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POLICY ARENA

REFORMING THE HEALTH SECTOR: TOWARDS A HEALTHY NEW PUBLIC MANAGEMENT

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Abstract: New public management (NPM) ideas have been reflected in the international health sector reform agenda. This paper summarizes the extent and depth of reform in the five countries studied, as reflected in four key policy arrangements, and reviews the various dimensions of capacity which have hindered policy development and implementation. The paper concludes that NPM reforms place demands on government which are not only technically complex but require political leadership, major institutional reform and shifts in organizational culture: it was thus not surprising that none of the case-study countries had undertaken far-reaching NPM reforms in the health sector. Key lessons for capacity strengthening are drawn from the country experiences.

1 HEALTH SECTOR REFORM AND THE NEW PUBLIC MANAGEMENT AGENDA

Ministries of Health in developing countries epitomize the bureaucratic model of direct service delivery so widely criticized as monopolistic, over centralized, hierarchical and unresponsive to users (Bossert *et al.*, 1998; Mills, 1995; World Bank, 1993). The international health sector reform agenda is a logical response, whose thrust is linked to the broad set of public sector reform ideas and initiatives collectively known as the 'new public management' (NPM) (see Table 1 in Mills, 1999).

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Table 1. Health sector reform and the new public management (*Sources*: Ferlie *et al.* (1996); Kaul (1997); Bennett *et al.* (1996))

Policy shifts to address problems with old bureaucratic models	General reforms advocated (the NPM agenda)	Manifestations in the health sector (the health sector reform agenda)
Monopolistic		
Increase competition Increase managers' financial responsibility	Deregulate and encourage pluralism Contract out Internal competition	Enablement and regulation of the private sector Clinical and non-clinical contracting Purchaser provider split with contracts and internal competition Provider payment reform: money follows patient
Centralized		
Ensure clarity of purpose Increase managers' financial responsibility Increase upward accountability Increase responsiveness or accountability downwards to users and community	Contracts and performance agreements Split policy making and service delivery functions Decentralize to cost centres and allocate financial responsibility to lower level managers Cost recovery Increase community 'voice' in management	Clinical and non-clinical contracting Purchaser-provider split Re-organize central MoH Decentralize to district and hospital managers User fees, health insurance Village, district or hospital level boards

This paper, on the basis of a number of country studies[1] which examined selected policy arrangements,[2] argues that most governments in low income countries do not possess the necessary political support to implement such a radical health reform agenda. Even where the political will to reform is present, capacity issues, defined broadly to encompass a range of dimensions from human resources and management systems through to political, institutional and economic contexts (Batley, 1997; Grindle and Hildebrand, 1995), are likely to prevent effective implementation. All four case-study countries studied were of low income, with a British colonial heritage: care therefore needs to be taken in applying lessons to other contexts.

2 REFORM EXPERIENCES AND FORCES FOR AND AGAINST REFORM

The extent and depth of policy change in the countries were limited (Table 2). Despite two decades of macroeconomic liberalization in Ghana and Sri Lanka, and nearly a decade in Zimbabwe, Ministries of Health remained relatively centralized bureaucratic organizations that continued to perform traditional direct service delivery roles.

[1] Country 'case-studies' were done in Ghana, Zimbabwe, Sri Lanka and India (Tamil Nadu state). A study of Thailand provided some comparative information for a rather richer country.
[2] User fees, autonomous hospitals, contracting out, regulation and enablement of the private sector.

