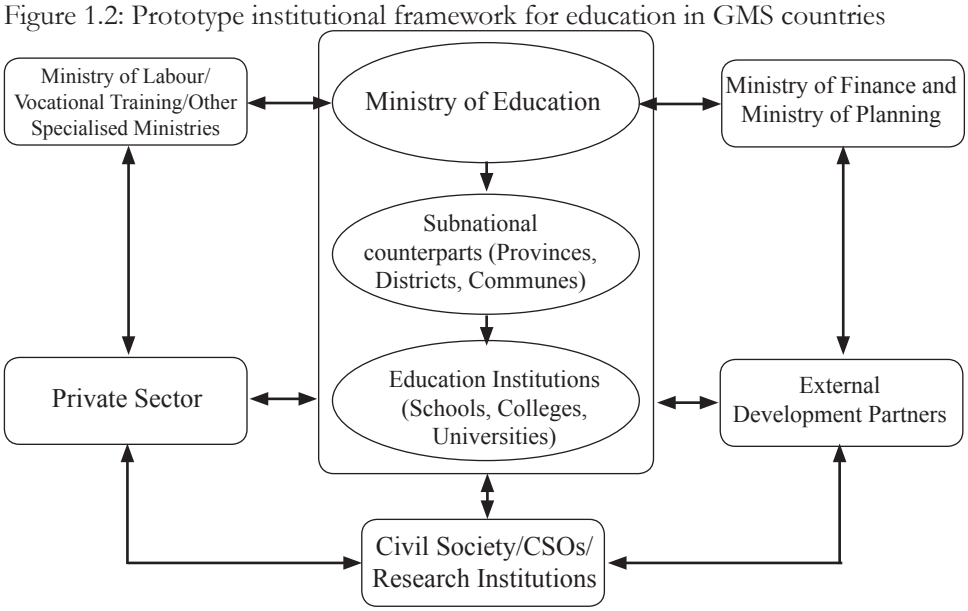
Vietnam's institutional framework for education is strikingly similar to that of Cambodia and Laos. The Ministry of Education and Training (MOET) is Vietnam's apex ministry responsible for education policy-making and implementation along with educational units at the subnational (provincial, district, and commune/township) levels; it also facilitates horizontal coordination with other ministries at the national level (Vietnam country chapter, this volume). The Ministry of Labour, War Invalids and Social Affairs (MOLISA) is responsible for the administration and management of TVET.

In keeping with Thailand's emphasis on higher education, the country has put in place an institutional structure with the Ministry of Education (MOE) playing a key role (Thailand country chapter, this volume). Directly under MOE's jurisdiction are the Higher Education Commission (HEC) and the autonomous universities. With the exception of two autonomous Buddhist universities, the other 168 higher education institutions, public or private, come under the purview of the HEC of MOE. The HEC is responsible for policies and planning, standards and quality, personnel management, and monitoring and evaluation of higher education institutions. As with other countries, such as Cambodia, TVET is outside the purview of MOE, but instead under a separate government agency—the Vocational Education Commission. In addition, five more line ministries/government bodies in public health, defence, transport, culture, science and technology, and the Bangkok Metropolitan Administration are in charge of various specialised higher education institutions.

China's institutional apparatus for education administration, management and governance of the education system is very similar to that of the other GMS countries. The Ministry of Education is at the top of the institutional hierarchy coordinating the education system both vertically (across the subnational governmental layers) and horizontally

(across the other ministries and at the national level), in addition to its responsibility to engage with other stakeholders such as the private sector and external development partners. Directly within the jurisdiction of the MOE are 32 institutions and social organisations and 75 universities and colleges (China chapter, this volume). Thus, with a few country-specific variations, a prototype institutional framework for policy-making and policy implementation among the GMS countries can be depicted (Figure 1.2).

Figure 1.2: Prototype institutional framework for education in GMS countries



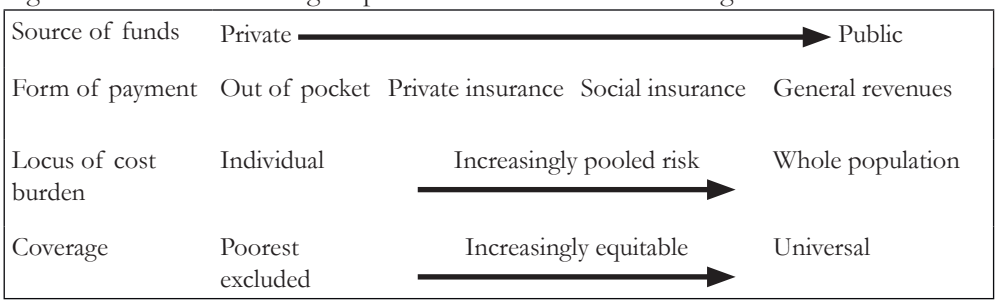
The national education ministry, its subnational counterparts and the education institutions (schools, colleges and universities) form the core of the framework. The education ministry has a two-fold task of intra-governmental coordination, vertically with its subnational counterparts and the education institutions under its jurisdiction and horizontally with the ministries of finance and planning on the one hand and with the ministries of labour/training and a few other specialised ministries on the other. It also has the responsibility of engaging many other stakeholders in the education sector such as external development partners, the private sector, domestic think tanks and research institutions and civil society more generally. A notable country-specific feature in Thailand in recent years is that the Ministry of Education has to work with three national education commissions that have much broader representation and play a key role in education policy-making and implementation. To some extent, therefore, ministerial control over the education sector is somewhat less in Thailand than in the other GMS countries (Thailand chapter, this volume).

