HEALTH SECTOR REFORM: KEY ISSUES IN LESS DEVELOPED COUNTRIES

Andrew Cassels
July 1995

A short version of this paper was originally prepared for the Overseas Development Administration (UK) and presented at the first meeting of the Forum on Health Sector Reform in December 1993. A substantially revised and expanded version was later written for the Journal of International Development and has been published in June 1995 (Vol. 7, No. 3, 329-347). WHO gratefully acknowledges the permission of the Journal of Internal Development to publish this version in the Discussion Paper Series of the Forum on Health Sector Reform.
ABOUT THE FORUM ON HEALTH SECTOR REFORM

The Forum on Health Sector Reform is a group of experienced senior technical people with a common interest in health policy and health sector reform who meet regularly. Members are currently drawn from bilateral and international agencies, regional development banks, ministries of health and selected resource institutions.

Forum meetings serve to share information about the scope and nature of current and planned activities related to supporting health sector reform; identify priority issues in health sector reform; review discussion papers on priority topics commissioned and produced by the Forum; discuss relevant country experiences as well as different agencies’ approaches to supporting the reform process in countries.

Members of the Forum on Health Sector Reform are:
Dr A Asamoa-Baah, Dr W Bichmann, Dr A Cassels, Dr E Castagnino, Mr A Creese, Dr F Decaillet, Mr R Emrey, Mr S Glovinsky, Dr D Gwatkin, Dr K Janovsky (secretary), Mr S Jarrett, Dr K Kalumba, Dr R Lea, Dr J Martin, Dr S Mogedal, Dr R Owona-Essomba, Dr M Palacio, Dr Sanguan Nitayarumphong, Dr F Schleiman, Ms J Thomason, Dr M Vienonen, and Ms E Wallstam.

For further information, write to

Secretary, Forum on Health Sector Reform
National Health Systems and Policies Unit
Division of Strengthening of Health Services
World Health Organization
1211 Geneva 27
Switzerland

Tel:  (41 22) 791 2568
Fax:  (41 22) 791 0746
E-mail: janovsky@who.ch
HEALTH SECTOR REFORM:  
KEY ISSUES IN LESS DEVELOPED COUNTRIES

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>WHAT IS HEALTH SECTOR REFORM AND WHY IS IT NECESSARY?</td>
<td>1</td>
</tr>
<tr>
<td>TOWARDS A MORE COHERENT APPROACH TO HEALTH SECTOR REFORM</td>
<td>4</td>
</tr>
<tr>
<td>Understanding the context</td>
<td>4</td>
</tr>
<tr>
<td>Understanding health care systems</td>
<td>5</td>
</tr>
<tr>
<td>Sources of ideas and experience</td>
<td>7</td>
</tr>
<tr>
<td>Information vs institutions: competing or complementary approaches?</td>
<td>8</td>
</tr>
<tr>
<td>Institutional reform: key principles</td>
<td>9</td>
</tr>
<tr>
<td>IMPLEMENTING REFORM: ISSUES AND OPTIONS</td>
<td>10</td>
</tr>
<tr>
<td>THE ROLE OF DONOR AGENCIES</td>
<td>18</td>
</tr>
<tr>
<td>CONCLUSIONS</td>
<td>19</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>21</td>
</tr>
</tbody>
</table>
INTRODUCTION

The term health sector reform is used with increasing frequency in the health development literature and there is now a measure of agreement about the dimensions, scope and objectives of reform in industrialised countries (OECD 1994). This international interest in health sector reform has also had the effect of increasing the potential range of strategies and options for achieving national health policy objectives in less developed countries. This is exciting and challenging after many years of somewhat sterile debate about different approaches to primary health care and limited progress in improving health outcomes. However, the extent to which the experience of industrialised nations is relevant in the political, economic, social and institutional context prevalent in the developing world remains controversial. Much recent criticism focuses on the uncritical promotion of market mechanisms by international agencies and the export of models from particular countries such as the UK (Collins et al 1994). However, there is little to be gained by further polarising this debate or merely analysing the theoretical merits and demerits of managed competition in less developed countries. Rather, there is a need for a more pragmatic assessment of what constitutes an appropriate agenda for reform in the light of the real problems that have to be addressed and the constraints that have to be overcome. This paper therefore aims to explore the meaning, and some of the practical implications, of health sector reform in low income countries.

The starting point of such an analysis is to look at what is meant by health sector reform and to examine what such reforms aim to achieve. Next, in an attempt to develop a more coherent approach to health sector reform, the paper looks in more detail at the context in which reforms are being implemented and the sources of ideas and experiences on which reform programmes can draw. The underlying question here is whether one can usefully develop a generally applicable set of organisational principles common to all reform programmes. The third section of the paper looks in more detail at country experience in relation to several options on the reform menu - focusing particularly on selected aspects of institutional change.

Recent experience in Europe and North America leave little doubt that health reform is a highly political and fiercely contested process. This is equally true in less developed countries, where in addition to the wide range of local actors, the situation is made more complex by the role of donor agencies. The analysis of reform issues would therefore be incomplete without a consideration of how different donor policies and practices affect the reform process.

