ELSEVIER

Health Policy 32 (1995) 13–28

HEALTH POLICY

Health sector reform: making health development sustainable

Peter Berman

Data for Decision Making Project, Department of Population and International Health, Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115, USA

Revision received 20 January 1995; accepted 24 January 1995

Abstract

Health sector reform is underway or under consideration in countries throughout the world and at all levels of income. This paper presents an overview of key concepts and approaches to health sector reform in developing countries. Reform implies sustained, purposeful, and fundamental changes in the health sector. While it is difficult to define precisely what constitutes a true reform, there is widespread consensus that reform is a process of change involving the what, who, and how of health sector action. Health is increasingly included as an important goal of national development. It can make development more sustainable. The paper outlines some general and specific health sector reform strategies that can contribute to sustainable development for countries at all levels of income, although the strategies will differ in content and emphasis. Health sector reform should be based on an holistic view of the health sector. The paper presents two frameworks to aid in reform design: one highlighting the linkages between different institutional actors in the health sector; the second addressing linkages across different functional areas of reform action. In order to develop and carry out reform, information and analysis is needed. A variety of practical tools now available for this purpose are discussed, encompassing all the different areas of action. While tool development should continue, reform proponents already have much to work with. Given global interest, the importance of health sector reform in development strategies, and significant existing knowledge and experience, country level analysis and action should proceed vigorously.

SSDI 0168-8510(95)00726-Z

Key words: Health sector reform; Developing countries; Decision making; Sustainability, development

1. Introduction

In 1994, the United States failed to pass health sector reform legislation, as consensus on this knotty issue continued to elude legislators after decades of national debate. Zambia formed a national Health Reform Implementation Team to develop and monitor its own reform program, begun in 1992. Colombia issued decrees to initiate ambitious changes in public and private health care financing and organization outlined in Law 100 of 1993. Russia and Vietnam struggled to develop new forms of insurance and service provision to fill the gaps left by the collapse of their state-financed national health services. Despite large differences in income, social structure, and health status, these and many other countries in the world today are undertaking or considering programs of health sector reform.

The idea of reform — leading to greater efficiency, equity, and effectiveness in health care — has wide appeal. The promise of medical technology — whether eliminating infectious disease or treating chronic and degenerative ailments — is increasingly familiar to populations. Health levels are improving in much of the world, but demands and costs may be rising as well. And in many countries large unmet needs for even the most basic health care persist.

Can the idea of reform be translated into action? Why is health sector reform important? What do we mean by reform and what are its essential components? Can we systematically address the problems of complex national health systems with policy change? What are the tools and methods now available to support this effort and how are they best applied? What can we learn from recent national experiences in the developed and developing countries? These and other questions were raised and discussed at the conference on *Health Sector Reform in Developing Countries: Issues for the 1990s* in September 1993.

This paper was developed to propose answers to some of these questions, as a foundation for the more specific contributions which follow in this collection. Section 2 discusses a working definition of health sector reform. While a precise definition is difficult to arrive at, health sector reform is best described as a process with certain recognizable characteristics, including a focus on fundamental change that is well-conceived and endures. In Section 3, the paper places health improvement and health sector reform in the context of international interest in sustainable development. Health sector reform can be seen as an important contributor to sustainable national development strategies and particularly supports gains in population and health.

Health sector reform should be based on a vision of the health sector as a whole. Section 4 presents and discusses two models of the health sector relevant for reform strategies. The first, based on [1], highlights the linkages between institutions in the health sector. The second shows how specific areas of action for reform, such as defining a package of benefits, or planning the organization of health care service delivery are linked. Reform action must consider the opportuni-

ties and constraints imposed by existing health sector conditions. Planning must also consider the effects of changes in one area of the health sector on other areas.

In Section 5, the paper briefly reviews recent advances in the method of developing health sector reform, such as the tools and methods now available for analyzing different areas of the health sector, for developing and assessing reform action, and for understanding political dimensions and developing consensus on strategies for change. The conclusion notes that the essential preconditions for analysis and development of action plans are present in many countries. There is no single universally applicable strategy for health sector reform. We can look forward to an exciting period of innovation and learning.

2. Defining health sector reform

The term health sector reform has wide appeal, and yet it is difficult to define precisely. Reform implies positive change, building upon and improving what already exists. The *Oxford English Dictionary* defines 'reform' as 'To convert into another or better form' or 'the amendment or altering for the better of some faulty state of things.' [2]. As commonly used, reform also signals substantial change, something more fundamental, complex, and extensive than just another new project or program. Reform implies change in what is done, how it is done, and who does it.

We began the development of this collection defining health sector reform as *sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector*. The health sector refers to the totality of policies, programs, institutions, and actors that provide health care — organized efforts to treat and prevent disease. For practical purposes, it is probably wise to refrain from discussions of health sector reform actions in other sectors which affect health here. This includes actions in areas such as food prices, housing development and education, although these are certainly important in national health gains.