4. Health: resource commitments and institutional arrangements in practice

4.1 Resource commitments

The institutional arrangements for financing described in the previous section underpin the patterns of health expenditures in the GMS region. This is a very important issue not just in terms of health outcomes, but in terms of equity as well. The manner in which healthcare is financed is critical because it could lead to the exclusion of certain segments of the population (Figure 1.3). Health care that is paid for largely by out-of-pocket payments will hit the poor the hardest, and could result in them being unable to seek care when needed.

Figure 1.3: Health financing: impact on cost burden and coverage



Source: WHO World Health Report (1999)

There are wide variations in total health expenditure (THE) trends across the GMS region (Tables 1.1 and 1.2). In 2011, THE as a percentage of GDP was highest in Vietnam at 6.8 percent, followed by Cambodia (5.7 percent), China (5.2 percent), Thailand (4.1 percent), Laos (2.8 percent) and Myanmar (2.0 percent). In Yunnan, China's total spending was far less than the national average at 2.7 percent.

Table 1.1: Health expenditure (percentage of GDP), 2011

	Total	Public	Private	Private out of pocket	Private insurance
Cambodia	5.7	2.1	3.6	3.2	0.4
Laos	2.8	1.5	1.3	1.1	0.2
Myanmar	2.0	0.2	1.8	1.6	0.2
Vietnam	6.8	2.6	4.2	3.8	0.4
Thailand	4.1	2.9	1.2	0.6	0.6
China	5.2	2.0	3.2	1.8	1.4
Yunnan	2.7				

Source: UNDP Human Development Report (2014)

However, a closer look at the composition of THE reveals that while Vietnam and Cambodia may be at the top of the league table in terms of total spending, much of this is actually coming from private sources, particularly out-of-pocket payments, which accounted for 90.5 percent of private health spending in Vietnam and nearly 89 percent

in Cambodia. In Laos, although public spending made up the bulk of THE with a share of nearly 54 percent, out-of-pocket payments still accounted for close to 85 percent of private health spending.

Table 1.2: Composition of health expenditure (percentage to total health expenditure): 2011

	Public	Private	Private out of Pocket	Private Insurance
Cambodia	36.8	63.2	88.9	11.1
Laos	53.6	46.4	84.6	15.4
Myanmar	10.0	90.0	88.9	11.1
Vietnam	38.2	61.8	90.5	9.5
Thailand	70.7	29.3	50.0	50.0
China	38.5	61.5	56.3	43.8
Yunnan	37.6	62.4	59.2	40.8

Source: UNDP Human Development Report (2014); for Yunnan, Yunnan Department of Health

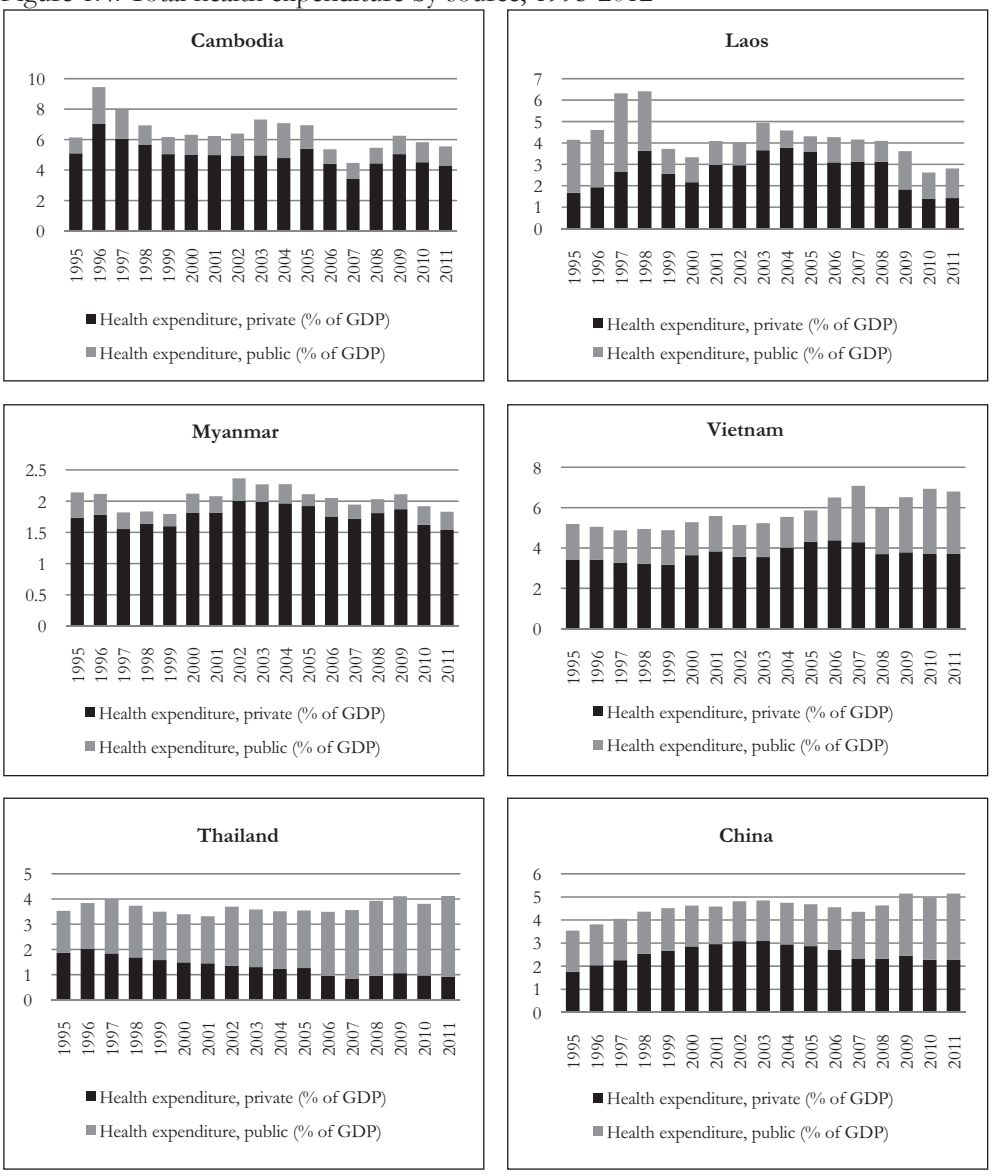
Myanmar's case is particularly alarming. Not only does it have the lowest level of total and public health spending in the region, it also has one of the highest rates of out-of-pocket spending: almost 89 percent of private expenditures in 2011.

