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# Health Sector Reform in Developing Countries: A Reality Check

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**Abstract**

Health sector reform has been the subject of increasing attention over the past decade, with considerable pressure being exerted on developing country governments to restructure and reform their health systems. This paper reviews health sector reform and why countries are engaging in reform, the results of the reform, and some key issues for future planning and implementation of reform. The paper concludes that: there has been an overemphasis on reform content, rather than process, which has led to persistent implementation problems; there has been insufficient tracking of the effects of the reforms; and a lack of analysis of the effects of policy reforms prior to implementation which has resulted in many unintended and often undesirable consequences of reforms. Further work identified includes the need for (1) a better understanding of the dynamics of the health sector in individual countries; (2) more sophisticated techniques to predict the effect of reform proposals; (3) mechanisms for tracking the effects of health sector reform; and (4) significant skill development and capacity building in local organisations.

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## Introduction

**Health Sector Reform** - the latest buzz word in international health parlance. What does it mean and why has reform come to be a common theme to preoccupy international health thinking over the past decade? This paper will endeavour to define reform and the form it has taken, but more importantly to identify why countries are engaging in health reform, the results of the reform, and some key issues for future planning and implementation of reform.

Health sector reform has been defined as *sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector* <sup>(1)</sup>. This notion has great appeal, but how has it been translated into action? Turning first to the manifestations of health reform, the major groups of health reform have been:

- **changes in financing methods**

- user charges;

- community financing schemes;

- insurance (social, private, compulsory insurance, community risk sharing schemes;

- stimulating private sector growth; and

- increased resources to health sector.

- **changes in health system organisation and management**

- decentralisation;

- contracting out of services; and

- reviewing public-private mix.

- **public sector reform**

- downsizing public sector;

- productivity improvement;

- introduction of competition;

- improving geographic coverage;

- increasing role of local government; and

- targeting role of public sector through packages of essential services.

These, however, are the means and methods of reform, but they provide little insight into the underlying goals of the reforms or indeed, why the reform is required. To understand these, it is necessary to turn to the underlying objectives of the reform efforts. Analysts of international health have, for approximately two decades, shared a common goal or vision for reform which has incorporated the concepts of universality and equity. This is best illuminated by a brief history of the last two decades of international health.

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### **A Brief History of Health Reform**

Once upon a time, and not so long ago, at a time when the global social conscience was in its ascendancy, the World Health Organisation (WHO) and UNICEF convened a landmark meeting to discuss international health in Alma Ata. The convened experts met, and they discussed, and they concluded. When they concluded - they said *Let there be Health for All* and then they said *We will do that through primary health care*. And they saw that it was good. And after they had rested, they returned to their respective corners of the globe and prepared themselves to spread the word about Health for All and Primary Health Care throughout the developing world. That was 1978.

From there WHO spread its global agenda throughout its many constituent parts in the developing world, other multilateral agencies joined the fray, bilaterals signed up, multitudes of *experts* joined too. They all travelled the world spreading the good news of *health for all through primary health care*. They moved in their droves throughout the developing world spreading their interpretation of the message ... many variations on the primary health care theme, many confusing.

They came and they exhorted developing countries governments to convert to the primary health care way... *give up your focus on curative care, don't spend money on expensive hospitals (you don't need them if you have enough prevention...)* , *stop looking after the rich urban dwellers (even if they are politicians), invest in prevention, promotion, community participation... its definitely much better! Reform! Remove the imperfections in your health systems - embrace primary health care.*

In 1981, only 3 years after that seminal declaration of Alma Ata came that famous oration *The Shattuck Lecture: Health Care in the Developing World Problems of Scarcity and Choice* <sup>(2)</sup>. The authors argued that health care resources are scarce in the developing world, and that demand will always exceed the supply therefore, Governments have to make choices about how they allocate these resources to the ever-increasing demands that are placed upon them. A significant obstacle in the road to Health for All was identified - *someone has to pay for it, and to do so they have to take money away from something else*. A difficult dilemma for any government.

