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# Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: a Review of Experience

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## EXECUTIVE SUMMARY

Health sector reform aims to alter the role of the state in health care financing and delivery. In a changing ideological and policy environment, the state is being encouraged to reduce *direct* provision of services, and to adopt an *indirect* role in service provision: to ensure health care is delivered, but often through other actors or agents. This new role requires the state to enter into new relationships with private, NGO and community actors. It must 'enable' or 'regulate' these actors, which might take the form of contracting out, the promotion of the private sector, or the creation of public 'arms-length' agencies.

The main purpose of these reforms is to encourage competition, greater managerial autonomy and responsibility, consumer choice, and to promote private sector and NGO operators. Through these operators, and the incentives generated by the new arrangements, service efficiency, responsiveness and quality are expected to improve.

The new models of service provision do not banish government but rather require it to take on roles that are different, often unfamiliar, and often more administratively complex and politically sensitive. But little attention has been given to considering *how* these new tasks should be performed, and whether governments have the capacity to adopt these new roles.

This review paper provides the background to research that will take place in four country case-studies to examine these issues. A key focus of this paper concerns government's capacity to fulfil the new roles expected of it. The paper selects four important new reform arrangements: autonomous hospitals; user fees; contracting out; and regulation or enablement of the private sector, since these represent different dimensions of the public/private mix. The rationale for each reform, the extent of change and lessons learned are briefly reviewed.

For all the reforms in the role of government considered, government capacity to manage the new service provision arrangements is questioned. The critical elements of capacity important to the organisations(s) involved in the service arrangement are often absent. For example, skills are often lacking (eg. government officers' ability to negotiate contracting out arrangements, or define appropriate

fee schedules). Organisations and systems for performing the new roles, particularly information systems for monitoring, are often undeveloped (eg. accounting systems for revenue, information systems for regulating private providers). And resources to fund governments' regulatory and enabling roles (eg. the financial resources of medical councils), and to develop important elements of capacity through training and infrastructure development, are often inadequate.

The broader external, institutional conditions (economic, political, legal) which promote capacity to provide services effectively are often uncertain or vulnerable. For example, the size of the private sector in many contexts places limits on the potential for contracting; the independence of autonomous hospitals from political and bureaucratic interference is limited; and the necessary administrative frameworks to allow facilities to retain fee revenue are lacking in a number of countries.

An understanding is required of what capacities are necessary to manage the new relationships. Where there exists considerable experience, as in the case of user fees, this is a relatively easy task. However, where there is less experience and consequently less understanding of the factors contributing towards success of a particular reform, the problem is more difficult. For example, with contracting, it is currently difficult to say which are important capacities for success: is it the existence of a large private sector, strong negotiating skills in the MOH, good economic analysis skills in the MOH, strong monitoring arrangements, or effective rule of law - or what combination of these capacities? The paper therefore raises many questions, which fieldwork in four countries (Ghana, Sri Lanka, India and Zimbabwe) will address.

## 1. INTRODUCTION

As a result of changing ideologies, donor pressure and fiscal constraints, many countries since the 1980s have experienced reforms in the role of government. Neo-liberal thinking, put into practice through stabilization and structural adjustment programmes, has advocated a reduction in the size and functions of the state. The new conventional view is that the state should not *directly* provide services, unless market failure makes direct provision necessary. Rather, the state should become an *indirect* provider, adopting a role which ensures that essential services are provided, but not necessarily producing or delivering these services. The state's new role should be to encourage (or enable) a diversity of service providers, including 'arms-length' public agencies, and actors in the private, non-governmental and community sectors. This might be achieved through service deregulation and contracting out of services. The state should also maintain some form of regulation. The main purpose of these reforms is to encourage competition, managerial responsibility and accountability and consumer choice, and through these to improve the efficiency, responsiveness and quality of service delivery.

The health sector has not escaped these trends. Health sector reforms in developing countries have changed, or aim to change, the role of the state in a number of ways: private finance has been introduced to supplement public funding; policies are being implemented to enable greater private sector participation in health care provision; governments are using public funds to purchase privately provided services; and there have been measures to restructure (decentralize) and commercialize (through arms-length agencies) the public sector.

This paper explores a number of issues relevant to these reforms. In particular the paper=s aims are to:

i. review the arguments relevant to the health sector which favour changes in the role of the state, including the failure of public sector bureaucracies, and economic and institutional arguments for new forms of service provision;

ii. review and analyse health sector reform experience in developing countries, focusing on selected new forms of health service financing and delivery and the lessons learnt from this experience;

iii. provide a context for subsequent country case study research, and help develop research questions on government capacity to perform its new service provision roles.

Section 2 reviews problems facing public sector bureaucracies in the health sector and introduces the notion of weak 'capacity' in such organizations. A broad typology of reforms being implemented in the health sector is presented.

Section 3 describes two conceptual frameworks (economic and institutional) which are, to differing degrees, informing reforms in the role of government in the West and in developing countries. These two frameworks were chosen because they are currently dominant amongst donors and in the international policy environment. It should be stressed that they are not necessarily the most appropriate perspectives for examining the role of government in developing country contexts. A range of competing perspectives on the role of the state - Marxist, structuralist and dependency theories - are not discussed because they are not explicitly informing the health sector reforms under review.

The new models of service provision do not banish government but rather require it to take on roles that are different, often unfamiliar, and often more administratively complex and politically sensitive. A key focus of the paper concerns government's capacity to fulfill the new roles expected of it: the final part of section 3 presents a framework for approaching the difficult and disputed issue of capacity.

Sections 4-7, which constitute the bulk of the paper, use the conceptual frameworks to analyse international experience of the new role of government in the health sector. The rationale, scope and nature of the changes are reviewed, and the key lessons or implications emerging with respect to government 'capacity' are highlighted.

## 2. PROBLEMS FACING PUBLIC SECTOR BUREAUCRACIES: SYMPTOMS AND DIAGNOSES

### 2.1 The Problem and Its Causes

Public sector bureaucracies face a hierarchy of problems which, in the health sector, often generate inefficient, inequitable, unresponsive and poor quality services. The main symptoms of bureaucratic failure in the health sector in developing countries are documented elsewhere (World Bank 1993; Mills 1995) and are highlighted in Table 1.

**Table 1: The size of the problem**

| Type of problem | Example |
|---|---|
| Allocative inefficiency | Resources are not allocated to the most cost-effective interventions which would reduce the burden of disease for those with the worst health status, namely the rural poor. Resource allocations are skewed towards urban, curative and hospital-based care |
| Technical inefficiency | Resources within a facility are used inefficiently: inputs of staff and drugs in particular may be inefficiently utilized. |
| Inequity | The distribution of resources and personnel do not favour those most in need. |
| Low responsiveness | Health services are not responsive or accountable to users, especially marginal groups. Also staff are not responsive to individual patients. |
| Quality | Poor structural and process quality: limited or poorly functioning equipment; lack of drugs; poor staff manners. |

Source: Mills 1995

Explanations for poor performance relate to questions of government (in)capacity to perform its roles. Explanations relating to different elements of weak bureaucratic capacity, and the institutional conditions within which bureaucracies operate, are suggested here. These broadly relate to the basic approach to capacity outlined in section 3.3.

***Skills and professionalization of actors within bureaucracies***

Within health sector bureaucratic organizations, actors who are responsible for policy planning or implementation have generated inefficiencies, primarily because of limited management skills, the

dominance of medical doctors in the bureaucratic hierarchy, and the poor incentive structures provided by bureaucratic institutions. High achievers in government service may not be rewarded, and may even be penalized. There may be little incentive for government staff to act as agents for consumers, and they may indeed identify more closely with the interests of service providers (Stewart 1993).

According to critics, the dominant role of the medical profession in decision-making generates both inefficient and inequitable consequences (Jackson and Price 1994). Doctors decide what level and mix of services are to be provided according to their own definition and assessment of need, without reference to users' perceptions or assessments. Allocative inefficiency in the health sector is also encouraged because professional status and incentive mechanisms encourage staff and resource allocations to favour hospital-based, curative and high-technology care. Sheltered from competition, doctors do not face the consequences of their resource use decisions, and sheltered from user choice, they may be more interested in improving their lifestyles and working conditions than in being accountable to and meeting the needs of users. Furthermore, doctors' priorities tend to be reflected and reinforced by wealthier, urban consumer preferences at the expense of meeting the needs of poorer groups.

In many developing countries health sector management is dominated by medically-trained staff who have limited management training (Mills 1995) and limited technical skills for planning. The lack of capacity in skills is exacerbated by the weak incentives to use these skills within bureaucracies, and by the weak managerial and information systems discussed below.

Finally an important factor affecting the efficiency of agents in the health sector is low funding. Limited resource availability exacerbates skill shortages and creates shortages of complementary inputs, essential for staff to carry out their tasks. Low and eroded wages also help explain poor staff motivation and the diversion of public resources to private use (Mills 1995).

***Bureaucratic organizations and administrative systems***

Critiques of public sector bureaucracies originate from trends in Western economies and societies more generally (Jackson and Price 1994). In the West new organizational forms and cultural-political values have emerged which emphasize the weaknesses of centralized, hierarchical organizations based on

command and control, and the strengths of flexible and devolved management and labour markets which ensure rapid response to changing needs, the primacy of the consumer and the power of market forces (Harvey 1989).

Health sector bureaucracies in developing countries are or have been over centralized. Centralized decision-making distances power from communities, reduces accountability, and can mean that decisions about services or prices do not reflect local health needs or economic circumstances. In other words centralization limits consultation and participation in the policy process.

Perhaps the key (neo-liberal) criticism of public sector bureaucracies is their monopolistic nature - historically they have been sheltered from the winds of competitive market forces. The monopoly power of bureaucratic decision-makers in the health sector, who are often medically qualified, strengthens this group=s influence over resource allocation decisions, and contributes to inefficient use of resources, reduced user choice and unresponsiveness to users. In the absence of market disciplinary powers, slack and wasteful practices arise because incentives seldom exist to ensure efficient use of budgets. There are no market sanctions which threaten job loss for the individual or market 'exit' (bankruptcy and closure) for the organization. Promotion for the individual, or market 'entry' for new competitors, is also restricted. Monopoly power allows providers (unconsciously or consciously) to lower the quality and quantity of services. In other words lack of competition causes services to be unresponsive to user demands ('voice') and dissatisfaction ('exit')[1].

Centralization, limited competitive pressures and the unfettered power of providers and professional groups in bureaucracies are reflected in the weak and inefficient management and information systems for planning, budgeting, accounting and monitoring. The following public enterprise weaknesses have been identified (World Bank 1994; Jackson and Price 1994):

C *unclear or non-existent goals and objectives*: leading to unclear management purpose or

[1] Lack of bureaucratic accountability to the public, particularly marginal groups with a limited political voice, are dangers that have been recognized by analysts on the left (for example Michels 1962). Weber (1968: 987) also viewed the rational, public-service orientated bureaucracy as an ideal-typical construction open to monopolistic and unaccountable tendencies: *"...'democracy' as such is opposed to the 'rule' of bureaucracy."*

direction; and preventing assessment of the organization's performance[2]. Inability to judge performance contributes to the reduced accountability of managers.

