Health sector reform deals with fundamental change processes in policies and institutional arrangements, usually guided by the government. A radical change is impossible without realistic and robust political leadership and sound scientific evidence. Experience of many countries suggests that the success of reforms lies in how the process is applied and by whom, rather than how the contents are formulated. Sustained information and education on health sector reform are needed to generate wider political and public understanding and support. Continuous monitoring and review of health systems development are required. Research support is required to provide valid scientific evidence for strengthening the processes and mechanisms of health sector reform.
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1. INTRODUCTION

Health sector reform is a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. It designs to improve the functioning and performance of the health sector and ultimately the health status of the people.

Health sector reform deals with equity, efficiency, quality, and financing and also defines the priorities, refines the policies and reforms the institutions through which policies are implemented.

The health sector is basically a network of relationships between key institutional components of the health system of a country. These key institutions can simply be classified as: (a) State or government institutions such as Ministry of Health and its subsidiary public institutions responsible for national health development; (b) health care providers in public, private, NGO and traditional sectors; (c) resource institutions such as training institutions and research centres; (d) purchasers of health care such as insurance funds, health authorities or health maintenance organizations; (e) other sectoral agencies and the socioeconomic and political environment; (f) organized interest groups such as professional associations, consumer groups, health industries including pharmaceutical industries; and (g) the population at large who can either produce health benefits through individual or collective action, or purchase health care. Various extrinsic and intrinsic factors facilitating and hindering the interaction of such relationships are major domains of health sector reform. When one considers health sector reform, new forms of relationships are developed to make complex changes and improve interactions among various components of the health system.

Whether developed, developing or least developed countries, an increasing number of them has introduced health sector reforms. Recent experiences in both developed and developing countries have shown that health sector reforms are highly political and fiercely contested processes. The reforms are more complex especially in developing countries due to the presence of a wide range of contracting partners, including donor agencies.

In most cases, the call for health sector reform is voiced more from outside of the countries than from within. And, the economic pressure on the governments, specifically on account of the health sector, has forced them to initiate a series of reforms within and beyond the health sector. The overall aim of all these reforms is to improve equity, efficiency and quality of health care. Most reform measures are meant to ensure that an appropriate share of public funds (overall government expenditure) is spent on health care, or there is an equitable distribution of public health expenditure across all levels of health care, or there
is an appropriate mix of public and private spending in health development (i.e. *allocative efficiency*). The users have to be satisfied with both the form and content of health services offered (i.e. *improved health status and client satisfaction*); and the benefits of publicly-funded health care (including preventive health interventions) are also equitably distributed (i.e. *improved equity of access to care*).

These health sector reforms vary according to social, economic and political environments of each country as well as the development stage of its health care system. As stated earlier, health sector reform implies a sustained process of fundamental and purposive changes in which the government plays a key role. The fundamental change is designed to improve health policy orientation, organization and management of health systems and their support environment. The process of change in most cases extends beyond a redefinition of policy objectives. However, in some countries, reform of the health sector is more incremental or evolutionary.

Health sector reforms have been affected by a multiplicity of factors. These varied in a combination of options of reform measures and the reliance on multidisciplinary tasks. The reforms also carry the risk of deviating from the original objectives and values of the health system, i.e. equity, efficiency, quality. Thus, the reforms demand an explicit link between policy-makers and decision-makers, planners, economists and researchers. Efforts have been made to ensure optimal use of the research findings on health reforms. While every reform experience is country-specific and is usually based on solid evidence, there are important lessons to be learnt by comparing the options, identifying the common issues addressed and the tools used and evaluating the effects of various reform initiatives.

2. EXPERIENCE ON HEALTH SECTOR REFORM

The experience of the countries of the South-East Asia Region or elsewhere shows that there is no universal package of measures which has been consistently applied for health sector reform in each country. Reform in most cases is usually provoked by drastic political and economic changes (macro-contextual factors), or by the arrival of a completely new administration, rather than by the need for change due to an overburden of diseases or dysfunctionality of the health system.

The content of the reform is not only complex by itself but the process of change is proceeding at a rapid rate in many countries. Most countries usually pay attention to the content of the reform, rather than to the process. This focus on content runs the risk of equating health sector reform with only one set of prescriptions such as the introduction of market mechanisms, user-charges, reducing the size of the public sector, cost-containment and redistribution of resources. These changes often ignore the question of feasibility of implementation.

An increasing understanding of the issues involved in the reform process is necessary to complement what has been learned about the content of reforms. Experiences with drug sector reforms in various countries showed that though the reforms were perfectly consistent in terms of content, they failed because of the opposition by professional bodies such as the medical profession and the pressure groups of the drug industry. Official policies to promote the use of generic drugs have not succeeded in some countries due to opposition from professional and industrial groups. Greater attention to the process of reform improves the chances of success in implementing the content. An
understanding of the relationship between the content and process of reform can lead to the development of appropriate government strategies for publicizing or marketing reforms in order to overcome the negative reactions of the organized interest groups.

2.1 Reforms in policy and organization, including health care financing

In most countries of the Region, health sector reform starts from the Ministries of Health with the aim of effecting a deliberate change in the health policy of the government to improve its performance in the health sector. These efforts at reform ensure the strengthening of health policy and planning functions, making organizational changes, introducing new management policies and practices, defining national, provincial and local-level disease priorities, setting standards for provision of health care, developing appropriate systems for monitoring performance (including quality assurance initiatives) and introducing effective health interventions.