This was followed by the famous and lively debate in the early 1980s on selective primary health care <sup>(3)(4)(5)(6)</sup> as a possible substitute for the comprehensive primary health care which had been so fully embraced by the international community a few years before. The debate engendered strong passions and the selective primary health care proponents were criticised for

redressing up the old and rejected vertical program approach and giving it a new name. Underlying this debate was a sense of unease in the international health community about how developing countries could afford to pay for primary health care on a universal basis.

In 1987, the World Bank entered the international health reform dialogue offering a solution in *Financing Health Services in the Developing World: An Agenda for Reform*<sup>(7)</sup> - the key message - *user charges - let them pay*. They also promoted decentralisation as a key reform. Note here the introduction of the term Reform into the vernacular of international health.

Ten years after the declaration of primary health care at Alma Ata - the goal of health for all remained elusive and costly. The focus of the debate during the 1980s shifting slowly but surely to issues of affordability and choice. Scarcity and choice - this is the bread and butter of economists! What an opportunity! The 1980s became the halcyon days of health economics. A positive mini-industry emerged as health economists busied themselves estimating the cost effectiveness of many and varied health interventions, and developing new and more sophisticated economic techniques to provide robust and objective tools for measuring value for money in health services. Not always with the interests of the developing countries in mind.

Then in 1993, after investing hundreds of hours of the minds of the greatest health economists and epidemiologists in the world - the World Bank presented the developing world with the DALY! The Disability Adjusted Life Year. With this remarkable tool - the World Bank offered to the developing world a robust, objective and cost effective tool for making choices<sup>(8)</sup>. The key assumption underlying the report is that the rational and objective approach designed by highly expert economists and epidemiologists is sufficient in itself to convince politicians and consumers to implement and accept the interventions proposed. This is naive and belies the highly complex process of policy making, implementation and consumer acceptance in any country. The DALY, however, was embraced by the international health community, by and large, and the DALY has been systematically promoted as the reform of choice on the road to health for all. To a large extent the agenda of this powerful organisation has been embraced without critical review, an unwise move, as some analysts have pointed out<sup>(9)</sup>.

So over the past twenty years since Alma Ata - the international health community has seen a series of stages in international health thinking about how to achieve that elusive goal of health for all.

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## **Understanding the Achievements**

In 1997, where are we now? The original goal of health for all remains elusive, the concept of primary health care remains by and large well supported, but the actual achievements have been modest. In some countries, such as parts of Africa, the primary health care reform agenda is barely off the ground, in others it has stalled, in others partial success has been reported. What is clear is that while the ideals of Alma Ata still have currency, they haven't been successfully realised throughout the developing world.

In the famous words of Professor Julius Sumner Miller - *Why is it so?*

There are three major reasons:

1. There has been continuing confusion between process and outcome in health reform and many of the reforms have been seen as legitimate outcomes rather than processes to achieve true health outcomes.
2. Reform in the health sector has been viewed by many analysts as the only legitimate goal and reforms have been viewed as discrete from other social, cultural and economic changes and indeed goals of government;
3. Very little attention has been given until recently to critical implementation issues in developing countries.

### **1. Process and Outcome of Health Sector Reform**

Much of the reform that has been carried out has been in pursuit of either bringing additional finance into the health sector, or making the use of health sector resources more efficient or equitable. The dominance of the discipline of economics over the past two decades, has sometimes led to confusion between the means and ends of health reform<sup>(10)</sup>. Implementing user charges, for example, has often been seen as an end in its self, and its success in actually bringing additional resources to the health sector to allow enhancement or expansion of health services has rarely been documented<sup>(11)</sup>. Furthermore, there is a growing body of evidence that user charges can act as a deterrent to use among people who require the services most - in effect, being inequitable, where equity has commonly been one of the key goals of health reform<sup>(12)</sup>.