WHAT IS HEALTH SECTOR REFORM AND WHY IS IT NECESSARY?

Whilst the range of options for effecting reform may be changing, the problems faced by many less developed countries remain dauntingly constant.
Scarce resources are used inefficiently: public funds are being spent on inappropriate and cost-ineffective services, too much is spent on salaries compared to operating costs, and on tertiary rather than primary levels of care. Existing services are badly managed, money does not get to where it is needed, and it is hard to monitor how it is spent. Systems for purchasing goods and services fail to ensure value for money.

People cannot access the health care they need: this results from a variety of factors - an individual’s poverty, geographical location, age, sex or lack of employment, unavailability of services to treat particular problems (such as sexually transmitted diseases) and, bad planning and management of services.

Services do not respond to what people want: people will not accept poor-quality services uncritically just because they are there, and services in many countries are therefore grossly underutilised. In the public sector, people face unmotivated and poorly trained staff, long waiting times, inconvenient clinic hours, inadequate supplies and drugs and lack of any confidentiality or privacy. In the private sector, they are at risk of financial exploitation, with no safeguards against potentially dangerous treatments (Nabarro and Cassels 1994).

The governments of developing countries have to ensure that an appropriate share of public revenue is allocated to health; that the benefits of publicly-funded health care are equitably distributed; and that resources are used as efficiently as possible - both in terms of maximum health gain for the funds invested and minimum cost for the range of services provided. They will also be concerned that users are satisfied with, and have some degree of control over, the form and content of services offered, and that individuals are protected from catastrophic expenditure in the event of serious accident or illness. These policy objectives have to be achieved in an economic environment where total per capita expenditure on health is little more than 2% of that in the established market economies, and where only modest increases can be expected. In absolute terms, 36 countries, the majority in sub-Saharan Africa, were each spending less than US$ 20 per capita in 1990 (Murray et al 1994).

Given that neither the problems nor the broader health policy objectives are new, and that governments have been attempting to address them with donor assistance for many years, we need to ask what constitutes health sector reform? Several dimensions to the debate are beginning to emerge. In terms of process, the term reform implies fundamental rather than merely incremental or evolutionary change. It is also likely to be a sustained rather than a one-off process and it must also be purposive (Berman 1993). The purpose of the change is to promote the achievement of overall health policy objectives.

It is also clear that the process of change needs to extend beyond the redefinition of policy objectives and discussions of the ideological orientation of the health care system.
Without institutional or structural change it is likely that existing organisational structures and management systems will continue to fail to deal adequately with the problems listed above. Health sector reform will therefore be concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented.

The process of reform and the difficulty of implementing policy and institutional change has been relatively neglected (Walt and Gilson 1994), compared to the debate about the content of reform. This focus on content not only ignores the question of the feasibility of implementing change, but runs the risk that health sector reform becomes equated with one particular set of prescriptions - such as the introduction of managed-market mechanisms, user charges, reducing the size of the public sector, cost-effective packages of services and privatisation. The need for creative solutions to deal with urgent and intractable problems can, as a result, easily get lost in discussions about the rights and wrongs of particular strategies.

The starting point for this paper is that there is no consistently-applied, universal package of measures that constitutes health sector reform. Rather, the precise agenda for reform will be defined by reviewing how well existing policies, institutions, structures and systems deal with issues of efficiency, access, cost-containment and responsiveness to popular demand. The relative importance of these issues will vary between less developed countries, industrialised countries and countries in transition from a command economy. Reform in the industrialised world has been designed to contend with sluggish economic growth, ageing populations, increasing popular expectations and the rising costs associated with medical technology (OECD 1994), but against a background of universal or near universal coverage and functioning institutions. In less developed countries, reform strategies need to address the issues of extending the coverage of basic services to under-served populations, improving poor service quality and addressing the inequitable distribution of resources, in the context of very limited institutional capacity. The need for systems to ration health care provision in line with national policy objectives is common to all countries.

A further dimension to the debate centres on whether the term refers to the reform of health care systems or to health reform in a more general sense. The latter view would hold that the reform of policies and institutions within the traditionally-defined health sector merely constitutes business as usual. The international interest in reform should therefore be taken as an opportunity to redefine approaches to improving health status through a broader approach to the reform of public policy and through the activities of agencies in other sectors such as education, housing, employment and agriculture (WHO 1993a). While these two views are not incompatible, the present analysis will focus on the reform of health care systems.
TOWARDS A MORE COHERENT APPROACH TO HEALTH SECTOR REFORM

Given the diversity of opinion about what constitutes health sector reform, there is a need for a framework for developing a more coherent approach to the process.