Most countries have made efforts to reorient and restructure the Ministries of Health. Bhutan, Indonesia, Nepal and Sri Lanka have attempted to make their Ministries of Health smaller and less hierarchical within the framework of the Government's decentralization efforts. India, Indonesia, Myanmar, Sri Lanka and Thailand to some extent, have tried to separate the functions of service provision and service financing to bring about better performance through competitive measures (e.g. service contracting, autonomous hospitals, functional grouping of institutions, integrating central health budget, setting up management boards at large public hospitals, joint ventures, etc.). Most countries have carried out reforms in human resources by shifting the emphasis from technical and medical training to training in management, finance and planning. In some cases, legislation has been introduced to regulate production and deployment of various categories of health workers, including medical professionals. Examples are: the new Health Act of Nepal to ensure that medical professionals are available in isolated areas; large-scale contracting of village midwives and other categories of health workers in Indonesia, and compulsory employment of medical doctors and regional allotment for selection of health workers for training in Myanmar. Except in a few countries, experiences in most cases in these areas of reform have not been well documented.

During the last two decades, SEAR countries have witnessed major changes in their political and economic situations, with consequential impact on the health status of the populations. The general trend in the Region has moved towards a more democratic form of government, dismantling in the process rigid central planning and controlled economic system, and pursuing economic and development policies based on a free-market approach and decentralization. Globalization, trade liberalization and technological advances have provided vast opportunities for economic and social growth in most countries. Some countries in the Region have enjoyed relatively long periods of political stability and sustainable economic growth.

On the other hand, the prospect of the flow of international financial resources is not bright in a world short of investment capital, and new and ever-increasing competing demands to finance countries in economic transition. If the defence spending in the countries of the Region is reduced, there might be some diversion of funds to the social sectors including health. Structural adjustments in the policies of the countries might also force a much tighter control over the expenditure for health and social services. Any social dividend would therefore be won in a hard way.
However, evidence indicates that countries such as Myanmar and Sri Lanka, and some states in India which have low levels of per capita income, could achieve remarkable success in health and human development (higher life expectancy, better health care coverage and high literacy). These successes have been achieved through persistent policy actions with greater emphasis on equity, efficiency, quality of care, social development and community involvement.

Table 1: Total health expenditure of selected SEAR countries, 1990

<table>
<thead>
<tr>
<th>Country</th>
<th>As percentage of GDP</th>
<th>Per capita (US$-1990)</th>
<th>Public expenditure as percentage of total</th>
<th>Private expenditure as percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>3.19</td>
<td>6</td>
<td>24.8</td>
<td>56.7</td>
</tr>
<tr>
<td>Bhutan</td>
<td>5.05</td>
<td>10</td>
<td>41.1</td>
<td>30.4</td>
</tr>
<tr>
<td>India</td>
<td>8.00</td>
<td>21</td>
<td>20.0</td>
<td>78.4</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.01</td>
<td>12</td>
<td>25.6</td>
<td>66.7</td>
</tr>
<tr>
<td>Nepal</td>
<td>4.54</td>
<td>7</td>
<td>23.0</td>
<td>51.7</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3.74</td>
<td>18</td>
<td>40.4</td>
<td>51.1</td>
</tr>
<tr>
<td>Thailand</td>
<td>4.98</td>
<td>72</td>
<td>20.4</td>
<td>78.7</td>
</tr>
</tbody>
</table>


When investment in the health sector is analysed, the total health expenditure in most countries is around 2-6 per cent of their GDPs. (Table 1) Most of this expenditure comes from the private out-of-pocket source. Public expenditure in Bhutan and Sri Lanka exceeds 40 per cent while other countries have a higher percentage of private expenditure in health, which ranges from 50 to 80 per cent, depending on the growth of the private health care system. Recognition of the limitations of the governments in financing health care from public sources was probably the major lesson of the last two decades. Of the 2-6 per cent of the national GDP spent on health, many countries are spending less than 60 per cent on local health care.

A worldwide study on external assistance to the health sector during 1972 to 1990 (C. Michaud & C.J.L. Murray, Bulletin of World Health Organization, 1994) shows that the smaller and poorer countries received more external assistance in the health sector than the larger and richer countries. Around 20-30 per cent of the total health expenditure of least developed countries such as Bangladesh, Bhutan and Nepal, was financed externally (Table 2).

An analysis of national health accounts of various countries also shows the policy and macroeconomic environment within which the health sector operates. These national health accounts describe explicitly where the funds come from and how they are used.
Table 2: External assistance to health sector in selected countries, 1990

<table>
<thead>
<tr>
<th>Country</th>
<th>Health sector assistance (in US$ mill.)</th>
<th>Per capita (US$)</th>
<th>As percentage of GDP</th>
<th>As percentage of total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>286</td>
<td>0.3</td>
<td>0.10</td>
<td>1.6</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>128</td>
<td>1.2</td>
<td>0.59</td>
<td>18.5</td>
</tr>
<tr>
<td>Bhutan</td>
<td>4</td>
<td>2.9</td>
<td>1.44</td>
<td>28.5</td>
</tr>
<tr>
<td>Indonesia</td>
<td>159</td>
<td>0.9</td>
<td>0.15</td>
<td>7.7</td>
</tr>
<tr>
<td>Nepal</td>
<td>33</td>
<td>1.8</td>
<td>1.15</td>
<td>25.4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>26</td>
<td>1.5</td>
<td>0.32</td>
<td>8.6</td>
</tr>
<tr>
<td>Thailand</td>
<td>36</td>
<td>0.7</td>
<td>0.05</td>
<td>0.9</td>
</tr>
</tbody>
</table>


In Sri Lanka (Table 3), health expenditures are almost equal both in the public and private sectors. The public expenditure mainly comes from public subsidies, and majority of this money goes to hospitals. The private sector spends nothing on public health and prevention.