Table 2. The extent and pace of policy development and implementation in the case study countries and Thailand (*Sources*: Bennett *et al.* (1998); Bennett & Muraleedharan (1998); Russell & Attanayake (1997); Russell *et al.* (1997); Smithson *et al.* (1997))

Selected policies from the NPM agenda	Ghana	Zimbabwe	India (Tamil Nadu)	Sri Lanka	Thailand
User fees	Fees implemented Cost recovery c. 10% Exemptions to the poor rare	Fees implemented Cost recovery c. 4% Exemption system weak	No national policy Fees in some states: not Tamil Nadu	No policy Not on policy agenda	Fees implemented Hospitals recover c. 50% of recurrent costs Relatively effective exemption system
Decentralization to districts	Decentralized budget control DHMTs created Management strengthening	Proposed only	Policy to reinvigorate local government in very early stages	Proposed only	Existed as policy for some time But management style still very centralised
Autonomous hospital boards	Legislation passed (1988; 1996) Limited implementation	Proposed only	No policy Not on policy agenda	No policy Not on policy agenda	No policy—though now on agenda In some respects hospital enjoy substantial autonomy due to fee revenue
Contracting out	Policy development stalled	Programme of non-clinical contracting implemented	Traditional tender system for some non clinical services	Traditional tender system for some non clinical services	Widespread non clinical contracting Contracting out for some high tech. clinical services and under social insurance scheme
Deregulation, enablement and regulation of the private sector	Extensive private sector in urban areas But policy measures weak Some revision of laws	Extensive private sector in urban areas But policy measures weak Some revision of laws	Extensive private sector But policy measures weak Some revision of laws	Extensive private sector To date weak policy measures But new legislation	Extensive private sector encouraged by subsidies Social insurance arrangements involve choice of private providers Strengthened regulatory framework needed

Note: depth of shading indicates the extent to which the selected policies have been implemented.

Thailand was the furthest down the reform path, though still with quite centralized service delivery. In Ghana and Zimbabwe the concepts and language used were consistent with the NPM agenda (MoHCW, 1996; Smithson *et al.*, 1997), but there had been limited progress with implementation. The main thrust of reform in practice, driven by economic crisis, was the introduction of user fees. In all case study countries, reform efforts focused on strengthening the traditional roles of the MoH through increased decentralization, with Ghana making most progress.

Why had there been so little change? Reform had to be initiated within an existing centralized bureaucratic model of direct service delivery, on which an alliance of vested interests in the interventionist state and its service provision arrangements had been built. Consequently the NPM reform agenda was blocked by:

- existing state institutions and
- vested interests which were suspicious of or opposed to reform.

The role of politicians varied between countries and types of reform. They opposed fees in all case-study countries, but in Ghana and Zimbabwe succumbed to economic imperatives and the strong demands of the MoH and MoF, backed by multilateral donors. With the exception of Ghana, national politicians were resistant also to decentralization. Reforms appeared to offer few concrete benefits but many political risks: they challenged long-standing bureaucratic arrangements and interests, made politicians vulnerable to accusations of 'privatization', and could lead to strikes, public opposition and electoral losses.

Senior bureaucrats commonly resisted decentralization. In Sri Lanka they used technical capacity constraints at sub-national levels to justify limited decentralization, arguing there would be management failure and corruption if central financial control were loosened.

Health workers were critical policy actors for reform implementation. In India and Sri Lanka, government health workers opposed user fees (on ideological grounds in Sri Lanka, for fear of loss of informal fee revenue in India), contracting out and hospital autonomy (for fear of job losses) and regulation of the private sector (in which they themselves practised, legally or otherwise). The medical profession was particularly influential: one of the main reasons why Ghana moved ahead with fees and decentralization was that the MoH and medical professionals led the reform process. In contrast in Sri Lanka, the Government Medical Officers Association consistently opposed decentralisation, which was seen to represent 'implementation of a failed system of autonomy from a developed country'.

There was little enthusiasm for NPM reforms among key national policy actors in South Asia, although in India interest might have been greater if broader bureaucratic constraints to reform (such as personnel regulations) were lifted. In the African countries caution and opposition were also widespread, but a key catalyst for reform was deeper economic crisis and a near collapse in service delivery which strengthened pressure for change from internal and external actors. In most of the countries the push for change came largely from an alliance between a few MoH technocrats and external technical advisors: as a result policy discussions used the 'right' language, but masked major difficulties with implementation. In Thailand government culture was shifting in favour of NPM-type reforms, though there was no political championing of reforms which in consequence were incremental.