Understanding the context

Just because change in the health sector is badly needed does not always mean that it is likely to happen, as recent events in the US have amply demonstrated. The need for reform, defined in terms of the severity of health problems or the dysfunctionality of health systems, is, on its own, a poor indicator of the potential for implementing reform. Something has to trigger the process, and it is likely that political and economic changes, and shifts in thinking about the role of government, will be more influential than epidemiological or demographic factors alone. Reform may be provoked by the kind of drastic political and economic changes that have occurred following the collapse of the former Soviet Union, or by the emergence of a country from civil war as is beginning to happen in Cambodia and Mozambique. In countries where economic problems or civil conflict have not led to a complete breakdown of systems, reform may have to await the arrival of a completely new administration. In Zambia, for example, despite the fact that reform was arguably needed throughout the 1980s, the serious attempt at fundamental change that is now under way had to await the election of the MMD Government in 1991. Similarly, radical political change has now unlocked the potential for reform in post-apartheid South Africa.

Political or economic crisis certainly does not guarantee a suitable environment for reform. The pressure to make rapid progress in reconstruction and rehabilitation may result in the recreation of the same type of inequitable or inefficient systems that existed prior to the period of instability. Furthermore, a country emerging from civil war may lack the human resources or institutional capacity to design and implement effective structures and systems. Emergence from conflict thus presents both particular constraints as well as opportunities for reform (Macrae et al 1994).

At the other end of the spectrum are those countries where the need for reform may be great, but the opportunities for implementing change are limited - not least as a result of the very stability of their systems of governance. Given the limited political support for fundamental change in the public sector in countries such as Nepal, Nigeria and Bangladesh, and the reluctance of donor agencies supporting those governments to address systemic as opposed to programmatic issues, the prospects for institutional reform are slim. Reform is likely to depend more on strengthening the hand of groups outside government (such as NGOs, research institutions, user groups, community organisations and private sector providers), who can influence the environment in which the civil service operates.
There is thus a need to analyse carefully the political, economic and institutional context in order to assess both the need and potential for reform. Whilst political leadership for reform is a prerequisite, it is important to recognise that political support can be fragile. The understanding of context needs to go far beyond statements of political intent, to include an analysis of the interest groups both within and outside government that can be expected to either support or oppose reform. This kind of analysis, whilst increasingly common in developed countries, is often ignored in the developing world (Walt 1994). Most donor agencies talk about the importance of local ownership of the reform process (contrasting programmes that are developed by foreign consultants which are not owned, with those prepared by governments that are), whilst failing to come to grips with the widely differing views of local stakeholders (Denning 1994).

**Understanding health care systems**

In addition to a more sophisticated understanding of the context in which health care systems operate, it is also important to increase our understanding of health systems themselves. We need conceptual tools which will define the key components of the health system and help in specifying the objectives of reform (Frenk 1994). National health systems are both complex and varied. As a result, generic models developed for the purpose of comparing health systems internationally, have tended to be expressed at a high level of abstraction, to cover all possible permutations (Roemer 1991). Roemer, while providing a convenient starting point, merely defines a health system as the "combination of resources, organisation, financing, and management that culminate in the delivery of health services to the population" (Roemer 1991). More recent models (Hurst 1991, Frenk 1994) have focused more on the nature of the relationships between the institutional actors as the basis for characterising health systems. Given that it is these relationships that are often the focus of reform, this constitutes a more useful approach. Table 1 sets out the major components of the health system and describes their major functions.

The next step is to define the relationship between different types or levels of change and the objectives that they are designed to achieve. Frenk (1994) identifies four major levels of policy: **systemic, programmatic, organisational and instrumental.** He links change or reform at each level with the desire to achieve different policy objectives. Changes at a systemic level address equity concerns through reform and realignment of the institutional linkages between the main actors in the health system. Programmatic changes deal with allocative efficiency through the definition of cost-effective packages of services, organisational changes ensure technical efficiency through improvements in productivity and quality, and instrumental policies generate the information needed to ensure improved performance.

Whilst this model is conceptually clear and useful in that it points to the interdependence of change at different levels, it is difficult to agree that changes at a systemic
### Table 1: The Health System: key institutional components

| The state: | government institutions responsible for the *financing, regulation, purchasing and provision of health care* |
| Service providers: | in the public, private, NGO and traditional sector. Most work in some kind of institutional setting such as a hospital, health centre or GP practice. Services include clinical care as well as support services |
| Resource institutions: | *produce the human and material resources for health care* - concerned with basic and in-service training of health personnel and health-related research and development (these will include universities, medical schools, schools of public health, R and D departments of private companies, foundations etc) |
| Institutional purchasers: | organisations such as insurance funds, district health authorities or health maintenance organisations which *define health needs for discrete populations and purchase clinical and support services from providers* using a variety of contractual mechanisms |
| Other sectoral agencies: | *produce health benefits indirectly* as result of the goods or services they provide (eg agriculture, education, housing, employment, communications, water supply) |
| Populations: | people acting individually or as households can *produce health benefits through individual or collective action*, lifestyle or behaviour; they are recipients of health care; they can *purchase health care*, and can *be employed to provide services*. Individuals form or join a variety of different organisations which *aim to influence the form, content, cost or quality of services* (eg: trade unions, political parties, user groups, village health committees, community health councils and so forth). |

Source: Cassels (1994a)

level are always concerned with the promotion of equity. Governments may be equally concerned with institutional change as a means of promoting efficiency, or indeed other policy objectives. Similarly, institutional reforms can have unintended or unexpected consequences and may have to deal with the trade-off between different objectives (Robinson and Le Grand 1994). The need then is for conceptual tools which help planners and policy makers design reform strategies, predict, and subsequently trace the effects of policy, institutional and systems change on the achievement of different and sometimes conflicting objectives.
Sources of ideas and experience

A comprehensive approach to health sector reform will draw on knowledge and experience from a number of different sources:

- **Civil service and public sector reform:** In many less developed countries, health sector reform will occur as part of, or in parallel with, changes in the civil service and public sector organisations. Whilst there is a growing literature on administrative reform in developing countries (ODA 1989, Moore 1993a), there is relatively limited documented experience on the relationship between civil service reform and health systems performance.