Efficiency, equity, and effectiveness are widely, if not always consistently, defined in the health policy literature [3,4]. Without reviewing those discussions here, this introduction of fundamental health sector goals into the definition of health sector reform implies that reform refers to significant change.

Health sector reform must also be sustained. This means that to qualify as reform, change must be more than just a one-time effort or sudden windfall — it must make a real difference in the way things work over time. For example, a government mandated social insurance scheme without adequate financing — which results in little real change in health or health care — is not a sustained reform. Reform ought to include provision for its own maintenance and continuation. Purposeful implies clearly defined objectives, strategies for achieving those objectives, and effort to monitor change and modify strategies as needed. The general goals of efficiency, equity, and effectiveness must be translated into specific objectives such as productivity increases, added benefits for the underserved, and changes in mortality or disability for specific causes and beneficiaries. Reform implies not only action, but the information to assess and modify that action as well as the means to use the information.

A recent World Health Organization report noted that reform requires changing both **policies** and **institutions** [5]. This acknowledges that more is needed than just a reorientation of goals and intentions. As previously stated, reform requires substantial change in both what is done as well as how it is done.

In reviewing this definition today, it is still unsatisfying. Must reform always be successful, that is, is a failed reform, by definition, not a reform? When does a set of new programs become a reform? For example, was the Child Survival and Development Revolution [6] health sector reform? How much change is needed to qualify as fundamental?

It is doubtful that any definition will be able to capture all the nuances of different types of change strategies in the health sector. Nor is a precise definition essential. For the purposes of policy discussion, we are more interested in assuring breadth and seriousness than in specific labelling. We should view health sector reform as a process with the characteristics described, rather than a well-defined object or action — as a verb, not a noun. Arguing about whether or not something is a reform is not likely to be very productive. Rather, we should acknowledge that the global concern with health sector reform reflects widespread recognition of profound problems in achieving health sector goals and the availability of potential solutions to those problems. The interest in health sector reform focuses our attention on fundamental problems and solutions.

The global interest in health sector reform has emphasized:

- The important connections between health, the health sector, and the broader goals of sustainable human development. Health improvement and health sector reform have important externalities affecting social well-being.
- A vision of the health sector as a whole, not just of one or another of the parts. Specifically, there is growing awareness of the importance of non-government health care providers in many developing countries. To be sure, reform efforts may involve more specific action only on some sub-sectors within a broader health system.
- A changing role for government in the health sector. In many developing countries, state efforts have gone almost exclusively into paying for government-provided health care. Governments increasingly need to redefine their role from one of service provider to one of financier and manager of growth and change in the health sector.
- New tools for both public and private action. Governments must develop their capacities in managing a broader array of fiscal tools: fees, taxes, subsidies, and incentives to bring about desired change. Legal and administrative tools, such as regulation, licensing, and quality control will also play a larger role. Governments can also increase their provision of information to both providers and consumers to improve health sector functions. Private financiers and providers must also develop new skills, as they may be required to increase their provision of public and merit goods.
- A wide range of specific reform strategies. These have been proposed based on analysis by international organizations and recent national experience in the richer and poorer countries. These strategies include strengthening public

management; explicit priority setting for a universal package of assured interventions; decentralization; new methods generating and managing finances for health; and enhancing the role of private providers in national health systems. Many of these are reviewed in more detail in the papers which follow.

3. Health sector reform and sustainable development

Health improvement and health sector reform both contribute positively to sustainable development, in different but complementary ways. Health improvement directly increases human well-being and augments the potential for economic and social development, that is, makes development more sustainable. Appropriate health policy, or health sector reform to put in place such policies and to translate them into action, is an important means to efficiency in producing such health gains. Thus, it has a role to play in health and development strategies, even in countries with very low income or poor health.

Rapid health gains also impose new costs on societies. Health sector reform can bring about policies and action which reduce unnecessary or inappropriate costs resulting from such gains. This can make both health and development more sustainable over time.

3.1. Health and sustainable development

It is now widely acknowledged that income growth is not the sole goal of development and that improvements in human well-being, in which reduced mortality and morbidity and freedom from the burdens of disease figure prominently, merit greater attention as goals [6]. The international community is devoting increasing effort and resources to this human face of development, as evidenced by the Year 2000 goals and the World Summit for Children [7], The Progress of Nations [8] and the United Nations attention to indices of human development [6]. Economic growth is essential for development, and both desirable and instrumental for achieving improvements in well-being. But it appears to be neither necessary nor sufficient to achieve broad-based welfare improvements [9], although it may be essential for increasing and sustaining such improvements.

Health improvements are also increasingly recognized as having an instrumental value in enhancing economic development. The arguments on this point include both the traditional human capital view in which individual human capacity gains, especially in education and health, are productivity enhancing; as well as synergism between health gains and fertility reduction, for example, increasing child survivorship as a contributing factor in early rapid demographic transition.

