HEALTH SECTOR REFORM

Issues and Opportunities*

Health sector reform deals with fundamental change of processes in policies and institutional arrangements of the health sector, usually guided by the government. The experience of many countries clearly shows that the success of reforms depends on how the process is applied, and by whom, rather than how the contents are formulated. Sustained information and education on health sector reform is needed to generate wider political and public understanding as well as support. Continuous monitoring and review of health systems development is also required. Research to provide valid scientific evidence for strengthening the processes and mechanisms of health sector reform is also essential.

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1. INTRODUCTION

Health sector reform is a sustained process of fundamental change in policies and institutional arrangements of the health sector¹, usually guided by the government. The process lays down a set of policy measures covering the four main core functions of the health system, viz., governance, provision, financing and resource generation. It is aimed at improving the functioning and performance of the health sector and, ultimately, the health status of the population.

Health sector reform deals with equity, efficiency, quality, financing, and sustainability in the provision of health care, and also in defining the priorities, refining the policies and reforming the institutions through which policies are implemented.

Meeting the essential health needs of the people has always been the goal of all governments in the WHO South-East Asia Region (WHO SEAR). Exactly two decades after the quest for health for all was set in motion at the World Health Assembly, the Health Ministers from Member countries of WHO SEAR, at their 15th meeting in August 1997 adopted the Declaration on Health Development in the South-East Asia Region in the 21st century. In this declaration, while realizing the challenges that lie ahead and the opportunities and potential of further enhancement in health development, the Health Ministers expressed their deepest concern and unstinting commitment to ensure access to health care to all. They affirmed the principles and strategies of health-for-all while reiterating that health is central to sustainable development and wellbeing.

The Ministers noted that the foremost challenges in the Region in the 21st century and, particularly, during next few decades, were: initiating health sector reform to reduce inequities in health; creating conditions that promote health and self-reliance; ensuring basic health services to all, and upholding and enforcing health ethics. The Ministers agreed that the governments have the main responsibility to overcome these challenges in partnership with other sectors and the community. The Ministers also highlighted a few priority reform activities, including attacking priority diseases causing high morbidity, mortality and disability; providing essential health care to all; investing in women’s health and development; making appropriate application of scientific knowledge and technology; and enhancing community participation.

At its 50th session in September 1997, the Regional Committee endorsed the Regional Declaration and noted the recommendations of the technical discussions on “Health Sector Reforms”. The Committee recognized that reforms in health sector were needed to attain the universal goal of health-for-all and in ensuring equity, solidarity and social justice. Rapid political and socioeconomic changes and the demographic and epidemiological transitions underway had accelerated the reform process. While some countries had initiated fundamental changes, others had initiated sequential, evolutionary, and incremental changes in the policy, organization and management of health systems. Through a resolution², the Regional Committee urged Member States to explore effective strategies for the political and administrative management of the process and content of health sector reform and to involve policy makers, providers of health services and the public in this process. The Committee also requested the Regional Director to promote exchange of experiences on health sector reform through appropriate consultations, documentation and

¹ Health sector and health systems are synonymously used throughout this paper.
² Resolution SEA/RC50/R3: Health Sector Reform
dissemination, including the use of national and international institutions, WHO Collaborating Centres and other technical forums, with a critical assessment of all aspects of the impact of such reforms. The progress made in the area of health sector reform and their impact in the Region are analyzed, reviewed and discussed in the following paragraphs.

2. ISSUES IN HEALTH SECTOR REFORM

From an analysis of health sector reform in the Region and elsewhere, it is seen that there is no consistently applied, universal package of measures that constitutes health sector reform. The process of reform is also proceeding rapidly in many countries. While considering health sector reform, new forms of relationships among the components of health systems can be developed to make complex changes and interactions. During the last few decades, most of these efforts are being spurred principally by a desire to improve equity and quality of care, to expand coverage, to decentralize health care management, and also to contain costs. The reforms sometimes are highly political and fiercely contested processes. In some countries, the reforms became more complex due to the presence of a wide range of contracting partners, including external agencies. While every reform experience is country-specific and usually based on solid evidence, there are important lessons to be learnt from comparing options, identifying common issues addressed and the tools used, and evaluating effects of various reform initiatives.