There are other causes for concern: in Cambodia, Laos and Myanmar, total health spending has fallen since 2009, and current levels are far below levels reached in the mid-1990s (Figure 1.4). Given constraints on government resources, these three countries also continue to rely heavily on external sources of health financing, possibly posing risks to long-run sustainability. In the case of Myanmar, external sources can be expected to increase further with the entry of more external partners (Figure 1.5). Self-financing options continue to be limited in Cambodia given difficulties with raising domestic tax revenues, and this is likely to persist for some years to come. The share of government revenue in Laos has risen sharply as a result of royalties and resource rents accruing to the government, and therefore the capacity for self-funding has dramatically increased over recent years (Menon and Warr 2013). A related question is whether an increase in public spending on public services such as health will favour the poor? In the case of Laos at least, this appears to be the case (Warr, Menon and Rasphone 2014).

China and Thailand are faring much better than their neighbours in the subregion. In China, while private expenditures still make up the bulk of THE, with a share of 61.5 percent, the share of public expenditures has been rising steadily over the last ten years. Out-of-pocket payments are also slowly being replaced by private insurance, which accounted for almost 44 percent of private expenditures in 2011. Thailand's pattern of health spending has been the most impressive. Public spending has increased steadily over the last few decades to reach almost 71 percent of THE in 2011. Moreover, sources of private expenditures are split evenly between out-of-pocket payments and private insurance.

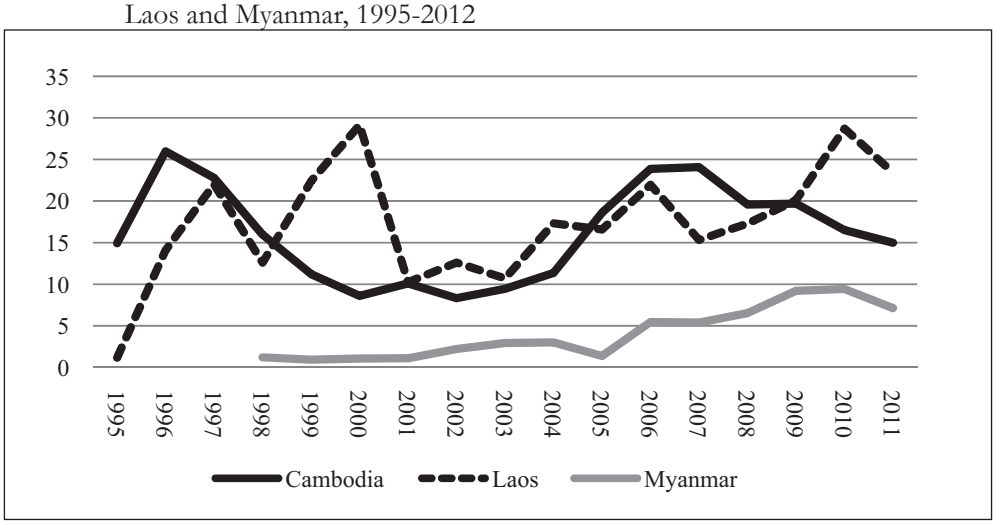
Global experience has shown that encouraging risk pooling through insurance and other prepayment schemes is the best way of achieving universal health coverage, and this is certainly the case in Thailand. Implementation of the Universal Coverage Scheme (UCS) has allowed Thailand to reach nearly universal health coverage, with 98 percent of the population covered as of 2009 (Tangcharaensathien et al. 2011). China's social insurance system already seems to be producing the same results. With their own systems undergoing substantial reforms, Laos and Vietnam will not be far behind. In fact, Vietnam has already started to move away towards capitation and case-mix payment systems like Thailand.