Anand and Sen [10] discuss sustainable development as a development which bequeaths to future generations an opportunity set for human welfare equal to or greater than that enjoyed by the current generation. They argue that enhanced capabilities, including at least basic achievements in health and nutrition are essential components of both the current and future welfare and that enhancing current health may increase the capacity for generating future capabilities.

...we have to see human development as having both *direct* and *indirect* impor-

tance...The material prosperity that is enhanced by human development can, in its turn, contribute to further increases in the quality of life (author's emphasis) ([10] pp. 47–48).

...Redistribution to the poor in the form of improving their health, education, and nutrition is not only intrinsically important...it is also instrumentally important...with lasting influence in the future. Thus, human development should be seen as a major contribution to the achievement of sustainability ([10] p. 33).

This latter point emphasizes the contribution of current health gains to increasing the sustainability of development, not just the generation of present and future wealth.

3.2. Health sector reform and sustainable development

The timing and pattern of demographic and health change can also affect sustainable development through the demands on and response of the health sector to population level changes. Consider an example in the health field. While the demographic and epidemiological transitions may reduce the total number of deaths in a population, there is also evidence that they increase the quantity of morbidity [11], at least morbidity that is reported and acted upon by the population[1]. They also increase the *proportion* of chronic and adult disease in total mortality and morbidity. These diseases are more costly to treat on a per episode basis and, in general, the health return to expenditure is lower (lower cost-effectiveness) resulting in an increasing cost burden and a decreasing social return to health expenditure over time.

Increases in reported morbidity may be caused by increasing awareness of health problems, substitution of morbidity for prevented deaths, or improved measurement. For all of these reasons, developing countries should expect that improving health will be accompanied by increases in perceived health needs. Such increased perceptions of health needs are also associated with rising incomes and education. The predictable result is increased demand for health care. This rising demand over time may include the full range of health care services, from symptomatic self-treatment with over-the-counter pharmaceuticals to advanced treatment of chronic disease in tertiary hospitals. Cross-sectional studies suggest substantial increases in all types of health care use as income rises and in some countries, this includes use of traditional medicine as well [13].

This increased demand for health care includes both benefits and costs to developing societies. Increased health care expenditure represents a benefit, in the sense that it reflects demand for treatment resulting from health gains such as deaths averted and from reductions in morbidity from infectious disease. It represents an increasing cost, however, in the sense that the marginal product of health expenditure is declining (in health terms, making equivalent health gains increasingly costly to produce). Also, as disease patterns shift there may be

---

[1]Most morbidity data represents 'perceived' morbidity as reported by respondents to survey interviewers. There are no positive measures of morbidity against which to measure true levels. Clinical evaluations provide another type of measure, but this suffers from other shortcomings [12].

increased potential for inappropriate expenditure, that is, expenditure which may bring little or no benefit in health or other terms[2]. Theoretically, the result of these countervailing trends (cost-reducing and cost-increasing tendencies as health increases) is indeterminate. The experience of the OECD countries, suggests, however, that rising health care demands and the declining marginal product of health expenditures eventually leads to rapidly escalating costs and profound social concerns about the value for money (in health terms) being produced.

Fig. 1 presents graphically the implications of these hypothesized trends in health and health services accompanying economic development. Aggregate life expectancy increases rapidly with economic growth in countries experiencing the epidemiological transition. The rate of increase decreases over time, ultimately reflecting the status of the currently industrialized countries where gains in life expectancy are small. Health care use, which could be represented by number of consultations, providers, or health expenditures may be quite low preceding the epidemiological transition but at some point begins to rise rapidly. The rate of growth in health services eventually exceeds the rate of growth in life expectancy.

These changes are not homogeneous within countries. Epidemiological polarization [14] implies a double burden for many countries. The increased demand for health care consumption might come from a minority of the population, but one with strong political influence (those covered by social insurance or the urban elite) and might result in limited capacity to provide those population and health inputs with very high social returns which best support sustainable development.

Thus, health improvement implies a rapid increase in health care consumption. This increase in health care consumption is antagonistic to sustainable develop-