- **Developments in financing the social sector:** Prompted in part by the publication of a World Bank document "Financing Health Services: An Agenda for Reform" in 1987 (World Bank 1987), changes in health financing, and particularly the introduction of user charges, were perceived by many to be the mainstay of health sector reform. Whilst this is no longer the case, the need to assess the advantages and disadvantages of user fees, community financing, voucher systems and different forms of insurance remains important and is the subject of a growing body of literature in both health and other parts of the social sector (WHO 1993b, see also Gilson et al 1995 in this issue).

- **Managed-market health care reforms:** Traditional bureaucratic structures do not necessarily provide sufficient incentives to guarantee cost-effective or user-friendly services, neither are unregulated private markets capable of achieving the mix of objectives that health systems seek to satisfy. There is a growing consensus in industrialised countries that the role of governments is to control and regulate public and private markets in health care. Although there is no shortage of ideological supporters both for and against the introduction of similar models in less developed countries, there have been relatively few attempts to define more analytically either the prerequisites, advantages or potential pitfalls of so doing (Broomberg 1994).

- **Developments in epidemiology and health economics:** The 1993 World Development Report (World Bank 1993) and subsequent publications by some of those whose work fed into it (Murray and Lopez 1994) have increased our understanding of the global and regional burden of disease and the cost-effectiveness of different health interventions. Whilst critics of this approach point to the limited institutional analysis in the WDR (Nabarro 1993, Save the Children Fund 1993), reform programmes can now draw on far more sophisticated analyses of the potential health gain per dollar spent than was previously possible.
Information vs institutions: competing or complementary approaches?

In addition to the debate touched on in the introduction between content and process (the what of health sector reform versus the how), the previous paragraphs point to a field of controversy within the area of content. At one level, there is a danger that health sector reform is simplistically equated with one or other of the areas of experience listed above. Clearly this is unhelpful, and there is a need instead to draw on these different bodies of knowledge to the extent that they provide insight into problems or suggest potentially useful strategies. However, there is a rather deeper level at which this type of debate persists. To what extent does reform depend on better information on which to base allocative decisions and to what extent does it depend on institutional reform?

Proponents of the need for better information point to the disappointing track record of institutional reform and to the fact that it is only recently that there has been an adequate database on which to base an objective analysis of allocative efficiency in the entire health sector (Murray 1993). Institutional issues, while not dismissed, are perceived to be important to the extent that they account for the difference between the theoretical efficacy and actual effectiveness of specific health interventions in field conditions. In other words, they are perceived by some to be of concern more in the improvement of technical rather than allocative efficiency.

The case for more attention to be paid to the reform of institutions is based primarily on practical experience rather than research. Indeed, one of the reasons why the World Development Report gave such limited coverage to institutional issues was because of the perceived scarcity of convincing published research in this field (Jamison pers comm). It is undoubtedly true that many cost-effective interventions achieve less than their predicted efficacy because of the failure of delivery systems or the behaviour of people. However, the most important political and institutional issues (such as the chronic imbalance between salary and operating costs, the power of professional associations, health service unions and other interest groups, and the lack of robust political leadership) are those that act at a higher level, and thus limit the capacity of the health system as a whole to make cost-effective or rational choices of any kind, irrespective of the quality of the information that is available.

The paper returns to the need for more research which analyses the outcomes of different approaches to institutional change in the conclusions of this paper. In practice, it is safe to conclude that the two approaches should be regarded as complementary. Sound economic, demographic and epidemiological data are needed to guide investment decisions, but their existence alone cannot be assumed to move governments or other significant actors to action.
Institutional reform: key principles

If the reform of institutions in the health sector is central to the whole process, we now need to ask whether it is possible to define some underlying guiding principles which are likely to be common to all reform programmes.

0 management and accountability

The capacity to make strategic or operational decisions in many ministries of health and health care institutions is often constrained by the fact that no-one is in overall charge. In the absence of clear management structures, consensus has to be reached between technical staff and generalist administrators, different professional cadres, and competing programme managers. Organisational structures frequently reflect the success of these different groups in lobbying for status rather than the need for managerial control. Similarly, the process of resource allocation is dominated by provider rather than managerial or societal interests. There is little support in the ministries of health in less developed countries for the introduction of professional managers. There is, however, a need for suitably-trained health professionals, working in organisational structures which link managerial and societal interests, to take on managerial roles which combine technical, financial and administrative responsibilities.