Encouragement of health insurance schemes as a means of improving the financing of the health sector has also been promoted by the international community, and governments attracted to the notion of reducing the burden on the public purse have participated, but recent evidence from Korea<sup>(13)</sup>, China<sup>(14)</sup> and the Philippines<sup>(15)</sup>, suggest that there have been significant issues with cost escalation under the insurance schemes implemented.

Similarly, decentralisation has been an ideologically attractive concept, promoting values such as devolution of powers to the people and local decision making. In reality, it has failed to produce the hoped for consequences as recent literature from Papua New Guinea<sup>(16)</sup> and Brazil<sup>(17)</sup> suggest.

Seeing the reforms as ends in themselves and failure to carefully monitor the implementation of reforms against the original goals of the reform agenda, has resulted in unimpressive performance of the reforms in many developing countries.

### **2. The Context of Health Sector Reform**

While the health sector reforms to achieve health for all were seen by the international health community to be paramount and often even viewed by purists as separate from other aspects of

economic and political development - it must be remembered that these reforms have been mooted within a far wider reaching reform agenda that has swept the developing and to some extent the industrialised world. Economic and political liberalism has dominated the world in the past decade - reducing the size of government, liberalising financial and trade structures, greater attention to macroeconomic policies to contain inflation and exchange rate fluctuations and a global pressure to become competitive<sup>(18)</sup>.

There are close connections between the wider political and economic reform agenda and the health reform agenda. Some analysts have seen the health reform agenda of the last decade, as being liberalising - decentralise Ministries of health, allow private markets to flourish, reduce government regulations and the size and scope of government, find new ways for people who can afford to pay for services to do so, and new ways to ensure equity for those who cannot pay<sup>(19)</sup>. Liberalising themes.

Many of the reforms are being forced by pressures far greater than an international health view that primary health care is a good thing to do and it is essential that health reforms are not separated from the overall national and international context within which they irrevocably fall.

### **3. Critical Implementation Issues in Health Sector Reform**

As recently as the World Development Report in 1993, recipes for reform have been accompanied by the somewhat naive set of assumptions that when presented with an ostensibly rational tool, that:

1. governments will adopt recommended policies,
2. the institutional capacity exists to implement the reforms,
3. communities will want to use the proposed package of services, and
4. the reforms will achieve the objectives they were designed to achieve

#### ***Assumption 1 - Governments will adopt recommended policies***

Governments do not operate in a vacuum, where they can deliberate on rational and informed choices based on the best available information. We may wish that they did, but they don't. In Western countries, health policy decisions are at best mediated events, taking the views of the electorate, powerful professional groups, pharmaceutical and insurance interests and community pressure groups. Somewhere in that dynamic process is a role for objective information, but it is not the determinant upon which policy decisions rise or fall.

The situation is no different in developing countries, perhaps, even more complex, and the role of key players such as professional and business groups has received inadequate attention. Yet these groups have enormous power to control quality, access and cost decisions in health care systems. They have the ability to stall or indeed stop policy change from occurring. Too little attention has been given in reform plans to political and social realities, with too strong an

emphasis on the content of the reforms, and a lack of attention to the actors and processes involved<sup>(20)</sup>. Political mapping has recently been developed as a way of analysing the political dimensions of health policy and in planning actions to manage the political environment<sup>(21)</sup>, and a great deal more work is required to understand policy implementation processes.

***Assumption 2 - the institutional capacity exists to implement the reforms***

Developing country public sectors have been consistently criticised for their unimpressive performance, yet it is these institutions that are expected to implement the reforms. Many of the reforms require a level of sophistication in policy analysis, research, information systems, management expertise and logistics system that is simply unavailable in many developing countries. To implement the reforms in many cases, requires sustained and long term capacity building across the system, including technical capability, research, health system components, information systems, management and a whole range of strategic functions.