Table 3: National health account for Sri Lanka, 1991 (percentage of total expenditures)

<table>
<thead>
<tr>
<th>Uses of Funds (Expenditures)</th>
<th>Source of Funds</th>
<th>Source of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public subsidies</td>
<td>Employers</td>
</tr>
<tr>
<td>Public expenditures</td>
<td>47.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>36.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Primary care</td>
<td>10.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Private expenditure</td>
<td>0.0%</td>
<td>0.75%</td>
</tr>
<tr>
<td>Providers</td>
<td>0.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Drugs</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>All uses</td>
<td>47.0%</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

Source: Rannan-Eliya and de Mel, 1996

An analysis of the national health account in Nepal shows that, for the financial year 1994-95, the total health expenditure amounted to Rs 11.2 billion, which is equivalent to 5.3 per cent of its GDP or US$ 11.2 per capita. Out of this expenditure, 72 per cent came from private out-of-pocket payments, 16 per cent from international donors, 10 per cent from the Government and the rest from other sources. Of the total money spent on health, 82 per cent was used by hospitals and clinics and 13 per cent on preventive health care.

In India, around one-fifth of the total expenditure is financed out of public subsidies. Almost half of public subsidies are spent on curative care. Only 9 per cent of the total expenditure goes to public health and preventive care. Insurance contributes relatively little. Large investments in health care, such as safe motherhood and child survival programmes, control of leprosy and tuberculosis and expansion of primary eye care have been made through loans from the World Bank. Such large-scale programmes are implemented through
nongovernmental institutions rather than public facilities. There are attempts to undertake joint venture schemes for the expansion or improvement of hospital care.

The national health account provides an opportunity for the government to review policy options: how can and should they allocate public subsidies? What should be the level of public and private expenditures? How can the private resources be mobilized for public expenditure? A careful analysis could be made as to what types of financing strategies are to be adopted, e.g. mobilizing financial resources from within the health sector, outside the health sector or improving the use of existing resources.

Most countries have introduced various financing reforms. These include: cost-recovery and cost-sharing schemes, user fees or charges, community financing, health card or voucher system, subsidized payment scheme, contracting services, social insurance scheme, and private insurance. The purpose is to ensure equitable access to efficient and effective health care. An appropriate mix of private and public health care financing mechanisms is established, the two sectors complementing each other to yield the best results. Most countries have concentrated on the content of reforms in health care financing rather than on the processes that may relate to reforms in the organizational and institutional structures.

In Maldives, the health care system is mainly financed through public sources. The Government has invested a higher percentage of its GDP for health care. After the establishment of the new IGM Hospital in the capital city of Male and a large number of private health institutions including a private hospital and pharmacies in the capital and other islands, the situation of health care financing has changed. A system of user-charges has been introduced at the IGM Hospital since its inception. The Ministry of Health is in the process of formulating a policy to address issues of service utilization and cost recovery.

In order to protect poor families, family card/health card schemes have been introduced in Indonesia, Myanmar and Thailand. Public-private joint venture initiatives for expansion of hospital care have been undertaken in Myanmar and Nepal and in some states in India. Major investments by international and national private corporations in hospital care and diagnostic centres have been initiated in India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand.

Indonesia has initiated a series of policy and system reforms for speeding up health development. These include enactment of a new and more comprehensive Health Act (No.23) in 1992, establishment of prepaid, managed care known as Community Health Maintenance Assurance (JPKM) and dana sehat, providing free care for the poor by katu sehat or health card scheme, creating self-managed or autonomous hospitals (Swadana hospitals), increasing private investment in health care and improving health insurance coverage. A series of research and development activities have been carried out, usually with largely external inputs. During the last decade, around US $ 1.4 billion has been invested to support health sector development.

Most countries in the Region have introduced various kinds of user-charges at public health facilities in order to lesson the burden on public expenditure. Considerable amount of evidence has been gathered 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 not sufficient to explain the effects of the fee system on these objectives. Managerial, organizational and quality factors are the central determinants of the impact of this policy reform. There is also evidence of the danger
that direct contribution of users to health financing leads to new cuts in national health budgets.

India, Nepal, Myanmar, Sri Lanka and Thailand have also introduced some form of social health insurance. The coverage of such health insurance schemes in most cases is limited to the employed sector (industrial and manual labour and government employees). Privately-provided health insurance is not uncommon in Bangladesh, India, Indonesia, Nepal, Myanmar, Sri Lanka and Thailand. An increasing number of private companies are now seeking health insurance for their employees. Individuals with resources seek insurance as a way to finance a higher quality of health care. This increase in health insurance coverage is not a goal of the health sector reform, but it can be an important means for making progress towards the goal of equity, efficiency and sustainability. Conversely, it can also result in the health systems moving away from these goals. The success of health insurance in achieving health reform goals is closely related to its peculiar institutional characteristics and managerial capability. Specific institutional arrangements of insurance, whether it is social insurance, social security, commercial insurance or community prepayment scheme, will vary across countries. However, governments must remain engaged in providing sufficient financial support in order to ensure that the part of population, which cannot afford to fully finance their own health insurance, is protected. WHO is undertaking a global study on rural risk sharing schemes, and the information thus gathered may highlight how governments could ensure that the vast rural populations in most countries are insured in an efficient manner.