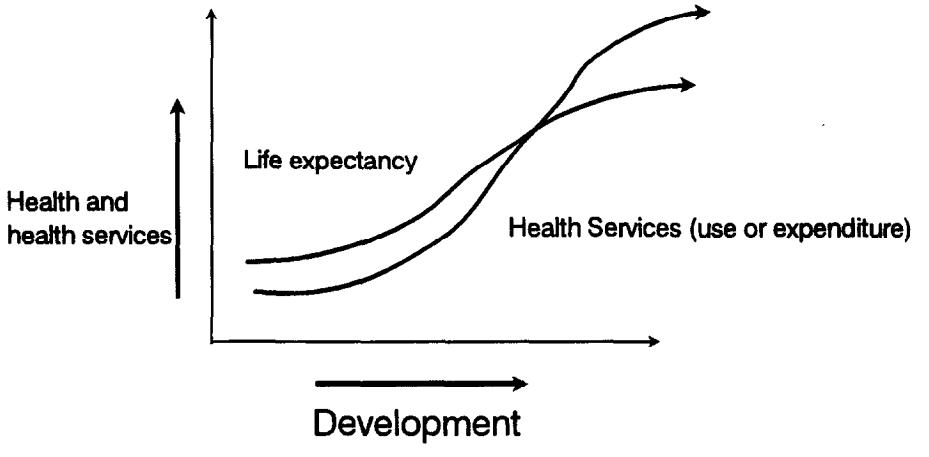

Fig. 1. How health and health services change with development.

[2]There may be benefits in terms other than health, for example utility or welfare, from health care use which does not produce much health. See Hammer and Berman [31] in this issue for further discussion of this point.

ment, to the extent that it: (a) is comprised of expenditure that does not improve health or future productivity; (b) is poorly distributed in society so that the returns to sustainable development could be higher if it were redistributed in some way.

Health sector reform strategies may help countries anticipate these changes and reduce their undesirable effects while retaining the positive contribution of health gains to sustainable development over the long term. In other words, to the extent that health improvement is integral to a sustainable development strategy, health sector reform enhances its efficiency.

Health sector reform is not only for the middle income countries. Appropriate health sector policies are needed in countries at all levels of development, although the content and mix of reform strategies will differ. For example, in the poorest countries or those with the worst health status, the core strategy should emphasize basic health improvements (including access to fertility control methods), while trying to put in place sustainable financing and provision structures and sound public management. Controlling excess consumption of public sector health care resources by affluent urban groups may also have an important role to play in reducing inappropriate burdens on government or poor use of scarce human and financial resources.

In contrast, for middle income countries, strategies might involve more focus on cost containment and reducing growth in some types of health care consumption, with some attention to assuring access to essential services for neglected groups. The desired outcome would be development of a health sector which contributed more to sustainable development on a lower cost trajectory.

Fig. 2 presents one version of what such a joint strategy could entail. In general, it would involve flattening the growth trajectory of health services/health expenditures over the course of development by raising expenditures in the least developed countries and allocating them more efficiently. At the more advanced levels of development, the emphasis would be on controlling the growth of health expenditure. For example, in the least developed countries, an absolute increase in the

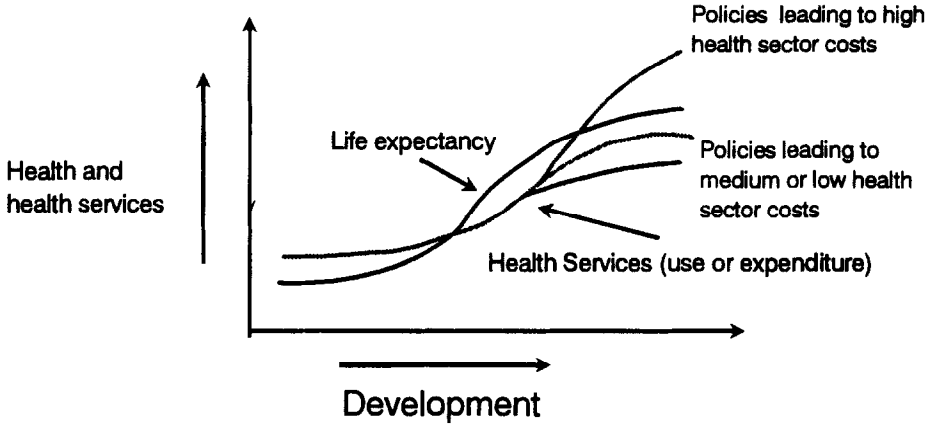

Fig. 2. Sustainable development strategies for the health sector.

quantity of health care provided (or health expenditure) may be needed since many in the population currently have little or no access to basic services. This is likely to require higher levels of health expenditures than the current average of approximately 4% of GDP in the low income countries. It may also mean focussing limited resources on more cost-effective services, as recommended in the 1993 World Development Report.

At the higher levels of life expectancy/income, new and relatively unexplored strategies are needed to lower the growth path of health expenditures as well as the burden of preventable disease. Such strategies might include reducing or postponing the burden of chronic diseases through behavioral changes (reducing smoking, alcoholism, violence, accidents, etc.) [15]; changing preferences for household and individual responses to perceived health needs, such as reducing the demand for costly and inappropriate medical interventions; and increasing the efficiency of medical expenditures in producing health services and health, for example through controlling access to unnecessary treatments and medical technology, improving hospital efficiency, and other supply-side cost containment measures. As shown in Fig. 2, each of these might be expected to reduce the growth path of medical expenditures, freeing up resources for activities with higher returns in terms of sustainable development, which could include higher expenditures on the basic health needs of disadvantaged populations within a country.

4. Domains of action for health sector reform

Reform involves change that affects goals, strategies, institutions, services, and human behavior. Changes to one part of the health sector will affect other parts and will also be constrained by existing capacities. How can we systematically approach the complex structures that make up a health care system and begin to trace these linkages in order to develop better reform strategies?

Frenk [1], in a paper presented to the conference, outlines a general model of a health care system, as shown in Fig. 3. This model highlights the linkages between five major types of actors in the system: providers, the population, the resource generators (institutions which organize, finance, and produce inputs for other actors), other sectors which act in health, and the state as collective mediator. The framework highlights the relationships amongst these actors, primarily in terms of transfers of resources and inputs, delivery of services, and processes of regulation and control.

Based on this schema, Frenk identifies four policy levels for reform action: the systemic, programmatic, organizational, and instrumental. These are described in Fig. 4[3].

The systemic level of policy action mainly addresses organizing and managing the linkages between the major actors in the system. For example, who provides the resources for the health sector? How are they collected and paid out again to

[3] Frenk's chapter in this collection charts the application of this framework in the development of health sector reform proposals for Mexico.

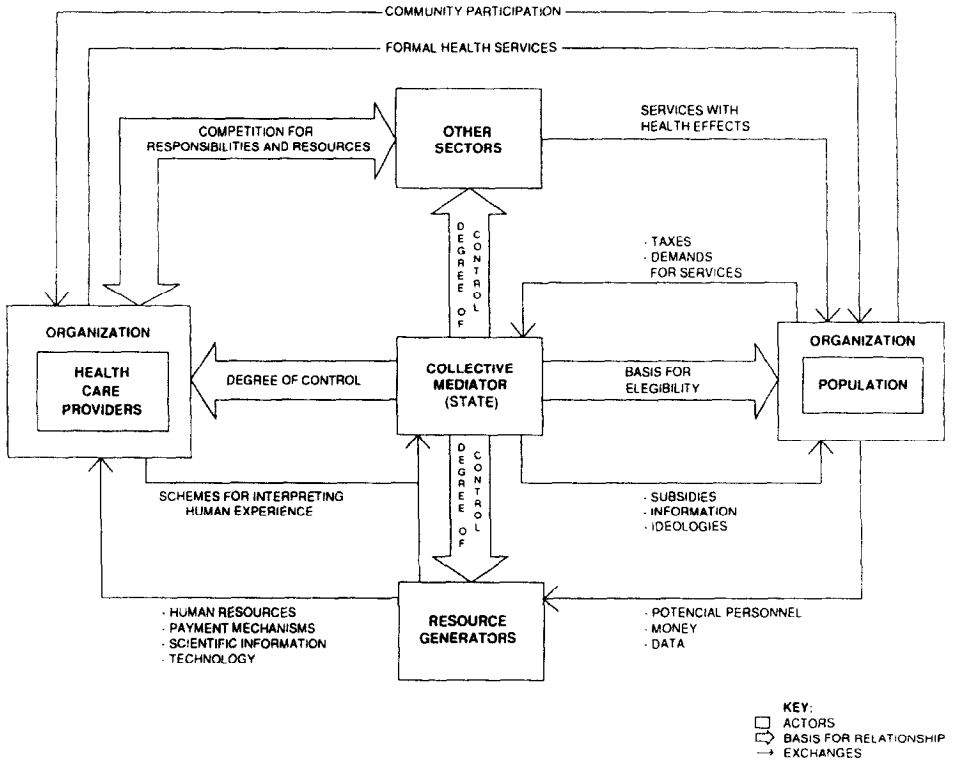

Fig. 3. Components and relationships of health systems. Source: [1].

providers? What should be the overall level of financing? What should be the relative role of the public and private health care sectors? What is the mix of health and health sector policy?

Frenk views the major issue at this systemic level as policies determining population eligibility for benefits in the health care system which determines equity or fairness of the system. For example, in some countries with mainly fee-for-service financing and access to care based on household income, eligibility is mainly a function of ability and willingness to pay. In others, policies have created intermediaries to create a broader distribution of access (through, for example, policies to distribute health providers more widely) or affordability (e.g. through insurance coverage).

The programmatic level addresses what the health service actors do. For example, what diseases will providers treat, with what types of technology and production process. Determining such allocatively efficient strategies often requires some formal approach to setting priorities across competing needs and demands for health care. Increasingly, the method of cost-effectiveness analysis is proposed for this purpose. Assuring universal access to an essential benefits package as proposed by the World Bank [16] for lower income developing countries is one example of applying cost-effectiveness analysis to develop policy at this programmatic level.

Health System Reform
Policy Levels, Objectives, and Issues

Policy Level	Main Objective	Issues
Systemic	Equity	Basis for population eligibility Institutional arrangements: • Public agencies involved in health care • Levels of government • Public/private mix • Population Involvement • Resources generators • Other sectors with effects on health
Programmatic	Allocational efficiency	Priority setting Cost-effectiveness of interventions
Organizational	Technical efficiency	Productivity Quality of care
Instrumental	Institutional Intelligence for performance enhancement	Information systems Scientific research Technological development Human resource development

Source: [1]

Fig. 4. Health system reform. Policy levels, objectives, and issues.

The organizational level focusses on the *how* of health care provision. Thus, it addresses questions such as what will be the best mix of staff, facilities, equipment and other inputs to assure both quality and low cost in providing services: questions of technical efficiency.

The final level in Frenk's framework is the instrumental level, which refers to policies for collection and use of health systems information, for research and technology development, and for the development of human resources and other inputs for health care.

Action at some or all of these levels often has effects on several different actors in the health care system. For example, reforms in the organization of financing, such as creation of a social insurance scheme for health care or changing physician payment practices (systemic level policies) may alter the mix of services that can be afforded (programmatic level) or the incentives faced by providers in the use of personnel and other inputs (organizational level). It is crucial in developing reform strategies to consider these interactions.

Fig. 5 presents another view of some of the more important linkages associated with major areas of reform often considered in developing countries, highlighting how change in one area affects and is affected by conditions in another area. The figure highlights four major areas of reform action: the package of benefits, health

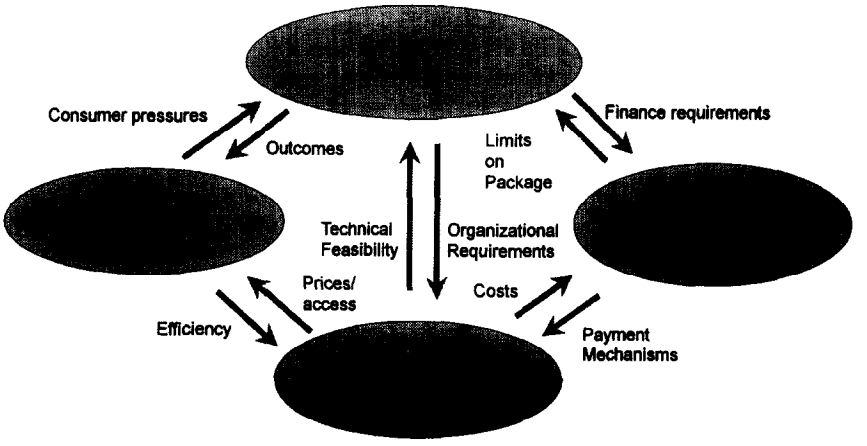

Fig. 5. Domains of action in health sector reform.

care financing, the organization of health care provision, and consumer demand and behavior. Surrounding all of these is a political environment which enables and constrains changes in all areas to varying degrees.

Establishing a package of services or benefits for health care is a major task for policy at Frenk's programmatic level. However, such a package of services affects and is affected by other policies. For example, the overall level of financing available for health services (which could be altered by tax or fee increases, budgetary reallocation, or development of insurance) is a critical factor limiting the breadth of the service package. Conversely, decisions to assure a certain essential package of services imply finance requirements. If resources are more limited (as they are in almost all the lower income countries in relation to World Bank's basic package [16]), then the package must be modified.

Financing reform also has implications for the organizational level, influencing both supply and demand [17]. It is well known, for example, that providers respond in different ways to different mechanisms of payment for their services [18]. Their responses could include changes in the overall supply of services, the production pattern used to generate services, or the prices they charge patients. Thus, financing can also influence the demand for services: increasing it by reducing prices to users or constraining it through shifting the burden of payment more towards the user.

The organization of health care provision also interacts closely with these other areas. How health services are organized is a major determinant of how much they are used and who uses them. In developing countries, health care organization strategies have focused heavily on reducing barriers to access such as travel time and cost. The development of primary health centers was intended to provide accessible medical care to all. The community health worker movement sought to further reduce physical distance and financial constraints to access, and to make lower level health care providers more socially acceptable [19]. The level of service

use for different types of health facilities in turn affects the costs of running those facilities as well as the cost-efficiency of health care provision [20].

Another important dimension of the organization of health care is the constraints it places on the capacity to carry out specific interventions. Smaller and more peripheral facilities may be more accessible to poor, rural populations, but it may be difficult to assure that they can provide essential interventions of adequate quality. The feasibility and cost of assuring drug supplies or providing important support services (laboratory or blood transfusion) is compounded for more remote facilities. This constrains the package of benefits and has implications for financing requirements. Similar linkages to the examples above can be traced between the various areas of action shown in Fig. 5. Viable health sector reform strategies must consider such linkages to come up with workable solutions.

5. Tools for developing health sector reform strategies

Our knowledge in developing countries about current practices and issues within each distinct area of action is increasing. A variety of tools are now available to researchers and policy analysts to address these different areas of reform action.