Most countries usually focus attention on the contents of the reform, rather than on the process. This focus on content runs the risk of equating health sector reform with one set of prescriptions, e.g. the introduction of market mechanisms; user charges; establishing joint management bodies with low responsibility; reducing the size of the public sector; cost-containment and redistribution of resources. The reform usually ignores the question of feasibility of implementing the change. What is needed is to increasingly understand the issues in reform processes to complement what has been learned about the content of reforms. Such an understanding might lead to the development of strategies for publicizing or marketing reforms or identification of ways that governments can anticipate and plan for the reactions of organized interest groups.

2.1 Health care financing reforms

The most striking reform in the health sector concerns securing sustainable financing for health care. When health sector investment is analyzed, it is seen that the situation over the past few decades has not changed with regard to low investment in health. According to recent national health accounts data as reported by WHO, the total health expenditure in most countries of the Region is around 2-8 per cent of their GDP.\(^3\) The proportion of government contributions as a percentage of total health expenditure in most countries ranged from 20-60 per cent, depending on the growth of private health care systems in respective countries. A worldwide study\(^4\) on external assistance to the health sector during 1972 to 1990 revealed that smaller and poorer countries received more funds from external assistance than larger and richer countries. Around 20-30 per cent of total health expenditure of least developed countries such as Bangladesh, Bhutan and Nepal comprised of external assistance.

The national health accounts provide useful insights to governments to review how they can and should allocate public resources for health, what should be the level of public and private expenditure, and how private resources can be mobilized for public health

\(^4\) C. Michaud & C.J.L. Murray, Bulletin of World Health Organization, 1994
expenditure. A careful analysis could be made to determine what types of financing strategies are to be adopted, e.g. mobilizing financial resources within the health sector, outside the health sector or improving the use of existing resources. Health care financing reforms have to be initiated in order to ensure equitable access and efficient and effective health care. An appropriate mix of private and public health care and financing mechanisms have to be established, so that the two sectors complement to each other, to yield best results.

Alternative health financing reforms such as cost-recovery and cost-sharing schemes, user fees/charges, community financing, health cards or voucher systems, subsidized payment schemes, contracting services, social insurance schemes, and private insurance, etc., are some examples of changes in financing mechanisms introduced under the umbrella of health sector reform. Most countries have concentrated on the contents of reforms in health care financing rather than on the processes resulting in failure or delays in implementation.

The fundamental principle of financing reforms is that health care funds (either for private health care or for community health prevention and promotion) are raised from the people according to their ability to pay, and not according to health need. It is also equally important that funds are spent according to health need, and not according to ability to pay. Everybody is entitled to pay an equal share of disposable income. This not only depends on the share of disposable income spent on health, but also the methods of financing, such as general taxation, insurance, or out-of-pocket payments. Fair financing deals with whether funds are raised through a progressive collection mechanism and protection of catastrophic health costs.

Even though the level of health spending (like total health expenditure or per capita health expenditure as percentage of GDP) is important, experiences of some high-and-middle-income countries show that more is not always better or always possible. What needs to be kept in mind is how far health expenditure is distributed according to health needs. The effects of good spending and utilization according to health needs are reflected in the level of inequities in health.

Many countries in the Region have introduced various financing mechanisms, including community-financing systems, particularly to protect poor families. Public-private joint venture initiatives for expansion of hospital care have been undertaken in some countries. Major investments by international and national private corporations in establishing big and medium-scale hospitals and diagnostic facilities have been made in some countries. Various forms of user charges at public health facilities have been introduced to relieve the burden of public expenditure in hospitals and health centres. Considerable evidence in developing countries, including those in WHO-SEAR has been documented on the consequences of imposing user-charges for health care, in the context of equity, efficiency and consumer satisfaction. This evidence clearly shows that price alone is insufficient to explain the effects of fee systems. Managerial and organizational factors are central determinants of the impact of this policy reform. There is also evidence of the danger that direct contribution by users to health financing leads to cuts in the State health budget.