The promotion of competition, either between providers or, more rarely, between financiers of health care, has been used as a strategy for financing reform programmes currently being carried out in industrialized countries. The use of government funds to buy clinical or non-clinical services from private providers is a strategy generally 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 a strategy 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 competitive approach has been introduced in a few countries of the Region.

Many countries have promoted or are in the process of promoting privatization in the health sector with or without the active participation of health ministries. Some countries have attempted to reduce public sector's 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 sector to abandon its role as providers of health services and concentrate instead on its normative and regulatory role has not always been accompanied by the strengthening of the normative mechanisms of the Ministries of Health. More research is required on what capacities, skills and information systems governments must acquire to play an expanded regulatory role.

Thailand's health care expenditure has been increased from around 4 per cent in 1980 to 6 per cent of the GDP in 1990. Private out-of-pocket money is the major source of finance. It is expected that the total health expenditure will be 8 per cent of the GDP by 2000, and the per capita expenditure will increase threefold. Coverage of health care of any form has increased from around 30 per cent in 1990 to 70 per cent in 1995. Health policy reform and health sector reform carried out in Thailand aim for more equitable health care and financing, and efficient health care delivery systems.
While recognizing the advantage of involving the private sector and consumers in future policy-making and regulatory processes, governments and especially the Ministries of Health need to be proactive in dealing with issues that might adversely affect the underprivileged segments of population. The public-private mix in health care provision or financing is complex in terms of policy and organizational issues. However, governments have to recognize the complementarity and need for partnership between the public and private sectors. **The Ministries of Health should improve and strengthen their capacities to study and explore alternative sources of financing of health care.** They should introduce appropriate reform measures for an optimal mix of public and private health care to ensure quality of services and accept social responsibility for the protection of consumers, especially the underprivileged.

The underprivileged populations need the greatest amount of health care. Improvement in the health status of these groups is possible only when the most cost-effective and efficient actions of primary health care are targeted to those most at risk or most in need. An optimal allocation of health resources thus involves a large share of expenditure for community-based health care.

Policy reforms in the area of health care financing are related to the organization and management of health systems. Thus, 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.

All countries of the Region are seriously concerned about the resource constraint which is adversely affecting their health programmes. Attention to the financing of health care goes beyond the search for additional resources. Whatever the shape of the reforms envisaged, the following are the common objectives of all these initiatives: (a) less financial burden on State funds resulting in more funds becoming available for health care; (b) change in the behaviour of the consumer becoming increasingly aware of the actual cost of care and quality considerations, and (c) improvement in the quality and coverage of health care.

### 2.2 Reforms for improving health care delivery

Most countries have introduced reforms in their health care delivery systems. These reforms include: deployment of a large number of health volunteers or partially-paid community workers for providing essential health care; change in the role of peripheral health workers from single purpose to multipurpose; expansion and deployment of new categories of health workers; reforming the mix or composition of health staff in hospitals and health centres at the district level and below; improving the efficiency of distribution and use of essential drugs; improving staff control and deployment through incentives and an increased role of private-profit and non-profit organizations and community facilities for health care. Integration of health care delivery to arrest the fragmentation of health care at the primary level is the major effort at change in most countries. A large number of existing health staff has been trained or retrained in new interventions, managerial skills and educational methods. Although the medical education system has been reoriented for community approaches, this may require further strengthening in most countries.

In strengthening district health systems, too, little attention has been given to the relationship of primary health care activities at the basic health centres and those of first and intermediate referral levels (i.e. rural and district hospitals). The linkage of health care at the
first level of community’s contact with other levels of the health system is important because of their ability to provide life-saving specialized care. Another dichotomy in the health systems in some countries is investment of a high amount of resources in the development of hospital-based care for some, at the cost of community-based care for many. 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 a balance and a firm policy-related budgeting, are required.

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 are being witnessed at districts which put into practice what is known as ‘decentralized management’. Much of the so-called management training cannot meet the practical needs: competence of middle-level health managers has largely been enhanced through actual experience of learning-by-doing and application of appropriate methodologies and technologies in real-life situations. Some of the innovations and concerted efforts of reform have not only won worldwide recognition but have also received several international prizes (e.g. Sasakawa Health Prize, HFA Medal, World No-Tobacco Day Award, Darling Foundation Award and Leon Bernard Foundation Award).

Health care coverage, with the essential elements of primary health care such as access to safe water supply and sanitation, immunization against six immunizable diseases, attendance by trained personnel during pregnancy and child-birth and availability of essential drugs, has clearly made progress during the last two decades. Immunization coverage of children under five years with DPT, BCG, measles and polio vaccines has been sustained above 80 per cent over the last few years. Immunization for polio especially has been maintained at a high level due to national immunization days as part of an all-out effort to eradicate polio in the Region.