Figure 1.4: Total health expenditure by source, 1995-2012



Source: World Bank (2014), World Development Indicators

Figure 1.5:External sources as a percentage of total health expenditure: Cambodia, Laos and Myanmar, 1995-2012



Source: World Bank (2014), World Development Indicators

Cambodia also seems to be on the right track, with the Strategic Framework for Health Financing 2008-15 and draft Master Plan for Social Health Protection signalling government's intention to adopt a unified social health protection coverage scheme that will extend and combine existing financing schemes (WHO Cambodia Health Service Delivery Profile 2012). This leaves Myanmar with a lot of catching up to do.

4.2 Institutional coordination

Different stakeholders from the public and private spheres are becoming involved in health policy planning and implementation. Even in countries where health sector provision and financing remains predominantly public, there is clearly a movement towards greater private sector and civil society participation. Not surprisingly, however, this transition brings with it several challenges. One common issue facing countries in the subregion is strengthening institutional coordination. This seems to be more pressing in the case of Cambodia, Laos and Vietnam.

In Cambodia, while vertical or upward accountability is functioning effectively, horizontal accountability remains weak due to unclear roles and responsibilities among the different ministries (Cambodia chapter, this volume; World Bank and Asia Foundation 2013). The WHO's report on Cambodia's health service delivery likewise notes continued fragmentation in activities, funding, monitoring, supervision and administrative lines of authority.

The same lack of coordination in planning, implementation and monitoring is evident in Laos. At the planning stage, policy consultation tends to be limited to a group of high-level administrative officials with little knowledge of operational issues, and there are limited opportunities for development partners to bring their evidence-based research to bear on policy deliberations. At the implementation stage, weak lines of

communication prevent policy guidance from reaching the grassroots, and mechanisms are missing that would allow local experiences to feed back into policy-making. Weak coordination among externally funded initiatives has also pushed up transaction costs and led to fragmentation and inefficiency. Meanwhile, monitoring is hampered by the lack of appropriate mechanisms (Laos country paper, this volume).

In Vietnam, creating a close link between agencies responsible for health sector planning, development, policy approval and implementation remains a big challenge. There is "glaring evidence of state failure in oversight, monitoring and evaluation of education and health care delivery, especially locally", citing the absence of grassroots mechanisms for collecting and assessing the needs of communities (Vietnam chapter, this volume). Other challenges include developing comprehensive and inter-sectoral approaches in some service areas, as well as strengthening monitoring and sharing of information with other service levels (WHO Vietnam Health Service Delivery Profile 2012).

In China, the biggest challenge seems to be rationalising the management of health providers across several sectors to improve integration and resource efficiency. There are several health care providers who fall outside the administrative purview of the health ministry, such as medical university hospitals that come under education (WHO China Health Service Delivery Profile 2012).

Lack of institutional coordination also seems to be a major factor behind poor linkages across health care providers. Referral mechanisms between grassroots facilities and higher-level services, and between public and private providers, need to be strengthened. More fundamentally, a better balance needs to be struck in resource allocation across primary, secondary and tertiary services, as well as between rural and urban areas.

4.3 Role of non-state actors

Ongoing efforts to involve a wider swathe of actors in policy-making and service provision and financing is a step in the right direction, particularly in countries where fiscal resources are severely constrained and public sector capacity is weak. Private for-profit as well as non-profit organisations can play a role not just in filling service and financing gaps, they can also be instrumental in raising awareness and mobilising communities. However, this behoves governments to ensure that appropriate governance mechanisms are in place to maximise engagement.

Given the private sector's growing role in service provision and finance, governments must urgently address gaps and weaknesses in regulation and monitoring. This is particularly urgent in countries such as Vietnam and China, where private sector involvement is growing fast. Apart from opening their doors to private providers, it seems China is actively encouraging private investors to sponsor non-profit hospitals, while Vietnam is encouraging private investments in medical equipment in public hospitals (WHO China and Vietnam Health Service Delivery Profiles 2012). Linkages between public and private facilities need to be strengthened, and care should be taken that the expansion in private health care does not come at the expense of publicly provided primary health care. For instance, Thailand's emergence as a medical hub seems to be exacerbating the

shortage of health personnel in public facilities by drawing medical personnel into the private sector (WHO Country Cooperation Strategy, Thailand 2012-16).

Inadequate involvement of communities and end-users in crafting policies and designing interventions often leads to lack of demand for health interventions. Limited opportunities exist for CSOs, communities and end-users to participate in the policy-making process, and participation is still weak in countries such as Cambodia, Laos and Vietnam.

5. Education: resource commitments and institutional frameworks in practice

5.1 Resource commitments

In terms of public resource commitments on education, the GMS countries exhibit large variations (Table 1.3). As a share of GDP, public spending on education now is the highest in Vietnam (6.3 percent) and the lowest in Myanmar (0.8 percent). As a share of the government budget too, education expenditure is the highest in Vietnam (21 percent) and the lowest in Myanmar (4 percent). Although it is difficult to judge what level of public expenditure on education should be considered low or high, UNESCO suggests a benchmark figure of about 5 percent of GDP (UNESCO 2014). Given that, on an average, total government expenditures account for about 20 percent of GDP in most developing countries, public education expenditure should work out to about 20 percent of the government budget.

