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

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Introduction

In September 1993, the Data for Decision-Making (DDM) Project organized ”The International Conference on Health Sector Reform in Developing Countries: Issues for 1990s.” At the time of this conference there was great enthusiasm for health reform. The United States was debating the Clinton Plan, the most significant health reform proposal in several decades. The United Kingdom, the Netherlands, Sweden, and other European countries were implementing new financing and delivery arrangements. Middle-income countries, such as Taiwan, were introducing new health insurance systems. The World Bank had just issued its 1993 World Development Report “Investing in Health”, which proposed a substantial rethinking of health sector strategies in the lower and middle income countries.

Important achievements of health care in developing nations during the preceding years included the movement towards universal childhood immunization; expansion of oral rehydration therapy; and the approaching eradication of polio in the Americas. There was also increased recognition of new challenges in reproductive health, management of the sick child, and HIV/AIDS. Vertical and categorical programs had made a mark. Nevertheless, it was also increasingly apparent that the health systems necessary to support and sustain these gains were seriously deficient and often deteriorating. As many sector reports and health sector assessments consistently demonstrated, health systems in numerous developing countries suffered from grossly inefficient and inequitable resource allocation, declining quality, and demoralized work forces. Patients were abandoning public systems, "voting with their feet," by choosing private care, which was often of questionable quality. These deteriorating health systems raised questions of whether the significant health gains would be sustained when intensified donor-supported efforts ended, whether simply injecting more funds would be wise or effective, and whether new gains would be possible in the poorest countries.

“Health sector reform” promised a period of new thinking and innovation in health systems that would address this gap. Concepts such as “new public management” or “public-private partnerships” heralded an exciting potential synthesis of public purpose and entrepreneurial creativity that could launch a new period of rapid health gains. Innovations in health care financing and delivery were seen to be invigorating bureaucratically-run health care systems in more advanced nations. Could they possibly bring new energy and results to the developing countries’ health care systems?

Since that period of optimism there has been a pronounced shift in the intellectual health community. At the end of the decade, while attending other international conferences, we heard leading health systems researchers decry “health sector reform” as a major problem that was damaging health systems in developing countries. Many in the audiences appeared to be in agreement. Lists of putative "problems" were attributed to the "failure of health reform," including the growing inequity imposed by user fees, the damage done to vertical immunization and family planning programs by decentralization, the reduction of access of the poor to quality services caused by inequitably organized insurance systems .

What happened in the intervening years? To what extent was the initial optimism (or is the later pessimism) justified? The completion of the DDM project offers an opportunity to examine these questions. Let us consider what has been learned about health sector reform in developing countries during the past decade that the project has been operating and ask what lessons can be learned for future action.

What is Health Sector Reform?

Reform means positive change. But health sector reform implies more than just any improvement in health or health care. In 1995 DDM advanced a definition of health sector reform as "sustained, purposeful and fundamental change" – "sustained" in the sense that it is not a "one shot" temporary effort that will not have enduring impacts; "purposeful" in the sense of emerging from a rational, planned and evidence-based process; and "fundamental" in the sense of addressing significant, strategic dimensions of health systems (Berman, 1995). Other authors listed specific dimensions of health system change that were typically part of reform strategies (Cassels, 1995). Clearly health sector reform can include a wide range of action on health systems.

Health sector reform is not a concept that demands a single global definition, nor should we try to be too specific in splitting hairs about what is and what is not reform (Cassels and Janovsky, 1996). Still, the emerging critique of the concept suggests that we should be more explicit about what was sought and what is now open to criticism. We need to be clearer about what qualifies as health sector reform in order to evaluate its effectiveness.

Following our initial definition, it is useful to specify what we mean by "fundamental" change. In an article to be published this Spring, William Hsiao (2000) specifies a set of "control knobs" that determine the major processes and outcomes of health care systems. Hsiao's framework implies that the major focus of health sector reform efforts is to establish, set, or adjust these control knobs of financing, payment, organization, regulation, and consumer behavior.

Making explicit such mechanisms of health system action can help us to characterize health sector reform more carefully. It may be useful to distinguish more strategic and fundamental programs of system change from those that are more limited, partial, or incremental. The former might be called "big R" reforms and the latter "little R" reforms. We propose that "big R" reforms are those that involve at least two or more of Hsiao's control knobs in programs that affect a substantial part of the health care system. "Little R" reforms are those that address only one control knob with a more limited scope of change.