However, in some countries the situation is quite different. Most of the coverage for essential health care remains at low levels. The trend for further expansion of health care coverage in these countries, especially in the least developed ones, is not encouraging due to factors which are beyond control. First, the external and internal resources for health infrastructure expansion may be limited, and, second, the most needy groups of population (20-30 per cent) may be hard to reach for any essential health care for economic or geographical reasons.

The Alma-Ata Declaration had proclaimed that primary health care included a minimum range of essential health care to be provided by health systems. This minimum range of eight essential elements is often grabbed by the advocates of selective health care. During the last two decades the core PHC elements and their scope at the first level of contact expanded in a much broader way in many countries. The 1993 World Development Report argued about the importance of adopting essential clinical and public health packages. Most countries, while formulating national health plans, tried to link economic investment in health with a core set of essential health care packages. These packages such as the Mother-Baby package, Integrated Management of Sick Child, Safe Motherhood and EPI-plus are 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 whole person rather than on single-disease condition.
The original core set of eight elements of primary health care has to be reviewed in the light of social, political, economic and epidemiological conditions and the stages of development of the health system. It is not the number of PHC elements that should matter in deciding what an essential health package should contain. What is of importance is the quality, accessibility and affordability of health care provided through these essential elements, either separately or together. Each country may need to look at which type of essential public health packages should be available at different levels of health systems and which are the ones which are universally acceptable, affordable and are of appropriate technology.

The debate on the two health care approaches, i.e. selective (vertical) vs. integrated health care, will continue for some more time. The situation is so complex that issues related to the organization of integrated health care should not be over-simplified. It has to be judged according to direct operational consequences. Some technologies such as immunization, oral rehydration, multi-drug therapy and fortification or supplementation of micronutrients are well established for the prevention and control of communicable and noncommunicable diseases. These health care interventions have been packaged in selective or integrated health care programmes. Selective programmes using campaign approaches such as national immunization days or mopping-up vaccination against polio, mass education, deworming and supply of iodized salt are used for prevention and control of priority diseases or micronutrient deficiencies. Specific problem-reduction targets have been set for such programmes, and special national programmes are being launched which would require considerable resource inputs to reach those targets.

The basic fact is whether selective health programmes merely use a passive health infrastructure or the health infrastructure adopts the selective programmes as an essential intrinsic function. The choice is never completely free. Many of the selective programmes, upon close examination, show that although the technology and programming have been selective and meticulous, the actual performance and achievement of targets depended upon such critical elements as community involvement, decentralization, education and information and 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 and protecting the technical quality of specialized and selective services.

Despite these reform initiatives, 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 programmes. The quality, quantity and balance of human resources for health are the main concerns of most countries. There are shortages in most categories of health personnel in some countries (Bhutan, Maldives, Indonesia and Nepal). Other countries (Bangladesh, India, Myanmar and Thailand) have sufficient or excess numbers of doctors but are short in other categories of health personnel. The shortage of nursing and midwifery personnel in most countries is one of the reasons for high maternal mortality and low accessibility to care during pregnancy and childbirth. Another dimension in the field of human resources is the imbalance in their deployment between rural and urban areas. A significant emerging factor, which may further aggravate this imbalance, is the increasing competition between the public and private sectors.

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. Countries have
successfully learned this principle through various innovations. Almost all countries consider community action for health as not only a political necessity but also an important and effective mechanism for planning, implementation and evaluation of health development at 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 for health and social development programmes by all countries in the Region. The Village Community Health Development Programme of the 1970s and the Integrated Health Package Programme (Pos Pelayanan Terpadu or POSYANDU) of the 1980s and 1990s in Indonesia; the Village Health Volunteer Scheme, Technical Cooperation Among Villages, and the Integrated Basic Minimum Needs programme of the 1980s in Thailand; the Community Health Care Programme, utilizing a large force of health volunteers of the Myanmar in the 1980s; and the Atoll team problem-solving during the 1990s in Maldives were some of the major national health development initiatives taken by countries, using community action for health as a strategic intervention.

Experience in the Region shows that the conventional approach of extending health care delivery has proved inadequate. **At present, it is proving economically impossible to bear the cost of full extension and expansion of the public sector health services to the entire population.** It is important to expand and strengthen the roles of individuals, families and communities in the promotion and protection of health. In many of the national health programmes, this approach has not yet been encouraged much. The conventional (allopathy-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 be developed further in order to complement the expanding (allopathy-based) health care systems. Since health needs are not always perceived and are not automatically translated into demand, the health care system must assist people to recognize their health needs and convert these into health demands, or encourage action for self-care where appropriate.

**Successful efforts to develop health systems are the result of:** (a) continuous and sustained political, social and financial commitment of successive governments; (b) strong management capabilities for implementation; (c) well-oriented, trained and committed health administrators, professionals and workers; (d) effective decentralization of administrative and technical decisions and responsibility; (e) increasing community action for health; (f) widespread deployment of affordable health protecting and life-saving technologies, and (g) sustained financing of development programmes.

Social mobilization forms 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 the real players in the partnership for development. Being in the role of change-agents, prime movers and HFA leaders among the community, the people are becoming more prominent as they help to remove obstacles and facilitate the development of action programmes which promote self-confidence, generate income and encourage participation. Careful attention should be given to leadership development, aimed at enhancing the ability and effectiveness of present and future leaders at all levels. Leadership development should be viewed as a participatory process, be people-centred and issue-oriented.
2.3 Reforms beyond the health sector

The usual focus of reform by governments, and, more particularly, by donors, has been the overall size of the civil service, including that in the health sector. Reducing the number of staff, introducing new pay scales and grading schemes, separating political and executive functions and decentralization and privatization efforts are a few examples of civil service reforms introduced in most countries of the world, including by those in the South East Asia Region.