There are a few countries where social security and health insurance schemes already cover a certain proportion of the general population (3-20%). The coverage is concentrated on the employed sector (industrial and manual labour and government employees). In some countries, various forms of community health-risk-sharing schemes have been developed through non-formal sector health insurance initiatives. A few initiatives in the Region especially in India, Indonesia and Bangladesh have been successful as they cover certain
While recognizing the advantage of involving the private sector and consumers in targeted groups such as poor women, low-wage labourers, and the semi-employed. Experience has shown that pooling risks for both health dangers and financial burden have increased the efficiency of health systems, creating better health outcomes. WHO conducted a global study in 1998 on “risk sharing schemes for informal sectors”. The information thus provided highlighted how governments could ensure that the vast rural population in most countries is pooled for health risk in the most efficient manner.

There is a danger that rapid expansion of health insurance coverage without appropriate safeguards result in health systems moving away from these goals. The success of health insurance in achieving health reform goals is closely related to its particular institutional characteristics and managerial capacity. Usually, middle- and high-income countries, whose economy could sustain a larger force of employed labour, attempted to expand the coverage of social health insurance. They initially started with multiple agencies handling social health insurance and managing through prepaid schemes. They tended to contract out health care to as many private providers as possible. Specific arrangements for insurance, such as social health insurance, social security, commercial health insurance, community prepayment schemes, etc., vary across countries. But, ultimately it is the government that must provide subsidies for the poor and disadvantaged groups, to ensure that those who cannot afford to fully finance their own “insurance” are protected. Some countries have made detailed studies on this aspect, in collaboration with external agencies including the International Labour Organization. More information is required to study these issues comprehensively in the Region.

The promotion of competition, either between providers or, more rarely, between financiers of health care, has been used as a strategy to finance reform programmes being carried out in industrialized countries. The strategy to use government funds to buy clinical or non-clinical services from private providers is intended to increase the productivity of public resources by purchasing the gains in efficiency perceived to exist in the private sector. Service contracting is primarily to improve the quality and/or increase the quantity of services that can be made available for a given amount of government expenditure. This kind of a competitive approach has been introduced in a few countries of the Region.

Many countries have promoted or are in the process of promoting privatization efforts in the health sector with or without the active participation of health ministries. Some countries have attempted to reduce public involvement in the management and delivery of health services as part of their privatization efforts. They have introduced appropriate policies towards the private sector, and have restricted government activities to policy formulation, monitoring, coordination and regulation. This practice of encouraging the public health sector to abandon health services provision and concentrate on its normative and regulatory role has not always been accompanied by strengthening the normative role of the ministries of health. More research is required on what capacities, skill, information systems, etc., governments need to develop to play an expanded regulatory role.

While recognizing the advantage of involving the private sector and consumers in future policy-making and regulatory processes, the governments, especially ministries of health, should be proactive in dealing with issues that might adversely affect the underprivileged segments of the population. The greatest health needs are among underprivileged populations. The maximum improvement in the health status of these groups is possible, only when the most cost-effective health actions are targeted to those most at risk or most in need. While an optimal allocation of health resources is required, different mechanisms and approaches are needed to ensure sharing of both disease and financial risk. Given the complexity of the public-private mix in health care provision or financing, and the complementarities and partnerships between the public and private sectors including the...
efforts of civil societies, the ministries of health should improve and strengthen their capacities of studying and exploring alternative financing of health care. They should introduce appropriate reform measures and ensure quality of services, and acceptable social responsibility of, and protection for, the consumers, especially the underprivileged.

