

Health Sector Reforms -- Measures, Muddles & Mires

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Public sector reforms for several decades have been premised on the assumption that improving the ability of government to manage its business will lead to improved social and economic progress. The 1997 World Bank Report describes a first generation of reforms in which steps were taken to cut government expenditures and to revive the private sector. Measures included budget cuts, tax reforms, limited privatization, liberalization of prices and, most conspicuously, efforts to downsize the public sector. The latter was almost invariably described as 'bloated' and therefore in need of surgery followed by a strictly enforced diet.

It soon became evident that the transformation of government would require a long period of time and that the savings from reduced bureaucratic costs would be insufficient to provide even basic levels of public services. A second generation of public sector reforms then sought to improve the efficiency and effectiveness of government. While the first generation reforms stressed downsizing, contracting out and improved control over budgeting and public expenditures, the second generation reforms advocated decentralization to sub-national levels, the creation of semi-autonomous agencies in the central government, and reforms of human resource management (recruitment, selection, training and performance).

More recently the agenda for reform has refocused yet again on improving the social outcomes and improving service delivery. This third-generation strategy has emphasized sector-wide approaches, particularly in health and education, in order to produce a coherent program for delivery of services that involves both governmental and non-governmental organizations.

These generations of reforms, of course, are overlapping rather than strictly sequential. But all reforms have been driven by a combination of external and internal agencies. Multilateral aid and bilateral aid often entail conditionalities that require a (commitment to) change in governmental behavior before money can be transferred. In turn, national planning commissions and ministries of finance require line agencies to adopt reforms that may include

a combination of these generations. The purposes of this chapter are to review the logic of New Public Management (NPM) in the health sector, to examine in more detail the reforms applied to the delivery of health services and to suggest strategies for reforming the health sector that take capacity into account. The chapter concludes with reflections on the emergent importance of the European Court of Justice for enforcing competitive approaches in the health sector throughout member states of the European Union.

Despite the rhetoric of increasing the role of the private sector and of ‘downsizing’ government, the private sector for the delivery of health care in developing countries is already extensive. Indeed, the private sector is often bigger than the public sector – but, due to ideological blinkers or ‘group think’, the private sector has not been acknowledged and therefore not measured, at least in public data sets. The private sector in health is also largely unregulated. Consequently, instead of ‘downsizing’ the number of staff as applied to the civil service, most of the NPM reforms found in the health sectors of developing countries emphasize internal reorganization of the public sector – particularly through decentralization.

There is a parallel with civil service reforms. In most cases, reforms in the health sector have been stimulated by economic recession and severe fiscal problems rather than by an ideologically driven taste for reform. Declining government budgets have adversely affected service delivery, even in those countries which previously had reasonably well performing systems for the public delivery of health services. Pressures for reform of health care often emanate from central ministries such as finance and planning. Ministries of Health then struggle to reinterpret and to respond to policy directives outside of their control. Creative leadership is required to initiate and sustain such reforms but the empirical track record has been erratic (Bossert *et al.* 1998; Nelson 2000).

Economic realities affect not only the types of policies that are implemented, but also the reaction to them by the users, beneficiaries and citizens. The stage of raising revenue through the introduction of user-fees in order to supplement government budgetary resources was critical for many governments because of the endemic economic crisis. But the success of the policy, no matter how logical in theory, was constrained by the dwindling capacity of the poor to pay for health care. And the transaction costs of administering the fee-system often exceed the revenue collected.

Public sector reforms range across streamlined budgets, staff reductions, raised tariffs, contracting out and other forms of privatization. Reform of the health sector has focused on

four main options, none of which is mutually exclusive, and all of which may occur at the same time. These are:

- the establishment of autonomous organizations;
- the introduction of user-fees;
- the contracting out of services; and
- the enablement and regulation of the private sector.