For example, establishing a new or greatly expanded system of national health insurance should properly involve substantial changes in financing, regulation, and delivery. Depending on how these are structured, they would significantly affect the organization of health care delivery as well. This would qualify as a "big R" reform. In contrast, "small R" reforms would include the introduction of user charges in public

clinics or granting of autonomy to the national teaching hospital. Such efforts can have important benefits, to be sure, but in isolation they are not of the same scope or degree of difficulty as the “big R” changes. While a "big R" reform may involve the implementation of many "small R" activities, it is the broad systemic package that makes a "big R" implementation more that the sum of its "small R" parts.

Secondly, the reform should be "purposeful." This means that the elements and components of the reform need to have been developed in a rational manner: identifying clearly the problems of the health systems—evidence-based—and linking the mechanisms of system change to solving those problems. A clearly articulated policy of health reform is required so that major actors responsible for implementing the change can specify goals and objectives, acknowledge the relationship of their activities to achieving the goals of reform, and the purposeful linkage among different components of system change.

Third, the reform should be “sustainable.” Most fundamental changes will be sustained because they involve significant transformation of systems and the creation of actors who will defend their new interests in the political process. However, reforms that are passed by legislation and not implemented would not qualify; nor would failed reform efforts that are later reversed. For instance, the ambitious "managed competition" reforms of the Netherlands were not sustainable—they were never fully implemented and the reform laws were amended to remove most of the anticipated system changes. We can certainly learn lessons from aborted or unsustainable reform efforts, but they are not complete examples of health sector reform.

The purpose of this distinction is not to develop a litmus test we would apply to country experiences in the last decade to determine which were big and which were little reforms. Rather it is a heuristic device to help us appraise more clearly the experience of the last decade in health reform.

Not All Health System Changes are Health Sector Reform

We think it is important to distinguish purposeful health reform from changes in the health sector that are imposed by reforms from outside the sector. This distinction allows us to evaluate health reforms on their own terms as purposeful means of achieving articulated goals. The use of the term "health sector reform" in many settings and by many actors with different motivations accounts for some of the negative experiences with health system change. Changes imposed by broad governmental initiatives, often with international donor support, usually do not have the explicit goal of improving the health system. Rather, they seek to achieve non-health goals such as macroeconomic stability or more democratic political systems. Changes of this type may or may not produce improvements in health systems or in health. They were often not designed explicitly to do so. We should be cautious in calling such changes "health sector reform," since they may tell us little about purposeful programs of health system change. They may nonetheless have important impacts.

Changes imposed from outside may come from a variety of sources:

1. Some health system changes have resulted from profound political, social, and economic reforms, such as those that occurred in the nations moving away from communist rule or socialist economics.
2. Other health system changes have resulted from movements to reform the state, most apparently in Latin America.
3. Still other health system changes have resulted from national programs to address acute financial crisis (usually in the form of "structural adjustment") initially in Latin America in the 1980s, and more recently and dramatically in sub-Saharan Africa.

By contrast "health sector reform," as we suggest above, can be characterized as "big R" (strategic and purposeful) and "small R" (incremental and purposeful) and the means of evaluating these two forms of health reform may be different.

In general we find that most purposeful health reform is of the "small R" variety. That is, only a few developing countries have undertaken a significant process of health system analysis resulting in planned strategic change. For only a handful of these countries can we observe the results of such "big R" reform and draw some conclusions. Far more common is implementation of "small R" reforms. We should expect that such modest changes would not fundamentally transform health care systems, although they often result in both positive and negative effects.

Some Examples of Different Reform Experiences

Let us look briefly at some of the types of reform described above. First we consider the health sector changes imposed from outside the health sector:

In the states emerging from communist rule—such as the states of the former Soviet Union and eastern Europe or those still retaining communist party government, but having opened up their economies to the world (i.e., the People's Republic of China and Viet Nam)—we find that structural and economic changes imposed by market reforms have had an impact, usually negative, on the health sector. In China, the economic changes that began in 1978 (Gu and Tang, 1995) rapidly dismantled the socialized mechanism for financing health care. The result was a sudden introduction of market forces into what had been a state-organized system. Primary level services lost their collective funding base in much of rural China. State budgets were inadequate to support urban hospitals. These changes unleashed a variety of subsequent changes such as privatization of village doctor practices, introduction of financial autonomy for hospitals, and cost escalation as prices were liberalized and providers were free to try to increase revenues. Health sector change in China has largely been *in response* to these economic reforms (Wei and Ren, 1999; Liu et al., 1995). To date, the state has given little priority to a purposeful health sector reform, although there are indications that there is interest now in using this period of change and experimentation in some provinces and cities to develop a more coherent national strategy.