### 2.2 Reform in provision of health care

After the World Bank in its 1993 World Development Report highlighted the importance of adopting essential clinical and public health packages, many countries, especially those receiving substantial external financial assistance from the Bank and other bilateral and multilateral donors, tried to link their economic investment in health with a core set of essential health care packages. Most countries in the Region, with support and guidance from WHO, field-tested different sets of health care packages. These included a mother-baby package, baby-friendly hospitals, health-promoting hospitals, Integrated Management of Childhood Illnesses (IMCI), Safe Motherhood Initiative (SMI), EPI-plus, and recently, Making Pregnancy Safer. These essential health packages aimed at improving health care and increasing efficiency by making the best use of contact between health workers and concentrating on the needs of the individual rather than focusing on the single disease. There has been a rapid expansion of selective essential health care interventions in the countries of the Region, during the past few decades. These selective primary health care efforts such as disease elimination and eradication are successful due to partnerships among countries as well as with development partners. However, the situation in other public health development areas is quite different. For example, provision of safe water supply and sanitation, provision of essential medical care including essential drugs, provision of essential obstetric care for pregnancy and delivery, leave much to be desired. The trend for further expansion of coverage of essential health care, especially in the least-developed countries, is not bright due to many uncontrollable factors (political, socioeconomic and financial). First, the external and internal resource inputs for health infrastructure expansion are scarce. Secondly, nearly 20-30% of the population, who are actually the most needy in terms of health care, is harder to reach for providing any essential health care, mainly due to economic or geographical reasons. The challenge, thus, is how to reach the unreached.

Two decades of implementing the primary health care (PHC) approach revealed a "new universalism". It denotes a renewed PHC approach that recognizes government’s limitations but retains government’s responsibility for the leadership and financing of health systems. The new universalism recognizes that the most cost-effective health interventions in a given setting are to be provided for all, but not all possible interventions for a whole population. Each country needs to look at what type of essential public health package should be available at various levels of the health system which is universally acceptable and affordable using appropriate technology.

The debate on the two approaches - selective (vertical) and integrated health care, is still on and will continue for some years at both the national and international levels. The situation is complex and should not be over-simplified. It has to be judged according to direct policy and operational consequences. Public health interventions such as immunization, oral rehydration, multi-drug therapy, fortification or supplementation of micronutrients (like Vitamin A, iodine, iron, and other essential minerals and vitamins) for the prevention and control of communicable and non-communicable diseases, are well established. These interventions are packaged in selective or integrated health care programmes, depending upon the urgency for control, the capacity for expansion and sustainability of coverage by the existing health infrastructure. Many such programmes have mostly used the campaign
approach, for prevention and control of priority diseases, for example, national immunization
days or mopping-up vaccinations against polio, mass education and supply of iodized salt,
multi-drug therapy for leprosy and filariasis. Specific problem reduction targets have been
set and special national campaigns launched requiring considerable resource inputs to
achieve the targets.

The central issue is whether such selective health programmes merely use a passive
health infrastructure, or, on the other hand, the health infrastructure adopts the selective
programme as its essential intrinsic function. The choice is never completely free. Many
selective programmes, upon close examination, show that although the technology and
programming have been selective and meticulous, the actual performance and achievement
of targets still depend upon such critical elements as the capacity of the health infrastructure,
community involvement, decentralization, education and information, intrasectoral and
intersectoral approaches -- all of which are essential and complementary support elements
of primary health care. Efforts are now being geared towards organizing integrated local
delivery of health care while, at the same time, ensuring the technical quality of specialized/
selective services.

2.3 Resource generation

Despite these reforms, there is still a large gap in people's health status as well as in the
development and implementation of policies, financing, organization, management and
delivery of health programmes. The quality, quantity and balance of human resources for
health are the main concerns. While attempts have been made to expand training
institutions as well as their production capacities, there are still shortages in most categories
of health personnel in Bhutan, Maldives, Indonesia, and Nepal. Some countries like
Bangladesh, India, Myanmar and Thailand, have sufficient or an excess of doctors but face
shortages in other categories of health care workers. The shortage of nursing and midwifery
personnel in many countries is one reason for high maternal mortality and low accessibility
of essential obstetric care during pregnancy and childbirth.

Another dimension of human resources is the imbalance in deployment between rural
and urban areas. A significant emerging factor, which further aggravates this situation, is the
increasing competition between the public and private sectors. The people themselves are
the most valuable resource for health. The principle adopted in Alma-Ata defined community
involvement as a process whereby individuals, families and communities assume
responsibility for their own health and welfare and develop the capacity to contribute to their
own and the community's development. Many countries have successfully learned this
principle through various innovations. Almost all countries consider community action for
health as a political necessity and also an important and effective mechanism for planning,
implementation and evaluation of health development at the local level. For effective
community action, certain prerequisites are necessary, such as local leadership,
decentralization, appropriate technology, sustainable mechanisms for partnerships, etc.