***Assumption 3 - communities will want to use the proposed package of services or intervention***

The literature is replete with examples of the provision of rational cost-effective health interventions which users are not interested in. By passing of lower level facilities to go to hospitals, use of polluted rivers and streams rather than the appropriate technology, low cost, but unpleasant tasting water from the hand pump... there are many more. Health consumers may have *imperfect information* as the economists define it, but they surely have strong preferences and their behaviour in regard to any proposed intervention must be analysed and accounted for in any implementation plan. This has rarely been a feature of health reform planning.

***Assumption 4 - the reforms will achieve the objectives they were designed to achieve***

In the western world, there is to say the least, equivocal data about the success of the reforms that have been implemented. The Dutch reforms have slowed and have been described as having failed in the British Medical Journal <sup>(22)</sup>. The New Zealand Reforms have been described as *jumping on the spot* and have required significant increases in funding to sustain <sup>(23)</sup>. The UK reforms are hard to evaluate, because they were implemented in conjunction with large increases in funding and the effects of the reforms and the funding are difficult to separate<sup>(24)</sup>

In the developing world, there is even less evidence of the success of reforms in achieving their broader objectives. One reason has been an absence of systematic tracking of the effects of health sector reforms, however, there is emerging evidence that many reforms have produced undesirable and unintended consequences. A recent review of health reform in Asia <sup>(25)</sup> identified a number of unintended consequences of reforms including: problems generated by incentive structures in the health insurance system in Korea <sup>(26)</sup>; the unanticipated burden of financing old-age insurance systems in Japan <sup>(27)</sup>; the insurance related cost escalation of health care in China <sup>(28)</sup> and the adverse impacts of health insurance on hospital costs in the Philippines<sup>(29)</sup>.

These highlight the need for careful analysis of the effects of policy reforms prior to their implementation and the continued monitoring of the effects during implementation. There is a

need for careful and systematic analysis of policy options prior to setting the policy direction and the need for continuing monitoring and evaluation during implementation to prevent adverse effects.

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### **Conclusions and Future Directions**

On the basis of the health reform experience in developing countries, it can be concluded that in the 20 years since Alma Ata, health reform has had a limited contribution to the realisation of the goal of health for all - it is still a long way off. Key limitations of approaches to health reform include:

- in international health reform there has been a greater focus on the content of reforms, than on process, which has led to persistent implementation problems;
  
- while there have been efforts through health reform to expand and redistribute health sector resources to achieve greater efficiency, equity and effectiveness, there has been inadequate tracking of the effects of the reforms; and
  
- there has been inadequate analysis of the effects of policy reforms prior to implementation which has resulted in many unintended and often undesirable consequences of reforms.

In response to the apparent lack of documented performance of health reforms, it is clear that a number of steps are required:

1. Better understanding is needed of the dynamics of the health sector in individual countries: what are the social, political and economic dimensions of policy making? what underlies private sector growth? what underlies decentralization? and what drives people or organizations to behave in a certain way?. Reform plans cannot continue to ignore the how and who of implementation.
  
2. More sophisticated techniques are needed to predict the effect of reform proposals, such as the effects of different prices, user-fees and decentralization on the operation of the health sector.
  
3. Mechanisms for tracking the effects of health sector reform need to be developed, and information from systematic evaluation of experience widely disseminated and discussed.
  
4. There needs to be significant skill development and capacity building in local organisations, strengthening national capacity for policy analysis and research and enhancing the quality of information available on policy changes. Institutional

strengthening is needed for policy makers and researchers, as well as health workers to develop the capacities to deal effectively with reform issues.

To conclude, in the words of Vincente Navarro (1984)

*Health is a profoundly political issue<sup>30</sup>. Health planning and implementation thus, is not, and will never be a rational process based on objective resource allocation decisions. The success of future health reform will require international experts to alight from their glorious pedestals into the murky depths of reality. The power, the politics, the players, the users - all matter. A great deal of time and money have been squandered in the ignorance of arrogance, it is time to move from intellectual idealism in international health to something much more fundamental - realism.*

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