While such reforms have been widely espoused in international fora as well as by technical experts, their implementation has been much more limited. It is difficult to assess the real potential for NPM reforms in the health sector because such reforms have been either partial or only recently introduced. More time is needed for proper assessment, particularly because social inertia and institutional lethargy require time-frames measured in decades rather than in months or years. Frequently, however, and rather ironically, countries with the most radical reform agenda appear to be those with the least capacity to implement them – or, as Caiden and Wildavsky (1974) commented caustically about budgeting: the smaller the capacity, the greater the ambition, and vice-versa. Perniciously the depth of the economic recession in such contexts requires a radical approach in terms of policy pronouncements, yet economic recession reduces the ability to implement such a radical agenda.

Different types of capacity constraints have been identified, none of which is unusual. Human resource constraints in terms of the number of skilled staff available, and the motivation of staff to carry out their assigned tasks, are widely prevalent problems. Organizational culture often militates against effective operation of the new modes of government. In organizations that favor hierarchy and command over initiatives and team development, the autonomy formally granted to government entities may not be fully acted upon. While the New Public Management emphasizes the importance of linking performance to rewards, parallel informal systems often undermine the formal reward systems. For example, promotions are often made on the basis of patronage and favors in the traditional patrimonial system, rather than on objective assessments of performance. Key systems, such as management information systems, frequently fail to function effectively. Another significant barrier is the lack of incentives for individuals within the health care sector to plan or to monitor their work in terms of the information that is produced. In other words, there is almost no feedback system for self-correcting action.

A further sign of weak capacity is poor coordination among different actors. Governments experience great difficulty in translating their broad policy statements into concrete strategies

for implementation. As a consequence, there are problems in specifying and then enacting the details of decentralization policies. It is not clear, for example, as to the level of government at which financial rights and responsibilities lie. Likewise, it is not clear which organization should report which data to whom. These are all simple, but disastrous, problems in coordination.

Of course, some of the constraints on capacity just noted are actually rooted in the broader public sector rather than only within the Ministry of Health or similar agencies. This is particularly true of human resource management, but it also applies to other systems. Traditionally centralized financial control has undermined innovative reforms. For example, until recently, all the revenues generated from user-fees in Zimbabwe had to be returned to the Ministry of Finance – thus providing little incentive for their collection (Dlodlo 1995). Such a disincentive more or less ensured that, contrary to the expectations of NPM, such fees had zero impact upon the quality of health care.

In contrast, a fascinating case in Jaipur (capital of Rajasthan state in India) now allows local hospitals to keep the user-fees that they collect rather than returning them to the state treasury (Björkman and Mathur 2002). Not only do those hospitals have a better record for collection of fees, but also they re-invest the surplus in such long-term benefits as higher quality equipment, more reliable stocks of pharmaceuticals and other medical supplies, and even lower (or exempted) fees for the truly destitute. The Rajasthan case demonstrates rapid returns on the three classic criteria for health care – that is, better quality of care, easier access to care, and lower cost of care.

Other factors influencing capacity that are outside the control of health ministries include the limited extent of private sector development. Limited development or inadequate depth of the private sector in health care hinders the efforts by government to contract out services. More importantly, it implies that government has few local examples of effective management practices in organizations from which to learn. And in the broad economy there is a limited reservoir of management skills upon which to draw.

Types of reforms

When describing Health Sector Reforms, questions include the types of HSRs being applied (or at least recommended) and whether they are working in local or even national contexts. When addressing these questions, one must be aware that generalizations – or their opposite:

limited particular examples – tend to caricature reality. The world, particularly the developing world, is vast and diverse. Furthermore, if one argues that HSRs are working, what tangible evidence exists for this claim? Conversely, if one is skeptical, what questions need to be asked?

It does not require a critical stance to observe that some of what is being proposed as HSR measures are Structural Adjustment measures in disguise. They are often complicated and mostly ‘top-down’. Other HSR measures call for major changes that are politically unsavory and would require strong determination to get underway. Yet weak and weakening states are no match for strong societies with well-entrenched interests (Migdal 1989; Myrdal 1968). Even getting started is so often such a problem that elaborate plans for implementation tend to remain on the drawing board.