- *lack of managerial autonomy, responsibility, and therefore accountability*: even if performance goals are clarified and made unambiguous, they cannot be achieved in an environment where managers have limited autonomy from their bureaucratic superiors, or from political interference. Centralized budgeting, for example, withdraws financial responsibility from hospital managers, and therefore provides them with little incentive to use resources cost-effectively. Political interference prevents the pursuit of controversial strategic decisions, such as rationalization of health staff and redundancies. Even at the top of the managerial hierarchy government regulations often prevent Ministries of Health from taking actions to improve efficiency, such as adjusting staff levels to local workloads (Mills 1995). Because national hospitals are often the symbolic focus of public and media health policy concerns, political interference in their management is also common. This mixed government/enterprise relationship blurs accountability and the allocation of responsibility: politicians can blame managers for non-achievement of objectives, while incompetent managers can blame these deviations on ministerial or other political interferences.

- *lack of information and transparency of information*: in the absence of competition, centralized health sector bureaucracies have fewer incentives to gather or reveal information on prices, quantities, costs etc. Moreover, they often do not have the capacity to gather such information. Monopolistic bureaucracies may measure performance internally, but if there are no competitive forces providing incentives to improve poor performance, the results of these evaluations may be inconsequential.

***Institutional conditions for capacity: the state and governmental frameworks***

It is not simply the characteristics of bureaucratic organizations and the actors operating within them which determine weak capacity and poor performance: the surrounding political and economic

[2] Merton's (1968) critiques of bureaucracies also identified the problem of goal displacement, whereby organizational procedures (means) come to dominate the work and objectives of the organization, replacing the original aims of the organization (serving the public).

environment may constrain or enable these organizations. In the 1990s, there has been increasing concern amongst donors about issues of good or bad 'governance' (Moore 1993). It is argued that poor economic performance, in particular a lack of private sector investment, is the result of failure of government and the institutions of the state more generally (AM90s 1994; World Bank 1992). Governments have not provided a stable environment and legal framework for private investment, and have delayed undertaking essential changes in state institutions which would be conducive to efficient public administration, such as reforms of the civil service, financial sectors and public enterprises.

The broader institutional problems or constraints facing governments in developing countries are often said to be rooted in the legacy of the colonial state (AM90s 1994; Cammack 1988). At independence the state was over-extended, centralized and authoritarian in structure with few organic links with civil society and therefore limited political legitimacy or accountability (Cammack 1988). After independence the centralized state and its bureaucracies expanded: health, education and jobs were provided by the state to help build a 'nation' (Anderson 1983), and to provide a basis of legitimacy and support for political leaders. These processes contributed to the development of neo-patrimonialism within these administrations, as the leaders of the state built a web of support through patronage.

As a result of the consequences of this legacy, the state in many developing countries has been criticized because it has stifled competition and has been a predatory as opposed to a service-orientated administration (AM90s 1994). In the health sector it is said to have weakened civil society and stifled private, NGO and community initiatives; allocated resources according to political and bureaucratic criteria (ie. rent seeking) rather than efficiency or equity goals; lacked the legitimacy or instruments to implement its plans; been inflexible to local needs or changing economic circumstances; and disempowered local communities and users of health services due to its centralized and unaccountable relationship with the mass of the population.

## 2.2 Responses and Prescriptions

Most health professionals and policy-makers in developing countries accept that health sector reforms of some type are required. During recent years a degree of consensus has been reached about the appropriate nature of reform (WHO 1993). Many analysts agree that public financing is desirable,

although there has been considerable interest in ways to supplement public finance for publicly provided services with private finance (through, for example, user fees or private insurance schemes). Most other reforms are directed at health care delivery. They attempt to change the bureaucratic or management structure (eg. decentralization) or introduce new market structures and incentive mechanisms (eg. contracting out) (Mills 1995).

Both bureaucratic and market-orientated reforms involve decentralization and new government-operator relationships, whereby more responsibility for service delivery is shifted from central government to arms length and more autonomous public bodies (eg. autonomous hospitals, district health management boards) or private operators.

Given the wide range of new government-operator relationships which have emerged, it is impossible to review them all. In sections 4-7 we have selected relationships which (i) appear to be important in terms of the scale and scope of their implementation and (ii) represent different dimensions of the public/private mix. These reforms are highlighted in bold in Table 2.

**Table 2: Categorization of policy responses to reform the role of the state in health care**

| | | PRODUCTION/DELIVERY | |
|---|---|---|---|
| | | Public | Private |
| FINANCING | Public | **Autonomous hospitals**<br>Decentralization | **Contracting out** |
| | Private | **User fees**<br>Community Financing | **Enhance role of pure private sector** |

## 3. THEORETICAL FRAMEWORKS FOR ANALYSIS

### 3.1 Economic Theory and the Role of Government

Neo-liberal arguments explain the need for state intervention in terms of problems of market failure. A number of problems are associated with the functioning of health care markets and these have been frequently reviewed (eg. Bennett 1991; Donaldson and Gerard 1993). There has been extensive debate about the severity of these problems in practice (Birdsall 1989). The key point is that the severity of market failure is an empirical question, the answer to which will differ according to the type of service under consideration. For example, treatment of cancer has strong asymmetries of information between provider and patient, the potential for monopoly and considerable uncertainty about the need for services. In contrast a service such as immunization has strong merit good and externality characteristics, but asymmetric information and monopoly are less likely to be problematic.

Furthermore the severity of market failure will depend upon the specific features of the country and health care system under consideration. Some critical external factors which affect the severity of market failure include:

i. *The epidemiological profile within the country*: the disease pattern commonly associated with low income countries is that of a high burden of disease from communicable diseases and a much lesser burden from non-communicable diseases and injuries[3]. As communicable diseases have greater externalities, it has been argued that as countries industrialize and their epidemiological profile shifts towards non-communicable diseases, the role of government should decline (Birdsall 1989). This however ignores the effect of other market failures such as informational asymmetries.

ii. *Sophistication of care provided*: the complexity of care exacerbates problems of imperfect information. The more high technology solutions which are available, the greater the chances

[3] For example, using the indicator Disability Adjusted Life Year (DALY) the World Bank (1993) estimated that in Sub-Saharan Africa 71.3% of the disease burden was caused by communicable diseases, whereas in the established market economies it was only 9.7%, with 78.4% caused by non-communicable diseases and 11.9% by injuries.

that people may be provided with unnecessary care. Purchasing power and the nature of a country's health care system will influence the extent to which sophisticated medical interventions become available.

iii. *Professional ethics and regulation*: asymmetric information between the doctor or health care provider and the patient may not lead to problems if the physician is a good agent for the patient: ie. s/he pays most attention to the preferences and needs of the patient rather than letting his or her own preferences dominate. Strong professional ethics or an active and effective regulatory system may encourage appropriate behaviour amongst health professionals.

iv. *Organization and development of the business sector*: in countries where the business sector is only minimally developed, problems of monopoly power are likely to be particularly acute. Alternatively there may be several private producers but implicit agreements between these producers inhibit competition.

v. *Education*: informational problems may be less acute amongst a well-educated populace who are relatively well informed, for example about the benefits of interventions such as immunization and ante-natal care.

vi. *The media and civil society*: if media within a country are free and active then they may reduce the degree of market failure within the health sector through, for example, helping to publicize and hence deter cases of medical malpractice, or providing information about the benefits (and costs) of different interventions. Consumer groups and trade unions may play a similar active role.

vii. *Social values*: the values prevalent in a society do not affect the severity of market failure as such, but will affect the degree to which health care is perceived as a merit good which should be accessible to all.

Thus economic theory suggests that the appropriate roles for the state vis-à-vis the market are context-specific and depend upon a precise specification of the service under consideration.

Furthermore the existence of market failure alone does not justify total public financing and production/delivery of health care:

- firstly, the range of market failures imply rather subtle and specific roles for governments, for example externality and merit good characteristics imply public subsidy of services, as opposed to public production or full public funding. Monopoly problems imply a need for government regulation of provider price and quality;

- secondly, the characteristics of health care which give rise to market failures are also likely to cause government failures. For example, problems of asymmetric information equally enable public sector doctors to pursue their own interests rather than the welfare of the patient: they may have different incentives to private sector doctors but these are not necessarily better.

The above analysis suggests that the appropriate role for government vis-à-vis the market should be considered empirically and cautiously:

> "*(T)he existence of market failure does not necessarily imply that the government should intervene. It has to be shown that the government can correct the market failure, without introducing offsetting problems.*' (Stiglitz 1988)

Perhaps ultimately, the appropriate role for the state depends upon government's capacity to intervene or regulate effectively.

Although economic analysis provides guidance as to which generic roles government should perform (financing, production, regulation, transfers), it says very little about the precise form which this intervention should take. For example an appropriate response to externality problems is government subsidy of the service. But how should this subsidy be delivered? It could take the form of vouchers direct to consumers, subsidies in kind to private providers combined with an agreement that the service is sold at a lower price, or the direct production of the service by the public sector and its delivery at a price less than marginal cost. Economic analysis of the role of state does not enable us to distinguish

which of these is optimal.

### 3.2 Institutional Approaches, Incentives and Motivations

An alternative approach to analysing the appropriate extent of market exchange is rooted in institutional economics. Williamson (1985) argued that the appropriate institutional form for producing and delivering a good depends on which form minimizes transaction costs. Where information is expensive to acquire, transactions costs are high and market-based arrangements may be inappropriate. Under such circumstances it may be more efficient for the service to be produced and delivered by a bureaucratic organization. However, for that organization to operate efficiently, it is essential that the individuals within the organization are faced with appropriate incentives.

The institutional relationships in the new forms of service production and delivery in industrialized countries, and the incentives generated by them, are a prominent rationale for the reforms. For example, Culyer *et al*. (1990) suggested that:

> "*The principle which permeates all these changes (ie. the NHS reforms) is the separation of the purchaser and provider functions and the creation thereby of greater 'transparency' in trading so that the prices, volume and quality of services are explicit and providers can be made more accountable*.'

Generating more information through these new institutional relationships to enhance accountability is seen to be a key aspect of reforms in the West (Jackson and Palmer 1988).

In developing countries institutional rationales for reform have been less commonly explored, but the institutional arguments for and against reform are particularly relevant in the developing country context. North (1990) argued that whilst it is possible to transplant new production processes and technologies in developing countries, it is not possible to transplant accompanying institutions which are important for success; institutions evolve over time in response to pressures upon them. To transplant health sector reforms devised in the West to developing countries may not be appropriate due to the different institutional characteristics of the recipient country. The reforms aim to create a division between direct

providers and the Ministry, which is financing or regulating these agencies. Monitoring and operating these new relationships requires more information and incurs higher transaction costs. Yet in many countries the institutions which can deal with resulting transaction costs may not be in place. This question highlights the underlying issue: do governments have the capacity to perform new service roles?