Increasing community awareness and creating active and effective mechanisms for
community involvement have been used as the main strategies of the health and social
development programmes of all countries of the Region. The successful community health
development programmes such as the Integrated Health Package Programme (Pos
Pelayanan Terpadu or POSYANDU) in Indonesia; the Village Health Volunteer Schemes
and the integrated Basic Minimum Needs (BMN) programme in Thailand; and the
Community Health Care Programme using a large force of health volunteers in Myanmar,
are at the cross-roads due to changes in health care management with private-public partnership.

Experiences in many countries show that the conventional approach of extending health care delivery through building more public hospitals and health centres has proved inadequate. It is proving economically impossible to bear the cost of full extension and expansion of public sector health services to the entire population. It is important to expand and strengthen the role that individuals, families and communities can play in the promotion and protection of health. This approach has not been encouraged much in many of the national health programmes. The conventional (allopathic-based) health delivery system should play a positive and catalytic role so that communities can own and maintain actions for health development both individually and collectively. The traditional medical care systems should also be developed further in order to complement the expanding (allopathic-based) health care systems. Since health needs are not always perceived and are not automatically translated into demands, the health care system must assist the people to recognize their health needs and convert them into health demands, or take action for self-care where appropriate.

Social mobilization constitutes the main strategy to build on the energy, inventiveness and capacity of the people themselves. The people, instead of being objects of the development process, become real partners. Community health cooperative schemes in many countries are successful examples of such partnerships. The influential people in the community are the prime movers and HFA leaders, and they are becoming more prominent as they help to remove the obstacles and facilitate the development of action programmes which promote self-confidence, income generation and participation. Careful attention should be given to local leadership development, aimed at enhancing the ability and the effectiveness of the leaders at all levels. Leadership development should be viewed as a people-centered and issue-oriented process.

In strengthening district health systems, little attention has been paid to the relationship between primary health care activities of basic health centres with those of first and intermediate referral levels (i.e. rural and district hospitals). Another dichotomy in development of health systems in some countries is the higher investment on development of hospital-based care at the cost of community-based care for the majority. Hence, finding an appropriate balance between primary, secondary and tertiary health care requires a clear understanding of appropriate interactions between the three levels, promotion of public and professional awareness of the need for such balance, as well as firm policy-making and policy-related budgeting. There is no doubt that an appropriate district health system is the level where integrated health development can be managed easily in response to local conditions and needs, using available infrastructure and resources.

Experience shows that creative management and real community involvement can be initiated at this level through devolution of functions and responsibilities. Many successful examples of health development can be seen in healthy districts movement, which has come to be known as "decentralized management". The competence of mid-level health managers has largely been enhanced through "learning-by-doing" and application of appropriate methodologies and technologies in real-life situations. Some of these innovations and efforts have won international recognition and have also received several international prizes, such as the Sasakawa Health Prize, HFA Medals, World No-Tobacco Day Awards, Darling Foundation Awards and Leon Bernard Foundation Awards, etc.

2.4 Governance
The reform process starts from the ministries of health, with the aim of reflecting a deliberate change in the policy of the government to improve performance. These reform efforts ensure the strengthening of policy and planning functions, setting of standards for health care provision and development of appropriate systems for monitoring performance (including quality assurance initiatives), introducing new management policies and practices, defining national and provincial disease priorities and introducing effective health interventions.