Table 1.3: Public expenditure on education in the GMS

	Percent of GDP	Percent of Budget
Cambodia (2010)	2.60	13.1
Laos (2012)	4.12	12.1
Myanmar (2011)	0.79	4.4
Vietnam (2010)	6.29	20.9
Thailand (2012)	3.80	17.6
China (2012)	4.00	-
Yunnan (2012)	6.70	19.0

Source: *UNESCO, institute for Statistics (2014),*for Cambodia, Myanmar and Vietnam; Other Country Chapters available in this volume

Only Vietnam at present satisfies UNESCO's benchmark. Overall, lack of public spending is not a major constraint on education delivery in Vietnam; however, there is ample scope for increasing the efficiency of public resource-use (Vietnam chapter, this volume). Although Thailand's public education expenditure is only 3.8 percent of its GDP, the need for improving efficiency of resource use by better teacher and educational quality, not so much a lack of public spending, seems to be the main challenge in the country (Thailand chapter, this volume).

In recent years, Laos is also inching towards UNESCO's benchmark expenditure-GDP ratio. After hovering between 2-3 percent of GDP during 2000 to 2011, Laos' public education expenditure increased to more than 4 percent in 2012-13. However, public expenditure on education remains highly erratic in Laos, and going forward sustaining the recent gains in these expenditures is a major policy challenge (Laos chapter, this volume).

For the country as a whole, China's public education expenditure is about 4 percent of GDP, higher than that of Cambodia and Myanmar but still lower than the UNESCO benchmark. Public expenditure on education in the province of Yunnan, one of the two provinces of China that are part of the GMS, however, constitutes about 6.5 percent of the province's GDP; it also accounts for about 19 percent of the province's budget. Yunnan's public education expenditure figures are comparable to Vietnam's both in its share in GDP and the budget.

Among the ASEAN members of the GMS, the challenge of increasing public expenditure on education is most pressing for Myanmar and Cambodia. Cambodia has taken big strides in public spending on education in the past two decades. Back in the mid-1990s, Cambodia's public expenditure on education was about 1 percent of GDP, but that figure has since more than doubled to 2.6 percent. A further doubling of Cambodia's share of public education expenditure in GDP is needed if the country were to reach the UNESCO international benchmark. Interestingly, Myanmar's share of public education expenditure in its GDP today is very similar to that of Cambodia and Laos in the mid-1990s (Madhur and Menon 2014).

Inadequate public spending on education in Cambodia leads to significant out-of-pocket education-related expenditures by families with school-going children. As a share of daily median household consumption, such out-of-pocket expenditures constituted about 7 percent per primary school child, about 13 percent per secondary student, and about 25 percent per upper secondary student in 2011 (Cambodia chapter, this volume, annex Table 1.3). "[T]here is still room to raise the allocated … funding (on education) by further cutting defence spending and downsizing the government" (Cambodia chapter, this volume). Encouragingly, Cambodia's government plans to increase the share of public expenditure on GDP from 2.6 percent now to 3 percent by 2018; the share of education expenditure in the budget is envisaged to increase from 13 percent now to 20 percent during the same period. (Cambodia chapter, this volume).

The allocation of public education expenditure on the different layers of education has a similar pattern across the GMS countries. The largest share of public education expenditure is on primary (including pre-schooling) education, followed by secondary and tertiary education (Table 1.4). In addition, Cambodia allocates about 13 percent of its public education expenditure on the non-tertiary, post secondary subsector, mostly on TVET. The shares of public education expenditure on TVET in other GMS countries are much lower than in Cambodia, although data limitations should be kept in mind when drawing firm conclusions on this issue.

Table 1.4: Composition of public expenditure on education in GMS

	Percentage to total public expenditure on education					
	Primary	Secondary	Tertiary	Post-secondary non-tertiary	Other	Total
Cambodia (2010)	44.2	17.9	14.6	12.7	10.6	100
Laos (2012)	33.0	25.1	9.7	5.5	26.7	100
Myanmar (2011)	50.6	24.1	19.0	6.3	0.0	100
Vietnam (2010)	42.9	38.2	14.6	4.3	0.0	100
Thailand (2010)	45.8	23.8	16.5	48	9.9	100
China (2012)	31.0	30.7	22.0	6.8	9.5	100
Yunnan (2012)	33.1	28.2	10.9	7.7	20.0	100

Source: *UNESCO, institute for Statistics (2014),*for Cambodia, Myanmar and Vietnam; for China, Chinese Statistic Book (2012); Yunnan, China Education Fund Statistics (2012);and other Country Chapters this volume

5.2 Functioning of the institutional framework

The ministries of education are the lynchpins of the institutional frameworks for education in most of the GMS countries. That said, decentralised delivery mechanisms imply that sub-national education departments/bodies at the provincial, district and commune levels are expected to play major roles in the system. Within this overall framework, however, there some key differences across the GMS countries.