With the introduction of general management comes the need to explore the issue of accountability. To whom should health care managers be accountable and how will their performance be assessed and/or sanctioned? Increasing accountability to the public frequently appears in statements of health policy and as an objective of public sector reform more generally. However, accountability, despite its positive connotations in the abstract, is a complex issue in practice, with several and sometimes conflicting dimensions. Public servants may be accountable to bureaucratic superiors, audit authorities, the legal system, professional peers, through politicians to parliaments, to their clients in the community and, not infrequently, to other more powerful patrons to whom they owe their position and, to some extent, their livelihood. As the interests of these groups vary, so do the criteria by which performance is judged. Furthermore, systems designed to promote accountability which assess performance are only useful to the extent that they are linked with systems that can sanction or modify behaviour (Moore 1993b).
specifying priorities, objectives, standards of performance, monitoring outputs and outcomes and tracking the use of resources

Many public bureaucracies survive by not defining priorities or making explicit what outputs are expected from health care providers. Providers cannot be held to output targets if they are expected to muddle through with a limited and uncertain flow of resources. It is politically difficult for governments to be explicit about what can and cannot be afforded when per capita spending is less than US$10. It is easier to set more politically attractive but unaffordable objectives and hope that more resources will be forthcoming from external assistance.

The capacity to define realistic objectives and to develop systems for tracking the distribution and use of human and financial resources is a critical factor in improving the functioning of existing bureaucracies. For those reform programmes that aim to improve performance by moving away from an integrated hierarchy, toward a network of public and private providers, in which relationships are dependent more on contractual and less on bureaucratic controls, effective monitoring systems are essential.

clear institutional relationships

As health systems become increasingly complex, so it becomes more important to clarify the nature of the linkages between the different institutional actors set out in Table 1. Of critical concern is the financial relationship between different organisations and the means by which performance is monitored. The focus of much of the debate has been about distinguishing the role of institutional purchasers of health care responsible for defining needs, specifying tasks and monitoring spending and performance, from the role of health care providers. In most developing countries, although purchasers and providers are not organisationally separate, these functions are distinct and the fact that organisations and individuals have to fulfil both roles can be a cause of conflict. It is equally important, however, to explore how the financial relationship between the state and other actors, such as research institutions, medical schools and NGOs, can be used to promote the achievement of health policy objectives.

IMPLEMENTING REFORM: ISSUES AND OPTIONS

Those designing programmes do not need prescriptive models to adapt. Rather, they need options for addressing key policy issues. Table 2 lists some of the main components of
reform programmes, set out as areas of work or menus, each of which contains a number of options.

Table 2: Components of health sector reform programmes

| Area 1: Improving the performance of the civil service | Reducing staff numbers, new pay and grading schemes (including performance related incentives and salary decompression), better job descriptions and appraisal systems, improved financial disbursement and accounting, establishing executive agencies |
| Area 2: Decentralisation | Decentralising responsibility for the management and/or provision of health care to local government or to agencies within the health sector |
| Area 3: Improving the functioning of national ministries of health | Establishing self-governing hospitals or autonomous district boards |
| Area 4: Broadening health financing options | Through organisational restructuring, improving human and financial resource management, strengthening policy and planning functions, setting standards for health care provision and developing systems for monitoring performance, defining national disease priorities and cost-effective clinical and public health interventions |
| Area 5: Introducing managed competition | Through the introduction of user fees, community finance, voucher systems, social insurance schemes and private insurance |
| Area 6: Working with the private sector | Promoting competition between providers of clinical care and/or support services through single or multiple purchasers |
| | Establishing systems for regulating, contracting with or franchising providers in the private sector including NGOs and for-profit organisations |

The issues to be addressed and the options to be selected will depend on the circumstances of the country, the relative importance of different problems and the feasibility of introducing specific changes. In the end, the choices made are likely to result from political decisions - even though technical specialists will provide information about the relative merits of different options and will be responsible for their implementation. These specialists, working in or advising ministries of health, need access to the experience of countries that have started to implement reforms. However, much of this experience is poorly documented and relatively little appears in the published literature.

It is not possible to cover all of the areas in Table 2 and several (particularly in the areas of finance and working with the private sector) have been well covered elsewhere.
Lessons from civil service reform

In most developing countries the agencies responsible for managing publicly-financed health care remain an integral part of the civil service. As such they are bound by service-wide regulations and norms. This creates both problems - when rules are inflexible and management systems inefficient - but also some opportunities and safeguards.

In terms of overall reform, the first focus of governments, and more particularly donors, has been overall size of the civil service. Reducing personnel establishments has been seen as the key to improving terms and conditions within a constrained budget, and thereby increasing efficiency. Success, especially in sub-Saharan Africa, has been limited, however - partly because of the political difficulties of retrenchment and partly because a reduction in the size of the workforce alone does not free up sufficient resources to make pay levels sufficiently attractive to those that remain. Indeed, it has been argued that an overemphasis on reducing the numbers of public sector employees can be counterproductive, if retrenchment is pursued at the expense of other measures to improve performance (ODA 1989).