Decentralization in the civil service has been the most common type of reform in the Region. Decentralization usually implies "the transfer of authority, or dispersal of power, in public planning, management and decision-making from the national level to the sub-national level, or, more generally, from higher to lower levels of government." It has three main distinct processes. For instance, Bhutan, India, Indonesia and Sri Lanka have made provisions under the constitutional arrangement for devolution of authority and responsibility from central government to local government agencies in political and administrative areas. Thus, their state or provincial governments are responsible for regional development and budgeting, including health and other social sectors. Some countries have taken legislative and other regulatory measures to deconcentrate government functions from higher to lower levels within the administrative apparatus (e.g. responsibility for managing health resources, deployment of human resources, managing hospitals and health centres). Some countries have delegated the responsibility and functions of central government units to more autonomous and/or specialized types of government agencies or specialized functional agencies, or the parastatals (e.g. establishment of national health research institutes, national nutrition centres and research and training institutes). In some cases, decentralization also refers to the transfer of functions from government to nongovernmental organizations, including private for-profit enterprises and NGOs in the established sense of the term.

Efforts in decentralization imply 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 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 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. This example points out that policies on decentralization of various functions or responsibilities or authorities are policy tools rather than mere policy objectives. Each country has to consider or identify an appropriate mix of centralized and decentralized functions, responsibilities and authorities, to meet the policy and participatory objectives. The issue of decentralization cannot, therefore, be viewed by Ministries of Health in isolation from any overall reform of the civil service a country may be undertaking.

With increasing participation of other sectors and agencies, including communities, in undertaking 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 the HFA strategies were adopted, intersectoral action and community action for health have been recognized as major strategies for health development.
However, some major constraints have made implementation of reforms difficult. Examples of problems, especially those deterring the forging of partnerships, are: (a) sustaining political commitment and its translation into operational means; (b) lack of common understanding of a 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 support of research to provide information on the impact of public policies on health.

There is no doubt that many sectoral development programmes, in addition to those directly carried out through the health sector, can contribute to health development. There are numerous examples of such programmes as: raising the status of women; educating people on health promotion and protection including school health education; promoting no-tobacco or no-alcohol lifestyle; having proper nutrition; empowering women for health and development; initiating poverty reduction; etc. What is more important is how the health sector should maintain its leadership role in such partnerships. It may not be enough to indicate what others can do for health, but to indicate as well what the health sector can do for others. Health sector reforms should foster new partnerships and strengthen existing partnerships in order to create health as the central theme for development, that is, affirm its true centrality to development.

With open-market approaches adopted by many countries of the Region, and the globalization of international trade, there is a growing concern on the part of health decision-makers with regard to the impact of international trade on health services. The current trade negotiations have given importance to opportunities for the 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 etc. including resource allocation.

Countries should therefore be aware of the impact of increased international trade in health services. They should also take full advantage of the potential benefits which can arise from agreements on regional cooperation, such as ASEAN, SAARC and APEC, or from general agreement on trade in services (GATS) as far as the international health care market is concerned.

The countries of the Region have varying experiences in international trade in health care. And, there is scanty information on international trade in health care. There is a need to review the current situation in the Region and to define the main issues so that an appropriate policy could be developed for better regional technical cooperation.

3. STRATEGIC SUPPORT FOR CHANGE

3.1 Capacity-building

One of the preconditions for reforms to be successful is national capacity to plan and manage change. The focus of capacity-building lies on the network of relationships between key institutional components of the health system. Most of the donor-assisted programmes address this well-known need for capacity-building. Since health sector reforms deal with the changing pattern of relationship between key institutions of the health system, the capacity-building also addresses the same domain. Capacity-building implies improving the
capability of individuals or groups of staff to perform a task or a group of tasks. It goes beyond training and development of human resources. Capacity-building incorporates many other elements which may overlap with institutional development. Thus, it also deals with improving or increasing the capacity to create and manage institutional mechanisms and processes. Human resource development and institutional strengthening are complementary and mutually reinforcing.

The pace of capacity-building is accelerated by repeated application of knowledge, skills and gaining of experience. A major constraint in capacity-building is the tendency to focus on the general assumption that policy and programme development are the concern of governments, and it is the latter who should be equipped for the task. This assumption, while true to some extent, overlooks important opportunities for capacity-building outside government structures. Many governments in South-East Asia create a planning department or unit (or something close to it) in Ministries of Health, or develop an institute, whose output and advice is sought by policy-makers.

In some countries, in order to have more dynamism and creativity, autonomous institutions and/or centres for strategic studies, public policy analysis or research and development have been established as free-standing entities. They may be part of academic institutions or even private sector organizations. These institutions have greater flexibility and provide good compensation and incentives, making it easier to attract and retain competent professionals.

3.2 Promotion of research for health sector reform

Health sector reform is itself a researchable issue. The research can be a proactive, prospective or retrospective activity. It contributes to overall health development within the ambit of dynamic socioeconomic and political changes which affect the health sector. Health policy analysis, both at macro and micro levels, also provide invaluable inputs to health sector reform. The main issue of research for health sector reform is more concerned with outcome orientation. The emphasis is on exploring options in consideration of all possible consequences of a given reform (including policy changes) to accomplish the goals and objectives of health development.