The allocation of the authority and power to organise the delivery of education takes different forms across the GMS countries. In Laos, Vietnam and China, it takes the form of *deconcentration*, where the national government assigns the task of education service delivery to sub-national governments led by officials appointed by the national government; hence the latter act as the centre's agents. In these systems, governance is centralised, but sub-national governments are given a significant degree of autonomy in organising the delivery of education services. In Cambodia and Thailand, it takes the form of *delegation*, where authority and power are exercised by the elected officials of the sub-national governments but the latter's autonomy is limited. Irrespective of whether it is a form of deconcentration or delegation, all the GMS countries have unitary forms of government. None of them, therefore, resort to devolution as in Australia or India, for instance, where the national government transfers to sub-national governments wide-ranging powers for managing local service delivery, indeed for managing most local affairs (UCLG 2008, 2010, 2013).

Despite the wide-ranging deconcentration and delegation of education service delivery to the sub-national governments, there are substantial differences across the GMS countries in the actual amount of public resources routed through sub-national governments (Table 1.5). In China, about 70 percent of all government expenditures are made by the sub-national governments, about 20 percent by the upper and the remaining 50 percent by the lower layers of government. Cambodia is at the opposite extreme, with the sub-national governments spending negligible shares of total government expenditures. In both Laos and Vietnam, sub-national governments spend closer to half of all government expenditures, while the corresponding figure for Thailand is almost half that in Laos and Vietnam.

Table 1.5: Subnational government's share of total public expenditure in GMS countries

	Share of total public expenditure (percent)			Share of total public revenue (percent)			Subnational expenditure _ revenue gap
	Subnational	Upper tier	Lower tier	Subnational	Upper tier	Lower tier	
Cambodia	< 5	na	<5	<1	na	<1	_
Laos	48	na	na	64	na	na	-16
Vietnam	45	30	15	35	25	10	10
Thailand	26	n.a	na	15	na	na	11
China	70	20	50	40	15	25	30

Source: IMF (2006) and UCLG (2010)

Except for Laos, the share of sub-national governments in government revenues, both tax and non tax, is generally lower than their expenditure shares—by about 10 percentage points in Thailand and Vietnam but by as much as 30 percentage points in China. In sharp contrast, the revenue share of sub-national governments in Laos is 10 percentage points higher than their expenditure share. Except in Vietnam, sub-national governments do not have legal authority to borrow funds.

The decentralised education delivery mechanisms face several constraints of institutional coordination too, especially among CLV countries. In Cambodia, democratic decentralisation in general is highly incomplete. Although political decentralisation has progressed well with regular elections held at the sub-national levels all the way up to the commune councils, administrative and fiscal decentralisation has proceeded much more slowly The revenue raising and spending capacities of the various layers of the sub-national governments are thus severely limited (CDRI 2013). This then constrains effective decentralised delivery of a whole range of public services and education is no exception. As for horizontal coordination of education policies and programmes, the multiplicity of government ministries, especially in higher education, leads to a lack of cohesion in implementing education policies and programmes (Sen and Ross 2013). At the minimum, there is a strong need for much better coordination of education policies and programmes between MOEYS and MOLVT (Cambodia chapter, this volume; Lonn and Madhur 2014).

In Laos, although sub-national governments are better resourced, guidelines and regulations are highly inadequate to support implementation of education policies, programmes and projects by local governments (Laos country chapter, this volume). Indeed, "communication is irregular and sometimes not aligned among the centre, province and districts, so policy guidance is not reaching grassroots level, and operational lessons are not fed back to inform policy" (Laos chapter, this volume). Even information sharing, let alone gaps in communication, is weak among the different vertical layers of the government units in the decentralised education delivery system. Quite apart from these weaknesses in vertical coordination, problems plague horizontal coordination between the different actors in the education sector too. In particular, weak coordination among

the various education sector programmes funded by Laos' development partners results in fragmented programme and project interventions, duplications in these interventions, and thus significant inefficiencies in educational resource use. Lack of monitoring and evaluation of the education policies and programmes adds further to the inefficiency of resource use.

In Vietnam, despite the impressive share of public resources, the government allocates for education (both as a percentage of GDP and the government budget) and robust resourcing of the sub-national governments, both policy-making and implementation remain highly top-down processes. Communes have little voice in district planning, districts have little voice in provincial planning, and provinces likewise do not have much say in national-level policy-making and implementation (Vietnam chapter, this volume). Horizontal institutional coordination is also much to be desired, with very weak coordination between MOET and the Ministry of Home Affairs (MOHA) (the agency responsible for government's personnel management), as also between the ministries of education and planning. And the involvement of too many agencies in managing education results in spreading resources too thinly. Indeed, many ministries and local governments push for opening their own universities, colleges or professional secondary schools leading to huge functional overlap among these different parts of the government and inefficient public resource use (Vietnam chapter, this volume).

Thailand has attempted to restructure its education system more than most of the other GMS countries, the most recent one focusing on restructuring the higher education system's administration and management by creating several autonomous agencies. The system has thus become much less centralised and rigid in recent years. Even so, in practice, the institutional framework is far too complex and lacks policy cohesion; this is partly because much of the budget is spent on the bureaucracy (Thailand chapter, this volume). As for horizontal coordination across ministries and development partners, the system appears to be driven in different directions, partly to accommodate the diverging agendas and priorities of the different development partners. Overall, therefore, "… the higher education system has been criticised as aimless, repetitive and lacking in quality and efficiency" (Thailand chapter, this volume).

