



**A Resource
For Managing
Health Sector
Reform**

Issue Brief



A Decade of Health Sector Reform: What Have We Learned?

DDM Issue Briefs communicate important findings of our research on critical issues in health sector reform to key health policy makers, counterparts, and colleagues in the field.

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For most of the last decade (1990-00) the DDM Project has worked to create resources for managing health sector reform. We have defined “health sector reform” as strategic, purposeful change—strategic in the sense of addressing significant, fundamental dimensions of health systems; and purposeful in the sense of having a rational, planned basis.

Major Types of Reform

Our review of efforts at health sector reform in developing countries highlights three major types:

- ❶ “Imposed Reform” driven by changes external to the health system; i.e., the collapse of communist governments; major state reforms; and structural adjustment programs.
- ❷ “Big R” reform derived from strategic, purposeful reform programs that introduced change in two or more of the “control knobs”¹ affecting health system performance across several parts of the system.
- ❸ “Small r” reform—still strategic and purposeful, but more narrowly focused on only one “control knob” and only one part of the system.

Much of what has been criticized in health sector reform to date is the result of rushed efforts to respond to change imposed from without.

Many African nations, for example, introduced user charges in public health facilities in the late 1980s and early 1990s, in response to falling real currency values and budget cuts resulting from structural adjustment. These responses were often labeled “health sector reform” programs and severely criticized for their negative impact on equity and failure to generate revenue. But can this imposed change be equated to health sector reform as strategic, purposeful change? We think not.

The International Experience

We find that “Big R” reform is not that common in developing countries. Our list of “Big R” reform countries in the 1990s includes Colombia, the Czech Republic, Poland, China (parts), Zambia, South Africa, and the Philippines. On this list, only China and Zambia could be considered lower income countries.

This is not surprising. Major reform demands a great deal of information and evidence as well as substantial institutional and human capacity—conditions not available everywhere and at all times.

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¹ Hsiao, William. (2000) “Inside the Black Box of Health Systems.” *Bulletin of the World Health Organization*.

Interestingly, “Big R” reform often emerges in conjunction with national crises or major, at times traumatic, political changes. This was the case with Colombia, often held up as a model of major reform in the 1990s. Colombia enacted comprehensive health sector reform legislation in response to a fiscal crisis in the publicly-financed social security system and the fiscal opportunity emerging from major new petroleum discoveries. Although this program has accomplished much, in recent years it has been hampered by institutional constraints and suffered from political instability.

Although “little r” reform has been promoted as being simpler and more focused, international experience suggests otherwise. DDM studies of hospital autonomy programs in five developing countries showed that even change on this scale was often not successful. Translating autonomy goals into effective legislation and changed administrative rules was not straightforward, nor was the actual movement from *de jure* autonomy to *de facto* autonomy at the hospital level.

Our main conclusion from this review is that there is not yet enough evidence on the impact of well-designed reform programs in developing countries to draw strong conclusions about whether reform works. We have learned some important lessons from the experiences of the last decade, but they are not sufficient to provide us with a comprehensive assessment.

But we do know that the old models were clearly not working. Ultimately, it will simply not be possible to evade the need for strengthened health care systems in the face of the continuing health and epidemiological transitions; health priorities that demand more complex interventions; and the dim prospects for new or increased resources for the health sector in the immediate future.

Some Useful Lessons Learned

❶ “Big R” reform is hard to do. It requires conditions—political opportunities, sound leadership, stability in government, capacities in human skills, information, and organization—that are difficult to achieve, especially in the lower income countries. Major health reform is not always viable.

❷ “Big R” reforms require major efforts in capacity-building. Much more emphasis should be placed on organizational development and training in the implementation of major reforms.

❸ “Little r” reforms, while seemingly less demanding, have also had mixed results. Sometimes the same conditions are lacking. And “little r” reform does not eliminate the need for sound systems analysis.

❹ Health sector reform, big or little, cannot be developed from a single global or even regional policy formula. Nevertheless, we need to strive to identify those lessons and approaches that can be generalized to guide our efforts.

❺ Reformers have not always focused enough on the actual outcomes of reform—improvements in health, equity, financial protection, and patient satisfaction. We need to develop better monitoring and evaluation.

For more information see Berman, P. and T. Bossert (2000). *A Decade of Health Sector Reform in Developing Countries: What Have We Learned?* DDM Report No. 81. Boston: Harvard School of Public Health. This and other DDM reports are available at www.hsph.harvard.edu/ihsq/ihsq

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