The researchable issues are to be identified from the gaps between the desired situation (equity, efficiency, quality and consumer satisfaction) and what is happening or supposed to be happening. It is vitally important to monitor and evaluate the processes of change.

Research for health sector reform is aimed at: (i) strengthening the relevance, coordination and contribution of health research related to health sector reforms; (ii) achieving greater access to health care for the underprivileged; (iii) obtaining both provider and consumer satisfaction, and (iv) establishing greater efficiency and effectiveness of health systems so as to promote the highest level of health status compatible with limited available resources. The whole process of research has to be closely knitted in an integrated manner by policy-makers and researchers requiring greater understanding of each other's work and its natural limitations. The scale and extent of in-depth analysis involved in the research process will depend on the urgency and importance of the identified areas of reform on the identification of researchable questions, and on the capacity available.
In most cases, research for health sector reform is conducted in situations where there is a likelihood of the results being obtained within a reasonable period of time so as to produce sustainable action in a most cost-effective manner. Political pressure and economic demands are major factors influencing research initiatives.

Various scientific methods could be used, e.g. conceptual research for development of policy framework; use of strategic analytical tools such as SWOT analysis; stake-holder analysis, resource analysis; priority settings; epidemiological methods; futures analysis, and various approaches such as rapid approach, operational research, economics and management models. The type of research required for health sector reform could be categorized as: **health policy analysis or research** (identification of health policy options, analysis of the implications of public policies on health, impact of reforms on the poor and the underprivileged); **health systems research** (research on policy and equity issues of the system); **health economics research** (economic studies on efficiency issues - priority-setting and cost-effectiveness/efficiency); **organizational and management studies** (on technical efficiency issues - productivity and quality of care); and **development studies** (those studies which deal with developmental issues – scientific research, technology assessment, human development and information systems). Each of these, or in combination, facilitate the identification of issues, factors, processes and outcomes of health sector reforms. The degree of importance to be accorded to each discipline depends upon the nature of the problem at hand. *(The above examples are illustrative and not exhaustive. In many cases, health systems research may deal with issue of operational or economic efficiency, and, similarly, economic research may focus on behavioural aspects or equity and technical efficiency).*

In the process of health sector reform, it is essential that reform initiatives include health policy and health systems research as an integral part of the reform agenda. Policy and organizational changes, managerial reorientation of Ministries of Health and their related sectors (institutional reforms), as mentioned above, are a means to an end.

Although there is a growing volume of literature which describes financial and organizational reforms in developing countries, there is a conspicuous dearth of evaluations of reforms or of attempts at reform. The development of health policy analysis and health systems research lags far behind epidemiological, demographic and economic research. Thus, continuous and simultaneous monitoring, review and research on health systems are necessary to keep track of changes and make appropriate improvements. It is also necessary to keep a track of health policy objectives which institutional reform of the health system is designed to achieve, such as improved efficiency and equity, more responsive services, and, ultimately, better health outcomes. The understanding of the consequences of reforms on health sector finance and organization has expanded tremendously over the years. But, there is still much more to be learned. **There is a need for better systems and methods that would enable planners to analyse different approaches to policy and institutional changes in the health sector.**

### 3.3 Exchange of information and learning by doing

All countries in the Region have provided documentary evidence of the steady progress made with various reform initiatives. This is especially so with regard to health care financing reforms. In addition, important insights have emerged with respect to the content of the health sector reform. One of the insights has been that there are many advantages of a strong linkage between the decision-making processes and research and development.
processes. Certain core values and operational principles have surfaced, such as equity, efficiency, effectiveness and quality. Consumers' choice and rights have to be protected.

There are ample examples of the mechanisms and processes to promote research for health sector reforms at national, regional and global levels. In each country, 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 Advisory Committee on Health Research (ACHR) of WHO and regular meetings of regional medical research councils and analogous bodies, which provide policy guidance and coordination. However, it is also recognized there are gaps between the production of research studies and the use of these products in policy formulation and decision-making processes. Some countries had attempted to make use of research results in decision-making by involving decision-makers at the start of research and for advocacy of results, including informing the consumers.

It is also recognized that the resource 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-makers and decision-makers.

It has also to be realized there is a need to document various reform initiatives. At least at the initial stage, a critical comparative review of health systems development of the countries of the Region has to be conducted using a common framework. There is a need to develop an appropriate country protocol or profile format so that the countries of the Region can make systematic records of health sector reform initiatives. This would further facilitate the processes of reform as well as identification of research agenda. At the same time, it will enable them to make critical reviews and comparative analysis. Health systems research and other forms of research studies will provide scientific evidence to strengthen the processes and mechanisms for health sector reform.

An appropriate regional forum on health sector reform needs to be established. This may consist of senior public health specialists and experienced researchers, who are involved in policy formulation and research management. The forum would serve to share and exchange information on health policy and health sector reform. It is proposed to review and facilitate reform processes and related research agenda in the countries of the Region. It could also review and analyse the tools and methods available and advise on the application of these tools and methods.

3.4 Role of WHO and international agencies

WHO, through its various collaborative programmes at all levels, involves itself in capacity-building. This includes institutional strengthening in order to promote expertise and properly manage reform in the health sector.