China channels a very high percentage of total government expenditures through sub-national government expenditures, making it perhaps the most decentralised resource allocator among the GMS countries. Despite this, China's decentralised institutional mechanism for education delivery suffers from the basic problem of poor communication and collaboration of policy-enforcing departments and institutions. Indeed, "there are problems and some basic problems of communication and collaboration among the personnel in every level and department (China chapter, this volume). Yunnan province is no exception to this national-level problem. Moreover, the public resource-sharing arrangement between central and sub-national governments, where the former provides about 70 percent of the education funds and the latter have to generate the remaining 30 percent, works to the disadvantage of poorer provinces such as Yunnan, as these provinces find it difficult to raise their share of resources. Education service delivery thus suffers in poorer provinces such as Yunnan (China chapter, this volume).

5.3 Role of private sector

In the GMS countries, the public sector provides and finances almost the entire education system up to high school level. However, the private sector plays a more significant role in the provision and financing of higher education in all the GMS countries, although the exact extent of that role varies a great deal across countries. In terms of the number of higher education institutions, the private sector's share is the highest in Laos (about 78 percent) and the lowest in Vietnam (13 percent), with Cambodia's figure close to that of Laos, and that of China closer to that of Vietnam (Table 1.6).

Table 1.6: Share of private sector in higher education

	No. of institutions (2011-2012)			Percentage of enrolment in total higher education institution (2011)
	Public	Private	Of which branches of foreign universities	
Cambodia	39	62	1	
Laos	22	77	_	60
Vietnam	187	28	1(2011)	26
Thailand	98	71	2	15
China	1887	836	13 (2011)	18

Source: Madhur (2013) and UNESCO (2014)

In student enrolments for higher education, which is the more relevant figure for assessing the role of private sector, Cambodia tops the list with the private sector's share in higher education enrolments at 60 percent and Vietnam has the lowest share at 15 percent. The corresponding figures for Thailand (18 percent) and Laos (26 percent) are closer to that of Vietnam. Interestingly, in terms of the private sector's share in total higher education enrolments, only Cambodia compares favourably with most other ASEAN countries including Singapore (64 percent), Philippines (63 percent), Indonesia (62 percent) and Malaysia (43 percent).

Cambodia's high share of private sector enrolments in higher education has been, however, a mixed blessing. It is true that opening up higher education for private investment has helped in partially easing the resource constraint on developing the higher education system. But it has also brought in its wake some unique problems such as too much emphasis on liberal arts education of dubious quality at the neglect of higher education in science, technology, engineering and mathematics, the types of skills increasingly demanded by the labour market of a rapidly growing and industrialising country (Madhur 2014).

To some extent, these problems arise because of the lack of a robust regulatory and supervisory framework and, above all, the government's failure in its stewardship role of enabling the private higher education institutions to provide quality education of the right kind to the country's youth. On its part, the government, as the steward of the higher education system, has also not effectively engaged the private sector in developing a long-term vision for the country's education system, the kinds of courses to be offered, and the development of appropriate curricula for higher education. This disconnect will have to be bridged and a stronger public-private partnership has to be

forged if the higher education system, including the TVET segment, is to effectively close the country's emerging skill gap (Madhur 2014).

In Laos and Vietnam, the private sector is much less significant in the education sector than in Cambodia (Laos and Vietnam chapters, this volume). Neither do these countries exhibit significant collaboration between public and private sectors in policy formulation and implementation. In Laos, however, the 2006-07 amendment to the country's education law specifically aims to increase the private sector's role in the education sector. In Vietnam, in view of the emerging skill mismatches in the labour market, a better collaboration between the public and private sector, with a much closer involvement of the latter in policy formulation and implementation, is crucial in the future (World Bank 2013). As in Laos and Vietnam, the private sector's role in education in Thailand and China in both the provision of education and engaging in the development of the long-term vision, policy-making and policy implementation is very limited (Thailand and China country papers, this volume).

5.4 Role of civil society

Along with the government and the private sector, civil society and civil society organisations can play an active role in the education sector. As an agent of change, civil society can engage in policy-making, policy analysis and policy advocacy. It can also play a major role in monitoring the performance of state and private sector educational institutions and enhance their accountability (Cheema 2011). In general, in GMS countries, civil society organisations such as NGOs play a modest role in providing pre-school education. Beyond this, the direct provision of education by civil society organisations is almost negligible in all the GMS countries. Not just that. The major role of civil society and civil society organisations among the GMS countries appears to be in the sphere of monitoring and strengthening the accountability of the state and the educational institutions in providing quality education to the youth. Even here, the role of civil society seems to be severely constrained among almost all the GMS countries.

Take the case of Cambodia. Despite more than a decade of experimentation with political decentralisation and deconcentration, the roles and responsibilities of civil society remain unclear. The introduction of the School Support Committees for participatory management of schools in Cambodia is a welcome initiative; despite this, in practice, local communities' participation in the management of schools is limited, villages do not have an effective mechanism to demand accountability from the schools, and parents do not have a functioning forum to engage productively in education policy-making and implementation (Cambodia chapter, this volume).