The second type of health system change imposed from outside resulted from the reform of the state and decentralization, which was particularly apparent in many Latin American countries. In the late 1980s and early 1990s, Latin America was inundated by a wave of interest in reform of the state as a response to the financial "debt" crisis of the 1980s and an interest in restoring democracy after decades of military rule in many countries (Grindel, 1996). In Bolivia, for example, the new government of President Sanchez Lozada assumed power in 1993. Reform of the state there took the form of reduction of state budgets and substantial decentralization of government functions to the municipalities. The government's health care functions were included in this decentralization program, but *not* as an intentional program of health sector reform. This reform initially resulted in reduced funding for health facilities, until a specific "small R" health reform directed municipalities to assign an earmarked portion of their funding to health (Ruiz and Guissani, 1998; Dymetriczenko ,1999)

Decentralization reforms also occurred in other continents and the experience of Senegal is particularly instructive. In Senegal, after years of efforts to decentralize to district health offices within the health sector, the government imposed a radical decentralization to local municipalities with no guidance on how to fund and operate the health system. This led to widespread breakdown of the health system and almost no communication between health officials and newly empowered mayors (Grundman, 2000). In both Bolivia and Senegal, health system managers and international organizations have tried to make a virtue out of necessity by investing in health systems improvements under the newly decentralized state. But that is a far cry from a purposeful policy of decentralization designed specifically to improve health systems.

Another source of outside reforms were the major programs of structural adjustment imposed on countries, especially in Africa, that faced major financial crises in the late 1980s and early 1990s. The programs of structural adjustment, led by

international financial institutions (World Bank and the International Monetary Fund), included allowing local currency to be devalued, reducing government expenditures (often including social expenditures) and debt, and cutting back on the civil service. Government resources for health were often significantly affected by this process, through spending cuts and price increases of imported goods. In analyzing these experiences, Sahn and Bernier (1995) reported that "structural adjustment…has not imperiled the functioning of the health sector through imposing fiscal austerity and reducing the size of the budget." But they also noted that structural adjustment "did not contribute to major intrasectoral reallocation of scarce… resources" and that "major shifts in health policy are the exception; reforms are more often than not incremental in nature." In other words, in response to these macro-economic reforms, the health sector most often responded with "small R" health financing reforms, such as the introduction of user fees in Kenya and Ghana, or the Bamako Initiative to encourage community financing of drugs.

Where health sector reform has been launched initially as a program to bring about significant health system change, the type of sustained, purposeful, and fundamental reform that was cited in DDM's 1993 definition has been quite rare. As a preliminary suggestion, we would list the following developing countries as examples of such "big R" reforms since the 1980s: Chile, Colombia, Zambia, Czech Republic, Hungary, Poland (after 1999), China (in pilot parts of the country), and South Africa. Only Zambia and China are lower income countries on this list. In contrast, a list of developing countries engaged in "small R" reforms (including introduction of new financing mechanisms such as user charges and local prepayment schemes; or new forms of management and organization such as decentralization and hospital autonomy among others), would be quite long.

Chile's health reforms began in the early 1980s and were among the first of the current wave of health reforms. (The prior wave was the establishment of major national health systems in many developing countries in the 1950s and 1960s.) The Chilean system created private insurance plans called ISAPRE and decentralized its primary care system (Castañada, 1992). It involved all the major "control knobs" in Hsiao's typology:

- major change in financing, by creating a significant private insurance system funded largely through social insurance contributions;
- decentralization of primary care facilities to municipal governments;
- changes in payments mechanisms involving first fee-for-service, then per capita payments;
- new regulatory regimes, including a *Superintendencia* of insurance; and
- new programs to change health behavior for preventable conditions.

The Colombian reforms of 1993 also covered all of the "control knobs" in an innovative social insurance scheme that allowed "managed competition" among public and private health insurance plans and contracting with public and private providers (Colombian Health Sector Reform Project, 1996).