The slow pace of reform in the civil service more generally has prompted ministries of health in several countries to try to go it alone. In Zambia, the Ministry of Health has secured agreement with the Cabinet Office that all health service staff will leave the civil service and become employees of a newly-established Federation of Health Service Boards. A twin-track approach to reform has thus started to emerge with Cabinet Office primarily concerned with improving the performance of the central civil service and the capacity of local government, while the ministry of health has started to operate as a semi-autonomous agency, which contracts with independent district and hospital health boards to provide health care.

The idea of establishing executive agencies as a means of separating political and executive functions and providing agency managers with the incentive to improve efficiency is an attractive proposition. Experience to date, however, suggests a note of caution. The Government of Ghana, for example, whilst constitutionally committed to the creation of a separate health service executive, is anxious not to repeat what happened with the Ghana Education Service. The creation of GES was driven primarily by the interests of providers keen to improve pay and conditions, with the result that recruitment and
expenditure started to accelerate to unaffordable levels. Unless executive agencies have the capacity to manage themselves efficiently within a limited budget, they can easily create as many problems as they solve. Autonomy has to be seen as a way of creating more responsive and efficient services - not purely as an escape route from central government control for the professionals.

Many ministries of health have a poor record in the area of human resource policy and planning. Staff salaries consume an increasing proportion of recurrent budgets and internal planning exercises are too often based on professionally-driven and needs-based assessments of staffing requirements. Information systems linked to the government payroll, implemented as part of civil service reform programmes, can provide ministries of health, often for the first time, with up-to-date data on staff numbers, distribution and costs. The advantage of such systems is that they provide a means by which central government agencies can impose human resource budget ceilings on reluctant spending ministries and mechanisms to monitor them. The disadvantage of relying on central controls is that civil service regulations rarely provide any incentive for health service managers to reduce personnel costs - any savings in personnel costs being retained by the treasury and unavailable for other health care expenditures.

Reorganising national ministries of health

Ministries of health at national level are increasingly trying to reduce their involvement in the management and delivery of services, restricting their activities to policy formulation, monitoring, coordination and regulation. That at least is usually the objective of the restructuring process that is under way in many countries. In practice a number of difficulties have been encountered, especially when restructuring has appeared as part of donor conditionality, and it is not unusual to discover that, despite good intentions, the MOH functions in much the same way following reorganization as it always has.

Few staff have experience of working at a strategic or policy level - being far more used to functioning as programme managers. If management responsibilities are removed, technical specialists have to adapt to an advisory role, which is not always welcomed, particularly if it means losing control over extra-budgetary resources. A less well-recognised problem concerns the power exerted by professional cadres - doctors, nurses, pharmacists and others. Recent experience suggests that this form of vertical organisation is possibly even more refractory than the well-documented issues surrounding vertical health programmes (Rifkin and Walt 1988). It is customary in most
anglophone African countries, for example, for senior nurses to exert control over nurses throughout the health sector and to be represented at the highest level by a Chief Nursing Officer who in practice functions not as a technical adviser on nursing issues, but as the personnel officer for nurses. The situation is similar with other cadres, such as pharmacists and environmental health officers. Attempts to change this situation, and establish more comprehensive personnel policy and management units responsible for all health service staff, can be met by fierce resistance. To avoid the common perception that such initiatives are an attack on the professional status of nurses and others, there is a need to ensure that health professionals other than just doctors are trained and eligible to apply for senior management positions. At present, the threat of industrial action by powerful cadre-based unions and professional associations needs to be recognised as one of the major obstacles to institutional reform.

A further issue which has constrained reorganisation is a failure to reform financial management systems in line with new structural arrangements (Cassels et al, in preparation). If control over funds remains in the hands of those in key positions of responsibility in the old organisation, it is unlikely that the new structure will work effectively. Whilst this may seem obvious, it is frequently overlooked and may require negotiation with ministries of finance to secure delegated responsibility for the control of departmental budgets.

**Decentralisation**

A full discussion of decentralisation policy is beyond the scope of this paper, and is dealt with in more detail elsewhere (see for example Møgedal et al 1995 in this issue of the Journal of International Development). It is useful, however, to make one or two general points from a national perspective.

Despite the development of more sophisticated frameworks for analysing different approaches (Conyers et al 1993), decentralisation is often equated with the devolution of responsibility to local government agencies. Even in countries such as Nigeria, where a promising start was made (Ransome-Kuti et al undated), many difficulties have arisen in the process of handing over a greater degree of responsibility to local government. Local government control, at least in theory, offers the advantage of making health services more accountable to the public. The difficulty is that in many countries local government authorities have very limited managerial capacity and are dependent on the centre for most, if not all, of their resources. When funds are scarce, local politicians are no more likely to favour preventive services over facility-based curative care than their national counterparts. In extreme
circumstances (as happened in Tanzania and Nigeria), health budgets are arbitrarily raided to finance the costs of the local administration itself. Political compromise and lack of a precise legal framework can lead to unclear divisions of responsibility, and the potential for conflict between ministries of health and ministries responsible for local government (Cassels and Janovsky 1992).