In Laos, the Education Development Committees, consisting of villagers, village heads, school directors and teachers, have mandates that are very similar to Cambodia's School Support Committees. Their actual participation in the management of the schools is quite limited, largely because these committees and other local actors often require directions and guidelines from higher authorities; there is thus a lack of local initiatives in implementation (Laos chapter, this volume).

In Vietnam, the 2007 Ordinance on Grassroots Democracy is supposed to encourage and strengthen local participation in public service delivery. Yet, local participation is quite limited since there are no clear guidelines on the implementation of the Ordinance. Indeed, non-state actors do not have even enough information about the Ordinance nor their rights and responsibilities enshrined in the Ordinance, leading to highly inadequate civil society participation in the education sector (Vietnam chapter, this volume).

The picture is not very different in Thailand and China. In Thailand, for example, there are huge gaps in the collaboration between the government and civil society organisations in terms of policy-making and policy implementation for the education sector (Thailand chapter, this volume). Local communities and civil society more generally have limited participation in China's education system, despite the substantial share of public budget allocated to the sub-national governments (China chapter, this volume). That said, it is noteworthy that two of the country's best known civil society organizations in education - China Children and Teenagers Fund and China Youth Development Foundation – have established more than 16,000 primary schools in poor areas and provided education opportunities for more than 5 million poor children and girls students in mountainous regions.

6. Conclusion

Health and education sectors hold centre stage in ensuring that the fruits of economic growth and development are shared more inclusively in developing countries. Recognising this, all the GMS countries attach high priority to providing equitable access to health and education services at affordable prices in their development strategies and plans. To achieve these development objectives, GMS countries have also put in place fairly detailed and decentralised institutional frameworks. Success of the health and education policies depends critically on the resources that a country commits to health and education development and the efficiency with which the allocated resources are managed to get the desired outcomes. Both these, in turn, depend on a multitude of factors, including the incentive compatibility of the entire system and how well the institutional frameworks work in practice

The policies and the formal institutional frameworks in the health and education sectors are broadly similar across GMS countries. The resource commitments, however, vary a great deal across the countries. Equally importantly, the actual functioning of the institutional frameworks in practice also varies a great deal across countries. Lack of effective government coordination, both horizontal and vertical, seems to plague the institutional frameworks for health and education almost across the GMS countries.

Government coordination failures, in turn, render the decentralised systems that have been put in place to deliver health and education services less effective. In other words, the key issue seems to be that although the formal institutional frameworks are quite similar, their actual functioning in practice is beset with many gaps, although the nature and the degree of these gaps vary quite a bit among the different GMS countries. This problem could also be seen as implementation failures: good polices and robust institutional frameworks, but ineffective implementation of these policies by the institutional frameworks in practice. In

other words, the institutional tunnels through which policies are translated into actual health and education outcomes are blocked (bottlenecks) at different layers of implementation to different degrees among the GMS countries.

Most health and education systems in the GMS countries are mixed/hybrid systems, with the state playing a dominant role in services provision and the private sector complementing that role. In addition to direct provision, the state also has what is called the "stewardship role", facilitating and regulating the private sector to work in synchronisation with the national objectives of health and education policies and strategies. There is also a huge diversity in the extent to which the non-state actors – especially the private sector, the civil society organisations, and civil society more generally, participate in the policy-making and implementation process across the GMS countries. That said, civil society organisations and civil society more generally play only a limited role in policy-making and implementation in the health and education sectors in the GMS countries.

The country chapters in this volume come up with several policy options to improve the actual functioning of the institutional frameworks for delivering health and education services specific to their country contexts. Most GMS countries seem to be in need of much better inter-ministerial (horizontal) and intra-ministerial (vertical) coordination, more effective implementation of the decentralised service delivery process, greater role for the private sector, and increased participation by civil society. The role of the state is to ensure all these things but at the same time effectively playing its own role as a steward for the health and the education sectors.

Evidence-informed policy-making and policy implementation is crucial for enabling the state to play this challenging role. Many GMS countries seem to face severe constraints on this front. In particular, Cambodia, Laos and Vietnam (CLMV) highlight this as a key constraint (country chapters, this volume). Even other GMS countries, for example, China, seem to face this constraint although to a lesser degree (Jiang and Shen 2013). In the CLV countries (as is of course truer in Myanmar), there is inadequate domestic capacity for credible policy-oriented development research (UNESCO 2014).

External development partners, especially multilateral institutions such as the International Monetary Fund (IMF), World Bank, Asian Development Bank (ADB), World Health Organization (WHO), UNESCO and UNICEF, do fill this gap to a large extent. Some of the bilateral donors also play a notable but largely a complementary knowledge-provision role, which development partners play in many of these countries. That said, for various reasons, the research priorities of development partners need not necessarily be always aligned with what is most needed for the countries. The CLMV countries would gain vastly by developing credible domestic development policy research institutions, including higher education institutions, which could better align their own research agenda with the development priorities of the country. Such domestic policy research capacity building is perhaps a more sustainable option for CLMV countries to ensure that their policy-making and policy implementation are much more grounded in research evidence.

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