The Zambian reforms initiated in 1991-92, and elaborated in subsequent years, included an innovative institutional restructuring of government health care by creating a Central Board of Health to oversee health care delivery matters external to the Ministry of Health. It also involved significant decentralization to district health management teams and health boards, the introduction of user-fees, and the development of a nationally defined benefits package (WHO et al., 1997).

The Central and Eastern European nations also instituted a variety of fundamental reforms of the Soviet style systems that had been imposed on them. The Czech Republic reforms in the early 1990s involved rapid privatization of state-owned services, the creation of multiple state-linked and private health insurance funds, and the introduction new payments mechanisms and regulatory organization. And, in Hungary, less ambitious reforms involved more modest privatization of primary care, introduction of a centralized social insurance system, and decentralization of ownership to the municipal level. While Poland experimented with decentralization, the creation of hospital and clinic autonomy and some pilots of privatization of primary care providers in selected regions and cities, it was not until it passed a health insurance act in 1997 that fundamental change was initiated (Berman, 1998).

The experience of the "big R" reform countries has a number of common elements. First, sometimes (but not always) "big R" was made possible by some type of acute crisis, opportunity, or both, either political or economic. For example, in Colombia, health reform legislation was introduced along with legislation to reform the national pension system, which was in crisis. Colombia had recently elected its first democratically chosen government in many years. Petroleum had also recently been discovered, giving the government a huge fiscal lift and the opportunity to propose expensive and highly popular policy changes. While this is not always the case, it does seem that big health system changes can be enabled by significant changes in the larger national environment. The implication of this statement is that simply needing change, having that need be recognized, and even being able to afford significant change, may not always provide sufficient conditions for "big R" reform. It is also true that some "big R" reforms, such as in the Chilean case, do occur without economic crisis or major political change.

While adequate design and planning of "big R" reforms ought to be preceded by a significant analytical effort, this is not always the case. Most of the countries listed above undertook major efforts of health system analysis, but only some of them did so before launching "big R" reform. Others discovered that substantial analysis was needed soon afterwards. The Chilean reform was designed by a small team of technocrats who were effective in overcoming resistance in the military regime because they had the best data and analysis of the health sector. In Zambia and Colombia, the reforms were initiated after a major analytical effort that involved assessments of utilization of services, burden of disease and cost effectiveness analysis, and in Colombia's case, the existing and proposed insurance systems. However, this effort was far from sufficient and a great deal of additional work was needed in developing the reform implementation.

In contrast to these cases, Poland initiated a new national health insurance program with very limited information or experience (Berman, 1998). Now in its second year, national authorities are working very hard to collect the evidence needed to manage the new system.

To be effectively implemented and sustained, "big R" reforms require substantial numbers of qualified human resources, as well as institutional commitment and stability. In almost all the countries mentioned, this was underestimated. For example, in Poland, national authorities debated for more than seven years about the structure of a proposed national health insurance system. However, when the system was finally launched, in January 1999, there was a significant lack of trained personnel to manage the seventeen regional sickness funds and to staff the central monitoring and regulatory bodies. The "managed competition" reforms in Colombia required significant new skills and organizational structures in public hospitals and in health authorities charged with new regulatory functions (Bossert et al., 1998).

The issue of institutional stability is especially problematic in the shifting political environment characterizing many developing countries. In the first six years after the reform legislation was passed in Colombia, there were five ministers of health. Each one of them brought into office their own senior management team, often several layers deep in the ministry's bureaucracy (Bossert et al., 1998). In Zambia, MOH leadership was more stable, but the political support for the health reforms and some of the supporting changes was not (Bossert et al., 2000).

Experience with "small R" reforms is, of course, quite varied. "Small R" might be defined as those efforts to address only one of Hsiao's control knobs, or reforms that target only one part of the health care system (for example, hospitals or health centers), one part of the population (rural or urban or formal sector employees), or one type of service (immunization or deliveries).

Most of us are quite familiar with "small R" reforms. The introduction of user fees in most of Africa is an example. In most countries these programs were introduced without other accompanying system changes and with little regard for their impact on the rest of the system (Creese, 1990). Decentralization of health systems that has involved only shifting a few functions to the district or regional MOH offices is another example that has been the norm in many Central American countries (Bossert, 1998). The creation of autonomous independent hospitals has also been implemented—in India, Kenya, and Zimbabwe for example—without system wide changes in financing and payments (Govindaraj and Chawla, 1996). In addition many efforts to promote the private sector, largely through NGOs, have been initiated with donor funding (McPake, 1997).