In order to support the health sector reform, a series of publications, both at regional and global levels, have been issued. WHO, along with interested agencies and institutions, has established a Forum on health sector reform. This international forum is a group of experienced senior public health specialists, with common interest in health policy and health sector reforms, which meets regularly. The forum serves to share and disseminate information on the scope and nature of current and planned activities related to supporting the health sector reform; identify priority issues; 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 Member Countries.

As a follow-up of the WHO Regional Committee's discussions at its 48th session in
1995 on Alternative Financing of Health Care, WHO/SEARO organized an intercountry
consultative meeting on health care financing reforms in Bangkok in October 1995. This
meeting provided an opportunity to act as a forum for the involvement, right from the
beginning, of decision-makers and researchers of the countries of the Region in the
development and promotion of research in health care financing reforms. The research
studies proposed at this meeting were selected by policy-makers, with the aim of full
utilization of results.

Following the recommendation of the Ad Hoc Committee on Health Research, relating
to future intervention options, WHO, with support of other agencies in 1996, initiated global
research on "Health research and development for the poor: Health Sector Reform
initiatives". Nearly US$ 1 million was provided to researchers around the world to
undertake comparative research studies on health sector reform. A few countries of the
Region have participated in this initiative. The second round of these studies are now under
development.

The countries of the Region, being aware of the importance of the subject, decided, in
September 1996, that the subject of Health Sector Reform should be selected for technical
discussion at this session of the WHO Regional Committee. Two sessions of the WHO/SEA
Regional Advisory Committee on Health Research (ACHR), held in 1996 and 1997, also
discussed promotion of research in health sector reforms. The ACHR noted reforms
must not be undertaken without giving due consideration to issues relating to Health for All.
The ACHR was aware that policy-makers should be involved right from the beginning of
research and they should ensure that the results of such research were fully utilized. It had
further reviewed the promotion of research in health sector reform and requested Member
Countries to work together and with WHO in this regard.

WHO, in collaboration with the Health Research Institute and the Health Systems
Research Institute in Thailand, had organized a regional consultative meeting on Research
on Health Sector Reform, in Bangkok in February 1997. The meeting provided a valuable
opportunity to assess the progress the reform initiatives undertaken by Bangladesh, India,
Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand had made. The meeting also
served as a technical forum for sharing experiences of health sector reform from national,
regional and global perspectives.

WHO continues to provide technical and financial support to Member Countries for
research and development in the area of health sector reform. WHO works together with
Member States, WHO collaborating centres and 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 of clearing-house function in order to disseminate
information on research and development on health sector reform. It is also promoting the
work of other institutions, particularly WHO collaborating centres, which are also carrying out
similar clearing-house function. The existing and future informatics technology is appropriately
exploited for promoting the exchange of information.
Existing regional and global mechanisms such as ACHR, ASEAN Sub-Committee on Health and Nutrition, SAARC Health Committee and Health Focal Point for Non-aligned Movement, etc., should be used for advocating and sharing information on health sector reform. Such regional and global bodies should discuss research and development issues related to health sector reform.

4. CONCLUSION AND POINTS FOR CONSIDERATION

*Health sector reform* can be a highly political and fiercely contested process. Generally, reforms were initiated more due to external pressure on the health sector rather than any pressure from within. *Radical reform is impossible without a realistic and robust political leadership.* Reforms usually are of sustained processes of fundamental change in the context of health policy and health institutional arrangements. Reforms in the South-East Asia Region are mostly sequential, evolutionary or incremental processes, except a few fundamental changes introduced in some countries. The issue is: "Can the analysis of the political process of health sector reform be put on the research agenda so that more can be learned about managing change?"

Health sector reform starts with making changes in policy and organization of health systems including health care financing. Most countries may have concentrated more on the content of the reform rather than on the process. 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 to better understand the issue of "process" to complement what has been learned about the "content". Both are equally vital.

Improvements in the functioning of the public sector, including civil service systems, will occur in parallel with changes in the health sector. Sometimes, the changes in other sectors are more dynamic and progressive so that the health sector has to follow them. For example, increasing privatization and market liberalization have a domino effect on the health sector, which is required to make subsequent changes to meet the many challenges ahead.

Research might involve: (a) developing strategies for publicizing or marketing reforms to policy-makers, providers and the general population, and (b) identifying ways that governments can anticipate and plan to meet the reactions of the organized interest groups. A major research issue may be to deal with the political process - defining effective strategies for the political management of the reform process. More researchable questions need to be identified. Sustained information and education on health sector reforms are needed to generate a wider political and public understanding and support for the process.

In order to promote regional exchange of experience and information and to create a pool of expertise, there is an urgent need to establish a regional scientists' forum on health sector reform. This forum will provide an opportunity to review and share experiences about reform initiatives; develop tools and methodologies, and provide support for capacity-building. This regional forum should, as early as possible, look into the immediate issue of development of a common framework for review and analysis of health sector reform in each individual country. There is also a need to create a home-page on World Wide Web to provide information about SEAR countries. WHO and national authorities should work out the possibility of creating an appropriate home-page document and provide an update periodically.
The remaining issue is what are the most practical and sustainable national mechanisms to promote research on health sector reform, together with a built-in monitoring system and feedback on the outcome of research. It is agreed that countries of the Region have great experience in health sector reform. However, they must continue to debate on identifiable research issues relevant to the processes, content and mechanisms of health sector reform, and on ways of dealing with such issues. This is a long-term effort, but one which may contribute to lasting results.

Suggested further reading