More importantly – and overshadowing the above constraints – is the fact that the proposed reforms have come to mean ‘market oriented’ interventions in the health sector. The concept has literally been hijacked or monopolized by a World Bank-led paradigm of health reforms that parallels and is embedded within the so-called Washington Consensus. It is important to address the underlying assumptions being made about market-oriented health sector reforms that are currently being aggressively promoted around the world.

Without much analysis, it is contended that a more decisive market orientation of the existing public health sector will bring about increased efficiency. Evidence that market-oriented health care systems are more efficient than public health care systems, however, is not even to be found in countries such as the US with its already highly market-oriented health care system (Marmor 1998). Almost twice as many financial resources (approximately 14% of GNP) are required in the US to provide the same type and quality of care available in Western European countries (which spend only 7-8% of their GNP) – a comparison which indicates that great inefficiencies remain in the most market-oriented health care system in the world.

One major reason for this pattern is that it remains profitable to provide unnecessary care; another is that – in systems where private-for-profit health insurance companies play a major role – transaction costs (administrative and other) are very high, in the order of 20-40%. Consequently, even using pure traditional efficiency criteria, evidence from many countries indicates that public health care systems can be not only more equity-oriented but also more efficient than market-oriented health care systems.

Of course, this observation does not imply that all public health care systems are efficient. The point is that inefficient public health care systems can be made more efficient by improving relevant public policies. Embracing a market orientation is not necessarily the preferred way to improve health care for people. Unfortunately, however, reforms that propose to strengthen public health policies and to ensure public financing of health care via taxes are gratuitously dismissed as supposedly ‘non-viable’ as a realistic option for the future.

This dismissal is reinforced by the theoretical contention of mainstream health economists that the role of government is ‘to adjust the market failures’ found in the health sector. The underlying assumption is that a ‘perfect market’ – one with no failures – will provide the best health care system. But this model implies that demand, as expressed by purchasing power, should ultimately determine the supply and utilization of health care services. It is thus, by definition, impossible for a perfect market to provide health care services according to need – regardless of ability to pay. Only if the groups with the greatest need for care would be those with the most resources for buying the care they need would the ‘market forces’ be a possible regulator of access to care.

In reality, as evident in all countries, the opposite is the truth. The economically least privileged groups are the ones experiencing the greatest disease burden, thus having the greatest need for care. If we acknowledge this reality – and if our objective remains the provision of health care according to need – we must look for ways to improve the public health care system, ones that can cater to the health needs of those with less ability to pay. This search does not exclude a role for a parallel private for-profit health care sector that follows market forces primarily catering to the needs of the most privileged groups. But the main concern for health sector reforms must be to secure quality health care services for the great majority of the population, thus reducing social inequities in terms of economic, geographic and ethnic access to care.

Let it be understood that there is nothing inherently wrong with market-oriented reforms in health, provided that:

- they work in the direction of greater efficiency and equity;
- they receive no government subsidies, and
- they comply with well-monitored regulations promulgated up-front.

But these prerequisites rarely exist anywhere at present – including countries with a ‘socialist market-oriented economy’ such as China and Vietnam.

In order to get reforms in the health sector on a more sustainable track, deep structural changes need to be enforced. Such a track has to assure minimum care for a growing number of poor people who have fallen through the safety-net. Public hospital care has become increasingly unaffordable for the poor due to steep user fees. Additional hidden costs complicate this situation – ‘under the table payments’ to doctors being just one type (Avetisyan 2002; Baru 1999). Subsidizing such a system, instead of reforming it, will only channel additional funds to the wrong (non-poor) recipients.

Health Sector Reforms have been used as crutches to pretend one is changing the system, but basically staying the course or even regressing. Historically there is a non-accidental link between Structural Adjustment Programs (SAPs) and HSRs. The link is a calculated internal logic to apply the principles of the market economy to the health sector. The bottom line is that HSRs alone (as conceptualized and promoted in much of the literature) cannot address the structural constraints faced by the poor in obtaining equitable access to preventive, curative and rehabilitative health services.