Decentralisation programmes have to fulfil a number of objectives - political, economic and managerial - which are not always compatible. Despite being stated as complementary objectives, it is virtually impossible in most countries to design a system of decentralisation which results in significant reductions in public expenditure and improvements in the quality of service provision. A further conflict arises when political objectives dictate decentralisation to an increased number of smaller districts and a reduction in the power of regional or provincial authorities. Managerial purposes, in contrast, can be better served by larger districts and a relatively strong intermediate level to support them (Conyers et al 1993). These potential conflicts can manifest themselves in the way decentralised structures and systems are designed, seriously limiting their effectiveness.

With the increasing enthusiasm for decentralisation as a strategy of promoting efficiency and public accountability it is important not to overlook the role of the centre - particularly in relation to equity issues. In Zambia, the original draft of the reform programme envisaged that district and hospital boards would be able to set their own levels of fees and charges, and the terms and conditions for the staff they employed (Republic of Zambia 1992). In practice this would have meant that those districts with relatively wealthy populations, and tertiary hospitals that could raise the most income, would have been able to exert greater drawing power to attract key staff, thus exacerbating the inequity that the reforms were designed to address. In a decentralised system, the centre needs to establish equitable means for allocating resources between districts and to ensure the existence of effective mechanisms for managing the health labour market.

Although it is vital that the centre retains some control over the distribution of human and financial resources, problems arise if this is achieved solely by insisting on continuing adherence to civil service-wide rules and regulations. In Ghana, for instance, district and regional health management teams have little incentive to make efficiency savings by reducing staff numbers. If they reduce staff numbers, any savings revert to the treasury and cannot be used for non-salary costs (Cassels et al in preparation). The issue of decentralisation cannot therefore be viewed by ministries of health in isolation from overall civil service reform.
Independent hospital boards

Independent hospital boards (IHBs) were established, usually to govern the operation of major teaching hospitals, in several anglophone African countries in the mid-1980s (examples include Mulago Hospital in Uganda, Muhumbili Hospital in Tanzania, The Royal Victoria Hospital, Banjul and Korle Bu and Konfo Anokye in Ghana). These boards had the dual objectives of promoting better management of the institutions concerned, by requiring hospital managers to work within a fixed global budget, and limiting the proportion of public funds spent on tertiary care.

To date, there has been no large-scale systematic review of the success of this relatively common strategy. However, initial studies (Weinberg et al in preparation) point to a variety of problems. In practice, managers have limited control over hospital resources, often remaining bound by civil service regulations despite the intention of the legislative frameworks that established the boards. They also lack information about the costs of services and the outcomes of treatment on which to base management decisions. The boards themselves tend to represent a wide range of political and professional interests and may, as a result, fail to provide the backing needed by Chief Executives, who are often themselves inexperienced managers. Neither does the establishment of an IHB guarantee that spending on tertiary care will be controlled. Board members with powerful political connections can deal directly with ministers of both health and finance and, in several cases, have succeeded in lobbying for increased funding.

Hospital management in most less developed countries is a relatively neglected area - arguably a casualty of the international focus on primary health care. Donors have been keen to discourage recipient governments from further capital investment in hospitals. However, the focus of most management support, and the majority of management training courses, has been primary services, with little attention being given to the problem of increasing the efficiency of large hospitals. The problems experienced by IHBs to date point to the need not to abandon a potentially useful strategy, but for more careful analytic work in this area to assess the extent to which real improvements are possible.

Managed competition

The promotion of competition either between providers or, more rarely, financiers of health care is an important component of the reform programmes currently being implemented in industrialised countries. The aim has been to
increase the technical efficiency of services and their responsiveness to users by harnessing market mechanisms, with the state acting as the regulator of the system. Competition may be manager-led, whereby institutional purchasers, as in the UK, act on behalf of the populations for whom they are responsible. Alternatively, competition may be patient-led, where systems are established so that "money follows patients" as in part of the Swedish system (Saltman and von Otter 1992).

To date, there is limited practical experience on which to base any definitive conclusions about the extent to which these strategies might be applicable in less developed countries. From a theoretical perspective, their potential will be limited if competition depends on the existence of excess service capacity, which is rare outside urban areas. In addition, few developing countries have information systems which can cope adequately with bilateral or uncontested contractual relationships. The introduction of competition, if it is based on criteria other than just cost, requires more sophisticated systems, which will enable the purchaser agency to compare the performance of different providers. It is also true that much of the competition that does take place - competitive tendering for consumables and public works, for example - is poorly managed and often a major source of corruption.

Before rejecting the idea of managed competition completely, however, it is important to face the fact that several of the problems that reform needs to address have been particularly resistant to purely bureaucratic solutions. Training supervisors and managers has, for the most part, not led to services becoming more user-friendly; conventional health planning has been singularly unsuccessful in shifting public resources away from tertiary care; regulation alone has had little influence on the behaviour of the for-profit private sector. More creative institutional solutions - moving from hierarchy to contract, if not to competition - should at least be considered.

New approaches using contractual incentives rather than bureaucratic controls to improve performance will need to be carefully designed and monitored. Areas that might be usefully explored include specifying the standards of care and service outputs expected of NGOs and missions receiving government funds; making provider institutions dependent for a proportion of their income on levels of utilisation; and allocating a proportion of referral hospital budgets to regions or urban districts so that they can purchase tertiary level services according to their needs.
THE ROLE OF DONOR AGENCIES

A recent analysis estimates that external assistance constitutes 2.8% of total health sector expenditure in less developed countries (Michaud and Murray 1994). This overall figure, however, disguises major variations by region and country. If South Africa is excluded, aid flows account for almost 20% of total health expenditure (and an even greater proportion of public sector health expenditure) in Africa compared to 0.6% in China and 1.6% in India.

Although external assistance is not a major source of finance in most developing countries, it is nevertheless influential in shaping policies and programmes, and is therefore an important factor in the analysis of health sector reform. Much of the criticism of donors centres on the concern of certain agencies to promote specific strategies (notably user charges, community financing and greater reliance on private care) rather than taking a more country-specific view and assisting recipient governments to analyze the implications of different options for reform. There is no doubt that this will continue to be a problem, resulting as it does from a mixture of ideological conviction, national experience and the need of some agencies to maintain an identifiable niche in the market for public and donor support.

While there has been a general shift in the policy of many donors in the health sector - away from discrete projects toward more broad-based sectoral support - there is an important question as to whether this shift in policy has been matched by similar changes in the form or range of aid instruments employed. A recent review of current practice has pointed to the need to examine more carefully the degree of fit between the form of aid and the development objectives that it is designed to achieve (Cassels 1994b). This is particularly important in the light of the increasing use, mainly in Africa, of budget support generated from programme aid by donors such as USAID and the European Union. There is limited documented experience of the use of budget support in the health sector either in the published literature or within donor agencies. A recent case study of USAID Non-Project Assistance in Niger and Nigeria (Foltz 1994) points to the difficulty of using fast-disbursing aid as a means to promote institutional reform, as opposed to certain aspects of policy reform. It also highlights the pitfalls associated with poorly designed conditionalities and the potential drawbacks of badly managed technical assistance.

A major area of contention in any review of the role of donors supporting health sector reform is financial accountability. In an ideal world, accounting requirements should follow from donors’ policy goals and not constrain them. If aid is provided to promote institutional reform, then in theory it should be accounted for in terms of whether those reforms have actually been implemented. The difficulty, however, is that most donors are required by their national parliaments, member states or governing bodies to account for how money was actually spent. The absence of robust national accounting systems favours the provision of tightly controlled project aid - which can easily distort government spending priorities - or the establishment of a plethora of parallel accounting and management.
systems, which can undermine the institutions which the aid programme aims to support. The reform of government budgetary, accounting and auditing systems needs, therefore to be a high priority for donors and governments alike. Even if the focus of accountability shifts more toward outcome measures, as is increasingly the case, there is limited experience in monitoring institutional change as compared, say, to looking at health outcomes in categorical disease control programmes.

CONCLUSIONS

There is no specific blueprint for health sector reform in less developed countries. Nor can reformers rely uncritically on models developed in the industrialised world. Those responsible for planning reform will need to draw on ideas and experiences from a wide range of sources, both within and outside the health sector, from developed and other less developed countries, and carefully match strategies to the problems they are designed to address.

This paper has stressed the importance of institutional reform. Institutional reform, however, is a means to an end, and it is necessary to keep sight of the policy objectives - improved efficiency, equity, more responsive services and, ultimately, better health outcomes - that institutional reform is designed to achieve. For this to be possible there is a need for better systems and methods for monitoring policy implementation.

The development of policy and institutional analysis in the health sector lags far behind epidemiological, demographic and economic research. As a result, the importance of the political and institutional context in which reforms have to be implemented has been undervalued in the international literature and in the thinking of some international organisations. Whilst reform is unlikely to be based on the results of research alone, there is a need for the development of methods which will enable planners to analyse the effects of different approaches to policy and institutional change.

Health sector reform is a political process. It will never be in everyone’s interest and cannot be advanced through technical analysis alone. Radical reform is impossible without robust political leadership, informed by sound technical advice. Growing experience in both developed and less developed countries suggests that the strength of provider interests, often supported by newspaper and broadcast media that are more likely to focus on individual than community interests, can present a major obstacle to making health systems more responsive to societal needs.

There is much that needs to be done to improve the functioning of public bureaucracies. This analysis has pointed in particular to the importance and relative neglect of government budgetary, disbursement, accounting and auditing systems. However, health sector reform is not a sequential process. Improvements in the functioning of the public
sector and civil service systems which govern the health sector will occur both in parallel with, and sometimes in response to, other aspects of institutional reform, such as increasing the role of private providers and increasing the autonomy of provider institutions.

Underlying this analysis is the understanding that there is no short cut to the reform of health systems in less developed countries - either through donor assistance or national efforts alone. Reformers in ministries of health will continue to have to strike a careful balance between taking on the do-able, whilst not disappointing the often ambitious expectations of the public and their political supporters.
REFERENCES