A special case of "small R" reforms are pilot programs which develop "big R" strategies in a limited area in order to develop and test new approaches. Given the political and technical complexity of "big R" reform, one might expect this to be quite common. Our observation, however, is that it is more the exception than the rule. Two

recent examples supported by USAID and others are the highly successful health insurance pilots in the Issy-Kul region of Kyrgyzstan and the pilots now being developed in Alexandria, Egypt. It is too early to tell if these pilots will result in major “big R” reforms in these countries. In the ideal world (favored by academics), piloting would seem to be the appropriate method for developing “big R” reforms. But, in fact, the evidence suggests that political leaders in developing countries favor making big changes quickly, despite the risks involved when they do use pilots, it is often a way to avoid making “big R” reforms.

It is of course, important to recognize that many "small R" activities are embedded in "big R" reforms. User fees are part of new incentive mechanisms in the reforms in Chile, Colombia, Zambia, and the European countries. Decentralization within the Ministry of Heath is a component of Zambia's larger reforms and decentralization involving municipal authorities is an important part of the reforms in Chile, Colombia, China, and the Central European countries. Hospital autonomy too is part of most "big R" health sector reforms. Many of these innovations are among the specific mechanisms that comprise a broader reform program. However, the effectiveness of each specific "small R" activity is likely to be affected by the transformations of other aspects of the system. The whole in a “big R” reform should be more than simply the sum of the parts. A central question, which has not yet been sufficiently analyzed, is under what circumstances and to what extent is systemic change likely to improve the effectiveness of these specific "small R" reform initiatives. In other words, is "big R" reform likely to produce better effects than the sum of "small R" reforms and therefore worth the greater effort and risk involved?

We should also note that all reform initiatives evolve and change. As problems in design and implementation arise, policy makers are making changes in policy to attempt to redesign and reorient the reforms. In Bolivia, when local governments were not funding health activities, the central government changed the decentralization policy to overcome the problem. Countries learn that it is not only a choice to reform or not to reform; there are more and less effective ways to do each type of reform. Hsiao's control knobs are levers of policy choice and some choices are better than others.

Has Health Sector Reform Been Bad for Health or Health Care?

The most serious critique of health sector reform is that it has actually harmed public health, basic services provision, and equity. This critique bears careful scrutiny.

We might start out with evaluating reform against the general objectives that we posited in the DDM conference in 1993. There we proposed that health reforms be designed to achieve improved equity of access and coverage, better efficiency in the use of health sector resources, improved quality of health services, and sustained financial soundness.

For health sector changes imposed by outside forces, we might generally conclude that they have not been very effective in achieving these objectives and indeed, may have created more problems. China's economic reforms led to the collapse of rural health systems and a significant increase in inequity of access to care (Liu et al., 1995). Senegal's decentralization has also severely endangered the local health services. In Poland and other transitional economies, economic reforms are reported to have led to an increase in the use of "informal payments" to providers that are likely to increase inequities of the system (Chawla et al., 1998).

The results of the "big R" reforms will be addressed in more detail in the presentations in the first session of this symposium. In general we feel that the jury is still out. Most of these reforms have had too little time to be implemented and do not have sufficient monitoring and evaluation data to determine their real impacts. Only a handful of countries with very poor populations (Zambia, China, and South Africa) have attempted “big R” reforms, where we might expect large and measurable health and equity gains. Preliminary evidence suggests that such reforms have experienced difficulties in reaching the objectives we have set out.

We have found that equity problems are significant in most "big R" countries. Colombia has expanded coverage through its social insurance system, but many remain uncovered and will be denied service in the future (Colombia Health Sector Reform Project, 1996). Chile's health insurance system has created a two-tiered system with private plans spending almost twice per capita as much as public services (Bitran and Almarza, 1997). Zambia's local districts are receiving less funding than before the reform and user fees may be limiting access (Chita, 2000). In most countries insurance reforms have been associated with shifting of resources from the general "solidarity pool" to private insurance and private providers who attend wealthier patients, in some cases with additional public subsidies. It is not clear that these inequalities have resulted in less service for the poor than were received before the reform, nor is it clear what would have happened to equity measures if no reform was implemented—the problem of the counterfactual.

With the exception of Zambia, where funding has remained stable or declined, countries with "big R" reforms have been increasing spending on health care significantly. This suggests that reform in developing countries has not primarily been cost reducing. What is not so clear is how to assess this effect. If expenditure increases are accompanied by more than proportional gains in efficiency or health and equity gains, this may be a positive outcome.

We have almost no measures of efficiency and quality to show the impact of health reform on these objectives. We know for instance that hospitals in Colombia and Eastern Europe are inefficient, with low utilization, excess beds, too many staff. However, we do not yet know if the reforms have had an impact on these measures. Quality is difficult to measure in more advanced countries, and while there are increasing use of quality surveys and TQM assessments (Lawthers and Rózanski, 1998), few can demonstrate system wide improvements.

For the "small R" reforms we also have conflicting data. One set of reform interventions that has been widely criticized is the introduction of user fees in public facilities, especially in African countries. The evidence from many of these programs suggests that equity was indeed harmed by introducing fees and that exemption mechanisms intended to reduce this problem rarely functioned well (Creese, 1990; Reddy and Vandemoortele, 1996). But, of course, it is difficult to know the counterfactual; i.e., how would fiscally stressed health services have fared without fees when government budgets were frozen or being cut?

There are also encouraging experiences. The implementation of user fees in Kenya seemed destined, in its early years, to result in problems well-known from other countries. But a major effort of technical assistance, with USAID support, was reportedly able to remedy many of the early failings and establish fiscally significant cost recovery with some equity protections in a very difficult environment (Collins et al., 1996).

Decentralization has often been criticized for increasing inequalities. Studies however show mixed results and in many cases only reflect inequalities that existed before decentralization was implemented (Bossert, 2000). Indeed, evidence from Chile suggests that inequities in municipal per capita health expenditures have been slightly reduced over the decade of decentralization reforms, suggesting that there may be ways to design decentralization so that it can improve equity. Other criticisms of decentralization suggest that it has disrupted effective vertical immunization and family planning programs. Again studies, such as one in Uganda, show mixed results and the causes of the decline in these programs may be attributed to other factors such as declining budgets (Hutchinson, 1999). As noted above, in Bolivia the central authorities were able to restore funding to priority activities by changing the rules of local choice and earmarking funds, without eliminating decentralization (Ruiz Mier et al., 2000).

Health Sector Reform in Developing Countries: What Have We Learned, What Next?

Our main conclusion from this review is that the jury is, properly, still out on health sector reform in developing countries. 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. Health sector reform is, by definition, a substantial undertaking. It will take more time to learn how to do it better and to gain a deeper understanding of its effects. We should also keep in mind the “compared to what” issue. Health reform may not have yet established a clear record of major achievements, but the systems that are being reformed were in dire conditions and were getting worse. The old models were clearly not working.

And, ultimately, can we really choose not to engage in health sector reform? The developing countries bear the bulk of the world’s disease burden and its negative effects. Yes, there have been dramatic improvements from the extension of a few highly efficacious interventions through vertical programs. But it will not be possible to evade the need for strengthened health care systems as larger forces are at work. The health and

epidemiological transitions continue their advance and will place new demands on health systems in countries at all levels of development. These demands may appear more acute in the middle-income countries, but they also drive policy in the poorer countries. Public health and population concerns are advancing a more complex set of problems and interventions for the future. These include meeting the clinical and social needs of women and men in reproductive health, addressing the needs of the sick child, and the catastrophic demands for care and prevention of HIV/AIDS. Health care systems in most developing countries suffer from serious deficiencies in financing, efficiency, equity, and quality. They are poorly prepared to meet these challenges.

The health reform experience of the past decade does provide a number of more specific lessons for us. These include:

1. "Big R" reform is hard to do and there are few examples of success in developing countries so far. Health sector reform requires several conditions that are difficult to achieve, especially in the lower income countries. These include a major political opportunity for change, sound leadership, stability in government over an extended period of time to allow for reforms to develop according to a coherent strategy, and significant capacities in human skills, information, and organizations. We have found in studies of Latin American countries and in Poland that it is difficult to build sufficient support for major reforms. Specific strategies, involving the creation of a politically allied "change team" of technocrats, in the Ministry of Health and other key ministries, are likely to be needed. It is also hard to sustain this political support. Some of the weakness in the implementation of the Colombian reform is due to the change in government after the reform law was passed and the less than enthusiastic support for reform by the government that followed. "Big R" is probably not for everyone at this time. Without sufficient political support, attempting major reform may not be the best way to achieve immediate health system goals.