Furthermore, as currently applied, HSRs use technical terminology with misleading imprecision. Examples that come to mind are:

- ‘efficiency’ (which is measured only in economic terms);
- ‘willingness to pay’ (which is used in lieu of the real determinant, namely ‘ability to pay’);
- ‘cost-sharing’ (which is applied to regressive fee-for-service systems – forgetting that general taxes have the potential of being a more progressive cost-sharing system when those who have more are made to pay more).

The issue is thus not whether people should share the costs – because the people always end up paying. The real issue is who is to pay more and who is to pay less or nothing at all. The point is that the terminology used is linked to one specific ideological outlook (and thus one type of health sector reform).

Interim Recommendations

What interventions would be more effective and sustainable? The best response to a part of this question is in another question: why not ask the beneficiaries directly to respond to this question? This response has the wisdom of – on top of so much that has already been said about it – accepting the fact that:

- localized responses will (and should be) multiple and varied;
- no single response fits all (or even many) diverse situations;
- technical expertise can be put to a more effective use in a genuine dialog with community representatives than in a technical dialog among (self-proclaimed) experts;
- an all-encompassing wisdom is not necessarily a trademark of communities (as so often is romantically implied): communities do not always know best (!) so mistakes will be made; and
- quickly learning from mistakes in an ongoing dialog between communities and professionals can lead to quicker sustainability than applying schemes imposed from outside, no matter how promising these look.

Paraphrasing Nobel laureate Amartya Sen, in order to understand people's choices one must know which alternatives are open to them in real life. Such a grassroots-centered approach calls for an unprecedented change in priorities and modus operandi. The locus of control has to shift to beneficiaries for decisions that affect them directly on an everyday basis.

At the same time, equity-oriented measures have to be implemented from the central level. In this era of almost automatic decentralization, the merits of centralization should not be overlooked. And that is the other part of the response to the question posed above. For the time being, and until the equity situation changes for the better, some of the key elements of such reforms could be the following (percentages are only illustrative and will change in each concrete context):

- Public rural health care services need to be primarily financed by governments (central and local). Government should cover around 70-75% of total costs; only up to 10-15% can be realistically expected to be raised by community contributions or rural health insurance schemes; 5% can come from direct user-fees, and an additional 10% perhaps from foreign aid.
- Financing public urban health care services probably need 50-60% government financing; health insurance could cover around 30% of costs and user-charges 15%; the rest could come from foreign aid.
- Financing of health care will have to move progressively away from regressive fee-for-service schemes and toward prepayment schemes where the whole population – not only the sick – contributes.
- Direct and indirect progressive taxes must constitute the financial base in an efficient, equity-oriented health care system. Government funds thus collected can then be used

directly to fund public health services or can subsidize social health insurance schemes that will gradually cover the whole population.

- Governments will have to reallocate resources gradually from rich provinces and districts to poorer ones according to a set of needs-based indices and by then amending recurrent and development budgets accordingly.
- General tax revenues that apply more to the rich (taxes on luxury items, spirits, tobacco, or on assets, estate and wealth) should be seriously considered as a source to obtain financial resources for the health sector.
- Existing resources (human, material, organizational and financial) should be rationalized to adapt them better to actual needs. This will entail reallocating (even shedding) personnel as well as mobilizing more resources for outreach work outside the health stations. All this should be linked to medium-term reforms that bring health staff income up to minimum standards of living, preferably based on a system of monetary and non-monetary incentives.

These are but a few of the central and local level options that merit careful examination. But most importantly, the process must open the doors to a more participatory and empowering dialog (especially engaging women) in order to generate more options and answers. For this to happen, the process has to be decisively steered to concrete departure and finishing lines – and health professionals can facilitate this task.

What is really needed is an ‘HSR of the public health care sector’, not one overwhelmingly biased in the direction of the private sector. The so often touted non-service-mindedness of the public sector is not a given. The public system has many flaws but also many strong points. As its core is streamlined and strengthened, one can indeed contract out some ancillary services to the private sector – provided there is a fair system of competition in place. Health sector reforms will explore these possibilities for improving the public sector in health care and keeping it at the core of a delivery system that can ensure equity at the highest levels of priority.

This brings us full-circle to the old ‘political will’ issue that – everyone should understand – is not really an issue of ‘will’ as such: it is an issue of ‘choice’, of political choice and subsequent commitment. And being an issue of choice, for the time being – short of an awakening of civil society initiatives and movements around the world – the responsibility to move towards appropriate HSRs is still squarely that of the respective governments.

Conclusion

In practice, many social policies have been designed and implemented as a 'residual' to the priorities of economic policies and have often been explicitly labeled 'compensatory' programs to 'alleviate' the social cost of economic adjustment. In contrast, a social reform strategy as argued above would require the development of an integrated and coordinated strategy comprising, first, broad-gauge measures and then practical health policies:

- Economic reform policies, including macroeconomic stabilization policies and structural adjustment policies that redistribute productive assets (eg, agrarian reforms, removing constraints to access to credit, etc) ;
- Social sector reform policies, comprising measures to improve the efficiency and equity of service delivery (health, education, housing) in order to facilitate equal opportunities for human development and social integration;
- Reform of social protection systems, including social safety nets (protection of vulnerable groups in the short run) and social security program; and – to complement and facilitate the above –
- Institutional and administrative reforms aimed at improving governance of public action through improvements in the decision-making process.

While the implications of these observations for capacity building approaches in the health sector have not been fully explored, a few lessons for the process of institutional reform in health have already emerged that are worth enumerating:

- 1) Health reforms need to be designed and phased in such a way as to reflect existing capacities. Rather than attempting to do too much all at once, it is helpful to identify easy entry points upon which reform programs can be built and through which incremental reforms can be achieved.
- 2) Some aspects of capacity – generally those internal to the implementing organization – are easier to address than others. Efforts to build capacity (or to remove constraints on capacity) should start with the objectives that are less difficult to achieve.
- 3) Many of the skills required to operate the new modes of government effectively cannot be easily taught in formal training courses because they are based on experience. Reform strategies should be designed to encourage experience-based learning – especially through apprenticeships and/or internships.

- 4) Elite units and autonomous organizations, so often used to bypass bottlenecks in government, should be deployed sparingly. While this strategy may be an effective mechanism for achieving a high priority short-run goal – such as the expansion of an AIDS control program – its longer-term effect is unintentionally pernicious. That is to say, long-term reliance on special elite and autonomous organizations can prevent fundamental problems from being addressed. The resurgence of malaria, after decades of attempting to eradicate it, is a case in point. If one can deploy military imagery, battles may be won but the war is lost.
- 5) Communities can be an important source of support to government in strengthening reforms. They also help to police the effectiveness of government, particularly in countries where there is a rich civil society. But such approaches should be used selectively in order not to overburden the ‘third’ sector. It is important to understand the capacities and constraints of the voluntary, non-governmental, community-based sector.
- 6) Finally, better communication of reforms to a variety of audiences – health workers, the general public, politicians and others – is critical. It is critical not only for the political viability of reforms in terms of generating support, but also so that these groups can fully participate in the reformed system.

None of these six recommended strategies is a fail-safe solution to the problem of reforming the health sector and its capacity to deliver good quality services to the appropriate population at reasonable cost. All of them have empirical merit. In some countries, however, particularly those in sub-Saharan Africa, there has been a severe depletion of institutional capacity. Basic systems fail to function, and reform agendas have further stretched Ministries of Health that are already exhausted. In such situations, capacity development will inevitably be long term, and policies should be devised accordingly. Those policies should start by addressing the basic capacities of government that are common to reformed and unreformed systems.

Finally, recent evidence indicates another source for market-oriented reforms in the health sector, namely judicial decisions about ensuring a competitive market. The obvious case in point is how provisions of the Single Common Market within the European Union have been interpreted and applied by the European Court of Justice (Koivusalo 2001; Hamilton 1996; Doorslaer *et al.* 1993). As new members are inducted into the charmed circle of blue stars, their health sectors may be compelled to open themselves to ever-greater competition. In the short run, the old public health agencies will predictably be undermined and public services

will deteriorate. The challenge is to provide reforms of the health sector that do not, in a hackneyed metaphor, 'throw the baby out with the bath water'.

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