Institutional approaches may also help to analyse issues of appropriate incentives and the motivation of individual actors within organizations. Organizations face the problem of motivating employees to work towards organizational goals. Although employment contracts allow the employer to specify a range of tasks to be carried out, motivating the employee to do the job better is not simply a question of giving commands. The command normally takes the form of an end goal, not the method and attitude of doing it. As Simon (1991) stressed, the manner in which a task is executed is a question of motivation and commitment. The organizational factors which provide incentives and disincentives for efficient and effective behaviour by human agents and organizations are clearly important considerations for policy-makers, and should influence policy mechanisms designed to promote appropriate worker motivation, loyalty and identification with organizational objectives. These organizational characteristics may be bureaucratic or market-based mechanisms (Simon 1991).

Many of the problems identified in public sector bureaucracies, such as lack of competition and accountability, inappropriate incentives for government staff and over-centralization, stem from institutional weaknesses. The new models of government-operator relationships attempt to respond to these institutional problems. Cassels (1995), one of the few authors to address institutional reform in the health sector, identifies three key principles:

- strengthening of management and accountability;
- specification of priorities, objectives, standards and monitoring of outputs, outcomes and resource use;
- clarification of institutional relationships.

These principles could be developed further. There are other important institutional aspects of reform including, for example:

- giving communities a greater role in decision-making (eg. community financing initiatives). This is linked to the principle of accountability;
- enhancing autonomy and responsibility of decision-makers (eg. trust hospital status may insulate large hospitals from political interference);
- creating the type of social environment which will support the new forms of government by strengthening the rule of law, mass media and interest groups.

### 3.3 Capacity

Both the economic approach, and more specifically the institutional approach, stress the importance of government capacity. There has been much debate about quite what the term 'capacity' envelopes[4]. The broad approach to the question ›*do governments have the capacity to provide public services effectively, efficiently and equitably?*‹ is outlined below.

The capacity to provide services is not only a matter of government capacity, but the capacity of other organizations involved in service provision - there are networks of organizations involved in many of the new service arrangements. Capacity can be examined at two levels:

- elements internal to the organization(s) or service arrangement;

- the surrounding constraints and incentives within which the organization(s) or arrangements operate - the social, economic and political (ie. institutional) contexts which influence capacity to perform effectively and efficiently.

***Elements of capacity***

The dimensions or elements of capacity within the organization(s) include the following (Batley 1995):

- *the skills and professionalization of personnel*: in this sense 'capacity building' often means developing skills to formulate policy, negotiate with donors, draw up plans, etc. More

[4] Refer to Batley (1995) for a fuller discussion of capacity and its assessment.

importantly, it concerns how the skills of staff are mobilized through incentives, such as personnel policies and reward systems. Skills may not be technical but may be experience-related and unstructured understandings.

- *organizational and administrative structures or systems*: do the systems to implement government policies exist, promote the right incentives, and run effectively? Are budgetary, monitoring and planning systems in place? Are there clear objectives and are responsibilities matched to implementation authorities? Is there an effective flow of information?

- *finance*: both of the above elements depend upon adequate financing. This is often an external factor, but in some of the reforms service arrangements have the capacity to raise their own resources, set budgets, plan and control expenditure. The capacity to raise and manage financial resources will be an important element of capacity for some service arrangements (eg. autonomous hospitals, user fees).

***Institutional conditions for capacity***

In order for government to fulfill its new roles, the institutions of the state and civil society must be structured in such a manner as to support new service arrangements. Some of the external factors which constrain or encourage providers to deliver services effectively, efficiently and equitably include:

- *financial and economic conditions*: eg. budget constraints, macro-economic recession.

- *civil-public sector interaction*: greater 'voice' for users will encourage accountability. The existence of active media, consumer groups, trade unions, professional associations, etc. will contribute to the extent and success of reforms which are designed to improve consumer choice and responsiveness to users. Collaboration may also bring new skills and experience into public sector management.

- *private sector development*: the private sector cannot be encouraged or contracted if it is weak and limited competition exists. A strong private sector may increase new service arrangements' capacity because of competitive forces, and because of the resources it can offer

for health care.

- *political structures and practices*: systems of electing or appointing senior staff will influence accountability, allegiance and planning horizons of an organization. The overall level of democracy and accountability, and the influence of the public vis-à-vis politicians and bureaucrats, will determine the nature of service arrangements and their performance with respect to allocative efficiency, equity and responsiveness to users.

- *legal and administrative frameworks*: these will shape the environment and the incentives which influence service arrangements: their powers and duties, their room for manoeuvre, the standards they are expected to achieve etc.

The elements and conditions of capacity listed above are broad variables which need to be explored when assessing capacity. But they do not show which particular elements or conditions (attributes) are necessary for a particular service arrangement to perform well, for two reasons. Firstly, different attributes of capacity will be required for different tasks. To consider capacity in the abstract is not particularly helpful; capacity needs to be defined with respect to specific functions. For example, we can speak of government's 'capacity to regulate private provider quality' or 'to contract out non-clinical services'. Thus a first step in assessing government's capacity to take on new government-operator relationships is to define precisely what tasks these new roles require of government. Secondly, good performance may be associated with unexpected and locally-specific capacity attributes.

To identify the attributes which indicate an arrangement has the capacity to provide services effectively, efficiently and equitably, there are at least two approaches:

i. by logical deduction - examining the roles of the service operators and government and listing the attributes considered necessary;

ii. by induction from observed cases of good practice, identifying the attributes associated with good performance.

Both approaches will be adopted in the research. In sections 4-7, which analyse and review international experience with the four policy reforms highlighted in Table 2, the inductive approach based on experience is dominant: the experience of four new service arrangements is reviewed, and the attributes contributing to good performance are summarized at the end of each arrangement.

## 4. BUREAUCRATIC COMMERCIALIZATION: AUTONOMOUS HOSPITALS

### 4.1 Introduction

The restructuring of public health bureaucracies has been proposed as a means to strengthen management incentives and to improve bureaucratic performance in developing countries (Mills 1995; World Bank 1993). Management decentralization is the most common prescription:

> "*.. (I)t seems clear that some measure of decentralization is a pre-requisite for improved efficiency since it is the first step in informing local managers of the resource consequences of their actions, and giving them some ability and incentive to improve their performance*" (Mills 1995).

The creation of independent hospital management boards at teaching and referral hospitals, previously directly managed by the Ministry of Health, is one form of decentralization proposed or implemented in many developing countries with the active support of donors. Large hospitals have been targeted for reform because they consume a high proportion of the national health budget and are often the most inefficient parts of the public health system (Barnum and Kutzin 1993; World Bank 1994). Making hospital management autonomous represents a form of delegation to a 'parastatal' or 'arms-length' agency (Mills *et al*. 1990), with boards being granted responsibility for planning (at least in the short to medium term), revenue raising, and management roles such as personnel, budgeting, expenditure and procurement of other inputs (see Table 3). Raising revenue to reduce the hospital's use of government funds is often a key reform objective.

Because autonomous hospital policy is at an early stage in most countries, few evaluations have been conducted. One issue which appears central to the success of autonomous hospital policy is the nature or degree of autonomy which is granted to the management board. If the board is delegated few responsibilities - in particular, if it has no control over staffing levels - or if control over a range of responsibilities is limited (as in the case of deconcentration - Table 3), management incentives will not be drastically changed. If, on the other hand, the government is willing to delegate full responsibility to the board for a range of management functions, especially with respect to financial control, the policy will be

expected to have a greater impact on management incentives and hospital performance. Furthermore, if the hospital board is made responsible for raising a large proportion of its revenue, the arrangement may be closer to a form of privatization than delegation. Clearly, across (and possibly within) countries the degree of autonomy given to hospitals will differ.

**Table 3: Types of decentralized system**

| Functions | Deconcentration to sub-national offices | Devolution to local government | Delegation to 'arms-length' parastatals | Privatization |
|---|---|---|---|---|
| Legislative | - | ** | - | - |
| Policy-making | - | ** | ** | ** |
| Regulation of NGO/private services | - | ** | * | - |
| Revenue raising | * | ** | *** | *** |
| Planning and resource allocation | ** | ** | *** | *** |
| Management | | | | |
| Personnel | * | ** | *** | *** |
| Budgeting & expenditure | ** | ** | *** | *** |
| Procurement of supplies | * | ** | *** | *** |
| Maintenance | * | ** | *** | *** |

Key: *** Extensive responsibilities ** Some responsibilities
* Limited responsibilities - No responsibilities

Source: Mills *et al*. (1990)

## 4.2 Rationale

Policy on autonomous hospitals in developing countries has been informed by health sector reforms in industrial countries (for example NHS trusts in the UK), and influenced by the health sector reform agenda of international actors such as the World Bank (McPake 1995). The arguments for change are both economic and institutional. The following policy objectives have been identified by McPake (1995).

### i. Improve efficiency

The policy creates a split between the purchaser (Ministry of Health and others) and the provider (the hospital), with managerial responsibility removed from a large, bureaucratic and hierarchical organization based on command and control mechanisms. According to proponents of public sector

commercialization or corporatization (World Bank 1994), greater independence from hierarchy and control will generate better management incentives, practices and performance at the hospital in the following ways:

- *Responsibility and accountability*: greater responsibility for hospital managers will provide incentives to spend budgets more efficiently and to generate revenue (if user fees are charged and retained at the hospital). Autonomy will also increase managers' ability to take action on perceived inefficiencies and may help clarify lines of responsibility;

- *Greater management flexibility and innovation*: for example through greater control over budgets with scope to vire funds between budget items according to the hospital's requirements (McPake 1995). Greater freedom to innovate may also facilitate the contracting out of non-clinical services, and contribute to the development of stronger management systems, such as the clarification of organizational objectives and the development of performance indicators;

- *Managerial freedom from interference*: efficiency may be increased if managers are free to pursue their objectives without interference from politicians or upper levels of the bureaucratic hierarchy (World Bank 1994). Politicians may oppose strategic or controversial decisions such as rationalization and politically sensitive redundancies, despite the fact that the hospital needs to adjust staff or bed levels to local workloads (Mills 1995).

**ii. Improve responsiveness to users**

Autonomy should make service delivery more responsive to users' needs and preferences through two mechanisms:

- *Market based incentives*: in situations where fees are charged and revenue is retained by the hospital, market-based incentives may cause providers to be more responsive to patients' needs and to provide better quality services;

- *Increasing downward accountability*: removing decision-making from a centralized bureaucracy to managers who are closer to service delivery, and involving public representatives on independent hospital management boards, has been advocated as a means of

increasing accountability downwards.