Table 1 lists some of the existing tools that can be used to analyze health sector conditions as well as to develop strategies for reform, and links these tools to the specific areas of action. For example:

Package of services. Burden of disease analysis and cost-effectiveness analysis have been applied to a global assessment of service priorities by Murray et al. [21] and the World Bank [16]. National studies have been or are being carried out in Mexico (Frenk, this volume), Colombia, and India, among other countries. Cost-effectiveness analysis of multiple interventions is also being done in Mexico, India, and Egypt, for example.

Financing. National health accounts is a tool for describing the total health care expenditures in a country as a flow of funds between sources and uses [22]. While the method must be adapted to local conditions, it is currently being applied in Mexico, Bolivia, Egypt, and the Philippines, for example. More extensive analysis

Table 1
Examples of important tools available for developing health sector reform stratagies

Package of services	• Burden of disease analysis
	• Demographic research
	• Epidemiological research
	• Cost-effectiveness analysis
Financing	• National health accounts
	• Finance simulation models
	• Economics analysis of provider response
Organization of provision	• Management information systems
	• Service planning simulation models
	• Cost analysis
Use and demand factors	• Economic analysis of demand
Political factors	• Political mapping

of health care financing using economic tools has been done in many developing countries [23,24].

Organization of provision. Health services costing methods have been used extensively in developing countries, increasingly using standardized approaches [25]. Health personnel planning techniques are also available [26]. Computer-based tools are becoming more widely used both for planning essential inputs to health care providers [27] and for assisting executives and service managers to improve quality and efficiency.

Consumer demand. Economic analysis of demand for health care has now been applied in a sizeable number of countries, allowing increasing standardization of data collection methods, analysis, and results [13,28,29].

Despite having an extensive toolbox at our disposal, our understanding of the dynamic processes linking these areas of action, as shown in Fig. 5, is much weaker. We have little empirical evidence, for example, of how public and private providers will respond to changes in health care financing. Alternatively, the World Bank's recommendation that countries identify a universal basic benefits package and restrict public financing to it has never been subjected to the scrutiny of consumer and provider groups in a developing country. Since health sector reform strategies need to take into account the full effects of changes on the health care system, developing such understanding is one of the major challenges facing reformers in the future.

The political dimensions of health sector reform also require attention and may, indeed, be far more important overall than the specific technical issues. As Cassels noted in WHO [5]: 'Health sector reform is a political process. It will never be in everyone's interest and cannot be promoted by rational argument alone'. Reich, in this collection, provides a more systematic analysis of how political conditions affect reform. He also introduces political mapping [30], a recently developed tool that can help in understanding the political forces supporting or inhibiting reform action. It can be applied *ex post* to explain the political process in response to reform proposals or implementation; or *ex ante* to assist in the development of reform strategies.

6. Conclusions

All human societies care about their health and devote resources to its maintenance and improvement. In most developing countries today, the resources provided for such improvements are inadequate. Even where relatively large amounts of resources are available, from both public and private sources, health sector performance often falls short of potential and of the populations expectations.

This paper began by accepting the notion that development is an instrument to improve human welfare. Hence, health is an essential end or goal of development. In addition, welfare improvements, specifically health improvements, are also instruments, both for increasing the rate of development, but also for assuring its *sustainability.* Health promotes sustainable development directly. The efficiency and equity of health care systems can also increase the sustainability of development, when they respond appropriately to current population needs and to changes in population health and demand which accompany development.

Health sector reform is the process of improving the performance of existing systems and of assuring their efficient and equitable response to future changes. It is defined as sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector. Health sector reform requires the successful management of political and social forces, as well as the application of sound technical analysis in the development of policies and actions.

National health sectors are complex and vary substantially from country to country. They can be characterized in many different ways in terms of actors, relationships between actors, and modalities for action, depending on the questions being asked or the focus of the analyst. Substantial health sector reform efforts should be based on some comprehensive view of the sector as a whole. They should explicitly consider both the political and technical dimensions of action. And they should expect that reform actions in one domain of health care systems will have effects on other domains, since there are numerous direct and indirect linkages across the parts.

Tools are increasingly available for analyzing health sector problems, developing solutions, and monitoring and evaluating results. While technical development of tools should continue, there is no need to await some new discovery to begin considering reform.

There is no single strategy for health sector reform. Countries inherit systems that impose advantages and constraints which must be incorporated into efforts at change. However, paralleling the efforts to understand health sector change in the industrialized countries, there is a growing comparative experience across developing countries. Countries in all the developing regions of the world are engaged in various aspects of health sector reform. There are many opportunities for mutual exchange and learning. The coming years offer the promise of significant change towards better health in much of the developing world.

Acknowledgements

The author would like to thank Michael Reich, Lincoln Chen, and Kara Hanson for their comments and suggestions. He also benefited from discussions at a round table on Population, Health, and Sustainable Development at USAID and in his class on Health Policy and the Health Sector at Harvard.

References

[1] Frenk, J., Dimensions of health sector reform, Health Policy, 27 (1994) 19–34.
[2] The Compact Edition of the Oxford English Dictionary, Volume II, Oxford University Press, London, 1971.
[3] Culyer, A., The Normative Economics of Health Care Finance and Provision, Oxford Review of Economic Policy, Vol. 5, No. 1, 1989.
[4] Wagstaff, A. and Van Doorslaer, E., Equity in the finance and delivery of health care: concepts and definitions. In: Equity in the Finance and Delivery of Health Care: An International Perspective, Oxford University Press, London, 1993, pp. 8–19.
[5] World Health Organization (WHO), Health Sector Reform: Report on a Consultation, WHO, Geneva, 1993.
[6] United Nations Development Programme (UNDP), Human Development Report 1994, Oxford University Press, London, 1994.

[7] United Nations Childrens Fund, The State of the World's Children 1993, Oxford University Press, London, 1993.
[8] United Nations Childrens Fund, The Progress of Nations 1993, UNICEF, New York, 1993.
[9] The Rockefeller Foundation, Good health at low cost. In S.B. Halstead et al. (Eds.), Proceedings of a Conference held at the Bellagio Conference Center, Bellagio, Italy, The Rockefeller Foundation, New York, 1985.
[10] Anand, S. and Sen, A., Sustainable Human Development: Concepts and Priorities, Harvard Center for Population and Development Studies, 1994.
[11] Murray, C. and Chen, L., In search of a contemporary theory for understanding mortality change. In L. Chen and A. Kleinman (Eds.), Ware, Health and Social Change in International Perspective, Harvard School of Public Health, Boston, 1994.
[12] Murray, C. and Chen, L., Understanding morbidity change, Population and Development Review, 18(3) (1992) 481–503.
[13] Gertler, P. and van der Gaag, J., The Willingness to Pay for Medical Care, Evidence from Two Developing Countries, World Bank, Washington, DC, 1990.
[14] Frenk, J. et al., Elements for a theory of the health transition, Health Transition Review, 1 (1991) 21–38.
[15] Bumgarner, J.R., China: Long-term Issues and Options in the Health Transition, A World Bank Country Study, World Bank, Washington, DC, 1992.
[16] World Bank, World Development Report 1993, Investing in Health, World Bank, Washington, DC, 1993.
[17] Ellis, R.P. and Maguire, T.G., Supply-side and demand-side cost sharing in health care, Journal of Economic Perspectives, 7 (1993) 135–151.
[18] Ellis, R.P. and Maguire, T.G., Optimal payments systems for health services, Journal of Health Economics, 9 (1990) 375–396.
[19] Berman, P., Gwatkin, D. and Burger, S., Community-based health workers: head start or false start towards health for all?, Social Science and Medicine, 25(5) (1987) 443–459.
[20] Berman, P., Brotowasisto, Nadjib, M., Sakai, S. and Gani, A., The cost of public primary health care services in rural Indonesia, Bulletin of the World Health Organization, 67(6) (1989) 685–694.
[21] Murray, C.J.L., Lopez, A.D. and Jamison, D.T., The global burden of disease in 1990: summary results, sensitivity analysis and future directions, Bulletin of the World Health Organization, 72 (1994) 495–509.
[22] Rannan-Eliya, R.P. and Berman, P., National Health Accounts in Developing Countries: Improving the Foundation, Data for Decision Making, Harvard School of Public Health, Boston, 1993.
[23] World Health Organization, Evaluation of Recent Changes in the Financing of Health Services, WHO, Geneva, 1993.
[24] Normand, C. and Weber, A., Social Health Insurance, A Guidebook for Planning, WHO, Geneva, 1994.
[25] World Health Organization. In A. Creese and D. Parker (Eds.), Cost Analysis in Primary Health Care, A Training Manual for Program Managers, WHO, Geneva, 1990.
[26] Hall, T.L., Human Resources for Health: A Tool Kit for Planning, Training, and Management, WHO, Geneva, 1991.
[27] Wolowyna, O. and Angeles, G., Health Resources Planning Model, Users Guide, Data for Decision Making, Harvard School of Public Health, Boston, 1993.
[28] Akin, J.S. et al., The Demand for Primary Health Services in the Third World, Rowman and Allanheld, NJ, 1985.
[29] Bitran, R.A. and McInnes, D.K., Health Care Demand in Latin America, Lessons for the Dominican Republic and El Salvador, EDI Seminar Paper No. 46, The World Bank, Washington, DC, 1993.
[30] Reich, M.R., Political Mapping of Health Policy, A Guide for Managing the Political Dimensions of Health Policy, Data for Decision Making, Harvard School of Public Health, Boston, 1994.
[31] Hammer, J.S. and Berman, P., Ends and means in public health policy in developing countries, Health Policy, 32 (1995) 27–43.