(1) **Reorientation and restructuring**

During the last few years, as part of health sector reform initiatives, many countries have implemented different forms of reorienting and restructuring their ministries of health. These can be categorized as follows: (a) making the ministries smaller and less hierarchical (as in most cases of decentralization efforts in Nepal, Indonesia, Sri Lanka and Thailand); (b) separating the functions of service provision and service financing to enable better performance through competitive measures (allocation of resources and financial management, e.g. expansion of health insurance coverage, service contracting, autonomous hospitals, functional groupings, integrating central health budget, setting up management boards at large public hospitals, joint ventures, etc., carried out in Thailand, India, Indonesia, Myanmar, and Sri Lanka); (c) shifting the mix of staff and skills from an emphasis on technical and medical training to that of management, finance, and planning of human resources for health in most countries; and (d) legislation and regulations for production and deployment of various categories of health workers including medical profession also e.g. new Health Act of Nepal, large scale contracting of village midwives and other categories of health workers in Indonesia; compulsory conscription of medical doctors in Myanmar; and the hospital accreditations in Thailand. Except in a few countries, most experiences in this area of reform have not been well documented.

The usual focus of reform by governments and, more particularly, donors has been on the reduction of the overall size of the civil service, including the health sector. **Reducing the total number of health staff, introducing new pay scales, grading structure and incentive schemes, separating political and executive functions, decentralization and privatization efforts** are examples of civil service reforms introduced in many countries, including those of the Region.

(2) **Decentralization**

As part of political and civil service reforms, decentralization is most common in almost all countries of the Region. Decentralization usually refers to three different types of processes. The first concerns the devolution of authority and responsibility from the central government to local government agencies in political and administrative areas. For example, State or Provincial or District Governments are responsible for their local development including health and other social sectors such as in India, Indonesia, Nepal and Sri Lanka. Bhutan, Myanmar and Thailand have also started their devolution process. The second process of decentralization is to deconcentrate the functions from higher to lower levels within the administrative apparatus of the countries. Many countries have introduced this process of delegation of responsibility for managing financial resources, deployment of human resources, and managing for hospitals and health centres. The third way is the delegation of responsibility and functions from central government units to other more autonomous and/or specialized types of government agencies or specialized functional agencies or parastatals in almost all countries. The establishment of national health research institutes, national
nutrition centres, national and regional research and training institutes, or institute of policy studies are a few examples. In some cases, decentralization also refers to the transfer of functions from government (public responsibility) to nongovernmental organizations, including private for-profit enterprises and NGOs in the established sense of the term.

Efforts in decentralization require fulfilling a number of objectives - political, economic and managerial, which are not always compatible. Although decentralization has been used as a strategy to promote efficiency and public accountability, it is important not to overlook the role of the central authority, particularly the need to establish equitable means for allocating resources and to ensure the existence of effective mechanisms for managing the health market. Experience has shown that in the field of essential drugs, there are various central government functions that should not be decentralized, e.g. selection of drugs that the centre authorizes for circulation in the national territory (drug regulation and registration), quality of standards and drug pricing policies, etc. This example illustrates that policies concerning the decentralization of various functions, responsibilities or authority are policy tools, and not merely policy objectives. Each country has to consider or identify an appropriate mix of centralized and decentralized functions, responsibility or authority to best meet policy objectives. The issue of decentralization cannot, therefore, be viewed by ministries of health in isolation from the overall civil service and political reform.

(3) Reform related with other sectors

With the increasing participation of other sectors and agencies including the community in health development, there is a need for the health sector to create a wider base for appropriate health action. Since the Alma-Ata declaration and HFA strategies were adopted, intersectoral action and community action for health have been recognized as major strategies for health development. However, a few major constraints have hindered progress. Some deterring factors are: (a) sustaining political commitment and translating it into operational means; (b) lack of common understanding of a comprehensive health system development framework resulting in ad hoc perceptions and sporadic decisions; (c) inadequacy of analytical and action-oriented information and clear directions for action and feedback; (d) absence of appropriate mechanisms for planning, implementation and monitoring; and (e) inadequate research support to provide information on the impact of public policies on health.

There is no denying that many development programmes of other sectors can contribute to health development. There are numerous examples, such as educating people on health promotion and protection; promoting no tobacco or alcohol use; having proper nutrition; empowering women to improve their health and development; initiating poverty reduction; etc. What is more important is how the health sector maintains its leadership role. It may not be enough to indicate what the others can do for health, but to indicate what the health sector can do for others. The health sector reforms should foster new partnerships and strengthen existing ones in order to place health at the centre of development activities.