3 THE FEASIBILITY OF NPM REFORM: CAPACITY CONSTRAINTS

3.1 Organisational Capacity

Skills

Ministries of Health generally possessed the staff skills for routine public administration, especially in India, Sri Lanka and especially Thailand. In Ghana significant strides had been made in the development of a cadre of trained regional and district public health managers although there were shortages of trained accountants, and in Zimbabwe there were shortages of skilled staff at sub-national levels.

Within the existing organizational paradigm, it is not surprising that the experience and skills needed to perform new tasks were largely absent: for example centralized structures had given local managers little opportunity to develop general management skills. Lack of ability to analyse data critically, identify patterns and take action was common.

Systems

The main systemic weaknesses were in areas of finance and accounting, and human resource management. Accounting systems were centralized and designed to ensure financial control rather than management information. User fee policy impact was particularly undermined by weak billing and collection systems in Zimbabwe and ineffective exemption systems, particularly in Ghana. NPM reforms which involve contracting out or 'unbundling' of public sector bureaucracies through greater autonomy demand more developed financial information systems: these were lacking in all countries.

Organisational cultures

The prevailing organizational culture was a key constraint underlying both poor performance within existing bureaucratic arrangements and reluctance to learn new skills necessary for the NPM agenda. A number of different aspects of organisational culture impeded effective reform:

- staff reward was unrelated to performance
- staff were frequently paid very poorly and had limited prospects for promotion, contributing to poor motivation
- bureaucratic regulations centralised decision making, dis-empowering staff and discouraging innovative behaviour.

Staff reluctance to invest in new skills and systems that involved information management reflected a deeper-rooted indifference to information as a management tool, and the absence of an organizational culture based on performance assessment. Existing management systems in all study countries were based on hierarchy, command from above and duty, and provided no incentives to use information. This was perhaps the most embedded institutional barrier to NPM reform across countries.

Furthermore, there was often lack of local ownership of reforms and consequently lack of commitment to implement the reform agenda. This was evident, for example, in the donor-supported initiative in Zimbabwe to improve and decentralize MoH

accounting systems. Only limited success had been achieved, partly because the Ministry of Finance had issued no directive to change accounting procedures.

In none of the countries studied was there a transformational leader who had attempted to change not only organizational structures but also organizational culture.

3.2 The Broader Policy Environment

Bureaucratic institutional constraints

Many of these capacity weaknesses derived from broader government structures and institutions in the case-study countries. *Centralized financial regulations and accounting systems* hindered MoH capacity to:

- monitor and manage user fee revenue or expenditure patterns
- decide on contracting out and monitor contractor performance
- decentralize financial authority to local managers and develop new accounting systems to ensure financial accountability and monitor the effects of reforms.

A second constraint was *centralized personnel management systems* that determined staff numbers, pay scales, promotion prospects and rules on hiring and firing:

- local managers' efforts to improve performance were constrained by centralized human resource management
- low salaries hindered recruitment of effective managers
- low pay and weak rewards and sanctions reduced staff performance and motivation to adopt new management skills or systems
- public sector workers did not view their job in a mission-orientated manner.

Embedded within overarching public sector institutions, Ministries of Health were restricted in what they could achieve without wider public sector reform and the support of the Ministry of Finance and Public Service Commission. Ghana appeared to have made the most progress in this area.

Economic constraints

Fundamental but often understated constraints to reform were the harsh economic conditions faced by governments. Reforms were introduced or proposed in Ghana and Zimbabwe when government capacity to implement policy was weakest due to economic crisis and associated resource shortages, salary erosion, low morale and a poorly functioning public administration. The difficult circumstances of reform also hindered phased implementation: for example the sudden implementation of user fees across all facilities in Ghana and Zimbabwe did not permit staff training, testing of fee schedules or administration systems, leading to predictable problems.