2. "Big R" reforms require major attention to reforming old institutions and creating new ones -- major efforts in capacity-building. Often reformers assume that changing the financing by making "payment follow the patient" and changing payment mechanisms to provide incentives for efficiency and quality will be sufficient to implement reforms. However, we often find that it is organizational rigidities, and bureaucratic organizational cultures that prevent institutions from effectively responding to these incentives. Reforms require new recruitment patterns, new skills in the workforce, and more adaptive organizational cultures in many different institutions -- public hospitals, insurance plans, local governments, ministries of health and other central government agencies. Much more emphasis should be placed on organizational development and training in the implementation of major reforms.

3. "Small R" reforms, while seemingly less demanding of system capacities, have also been mixed in their implementation and results. Sometimes this is because the same conditions needed for successful "Big R" reforms – new or retrained human resources, better information to identify problems and to design modifications in policy, and organizational strengthening and stability – are also not sufficiently developed in "small R" reforms. However, sometimes "small R" reforms have not

been appropriate chosen or designed to solve the right problems or have caused other problems that may be worse than those they were intended to solve. “Small R” does not eliminate the need for sound systems analysis and attention to how other changes in the system may be conditions for effective implementation.

4. The “devil is in the details.” While there are no clear and simple models of “the right” way to do health reform, be it “big” or “small,” we can identify some important ways that new financing mechanisms, decentralization, hospital autonomy, and other activities can be implemented so as to enhance their effectiveness. There are financing mechanisms in the form of restricted intergovernmental transfers and equity funds that can assure more equity in a decentralized health system. There is sufficient evidence to suggest caution when using fee-for-service payment mechanisms and that for some levels of care, per capita payment is more appropriate. There is growing evidence that under some conditions, community participation can be more effective in implementing an exemption policy for the poor in user fee programs. It may be more important for us to expand on this kind of knowledge -- how to make the reforms more effective -- than on whether to make changes or not.

5. Health sector reform, big or little, cannot be developed from a single global or even regional policy formula. Since we do not have consensus on what effective health reform should be, we need to give attention to national history, values, and culture to help each country define the appropriate approach to reforms. In addition, it is important to have sufficient information and strong analytical tools to define the most pressing problems and to develop and monitor solutions that are appropriate to the specific country conditions. This implies substantial attention both to the analytical basis of the design of health sector reform as well as to investment in the essential underpinnings of implementing reform.

    a. This decade has seen substantial development of tools and methods for assessing health system performance and diagnosing the causes of problems and their potential remedies. We should continue to assist countries and international organizations in the development and application of these tools, such as national health accounts, burden of disease, and political analysis. We also need to develop new tools, such as those for analyzing the organization of health care delivery, quality of care, and community participation. These tools and the information they generate are relatively low cost. They are important international public goods with substantial externalities and scale economies.

    b. Successful programs, be they categorical or sector-wide, require investments in people and systems. The new reforms seem to require that developing country governments emphasize more their role in “steering” the health care system -- regulating a mixed public and private market -- as contrasted with “rowing”, the direct delivery of services (Preker et al., 1999; Musgrove, 1998). The skills and information needed to successfully carry out these roles are underdeveloped. We should not ignore this capacity-building requirement in the interest of achieving only short-term gains.

Reformers have not focused enough attention on the outcomes of reform – the improvements in health, equity, financial protection, and patient satisfaction – that reform is supposed to accomplish. Rather, we have been too focused on the technicalities of design and implementation in financing, delivery, and management. While it may be too soon to really evaluate the long-term outcomes of complex system changes in "Big R" reforms, we need to develop the information needed for this evaluation. In "small R" reforms also we need more careful analysis of what is working to improve outcomes and under what systemic conditions they seem to work in order to make appropriate recommendations about these programs. We have sometimes resented the hard question often posed by some USAID officials: "what was the *result* of all this effort?" Answering honestly that "the returns are not in yet", is a call to pay more attention to evaluation. We have some results, such as studies of user fees and of decentralization, that do indicate some of the impacts of reform. For user fees we have identified some down side impacts. For decentralization we have found little clear evidence of major impacts – either positive or negative. These are just the first results of the inquiries; we should seek answers more actively and need to think more about that question in designing reform and in program monitoring and evaluation. We could do better, especially in the lowest income countries where perhaps some of the more comprehensive reform strategies are not the highest priority. At the same time, our funders need to acknowledge that it is indeed a *hard question*. How should we value the capacity improvements that, even if they don't result in significant immediate impact, prepare the way for change later? Are funders prepared to put more resources into health systems research to answer evaluative questions? More effort on evaluation of reform, including impact evaluation, is needed.

What Next?

Over the decade-long course of the Data for Decision Making project (1991-2000), there has been a steady increase in global interest in understanding health care systems and designing strategies to make them work better. This year's World Health Report, which represents significant collaboration between WHO and the World Bank, will focus on analysis of health systems. It will report on much of the progress in developing more complete and better quality evidence on health system performance. It will also encourage an expanded view of health system objectives and outcomes including population health, financial protection, and responsiveness to population needs and demands.

Without USAID support, much of this evidence base on health and health systems would not exist. This work has been done through several significant evidence-focused projects as well as within more categorical global and regional projects and bilateral activities. With the new leadership in WHO and the emphasis on developing and using evidence for policy, continued support is needed.

USAID's strategy today is to focus on its five main strategic objectives in population, health, and nutrition: 1) reduction of unintended and mistimed pregnancies; 2) reduction of death and adverse health outcomes to women as a result of pregnancy and childbirth; 3) improvement in infant and child health and nutrition and reduction in child

mortality; 4) reduction of HIV transmission and the negative impact of the HIV/AIDS pandemic; and 5) reduction of the threat of infectious diseases of major public health importance. Health systems evidence and health reform are seen as supporting efforts for these priority objectives. But we can also identify some critical cross-cutting issues that must be addressed for all of the strategic objectives and acknowledge that it could be wasteful to try to address them through duplication under each categorical area.

The three such cross-cutting issues we think are particularly important *and* amenable to progress.

1. *Development of sustainable financing strategies for priority services in the lower income countries, especially in Africa*. As development assistance moves more towards sector-wide approaches and linking debt relief with assuring finance for health and education, the opportunity exists for a more substantial and collaborative program to develop, test, and evaluate strategies for increasing and sustaining resources for priority programs. For USAID, this work is being done through many different programs and projects, but it has been difficult to link these efforts together effectively. We propose a major new effort to focus resources, analysis, and evaluation on how to integrate appropriate financing, organizational and regulatory system level reforms so that they assure continuing or expanded support for implementation of priority services such as child survival, family planning, and HIV/AIDS.

2. *Strengthening government approaches to non-government health care providers at the primary level*. Evidence from DHS and many other sources clearly reflects the importance of non-government primary care providers in delivering services for many priority health needs (Berman, 2000). USAID has been a global leader in responding to this evidence with interventions to strengthen public-private cooperation in immunization, diarrheal disease control, family planning, and reproductive health. But many of these interventions have been confined to specific categorical programs. Yet governments also need support at the system level to develop more comprehensive strategies for public-private collaboration and to manage those strategies through training, finance, and regulation. We propose that more systematic attention be given to how to integrate non-governmental providers into broader health reform efforts. An example of this is currently being developed in the LAC Health Sector Reform Initiative that might be used as a basis for global expansion of this effort.

3. *Improving governance in health ministries, local health departments, and health care provider organizations*. The solution to poor public governance has often been to go outside of existing structures, either by creating new vertical programs or working exclusively with NGOs. This may be expedient, but it doesn't address the underlying problem. Can we do more to try to develop new strategies, tools, and training to improve governance, borrowing from the innovation in the U.S. and other advanced countries? We propose a

major new program to focus on how governance and accountability can be improved within health reform efforts.

These kinds of issues can be addressed in ways that create value-added for many countries through well-designed global and regional projects. For USAID, such projects typically serve a dual function; both providing technical resources for USAID missions and regional bureaus as well as providing new thinking and innovation to address cross-cutting problems. The constraint has been that there are often several different projects working on these problems without a common set of objectives or concepts. The country-focused technical work can easily crowd out the cross-cutting and concept-development work. We could strike a better balance with more focused strategies for cross-cutting issues which would ultimately provide better support for the country programs and strategic objectives.

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