With the globalization and liberalization of international trade, there is growing concern on the part of health decision-makers, regarding the impact of international trade on health services. The current international trade negotiations have given importance to opportunities for promotion of international trade in services, including health care. At the same time, market exploitation of international investment in health care could jeopardize national health systems, including resource allocation. Thus, countries should be aware of the impact of increased international trade in health services. They should also take full advantage of the potential benefits that can arise from agreements on regional integration such as AFTA,
One of the preconditions for successful reform is the national capacity to plan and manage health sector programmes. Most of the external donor-assisted programmes address this well-known need. Capacity building has many dimensions. It goes beyond training to incorporate many other elements, which may also overlap with institutional development. In the area of human resources development, it is recognized that insufficient attention had been paid to the needs of the health sector. In many countries, in order to reduce the degenerative effects of bureaucratic entities leading to little dynamism and creativity, autonomous institutions and centres for policy analysis or research and development, including health, have been established as freestanding entities or as part of academic institutions or even private sector organizations. These institutions have greater flexibility, good compensation and incentives to attract and retain competent professionals.

One of the challenges was to strengthen national capacity for managing health sector within the framework using sector-wide approaches in health policy and programme development. As decentralization efforts in many countries are being accelerated in recent years, the adoption of sector-wide approaches in health development planning and management will provide many opportunities for channeling the external resources. This move will make a step forward from development assistance programme to a comprehensive developmental process where donors and nationals agree to work on common goals and priorities. The focus of health development through sector-wide approaches moves from planning and management of individual programmes (for specific health priorities or geographical areas) to the overall policy, institutional and financial framework within which health actions are undertaken. Ultimately, there is a move progressively towards development of a more comprehensive sectoral programme with pooled resources (both internal and external). Bangladesh has started implementing its medium-term health and population sector programme (HPSP) since 1998. Nepal, Sri Lanka, Indonesia, Myanmar and Thailand are also embarking on developing medium-term health sector development programme for the next few years.

3.2 Promotion of research for health sector reform
Health sector reform is itself a researchable issue. The research can be a proactive, a prospective or a retrospective activity. It contributes to the overall health development within the background of dynamic socioeconomic and political changes. Health policy analysis, both at macro- and micro-levels, also provides invaluable inputs to health sector reform. The main issue for research covering health sector reform is **how to improve the health system performance rather than fact-finding or hypothesis formulation.** The researchable issues are to be identified from the gaps between the desired health situation (equity, efficiency, quality and responsiveness) and what is actually happening or supposed to be happening. It is more important to monitor and evaluate the processes of change rather than looking at the contents of change.

In the process of reform, it is essential that the initiatives include health policy and health systems research as an integral part of the reform agenda. The policy and organizational changes and managerial reorientation of ministries of health and their related sectors (institutional reforms), as mentioned above, are the means to an end. The development of health policy analysis and health systems research lags far behind the epidemiological, demographic and economic research studies. Thus, **continuous and simultaneous monitoring, review and research on health systems are necessary to keep track of changes and to make appropriate improvements.** The understanding of the consequences of reforms to health sector financing and organization has improved tremendously over the years. But, there is much more to be learned. **There is a need for better systems and mechanisms to enable planners to analyze different approaches to policy and institutional changes in the health sector.** Continuous monitoring and evaluation of health financing reforms must, of necessity, involve analysis and understanding of institutional and organizational changes taking place in the health sector as a whole.

In March 2000, the Global Forum for Health Research (GFHR) in collaboration with WHO and several other institutional and donor partners launched the Alliance for Health Policy and Systems Research initiative. The aim of the Alliance is to contribute to health systems development and the efficiency and equity of health systems through research on and for policy. Countries should take advantage of the Alliance to strengthen their research capabilities.

**3.3 Exchange of information and learning-by-doing**

All countries have provided documentary evidence on the steady progress made with various reform initiatives, especially on health care financing. In addition, important insights have emerged with respect to the major content of health sector reform. One such insight was that there are many advantages of a strong linkage of the decision-making processes with those related to health systems research.