The limited extent of private sector development could constrain government capacity to implement contracting out reforms. In Zimbabwe there were too few firms to permit a country-wide policy of contracting out; whereas in India, Sri Lanka and Thailand this was less of a constraint. A small private business sector was also a disadvantage in limiting exposure to new management skills and techniques.

Politics and civil society

In the case study countries, politicisation of government administration could undermine the intended impact of NPM reforms. In Sri Lanka for example, government contracting procedures were often influenced by kickbacks promised to politicians, and capital investments often driven by electoral and political patronage considerations. A political culture of interference in the day-to-day management of hospitals would threaten any potential shifts towards management autonomy.

In some countries, such as India, there was a very rich civil society which could have complemented government's roles in both direct service delivery, and in regulation and information provision. While NGOs had been active in these roles for some time, government was only beginning to recognize their potential and work more effectively with them. Commonly in the study countries, NGOs had not been fully mobilized behind reform efforts, and governments had made very little effort to communicate to the general population the objectives and contents of reform programmes. Thailand was the most advanced in having a civil society which was increasingly influential.

4 TOWARDS A HEALTHY NEW PUBLIC MANAGEMENT

The inefficiencies and inequities of public health systems in developing countries, and the need for reform, are widely acknowledged (Cassels, 1995; Mills, 1995; World Bank, 1993). Which aspects of the NPM agenda are most appropriate within existing political, institutional and organizational settings, and how can capacity be strengthened to take such reforms forward?

None of the case study countries examined had undertaken far-reaching NPM reforms within the health sector. The experience of industrialized countries, such as the UK and New Zealand, suggests that these types of reform require political championing from the highest level and a broader swathe of public sector reform, designed to bring about fundamental changes in the way government operates, if they are to be successful. In the case study countries there was little political support for reform, it had mainly been driven by economic crisis, and there was very limited public debate about what reform entailed. In none of the countries was there a broad thrust of reform across government sectors, but rather isolated items taken from the reform menu.

There are a few low income countries, such as Zambia, which have succeeded in implementing a programme of radical reform. However it seems rare that there is sufficient political will to proceed with this type of reform.

Many elements of the NPM agenda require not only changes in organizational structure but also organizational culture. For effective implementation of contracting out or autonomous hospitals, there needs to be a shift away from patronage and hierarchical command and control towards more market-based relations. Such a transformation of organizational culture (and the social relations upon which it is based) cannot be quickly achieved, and those who did well under the previous system of relationships are unlikely to be willing to give up their influence. Nor can change be effected through formal training alone: the new skills necessary need to be learnt through hands-on practice.

In contexts where radical, politically-championed, reform is neither feasible nor desirable, Ministries of Health need to identify easy entry points which potentially unlock a sustainable process of reform. Limited decentralization of budget control to

hospital managers (as in Ghana), or non clinical contracting for services where performance agreements are easier to specify (as in Zimbabwe) may be potential examples of reforms which are politically feasible to implement, bring considerable benefits, and further enhance government capacity.

There are other key lessons which have emerged from the research:

- There has been severe decay in government performance, including performance of basic routine administrative functions, in countries which experienced acute economic crisis. In such contexts, rebuilding basic government roles must be given priority (as in Ghana where much effort was dedicated to strengthening traditional roles of government).
- Internal dimensions of capacity are probably easiest to tackle first since changes do not require wider reforms or the co-operation of other state actors.
- Capacity building should be gradual and iterative. In the case of decentralization, managers need to be given opportunities to make decisions and use skills, to prepare them for the next phase of reform.
- Reform phasing should be an integral component of capacity building. Reforms should be based upon an assessment of existing capacities and a reform path mapped which gradually expands capacity, though there needs to be much more understanding of how different elements of reform fit together and complement each other.

While these questions of sequencing are integral to effective reform and require serious consideration, there is unlikely to be a single blueprint for success. Specific capacities and institutional constellations vary by country. Political contexts will provide differing levels of tolerance and support of radical reform. There are no easy answers to how to move reforms from superficial organizational restructuring to a more deeply embedded programme reforming organisational culture and functioning.

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