**iii. Reduce the financial and managerial burden of central hospitals**

Autonomous hospital policy can be viewed as part of a strategy to shift government financing away from tertiary care towards more cost-effective care (McPake 1995). Autonomous hospitals are normally expected to develop alternative sources of financing to reduce the burden they impose on the Ministry of Health budget, allowing reallocation of government resources to an essential package of cost-effective interventions (World Bank 1993). In Ghana and The Gambia the policy was also seen as a way of reducing the Ministry's managerial responsibilities, freeing scarce personnel to deal with more important tasks (McPake 1995; Weinberg 1993).

## 4.3 The Extent and Nature of Autonomous Hospital Policy

Hospital boards are not a new arrangement. In many developing countries teaching and referral hospitals have had separate or distinct management arrangements for many years. However the autonomy of these boards has been relatively limited with respect to raising and retaining revenue or management functions. Since the 1980s reforms have, at least on paper, strengthened or created new management boards at tertiary hospitals in a number of countries including Burkina Faso, Burundi, The Gambia, Ghana, Kenya, Mauritania, Tunisia, Uganda, Zambia and Zimbabwe (McPake 1995; Mills 1995; World Bank 1993). The policy appears particularly prevalent in Sub-Saharan Africa.

The range of functions delegated in principle and in practice, and therefore the degree of decentralization (see Table 3), varies from country to country. In Ghana and The Gambia autonomous hospitals have not been granted increased autonomy over the full range of functions listed. In The Gambia the duties of the Royal Victoria Hospital Management Board, created under the legal framework of the Medical Services Act of 1988, are to:

> "*formulate policies for the efficient operations of the hospital.. and any other institution under its control*" (quoted from McPake 1995).

But the Board has little control over key aspects of financial and personnel policy: assets cannot be sold

without the approval of the Ministry of Finance; fee levels are set by the centre; the Board has no influence over conditions of employment or disciplinary matters and only a consultative role in the hiring of staff (McPake 1995). In Ghana the legal framework for hospital reform provides a broader range of powers or functions for the two hospital boards in the country. The following roles are specified in PNDC Law 209, though this legislation has not yet been implemented:

> "*improve and monitor the quality of care; appoint and evaluate the administrator and other hospital staff; assess periodically the adequacy of the hospital's resources; recommend fee levels; and provide.. the facilities and equipment of the hospitals*" (Government of Ghana document, quoted in McPake 1995).

In both these countries hospital managers' control over budgets is restricted, for example managers cannot vire resources between budget headings (Weinberg, 1993). Ability to procure supplies and complementary inputs is also restricted.

Since 1990 the Tunisian government has converted eleven large public hospitals into semi-autonomous organizations (World Bank 1993). The hospitals must operate within their annual budget and have the freedom to shift funds across budget categories, but they still have limited autonomy over the key aspect of staffing, as all staff are governed by civil service regulations.

### 4.4 Lessons from Experience

As there are almost no evaluations of the policy's performance in terms of achievement of objectives (for example, greater efficiency or responsiveness), this section considers whether the organizational structures created by the reforms, and the contexts in which they have been implemented, are likely to improve incentives and achieve the policy's objectives. Lessons are discussed in relation to the three goals of commercialization presented above.

#### i. Promoting efficiency

From deduction, and from limited experience in Ghana, The Gambia and Tunisia, the following dimensions of the reform appear to be important for generating management incentives and mechanisms

to improve efficiency.

*Organizational structure*. The power and roles allotted to the Board and its degree of autonomy from the Ministry of Health influence success. In the countries in which experience with hospital boards has been documented (notably Ghana, The Gambia and Tunisia) the centre appears to have delegated some day-to-day management functions to the Boards, but excluded them from important financial roles and longer term strategic activities. Restrictions on capital investment and personnel policy, in particular, are key areas of decision-making which affect the hospitals' resource use, service provision and efficiency.

Governments may be reluctant to delegate these functions because of the hospital's prominence in the national health system and the need for national coordination. As a result the incentives facing hospital managers will not have changed significantly, while managers' ability to take action on perceived inefficiencies will still be very limited. However, complete separation from the Ministry of Health was considered undesirable by managers in Ghana and The Gambia, since health sector activities would be more difficult to coordinate (Weinberg 1993). These opinions suggest that while greater autonomy is desired by management, there is recognition that a national hospital provides a public service and cannot function as an independent private firm.

Whatever degree of autonomy is delegated, clear legal frameworks and organizational structure are important to avoid confused lines of responsibility and accountability - a common situation with 'arms-length' agencies (Gilson *et al*. 1994).

*Board composition and skills*. The Board's composition and the skills of its members will determine its representativeness and the effectiveness of decision-making. With respect to composition, there is a trade-off between participative objectives and effective functioning. A diversity of interests represented on the Board may constrain quick and decisive decision-making, and a less participative approach may increase the effective functioning of the Board (McPake 1995). However, representation of diverse interests and negotiation may lead to more effective debate, questioning and a consensus on problem resolution, increasing the legitimacy of decision-making.

If innovative management and budgeting are to be a priority for the Board, business and financial

management skills will be required (Weinberg 1993). For example, experiments with functional budgeting at the Royal Victoria hospital in The Gambia, and with programme budgeting in Ghana, faced constraints because of shortages in skilled staff (Issaka-Tinorgah and Waddington 1993). The management functions delegated to a board will determine the mix of skills required to fulfil these functions. At a more general level, however, factors constraining the introduction of new personnel and skills onto boards might include:

- the availability of managers with appropriate skills, and the resources and organizations necessary for training;

- the ability to recruit and legitimize the presence of staff with business skills on hospital boards: shifting the balance of power within hospital management away from clinicians to managers has been a controversial aspect of health sector reform in the UK (Peck and Spurgeon 1993), and is likely to be difficult in developing countries where the medical profession dominates management;

- the legitimacy of and health worker compliance with a board's new management philosophy and practices: new private sector management practices and styles may conflict with traditional public service values and objectives, such as equity. This may undermine the reform, since success will be dependent on agreement of objectives between management and employees (Flynn 1990; Simon 1991). If management adopts efficiency-based values while its employees remain loyal to public service objectives, potential efficiency gains may not be achieved. Changing the organizational culture, incentives and motivation of employees, for example through performance- related bonus payments, may be the most difficult task facing these new arrangements.

*Market contexts.* The creation of autonomous hospitals in most developing country contexts is unlikely to result in competitive, market-based incentives to improve efficiency, due to the absence of competition (Mills 1995). The policy involves a purchaser-provider split, but large public hospitals may not face any competition on the provider side.

**ii. Improving responsiveness to users**

As yet there is no evidence that autonomous hospital status increases staff responsiveness to users' needs. Evidence is needed to illustrate how the two mechanisms for improving responsiveness described in section 4.2 affect responsiveness.

- Do user fees make staff more responsive to their patients= needs? This mechanism is only likely to work if the conditions for consumer-led competition exist (including the existence of alternative providers, effective demand on the part of consumers, informed consumers). In particular, users must have the opportunity to shift their demand - or to 'exit'.

- Does the creation of an arms-length agency bring managers closer to users and service delivery practices, and does the inclusion of community representatives on the hospital board increase the accountability of hospital management downwards and give consumers a greater 'voice' in decision-making? In particular, does the new organizational structure have clear lines of accountability? Inability to identify exactly who is responsible for different functions, or who is responsible for poor performance or for the solution of specific problems, is a common problem associated with decentralization (Mogedal *et al*. 1995).

**iii. Reduce the financial and managerial burden of national hospitals**

Data on cost recovery levels at particular autonomous hospitals were not found in the literature. Raising cost recovery rates to increase financial autonomy will be a difficult task for hospital management, given the low income of many patients and the capacities required to develop cost information and improve billing and collection of fees. In Sri Lanka the Sri Jayawardana Hospital, an autonomous hospital established by the Parliamentary Act no.54 (1983), has failed to recover costs due to a low bed occupancy rate of about 50% and faces severe financial difficulties (personal communication, N. Attanayake). If fees are set at cost recovery levels many users will require either insurance or exemptions (Mills 1995). Withdrawal of state financing from national hospitals, or even partial withdrawal, will be politically difficult. Despite the fact that autonomy will reduce formal government responsibility for a hospital board's decisions, the government is likely to face problems if services are withdrawn or if fees are increased. Final accountability for a national hospital is still likely to lie at the door of the Minister: in The Gambia, boards are established by the Minister of Health; in Ghana the

boards of the two teaching hospitals are directly accountable to the Minister of Health (McPake 1995).

## 4.5 Implications for Government Capacity

The attributes of capacity required for good autonomous hospital performance are mainly identified from logical deduction, since experience of the attributes which determine good performance is limited. The following appear to be important capacity issues:

**Elements of capacity**

- composition and skills of the management board: do board members have familiarity with private sector management practices; do users and other stakeholders have a voice - are they represented on the board; are hospital staff represented and do they agree with the direction of hospital policy; does management have financial skills?

- clear specification of the Board's responsibilities, vis-à-vis the centre: clear organizational structure and lines of responsibility;

- relatively autonomous status from the centre: adequate authority delegated to the Board to use funds flexibly to meet local circumstances, especially in relation to control over staff levels and wages;

- capacity to collect fees and administer an exemption policy;

**Broader conditions**

- economic resources: sufficient revenue to enable the hospital to function without periodic financial crises, and to reduce the budget allocated to the hospital from the centre;

- legal frameworks: to establish boards and clarify functions and accountability;

- political factors: transparent procedures for appointing senior staff; political feasibility of reducing the Ministry's commitment and responsibility for the hospital.

# 5. INCREASING PRIVATE FINANCE: USER FEES

## 5.1 Introduction

User fees for government health services have been introduced or increased in many developing countries. Policy reviews emphasise that user fees should not be seen as an isolated revenue raising device, but as a means of contributing to better incentives and improved performance in the public sector in terms of equity, quality, efficiency and sustainability (Creese 1991; Kutzin 1994; Gilson *et al*. 1995; Bennett and Ngalande-Banda 1994).

For user fees to be an effective policy tool, experience indicates that governments must support the aims of user fee systems with policies to promote equity (including exemptions), and a broader reform 'package' including administrative or organizational restructuring (eg. decentralization and greater local responsibility for revenue use) to improve managerial incentives and capacities. Without these reforms, it is unlikely that user fee revenue will be converted into quality improvements, that poor or vulnerable groups will be protected from the burden of fees, or that efficiency gains will be realized (Creese and Kutzin 1994; Kutzin 1994; Gilson *et al*. 1995; Russell and Gilson 1995; Bennett and Ngalande-Banda 1994).

## 5.2 Rationale

The following rationales for charging patients have been identified:

- raising additional revenue
- improving the quality of care
- increasing efficiency
- improving the equity of financing.

Efficiency may be enhanced on the demand-side if fees discourage 'frivolous' use of services (World Bank 1987) and if fee schedules can be designed to encourage appropriate use of the referral system (through 'cascading' prices) and greater utilization of services essential to public health (through

exemptions). On the supply-side, fee revenue can enhance technical efficiency by financing complementary inputs (Mills 1995).

User fees may contribute to a more equitable financing system by charging those who can afford to pay and exempting the poor. Charging patients who are able to pay will also release more public resources for services which benefit the poor. In addition, as the poor often resort to private care because government facility standards are so low, user fees combined with quality improvements (especially improved drug supplies) may make government care relatively more affordable than that of more distant private providers (Litvack and Bodart 1993). This emphasizes the importance of converting fee revenue into service improvements.

The institutional arguments for user fees are closely related to economic rationales. User fees may make providers more accountable to communities and responsive to patients' needs because they need to attract patients and their money. Providers may also become more efficient because of this consumer led competition (Mills 1995). The reforms necessary to support user fees also have institutional implications. For example, decentralization to allow facilities to retain revenue may enhance facility managers' financial autonomy and their sense of responsibility for using budgets efficiently.

### 5.3 The Extent and Nature of User Fee Systems

Two broad user fee 'models' have been distinguished in the literature: national user fee systems which are often centrally organized; and more decentralized community financing schemes (Nolan and Turbat 1993). Often the two models co-exist (Cameroon, Kenya, Zambia). This review focuses on the experience of national user fee policies, but relevant evidence from community financing projects is referred to.

User fee reforms have been most extensive in sub-Saharan Africa, where the gap between resources and health needs and the influence of international donors have perhaps been greatest. Most countries in sub-Saharan Africa had user fee systems in operation by 1993 (Table 4). In South Asia political traditions of free service delivery are still relatively powerful (Bangladesh, India, Sri Lanka), but in other Asian countries there are both relatively new fee systems (Papua New Guinea) and well established fee

systems (Thailand). In Asian countries experiencing rapid liberalization (Cambodia, China, Vietnam) there has been a rapid shift towards charging patients. Evidence from Latin America and the Middle-Eastern crescent is more patchy.

**Table 4: Countries with user fee systems**

| Region | National user fee system | User fees charged, but not part of a national system[a] |
|---|---|---|
| Sub-Saharan Africa | Benin, Burundi, Cameroon, Cote D'Ivoire, Djibouti, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Lesotho, Mali, Mozambique, Namibia, Niger, Senegal, South Africa, Swaziland, Zimbabwe | Burkina Faso, Central African Republic, Madagascar, Mauritania, Niger, Zaire, Zambia |
| South Asia | | Bangladesh[c], India, Nepal |
| Central, South-East and East Asia | China, Cambodia, Indonesia, Malaysia, Papua New Guinea, South Korea[b], Thailand, Vietnam | Thailand, Vietnam |
| Latin America and the Caribbean | Belize, Bolivia, Brazil[b], Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Honduras, Jamaica, Mexico, Peru, St. Lucia | no information |
| Middle-Eastern Crescent | Egypt, Iran, Jordan, Yemen Arab Republic | no information |

[a] User fee or pre-payment community financing schemes, set up as projects in specific areas of a country
[b] In South Korea and Brazil most hospital services are provided by the private sector, financed by national insurance (Barnum and Kutzin 1993)
[c] In Bangladesh most health services are free, but a small outpatient fee is charged at district or regional hospitals

Sources: Barnum and Kutzin 1993; Nolan and Turbat 1993; Russell and Gilson 1995

User fee systems vary considerably from country to country. In some, fee schedules are relatively clear, relatively up to date and consistently enforced by a strong state (Thailand), while in others fees are inconsistently applied, or less well established and rapidly evolving (Kenya, Zambia). In some countries a weak state presence during periods of conflict facilitated the local and *ad hoc* development of user fees (Cambodia, Uganda): in these countries governments are trying to establish a framework for more effective implementation and coordination of fee systems.

## 5.4 Lessons from Experience

Of the policy reforms considered in this paper user fees are the most widely implemented and analysed.

It is not possible here to provide a complete review of experience; instead we focus on three key areas of policy design and implementation (setting fee schedules, managing revenue, and exemptions for the poor) which appear to be critical to the success of user fee policies and raise serious questions about government capacity.

**i. Setting and coordinating fee schedules**

Governments need to structure fee schedules carefully in order to generate the right incentives for users and providers and achieve broader health sector objectives such as efficiency and equity. From experience, fee schedule design and implementation should consider the following points.

- *Fee charging systems*: different fee charging systems (registration fee, fee per consultation, per episode of illness, per prescription script, per drug item) generate different incentives on user and provider sides. For example, charging registration or consultation fees when drugs or supplies are not available has proved very unpopular (Kenya - Mbiti *et al*. 1993; Zambia - Booth *et al*. 1995). Payment for aspects of service quality which are more perceptible and valued by patients, such as readily available drugs, appears to be a more acceptable method of raising money.

- *Fee schedules*: if fees are to recover costs and encourage efficiency, they should reflect the costs of providing services. But cost information in many Ministries of Health is currently limited (Zimbabwe - Hecht *et al*. 1993). A system of 'cascading' charges is recommended to promote appropriate use of the referral system (lowest prices at first contact facilities, higher prices in district hospitals, and the highest prices in general hospitals). To complement these incentives, waivers or reduced prices for referrals should be built into fee schedules.

- *Fee increases*: where the level of prices is set by law, fee levels are infrequently increased and inflation erodes the real value of fee revenue (Barnum and Kutzin 1993; Kutzin 1994; Zimbabwe - Hecht *et al* 1993). Periodic adjustments to fee levels linked to inflation should be built into the system as an administrative procedure rather than a political act.

- *Public and staff information*: in Papua New Guinea fees were introduced at rural health centres and aidposts without consultation with staff and the public. This led to resentment amongst staff and confusion in the community: people stayed away from facilities in fear of being

charged excessive fees (Thomason *et al*. 1994). To ensure consistent policy implementation, health workers should be familiar with fee schedules. To inform patients and ensure staff compliance, fee schedules should be displayed at facilities and public information campaigns conducted.

- *Levels of decision-making and accountability*: prices should be flexible across geographical areas, set according to local economic circumstances and needs. Flexibility and accountability downwards to the community requires sub-national decision-making capacity either at the facility, community or district level. In addition central guidelines are required to support and coordinate local efforts.

National user fee systems have frequently been implemented without sufficient planning or local capacity. As a result fee levels have been uncoordinated. In Papua New Guinea, for example, inadequate policy guidelines resulted in fees at health centres that were equal to or higher than those in hospitals (Thomason *et al*. 1994).

**ii. Retention and management of revenue**

Quality improvement is one of the most important objectives of user fee policy. Drug availability in particular has been shown to be a crucial variable contributing to increased service utilization after the introduction of fees (Litvack and Bodart 1993; Knippenberg *et al*. 1990). In order to ensure that user fees lead to improvements in quality, a number of capacities are required.

- *Collection and local retention of revenue*: fee collection requires the development of a swift billing and collection system which is consistently enforced by trained clerks (Hecht *et al*. 1993). Revenue retention at the collecting facility provides incentives for effective fee collection and the revenue is more likely to support quality improvements (Mills 1995; Bennett and Ngalande-Banda 1994). However, in a number of countries local revenue retention is not permitted and revenue is lost to the treasury (Russell and Gilson 1995).

- *Accounting, banking and auditing*: management systems and skills for accounting, banking, making expenditure plans and auditing are essential requirements for a user fee system, but in

many countries these skills and systems are often inadequate or do not exist (Zimbabwe - Hecht *et al*. 1993; Papua New Guinea - Thomason *et al*. 1994). In Kenya recent user fee policies have given high priority to staff training which covers aspects of financial management and the development of financial information systems (Mbiti *et al*. 1993). Local banking capacity is also essential for paying in revenue.

- *Revenue expenditure decisions*: the degree of decentralization of decision-making and accountability may be an important factor affecting whether or not quality improvements occur (Gilson *et al*. 1995). Involving communities and health workers in the management of revenue (for example, on local health boards) will contribute to more accountable and transparent decision-making that is more acceptable to local people and better targeted at local health needs and priorities (Bennett and Ngalande-Banda 1994). Upward accountability is also important: local expenditure decisions should be supported and coordinated by national guidelines to ensure broader policy objectives are being pursued. In Kenya local expenditure plans have to be checked by the district accountant and Health Management Board, and by the national Health Care Financing Secretariat (Russell and Gilson 1995).

To date, there is mixed evidence of quality improvements following the introduction of fees. The factors which influence fees' impact on quality remain largely unexplored, but decentralized financial control appears to be a key factor promoting community involvement in decision-making and service improvements.

**iii. Exemptions for the poor**

There is no documentation of an exemption policy in a developing country which successfully, consistently and cost-effectively distinguishes between those able and unable to pay (Kutzin 1994; Gilson *et al*. 1995). In the design and implementation of exemption policies, governments must address the following questions and responsibilities.

- *Definition of eligibility criteria*: criteria for defining the eligible poor are normally vague (the 'indigent', the 'destitute') and offer little guidance to health or community workers implementing the policy (Nolan and Turbat 1993; Russell and Gilson 1995). In only two countries are

household income criteria specified in quantitative terms (Thailand and Zimbabwe - Russell and Gilson 1995), but such fixed criteria are also problematic[5].

- *Screening procedures*: effective implementation of means testing, either in the facility or the community, is often constrained by limited information about households' ability to pay and the costs of obtaining the information (Russell and Gilson 1995). Exemption policies need to be implemented locally as health staff (at least in lower level facilities) and community leaders are likely to be familiar with local people and their livelihoods (Willis 1993). Upward accountability to national policy guidelines is also necessary to ensure access to exemptions is available across facilities. A disadvantage of decentralized discretion over exemptions is that local administrators may be exposed to pressure from friends, relatives and influential economic and political contacts (Gilson *et al*. 1995; Willis 1993), causing 'leakage' of benefits to non-eligible groups.

- *Public and staff information*: ignorance of eligibility for exemption is a common reason for non-utilization of services, or for not claiming exemptions (Zambia - Booth *et al*. 1995; Papua New Guinea - Thomason *et al*. 1994). Clear information about eligibility for exemptions needs to be provided to the public, especially the poor, and health workers should be familiar with all eligibility criteria, especially for special cases such as referrals.

### 5.5 Implications for Government Capacity

From the above lessons, it is clear that a broad range of capacities are required by governments to design and implement a successful user fee policy 'package'. The attributes of capacity required for good user fee performance are described below.

#### *Elements of capacity*

From experience, sub-national decision-making levels (facility, community, district) have played an important role in the implementation of user fee and exemption policy. Trained staff and adequate systems are required for billing and collecting fees, conducting means tests/granting exemptions, keeping

[5] Eligibility criteria based upon household income may be inappropriate to people's economic circumstances in some areas and are often not adjusted for inflation (Zimbabwe - Hecht *et al.* 1993). Most importantly, measuring household income is difficult.

accounts, budgeting, development of expenditure plans and overseeing expenditure, and measuring and monitoring outputs (including revenues, expenditures, service utilization rates, numbers and types of people exempted).

Local management systems must be sufficient to specify objectives or target outputs, and must be capable of maintaining and using financial information. Local management's decision-making structures for setting fees and spending revenue need to be accountable and transparent to the community.

However, the role of the centre remains critical. The centre must have the systems to provide policy guidelines for sub-national levels, in order to support and coordinate the implementation of fee schedules, criteria and procedures for means testing patients, and spending revenue. This may include compiling cost information to help set fees, monitoring the impact of fees nationally, checking that guidelines on fees, exemption procedures and revenue expenditure are adhered to, and auditing accounts. To prevent regional inequities developing, the central level needs to be able to redirect resources to support facilities in poorer areas which exempt a large proportion of patients. Significant economic resources are likely to be required to ensure that staff receive appropriate support and management training, and that the user fee policy is well publicized.

***Broader conditions***

Legal or administrative frameworks which allow retention of fee revenue at facility level need to be in place. In several countries (for example Ethiopia, Jordan, Namibia, South Africa and Zimbabwe in 1993) facilities could not retain revenue, providing disincentives to collect fees and limiting potential quality improvements (Barnum and Kutzin 1993; Hecht *et al*. 1993; Russell and Gilson 1995). Such frameworks require reform, but this can be a long and difficult process involving negotiation with the Ministry of Finance (Papua New Guinea - Thomason *et al*. 1994).

The political feasibility of reforms which involve decentralization, retention of revenue at the facility, resource reallocation and exemptions for the poor is open to question on many counts, and will depend upon established power structures, types of democratic representation, and the government's standing with vested interest groups. The location and accountability of decision-making are important factors influencing processes such as fee setting, revenue expenditure and granting exemptions. Involving

communities and their representatives in decision-making will, in theory, enhance decision-making capacity by increasing the power of user voices and a sense of ownership and accountability in public decision-making. However, these civil-governmental structures may be difficult to develop in contexts where the state has traditionally been overextended or centralized, where local organizations are poorly developed, or where the poor do not have a voice in local 'community' organizations.

# 6. GOVERNMENT PURCHASE OF PRIVATE SERVICES

## 6.1 Introduction

The most important developments in this category constitute various forms of contracting arrangements whereby government uses public funds to purchase the services of private sector providers. It has been suggested that contracting arrangements enable governments to enjoy some of the positive aspects of markets whilst retaining control over quality, quantity and the price of services provided. In industrialized countries there has been considerable interest in the managed market concept whereby contracting arrangements for clinical services are used throughout the health sector in order to promote competition between different providers (Enthoven 1988, Hurst 1991). There has been considerable discussion about the extent to which such reforms are either replicable or desirable in the developing country context (Mills 1995, Broomberg 1994, Collins *et al*. 1994). However, there are alternative forms of contracting which constitute less dramatic departures from the status quo and which have been spreading rapidly in both developed and developing worlds.

Forms of contracting include:

- *Non-clinical contracting out:* contracting of private providers to produce services such as laundry, waste disposal, billing, catering, cleaning etc.
- *Clinical contracting out:* contracting of private providers to provide clinical services such as ambulatory care, acute care, chronic care and diagnostic services.
- *Whole hospital management arrangements:* assets are retained by the public sector but responsibility for managing and operating these assets are contracted out to the private sector. This arrangement may take numerous forms, for example medical and nursing staff may continue to be publicly employed or may be hired privately.
- *Leasing:* public sector leases or rents private sector assets. This is particularly common for high cost high-technology assets. In general under a leasing arrangement the public sector would be responsible for the operation and use of the asset. If this is not the case then the arrangement is substantially similar to a contracting out arrangement as described above.
- *Joint ventures*: the distinguishing feature of such arrangements is that both public and private sectors contribute to the capital requirements of a project. Who takes responsibility for

operating the new facility and how revenue is shared between public and private sector interests will vary between contracts.

One form of contracting which is common in certain developing countries is that of a contractual relationship between an insurance agency and health care providers. Where the insurance agency is publicly owned this is a form of government purchase of private services. Such arrangements have often been in existence for a long time and have not been introduced specifically as part of the changes in the role of the state under adjustment.

## 6.2 Rationale

### *Economic rationale*

The core reason for contracting is to promote efficiency. This may mean providing the same standard of service at a lower cost or providing a higher standard of service at the same cost. There are a number of economic reasons why contracting arrangements may enhance efficiency.

- *Creation of competition amongst providers*: most attention has been given to this point. However, there has been considerable debate about the extent to which real competition is likely to occur in developing countries due to the limited size of the private sector (Broomberg 1994). This is more obviously the case for contracting out clinical services. For non-clinical services (such as cleaning and laundry) the market may be rather more competitive.
- *Increased technical efficiency through economies of scale or economies of scope*: one contractor may be able to provide the same service to a number of different health care facilities in order to reap economies of scale. Or, for certain non-clinical services such as laundry and catering, the same contractor may provide the service across different sectors (eg. by also providing laundry facilities to hotels).
- *Improved allocation of risk*: contracting allows a redistribution of risk, which may be efficient if different actors have different degrees of risk averseness.

***Institutional rationale***

- *Clarification of organizational objectives*: in theory the process of contracting requires the government to clarify organizational objectives and determine means by which achievement of objectives will be measured. It is thus likely to promote transparency.
- *Autonomy*: contracting services may be a means to promote the autonomy of decision makers and protect them from unnecessary political or central government interference.
- *Freedom from bureaucratic regulations*: this might take many forms. For example, by operating outside the public sector, contracted services may escape over-rigid personnel or procurement systems. Leasing arrangements allow government to access private sector capital, which may be more readily and quickly available than public investment funds.
- *Innovation*: contractual arrangements may facilitate more innovative forms of service delivery by introducing private sector niche players into the market.

## 6.3 The Extent and Nature of Change

Up to now no developing countries have implemented a full-blown managed market approach to health care such as that upon which the UK and Dutch reforms are based. However, Colombian reforms involve distinguishing purchaser and provider roles and consumer choice between competing health plans offered by both public and private providers (Gonzalez-Sedano 1995) and Mexico is similarly planning a purchaser/provider split (Frenk *et al*. 1994). Decentralization reforms in Zambia involve individual district health teams being contracted by the MOH to provide services (Government of the Republic of Zambia 1992). Zimbabwe is apparently considering a managed market approach with the assistance of ODA (personal communication, K. Grant). More limited forms of contracting, particularly contracting for non-clinical services, are widespread in the developing world (see Table 5), though it is difficult to say to what extent the contracts cited in the table are new and associated with recent changes in the role of government. The extent of clinical contracting is considerably more limited than that of non-clinical contracting. For general inpatient and outpatient services, contracting arrangements seem most established in Southern Africa. Often these arrangements have been in place for several years. South-East Asia provides several examples of contracting for high technology services. Organizations have engaged in such contracts both in order to allow rapid investment in high technology services and to limit the risk of these expensive items of equipment rapidly becoming obsolete. Leasing arrangements

do not appear popular elsewhere. It is possible that in many developing countries private sector access to capital is poorer than that of the public sector.

**Table 5: Known contracting arrangements in the health sectors of developing countries[6]**

| Type of contract | Service | Country/region with arrangement |
|---|---|---|
| Non-clinical | Laundry<br>Cleaning<br>Security<br>Maintenance<br>Billing<br>Catering | Bombay, Malaysia, RSA, Sri Lanka, Zimbabwe<br>Thailand, Jamaica<br>Lesotho, RSA<br>Venezuela, RSA, Zimbabwe<br>Zimbabwe<br>Bombay, Lesotho, Malaysia, RSA |
| Clinical | Acute care<br><br><br>Ambulatory<br>Long term<br>Diagnostic<br><br>Laboratory<br>Public Health | RSA, Zimbabwe and PNG (mine hospital), (many countries in Sub-Saharan Africa if implicit contracts with mission facilities are considered)<br>Namibia, RSA (GPs)<br>RSA (TB and psychiatric care)<br>Thailand (CT, ESWL, MRI), Malaysia (CT, X-ray, radiotherapy)<br>Nigeria, RSA<br>Bombay (vector control) |
| Whole hospital management | | China, Bolivia |
| Leasing | High tech diagnostic | Thailand (contracting arrangements for such services vary, but fall somewhere between contracting out and leasing). |
| Joint ventures | | Not known |

Sources: Aljunid 1995, Bennett and Ngalande-Banda 1994, Bhatia 1995, Alvarez *et al* 1995, WHO 1991.

There is also only limited experience with management contracts, perhaps with the sole exception of China. In China, management contracts for health departments and institutions have recently become widespread with more than 50% of health care institutions run on a contract basis in 1992 and over 90% in some more commercialized regions such as Guangdong and Jilin (Dezhi 1992). The popularity of management contracts for health facilities in China is perhaps explained by the widespread use of such contracts in public enterprises. In Bolivia a donor-supported NGO took on the management

[6] This table is far from comprehensive but it depicts the arrangements found from a literature review on clinical and non-clinical contracting in six countries and from research commissioned by the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine.

contract for a number of ambulatory care facilities (Fiedler 1990). There appear to be few instances of joint ventures in the developing world.

### 6.4 Lessons from experience

Evaluations of contracting arrangements for health care in developing countries are few and far between so much of the available evidence is anecdotal[7]. Literature from industrialized countries has shed doubt on the ability of competitive contracting arrangements for clinical services to reap efficiency gains. Contractual relationships are frequently characterized by trust between the two main parties; studies of contracting out for social services in the US suggest that over time strong bilateral relationships develop limiting the degree of competition when the contract is renewed (Propper 1992). Institutional economics would offer an explanation for this: when there is a considerable degree of uncertainty inherent in the contract (as there almost always is in health care) then the conditions set out in the contract must be complemented by trust between the two contracting partners (Williamson 1985). Evidence is stronger for efficiency gains from non-clinical contracting (Walsh 1995).

The limited evidence from developing countries does suggest that contracting may bring with it greater efficiency, at least in certain respects. A study of clinical services provided by a mining hospital in Zimbabwe, under contract to the Ministry of Public Health, indicated that the prices charged to government by the mining hospital were comparable to the costs to government of running a nearby public hospital, but quality of care at the mine hospital was considerably higher (McPake and Hongoro 1993). In Bombay, catering services offered by privately contracted companies appeared to offer better value for money than those provided in-house (Bhatia 1995). An assessment of the contracting out of cleaning services in Thailand suggested that the service was purchased from the private sector at a considerably lower price than it would cost to provide in-house (Tangcharoensathien *et al*. 1995).

However, these same studies also identified problems with the contracting arrangement which may adversely affect efficiency. In Thailand, for example, ward sisters complained that when cleaning services were provided in-house, cleaning staff could be requested to carry out simple patient service

[7] The results of the research commissioned by the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine are currently being prepared for publication.

functions if the need arose, whereas when the service was contracted out this was no longer possible (Tangcharoensathien *et al*. 1995). Elsewhere, when maintenance services have been contracted out it has been observed that although the service operates more efficiently overall, hospital staff have less control over the contracted service and may find that the order in which items of equipment are repaired does not match hospital priorities (WHO 1991). If efficiency is improved through contracting then the mechanism through which this occurs is not yet clear. There is little good evidence of competition amongst contractors in the developing world.

There is no evidence as yet that contracting out in developing countries has helped capture economies of scale. In Bombay a study of contracted-out laundry services found that some contracted-out services were performed on a much smaller scale (by dhobis washing by hand) and at low cost (Bhatia 1995).

There is certainly evidence of risk shifting in contracting out arrangements. However this does not always work in the government's favour. In South Africa analysis of the pricing structure for contracted clinical services suggested that the government almost wholly bore the risks associated with variations in the costs of care at contracted hospitals (personal communication, J. Broomberg). Similarly, in Thailand the contracts for high technology equipment seemed to shift the risk towards government rather than away from it.

One of the supposed institutional rationales for contracting was the clarification of organizational objectives. None of the developing country studies available suggest that this was either a stated goal of reform or an unplanned yet beneficial result. In fact contracting often seems to have developed in an ad hoc manner with little concrete planning and few specified objectives. For example, the contract with the mine hospital in Zimbabwe did not clearly define the type of cases which the hospital should treat, but simply agreed to reimburse on a fee-for-service basis all care provided by the hospital to the general populace. As a result the cost of services at the hospital accounted for 70% of the total provincial non-salary health costs (McPake and Hongoro 1993). One of the most significant forms of government purchase of private services in Sub-Saharan Africa is that of government subsidies to mission hospitals. Yet there is generally only a broad agreement between government and an umbrella organization representing the missions. Tanzania appears to be an exception: there are explicit contracts in place between the various dioceses and government, identifying the functions and objectives which mission

hospitals should pursue.

It was also hypothesized that the contracting process may help to avoid overly bureaucratic government regulations and generally promote greater flexibility. On occasion Ministries of Health have clearly entered into contracts for this reason. In Lesotho security services at the main hospital were contracted out since it took a long time to dismiss and replace in-house security guards who were found to be corrupt. In Thailand interviews with hospital managers suggested that one of the main reasons why leasing arrangements for high-technology equipment had been negotiated with the private sector was to enable teaching hospitals to gain access to new items of equipment without going through lengthy government procedures. In Zambia the new decentralized system with contracting between the MOH and the districts was partially motivated by a desire to free health care delivery from rigid and over-centralized bureaucratic regulations and to give districts greater autonomy (Government of the Republic of Zambia 1992).

At the same time bureaucratic controls may affect the contracting process itself. In Thailand the price for cleaning service contracts was centrally controlled by the Ministry of Finance. Ministry of Health analysts argued that cleaning a hospital was substantially harder work than cleaning other public facilities such as schools and offices, and that the quality of service procured under the contracting arrangement could be inadequate because of the low price (Tangcharoensathien *et al*. 1995).

## 6.5 Implications for Government Capacity

The evidence available suggests that contracting may in some circumstances offer benefits. However, in order for these benefits to be reaped a number of preconditions must hold.

### *Elements of capacity*

At the level of individual skills there are a number of capacities which Ministries of Health require in order to contract services successfully. Planning skills are necessary to set realistic objectives and monitor their achievement. Skills are required to negotiate with contractors and advise on legally binding contracts. Some capacity for economic analysis is required to assess whether or not contracting services truly represents a more efficient option than in-house provision. Appropriate systems are

necessary to underpin these skills. For example, monitoring of providers requires good information systems.

The review of experience would suggest that these skills and systems are rarely sufficiently strong. Contracted services rarely seem to have benefited from the formulation of clear and achievable objectives and thus contracting has not been able significantly to improve transparency. It could be argued that if the necessary skills to formulate clear objectives were missing from direct service provision then they are unlikely to materialize simply because contracting is established. The fact that under many contracts in developing countries government almost entirely bears the risk suggests that negotiating skills in government tend to be weaker than those in the private sector.

Contracting may occur at many different levels in the health care system: an individual hospital may contract out services, a district may do so, or the Ministry of Health may develop contracts with the districts (as in Zambia). Many of the contracts discussed above operate at the facility level (eg. the laundry service for a particular hospital is contracted out), and thus facility level staff have a key role in monitoring. Successful contracting may thus require at least some of the skills and systems listed above to be possessed at relatively low levels of the health care system. Where a whole service is contracted out by the central ministry it is possible that the government is quite distanced from the service provider. Particularly careful monitoring is required under these circumstances. In the 1970s there was a public outcry in South Africa about the quality of care provided to mentally ill people by a private provider under contract to the government. Government appeared not to be monitoring the quality of care and the outcry was stimulated by the media, highlighting the importance of broader institutions, and in particular a relatively well-developed media.

***Broader conditions***

Much of the concern voiced in the literature about contracting for health care in developing countries relates to the limited size of the private sector (Broomberg 1994; Mills 1995). The lack of joint ventures and leasing arrangements observed in developing countries may suggest that private sector capacity is indeed too limited for more complex forms of contracting to be viable.

Furthermore, instability in the revenue base of developing country governments may also inhibit

successful contracting. Contractual arrangements may require government to commit funds for an extended period and require regular payments. However, government budgetary cycles are generally annual and given the financial uncertainty, Ministries of Health may wish to retain some degree of flexibility in the use of funds during the mid to long term (Mills 1995). Private firms may not wish to enter into contracts if they fear they will not be paid on time.

## 7. THE PURE PRIVATE SECTOR

### 7.1 Introduction

Whereas in industrial sectors of the economy the emphasis in reform has been in shifting to 'purely private' forms of services, in health care purely private solutions have received less attention. There have been only extremely limited attempts to transfer ownership of existing government health care facilities. Instead the focus of reform has been on defining which services should be delivered privately and which publicly, and on improving links with the existing (often substantial) private sector. The 1993 World Development Report (World Bank 1993) recommended that certain low priority services be provided entirely by the private sector as their publicly funded provision could not be justified. At the same time the World Development Report recognized the need for improved government regulation of the private sector. Given that the key concern of this document is capacity, our focus in this section is not on the private sector *per se* but rather on government's relationship with the private sector, especially government's ability to regulate and enable the private sector.

The size, scale and nature of the pure, private health care sector in developing countries varies considerably. In many developing countries, particularly those in South and South-East Asia, there has always been a substantial private sector. In Sub-Saharan Africa the private for-profit sector tends to be small (except for traditional healers) but mission health care providers often play a key role. The range of existing situations means that countries' attempts to regulate and enable the private sector have taken a variety of forms.

Maynard defined regulation as the 'control of prices, quality or quantity of health care' (Maynard 1982). In addition governments may wish to control the distribution of providers through regulatory instruments. Enabling has more positive connotations than regulation; however it may be directed at similar variables. For example, enabling actions may be aimed at increasing the number of private providers, or improving the quality of care which they offer, or encouraging providers to locate in rural areas. A wide range of specific regulatory and enabling instruments have been adopted by different

countries.

- Licensing: both of individual practitioners and the private premises from which they operate. Licensing of different cadres of medical staff controls both the quality and quantity of medical manpower. Licensing of private premises also controls the number and distribution of private practices and may specify certain structural standards which must be met in order for the practice to operate.

- Price setting: either in a band or specified fixed fees.

- Malpractice legislation: enabling authorities to identify and punish providers who offer unacceptable standards of care. Private practitioners may be prosecuted through the law courts or face investigation by the medical council.

- Control of medical school curricula.

- Certificate of need legislation: controlling the accumulation of high-technology equipment and facilities by private providers.

- Financial incentives: including (i) incentives such as tax breaks aimed at increasing the number or shifting the distribution of private providers and (ii) incentives aimed at encouraging private providers to perform certain activities, generally public health activities such as immunization or disease notification.

- Control of private practice by doctors employed in the public sector.

- Training schemes for private providers.

- Accreditation schemes for private facilities.

- Structuring the financial incentives which private providers face through payment schemes: this

strategy can only be pursued where there is a substantial degree of health insurance or public funding and the state has influence over the form of payment. As health insurance and public subsidy tend to be limited in low income countries, this is primarily a strategy pursued by middle and high income countries.

It is interesting to note that few of the measures listed above are targeted directly at increasing the size of the pure private sector; instead they aim to enhance the role of the sector in contributing to the nation's health.

## 7.2 Rationale

In section 3.1 it was pointed out that different forms of market failure will occur with different types of health care services, and thus different forms of government intervention will be more or less appropriate. The principal reasons for government intervention in the health care market place are likely to relate to (i) imperfect information and the consequent need for some form of quality control and (ii) lack of attention by private providers to public health issues.

## 7.3 The Extent and Nature of Change

The main changes associated with structural adjustment which have taken place in the relationship between government and the private sector are reviewed in Table 6, with country examples. Many of the key instruments enabling government to influence the behaviour of the private sector, such as the establishment of medical and other professional councils, licensing laws and, in Sub-Saharan Africa, subsidies to mission hospitals, have been in place for many years and thus are not included in the table. These basic instruments probably continue to be the most important ones in regulating and enabling the private sector.

Although several countries have on paper espoused policies enhancing the role of the private sector, the extent of change in this area is not great. Perhaps the clearest sign of liberalization and changing policies

is the repeal of prohibitive legislation. A handful of Sub-Saharan African countries prohibited or heavily circumscribed the role of private for-profit practitioners shortly after Independence, but during the past five to ten years all of these countries have repealed or altered this legislation so as to facilitate private practice.

Several countries have developed schemes attempting to encourage private practitioners to play a more active role in public health. These schemes include provision of free inputs for public health activities (such as provision of free vaccines in Nigeria, Malaysia, Iran and Sri Lanka, and provision of free condoms in Nigeria and Zimbabwe) (WHO 1991). Elsewhere (such as Ethiopia) private providers may purchase supplies from the government store thus benefiting from an implicit subsidy (Bennett and Ngalande-Banda 1994).

**Table 6: Extent of change in the relationship between government and the pure private sector**

| **Reform** | **Examples of countries which have adopted reform** |
|---|---|
| Repeal of prohibitive legislation | Malawi, Mozambique, Tanzania, Zambia |
| Untargeted government subsidies | Pakistan, Thailand, Zimbabwe |
| Incentives targeted at increasing the private supply of public health services | Nigeria, Malaysia, Iran, Sri Lanka, Zimbabwe |
| Liberalization of regulations governing private practice by public doctors | Malaysia, Mozambique |
| Training | Nepal, Zimbabwe |
| Accreditation schemes | Mexico |
| National health insurance schemes permitting access to private providers | Taiwan, Thailand |

Sources: Aljunid 1995, Bennett *et al* 1994, Kafle *et al* 1992, Ngalande-Banda and Walt 1995, WHO 1991.

A number of studies have documented a complex pattern of government subsidies in countries. Often these subsidies are not products of recent policies to enhance the role of the private sector, but rather reflect the political influence of private providers. In Thailand the Board of Investment was able to grant tax holidays to new or newly expanding private hospitals; this was done for many years without any

coordination with the MOH (Bennett and Tangcharoensathien 1994). A study in Zimbabwe shortly after Independence found that government subsidies through tax relief on insurance premiums etc were highly inequitable.

In many middle income countries there has been recent interest in compulsory health insurance schemes. Thailand introduced such a scheme in 1991, Taiwan has just expanded coverage of health insurance schemes to cover the whole population and Malaysia is carefully considering the establishment of such a scheme. Where such schemes exist and become significant purchasers of private health care, they offer perhaps the best chance of influencing private provider behaviour. In Latin America compulsory schemes have been established for many years, and many of them are currently undergoing radical reform. One of the objectives of ongoing reform efforts is to create improved incentives for service providers to control the cost of service provision while maintaining quality.

### 7.4 Lessons from Experience

There has been a notable lack of analysis of country experience with instruments to influence the private sector. In particular, comparative analysis examining the success of alternative regulatory and enabling instruments is lacking. Available information tends to be from case-studies which draw upon a country's experience with a particular reform or policy. Given the differences in country experience and the wide range of regulatory and enabling instruments, it is difficult to draw out general lessons.

Ngalande-Banda and Walt (1995) analysed the effects of the 1987 legislation in Malawi liberalizing private practice. Their study suggests that there was rapid expansion of private practice amongst the paramedical cadres but only limited growth amongst private physicians. This was partly attributed to investment barriers and partly to the uncertain economic and political climate in Malawi. In Mozambique liberalization was targeted at the private non-profit sector (WHO 1991) and there has apparently been considerable expansion in this sector, at least in Maputo.

A critical question concerns the effectiveness of regulations governing the private sector once private sector activity is liberalized. Unfortunately the evidence available suggests that regulation is often ineffective. In Malaysia only 39 complaints came before the Medical Council in a five year period

despite many more accusations of malpractice in the newspapers (Aljunid 1995). In India the integrity of some medical councils[8] has been questioned as complaints to councils have been ignored, mislaid or only brought to a hearing when considerable pressure has been exerted by consumer organizations (*Times of India* 1992, Yesudian 1994). In Zimbabwe the Ministry of Health has had to intervene on occasion to ensure that malpractice hearings were publicized rather than 'hushed up' by the medical council (Bennett and Ngalande-Banda 1994). Analysis of experience in the industrialized world suggests a similar situation; medical councils being more concerned to protect the role and reputation of the professional rather than the health of the patient (Rosenthal 1992).

In Sub-Saharan Africa resource shortages have been cited as a major problem affecting the effectiveness of regulatory bodies. In Malawi, although the Medical Council has managed to maintain its basic functions of licensing practitioners, limited funds have prevented it from securing regular patient reporting from private practitioners, or ensuring that practitioners attend refresher courses on an annual basis. Both of these are functions which it is officially responsible for carrying out (Ngalande-Banda and Walt 1995). In Ghana medical and professional councils were established during the 1950s; however it was only during the late 1980s that these bodies started to receive funds from government and operate effectively. The greater the size of the private sector, the greater the resources necessary to ensure effective regulation.

Problems do not lie only with medical councils. Licensing and inspection divisions of government ministries (including the Ministry of Health) tend to be susceptible to corruption (Klitgaard 1988); licences may be granted to the politically powerful or wealthy rather than to those providing satisfactory facilities.

Although government subsidies to private health care providers appear widespread, there have been few attempts to analyse their success. In Malaysia a government programme to encourage private practitioners to offer hepatitis B vaccinations by subsidizing the vaccine foundered when cheaper vaccines became commercially available (Aljunid 1995). In Zimbabwe during the early 1980s vaccines were provided free to private practitioners. However, when it was found that private practitioners were

[8] Medical councils in India are established at the state level.

still charging for immunizations, this programme also ended (Bennett and Ngalande-Banda 1994). It would appear in this case that the agreement between the private sector and government was not sufficiently clear or enforceable. Other subsidies to the private sector often have very poorly defined objectives and are open to capture by influential groups. In Thailand until recently, significant subsidies were being given to the private sector through tax relief on high technology equipment imported from overseas, although increasing the availability of high technology equipment was not in line with official MOH policy. Moreover, the Board of Investment continued to provide corporate tax relief to new private hospitals starting up in Bangkok although the bed to population ratio in Bangkok was already higher than MOH targets (Bennett and Tangcharoensathien 1994).

Some 'enabling' measures seem to have met with more success. Kafle *et al*. (1992) describe a programme of training for private pharmacy assistants in Nepal which would appear to have raised the quality of care provided by pharmacies. Garner and Lorenz (1992) write optimistically about the implementation of a privately organized accreditation scheme in Mexico, although at the time of writing the scheme was not yet implemented.

Despite limited evidence, it would appear that there are systematic problems in the implementation of regulations in both developed and developing countries. Experience with less punitive means to influence private sector behaviour (such as training and accreditation schemes) is perhaps more positive, but much more analysis is required to support this assertion. In conclusion, policies to expand the role of the private sector need to be accompanied by careful thought as to how quality of care in the sector can be assured.

### 7.5 Implications for Government Capacity

A report of a 1991 WHO meeting states that '*Countries often felt that although they have the authority to monitor (private sector behaviour) they do not have the capacity*' (WHO 1991). This assertion was supported by a statement from the Sri Lankan government noting that '*There is adequate provision in the legislation to take regulatory action whenever the need arises. The monitoring mechanisms need further strengthening, the constraint being inadequate funding and personnel*'. The question of information and monitoring is key to the success of regulatory and enabling measures.

Regulation requires that the regulator have sufficient information about the behaviour of health care providers to be able to determine when a violation of legislation has taken place, and moreover to have sufficient evidence to prove that this is the case. Equally, for enabling measures (such as financial incentives for vaccinations) to work, government must be able to determine who deserves payment and how much. Regulation and enabling measures also depend upon a good understanding of the incentives which private providers face and how these can be manipulated.

Considerable individual skills are thus required for effective regulation and enablement. At the level of systems, strong information and monitoring systems are critical. For example, without a database holding basic details of all private providers, many providers will escape the regulatory net. Often such databases in developing countries are poorly organized and out of date. Much regulatory authority tends to be delegated to medical councils. As the behaviour of such councils suggests that they do not always pursue the interests of the consumer, it is important that the MOH carefully monitors their behaviour. It would appear that several governments have under-estimated the resources which effective regulation requires.

There are also several broader institutional factors which are likely to affect the success of regulation and enabling. Dealings between government and the private sector need to be transparent. Government bodies dealing with the private sector must have a clear line of accountability; otherwise it becomes very easy for regulatory capture, or even corruption, to occur. The experiences described above point to the importance of civil society in regulation and enabling. The role of the media (as in Zimbabwe and India) and of consumer organizations (as in India) may be critical to ensuring that private providers offer adequate care.

## 8. CONCLUSIONS AND IMPLICATIONS FOR RESEARCH

This paper has examined the broad arguments for reform of the role of government in health care, as well as actual experience in four specific areas: autonomous hospitals, user fees, contracting with the private sector and regulating and enabling the private sector. Subsequent research in four country case studies (Ghana, Sri Lanka, India, Zimbabwe) will examine these same reforms where possible.

Sections 4-7 of the paper suggest that the extent of country experience with, and consequently analysis of, these reforms is mixed. Implementation of user fees is perhaps the most widespread reform and also the most analysed, and there is now a relatively good understanding of the types of capacities and preconditions necessary for user fee systems to operate successfully. Despite policy statements by both individual country governments and international donors advocating private sector expansion in health care, it would appear that only a handful of countries have implemented policy measures deliberately designed to expand the private sector. These countries tend to be those which previously had the most repressive policies vis-à-vis the private sector. However, many developing countries already have a significant private health care sector and measures in place to influence the behaviour of this sector. There has been virtually no research analysing the success (or failure) of these regulatory and enabling measures.

Experience to date with autonomous hospitals and contracting is quite limited, although preliminary analyses of these experiences are just beginning to emerge. Although extensive contracting arrangements in the form of managed markets are not observed in developing countries, small scale contracting is much more widespread. Reforms creating autonomous hospitals have been undertaken in only a handful of developing countries.

Using economic and institutional perspectives, section 3 of the paper suggested that there were reasons for reforming the role of government in health care. The review of experience would suggest that institutional arguments are at least as important as economic ones: although the overall reforms are driven by a free market ideology rooted in neo-liberal economic theory, neo-liberal theory has little to say about what to do if markets are imperfect. The precise forms which reforms have taken depend far more on a series of institutional concerns (relating to autonomy, accountability, transparency etc).

Understanding of the full range of institutional principles behind reform in the health sector is still relatively weak and could be further strengthened.

One of the features of this paper has been to highlight the great variety in the reforms taking place. This has considerable implications for the country-level fieldwork where it will be essential to specify tightly:

- the service being produced
- the new form of service provision being used
- the institutional context.

Section 4 has started to provide the necessary frameworks for this description (eg. the listing of different forms of contracting, different regulatory and enabling measures etc) but will be added to and revised as the research progresses.

For all of the reforms in the role of government considered above, government capacity to manage the new service provision arrangements has been questioned. The critical elements of capacity important for the organizations(s) involved in the service arrangement were often lacking. For example, skills were often lacking (eg. government officers' ability to negotiate contracting out arrangements, or define appropriate fee schedules). Organizations and systems for performing the new roles, particularly information systems for monitoring, were often undeveloped (eg. accounting systems for revenue collected, information systems for regulating private providers). And resources to fund governments= regulatory and enabling roles (eg. financial resources made available to medical councils), and to develop important elements of capacity through training and infrastructure development, were often inadequate.

The broader external conditions (economic, political, legal) which promote capacity to provide services effectively were often uncertain or vulnerable. For example, the size of the private sector in many contexts places limits on the potential for contracting. The independence of autonomous hospitals from political interference was limited. And the necessary administrative frameworks to allow facilities to retain fee revenue were lacking in a number of countries.

The analysis of capacity presented in sections 4-7 was somewhat eclectic, drawing only upon the incapacities already identified in published studies. In order for fieldwork to provide a more thorough analysis of capacity, an understanding is required of what capacities are necessary to manage the new relationships. Where there exists considerable experience, as in the case of user fees, this is a relatively easy task. In fact section 5.5 already provides a reasonable checklist for the necessary capacities. However, where there is less experience and consequently less understanding of the factors contributing towards the success of a particular reform, the problem is more intractable. For example, with contracting it is currently difficult to say which are important capacities for success: is it the existence of a large private sector, strong negotiating skills in the MOH, good economic analysis in the MOH, strong monitoring arrangements or effective rule of law - or what combination of these capacities? Such an understanding can only be built up over time as documentation of country experience accumulates.

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