Certain core values and operational principles have surfaced, such as equity, efficiency, effectiveness, and quality. Consumers' choice and rights as responsiveness of every health system have to be respected. There are several examples of mechanisms and processes to promote research for health sector reforms at national, regional and global levels. In each country, the national research promotion and development councils or analogous bodies are responsible for research promotion and strategy coordination. The same applies to the importance of regional bodies such as the regional health research advisory bodies (ACHR), which provide policy guidance and coordination. However, it is also recognized that there are some gaps between the production of research studies and the use of these products in the policy formulation and decision-making processes. Some
countries have attempted to make use of research results in decision-making by involving the decision-makers at the start of research, and advocating results at various forums including information to consumers. It is also recognized that the resources for research and development of reform is not a major issue. Both internal and external resources could be made available provided that the research agenda fits in with the needs of policy and decision-makers.

It should also be realized that there is a need to document various health sector reform initiatives. There is an attempt by WHO, in collaboration with Member countries and institutions, to conduct a critical comparative review of health systems development in various parts of the world using a common framework. An appropriate country protocol or profile format has been used so that the countries can record health sector reform initiatives systematically. It would also further facilitate the processes of reform as well as help in identification of research agenda, and also enable them to make critical reviews and comparative analysis.

3.4 Role of WHO and international agencies

WHO, through its various collaborative programmes, involves itself in capacity building in Member Countries to help take care of the evolving reforms in the health sector. In order to support health sector reform, a series of publications, both at the regional and global levels, have been issued. WHO-SEARO, along with interested institutions, has established a regional forum on health sector reform, as part of the “Asia-Pacific Health Systems and Health Policy Research Network”.

WHO continues to provide technical and financial support to the countries for research and development in the area of health sector reform. WHO also works closely with WHO Collaborating Centres (WHO CCs) and other relevant national and international institutions, in order to make the health sector more productive, efficient and effective in achieving the goals of health for all. WHO is strengthening its role as clearing-house to disseminate information on research and development on health sector reform. Informatics technology is appropriately being exploited for promoting the exchange of information. Existing regional and global mechanisms such as global and regional ACHR, the ASEAN Health Ministers’ forum, the SAARC Health Committee and the meeting of the health focal points for Non-aligned Movement, etc., should be used for advocating and sharing information on health sector reform. Furthermore, the meetings of such regional and global bodies could include research and development issues related to health sector reform on their agendas.

4. CONCLUSION AND POINTS FOR CONSIDERATION

“Health sector reform” is a political and dynamic process. Reforms should take place as sustained processes of fundamental change in the context of health policy and health institutional arrangements. They are not sequential or incremental processes. The issue is: “Can analysis of the political process of health sector reform be put on the research agenda, so that more can be learned about managing change?”

In general, improvements in the functioning of the public sector and civil service systems will occur in parallel with, and sometimes in response to, other aspects of institutional reform, such as increasing privatization. In some cases, the reforms are limited to the public sector. Leaving the private sector entirely to market forces may mean giving up
equity considerations. Experiences of many countries, within and outside the Region, clearly confirm that the success of reforms lies with how the process is to be applied and by whom, rather than on how the contents are formulated. There is a need for better understanding of the "process" issues to complement what has been learned about the "contents".

Research might involve, for example, (a) strategies for publicizing or marketing reforms to policy makers, providers and the general population; and (b) ways that government can anticipate and plan for the reactions of organized interest groups. The major research issue may be to deal with the political process - what are the effective strategies for the political management of the reform process?

Sustained information and education on health sector reform is needed to generate wider political and public understanding and support. In order to promote regional exchange of experience and information and to create a pool of expertise, there is an urgent need to strengthen the regional scientists’ forum on health sector reform. This forum will provide an opportunity to review and share the experience of reform initiatives; develop tools and methodologies; and provide support for capacity building. The issue that remains to be addressed is what are the practical and sustained national mechanisms to promote research on health sector reform together with built-in monitoring system and feedback of outcome of research? It is acknowledged that countries of the Region have considerable experience in health sector reform. However, they must continue to debate on identifiable research issues relevant to the processes and mechanisms of health sector reform and on ways of dealing with such issues.

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Suggested further reading:


